LAW AND GUIDANCE IN RELATION TO RESTRAINT

> *"Research into the factors that contribute to aggressive behaviour in residential settings find that most instances are not caused directly by the person's 'psychopathology'. Most are fully understandable at the human and interpersonal level; and are due to everyday frustrations that come from communal living in a setting where the people lack autonomy and control over their lives. If staff can create an environment that minimises these general frustrations and work with individuals to identify and anticipate specific triggers that cause them distress, they will reduce the need to resort to restrictive interventions."*
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> *Royal College of Psychiatrists, 2018*

1. All Court of Protection practitioners in the welfare field will have encountered Positive Behaviour Support ("**PBS**") plans for learning disabled people which incorporate the use of physical restraint. It is not unusual for such plans to have been in place for a number of years, and for restraint to have been a feature of the person's life for a long period and across different settings. Close scrutiny of individual episodes of restraint is relatively rare within the court arena, unless the restraint is very frequent or intensive. That close scrutiny can reveal serious problems with the way care is being provided, and most experienced practitioners will be able to think of an example where a change of care provider, a move to a new setting, or some other change to the person's environment resulted in a significant decrease in the use of restraint, or its elimination. Often, monitoring by psychologists is infrequent or absent, leaving local authorities and care providers to continue implementing plans without any progress in reducing the use of restraint.

2. This paper identifies aspects of the caselaw and guidance that touch on these issues.

RESTRAINT UNDER THE MENTAL CAPACITY ACT 2005 ("MCA")

3. Section 5 MCA provides a defence to acts carried out in connection with the care or treatment of a person, provided that the decision-maker has a reasonable belief that the person lacks capacity in relation to the specific decision, and that it is in their best interests for the act to be carried out. Section

6 MCA imposes additional requirements where restraint is used, namely that it is necessary to protect the person from harm and a proportionate response to the likelihood and seriousness of that harm. Restraint is defined in Section 6(4) of the MCA as "*when someone uses force (or threatens to) to make someone do something they are resisting, and when someone's freedom of movement is restricted, whether or not they are resisting.*"

4. The starting point, is a strong presumption on minimal restraint and intervention. This reflects the European Court of Human Rights ("**ECtHR**") stance on proportionality, and sections 1(5) and 1(6) of the MCA 2005 which set out the principles that apply:

> *"1(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*
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> *1(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."*

5. Further, the current MCA Code of Practice at 6.44 requires that restraint must be the minimum amount of force for the shortest amount of time possible. In the new draft of the MCA Code of Practice, which is currently out for consultation, there is further guidance at paragraphs 6.71 – 6.75 which largely repeats the contents of the MCA provisions, but also provides that:

> *"6.77. Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible. There is less likelihood of restraint being necessary when the principles of the MCA are followed and there is a real understanding of the person's wishes, feelings, beliefs and values.*
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> *6.78. The Act does not define 'harm', because it will vary depending on the situation. For example, a person with learning disabilities might run into a busy road without warning, if they do not understand the dangers of cars, or a person with dementia may wander away from home and get lost, if they cannot remember where they live.*
>
> *6.79. Common sense measures can often help remove the risk of harm (for example, by locking away poisonous chemicals or removing obstacles). Also,*

care planning should include risk assessments and set out appropriate actions to try to prevent possible risks. But it is impossible to remove all risk, and a proportionate response is needed when the risk of harm does arise."

6. The definition of 'proportionate response' is set out at paragraphs 6. 80 – 6.81

> *"6.80. A 'proportionate response' means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity. On occasions when the use of force may be necessary, carers and healthcare and social care staff should use the minimum amount of force for the shortest possible time.*
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> *6.81. For example, a carer may need to hold a person's arm while they cross the road if the person does not understand the dangers of roads. But it would not be a proportionate response to stop the person going outdoors at all. It may be appropriate to have a secure lock on a door that faces a busy road, but it would not be a proportionate response to lock someone in a bedroom all the time to prevent them from attempting to cross the road."*

7. At paragraph 6.82 the guidance states that carers and healthcare and social care staff "*should consider less restrictive options before using restraint. Where possible, they should ask other people involved in the person's care what action they think is necessary to protect the person from harm."*

CASE LAW

8. There is surprisingly little domestic caselaw about the restraint of people with learning disabilities, and its lawfulness or otherwise.

9. In the case of *ZH v Commissioner of Police of the Metropolis* [2013] 1 W.L.R. 3021 (see 39 Essex commentary here) it was found that the Metropolitan Police Service ("**MPS**") had, in restraining an autistic boy after removing him from a swimming pool, acted unlawfully. While ZH did not suffer a physical injury he had suffered psychological trauma as a result of his experience which exacerbated his epileptic seizures. The MPS relied, in its defence on the 'best interests' defence under the MCA 2005. The MPS lost at first instance, and on appeal argued that that the first instance judge had failed to have recognise that the "*reasonableness of the officers' conduct and beliefs fell to be assessed by reference to a fast moving situation."*

10. The Court of Appeal dismissed the appeal, finding at [49] that it was practicable and appropriate for officers to consult carers before approaching and touching ZH:

> *"the MCA does not impose impossible demands on those who do acts in connection with the care or treatment of others. It requires no more than what is reasonable, practicable and appropriate. What that entails depends on all the circumstances of the case. As the judge recognised, what is reasonable, practicable and appropriate where there is time to reflect and take measured action may be quite different in an emergency or what is reasonably believed to be an emergency."*

11. *R (C) v A Local Authority & Others* [2011] EWHC 1539 (Admin) (see 39 Essex commentary here) also known as the 'Blue Room' case concerned C, an 18-year-old boy who had been resident in a school for some years, and who had a severe learning disability and autism. He was often kept in a padded blue room in conditions that were later the subject of a successful damages claim. In the case, the Court of Protection gave guidance about the use segregation and seclusion outside the confines of the Mental Health Act 1983 ("**MHA 1983**"), holding that while seclusion might be lawful for a short period in accordance with an appropriate care plan, it was not lawful to seclude C solely because he had removed his clothes and was naked, nor as a punishment as part of a behaviour management plan, and nor if C was at risk of self-harm, unless he was also behaving in an aggressive manner.

12. In the recent case of *An NHS Trust v ST (Refusal of Deprivation of Liberty Order)* [2022] EWHC 719 the court considered the deprivation of liberty of a child in hospital. The case included multiple incidences of physical and chemical restraint (see [16] for details). The judge was highly critical of the use of restraint, stating at [32] that:

> *"[…] I cannot, in good conscience, conclude that it is in the best interest of a 14 year old child with a diagnosis of Autism Spectrum Disorder and moderate learning disability to be subject to a regime that includes regular physical restraint by multiple adults, the identity of whom changes from day to day under a rolling commercial contract."*

13. In Bureš v The Czech Republic [2012] ECHR 1819 (see 39 Essex summary here) the ECtHR set out the principles that apply in respect of Article 3:

a) *"In respect of persons deprived of their liberty, recourse to physical force which has not been made strictly necessary by their own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3 of the Convention."*
b) *"The position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. Nevertheless, it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible. The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist."*

14. On the facts of the case, since the national guidance said that mechanical restraints should only be used as a last resort and when they were the only option available, and since no other options had been attempted, the government had failed to show that their use had been necessary and proportionate.

15. The question of whether restraint in itself amounts to a deprivation of liberty was considered in *Cheshire West & Chester Council v P&M* [2011] EWHC 1330. If restraint constitutes a deprivation of liberty, and breaches Article 5 of the European Convention of Human Rights ("**ECHR**") s.5-6 MCA cannot be relied on. *Cheshire West* concerned P, a 39 year old man with learning disabilities and autism. The staff at his care home placed him in a 'body suit' zipped at the back to prevent him from accessing his continence pads which he had a habit of eating. The court concluded that the steps required to deal with P's challenging behaviour, looked at overall, amounted to a deprivation of liberty. At first instance Mr Justice Baker went on to give clarification on the use of restraint and hold at [61]:

> *"In my judgment, it is almost inevitable that, even after he has been supplied with a bodysuit, P will on occasions gain access to his pads and seek to ingest pieces of padding and faeces in a manner that will call for urgent and firm intervention. Those actions will be in his best interests and therefore justifiable, but they will, as a matter of concrete fact and legal principle, involve a deprivation of his liberty." (emphasis added)*
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> *The consequences were twofold. First, 'those working with P are under a clear obligation to ensure that the measures taken are the least interventionist possible'. This required regular reassessments to consider*

alternative management strategies, such as the bodysuit and educating P not to behave in ways that required restraint (para 62). Secondly, the Court would have to conduct regular reviews, which the local authority had requested in any event (para 63)

Departing from the general rule, the Court ordered the local authority to pay a proportion of the other parties' costs because an employee, who was subsequently dismissed, had misled the Court and tampered with P's daily care records. Such misconduct was also held to justify the naming of the local authority, after the Court balanced the Article 10 public interest considerations with the Article 8 right to respect for privacy of P and others"

16. On appeal to the Court of Appeal it was found that the restraint adopted was not a deprivation of liberty.

"[23] (…) Similarly, restraint must be distinguished from deprivation of liberty. In extreme cases, no doubt, restraint may be so pervasive as to constitute a deprivation of liberty, but restraint by itself is not a deprivation of liberty."

(…) [114] The "body suit" that P wears is an 'all-in-one' garment, the essential feature of which is that the zip is at the back, rather than the front, so that P cannot access his continence pads […] Of course it involves a degree of restraint, although only briefly, but this degree of restraint is far removed from anything that begins to approach a deprivation of liberty. Restraint must be distinguished from deprivation of liberty. In extreme cases restraint may be so pervasive as to constitute a deprivation of liberty, but restraint by itself is not deprivation of liberty."

17. In the Supreme Court, every member of the court found that P was deprived of his liberty, even though some considered it to be a borderline or marginal case. While Lords Carnworth and Hodge were sympathetic to the Court of Appeal's view that "*occasional restraint for purely therapeutic purposes should not be enough in itself to tip "restriction" over the edge into "deprivation"*" even they considered that P's circumstances could properly be seen as falling within Article 5. The questions of what counts as merely occasional restraint, and what counts as restraint for purely therapeutic purposes, remain unanswered.

18. *AJ v A Local Authority* 2015 EWCOP 5 concerned an 88-year old woman with vascular dementia. The case is usually relied on in relation to procedural aspects of DoLS, but it also includes useful guidance about how physical restraint should be recorded in care plans, best interests assessments and in DoLS documentation. It is worth noting that the restraint in issue was the use

of 'blocking' to prevent AJ from lashing out when receiving personal care, and that there was a dispute as to whether that fell within the definition of restraint in the MCA.

> *"25. In supplemental submissions, Ms Butler-Cole on behalf of the Official Solicitor submitted that in any case in which physical restraint is used in the care of an incapacitated adult, any physical intervention, whether considered to amount to "restraint" or not, should be recorded in the care plan maintained by the service provider and monitored by the statutory body responsible for commissioning the person's care. Furthermore, precise details of all physical interventions should be ascertained and documented as part of the Deprivation of Liberty Safeguards process or indeed any best interest assessment from direct discussion with care staff implementing the interventions*
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> *26. I agree. In this case, whilst there may at one stage have been a discrepancy between the care plan and what was actually being provided, I am now satisfied that the local authority has addressed this issue in its amended plan. If, however, any further issue arises, or any party seeks any further declaration or order on this issue, the matter should be referred to me for further review."*

19. In *Munjaz v United Kingdom* 2913/06 [2012] ECHR 1704 (see 39 Essex summary here) the ECtHR held that even where someone is lawfully deprived of their liberty, there can be a further deprivation of liberty if restrictive practices are immplemented. The duration, effect and manner of implementation (as set out at [66]) are all relevant to the question of determining "*whether a person who has already been deprived of his liberty has been subject to a further deprivation of liberty*". The judgement makes reference at [37] to the UN General Assembly resolution 46/119 which provides at paragraph 11 that *"Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient."*

20. Following Munjaz and AJ, physical restraint must, as a measure which could amount to a further deprivation of liberty, be spelled out in full in documentation authorised by the Court or under Schedule A1 MCA 2005. In both cases, if the form, or length or effect of the restraint changes, the authorisation will likely need to be reviewed.

PROFESSIONAL GUIDANCE

21. The Department of Health's guidance on positive and proactive care was published in 2014 with the aim of "*developing a culture across health and social care where physical interventions are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time*". Events since 2014 including at Whorlton Hall, and the ongoing CQC 'Out of Sight' programme show that this culture is far from being established in hospitals. There are similar concerns in residential care settings and supported living, where issues such as excessive use of agency staff, lack of staff training, and use of punishment and behaviour modification strategies all arise.

22. Paragraph 70 of the DoH guidance states that: "*People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.*" Further at paragraph 72 the guidance states: "*If exceptionally a person is restrained unintentionally in a prone/face down position, staff should either release their holds or reposition into a safer alternative as soon as possible*". It is worth noting the ambiguity in the guidance in relation to what constitutes a planned act, and the allowance at paragraph 72 for prone restraint to be used in exceptional circumstances. Even in respect of this most drastic and risky form of physical restraint, there is a lack of clarity about what is, and is not permissible.

23. The Restraint Reduction Network has produced a blanket restrictions toolkit in partnership with NHS England to attempt to reduce restrictive practices including restraint and seclusion. A practice note is available for practice leaders, and senior leaders, and includes the following guidance: "*Heavy reliance on blanket restrictions can be a sign that a service is on a slippery slope to developing a toxic culture and the use of more obvious restrictive practices (e.g. physical restraints).*"

24. The Royal College of Psychiatrists' paper '*Restrictive interventions in in-patient intellectual disability services: How to record, monitor and regulate*' quoted at the

start of this paper makes recommendations on how restrictive interventions should be recorded, monitored, regulated and published.

25. The recent CQC report _Out of sight – who cares?: Restraint, segregation and seclusion review_ found that in adult social care services, things were largely more positive than in hospitals. However, the review flagged up serious problems including:

- "*a lack of training for staff to be able to understand people with a learning disability and/or autistic people. For example, one service had training on the Mental Capacity Act, but staff were not trained in communication tools like Makaton or Picture Exchange Communication System (PECS) to help people with a learning disability to communicate. Other services did not provide training on autism.*
- *training was not standardised. As a result, each provider's training was slightly different and meant that some training was better quality than others, for example more person-centred and bespoke training courses were available and tailored to those in the service. It also meant that agency staff may not be trained in the relevant approaches for the different services they work for."*
- *"there is no national reporting system for restrictive practice"* in adult social care, and use of restrictive practices and restraint is "*not currently notifiable to CQC*" unless it has led to a safeguarding alert being made.
- Some providers were using prone restraint, despite the DoH guidance.
- *"Although there was less use of restraint overall, when it was used for some individuals, it was used often and we found evidence of the same person being restrained 100 times in a month.*
  It is clear that when restraint is used frequently, services can become stuck in a cycle of repeatedly restraining people, which can be hard to get out of."
- Commissioners such as local authorities and CCGs were not always aware of levels of restrictive practice. Some services did not even record restraint, and fewer than half said they would report its use to the commissioners.

26. The NICE Guidelines on _Violence and aggression: short-term management in mental health, health and community settings_ set out high level principles. These include the need to improve service user experience and to "*ensure that the safety and dignity of service users and the safety of staff are priorities*". The guidelines include a section on reducing the use of restrictive interventions covering staff training at 1.2.1, the importance of implementing a restrictive intervention reduction programme at 1.2.2, for all provider organisations to collate, analyse, *and* synthesise data about the use of restrictive interventions at 1.2.4, to establish a monitoring unit led by service users to report and analyse data on restrictive interventions at 1.2.5 and to publish reports on the same at 1.2.6

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27. The guidelines at 1.4.24 provide the following guidance on prone restraint:

> *1.4.24 When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary:*
>
> *use the supine (face up) position if possible* ***or***
>
> *if the prone (face down) position is necessary, use it for as short a time as possible.*

28. In respect of manual restraint in general, 1.4.29 states "*Do not routinely use manual restraint for more than 10 minutes*" and 1.4.30 states "*Consider rapid tranquilisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes).*" Guideline 1.4.46 states that seclusion in adults should only be used if the service user is detained in accordance with the MHA 1983, and if not, a mental health assessment should be arranged immediately. It is not clear that all the provisions of the NICE guidelines sit consistently with other guidance outlined in this paper, and court decisions.

SENI'S LAW

29. The Mental Health Units (Use of Force) Act 2018 ("**MHUA 2018**"), also known as 'Seni's Law' was introduced in December 2021 to ensure patients in mental health settings will be better protected from inappropriate use of force. The act applies to all patients being assessed or treated in a mental health unit for a mental health disorder both in NHS and independent hospitals. It does not apply to care homes. The legislative intent is to protect patients and workforce by providing a much-needed drive for improved record-keeping and reporting of data on the use of force, the quality of staff training and the way in which investigations are carried out.

30. It is worth noting that the definition of restraint as set out in subsection (7) is different to that in the MCA and is broken down into physical, mechanical and chemical restraint:

> *" "physical restraint" means the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient's body;*
>
> *"mechanical restraint" means the use of a device which –*
>
> *(a) is intended to prevent, restrict or subdue movement of any part of the patient's body, and*

(b) is for the primary purpose of behavioural control;

"chemical restraint" means the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body;"

31. There is also Statutory Guidance on Seni's Law which includes further descriptions of each of the types of restraint. It also links to the need for staff to be trained in accordance with the Restraint Reduction Network national training standards. The MHUA 2018 requires the Secretary of State to publish annual statistics about the use of force in mental health units. These types of checks and balances, including clear definitions of the types of restraint applied, the requirement for clear and comprehensive reporting and the need for publicly accessible statistics. It is not obvious why the same requirements should not apply in other institutional settings including residential care homes, or other places where restraint is used against people with mental impairments, including in supported living.

GUIDANCE ON RESTRAINT IN OTHER SETTINGS AND OTHER RESOURCES

32. The Police College has provided guidance on control, restraint and searches. The guidance states: "*All police officers and custody staff should be aware of the dangers of positional asphyxia and restraining people experiencing acute behavioural disturbance (ABD), which is a medical emergency. A custody office is a controlled environment and the overriding objectives should be to avoid using force in custody. Staff should treat detainees with dignity and respect and aim to de-escalate any situations that may lead to force having to be used. Custody officers should manage their nvironment so that situations where the use of force may be necessary are de-escalated. All uses of force must be proportionate, lawful and necessary in the circumstances. Officers will be accountable for all instances where force is used.*"

33. The independent advisory council of deaths in custody has also produced a note on safer restraint, following Professor Richard Shepherd's review of medical theories on restraint deaths. The council formulated a common set of principles for custody sectors on the use of restraint. Standards were developed in conjunction with agencies, and resulted in a document '*Common principles for safer restraint*' and these were amended to ensure relevance to mental health settings. The guidance includes provisions in relation to training that emphasise the need for staff to have been fully trained in the safe application of techniques, and for skills in de-escalation to be maintained during regular training. Further, the guidance emphasises the need for all episodes to not only be document, but to be video recorded if at all possible, and for detailed and

accurate records to be analysed locally and centrally – and then used to "*review techniques and practices and to inform staff appraisals, training and development.*" Finally, there is a requirement for debriefing where three or more officers are involved in a single episode of restraint.

34. The Royal College of *Nursing* ("**RCN**") guidelines on reducing restrictive practices make reference to the Safewards programme which demonstrated significant reductions in incidents of aggression, violence, self-harm, suicide, absconding and substance use as well as reduced use of medication, physical restraint, seclusion, special observation. The cost effectiveness of shifts towards the reduction of restrictive interventions cited by the RCN guidelines suggest that similar practices should be used elsewhere.

CONCLUSION

35. As the review above demonstrates, while there are a wide range of different guidelines from organisations concerned about the use of restraint in care settings, and an overall commitment to reduction in restraint, much of the focus is on hospitals, rather than other settings where restraint is routinely used and even authorised by commissioners and the Court of Protection.

36. Techniques and institutional arrangements for reducing restraint that have been identified in adjacent contexts (such as policing and on mental health wards) include much clearer guidance in a number of areas. These include about what constitutes restraint,; requirements for a greater level of training of staff (and in particular that only trained staff use restraints); and strict reporting requirements, with the requirement for data to be both published and analysed to ensure that the use of restraint is monitored with the ultimate aim of reducing its use.

37. The following issues could usefully be the subject of judicial consideration and guidance, in the context of people who lack capacity to consent to the arrangements for their care and have care plans which permit the use of restraint:

- The definition of restraint under the MCA
- The appropriate requirements for documentation of episodes of restraint including the quality, frequency and nature of such documentation.

- The need for transparency and open data on the frequency of restraint episodes, to improve monitoring and oversight.
- Requirements for analysis and intervention at an institutional and local level.
- Accountability of providers and commissioners.
- Requirements for training – in particular for short term contract/agency staff.
- Clarification about the application of advice and principles from hospital settings to non-hospital settings.
- More detailed guidance on what is necessary, proportionate, in a person's best interests, and compliant with Articles 3, 5 and 8 ECHR.

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