

dignity &
rights
ethical treat
respect ca
& equality

GOOD PRACTICE GUIDE

Rights, risks and limits to freedom

Contents

1 Restraint and limits to freedom – what does it mean?	5	Appendix 1: A discussion of the legal issues relating to restraint	33
1.1 Recognising restraint	7	i Introduction	34
1.2 Who is at risk?	8	ii Criminal law	35
1.3 Dilemmas for care staff – differences of opinion	8	iii Civil law	36
1.4 Environmental design	8	iv Legal justifications for restraint	36
1.5 Legislation and regulation	9	v Safeguards	38
2 Using this guidance	11	vi Human rights safeguards	40
3 General principles	13	vii Restraint and the Adults with Incapacity (Scotland) Act 2000	43
3.1 Considering the use of restraint	14	viii Restraint and the Mental Health (Care and Treatment) (Scotland) Act 2003	45
3.2 Direct physical restraint	18	ix Restraint of children and young people	47
3.3 Direct mechanical restraint	20	x Medical treatment and restraint	48
3.4 Locking the doors	23	xi Summary	49
3.5 Wandering technology	26	4 Bibliography	50
3.6 Video surveillance	28		
3.7 Passive alarms	29		
3.8 Medication as restraint	30		
3.9 Indirect limits to freedom	32		

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Restraint and limits
to freedom – what
does it mean?

principles

leadership

dignity &

human r

commun

“We believe that restraint should be seen as a ‘last resort’, where there is absolutely no alternative.”

In its broadest sense, restraint is taking place when the planned or unplanned, deliberate or unintentional actions of care staff prevent a person from doing what he or she wishes to do and as a result places limits on his or her freedom of movement. Restraint is defined in relation to the degree of control, consent and intended purpose of the intervention.

Is there ever any justification for the use of restraint?

Think how you would feel if you were prevented from getting out of your chair or had your movements restricted in some way. Being restrained can be frightening, potentially dangerous and undignified. We believe that restraint should be seen as a ‘last resort’ intervention. It should be used only where there is absolutely no alternative that would reduce an identified, specific risk to the person concerned to an acceptable level. We also think that staff must always be vigilant against unnecessarily restricting the freedom of their clients in other less specific ways.

Many actions by care staff, deliberate or unintentional, can unnecessarily limit the freedom of the people they are looking after. Often these are not in the interests of the individual but in the interests of the care home, hospital or other setting in which the person is being cared for.

The justification given for the use of restraint is to reduce risk to the individual concerned. As a rule we all have the right to take risks in our lives; risk-taking is a part of normal life. Any activity has some degree of risk attached to it, but that risk can change according to our capabilities. There is hardly any risk to a fit and able adolescent when he or she jumps out of bed, but the risk of falling could be high for an older person who has problems with moving around. So, if people have a right to take risks how do care staff strike the right balance between freedom and risk of harm and when should they intervene? Our guidance aims to help with these difficult decisions by providing general guidance and setting out questions that should be considered before embarking on the use of restraint.

We think that as a rule the use of restraint, without the consent of the individual concerned, should only be considered where that person has a significant degree of diminished capacity to understand the risk that he or she is putting themselves or others in e.g stopping a person doing something or restricting access to items which could do them harm. In addition, the risk must be of a degree that justifies such a major intervention in that person's life.

(Here and elsewhere in this document, "individual" means a person with mental illness, learning disability or related condition.)

1.1 Recognising restraint

In situations where a person is being cared for by others, some actions can clearly be recognised as restraint. These can include any direct interference with the bodily movement of an individual, whether by the direct action of another person or by mechanical means; any physical or electronic barriers to freedom of movement in a care setting; and the use of drug treatment to limit physical movement by sedation.

However, 'softer' methods of limiting freedom such as verbal control, psychological pressure or social exclusion can have just as restraining an effect on a person's behaviour as direct physical intervention. Unfriendly, brusque or bullying attitudes by staff do not encourage individuals to ask for help to move to another room, or go to the toilet and can be seen as having a restraining effect on the freedom of movement of the individual concerned. Not providing someone with a walking aid, not providing assistance with using stairs, doors that are difficult to open are, in effect, limiting a person's freedom by failing to take positive action to overcome a disability.

Staff must be sensitive to the effects of their actions. Tightly tucking in a person's bedclothes in a way that restricts movement, or positioning furniture to prevent a door being opened, might be done with good intentions but is in effect restraint. It is also potentially dangerous and frightening to the person concerned. The attitudes and training of staff and the ethos of care in any setting must ensure that:

- care is given in such a way as to recognise what are acceptable risks;
- restraint is minimised and proportionate;
- restraint is used only when there is a clear and unequivocal benefit to the individual.

Some interventions may seem like restraint, but have a purpose other than to control behaviour e.g. postural support or treatment of a medical condition.

Financial restraints are not considered in this guidance but clearly the control of a person's money could have a limiting effect on their freedom to act and on their liberty. Where an individual's access to money is being controlled to limit their freedom of action, then full consideration must be given to the relevant provisions of the Adults with Incapacity (Scotland) Act 2000.

1.2 Who is at risk?

Staff in care homes, hospitals and in community settings do not look after individual people in isolation. There can be many competing pressures on staff to generally 'keep things safe' while carrying out the day-to-day tasks necessary to keep a service running. If a person who is at risk of falling is prevented from, or not assisted in, being mobile it may be easier for care staff but is clearly not in that person's interests. Inactivity is well recognised as having adverse effects on physical and mental well being. Put simply – sitting still is bad for your health. Activity and physical fitness may reduce the risk of falling. When assessments of risk are made as part of a person's care plan it is the risk to the individual that is paramount, not the risk to the care home or hospital in which they are receiving care and treatment.

1.3 Dilemmas for care staff – differences of opinion

Staff face a difficult dilemma when they are attempting to carry out their duty of care and the person concerned is confused, fearful and refusing their help. What degree of intervention is appropriate to make sure that the person is physically well cared for and appropriately dressed? Is it appropriate to physically restrain someone to make them have a bath or to change their clothes? Where a person has fallen and their relatives are insisting that he or she be prevented from freely walking about, staff can feel under considerable pressure to eliminate all risk. Ultimately, there is a balance to be struck between the risks arising from restraint in any form and the risk to the person of not intervening. This guidance points to the importance of careful assessment to understand why someone is behaving in a particular the way, of recognising what the risks actually are and arriving at appropriate interventions in an open and transparent way that has involved all interested parties.

1.4 Environmental design

The design of a residential care setting can have a significant influence on the behaviour of people affected by dementia. A well-designed facility can aid orientation and reduce the kinds of behaviour that lead to interventions that restrict their freedom of movement. National guidance on the management of patients with dementia published by SIGN provides guidance on non-pharmacological interventions including environmental design. The Dementia Services Development Centre at Stirling University produces a number of publications on the design of dementia- friendly environments.

1.5 Legislation and regulation

People using restraint in care settings need to make sure that what they are doing respects human rights, and complies with the law and relevant care regulations. More detail on the legal background in Scotland relating to the use of restraint can be found in Appendix 1.

The Human Rights Act, 1998 makes it unlawful for any public body to act in a way which is incompatible with the European Convention on Human Rights. The Adults with Incapacity (Scotland) Act 2000 provides a legal framework for intervening in the affairs of adults with incapacity. The Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for the treatment of persons with a mental disorder. These pieces of legislation provide sets of principles relating to their operation. It is likely that the use of restraint will be considered only in the care of persons with some degree of impaired capacity and/or impaired judgment arising from what the Act calls "mental disorder". The Mental Welfare Commission believes that the 1998 Act and the principles of the 2000 and 2003 Acts should be seen as the foundation of our guidance on restraint and limits to freedom.

The Independent Regulator of Social Care and Social Work Services across Scotland (the Care Inspectorate) is the body that registers and inspects standards of social care in Scotland using the National Care Standards. These make specific reference to risks, safety of individuals and restraint. It is our intention that this guidance be used by care providers to support the National Care Standards by providing general principles and more detailed comment on specific methods of restraint.

1.5.1 Principles of the Adults With Incapacity (Scotland) Act 2000

Anyone planning an intervention under this law must ensure the following principles are upheld:

Principle 1

The intervention must be of benefit to the individual.

Principle 2

The intervention must be the least restrictive in relation to the person's freedom in order to achieve the desired benefit.

Principle 3

Interventions should take account of the past and present wishes of the adult.

Principle 4

Interventions take account of the views of relevant other parties.

Principle 5

Interventions should encourage the adult to use existing skills and develop new skills.

1.5.2 Principles of the Mental Health (Care and Treatment) (Scotland) Act 2003

Anyone who is providing treatment under this law must take into account:

- The person's past and present wishes about their care and treatment
- The care and treatment that will be of most benefit
- The range of options available for care and treatment of the individual
- The person's individual abilities and background
- The person's age, gender, sexual orientation, religion, racial origin or membership of any ethnic group.

People providing care should also make sure that:

- Any restrictions on a person's freedom are proportionate and the least necessary.
- The person being treated under the act shouldn't be treated any less favourably than anyone else being treated for a mental illness, or other mental disorder.
- Carers' needs are taken into account.
- The person being treated is getting services that are right for them.
- When a person is no longer receiving compulsory treatment, he or she should still continue to get care and treatment if it is needed.
- If the person being treated is under 18, his or her welfare is of the highest priority.

1.5.3 Human Rights Act, 1998

Anyone planning an intervention under this law should consider the following rights:

Article 2

Right to life, where failure to intervene may lead to danger of death.

Article 3

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 5

Right to liberty and security of person. Any infringement of article 5 rights should allow the person right of appeal.

Article 8

Right to respect for private and family life. Any interference with article 8 rights must be necessary and proportionate and in accordance with the law.

Using this guidance

principles

leadership

dignity &

human r

commun

This guidance cannot give definitive answers in every situation. What this guidance aims to do is to help guide thinking on the use of restraint and encourage all care staff to consider their actions and the impact that those actions may have on the people they are caring for. Staff will normally want to do what is best for those in their care. Environmental, organisational and institutional pressures however, combined with poor support and lack of training, can lead to insufficient attention being paid to the rights and needs of individuals.

When assessing risks and considering interventions, care providers must never forget that it is a person, with their own life experiences and their own wishes, who is at the heart of the decision.

This guidance sets out a number of general principles that the Commission believes apply to the use of restraint in any setting. These general principles should be taken into account when restraint is being considered in the care of any person who has a learning disability, dementia or related disorder. The guidance also includes sections on particular types of restraint and interventions that can lead to the freedom of movement and liberty of individuals being limited in some way.

These sections should only be considered in the light of the general principles. The guidance is intended to help health care providers in the preparation of their own policies on restraint. It should be considered alongside the standards produced in Scotland including National Care Standards and Dementia Standards.

General principles

principles

leadership

dignity &

“Life is never risk-free. Some degree of risk-taking is an essential part of good care.”

The following general principles are applicable to all situations in which restraint of a mentally impaired person is contemplated.

3.1 Considering the use of restraint

People who are in hospital, in care homes, or receiving care in the community retain their full human rights, unless these have been restricted by a legal process and then only to the extent allowed by the law.

3.1.1 Individuals should, where possible, always be involved in any discussion of restraint, even where they lack capacity. Almost all individuals will have some ability to express, verbally or otherwise (e.g. by gesture or by signing), their views about how they wish to be treated, or may have expressed their views in the past. Wherever possible and reasonable, the person's informed, free and full consent to any restraining action should be obtained. Any relatives, advocates, welfare attorneys or guardians should be involved in the discussions. In all cases some explanation should be given, at a level the person can understand.

3.1.2 Self-determination and freedom of choice and movement should be paramount, unless there are compelling reasons why this should not be so.

3.1.3 Some degree of risk-taking is an essential part of good care. Each care home, hospital or other care provider should have an explicit policy which determines the balance between a person's personal autonomy and staff's duty to care. The principal aim of any policy should be to avoid restraint wherever possible. *This should be fully discussed by all concerned. Individuals, nearest relatives, welfare attorneys or guardians, legal or other representatives such as advocacy workers, as well as managers and staff need to be fully informed of these policies. They may be briefly explained, for example, in descriptive leaflets, but should be available in full written form. Policies should emphasise the necessity of some degree of risk-taking to allow freedom of action and movement, respect for autonomy, privacy and the dignity of the individual.*

3.1.4 Restraint should never be used to cover any deficiency of service, lack of professional skill, or defects in the environment.

Initial assessment

3.1.5 Assessment of any risks should be a normal part of care planning for each person with mental impairment. These care plans should include strategies to anticipate and manage future risks.

3.1.6 Individuals should be able to expect that any care setting can accommodate his or her normal level of physical activity. Establishing that level of activity is a key aspect of any assessment of risk.

3.1.7 When an individual's behaviour is such that restraint is contemplated, the first step should be to assess why the person is acting in the way that is causing concern and what meaning the behaviour has for them. *This should lead to a full re-assessment of the person's problems, including, in most cases, a medical assessment. Factors such as physical illness, discomfort or pain, side effects of drugs, psychological distress perhaps arising from life events such as loss and bereavement, poor relationships and incompatibility between the person and their carers, other individual or environment all need to be considered. Behavioural problems secondary to psychiatric illness or epilepsy may be particularly difficult to assess and require specialist input.*

3.1.8 All interested parties should be consulted and informed about any intended restraint of an individual. *For example, in a care home this could involve any or all of the relatives, managers, general practitioners, social workers, and community psychiatric nurses. Restraint procedures should be discussed with the local **Care Inspectorate's** Registration and Inspection Team. The relevant National Care Standards for Care Homes must be complied with. Hospitals need clear procedures for informing managers of individual cases where restraint is considered, as well as involving managers in the formulation of policies on restraint. Policies relating to personal autonomy and restraint should be considered by commissioners of services as part of the process of contracting for a service.*

3.1.9 The assessment of the individual's behaviour should include full consideration of the influence of that person's ethnic and cultural background and any consequent communication difficulties. *Staff should have training in the provision of care that is culturally appropriate for individuals from an ethnic minority background. Communication difficulties and/or the provision of culturally inappropriate care could increase the likelihood of confusion and adversely affect behaviour.*

3.1.10 Assessment of a possible need for restraint should always take account of potential distress and increased risk caused by the restraint itself. There are considerable health and safety issues associated with the use of restraint which must be considered fully. *Restraint can increase the level of risk, or add new risks (e.g. expose an individual to hazards created by the behaviour of others which they cannot avoid, or confine him or her in such a way that attempts to escape are potentially harmful).*

3.1.11 Assessment of a possible need for restraint should include an assessment of any possible benefits to the individual, whose interests should be paramount. *By avoiding risks of injury, restraint may, on occasion enhance the freedom of an individual and will sometimes enhance the freedom of other individuals by reducing risks to them.*

3.1.12 It is highly undesirable to restrain a person in a way which causes greater distress than the original problem. *Multi-disciplinary discussion should attempt to predict and understand how the individual is likely to feel if their movement is limited. Any reduction in social contact caused by restraint may, in itself, be distressing, as may the social stigma of 'needing' restraint. It is recognised that some people with learning disability may require brief removal from a situation which they have found over-stimulating or distressing.*

This diversion to a low-stimulus environment should be clearly distinguished from 'time-out' (i.e. a carefully planned intervention which is part of a behaviour modification programme), which should never be instituted without specialist consultation and monitoring.

Acceptable risk

3.1.13 If no remediable cause is found, the next step is to assess the degree of risk inherent in the person remaining unrestrained, remembering that people are entitled to take risks. Only if that risk is unacceptable should further discussion of restraint proceed.

3.1.14 Discussion of the risks that are leading to the consideration of the restraint of an individual, should involve all relevant members of staff on a multi-disciplinary basis. This discussion should include the person in direct charge of the ward or care home and nearest relatives, advocates, welfare attorneys, guardians or other representatives.

“Restraint must never be used as a threat in order to control behaviour.”

Alternatives

3.115 Alternatives to physical restraint should always be considered first. *These may include medical, psychological or other treatments, and/or modifications of observation policy, care regimes, the person's activities, or even buildings. The assessment should pay careful attention to identifying any existing intervention, or aspect of the care environment, that may be a cause of the behaviour for which restraint is being considered.*

Applying restraint

3.116 If restraint is considered necessary it should be the minimum required to deal with the agreed risk, applied for the minimum possible time.

3.117 On each occasion when restraint is applied, a careful explanation should be given to the person, in terms which he or she can understand. *This should include the reasons for the restraint, the way it will be applied, the likely duration, and which staff will be available during the period of restraint. Wherever practicable and appropriate, explanations should be oral, in writing or with augmented communication aids i.e. symbols.*

3.118 Restraint must never be used as a threat in an attempt to control behaviour seen as undesirable by staff.

3.119 During any period where an individual's movements are subject to physical restraint, one or more staff members must be in direct, continuing visual and verbal contact with the person, unless risk assessment has deemed that this is not necessary.

3.120 If it is likely that someone may need regular or repeated use of restraint, legal provisions should be seriously considered (welfare guardianship powers granted under the Adults with Incapacity (Scotland) Act 2000 or compulsory powers under the Mental Health (Care and Treatment) (Scotland) Act 2003).

3.121 Restraint procedures should only be used by staff who have been fully trained in non-restrictive methods of care and also in the methods of restraint. A carer properly trained in restraint procedures may be less likely to feel the need to use them. *Information on training of staff should be available to service users and relatives and should be examined as part of any inspection of the service. Restraint should, where possible, be based on well researched and recognised practice.*

Continuous re-assessment

3.1.22 Any restraint used must be a considered part of the individual's care plan. Its use should follow multi- disciplinary discussion, and be fully described in the care plan, together with the decisions taken and the arrangements for regular review within specified periods of time.

3.1.23 Each episode of restraint must be recorded in a clear standard format and must include a record of the duration of the restraint.

Unplanned restraint

3.1.24 In order to prevent harm in an emergency, restraint may be applied to someone who lacks capacity to consent. Should this occur, it is important that a full explanation and support is offered to the individual as soon as reasonably possible after the event. *Following any emergency restraint, there should be a review of the circumstances which led to the restraint and, where appropriate, a review of the person's care plan.*

3.1.25 All episodes of unplanned 'emergency' restraint must be recorded in the person's care plan and in the care provider's *incident reporting* procedures. The type and duration of these restraints should be proportionate to the likelihood and seriousness of harm.

Monitoring the use of restraint

3.1.26 Managers of care homes, hospitals and community services should audit patterns of restraint use and relevant incidents or accidents. Such audit should inform local policy and practice and must be recorded.

3.2 Direct physical restraint

The following sections refer to the various types of restraint which may be considered in an individual case. In each section, only the specific considerations of the particular method of restraint under discussion are described.

This guidance should be used only in conjunction with the general principles detailed in Section 1.

3.2.1 Definition

Physical restraint is the actual or threatened laying of hands on a person to stop him or her from either embarking on some movement or activity, or following it through. The grounds for intervention are that the person's action is likely to lead to hurt or harm to the person or others, or prevent necessary help being given.

3.2.2 Compulsory powers and the law

The Mental Health (Care and Treatment) (Scotland) Act 2003 authorises the use of compulsory measures where a person's mental disorder makes him or her a risk to his or herself or to others and where the person's ability to make decisions about treatment is significantly impaired. The Adults With Incapacity (Scotland) Act 2000 provides a framework for taking medical, welfare and financial decisions for adults who are unable, because of mental disorder, to make such decisions themselves. The law and restraint is discussed in more detail in the legal section of this document.

3.2.3 Duty to care

It is generally accepted that nurses and other care staff have the same rights as any other citizen in using minimum necessary restraint, either to prevent an offence or to save someone from harm. The duty to care brings additional responsibilities. Staff are expected to behave as professionals, neither neglecting individuals in their care, nor putting them at unnecessary risk.

3.2.4 Guidelines

Direct physical restraint must only be applied under clear guidelines with careful monitoring and review. Best practice would be to have an individual prescriptive plan, accessible to outside observers including relatives and inspection teams. Relatives need to know that risks cannot be totally eliminated, even when a person is in hospital or residential care, and that quality of life factors and the expressed wishes of people may require that risks are taken. Policies on restraint should always be discussed with individuals where possible, and certainly with the immediate family when available.

3.2.5 Restraint in non-health settings

It is sometimes felt, that what might be regarded as acceptable management by qualified nurses, is not necessarily so when applied by persons with different or less in-depth training and qualifications. Support staff in care homes and in the community should recognise however, that their duty to provide effective care and not to put others at unnecessary risk is not dissimilar to the duty of nursing staff to care for patients in hospital. (National Care Standards: care homes for older people, scotland.gov.uk, 2011)

3.2.6 Training

Restraint techniques require to be taught effectively with regular refresher courses. Incorrect use of restraint techniques can lead to injuries. Recognised training in such techniques should, therefore, be an essential part of all nursing and care staff education. Training should also be tailored to the specific needs of particular care groups in order to ensure that the least restrictive methods are always used.

3.3 Direct mechanical restraint

This guidance should be used only in conjunction with the general principles of Section 1.

3.3.1 Definition

The commonest form of direct mechanical restraint in use is the restraining chair and/or belts for people who are mobile, or think they are mobile, but are liable to fall or otherwise injure themselves when they walk or attempt to walk. Other forms of mechanical restraint sometimes considered include limb restrictions, for those who repeatedly harm themselves, and cot sides, or secure sleeping bags for those who are restless at night.

3.3.2 Normal activity

Staff should know how active a person normally is, what form their activity normally takes and what time of day is their most active. Information from relatives or other carers is essential in building a picture of the person's usual behaviour and likes and dislikes. The care plan should include provision for their normal activity.

3.3.3 Assessment

Individuals who are restless or have reduced mobility should have a full physical examination to look for causes and identify effective treatment where possible. Medication should be reviewed, and reduced, increased or changed where appropriate.

3.3.4 Alternatives

In all cases, alternatives to mechanical restraint should be considered first. These include:

- increase in supervised exercise;
- redeployment or increase in staffing for observation and supervision;
- change in the pattern of rest periods in bed;
- provision of engrossing seated activities for the individual or for a group;
- imaginative use of diversional or occupational therapy;
- use of special environments.

3.3.5 Exercise

Active exercise may improve mobility, thereby reducing frustration and distress caused by lack of activity and boredom. This may consequently reduce risk.

3.3.6 Staffing

Many of the repercussions of restlessness and associated risk could be solved by increased staffing levels. Where one person is at considerable risk, or a number of people are at some risk, staffing ratios should be reviewed.

3.3.7 Environment

Environmental factors should be considered including:

- temperature of the ward or home;
- distressing noise levels, including 'background' music and 'background' TV;
- poor lighting;
- restrictive, or oppressive, spaces or decor;
- overcrowding;
- ease of observation.

3.3.8 Safety

The safety of the environment is also important, avoiding:

- big open spaces;
- steps and stairs;
- things to trip over;
- hard and sharp edges;
- hard or rough floors;
- slippery floors.

3.3.9 Special environments

Use of special environments, such as Snoezelen techniques and rooms need further research. These should only be considered following careful assessment of their suitability and if there is benefit to the individual. Some individuals can find them confusing and distressing.

3.3.10 Safety clothing

It is reasonable to consider the use of padded clothing, knee pads, hip protectors, helmets and other safety devices for individuals who like to walk but are in danger of falling. Such safety clothing can in a suitable case enhance freedom, but the possible stigma to the wearer should be carefully taken into account.

3.3.11 Use of night attire to restrict movement

It is never acceptable to use night attire with the purpose of preventing a person from leaving the building. There may be those who choose to wear less formal clothing, and some who, at particular times of day, like to wear night attire. However, this should not be imposed on people. It is potentially stigmatising and confusing.

“It is completely unacceptable that the use of restraint increases the overall risk to an individual.”

3.3.12 Comfort

Any chair that has the effect of restraining a person should look, and feel, comfortable to them. It must therefore be individually fitted for his or her requirements. It should allow a considerable degree of freedom of movement. It should allow the person to engage in eating and drinking and, if possible, in other activities such as reading, or manipulating objects with their hands for diversion. Similarly, a chair should not inhibit someone from being in contact with other people. It should never be a form of seclusion. Individual care plans should set out clearly what is an acceptable length of time for a person to remain seated without an offer of assistance to exercise or to go to the toilet.

Restraining chairs should not be used indiscriminately in hospital wards or care homes and should only be considered following careful assessment and full consultation with relevant others.

3.3.13 Physical disability

Some individuals may have a physical disability as well as mental impairment. Individuals with spasticity or spinal deformity may require a snug-fitting chair with special cushions, pommels and pelvic belts to ensure a good seated position. This may, in turn, improve comfort, reduce the risk of contractures and deformities, and improve independence. Therefore, there are some situations in which a belt can be used as an aid to comfortable seating and safety.

3.3.14 Trays

Trays fixed to chairs should not be used for the primary purpose of restraint. However, trays fixed with Velcro can give a useful surface for someone to eat from, read at or to engage in other selective activities. Trays are likely to feel restrictive and should not be used for extended periods of time.

3.3.15 Limb restrictions

The tying of limbs, or the tying of a person's body into their chair, will inevitably feel very restrictive and should in almost no circumstances be considered. There will always be alternatives to consider. The only possible rare exception would be where someone was specifically in danger of damaging one area of the body (e.g. by severe picking or scratching, or because he or she required intravenous infusion) and it is believed that a temporary use of restraint would result in a longer-term reduction in self-harming behaviour. Special nursing is always preferable to this form of physical restraint.

3.3.16 The use of bed rails (cot sides) and restraint in bed

For people who may be restless at night the use of bed rails or other types of restraint such as 'cocoon' may be contemplated. Again, causes of restlessness and alternative solutions must be sought. The person's perceptions and the possible risks of trying to get out of bed with the bed rails in place should be considered. It is highly likely that the use of bed rails will increase the risk of injury from falling, as the individual must climb higher to get past the obstruction. The options of lowering the bed or putting the mattress on the floor may be perfectly reasonable, if it can be done in a way which is not demeaning to the individual and does not adversely affect comfort.

3.3.17 Risks from restraint

Accidents and deaths have arisen from the poorly planned and inappropriate use of restraint. The risks to the person arising from the use of restraint must be considered. It is completely unacceptable for the use of restraint to increase the overall risk.

3.3.18 Observation

A person who is the subject of any mechanical restraint should be risk assessed regarding whether this restriction can be carried out unobserved. A care plan will then follow from discussion amongst interested parties, reflecting the balance between safety and right to freedom of movement.

3.4 Locking the doors

This guidance should be used only in conjunction with the general principles of Section 1.

3.4.1 Freedom

Freedom to move around and to go where one wants is normal. Any restriction placed on that freedom by others is a serious matter and should only be considered when an individual is: at risk; out and about unsupervised; and has diminished capacity to judge when and where it is safe to go. Consideration must also be given to any potential risks to others.

3.4.2 Deployment of staff

Theoretically, locked doors could be avoided by the presence of sufficient well trained staff who can provide observation, supervision and activities. Realistically this is not always possible, but doors, which normally would be open, should not be locked to cover deficiencies in staff numbers. Within available resources, deployment of staff should be reviewed to allow at least one staff member to have responsibility for supervision of any individuals who might be at risk where there is an open front door. This staff member should perform such duties in a discreet and non-intrusive manner and not act as a 'guard'.

3.4.3 Aids to observation

The use of mirrors and alarms (Sections 3.5 and 3.6) should be considered, especially if they can promote greater independence. However, the technological advances of telecare should never be used simply to make up for deficiencies in observation and supervision by human contact.

“Staff need to consider the balance between the individual’s self-determination and the duty to care.”

3.4.4 Coping with restlessness

Individuals who are restless or wandering need proper medical and psychological assessment, treatment where necessary, and a programme of activities which aims to diminish restlessness. Wandering or ‘purposeful walking’ is not a problem in itself and should not automatically be seen by care staff as such.

3.4.5 Types of locked door

If a door has to be locked there are a number of methods that may be used. Outside doors may have to be locked to outsiders for reasons of safety, e.g. to prevent crime, particularly at night, to ensure privacy and to protect individuals and staff. However, individuals should be assured that all visitors have permission to enter the premises. On the inside of the door there are the possibilities of using double handles, code number pads, ‘slow door’ delayed opening and other special electronic devices, so that staff, visitors and, where appropriate, individuals can use the door. An alarmed open door is a reasonable alternative.

3.4.6 Balance of duty

Staff need to consider the balance between self-determination and the duty to care, without putting individuals at unnecessary risk. Doors should be locked only after careful consideration of individuals’ needs, and when alternatives have been fully explored.

3.4.7 Other individuals

The position of individuals who do not need the door locked must equally be fully considered, so that they can have free access to the outside world. They should have written information and instruction, if necessary, on how to come and go from the care setting.

3.4.8 Sharing information on policy

Policy on door locking needs to be clearly stated at admission and available to staff and visitors. The policy should include information on how the person can come and go freely.

3.4.9 Use of legal provisions

Where someone is repeatedly attempting to leave through a locked door or otherwise protesting, there should be a full re-assessment of the reasons for his or her restlessness and of the care needs, including the need for any specialist input. Use of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000 should always be considered in such a case.

3.4.10 Personal space

Within a care home individuals should, where possible, be able to lock their doors for security of their possessions, and lock themselves in their room for privacy. Key access should always be possible for staff to gain entry if absolutely necessary.

Individuals should never be locked in their rooms.

3.4.11 Design

Wards and care homes for people with dementia or learning disabilities should be designed in such a way that exits are easily observable by staff at all times. Exits should go to outside areas that are in view, e.g. front doors should be visible from the main sitting area. There should be sufficient space to walk about in. Places where individuals walk should not encourage approaches to the exit. They should be spacious and interesting. The long central corridor leading to the front door is an example of poor design. Front doors can be set to one side and de-emphasised. Fire regulations will, of course, have to be taken into account. Wherever possible, front doors should be reserved for the use of patients and their visitors. All care areas should have a safe outside space in which to walk about, such as an enclosed garden or patio, or a large conservatory which individuals should have access to at all reasonable times.

A wide variety of literature and research in good design of care homes and hospital wards is now available. (e.g. Best Practice in Design for People with Dementia, University of Stirling Dementia Services Development Centre, 2007)

3.4.12 Modifications to design

In wards or homes which are locked, serious consideration should be given to modifying the design to help avoid having to lock the door.

3.4.13 Locking doors in the person's own home

Relatives who provide care for an adult in their own home, either solely or as part of a package of care, may decide to lock internal or external doors. Where this is done, there should be an assessment carried out, considering the risk to safety of the individual leaving versus the risk of not being able to get out if necessary. In some cases, this may be authorised by guardianship powers. However, in others there may be no such powers. Where the individual finds this repeatedly distressing, a risk assessment should be undertaken to determine whether this is appropriate.

It may be that this action introduces new risks. In these circumstances, the adult may require an increase in level of available support. Evaluation of this form of restraint should take into account the unique circumstances of the adult, weighing up the advantages against any possible breach of human rights.

3.5. Wandering technology

This guidance should be used only in conjunction with the general principles of Section 1.

Increasingly, technology is being used in care homes, hospitals and domestic settings to assist people with impaired capacity, to function as independently as is practicable. Previous editions of this guidance referred to the use of electronic 'tagging' in the care of people with dementia or learning disabilities. The term 'tagging' is often associated with the criminal justice system and with surveillance, shoplifting and the prevention of crime. Global positioning systems are used in conjunction with electronic tags as alternatives to imprisonment or to monitor potentially dangerous offenders.

The use of electronic tagging described here is in relation only to care settings and is unrelated to any aspect of the criminal justice system. The term 'wandering' suggests aimless walking. Sometimes this may be the case, but it is more likely that the behaviour has some meaning for the person concerned. It is important to recognise where the person is trying to go and that walking to particular destinations of interest will be of benefit to the person. To be prevented from making your way to somewhere you wish to be can be very distressing, particularly in the context of confusion and impaired memory. It is very important to recognise that wandering is not necessarily negative, and that the person must be enabled to walk as freely and safely as is possible.

The Commission has produced specific guidance on the use of wandering technologies. 'Safe to Wander', 2007 can be downloaded from www.mwcscot.org.uk.

3.5.1 Definition

Tagging is an emotive term when used in care settings and we choose to refer to 'wandering technology' as it better reflects the purpose of such equipment. Wandering technology involves the attachment of an electronic device to a person or their clothing, so that if they pass across a particular boundary an alarm goes off, and staff are somehow alerted. Wandering technology can also involve tracking devices which can locate the wearer if he or she becomes lost or fails to return.

3.5.2 Assessment

As set out in the general principles of this guidance, prior to the use of any form of wandering technology there must be a full physical and psychological assessment: to identify the cause of the person's wandering behaviour; to consider alternatives; to consult with others; to look at the legal and ethical implications; and as part of an agreed and regularly reviewed care plan.

3.5.3 Freedom

Here again, it must be stated that going outside the boundaries of the care home or hospital will not be a problem for many individuals.

Freedom of movement is the norm and any restriction of that freedom by others is a serious matter. Restriction should only be considered when an individual is at risk out and about unsupervised and where he or she has diminished capacity, to the extent that judgement about his or her own safety is impaired.

3.5.4 Extent of use

Wandering technology should not be considered unless a particular individual is at serious risk from wandering and where all alternatives have been tried and failed. It is highly unlikely that all, or even a few, individuals in one unit would have a device applied. The use of wandering technology devices must be enabling to the wearer, not limiting.

3.5.5 Freedom of movement

Individuals, in whose care wandering technology is being applied should, in all cases, have their freedom of movement and choice of activity enhanced, not diminished, by the procedure. If this is not the case, the technology could be seen as an unwarranted invasion of personal liberty.

3.5.6 Care plan

Wandering technology should never be the only element of a care plan. It should be part of a wider plan which also addresses the person's need for movement and activity in a positive way.

3.5.7 Visibility

If wandering technology is found to be necessary for certain individuals, it should be discreetly applied, so that the individual is not 'labelled'. Furthermore, to be effective, it needs to be small, comfortable and unobtrusive for the benefit of the person. A visible, uncomfortable device is likely to be undignified, stigmatising and rejected.

3.5.8 Individual attention

Wandering technology should not be an excuse to ignore a person. If attention is only paid to individuals when they breach the boundary of the care area, it is almost inevitable that they are getting the wrong kind of attention and missing the attention that they require. Attention at the boundary might even encourage wandering by bringing a reward.

3.5.9 Discretion

Breaching the boundary need not inevitably lead to restrictive action by staff. In many cases it may simply lead to discreet observation, allowing the individual to return of his or her own volition, or to staff engaging the person in some outside activity, such as going for a walk.

3.5.10 Guidelines

For each individual case, the procedures and responsibilities for responding to the alarm must be clearly worked out and recorded in the care plan.

3.5.11 Temptation to over-use

Wandering technology should not be used just because it is available. It is perfectly acceptable to have a wandering technology system which is not in active use by any individual at a particular time.

3.6 Video surveillance

This guidance should be used only in conjunction with the general principles of Section 1.

3.6.1 Definition

Video surveillance is sometimes considered to assist observation of common spaces, such as day rooms and corridors, of boundaries such as doors, and, less often, of individuals' private spaces.

3.6.2 External security

Video surveillance is sometimes used for external security of care premises to prevent crime and in this context is perfectly acceptable. It could also be used to help locate individuals who have gone beyond the boundary of the care area, for example, in association with the use of wandering technologies. This again may be acceptable as long as the general principles of restraint and the considerations below are applied.

3.6.3 Monitors

Video surveillance could only be effective if a member of staff attends a monitor at all times of risk. In most cases, this is likely to be undesirable. The staff member would be better employed in direct contact with individuals. Monitors placed in staff rooms, nursing stations or reception desks will inevitably compete for the attention of staff involved in their normal duties and activities.

3.6.4 Court ruling

In a fatal accident inquiry at Airdrie Sheriff Court in 1991 the Sheriff suggested that video surveillance in unmanned corridor areas could increase safety and was acceptable, if it did not impinge on the privacy of individuals. However, the Commission is of the view that individual privacy is paramount and video surveillance should not be used in private living areas such as bedrooms, bathrooms or toilets.

3.6.5 Design and staffing

A care unit which has significant public areas, such as corridors or reception areas, which are not easily visible to care staff should consider whether alterations to design are possible and should review staffing ratios.

3.6.6 Accidents

Video surveillance and passive alarms are unlikely to prevent individual accidents, since most of these happen very quickly, though it could be argued that immediate awareness of an accident can bring help sooner.

“Care of people with a mental disorder is best carried out through human interaction.”

3.6.7 General effects

Unlike other methods of restraint, video surveillance is indiscriminate. It is most unlikely that more than a few individuals in any care unit would require such observation. The potential intrusion into the privacy and freedom of other individuals needs to be carefully considered when video surveillance is contemplated. The consent of all individuals involved should be sought wherever possible.

3.6.8 Temptation to over-use

If surveillance is available it is likely that there may be a temptation to rely on it excessively and see it as ‘labour-saving’. This is undesirable. The care of individuals is best carried out through human interaction.

3.6.9 Individual surveillance

Video or microphone surveillance in a person’s private living space is unlikely to be justified, given the considerations above. However, there may be unusual circumstances where, if possible with the person’s consent, such surveillance can be seen as enhancing the person’s freedom of movement and choice. While this may be considered as part of a wider care programme, the problem of monitoring, the absence of personal contact and the intensive nature of the surveillance all argue against its use. In particular, it must only be undertaken where there is the proper legal authorisation in place, e.g. authorisation via a guardianship order with the specific power to use CCTV in respect of the individual’s welfare.

(MWC joint position statement on use of CCTV in collaboration with SCSWIS and the Scottish Human Rights Commission, http://www.mwcscot.org.uk/media/90969/joint_statement_on_the_use_of_cctv_in_care_facilities.pdf).

3.7 Passive alarms

This guidance should be used only in conjunction with the general principles of Section 1.

3.7.1 Definition

‘Passive alarms’, including pads under mats beside the person’s bed or at bathroom or external doors, and infra-red alarms, are being increasingly used in care homes. Infra-red alarms can be programmed to be alert to a person’s specific habitual actions. A passive alarm, signaling a particular individual’s movements, is a less restrictive option than video surveillance and may be more easily justified, as long as the general principles on restraint are followed.

3.7.2 Monitoring the alarm

'Passive alarms' are only effective if staff are available to attend when the alarm sounds. Alarms should be discreet and should cause the minimum possible interference to other individuals.

3.7.3 Accidents

Passive alarms are unlikely to prevent individual accidents, since most of these happen very quickly, but immediate awareness of an accident can bring help sooner.

3.7.4 Information to the individual

In all cases where passive alarms are used as part of a care plan, the individual and relevant others including relatives, advocates, welfare attorneys/guardians or other representatives, should be informed as fully as possible of their existence and the consequences of crossing the boundary. There should never be any sense of threat in this information.

3.8 Medication as restraint

This guidance should be used only in conjunction with the general principles of Section 1.

3.8.1 Definition

This is the use of sedative or tranquillising drugs for purely symptomatic treatment of restlessness or other disturbed behaviour. Drug treatments for medical or psychiatric conditions which underlie the disturbance are not included. For example, an antidepressant may be prescribed to treat a person who is suffering from depressive illness, one of the symptoms of which is agitation. It must be recognised, however, that the boundary between these two methods of drug use is not always clear. For example, it is sometimes postulated as a justification for tranquilliser use that restlessness is due to an underlying, but unidentified, distress.

3.8.2 Assessment

A full and clear multi-disciplinary assessment of the symptoms of disturbance and their causes is essential before drug treatment of disturbed behaviour is considered. Any drug treatment used should be for a specific purpose after such full assessment. (Scotland's National Dementia Strategy, Part 14, VI, section 95, 2010)

3.8.3 Alternatives

In most cases drug treatment can be avoided unless there is a clear underlying cause, such as a medical condition, depression, fixed delusions, severe anxiety or emotional lability.

3.8.4 Monitoring

Whenever a drug treatment is used, frequent medical monitoring of the dosage and its continuing need must be carried out for as long as the drug is prescribed. It is essential, therefore, that the individual, and as far as possible, informal and formal carers, know the reason for the prescription and the signs of its success.

3.8.5 Side-effects

It is vital that all concerned are fully aware of potential side-effects. Most tranquilliser and sedative drugs have a range of side-effects which need to be carefully monitored. These side-effects may include restlessness, which can lead staff to feel mistakenly that an increase in drug dosage is required.

3.8.6 Medical responsibility

For all these reasons, the prescribing doctor should be closely and continually involved with any person who has been given sedative or tranquilliser drugs over a period. Staff need to have easy access to a doctor on call.

3.8.7 Individual variation

There are enormous variations in individual responses to drugs and in some cases a process of 'trial and error' will have to be used. Again, the role of the doctor is central to this.

3.8.8 Consent

There are many circumstances when a person will consent to drug treatment for distressing restlessness. In other cases the person may be incapable of giving consent, but is not obviously objecting to the treatment. Welfare attorneys and welfare guardians appointed under the Adults with Incapacity (Scotland) Act 2000, if granted the power, may give consent to certain treatments. Part 5 of the Adults with Incapacity (Scotland) Act 2000 makes provision for the medical treatment of adults with impaired capacity. Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for the treatment of mental disorder. In cases where a person with a mental disorder is incapable or refuses to consent to tranquillising or sedative drug treatment, and the treatment is considered necessary, the use of the 2003 or 2000 Acts must be considered.

3.8.9 'Disguised' or covert medication

The giving of medication, for whatever reason, without the consent or knowledge of the individual is potentially an assault and should only be considered in exceptional cases. The Mental Welfare Commission has produced separate guidance on the covert use of medication (Covert Medication, 2006).

3.8.10 Intermittent disturbance

Much disturbed behaviour is intermittent rather than constant. It is not generally good practice to give a long-acting depot drug for disturbed behaviour which happens only occasionally. It is preferable that staff learn how to anticipate episodes of disturbed behaviour and defuse the situation, or divert the person into other activities.

3.8.11 Control of drugs

Tranquillising and sedative drugs are potentially poisonous and open to abuse by patients and others. It is vital that all care settings have a system of individual prescription and recording of administration and stock control under the supervision of managers, pharmacists, doctors and inspection teams, in accordance with the relevant legislation and guidance.

3.9 Indirect limits to freedom

This guidance should be used only in conjunction with the general principles of Section 1.

3.9.1 Restraint by default

Examples of restraint by default include the individual's movement being limited by deliberately not being provided with walking aids or a wheelchair, not being assisted with stairs or where there is no lift. These indirect actions must be recognised as restraint and be subject to a full process of assessment and review. Such interventions are highly undesirable and should only be considered in the context of the person's wider care and then only when it is clearly in their best interests.

3.9.2 Restraint as a result of interpersonal control by staff

Verbal control by staff, such as distracting someone who is trying to leave the home or being 'guided' without physical contact, can be considered restraint when regularly used as a method of controlling the person's desired actions. These interventions may be the least restrictive intervention and may be preferable to more restrictive methods of controlling behaviour. However, where such interventions are regularly used then they should be considered as a form of restraint and be fully assessed and discussed as part of the plan of care.

Appendix 1

principles

leadership

dignity &

human r

commun

A discussion of the legal issues relating to restraint

i. Introduction

Anyone using restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings. This section looks at when the use of restraint can be lawful and the requirements the law imposes.

There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a hospital or care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 and implied under the Mental Health (Care and Treatment) (Scotland) Act 2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers.

The European Convention on Human Rights has had a major impact. The law must now be read in light of human rights requirements. A public authority, such as a hospital or care provider must, act in accordance with human rights.

The term 'restraint' encompasses a range of actions intended to limit the ability of a person to do something which another person or persons (in this context either care or hospital staff) consider undesirable.

ii. Criminal law

Restraint exercised without legal authority may be a criminal offence. In these circumstances the individual carrying out the restraint may face prosecution as well as disciplinary action. Prosecution is the responsibility of the Crown, exercised through the local procurator fiscal. Any decision to prosecute will depend on the evidence available and whether or not this would be in the public interest.

Criminal cases involving restraint have been rare in Scotland. There would not normally be a criminal prosecution, unless the restraint goes beyond what most care professionals would accept as justified. However, improper use of restraint could constitute a crime under a number of legal provisions:

Assault

Assault is a 'common law' crime. This means that it is not defined in any Act of Parliament. Instead, a judge or sheriff decides whether particular actions in a particular case constitute an assault. Any physical act which causes injury, affront or harm to the victim could constitute an assault if there is no lawful justification for its use. Actions such as holding or tying a person down, or threatening or intimidating gestures could be viewed as assaults. Assault committed by a person in a caring role is particularly serious and might be prosecuted as 'aggravated assault'.

Unlawful detention

It is a crime to detain a person against his or her will without legal authority. Clearly some forms of restraint could constitute 'detention' and so need legal authority. (See below). There is a common law power to detain persons of unsound mind who are a risk to themselves or others until a 'warrant is obtained', but this is not available to people or agencies who have statutory powers to detain people available to them¹.

A doctor or hospital should normally use the provisions of the Mental Health (Care and Treatment) Act if someone needs to be detained in a hospital or community setting. Other people or agencies should detain only for as long as may be reasonably necessary to allow the proper authorities to intervene.

Cruel and unnatural treatment

This common law crime encompasses a range of activities, such as refusing to feed a person, or acting in a way incompatible with his or her human dignity. The treatment would have to be something generally agreed to be outside the accepted norms of caring for vulnerable adults.

¹ *B v Forsey* 1988 SLT 572(HL).

Adults with Incapacity (Scotland) Act 2000

Section 83 of this Act makes it an offence for anyone exercising powers under the Act to ill-treat or wilfully neglect a person with mental incapacities in his or her care.

Mental Health (Care and Treatment) Act 2003

It is an offence for anyone employed in, or providing services to, a hospital or providing care services to ill-treat, or wilfully neglect anyone under his or her care. This is regardless of whether the person is subject to an order under the Act.

iii. Civil law

Inappropriate restraint may also give someone the right to claim damages, and/or ask for a court order preventing any future unlawful restraint. This will normally be on the basis that there has been a breach of a duty of care.

A civil case can be started even if there has not been a criminal prosecution. It is easier to prove a civil case, in that a wider range of evidence is admissible, and the standard of proof is lower. Civil cases are decided on the 'balance of probabilities' while criminal cases need to be proven 'beyond reasonable doubt'.

Civil legal action will normally be against the employer, not the staff member alone, unless the employee has acted in a way that was inconsistent with his or her contract of employment.

Even where restraint is justified, there could be a civil case if the restraint caused harm unnecessarily or took place for too long. If it is foreseeable that restraint may be necessary, the law would expect that there would be a risk assessment, the restraint should form part of the person's care plan, and that staff will have received proper training.

iv. Legal justifications for restraint

Even if restraint is justified, it must not be for longer, or involve more force than is reasonably necessary.

Self defence

The common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm.

No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law.

Necessity

The common law also allows someone to restrain another person if this is necessary to prevent immediate harm to others or serious damage to property, or to stop someone from committing a crime. This could include stopping someone harming him or herself. The level of restraint must be reasonable, and the restraint should continue only for as long as is necessary to bring the situation under control. (Any further restraint to punish the person is not justified.) What is a reasonable or unreasonable length of time depends on the particular circumstances of each case.

In a Scottish case before the House of Lords, the court said the use of such powers in hospital should only be where someone *'is a manifest danger either to himself or to others'*. The use of restraint by a private individual should be *'temporary'* until the person can be *'handed over to the proper authority'*. A doctor or nurse should use the Mental Health (Care and Treatment) Act rather than common law powers if the restraint amounts to detention². (See part 6 for detention.)

Duty of care

If a learning disability, mental illness or related disorder puts someone at risk, carers may have a legal duty to restrain the person in his or her own interests. Where someone takes on a caring role, he or she owes a 'duty of care' to the person. This means that the carer must do what is reasonable to protect the person from reasonably foreseeable harm. If someone's actions could put other people at risk, staff have a duty of care to restrain the person to prevent harm. The hospital managers have health and safety duties to ensure the protection of their staff.

The courts in Scotland have accepted that nurses have a duty to use reasonable force to 'control' a patient with a mental illness, learning disability or related condition, for the person's protection or to protect other patients. The force they use should be the minimum necessary and should not go beyond what is normal or permissible good practice³.

Consent

A person may consent to restraint or limits to freedom because he or she understands that he or she is at risk. The consent is valid only if the person is mentally competent to take the decision. It is not valid if the person is put under undue pressure to consent or if the restraint is excessive, cruel, unnatural or unnecessary in the circumstances. Where consent is variable, it should not be assumed.

In some cases consent may be implied. It may be possible to rely on implied consent if the person has the legal capacity to object, is free to leave and accepts the limits to freedom. Any undue pressure would remove the presumption of implied consent.

² *B v Forsey* 1988 SLT 572(HL).

³ *Skinner v Robertson* 1980 SLT (Sh Ct) 43. *Norman v Smith* 1983 SCCR 100.

A person concerned about the use of restraint might wish to make an advance statement or personal statement giving information about how best to treat or respond to certain behaviour symptoms. This might help avoid the need for restraint in the future.

No one can consent to the use of restraint on behalf of another person, unless he or she has specific powers, granted by the court to take such a decision under the Adults with Incapacity Act. (See below.)

v. Safeguards

Restraint must be justified

Any person using restraint has to be able to justify it in a court of law, if necessary. However, in a civil case, even if the restraint was admitted, the pursuer would still need to show it was a breach of duty of care. On the face of it, restraint should be legally authorised, proportionate and necessary. It is for the person using it to justify both the use of restraint and the way in which he or she used it. This is a requirement of the common law and the European Convention on Human Rights.

If restraint is excessive, unnecessary, degrading or unnatural, the courts are likely to regard it as an assault as well as a breach of human rights. Those involved could face criminal prosecution.

Care standards

Registered establishments, such as residential care homes and nursing homes, must comply with the reasonable requirements of the Care Inspectorate and any relevant care standards, insofar as they are within the scope of the registration legislation.

The managers of care services owe a duty of care to individuals to ensure that staff operate any restraint properly. This involves having a policy about the use of restraint and the recording of incidents, spelling out in the person's care plan how restraint might be appropriate and ensuring that staff called upon to restrain someone have proper training and qualifications.

Regulations made under the Regulation of Care (Scotland) Act 2001 deal with care providers' use of restraint⁴. These regulations apply to care home and day care services, but not NHS hospitals. The regulations stress the importance of treating clients with dignity and respect⁵.

No client is to be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or of other clients.

⁴ The Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, SSI 2002/114.

⁵ SSI 2002/114, reg 4.

Staff must record the use of restraint in the client's personal file. The person providing the care service must keep a record of each occasion on which restraint/control is used, giving details of the form of restraint/control, the reason it was necessary and the name of the person authorising it⁶.

The National Care Standards similarly state that staff will explain, justify and record any limits on the person's independence in his or her care plan and will review the plan regularly⁷. Restraint should be a last resort (unless it is legally required).

Standards in NHS

Standards in the NHS are matters of 'clinical governance', the responsibility of the health board and hospital management. All hospitals and community health facilities in Scotland should have policies on the use of restraint, covering its use, training of staff, reporting etc⁸. NICE guidelines in England and Wales give detailed good practice guidance⁹. In Scotland, there is the Management of Patients with Dementia - Scottish Intercollegiate Guideline Network, SIGN 86(2006) and Care Inspectorate¹⁰.

Professional standards and guidance

Most people working in care homes and hospitals are subject to professional standards. Professional standards may cover the use of restraint. All professionals will need to ensure that they can justify any decision to use restraint in the light of their professional and ethical standards.

Contractual obligations

Any establishment providing services under contract to a local authority must comply with the terms of the contract. The local authority might impose requirements about proper policies on restraint, reporting, recording etc. Similarly, if a local authority chief social work officer delegates certain of his or her guardianship powers to a care home, he or she should monitor how these powers are exercised and should be clear that the establishment's rules on issues such as restraint are appropriate.

Health and safety issues

Employers have a legal responsibility to take reasonable steps to secure the health and safety of their workforce, and are obliged to undertake risk assessments of potential hazards. Employers must anticipate situations where clients may cause risks to staff, and devise appropriate methods to minimise these. These duties reinforce the requirement for employers to train staff in safe methods of restraint where necessary.

⁶ Regulation 19(3).

⁷ National Care Standards care homes for people with mental health problems Scottish Executive December 2001 (revised March 2005), care standards 6.2, 17.

⁸ NHSScotland *Managing health at work partnership network guidelines*, Scottish Executive 2004, guideline 6.

⁹ National Institute for Clinical Excellence, *The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments* February 2005.

¹⁰ *Safe care: consideration of the recommendations from the inquiry (England) into the death of David Bennett* Scottish Executive Health Department 17 December 2004. Also Management of Patients with Dementia - Scottish Intercollegiate Guideline Network, SIGN 86(2006) and Care Inspectorate

Limits to common law

If someone is likely to need restraint on a regular basis as part of a care package, those involved should consider applying for specific powers in a guardianship order under the Adults with Incapacity Act – or a compulsory treatment order under the Mental Health (Care and Treatment) Act. The person should have the rights of appeal to the courts or the Mental Health Tribunal and recourse to and monitoring by the Mental Welfare Commission available under those Acts.

The Scottish Law Commission recommended someone exercising extensive informal controls over someone's life on a regular basis should seek an Adults with Incapacity Act order¹¹. Regular use of restraint is exercising extensive controls. If restraint could amount to a deprivation of liberty within human rights law, an order is essential. See below.

Reporting of incidents

Any injury caused during the use of restraint should be the subject of critical incident review locally and serious injuries should be reported to the Mental Welfare Commission. The Commission has, together with the Care Inspectorate, established a protocol for reporting incidents (Notifying the Commission, mwscot.org.uk).

vi. Human rights safeguards

Human rights law is increasingly important in considering matters such as the appropriate use of restraint.

Courts in Scotland can hear arguments about, and make decisions based on, the European Convention on Human Rights.

Under Article 2 of the ECHR¹², the NHS has a positive duty to protect life against the risk of suicide of psychiatric patients. While there are differences between detained and voluntary psychiatric patients, these should not be exaggerated. (*The case of Rabone v Pennine Care NHS Trust*)

Article 3 of the ECHR prohibits inhumane and degrading treatment. Poor practice in restraint could fall within this category. If treatment is inhumane and degrading, it is not a defence that it is necessary for the person's protection.

The use of restraint could also be challenged under Article 8, respect for private life. Article 8 permits interference with someone's autonomy if this is lawful and necessary for public safety, the protection of health or the protection of others. Any of these might be a justification for the use of restraint. Staff should tell the person why he or she is being restrained, if possible.

¹¹ *Report on incapable adults*, para 2.53

¹² The European Convention on Human Rights, Fourth protocol, Article 2.

Article 5 would also allow a challenge in relation to deprivation of liberty/ unlawful detention.

Under Articles 5 and 8 however, there could be a justifiable interference with human rights, provided the interference is lawful, proportionate and necessary. Under any circumstances, however, the individual must be treated with dignity and respect.

The common law can give legal authority but it must be consistent, clear and accessible¹³. Clear policies can help to provide such clarity and consistency. If a public authority has no such policy, this could be open to challenge on human rights grounds¹⁴. Staff should always know under what legal authority they are acting when restraining someone.

Any restriction of someone's liberty should be in proportion to the risk posed. There should be good reason for it and evidence that other options have been considered. Even if the use of restraint is justified, it will become unlawful if the methods used are excessive or if it continues for longer than necessary. Therefore, regular review should be a key part of the process.

Restraint and detention

Article 5 gives the right to the liberty and security of the person. There is an exception for people of 'unsound mind', who may be detained in the interests of their health and safety or that of others. There must be objective medical evidence that the person is of 'unsound mind'. The person's condition must justify compulsory detention and the condition must persist throughout the detention¹⁵. The detention must be in accordance with a procedure prescribed by law. (Less stringent requirements apply in emergencies, although a doctor should see the patient as soon as possible.)

If restraint could constitute 'detention', those involved should seek legal authority for the detention, under either the Mental Health (Care and Treatment) Act or through under the Adults with Incapacity Act. Reliance on common law powers is unlikely to satisfy the ECHR requirements of due process. The difference between restraint and detention is a matter of degree. There is no difference in the nature or substance of the controls. The law says restraint is a restriction on someone's liberty and detention is deprivation of liberty. Regular and consistent restraint may amount to detention.

Whether someone has been deprived of his or her liberty depends on the specific situation of the individual concerned. The court takes account of a range of factors such as:

- The degree and intensity of the controls over the person's movements.
- For how long these controls are likely to be necessary.

¹³ See *HL v UK* (2004) ECtHR 471 at para 116. (The 'Bournewood' case.)

¹⁴ *R v. Ashworth Hospital Authority ex parte Munjaz* (2005) UKHL 58.

¹⁵ *Winterwerp v the Netherlands* (1981) ECHR 7.

- The intentions of those controlling the person. If the intention is to stop him or her from leaving, there may be a deprivation of liberty even if the person does not attempt to leave or staff persuade him or her not to leave.
- How the controls are used. Physical restraints can amount to detention, as can the use of sedation and observation.
- What access to the outside world the person is likely to have, including access to family and carers.
- Whether the person is likely to attempt to leave. If someone attempts to leave and staff stop him or her, this is likely to be a deprivation of liberty. It is more complex if the person does not attempt to leave or makes an 'uninformed' attempt to leave, perhaps of not understanding where he or she is or where the door leads.
- Whether the cumulative effect of restrictions could amount to detention¹⁶.

Legal advice may be necessary as to whether arrangements amount to detention.

Arrangements which involve restraint to a certain degree, yet aim to give someone the maximum freedom consistent with any limitations because of the person's disability, may not constitute a deprivation of liberty but may be seen as respecting the person's right to life and health. The courts in England have said that restrictions primarily for the benefit of the person, as opposed to protecting the public, might not be deprivations of liberty¹⁷.

In conclusion, to ensure that the use of restraint complies with human rights law:

- Restrictions on a person's liberty should be necessary in the circumstances;
- If a person is shown to have a genuine mental disorder, the European Convention on Human Rights recognises that he or she may need restraining either in his or her own interests or to protect others;
- Any restrictions should be reasonable and should last only as long as necessary;
- If there is a complaint, the court will investigate whether the use of restraint was both in accordance with good practice and appropriate in that particular case;
- The person should have the reasons for the restraint explained to him or her;
- If the use of restraint could amount to detention, legal authority will be necessary under either the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act.

Those exercising restraint, therefore, will have to be prepared to justify their policies and their use of such policies in individual circumstances. They will need to obtain specific legal authority for any restraint tantamount to detention. In all other cases if the use of restraint is in accordance with generally agreed good practice, it is unlikely that there would be a breach of the European Convention on Human Rights.

¹⁶ *HL v UK* (2004) ECtHR 471 at para 89.

¹⁷ *R (Secretary of State for the Home Department) v Mental Health Review Tribunal* (2002) EWCA Civ 1868; *R (G) v Mental Health Review Tribunal* (2004) EWHC 2193.

vii. Restraint and the Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity Act provides a comprehensive framework for taking medical, welfare and financial decisions for people who are unable, because of mental disorder, to take such decisions themselves.

'Incapacity' means someone is not able to make decisions or take actions about the particular matter in question. A person may be incapable because he or she cannot act, make a decision, understand the decision, communicate or retain the memory of the decision. The test relates to the decision which has to be taken. Someone may be able to decide, for example, what he or she wants to wear, but if the person is not able to act to protect his or her own welfare, he or she would fall within the ambit of the Adults with Incapacity Act for this purpose.

The Adults with Incapacity Act does not do away with the existing law, such as on duty of care, self-defence, necessity etc. The Act does not deal specifically with restraint, but if someone is unable to take decisions on such matters him or herself and there is a need to get legal authority to restrain him or her, the Act may allow those involved to apply for an order authorising restraint.

The Scottish Law Commission (Discussion paper on Adults with Incapacity) are currently looking at some of these issues and in particular deprivation of liberty in residential establishments.

Adults with Incapacity Act Principles

The Adults with Incapacity Act sets out the general principles which should apply before there is any intervention under the Act. These principles represent agreed good practice. They could usefully form part of any restraint policy. Any court hearing an application under the Adults with Incapacity Act will consider the application of the principles. A guardian or attorney appointed under the Act must comply with the principles.

These principles, which are set out in Part One of this Guidance, are very important. People acting under the Adults with Incapacity Act have legal protection from liability if they act in accordance with them. If they do not, that protection fails¹⁸.

Medical treatment

If someone is incapable of taking medical decisions, the doctor or health professional treating him or her will have a general authority under Part 5 of the Adults with Incapacity Act to do what is reasonable to promote or safeguard the person's mental or physical health if he or she signs the necessary certificate of incapacity.

¹⁸ Adults with Incapacity (Scotland) Act 2000, s82.

The health professional cannot use force or detention unless this is immediately necessary and only for so long as necessary¹⁹. If ongoing restraint or detention is indicated, he or she should consider seeking an order under Part 6 of the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act where appropriate²⁰. An example would be where someone in community facilities needs restraint in connection with the giving of care such as washing or dressing. An Adults with Incapacity Act order might be appropriate. An order under the Mental Health (Care and Treatment) Act would not be appropriate, as the treatment is not for 'mental disorder'. A health professional can give medical treatment to someone unable to consent to treatment (authorised by a section 47 AWI Act certificate) even if the person objects to or resists the treatment. However, if the person is likely to object on an ongoing basis, the health professional should consider an order under the Adults with Incapacity Act or Mental Health (Care and Treatment) Act. See also Right to Treat, 2011.

Restraint and guardians

The Adults with Incapacity Act is not clear how far it is appropriate for a welfare guardian to use force, restraint and/or detention if an adult does not comply with the guardian's instructions. This contrasts with the Mental Capacity Act for England and Wales, which clearly limits the circumstances in which a guardian (called a 'deputy') can use force or restraint²¹.

Part 6 of the AWI Act Code of Practice does not envisage the use of force or detention by guardians. It says that on occasions a guardian, paying heed to the principles of the Act and having sought additional advice, may have to 'insist' on having his or her way, but it links the use of compulsion to the enforcement procedures in the Act²².

It suggests, a guardian may wish to seek directions from the sheriff under section 3(3). There is also a right to apply to the sheriff under section 70 of the Act for an order compelling the adult to comply with the decisions of the guardian.

It may be that the law should draw a distinction between local authority guardians and private guardians for these purposes. A private guardian who is a carer may be able to rely on common law powers and duties to restrain the person. The law is less happy with statutory bodies relying on common law powers, particularly when a statutory code is available²³.

¹⁹ Adults with Incapacity (Scotland) Act 2000, s47(7).

²⁰ The Part 5 Code of Practice mentions the possibility of Mental Health (Care and Treatment) Act orders, but not guardianship orders in this situation (para 2.55). A local authority has duties to apply for an order if needed to protect the person's interests. Adults with Incapacity (Scotland) Act 2000, s57(2).

²¹ Mental Incapacity Act 2005, s20.

²² Code of practice. Adults with Incapacity (Scotland) Act 2000 6.61, 6.76

²³ *B v Forsey* (above) and *HL v UK* (above).

Applying for power to restrain

It would be good practice for any prospective guardian envisaging the use of restraint, force or detention to refer to this specifically in the guardianship application. Such significant limitations on the adult's civil liberties should be explicit, not implied in a general grant of powers to take all welfare decisions for the person.

Where the chief officer of the local authority is guardian, he or she will want to ensure that the restraint policy in the place where the person is to live is acceptable and properly monitored. The guardian, though able to delegate powers, remains liable for the proper performance of his or her functions. He or she could be liable to criminal neglect if people acting on his or her behalf are negligent or poorly trained.

Attorneys

The Act does not ipso facto give welfare attorneys any power to exercise force or restraint. The power of attorney document could specifically authorise the attorney to exercise such restraint as the person might need, in accordance with the principles of the Act. If the document does not give such powers, the attorney who is a carer will need to rely on his or her common law powers and duties (see above). If a power of attorney contains the power to approve where the person should live, this could include the power to decide he or she should live in a place which may restrict his or her liberty, if appropriate under the principles of the Act.

viii. Restraint and the Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 authorises the use of compulsory measures, where a person's mental disorder makes him or her a risk to others and the person's ability to make treatment decisions is significantly impaired. A person may be detained in hospital or required to live in a specified place in the community. The person may be required to accept medical treatment even if he or she does not consent to the treatment.

There is very little in the Act or its Code of Practice dealing with the use of force and restraint but the law says that the statutory powers in an Act of Parliament include any related powers necessary to operate the powers in the statute²⁴.

If a patient challenges the use of restraint, the hospital will need to be able to demonstrate that it has the legal authority to act and that its action is an appropriate response in the individual circumstances of the case.

It will also need to show the use of force is in accordance with the principles of the Act, and in particular is the least restrictive alternative.

²⁴ Bennion, *Statutory Interpretation*, 4th edition, section 174.

Restraint in hospital

Although the Act does not state this explicitly, the fact that someone is detained in hospital means that staff have authority to restrain the person if he or she attempts to leave the ward or the hospital or without the consent of the responsible medical officer. The person cannot leave the hospital without the authority of the responsible medical officer²⁵.

A person subject to compulsory measures under the Mental Health (Care and Treatment) Act will generally be subject to an order requiring him or her to accept medical treatment under Part 16 of the Act. Medical treatment is widely defined. It includes nursing and care²⁶. Nursing could include restraining someone to prevent risk to self or others, if necessary and in accordance with the principles of the Act.

The Act authorises the giving of medical treatment where the person does not consent. The Act does not say that staff may use force or restraint to give such treatment if the person resists, but this is a necessary consequence. The Act does not authorise force to treat a person while he or she is in the community²⁷. The implication is that someone in hospital can receive treatment by force in certain circumstances.

The Code of Practice deals with the use of force, but only in the context of urgent treatment. If staff use force to give urgent treatment, they should have received training in its use and should include details about any use of force in the report to the Mental Welfare Commission²⁸.

Restraint in community-based settings

Staff supervising someone living on a community-based compulsory treatment order should not use force or restraint to keep the person there, if the person attempts to leave. A community-based compulsory treatment order does not detain the person in the community facility, but requires him or her to live in the place specified in the order. If the person leaves, he or she is in breach of the order. The person may be brought back to the place where he or she is to live, or taken to hospital. This does not mean that there is a power to detain or restrain the person in the community. People living in the community cannot receive medical treatment by force. (See above.)

If a hospital-based order is suspended and the person is kept in the charge of a nurse or other person, it would seem likely that the Act would allow the nurse to restrain the person should he or she attempt to leave. The person remains a detained patient, subject to the control of the responsible medical officer, even though the order is suspended.

²⁵ See, for example, Mental Health (Care and Treatment) (Scotland) Act 2003, s127. Only the responsible medical officer can suspend the terms of a compulsory treatment order to allow the person to leave.

²⁶ Mental Health (Care and Treatment) (Scotland) Act 2003, s329.

²⁷ See, for example, s241(4).

²⁸ Code of Practice, vol 1, para 10.87.

Safeguards

The fact that a person is subject to compulsory measures under the Mental Health (Care and Treatment) Act does not remove the need for monitoring and recording of the use of restraint. All the safeguards above apply.

The principles of the Act, and in particular the principle of minimum necessary intervention, mean that any restraint should be justifiable in the circumstances and the minimum necessary to deal with the situation. A nurse or other professional unable to show he or she has acted in accordance with good practice and with reference to the principles of the Act might have difficulty in justifying his or her action to a court.

Code of Practice

There is little in the extensive Mental Health (Care and Treatment) Act Code of Practice about the use of force or restraint. The Code of Practice recommends that staff advise informal patients of their rights when they are admitted to hospital. This should include information about any restrictions on movement staff may prescribe. The Code concludes that inappropriate use of restraint or limitations to an informal patient's liberty might constitute ill-treatment or wilful neglect²⁹. A person whose liberty is restricted in this way could appeal to the Tribunal under section 291 of the Act. The Tribunal could decide that, although the patient is an informal patient, he or she is unlawfully detained.

ix. Restraint of children and young people

Different rules apply if a child or young person requires restraint.

Generally the child's parent(s) (or the people with parental responsibilities and rights in respect of the child), have the right and the duty to take what action is necessary to protect a child or young person until he or she is 16. This could, on occasions, include the need for restraint. A person with temporary care of the child or young person also has such powers and duties. These powers must be exercised reasonably and in the interests of the welfare of the child.

The kind of restraint that is appropriate for a three-year-old would not be appropriate for a 15-year-old. Parental rights must be exercised in good faith. Restraint that is cruel, humiliating or manifestly unnecessary would not be lawful.

If medication is intended at least partly to restrain a child or young person, the parent can consent to this on the child's behalf until the child has sufficient maturity and understanding to make a competent decision him or herself.

If a child or young person with capacity to make medical decisions refuses such treatment, a health professional must respect the refusal. He or she may consider using other means, such as compulsory

²⁹ Code of Practice, vol 1, paras 8.05-07.

measures under the Mental Health (Care and Treatment) Act or applying to the court under the Children (Scotland) Act 1995.

x. Medical treatment and restraint

A person may require medication for the purpose, at least in part, of restraining him or her. Medical treatment requires the consent of the patient, unless the treatment is authorised under the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act.

There is a common law power to give a person medical treatment without his or her consent in an emergency. This could include giving medication where the purpose is at least in part to restrain a person, if this is immediately necessary for the protection of the person or others. Long-term use of such powers would not be permitted under the common law. Appropriate authority should be sought under the Adults with Incapacity Act or the Mental Health (Care and Treatment) Act as appropriate.

Covert medication

Covert or disguised medication describes the practice of concealing medication in food or drinks. The patient does not know he or she is receiving the medication. See **Covert Medication**, 2006.

A patient with legal capacity must never receive medication surreptitiously. This would be an assault, a civil wrong. Where someone is unable to consent to treatment, and is likely to resist or object to the treatment, it may be appropriate for a doctor or healthcare professional to give medication surreptitiously in exceptional circumstances.

Guidance from the British Medical Association recognises that it may sometimes be appropriate to give medicines covertly where this is authorised by law, and as an alternative to giving the treatment by force³⁰. There is also guidance from the Royal College of Psychiatrists³¹ and the Nursing and Midwifery Council³². The National Care Standards say that even if the law allows treatment without the person's consent, the person should receive covert medication only if he or she has refused treatment and his/her health is at risk. Any use of covert medication should be recorded³³. Any decision to give covert medication requires the authorisation of the doctor who prescribed the treatment. This is a requirement of the Medicines Act³⁴.

All sources of guidance stress that there must be a clear medical need for the treatment and that the measures will avoid significant mental or physical harm to the person. The decision to give covert medication should be discussed within the team and with carers and significant others and recorded.

³⁰ *Medical ethics today* BMA 2004.

³¹ College Statement on Covert Administration of Medicines *Psychiatric Bulletin* (2004) 28: 385- 386.

³² *Position statement on the covert administration of medicines* August 2005.

³³ National care standards, care homes for people with mental health problems, March 2005, standard 15.13.

³⁴ Medicines Act 1968, s58(2)(b).

Medication should not be given surreptitiously for the convenience of staff.

The Royal College of Psychiatrists says such treatment can be justified only when there is no likelihood that the person will be able to take treatment decisions.

Giving medicines in a different form may alter its effects and may mean that the use of the medication is unlicensed³⁵.

The doctor should seek advice from a pharmacist before approving the covert administration of medication. Staff should make regular efforts to persuade the person to accept the medication and staff should regularly review a decision to give covert medication.

Any staff member who fails to have regard to such guidance could face a charge of professional misconduct as well as criminal charges, if medication is given covertly to someone who has capacity to refuse the treatment.

xi. Summary

Although the law is complex and restraint covers a variety of activities, the following is a general summary of the law:

- Restraint is unlawful unless there is a legal justification. The most common justification is the prevention of harm to others or to the person being restrained.
- The degree and type of restraint should always be the minimum which is reasonably necessary, for the minimum possible time.
- Caregivers should anticipate when restraint might be required, plan accordingly and train staff.
- Establishments should have policies on the use of restraint available to clients, their relatives and carers, registration authorities and commissioners of services. All policies should comply with relevant care standards as appropriate.
- Where restraint constitutes 'deprivation of liberty', legal authority for such use must be obtained. A doctor or local authority may seek authority under the Adults with Incapacity (Scotland) Act 2000 or may need to seek a compulsory order under the Mental Health (Care and Treatment) (Scotland) Act 2003.
- Restraint must be for a clear purpose and if possible the client should be told what this purpose is.
- Restraint should not be used as a punishment, or done with hostile intent.
- Different rules apply if a child or young person requires restraint. Legal advice should be sought on best practice.

³⁵ *Tablet crushing and the law* Richard Griffith, the *Pharmaceutical Journal* (Vol 271) 19 July 2003. *Covert Medication*, mwscot.org.uk, 2006

Bibliography

principles

leadership

dignity &

human r

commun

Legislation

Adults with Incapacity (Scotland) Act 2000. The Stationery Office, Edinburgh, 2000.

Children (Scotland) Act 1995. HMSO 1995.

College Statement on Covert Administration of Medicines Psychiatric Bulletin (2004) 28: 385-386.

Human Rights Act 1998. HMSO 1998.

Mental Health (Care and Treatment) (Scotland) Act 2003. HMSO 2003.

Mental Incapacity Act 2005, s20.

Regulation of Care (Scotland) Act 2001. The Stationery Office, Edinburgh, 2001.

Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, (SI 2002 No. 114). The Stationery Office, Edinburgh, 2001.

Other

B v Forsey 1988 SLT 572 (HL).

Management of patients with dementia. Scottish Intercollegiate Guidelines Network (SIGN), Edinburgh, 2006.

National Care Standards. National Care Standards Committee, Stationery Office, Edinburgh, 2001-2002.

Norman v Smith 1983 SCCR 100.

Position Statement on the Covert Administration of Medicines. Nursing and Midwifery Council (NMC), London, 2001.

Skinner v Robertson 1980 SLT (Sh Ct) 43.

National Care Standards care homes for people with mental health problems Scottish Executive December 2001 (revised March 2005), care standards 6.2, 17.

NHSScotland *Managing health at work partnership network guidelines*, Scottish Executive 2004, guideline 6.

National Institute for Clinical Excellence, *The short-term management of disturbed/ violent behaviour in in-patient psychiatric settings and emergency departments*, February 2005.

The latest information from the Scottish Executive is in *Safe care: consideration of the recommendations from the inquiry (England) into the death of David Bennett*, Scottish Executive Health Department 17 December 2004.

Report on incapable adults, para 2.53.

The European Convention on Human Rights, Fourth protocol, Article 2.

See *HL v UK* (2004) ECtHR 471 at para 116. (The 'Bournewood' case.)

R v. Ashworth Hospital Authority ex parte Munjaz (2005) UKHL 58.

Winterwerp v the Netherlands (1981) ECHR 7.

HL v UK (2004) ECtHR 471 at para 89.

R (Secretary of State for the Home Department) v Mental Health Review Tribunal (2002) EWCA Civ 1868;
R (G) v Mental Health Review Tribunal (2004) EWHC 2193.

Bennion, *Statutory Interpretation*, 4th edition, section 174.

Medical ethics today BMA 2004.

Position statement on the covert administration of medicines August 2005.

Tablet crushing and the law Richard Griffith, *the Pharmaceutical Journal* (Vol 271) 19 July 2003.

National Care Standards: care homes for older people, scotland.gov.uk, 2011.

MWC joint position statement on use of CCTV in collaboration with SCSWIS and the Scottish Human Rights Commission, mwscot.org.uk

Scotland's National Dementia Strategy, Part 14, VI, section 95, 2010.

Notifying the Commission, mwscot.org.uk

The case of *Rabone v Pennine Care NHS Trust*.

Standards of Care for Dementia in Scotland: Action to support the change programme.
Scotland's National Dementia Strategy, June 2011.





Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwscot.org.uk
www.mwscot.org.uk

APS Group 254654 (03/13)

March 2013