



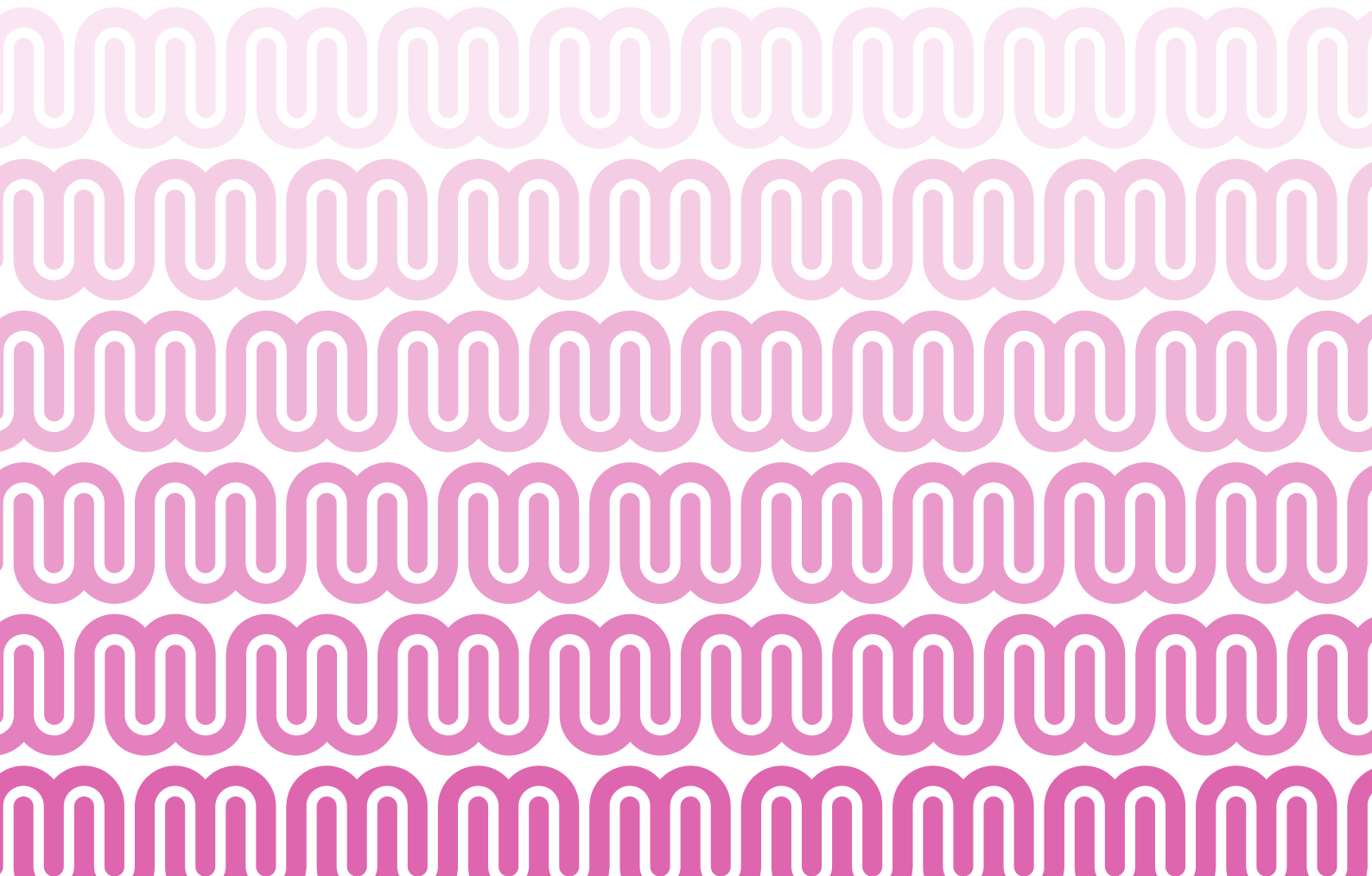
**mental welfare**  
commission for scotland

# **Rights, risks, and limits to freedom**

Good practice guide

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March 2021



# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

## Contents

Introduction .....	8
1 Restraint and limits to freedom – what does it mean?.....	9
1.1 What is restraint? .....	9
1.2 Is there ever any justification for the use of restraint? .....	9
1.3 Recognising restraint .....	10
1.4 Who is at risk?.....	11
1.5 Dilemmas for care staff – balancing risks .....	11
1.6 Environmental design.....	11
1.7 Legislation and regulation.....	12
1.7.1 Principles of the Adults with Incapacity (Scotland) Act 2000.....	12
1.7.2 Principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 .....	13
1.7.3 Human Rights Act, 1998 .....	13
2 Using this guidance .....	14
3 General principles and practice guidance.....	15
3.1 General principles .....	15
3.1.1 Human rights .....	15
3.1.2 Involvement.....	15
3.1.3 Self-determination .....	15
3.1.4 Positive risk-taking .....	15
3.1.5 Alternatives .....	16
3.1.6 Unacceptable reasons for considering restraint .....	16
3.1.7 Minimum necessary .....	16
3.1.8 Policy .....	16
3.1.9 Training.....	16
3.1.10 Monitoring the use of restraint.....	16
3.2 Compulsory powers and the law .....	16
3.3 Duty to care .....	17
3.4 Initial assessment.....	17
3.5 Acceptable risk .....	18
3.6 Applying restraint.....	18
3.7 Continuous re-assessment .....	19
3.8 Unplanned restraint .....	19
4 Types of restraint and interventions .....	20
4.1 Direct physical restraint .....	20
4.1.1 Definition .....	20

4.1.2 Guidelines.....	20
4.1.3 Restraint in non-health settings.....	20
4.2 Direct mechanical restraint.....	20
4.2.1 Definition.....	20
4.2.2 Normal activity.....	21
4.2.3 Assessment.....	21
4.2.4 Alternatives.....	21
4.2.5 Staffing.....	21
4.2.6 Environment.....	21
4.2.7 Safety.....	22
4.2.8 Special environments.....	22
4.2.9 Safety clothing.....	22
4.2.10 Use of nightwear to restrict movement.....	22
4.2.11 Comfort.....	22
4.2.12 Physical disability.....	23
4.2.13 Trays.....	23
4.2.14 Limb restrictions.....	23
4.2.15 The use of bed rails (cot sides) and restraint in bed.....	23
4.2.16 Risks from restraint.....	23
4.2.17 Observation.....	23
4.2.18 Restraint in vehicles.....	23
4.3 Locking the doors.....	24
4.3.1 Freedom.....	24
4.3.2 Deployment of staff.....	24
4.3.3 Aids to observation.....	24
4.3.4 Coping with restlessness.....	24
4.3.5 Types of locked door.....	24
4.3.6 Balance of duty.....	25
4.3.7 Other individuals.....	25
4.3.8 Sharing information on policy.....	25
4.3.9 Use of legal provisions.....	25
4.3.10 Personal space.....	25
4.3.11 Design.....	25
4.3.12 Modifications to design.....	26
4.3.13 Locking doors in the person's own home.....	26
4.4 Location technology.....	26

4.4.1 Definition .....	26
4.4.2 Assessment .....	27
4.4.3 Freedom .....	27
4.4.4 Extent of use .....	27
4.4.5 Freedom of movement.....	27
4.4.6 Care plan .....	27
4.4.7 Visibility .....	27
4.4.8 Individual attention .....	27
4.4.9 Discretion .....	28
4.4.10 Guidelines.....	28
4.4.11 Temptation to over-use.....	28
4.5 Video surveillance.....	28
4.5.1 Definition .....	28
4.5.2 External security .....	28
4.5.3 Monitors .....	28
4.5.4 Court ruling.....	28
4.5.5 Design and staffing .....	28
4.5.6 Accidents.....	29
4.5.7 General effects.....	29
4.5.8 Temptation to over-use .....	29
4.5.9 Individual surveillance .....	29
4.6 Passive alarms.....	29
4.6.1 Definition .....	29
4.6.2 Monitoring the alarm .....	29
4.6.3 Accidents.....	30
4.6.4 Information to the individual.....	30
4.7 Medication as restraint .....	30
4.7.1 Definition .....	30
4.7.2 Assessment .....	30
4.7.3 Alternatives .....	30
4.7.4 Monitoring .....	30
4.7.5 Side-effects .....	30
4.7.6 Medical responsibility .....	30
4.7.7 Individual variation.....	31
4.7.8 Consent .....	31
4.7.9 'Disguised' or covert medication .....	31

4.7.10 Intermittent disturbance .....	31
4.7.11 Control of drugs .....	31
4.8 Indirect limits to freedom.....	31
4.8.1 Restraint by default.....	31
4.8.2 Restraint as a result of interpersonal control by staff .....	32
4.9 Personal protective equipment.....	32
Appendix 1 - A discussion of the legal issues relating to restraint .....	33
i. Introduction .....	33
ii. Criminal law .....	33
Assault .....	33
Unlawful detention .....	34
Cruel and unnatural treatment .....	34
Ill-treatment and wilful neglect.....	34
iii. Civil law .....	34
iv. Legal justifications for restraint.....	35
Self defence.....	35
Necessity .....	35
Duty of care .....	35
Consent.....	36
v. Safeguards .....	36
Restraint must be justified .....	36
Care standards .....	36
Standards in NHS.....	37
Professional standards and guidance.....	37
Contractual obligations .....	37
Health and safety issues .....	38
Limits to common law .....	38
Reporting of incidents.....	38
vi. Human rights safeguards .....	38
European Convention on Human Rights .....	39
Restraint and detention .....	40
The UN Convention on the Rights of Persons with Disabilities .....	41
Summary.....	42
vii. Restraint and the Adults with Incapacity (Scotland) Act 2000 .....	42
Adults with Incapacity Act principles .....	43
Medical treatment.....	43

Restraint and guardians.....	43
Applying for power to restrain.....	44
Attorneys.....	44
viii. Restraint and the Mental Health (Care and Treatment) (Scotland) Act 2003 .....	45
Restraint in hospital .....	45
Eating Disorders .....	46
Restraint in community-based settings.....	46
Safeguards .....	46
Code of Practice.....	46
ix. Restraint of children and young people.....	47
x. Medical treatment and restraint .....	47
xi. Equality and non-discrimination.....	47
xii. Summary.....	48
Appendix 2 - Other useful information .....	49

## Introduction

This guidance is for staff supporting people using health and social care services. It looks at the legal, ethical and practical considerations which must be taken into account when considering whether someone's freedom of movement may need to be limited, and how the balance of potential risks and benefits for the individual must be considered.

The guidance outlines the principles which must be taken into account and specific issues relating to different types of intervention which may be encountered. The scope of the guidance is limited to care and treatment of individuals in health and social care settings and is not intended to apply to interventions in relation to other situations e.g. children in educational establishments.



# 1 Restraint and limits to freedom – what does it mean?

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

## 1.1 What is restraint?

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.

## 1.2 Is there ever any justification for the use of restraint?

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 individuals<sup>1</sup> in their care 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 usually to reduce risk: to the individual concerned or, more commonly, to others around them. However, 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; eg stopping a person doing something or restricting access to items which could do harm. In addition, the risk must be of a degree that justifies such a major intervention in that person’s life.

Such interventions should be therapeutic rather than punitive; should be in the individual’s best interests; and should take into consideration their human rights. There should be a focus on

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<sup>1</sup> Here and elsewhere in this document, “individual” means an adult with mental illness, learning disability or related condition.

prevention, de-escalation and reflective practice. And staff should aim to promote a positive culture; to understand the causes of behaviour; and to acknowledge that behaviours may result from distress caused by unmet need.

### **1.3 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. The use of technology such as door monitors, electronic tagging or CCTV surveillance can also constitute a subtle and less overt form of restraint, in that the outcome may be a restriction in freedom of movement.

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, or 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 fact 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. (See the Commission's [Money Matters Good Practice Guidance](#).)

## 1.4 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. But, for example, 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.

## 1.5 Dilemmas for care staff – balancing risks

Staff may face difficult dilemmas, such as when they are attempting to carry out their duty of care and the person concerned is confused, fearful and refusing their help, or when there are differences of opinion. For example:

- 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 preventable injury. What is the balance between the risk of falling and the risks of immobility?

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 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.

## 1.6 Environmental design

The design of a residential care setting can have a significant influence on the behaviour of people affected by dementia and other conditions. A well-designed environment can aid orientation and reduce the kinds of behaviour that lead to interventions that restrict their freedom of movement. The [Standards of Care for Dementia](#) provide overall standards on dementia care, including the options which should be considered before considering prescribing sedative, or psychoactive, medication. The [Dementia Services Development Centre](#) at Stirling University has produced a number of publications on the design of dementia-friendly environments.

## 1.7 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 Acts call “mental disorder”. 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 Care Inspectorate registers and inspects standards of social care in Scotland using the Health and Social Care Standards.<sup>2</sup> These standards are also relevant to care provided in the NHS.

We intend our guidance to be used by care providers to support the Health and Social Care Standards by providing general principles and more detailed comment on specific methods of restraint.

### 1.7.1 Principles of the Adults with Incapacity (Scotland) Act 2000

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

- The intervention must be of benefit to the individual.
- The intervention must be the least restrictive in relation to the person’s freedom in order to achieve the desired benefit.
- Interventions should take account of the past and present wishes of the adult.
- Interventions should take account of the views of relevant other parties.
- Interventions should encourage the adult to use existing skills and develop new skills.

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<sup>2</sup> <https://www.gov.scot/publications/health-social-care-standards-support-life/pages>

### **1.7.2 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.

### **1.7.3 Human Rights Act, 1998**

Anyone planning an intervention 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 must have a legal basis and proper justification.
- 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.

## 2 Using this guidance

This guidance cannot give definitive answers in every situation. It aims 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 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.

Chapter 3 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 mental illness, dementia, autistic spectrum disorder, learning disability, or other related disorders. Chapter 3 also provides practice guidance on initial assessment, consideration of risk, alternatives to restraint, applying restraint, continuous reassessment, unplanned restraint and monitoring the use of restraint.

Chapter 4 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 in chapter 3. This guidance is intended to help health and social care providers in the preparation of their own local policies on restraint. It should be considered alongside the standards produced in Scotland including Health and Social Care Standards and Dementia Standards.

## 3 General principles and practice guidance

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

### 3.1 General principles

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

#### 3.1.1 Human rights

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.

#### 3.1.2 Involvement

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. They may have expressed their views in the past. Wherever possible, these views should be taken into account. Any relatives, advocates, welfare attorneys or guardians, where available, should always be involved in the discussions.

In all cases some explanation should be given, at a level the person can understand.

#### 3.1.3 Self-determination

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

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

#### 3.1.4 Positive risk-taking

Some degree of positive 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, involving the need for use of restraint, should be to respect and protect human rights. 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.

### **3.1.5 Alternatives**

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.

### **3.1.6 Unacceptable reasons for considering restraint**

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

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

### **3.1.7 Minimum necessary**

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

### **3.1.8 Policy**

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 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.

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.

### **3.1.10 Monitoring the use of restraint**

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 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 section 1.5 and in the appendix.



### **3.3 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.

### **3.4 Initial assessment**

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.

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.

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 or other individuals and the environment all need to be considered. Behavioural problems secondary to psychiatric illness or epilepsy may be particularly difficult to assess and require specialist input.

Positive Behavioural Support is one model of assessment used in this context for complex presentations.

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 individual's 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 Health and Social Care Standards and the Requirements for Care Services Regulations<sup>3</sup> 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.

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 and for other diversity groups such as lesbian, gay, bisexual and transgender people. Communication difficulties, lack of understanding of an individual's behaviour in the context of their background and/or the provision of culturally inappropriate care could increase the likelihood of confusion and adversely affect behaviour.

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<sup>3</sup> The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210. Details of the requirements monitored by the Care Inspectorate can be found at <https://www.careinspectorate.com/index.php/register-a-care-service>

Consideration of gender may also be relevant, for example stereotyping some males as more threatening, or being aware of the risk of restraint bringing back memories of previous abusive experiences.

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 (eg it may expose an individual to hazards created by the behaviour of others which he or she cannot avoid, or confine him or her in such a way that attempts to escape are potentially harmful).

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.

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.

### **3.5 Acceptable risk**

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.

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.

### **3.6 Applying restraint**

Any restraint used must be the minimum required to deal with the agreed risk, applied for the minimum possible time.

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.

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.

If it is likely that someone may need regular or repeated use of restraint, legal provisions should be 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). This will depend on the specific situation and which legal framework is appropriate in the circumstances.

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. Staff properly trained in restraint procedures may be less likely to feel the need to use them.

### **3.7 Continuous re-assessment**

Any restraint used must be a considered part of the individual's care plan and included in an Adults with Incapacity Act section 47 treatment plan where appropriate. Its use should follow multi-disciplinary discussion, and be fully described in the care or treatment plan, together with the decisions taken and the arrangements for regular review within specified periods of time. This does not preclude the need for legal authorisation for restraint, as described above.

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

### **3.8 Unplanned restraint**

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.

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.

## **4 Types of restraint and interventions**

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 above.

### **4.1 Direct physical restraint**

#### **4.1.1 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.

#### **4.1.2 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.

#### **4.1.3 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. (Health and Social Care Standards, 2018).

### **4.2 Direct mechanical restraint**

This guidance should be used only in conjunction with the general principles above.

#### **4.2.1 Definition**

The commonest form of direct mechanical restraint in use is a 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.

#### **4.2.2 Normal activity**

Staff should know how active a person normally is, what form their activity normally takes and what times of day are 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 use of Just Checking technology can also provide a clear picture of activity over a 24 hour period without the presence of staff. This can be used as a planning tool to ensure care is appropriately targeted. The care plan should include provision for provision of normal activity.

#### **4.2.3 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.

#### **4.2.4 Alternatives**

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

- increase in supervised exercise; active exercise may improve mobility, thereby reducing frustration and distress caused by lack of activity and boredom. This may consequently reduce risk.
- redeployment or increase in staffing for observation and supervision;
- change in the pattern of rest periods in bed;
- provision of appropriate seated activities for the individual or for a group;
- imaginative use of diversional or occupational therapy;
- use of technology;
- use of special environments.

#### **4.2.5 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.

#### **4.2.6 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.

#### **4.2.7 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.

#### **4.2.8 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.

#### **4.2.9 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.

#### **4.2.10 Use of nightwear to restrict movement**

It is never acceptable to use nightwear 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."*

#### **4.2.11 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 in hospital wards or care homes and should only be considered following careful assessment and full consultation with relevant others.

#### **4.2.12 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.

#### **4.2.13 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.

#### **4.2.14 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.

#### **4.2.15 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 'cocoons' 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. The use of bed monitors alerts staff to an adult getting out of bed and potentially requiring support. This is less intrusive than bed rails, where appropriate.

#### **4.2.16 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.

#### **4.2.17 Observation**

A person who is the subject of any mechanical restraint should be risk assessed regarding the level of observation required. A care plan will then follow from discussion amongst interested parties, reflecting the balance between safety and right to freedom of movement.

#### **4.2.18 Restraint in vehicles**

Transporting individuals in vehicles can be problematic where there is a risk that the seatbelt may be removed whilst the vehicle is in motion thereby placing the individual at risk and in breach of the law. One solution is to use a form of restraint e.g. a safety harness, so long as it is only used for the minimum time whilst the journey is taking place, effectively having the same function as the seatbelt. Where this is used, there must be a member of staff in attendance to supervise during the journey.

Some might argue that any individual who lacks capacity and has a habit of undoing the seatbelt during the course of a journey should be made subject to welfare guardianship solely for the purpose of providing powers to maintain safety on car journeys. That would in most cases be considered overly restrictive.

In our view, a safety harness used in this way is another way of keeping someone, who lacks capacity to understand the dangers, in safety on a journey. It is not a deprivation of liberty since it would be illegal to travel without restraint. Not to use it would also prevent the individual from going on the journey and, as a consequence, missing out on a valuable opportunity for activities. Should the individual become distressed, and this may be the concern for support staff, having legal authority to restrain is not going to alter that situation. The staff should be looking at ways to distract the individual and thereby making it less of an issue.

### **4.3 Locking the doors**

This guidance should be used only in conjunction with the general principles above.

#### **4.3.1 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.

#### **4.3.2 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. However, 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 door. This staff member should perform such duties in a discreet and non-intrusive manner and not act as a 'guard'.

#### **4.3.3 Aids to observation**

The use of mirrors and alarms should be considered, especially if they can promote greater independence. There is also an option for the use of smart supports e.g. door monitors, or personal tracking technology. However, the technological advances of telecare should never be used simply to make up for deficiencies in observation and supervision by human contact.

#### **4.3.4 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. Walking is not a problem in itself and should not automatically be seen by care staff as such.

#### **4.3.5 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. The service should have a locked door policy which makes clear how individuals able to leave can do so.

#### **4.3.6 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.

#### **4.3.7 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.

#### **4.3.8 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.

#### **4.3.9 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.

*"Staff need to consider the balance between the individual's self determination and the duty to care."*

#### **4.3.10 Personal space**

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

#### **4.3.11 Design**

Wards, care homes and supported shared tenancies for people with dementia, autism 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)

### **4.3.12 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.

### **4.3.13 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.

## **4.4 Location technology**

This guidance should be used only in conjunction with the general principles above.

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 issue being addressed with this technology has been termed 'wandering'. However, this suggests aimless walking. Sometimes this may be the case, but it is more likely that the behaviour has some meaning for the person concerned. They may feel the need for exercise or wish to go somewhere. It is important to recognise the reason of the person walking, such as 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 guidance on use of technology in this context: [Decisions about technology: Principles and guidance on good practice when considering the use of telecare and assistive technology for people with dementia, learning disability and related disorders](#).

### **4.4.1 Definition**

Tagging is an emotive term when used in care settings and we choose to refer to 'location technology' as it better reflects the purpose of such equipment. Location technology can involve 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. Location technology can also involve tracking devices which can locate the wearer if he or she becomes lost or fails to return.

#### **4.4.2 Assessment**

As set out in the general principles of this guidance, prior to the use of any form of location 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.

#### **4.4.3 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.

#### **4.4.4 Extent of use**

Location technology should not be considered unless a particular individual is at serious risk from walking outside the boundaries of the care home or hospital 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 location technology devices must be enabling to the wearer, not limiting.

#### **4.4.5 Freedom of movement**

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

#### **4.4.6 Care plan**

Location 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.

#### **4.4.7 Visibility**

If location 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.

#### **4.4.8 Individual attention**

Location 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 people to walk away, by bringing a reward.

If an individual is judged not to be at risk from walking about in the local area, but the risk is that they may get lost, consideration could be given to a wearable GPS device which allows the user to be located. This could allow the individual the freedom to go out, with the reassurance (to the individual as well as to relatives and staff) that they can be found if necessary.

#### **4.4.9 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.

#### **4.4.10 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.

#### **4.4.11 Temptation to over-use**

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

### **4.5 Video surveillance**

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

#### **4.5.1 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.

#### **4.5.2 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 location technologies. This again may be acceptable as long as the general principles of restraint and the considerations below are applied.

#### **4.5.3 Monitors**

Video surveillance can 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 and usually impractical. 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.

#### **4.5.4 Court ruling**

In a fatal accident inquiry at Airdrie Sheriff Court in 1991 the Sheriff suggested that video surveillance in unstaffed corridor areas could increase safety and was acceptable, if it did not impinge on the privacy of individuals. 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.

#### **4.5.5 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.

#### **4.5.6 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.

#### **4.5.7 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.

#### **4.5.8 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.

#### **4.5.9 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, eg authorisation via a guardianship order with the specific power to use CCTV in respect of the individual's welfare. See the Commission's advice note, [Hidden surveillance](#).

*"Care of people with a mental disorder is best carried out through human interaction."*

### **4.6 Passive alarms**

This guidance should be used only in conjunction with the general principles above.

#### **4.6.1 Definition**

'Passive alarms', including pads under mats beside the person's bed or at bathroom or external doors, and infra-red alarms, are often used in hospitals, care homes and supported tenancies. Infra-red alarms can be programmed to be alert to a person's specific habitual actions. A passive alarm, signalling 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.

#### **4.6.2 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.

### **4.6.3 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.

### **4.6.4 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.

## **4.7 Medication as restraint**

This guidance should be used only in conjunction with the general principles above.

### **4.7.1 Definition**

This is the use of sedative or tranquillising drugs for purely symptomatic treatment of restlessness or stressed or distressed 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.

### **4.7.2 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, and non-pharmacological alternatives considered as the first option.

### **4.7.3 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.

### **4.7.4 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.

### **4.7.5 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.

### **4.7.6 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.

#### **4.7.7 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. Older adults with dementia are especially vulnerable to side effects of medication and falls are commonplace with sedation. Again, the role of the doctor is central to this.

#### **4.7.8 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. Part 5 of the Adults with Incapacity (Scotland) Act 2000 makes provision for the medical treatment of adults with impaired capacity. 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 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.

#### **4.7.9 '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 good practice guidance on [Covert Medication](#).

#### **4.7.10 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.

#### **4.7.11 Control of drugs**

Tranquillising and sedative drugs are potentially poisonous, addictive 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.

### **4.8 Indirect limits to freedom**

This guidance should be used only in conjunction with the general principles above.

#### **4.8.1 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 by an environment 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.

#### **4.8.2 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.

#### **4.9 Personal protective equipment**

There will be occasions when staff may be put at risk due to cross infection via bodily fluids, eg via spittle. Personal protective equipment should be readily available and can be used in these situations to enhance safety of all involved. Various formats are in use offering differing levels of protection to the face.

Placing masks or hoods on those subject to restraint would most likely be impractical and undignified for the individual and is not recommended. There would be a risk that they might constitute degrading treatment if wrongly used (too often, for too long, or too automatically). They *might* be used for very short periods of time e.g. while moving someone who may otherwise be subject to even more intrusive restraint, but it would depend on careful analysis of risks, alternatives etc.



# Appendix 1 - 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 Public Services Reform (Scotland) Act 2010 concerning the use of restraint by registered 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. Although it does not have the same force in law, public bodies should also pay attention to the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

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. Nevertheless, 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 the more serious crime of '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 for a short period persons of unsound mind who are a risk to themselves or others. However the House of Lords ruled in the case of *B v Forsey* that this is not available to people or agencies who have statutory powers to detain people available to them<sup>4</sup>, particularly doctors who can detain in hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003. The same rule probably applies to nurses who can use their holding power under the 2003 Act to prevent someone from leaving hospital if they need to be assessed for emergency detention.

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.

## **Ill-treatment and wilful neglect**

There are three statutory crimes which use this term. Under Part 3 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, a care worker who ill-treats or wilfully neglects an individual in their care commits an offence. In some circumstances the person or organisation managing the care can also be convicted. Section 83 of the Adults with Incapacity (Scotland) Act makes it an offence for anyone exercising powers under the Act relating to personal welfare to ill-treat or wilfully neglect a person with mental incapacity.

Section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 makes it 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'.

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<sup>4</sup> *B v Forsey* 1988 SLT 572 (HL)

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.

##### **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 the *B v Forsey* case discussed above, one of the judges (Lord Griffiths) said the use of such common law powers against a mentally unwell person 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 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 practice<sup>5</sup>.

## **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.

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.

An advance statement agreeing to restraint should it be needed in the future when the person has lost capacity may be helpful in deciding whether the restraint is justified. However it probably cannot on its own make restraint lawful if it would otherwise be unlawful.

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. , 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 health and social 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

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<sup>5</sup> *Skinner v Robertson* 1980 SLT (Sh Ct) 43. *Norman v Smith* 1983 SCCR 100

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 Public Services Reform (Scotland) Act 2010 deal with care providers' use of restraint<sup>6</sup>. These regulations apply to care home and day care services, but not NHS hospitals. The regulations stress the importance of respecting the dignity of clients<sup>7</sup>. 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 individual or other service users.

Health and Social Care Standards<sup>8</sup> state that any restriction of someone's independence, control and choice must comply with relevant legislation and any restrictions must be justified, kept to a minimum and carried out sensitively, with the individual as involved as possible. If physical detention, restraint or searching is used, the individual concerned will usually be subject to a formal legal order authorising this.

### **Standards in NHS**

These Health and Social Care Standards are also relevant for the NHS, and are taken into account by Healthcare Improvement Scotland in their oversight of NHS services. More generally, standards in the NHS are largely 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 etc<sup>9</sup>. NICE guidelines in England and Wales give detailed good practice guidance<sup>10</sup>.

### **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. Failure to do this may result in action by their regulatory body (e.g. the General Medical Council for doctors, the Scottish Social Services Council for care workers).

### **Contractual obligations**

Any establishment providing services under contract to a local authority or health and social care partnership must comply with the terms of the contract. The local authority or HSCP 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

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<sup>6</sup> The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210

<sup>7</sup> SSI 2011/210, reg 4

<sup>8</sup> <https://www.gov.scot/publications/health-social-care-standards-support-life/pages/>

<sup>9</sup> NHSScotland Managing health at work partnership network guidelines, Scottish Executive 2004, guideline 6

<sup>10</sup> Violent and aggressive behaviours in people with mental health problems, NICE, 2017  
<https://www.nice.org.uk/guidance/qs154>

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<sup>11</sup> 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.

### **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.

Someone exercising extensive informal controls over someone's life on a regular basis should seek an Adults with Incapacity Act order. 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 a protocol for reporting incidents ([Notifying the Commission](#)). Registered care services also have a responsibility to notify a range of incidents to the Care Inspectorate.<sup>12</sup> In the NHS, a serious incident may require an internal Significant Adverse Event Review, which should be reported to HIS.<sup>13</sup>

## **vi. Human rights safeguards**

Human rights law is increasingly important in considering matters of restraint. Courts in Scotland can hear arguments about, and make decisions based on, the European Convention on Human Rights. They may also have regard to the UN Convention on the Rights of Persons with Disabilities. The Equality and Human Rights Commission have published a useful guide to human rights issues in restraint.<sup>14</sup>

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<sup>11</sup> Under the Health and Safety at Work (etc.) Act 1974 and associated regulations

<sup>12</sup> Guidance on this is at <https://www.careinspectorate.com/index.php/notifications>

<sup>13</sup> Information on this is at

[http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/management\\_of\\_adverse\\_events/national\\_framework.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/management_of_adverse_events/national_framework.aspx)

<sup>14</sup> <https://www.equalityhumanrights.com/en/publication-download/human-rights-framework-restraint>

## European Convention on Human Rights

Under Article 2 of the ECHR<sup>15</sup>, the NHS has a positive duty to protect life against the risk of suicide of psychiatric patients, particularly where that risk is 'real and immediate'. This may include preventing a person from leaving hospital, even if they are an informal patient. However, as set out above, this should be by use of the legal powers in the 2003 Act.

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, or that there is some form of lawful authority. Such treatment can never be justified.

In the case of *Bures*,<sup>16</sup> the European Court of Human Rights found a breach of article 3 in a case where a mentally unwell person was strapped to a bed for two hours in a 'sobering up centre', sustaining injuries to his arms. The Court's judgment included the following comments (paras 85-87):

'The Court has recognised the special vulnerability of mentally ill persons in its case-law ...

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 ...

Regarding the use of restraining belts, the Court accepted that aggressive behaviour on the part of an intoxicated individual may require recourse to the use of restraining belts, provided of course that checks are periodically carried out on the welfare of the immobilised individual. The application of such restraints must, however, be necessary under the circumstances and its length must not be excessive ...

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.'

Article 8 sets out a right to respect for private and family life, which the courts have held protects a range of rights to personal autonomy. 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. Restraint must be proportionate and the individual must be treated with dignity and respect.

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<sup>15</sup> *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2

<sup>16</sup> *Bures v Czech Republic* Case 37679/08, 18<sup>th</sup> October 2012

In the case of *Munjaz v UK*, the European Court of Human Rights considered whether seclusion in Ashworth High Secure Hospital breached the patient's Article 8 rights. They concluded that Article 8 was relevant, although the seclusion was justified. Importantly, they said<sup>17</sup>

"the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demand that, when a person's personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left."

In other words, the fact that you are detained under mental health law means the protection of ECHR against further restrictions is more relevant, not less.

The common law can give legal authority but it must be consistent, clear and accessible<sup>18</sup>. 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 grounds<sup>19</sup>. 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.

In the English case of *Commissioner for Metropolitan Police v ZH*<sup>20</sup> the police were held to have breached Articles 3, 5 and 8 of the ECHR, and the Disability Discrimination Act 1995<sup>21</sup> when they removed an autistic young man from a swimming pool, put him in handcuffs and leg restraints, and held him in a cage in a police van for 40 minutes. Among the criticisms of the police was that they failed to consult carers, which might have helped them defuse the situation.

## **Restraint and detention**

Article 5 gives the right to the liberty and security of the person. No one should be *deprived of liberty* except in accordance with a procedure prescribed by law, and the case must fall into one of a list of specific justifications. One of these is the lawful detention of 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 detention<sup>22</sup>. (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 under the Adults with

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<sup>17</sup> *Munjaz v. the United Kingdom* (Application no. 2913/06) 17 July 2012, paragraph 80

<sup>18</sup> See *HL v UK* (2004) ECtHR 471 at para 116. (The '*Bournemouth*' case)

<sup>19</sup> *R v. Ashworth Hospital Authority ex parte Munjaz* (2005) UKHL 58

<sup>20</sup> Court of Appeal [2013] EWCA Civ 69

<sup>21</sup> The provisions of the Disability Discrimination Act are now in the Equality Act 2010

<sup>22</sup> *Winterwerp v the Netherlands* (1981) ECHR 7



Incapacity Act. Reliance on common law powers is unlikely to satisfy the ECHR requirements of due process<sup>23</sup>. The difference between restraint and detention is a matter of degree. 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<sup>24</sup>. 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.
- 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.
- Whether the cumulative effect of restrictions could amount to detention.

Although Article 5 is normally considered in the context of long-term arrangements, a short period of detention (even less than an hour) can constitute a deprivation of liberty which comes under the scope of Article 5<sup>25</sup>.

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

### **The UN Convention on the Rights of Persons with Disabilities**

The UNCRPD is also relevant in deciding whether actions comply with human rights principles. It is not directly enforceable in the same manner as the ECHR, but a court may look at it to decide how to interpret domestic law or the ECHR. It contains many similar provisions as the ECHR, but emphasises even more strongly the prohibition against discrimination<sup>26</sup>. So restraint which would be unlawful if done to a person without a mental illness or learning disability should also be treated as unlawful if done to a person with a mental illness or learning disability.

Important UNCRPD provisions include:

Article 5 – Disabled persons are entitled to the equal protection and benefit of the law without discrimination.

Article 12 – All measures affecting the exercise by a person of their legal capacity should have effective safeguards to prevent abuse, and should respect the rights, will and preferences of the person.

Article 14 – The state must ensure that persons with disabilities enjoy rights to liberty and security of person on an equal basis with others. The existence of a disability shall in no case justify a deprivation of liberty.

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<sup>23</sup> *HL v UK* (2004) ECtHR 471

<sup>24</sup> *HL v UK* (2004) ECHR 471 at para 89

<sup>25</sup> *Commissioner for Metropolitan Police v ZH* [2013] EWCA Civ 69 para 83

<sup>26</sup> The UN Committee which oversees the CRPD sets out its views on this principle in its General Comment Number 6 - <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/GC.aspx>

Article 15 – The state must ‘take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.’

Article 16 – The state must take measures to protect persons with disabilities from all forms of exploitation, violence and abuse.

Article 17 – ‘Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.’

## **Summary**

In conclusion, in order that the use of restraint complies with human rights law:

- Restrictions on a person’s liberty should be necessary in the circumstances;
- Any restrictions should be reasonable and proportionate, 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, and the circumstances of the restraint should be properly recorded;
- If the use of restraint could amount to detention (a deprivation of liberty), 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 justifiable in the individual case and in accordance with generally agreed good practice, it is unlikely that there would be a breach of the European Convention on Human Rights.

## **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.

### **Adults with Incapacity Act principles**

The Adults with Incapacity Act sets out<sup>27</sup> 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 fails<sup>28</sup>.

### **Medical treatment**

If someone is certified by a doctor or other qualified health professional as incapable of taking medical decisions, the health professional 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.

The health professional cannot use force or detention unless this is immediately necessary and only for so long as necessary<sup>29</sup>. 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 appropriate<sup>30</sup>. 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 (such as welfare guardianship) 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'. See the Commission's good practice guide [Right to Treat – delivering physical healthcare](#).

### **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 restraint<sup>31</sup>.

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<sup>27</sup> Adults with Incapacity (Scotland) Act 2000, s1

<sup>28</sup> Adults with Incapacity (Scotland) Act 2000, s82

<sup>29</sup> Adults with Incapacity (Scotland) Act 2000, s47(7)

<sup>30</sup> 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 2.56, Third Edition 2010). 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).

<sup>31</sup> Mental Capacity Act 2005, s20 The factors it lists are (a) that the deputy is acting under a power expressly conferred by the court (b) that the deputy reasonably believes the adult lacks capacity in

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 Act<sup>32</sup>.

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. A third option would be to ask the sheriff to vary the powers under s74 of the Act.

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 available<sup>33</sup>.

### **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 should 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 in breach of their legal responsibilities if people acting on their behalf are negligent or poorly trained.

### **Attorneys**

The Act does not give welfare attorneys any specific 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, an 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. However, it could not authorise use of restraint to prevent them from leaving, and it may not be sufficient to authorise a situation amounting to a [deprivation of liberty](#)<sup>34</sup>.

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relation to the matter in question (c) that the deputy reasonably believes the restraint is necessary to prevent harm to the adult and (d) that the act is a proportionate response.

<sup>32</sup> Adults with Incapacity (Scotland) Act 2000 Code of practice For persons authorised under intervention orders and guardians . 6.61, 6.76

<sup>33</sup> *B v Forsey* (above) and *HL v UK* (above)

<sup>34</sup> This is discussed in more detail in the Commission's good practice guide 'Common concerns with powers of attorney' and advice note 'Deprivation of Liberty'

## **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 there is a general rule that the statutory powers in an Act of Parliament include any related powers necessary to operate the powers in the statute. The English courts have said that the power to seclude a patient is implied from the power to detain<sup>35</sup>, and it is likely that the same would be said of restraint.

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.

### **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 officer<sup>36</sup>.

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 care<sup>37</sup>. Nursing could include restraining someone to prevent risk to self or others, if necessary and in accordance with the principles of the Act.

Part 16 of 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 community<sup>38</sup>. 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

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<sup>35</sup> R v Ashworth Hospital Authority ex parte Munjaz [2005] UKHL 58 at para 34, citing R v Broadmoor Special Hospital Authority, ex parte S, H and D [1998] EWCA Civ 160, which concerned the power to search patients

<sup>36</sup> 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.

<sup>37</sup> Mental Health (Care and Treatment) (Scotland) Act 2003, s329

<sup>38</sup> See, for example, s241(4)

should include details about any use of force in the report to the Mental Welfare Commission<sup>39</sup>.

## **Eating Disorders**

Nutrition by artificial means may include enteral feeding such as naso-gastric (NG) tube or Percutaneous Endoscopic Gastronomy (PEG) feeding and may need to be completed with the use of physical interventions in the most complex cases. There is specific guidance on 'Force and the use of restraint' in the Commission's good practice guide on [Nutrition by Artificial Means](#).<sup>40</sup>

## **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 the hospital detention requirement of 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.

## **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

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<sup>39</sup> Code of Practice, vol 1, para 10.87

<sup>40</sup> Nutrition by artificial means. A good practice guide. Mental Welfare Commission (2015)

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 neglect<sup>41</sup>. 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 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.

## **xi. Equality and non-discrimination**

All organisations need to comply with the Equality Act 2010. They need to take care to be sure that they are not operating restraint in a discriminatory manner. An example would be if people from particular ethnic minorities were restrained more often than others. Restraint particularly affecting particular types of disability (for example autistic people) might also breach the duties under the Equality Act.

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<sup>41</sup> Code of Practice, vol 1, paras 8.05-07

The duty to make 'reasonable adjustments'<sup>42</sup> for disabled people is also relevant. For example, this might mean recognising that a person with a mental illness or learning disability may need to be communicated with differently if they are behaving in a dangerous way. In situations where restraint is justified, they may need additional support to manage any trauma which results.

As well as avoiding discrimination in individual cases, organisations should record and monitor data about the use of restraint to identify any patterns which may indicate unconscious discrimination, and address it when it arises.

## **xii. 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.
- Registered services 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 treatment order under the Mental Health (Care and Treatment) (Scotland) Act 2003.
- Restraint must be for a clear purpose and if possible the individual 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.

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<sup>42</sup> Equality Act 2010 s20



## Appendix 2 - Other useful information

[Nutrition by artificial means](#). A good practice guide. Mental Welfare Commission (2015)

[Decisions about technology](#). Principles and guidance on good practice when considering the use of telecare and assistive technology for people with dementia, learning disability and related disorders. (Mental Welfare Commission, 2015)

[Covert medication](#): Good practice guide (Mental Welfare Commission, 2017)

[No Safe Place: Restraint and Seclusion in Scotland's schools](#) . Report by Children and Young people's Commissioner Scotland (2018)

[Human rights framework for restraint](#) (Equality and Human Rights Commission, 2019)



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