Restraint Reduction Network

NHS
Sheffield Health and Social Care
NHS Foundation Trust

## Rights based approach to thinking about

# Psychological Restraint

A document to promote discussion about the justification for the use of psychological restraint



A note on the text: This is not legal advice. If readers are seeking legal advice, contact appropriate in-house legal team (if working in the NHS, a care provider agency or a local authority); individuals should seek out guidance from appropriate advocacy agencies or solicitors.

This is part of a set of information about **Psychological Restraint**.

There is:

- A poster which summarises how staff should care for people.
- A booklet called, **'Psychological Restraint: a discussion document for senior and practice leaders'**. It aims to promote reflection on the use of communications and interactions in mental health services.
- A summary called, **'Psychological Restraint: a guide for staff working in mental health inpatient units'**. It has some key points that you should know about the way that people in mental health inpatient units should be cared for.
- An evaluation form called, **'How staff communicate with me'**. These resources can help people to assess how staff on the ward communicate with them and how this makes them feel.
- An animation and '**Psychological Restraint Animation Reflection**' which can help educate people on the use of psychological restraint in inpatient settings.
- A **rights based framework** for psychological restraint. It prompts reflection on examples of psychological restraint used in practice.

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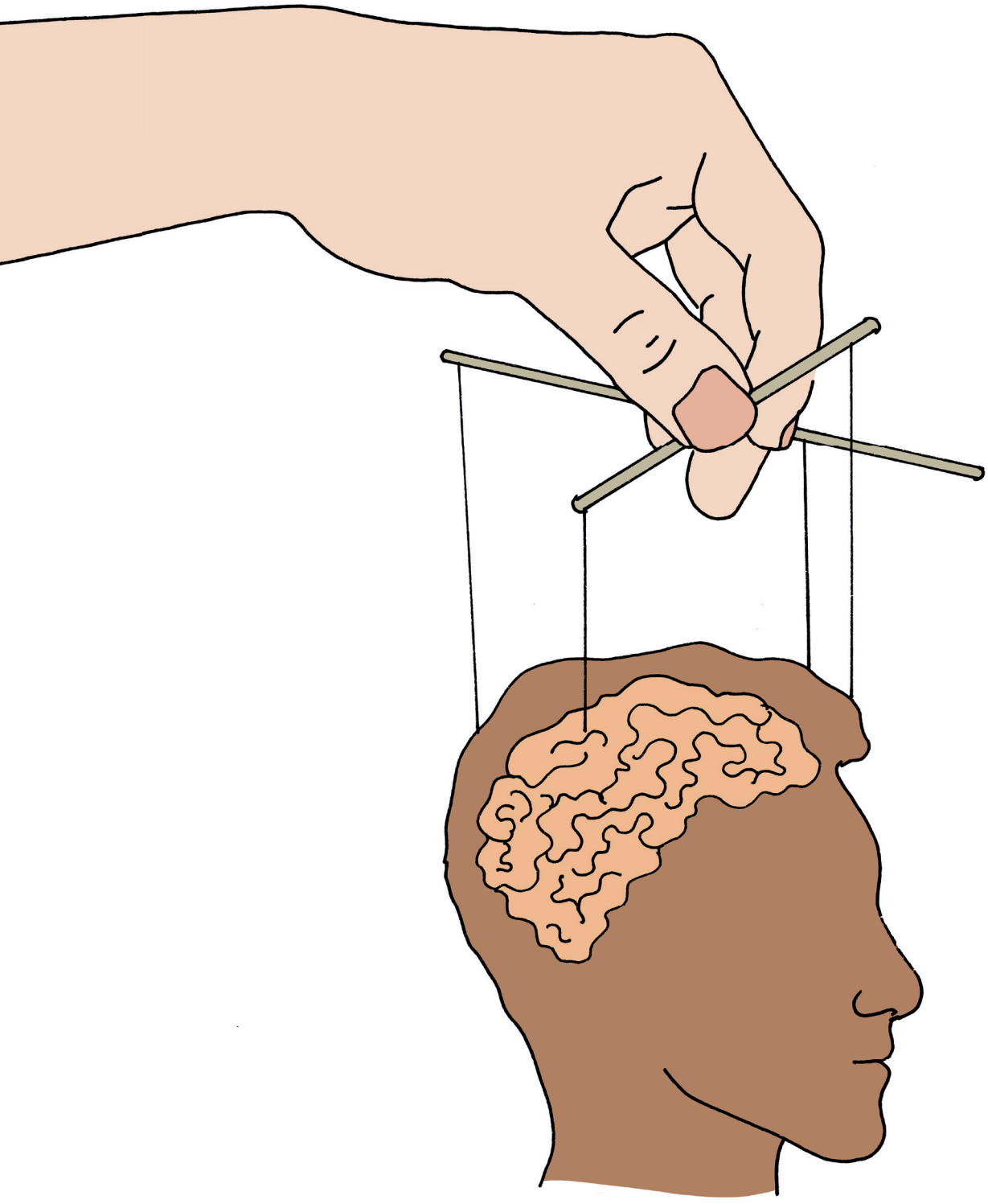

# Introduction

This document provides rights-based thinking rooted in the Human Rights Act 1998 (HRA) as it relates to the concept of psychological restraint pertaining to people detained in inpatient mental health settings only. Human rights are not optional or aspirational. The HRA requires that public sector bodies (such as the NHS), or bodies in receipt of public funding (such as care home placements arranged by NHS or a local authority) protect, respect and fulfil human rights obligations. Where the Mental Health Act 1983 (as amended in 2007) (MHA) and/or the Mental Capacity Act 2005 (MCA) are engaged, they must be followed together with the HRA.

A key aspect of this document are principles of least restrictive practice. This means restrictions should never be more than is strictly necessary to achieve the aim of imposing the restriction. To impose restrictions that go beyond least restrictive options justified as strictly necessary, might violate the law by the state, the hospital, and the staff members involved.

# Restrictive practice defined

In the UK the frameworks governing the lawful use of restraint stem from:

### 1. The Mental Health Act 1983

The 'Mental Health Act 1983: Code of Practice' (MHA COP) is the statutory guidance to which health and social care staff must have regard (see section 118 of the MHA for full list of who must have regard for the MHA COP. Furthermore, the guidance given in the MHA COP to local authorities and their staff is statutory guidance given under section 7 of the Local Authority Social Services Act 1970). The MHA COP along with the Department of Health policy guidance, 'Positive and Proactive Care; reducing the need for restrictive interventions' are component parts of the lawful framework governing the use of restraint in psychiatric hospitals.[1]

The Mental Health Act 1983: Code of Practice' defines restrictive practices/ interventions as follows:

"Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others. Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation." [2]

1 Equality and Human Rights Commission, 'Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions' (Equality and Human Rights Commission, March 2019) 7;< https://www.equalityhumanrights.com/sites/default/files/human-rights-framework-restraint.pdf> accessed 08 Feb 2023;

Department of Health, 'Mental Health Act 1983: Code of Practice:' (HM Government 2015) 26.36. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF> accessed 08 Feb 2023;

Social Care, Local Government and Care Partnership Directorate, 'Positive and Proactive Care: reducing the need for restrictive interventions:' (HM Government 2014) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf > accessed 08 Feb 2023

2 DOH, 'Mental Health Act 1983: Code of Practice:' (n1) 26.36

Chapter 26 of the MHA COP provides comprehensive statutory guidance on the use of force and restraint, which social health and care staff are duty bound to regard in relation to patients detained under the Mental Health Act 1983.[3] The MHA COP recognises enhanced observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion and long-term segregation as part of 'safe and therapeutic responses to disturbed behaviour', but only if used in a way that respects human rights.[4]

The MHA CoP states:

"Any restrictions should be the minimum necessary to safely provide the care or treatment required, having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action."[5]

The MHA COP emphasises that a culture of prevention, early recognition of distress, and de-escalation should be prioritised. [6] The MHA COP further states that in considering the use of restraint, decision-makers should carefully consider the need to respect an individual's liberty and autonomy.[7]

## 2. The Mental Capacity Act 2005

Section 6 of the Mental Capacity Act 2005 provides lawful authority for restraint to be used (for the protection of individuals from not for the protection of others).

(a) on a person who lacks capacity, where

(b) it is reasonably believed to be necessary and proportionate to protect them from harm.[8]

3 Ibid Chapter 26; Mental Health Act 1983, (as amended in 2007) Section 118 (1) (a)-(b); Local Authority Social Services Act 1970, Section 7

4 Ibid 26.2

5 Ibid 1.3

6 Ibid 26.4

7 MHA COP (13.34)

8 The Mental Capacity Act 2005, Section 6

Section 6(4) of the MCA defines someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not. [9]

Restraint is considered appropriate when used occasionally to prevent serious harm to a person who lacks capacity. It must be a proportionate response relative to the probability and seriousness of the harm, and all other less restrictive options must have been attempted. Records need to be kept carefully and need to show:

- The assessment and decision-making process.
- The less restrictive alternatives that were considered and give reasons why they were rejected. [10]

The 'Mental Capacity Act 2005:Code of Practice' is the statutory guidance , that must be regarded when using restraint on those without capacity. [11]

9 The Mental Capacity Act 2005, Section 6(4)

10 Care Quality Commission , 'Mental Capacity Act deprivation of liberty safeguards: Guidance for providers' (Care Quality Commission October 2011) 7 <https://www.cqc.org.uk/sites/default/files/documents/rp_poc1b2b_100564_20111223_v4_00_guidance_for_providers_mca_dols_for_external_publication.pdf> accessed 08 Feb 2023;

11 Department for Constitutional Affairs, 'Mental Capacity Act 2005: Code of Practice (TSO 2007) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf> accessed 08 Feb 2023;

# Defining psychological restraint

The term 'psychological restraint' does not appear in The Mental Health Act itself or the Mental Health Act 1983: Code of Practice nor in the Mental Capacity Act 2005 or the Mental Capacity Act 2005 Code of Practice.

In absence of a specific definition of psychological restraint other sources do provide conceptual guidance.

The Mental Welfare Commission for Scotland a non-departmental public body, responsible for safeguarding the rights and welfare of people in Scotland who have a learning disability, mental illness, or other mental disorder, notes that:

> "…'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." [12]

The current *Pennsylvania Code* gives the following definition.

> "Psychological restraints include those therapeutic regimes or programs which involve the withholding of privileges and participation in activities. Sometimes these measures take the form of blackmail, and the patient is told that they will be kept in force until he behaves 'well' or, more precisely, if he does not comply with the staff orders (the so-called 'consequence-driven strategies')." [13]

The Royal College of Nursing also recognises the concept of psychological restraint in their publications Let's talk about restraint: Rights, risks and responsibility:

> "…constantly telling the person not to do something, or that doing what they want to do is not allowed or is too dangerous. It may include depriving a person of lifestyle choices – by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do. For example, taking away walking aids, glasses or outdoor clothing, or keeping the person in nightwear with the intention of stopping them from leaving." [14]

12 The Mental Welfare Commission for Scotland, Rights, risks, and limits to freedom: Good Practice Guide (Mental Welfare Commission for Scotland,2021) 10 < https://www.mwcscot.org.uk/sites/default/files/2021-03/RightsRisksAndLimitsToFreedom_March2021.pdf> accessed 08 Feb 2023

13 Pennsylvania Code (2014), 055 Pa. Code § 13.9. cited in: Negroni, A A 'On the concept of restraint in psychiatry' *The European Journal Of Psychiatry*; [2017} 31(3), 102 < https://www.elsevier.es/en-revista-european-journal-psychiatry-431-articulo-on-concept-restraint-in-psychiatry-S0213616316300143#bib0305> accessed 08 Feb 2023 ;

14 Royal College of Nursing, 'Let's talk about restraint: Rights, risks and responsibility' (Royal College of Nursing, 2008) 3. < https://restraintreductionnetwork.org/wp-content/uploads/2016/11/Lets-talk-about-restraint.pdf> accessed 08 Feb 2023;

The RCN discusses this restrictive practice further in their publication *Three Steps to Positive Practice*.

> "It is important to recognise that restrictive practices can be psychological. Attempting to exert control or force compliance by what is said or how it is said, and/or the use of body language and nonverbal methods of communication, are equally restrictive."[15]

Thus, there is an emerging body of work, from reputable sources, that recognise psychological restraint as conceptually valid. This is neatly summarised by the Restraint Reduction Network, who define the concept as:

> "Psychological restraint is when staff [in mental health units] use communication strategies to put psychological pressure on a person to do something they don't want to do or to stop them from doing something they want to do."[16]

Ultimately psychological restraint emerges from the cultural and environmental factors present in a ward. Patients having pressure put on them, or being ignored, talked down to, failing to have issues that concern them explained, failure to involve patients in discussions that pertain to their care, and maintaining punitive/disciplinarian attitudes and behaviours are all means by which a culture of psychological restraint is developed and maintained. This can be compounded by environmental factors and blanket restrictions such as surveillance, property confiscation, restricted access to private and communal spaces etc. Indeed, staff may directly or indirectly draw on the wider environment e.g., locked doors and legislation that enables detention, as a backdrop to assert and exacerbate power differentials between staff and the people they care for when communicating.

What can be seen here and from the Restraint Reduction Networks resources on this topic (that accompany this document), is that psychological restraint is a very real and felt phenomenon. Unlike physical/chemical/mechanical restraints, psychological restraint is an intangible form of restraint, and is much harder to regulate, control and document. Oftentimes its use (whether deliberate or not) will be difficult to capture in data or reporting mechanisms, thereby making it hard to challenge or seek recourse against.

15 Royal College of Nursing, '*Three Steps to Positive Practice A rights based approach when considering and reviewing the use of restrictive interventions*' (Royal College of Nursing, 2017). 7

16 Restraint Reduction Network, 'Psychological restraint poster' Restraint Reduction Network, 2023

# The Human Rights Act

The HRA imposes a duty on all public sector bodies (including the National Health Service (NHS)) to protect and respect the human rights listed in the 16 'Articles' (known as 'Convention rights').[17] The most encountered Convention rights in mental health care contexts are the following.

- **Right to life** (Article 2) - in particular protection of this right from real and immediate risks that may lead to danger of death.
- **Prohibition of inhuman or degrading treatment or punishment** (Article 3).
- **Right to liberty** (Article 5). Any infringement of Article 5 rights must have a legal basis and proper justification.
- **Right to respect for private and family life** (Article 8).
- **Protection from discrimination** (Article 14) requires that all the rights and freedoms set out in the Act must be protected and applied without discrimination.

## Absolute and qualified rights

Some human rights are ***absolute***. This means there is no lawful circumstance in which that right can be limited or restricted. Articles 2 and 3 are absolute rights.

Some rights are ***qualified***. This means that limits and restrictions can be imposed, only if this is done in the following three ways.

1. **Lawfully** – there is a legal basis on which a restriction can be imposed on a patient by the state. This legal basis should be carefully checked and understood.

2. **For a legitimate purpose** – usually to prevent a risk or harm:
   a. in the interests of national security, public safety or the economic wellbeing of the country
   b. for the prevention of disorder or crime
   c. for the protection of health or morals, or
   d. for the protection of the rights and freedoms of others[18] (European Court of Human Rights and

3. **Proportionately** –Any restriction should be the least restrictive option, imposed for the shortest possible time and subject to regular review.

17 Human Rights Act 1998, Schedule 1

18 Human Rights Act 1998, Schedule 1, Article 8(2)

## The 'least restrictive' principle

If a person's qualified human rights are being restricted, the guiding principle of least restriction applies. This means that only the absolute minimum amount of limitation can be placed on a right, for the shortest period possible, and no more than necessary to accomplish the aim of its imposition.

When considering whether an interference with a qualified right is proportionate, the burden lies on the state agents/ public servants (for example nurses and doctors) to justify its actions and ensure that the interference must go no further than strictly necessary to achieve its permitted purpose. The more substantial the interference, the more is required to justify it.[19]

## Article 3: Prohibition of inhuman or degrading treatment or punishment

As previously mentioned, Article 3 is an absolute right. This means there are no circumstances in which it is lawful, legitimate, or proportionate to interfere with this right.

The most likely area of Article 3 related to psychological restraint is that of degrading treatment and/or mental suffering. Whether or not treatment becomes degrading and/or causes mental suffering depends on the circumstances of each case.[20]

Article 3 imposes duties on public authorities to ensure that no one should be subjected to inhumane and degrading treatment, or punishment. State authorities have a duty, not only not to cause such suffering, but also to provide protection from such harm, including taking reasonable steps to prevent ill treatment, of which the authorities have, or ought to have knowledge.[21]

Forced medical treatment administered to detained patients is not inherently a violation of Article 3, if there is a therapeutic or medical necessity for it, and if it can be shown to be appropriate.[22]

19 R (on the application of N) v Ashworth Special Hospital Authority and the Secretary of State for Health' [2001], EWHC Admin 339; M.H.L.R. 77 at [9]

20 Pretty v Director of Public Prosecutions' [2001] UKHL 61 (HL)

21 'R (Munjaz) v Ashworth Hospital Authority' [2005] UKHL 58[2006] 2 AC at [78]

22 B v Responsible Medical Officer, Broadmoor Hospital and Others' [2005] EWHC 1936 (Admin); R (JB) v Dr Haddock [2006] EWCA Civ 961

Where treatment humiliates or debases an individual, showing lack of respect for or diminishing their human dignity, or arousing feelings of fear, anguish or inferiority capable of breaking an individual's morale or physical resistance, this may be characterised as degrading and fall within the prohibition of Article 3.[23] Degrading treatment is more than just a loss of dignity. What constates degrading treatment can be somewhat subjective, depending on the effect that treatment has on the victim.[24] The issue therefore is the effect upon the individual.[25] It would be an Article 3 breach if a patient were able to demonstrate that they experienced serious suffering in terms of physical and psychiatric injury, psychological harm or particularly serious evidenced distress.[26]

As Amos notes:

"The detention of psychiatric patients is a means to an end, namely the assessment and treatment of their mental disorder. If the conditions of detention defeat rather than promote that end, these are more likely to be inhumane and degrading treatment." [27]

Detained people with mental illnesses may experience increased suffering as a result of their condition, which can reach the requisite level of severity to meet Article 3 breaches - even if this is unintentional.[28]

It should be noted that Article 3 is a high threshold to reach in terms of demonstrating whether or not it has been breached.

23 Pretty v United Kingdom 2346/02 [2002] ECHR 427

24 Merris Amos, 'Human Rights Law: 3rd Edition', (Hart Publishing 2021) 262-263

25 R (on the application of Turgut) v Secretary of State For Home 1 All ER 719, [2000]

26 Grant v Ministry of Justice, [2011] EWHC 3379 (QB)

27 Amos (n 24) 277

28 R (on the application of S) v Secretary of State for the Home Department [2011] EWHC 2120 (Admin)

## Article 5: **Right to liberty**

Article 5 is a qualified right, meaning that limitations that can be placed on an individual's freedom. It is worth noting that detention under the MHA, or deprivation of liberty under a DoLS regime, is not the same as depriving someone of their freedom of movement in context of their initial detention. There is a presumption that detained persons continue to enjoy all the fundamental rights and freedoms guaranteed under the HRA save for the right to liberty, where lawfully imposed detention expressly falls within the scope of Article 5.[29] Any additional restriction on those rights must be justified in each individual case.[30]

## Article 8: **Right to respect for private and family life**

Article 8 protects the physical and psychological integrity of individuals. This extends to the elements that are integral to that person's identity and autonomy.[31] Article 8 is a qualified right and therefore can be restricted. However, as previously stated, only where it is lawful, justified and proportionate to do so. The threshold for an Article 8 breach, is lower than that of Article 3.

29 R (on the application of Munjaz) v Ashworth Hospital Authority' [2005] UKHL 58[2006] 2 AC

30 Dickson v United Kingdom [2008] 46 E.H.R.R 41

31 R (on the application of Razgar) v Secretary of State for the Home Department [2004] UKHL 27; B v Responsible Medical Officer, Broadmoor Hospital and Others' [2005] EWHC 1936 (Admin)

# Can psychological restraint ever be justified?

Harassment, put-downs, mockery, threats, provocation, bullying, gaslighting, name calling, gossiping about patients and manipulation would all be examples, not of psychological restraint, but of outright abuse. These have no lawful or legitimate justification in a health and social care setting. Such abuse would be likely to fall within the remits of Article 3 and/or Article 8. This would be actively bad practice to such an extent that disciplinary procedures, tribunals by profession bodies and even criminal prosecutions against any staff member engaging in such actions could be launched. Furthermore, any NHS body that knew, or ought to have known, that this abuse was going on, and allowed it to occur, could face potential litigation.

As with many human rights issues, outright and obvious cases are easier to identify than where breaches occur inadvertently.

Given that psychological restraint is often by its nature something that emerges from the culture of the ward and attitudes of staff towards communication (body language, use of vocabulary, tone of voice) it is difficult to see how such a strategy could be planned for ahead of its use in the terms of lawfulness, justification, and proportionality to be permittable for the majority of people.

In cases where such a plan was made, the practitioner would need to address the questions:

- how is a deliberate use of a psychological restraint strategy going to stop or prevent a harm or risk?
- Or how is it clinical necessary?
- And what other options are being rejected as more restrictive to make such a strategy the least restrictive option?

# Psychological restraint as a risk flashpoint for inadvertent rights breach

Given the cultural and environmental elements that make up the use of psychological restraint it is more likely that psychological restraint is something that would likely be an inadvertent form of restraint and an inadvertent rights breach (if it is not a deliberate tactic of abuse).

Physical restraint is clearer to understand, as the framework for this is more obvious. Whereas the concept of psychological restraint presents areas that health and social care staff may find difficult to navigate. For example, at what point does explanation become restraint? Explaining to a patient how escalation may occur in certain circumstances could be perceived by a patient as threatening. However, the staff's motivation for providing such an explanation might simply be to provide transparency regarding clinical policy and practice. Put differently, there can be many opportunities for miscommunication and/or misinterpretation when staff members communicate with the people they care for, especially where time resources are limited. Staff therefore need to ensure they use clear and accessible communication as well as provide multiple options/ choices for people to avoid this happening.

Other risk flashpoints may come in the form of a lack of precision of language in discussing care planning and support plans with patients, and/or family and carers and in particular how the process of asking patients to agree to such plans or to make decisions is talked about with them. (Further information about what health and social care staff need to consider in making best interest decisions can be found in Section 4 of the MCA- for staff unsure of this they should consult their in-house legal teams).

In general, the role of mental health services is to help people to a point where they can make decisions as autonomously as possible, and to get to a place they can lead their lives as freely as they can. It is not the role of health and social care facilities to educate, punish or discipline. Nor is it the role of services to 'correct' choices that staff deem to be unwise. An unwise decision, or one clinicians regard as irrational, does not mean a person lacks capacity to make one.[32]

32 Re C (adult: refusal of medical treatment) [1994] 1 All ER 819 (QBD)

# Strategies to avoid psychological restraint

The Restraint Reduction Network has devised six ways in which communication strategies can be persuaded by staff that will help to avoid psychological restraints and enhance rights respecting practice.

1. Helping patients to explore their choices
2. Staff should try to understand how patients might feel
3. To talk, listen and respond in a spirit of equality
4. Staff should try to support decision making, this including people making discussions they regard as unwise
5. When staff do have to make decisions for a patients they should do so mindful of the need to treat the person who is having a decision made for them with care and compassion
6. When a patient is restrained staff should support that patient and draw lessons from the experience [33]

33 Restraint Reduction Network, 'Psychological restraint poster' Restraint Reduction Network, 2023

# Conclusion

As with many human rights issues the most import question that any clinician can ask is "what about this person's human rights?" This is not a question that requires advanced legal knowledge - for legal questions this should be referred appropriately. Asking such a question can open up conversations about practice that can highlight issues that before have gone unnoticed until they are framed in human rights terms.

The vast majority of staff in mental health units are driven by a desire to do what is best for their patients. Many would be saddened to think that they were causing those they care for distress. In the context of busy, high-pressure jobs often carried out in context of limited resources, staff may not appreciate the potential toxicity of a wards culture and how this might be filtering into their communication. They may not realise the power that their words and behaviours have on patients and may not identify the way these constitute psychological restraint. A human rights-based approach to practice can go a long way in dealing with these issues and stopping psychological restraint before it starts.

The resources that accompany this document help provide the tools that can support the identification of cultural and environmental factors that give rise to psychological restraint. They will not only help practitioners to understand more clearly the ways psychological restraint manifests, but also assist in identifying whether there are issues emergent on a ward's culture that point to a potential problem with the use of psychological restraint.

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