

**HUMAN RIGHTS WORKING GROUP ON
RESTRAINT AND SECLUSION**

**Guidance on
Restraint and Seclusion
in Health and Personal Social Services**

AUGUST 2005

CONTENTS

	Paragraph	Page
WHO SHOULD READ THIS GUIDANCE?		7
1. INTRODUCTION		
Background to this guidance	1.1-1.2	9
Purpose of this guidance	1.3-1.6	9
Legislative context	1.7-1.9	10
Legislative position	1.10-1.11	10
When may restraint or seclusion be appropriate?	1.12-1.13	11
Risk assessment	1.14	11
Current position – questionnaire	1.15	11
Existing professional or practice guidance	1.16	12
Equality Impact Assessment: equality screening	1.17	12
2. DEFINITIONS AND CONCEPTS		
Definition of “service user”	2.1	13
Definition of “restraint”	2.2-2.5	13
Definition of “proportionate”	2.6-2.8	14
Definition of “seclusion”	2.9-2.12	15
Definition of “time out”	2.13	16
Nature and types of physical interventions	2.14-2.16	16
Planned physical interventions	2.17-2.19	17
<i>(i) Ecological strategies and the environment of the service user (primary prevention)</i>	2.20-2.24	17
<i>(ii) Early intervention and de-escalation (secondary prevention)</i>	2.25-2.26	18
<i>(iii) Emergency use of physical interventions</i>	2.27-2.28	19

	Paragraph	Page
3. QUALITY ASSURANCES, COMPLAINTS AND ADVOCACY ARRANGEMENTS AND POST-INCIDENT MANAGEMENT AND MONITORING		
Quality assurances	3.1-3.4	21
Complaints and advocacy arrangements	3.5-3.8	22
Post-Incident Management and Monitoring	3.9-3.18	22
4. LEGISLATIVE CONTEXT		
General	4.1-4.2	27
The Rights of the Child (UNCRC)		
The European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998	4.3-4.8	27
The United Nations Convention on the Rights of the Child (UNCRC)	4.9-4.23	28
Restraint and seclusion: human rights issues and the key caselaw	4.24-4.31	31
Impact of legislation for specific service users	4.32-4.54	33
Conclusion	4.55	40
5. PRINCIPLES INVOLVED		
General	5.1-5.10	41
Proactive use of restrictive physical interventions	5.11-5.12	43
Emergency use of restrictive physical interventions	5.13-5.18	43
<i>STATEMENT OF PRINCIPLES</i>	5.19	45

6. REFERENCE/BIBLIOGRAPHY

47

ANNEXES

- Annex A: Outline Terms of Reference**
- Annex B: Membership of Working Group**
- Annex C: Membership of Sub-Group on Legislative Context**
- Annex D: Example of HSS Trust Management of Aggression Policy**
- Annex E: Example of HSS Trust Protocol on the Use of Physical Restraint**
- Annex F: Example of HSS Trust Policy on Seclusion**
- Annex G: Questionnaire and Summary of Findings**
- Annex H: Equality Impact Assessment: equality screening**
- Annex I: (a) Example of HSS Trust Restraint Report Form
(b) Example of HSS Trust Seclusion Report Form**
- Annex J: DE Circular 1999/9 "Guidance on the Use of Reasonable Force to Restrain or Control Pupils"**

WHO SHOULD READ THIS GUIDANCE?

This guidance is intended to be used by:

- service commissioners in health and social care;
- managers of health and social care services;
- staff/professionals working with children and adults who may require to use restraint and/or seclusion;
- internal monitors of services and/or facilities;
- persons responsible for the operation of independent sector services or homes;
- Registration and Inspection staff;
- trainers and training providers.

The information in this guidance may also be helpful to:

- parents and those with parental responsibilities;
- Health and Social Services Councils;
- the Mental Health Review Tribunal;
- the Mental Health Commission;
- independent advocates;
- service users.

1. INTRODUCTION

Background to this guidance

- 1.1 This guidance on the use of restraint and seclusion is issued by the Department of Health and Social Services (DHSSPS) to inform practice across the Health and Personal Social Services (HPSS) bodies and their agents. It is the result of work undertaken by a HPSS Working Group, initiated by the DHSSPS Human Rights Liaison Group to assist in promoting human rights in these key areas.
- 1.2 The Liaison Group recognised that restraint and seclusion was an issue of common concern across HPSS and best tackled collaboratively. The Working Group which compiled the guidance was multi-professional and comprised of members from both the voluntary and statutory sectors. The outline terms of reference of the group are provided at **Annex A** and the membership at **Annex B**. Aspects of this guidance relating to the legislative context were taken forward through a sub-group and **Annex C** provides details of those involved.

Purpose of this guidance

- 1.3 The guidance is intended to be of an overarching nature, to be used to inform at provider level, the development of policies and procedures, training and practice across the relevant client groups in both hospital and other residential settings. The starting point for establishing good practice in the use of restraint and seclusion is the development of organisational policies, which reflect current legislation and case law as well as Departmental guidance, professional Codes of Practice and local circumstances, including the characteristics of the children or adults cared for within particular services. Every agency included within the remit of this guidance is expected to have a policy on the use of restraint and/or seclusion. The definitions of restraint and seclusion for the purpose of this guidance are examined at Section 2. The amount of detail needed will depend upon local circumstances but it should cover the areas set out in **Annex D** (example of HSS Trust Management of Aggression Policy), **Annex E** (example of HSS Trust Protocol on the Use of Physical Restraint and **Annex F** (example of HSS Trust Policy on Seclusion), as appropriate.
- 1.4 This guidance is issued to help ensure that staff working in various health and social care settings adopt consistent practices in the use of restrictive physical interventions and seclusion based upon common sets of principles. This will provide the most effective support for individual service users and reduce the possibility of confusion or disagreements between staff employed by different agencies.
- 1.5 This guidance will help staff in health and social services and elsewhere to address important outcomes for children and other service users, such as protecting and promoting their rights, providing appropriate choices, promoting independence and encouraging their social inclusion.

- 1.6 This guidance, by providing a clear framework to inform staff's practice in these complex areas of work, seeks to facilitate service standards which are consistent with best practice in relation to safeguarding service users and the Human Rights Act and that also reduce the risk to staff of litigation. **HSS Trusts should use the guidance to inform the production of policies and procedures on the use of restraint and/or seclusion.**

Legislative context

- 1.7 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to:

- respect for his/her private and family life;
- the right not to be subjected to inhumane or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.

- 1.8 People are also protected under domestic legislation in terms both of the protection of their rights and the potential for redress through the criminal and civil law for assaults against the person.

- 1.9 Underlying this guidance is the principle that actions must both comply with the letter of the law and incorporate the spirit of respect for human rights.

Legislative position

- 1.10 The issues of restraint and seclusion are not usually dealt with in primary legislation. Generally, these procedures are informed by guidance and regulations. There is, therefore, little uniformity of approach across both client groups and service areas. There is an increasing focus on the legitimacy of restricting the liberty of an individual, arising from increased awareness of the potential for challenge as a breach of an individual's rights. In addition, increased awareness of individual's rights to seek redress through resort to the criminal and civil courts has raised both staff's and employers' interest in ensuring these processes are used as a last resort, in a safe and therapeutic manner and in a way which protects both staff and the service user.

- 1.11 Section 4 (Legislative Context) and paragraph 5.2 of this guidance provide detailed consideration of some of the key legislative considerations which need to be considered when using either restraint or seclusion.

When may restraint or seclusion be appropriate?

1.12 Restraint and seclusion should be used only for controlling violent behaviour or to protect the service user or other persons. In exceptional circumstances, physical intervention may be necessary to give essential medical treatment. The decision to use either is extremely serious and restraint and seclusion should only be used as follows:

- as intervention of **last resort**;
- where other, less restrictive, strategies have been unsuccessful, although an emergency situation may now allow time to try those other strategies;
- **never** for punishment;
- in reaching the decision, consideration should also be given to the individual needs of each service user in deciding the best method of control or restraint to be employed.

1.13 Decisions to use either restraint or seclusion have serious civil liberties implications as these interventions limit or restrict the freedom of movement of an individual. Section 4 on the Legislative Context covers these issues in more detail.

Risk assessment

1.14 Risk assessment is an essential element in the care and treatment of all patients and clients and should underpin the guidance which service providers make available to staff. It could be argued that it is one of the most fundamental interventions in the recognition, prevention and therapeutic management of violence and aggression. The use of other interventions such as observation, psychosocial interventions or restraint should be part of a management plan based on an assessment of risk. While it is acknowledged that the occurrence of aggressive or violent incidents are not always predictable, assessment of risk, followed by a properly developed management plan is essential to the prevention and management of aggression and violence. Being able to predict who is more likely to engage in a violent act may enable staff to reduce the risk.

Current position - questionnaire

1.15 To examine the current available guidance across Northern Ireland, the working group issued a questionnaire to all statutory agencies and a selection of independent providers. A copy of the questionnaire and the summary findings are at **Annex G**.

Existing professional or practice guidance

- 1.16 Guidance on the use of restraint for adults is available in the book *Physical Interventions: A Policy Framework* (BILD 1996), which provides advice and information on the use of physical interventions in different service settings.

Equality Impact Assessment: equality screening

- 1.17 This paper has been screened for equality implications and the findings are given in **Annex H**.

2. DEFINITIONS AND CONCEPTS

Definition of “service user”

- 2.1 In this guidance, the term ‘service user’ is used to refer to adults and children who receive services from HPSS organisations and their agents in care establishments, hospitals or any other health settings and within their own homes.

Definition of “restraint”

- 2.2 **Different forms of physical intervention are summarised in the table below.** The table demonstrates the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons, this guidance is specifically concerned with the use of restrictive physical interventions. For the purpose of this guidance the terms “restraint” and “physical restraint” mean “restrictive physical interventions”.

Examples of non-restrictive and restrictive physical interventions

	Bodily contact	Mechanical	Environmental change
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

- 2.3 Physical restraint can, therefore be summarised as:

The use of any part of one's body, or mechanical method, to prevent, restrict or subdue movement of any part of another person's body. It can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;
- to separate the person from a ‘trigger’, for example, removing one service user who has responded to another with physical aggression;
- to protect a service user from a dangerous situation – for example, the hazards of a busy road.

2.4 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans; and
- *emergency or unplanned* use of force which occurs in response to unforeseen events.

2.5 In common law anyone who has the duty to care for another person is expected not to interfere unduly with the personal freedom and autonomy of the person in his/her care. Nevertheless, if restraint is necessary for the safety of that person or others it may be justified as long as it is the **absolute minimum necessary for the minimum time possible**. As this raises the questions of what constitutes necessity and what is the absolute minimum of restraint in a given situation, it is useful to identify general principles. The section on Principles Involved (including Statement of Principles at paragraph 5.19) addresses this in more detail.

Definition of “proportionate”

2.6 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm likely to be caused. These judgements have to be made at the time, taking due account of all the circumstances, the unpredictable nature of the work and including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques employed should be those with which the staff involved are familiar and able to use safely and are described in the service user's support plan. Where possible, there should be careful planning of responses to individual service users who are known to be at risk of self-harm, or of harming others.

2.7 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming or potentially self-harming behaviours;
- injury to self, other service-users, or staff ;

- serious damage to property;
 - an offence being committed.
- 2.8 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses, where possible. (See paragraph 1.14 on “Risk assessment”.)

Definition of “seclusion”

- 2.9 Seclusion is the **supervised confinement** of a service user alone in a room, the essence being the involuntary isolation of the individual. In the Mental Health (Northern Ireland) Order 1986 Code of Practice, the Mental Health Commission define seclusion as ‘the forcible denial of the company of other people by constraint within a closed environment’. The service user is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit available to the service user. This situation would also arise where the door is not locked from outside but the service user is unable to open the door, due to, for example, the height of the door handles or the person’s physical disability. The breadth of the definition is important because the practice of seclusion is subject to very stringent control and recording in comparison to other procedures.
- 2.10 The issue of seclusion is particularly complex. Seclusion is an emergency procedure, only to be resorted to when there is an immediate risk of significant physical harm. There is general agreement that it should not be considered as a form of treatment; the aim should be simply that of safe containment. Seclusion is usually unpleasant, and difficult for a service user to view other than as punishment, and not a therapeutic experience. In 1996, the Royal Colleges of Psychiatry and Nursing published a joint review into strategies for managing disturbed violent patients (“*Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units*”). The reason for the review stemmed from the well-founded and widespread concern about the potential for the misuse of seclusion. Concerns had focused on its use for prolonged periods of time (Department of Health and Social Security, 1980; Department of Health and Social Security, 1985 – full references to these reports and those below in this paragraph are given at section 6 of this guidance) as well as on the indications for, and frequency of, its use. Matters came to a head with the occurrence of several deaths, notably those of Sean Walton at Moss Side Hospital in 1988 and of three patients at Broadmoor Hospital (Department of Health, 1993). In 1992 the Committee of Inquiry into complaints at Ashworth Hospital strongly recommended the abolition of seclusion within that hospital as well as a wider, statutory prohibition (Department of Health, 1992). Since the Ashworth Inquiry the Special Hospitals have made it their stated policy to limit the use of seclusion to exceptional circumstances and to promote alternative approaches for the

management of violence. **This approach is endorsed by this Working Group which recommends its adoption.**

2.11 In considering seclusion there is a need to draw a distinction between:

- *seclusion* where a service user is forced to spend time alone against his/her will;
- *time out* which involves restricting the service user's access to all positive reinforcements as part of a behavioural programme (this is explored in more detail in paragraph 2.13); and
- *withdrawal* which involves removing the person from a situation which causes anxiety or distress, to a location where he/she can be continuously observed and supported until ready to resume usual activities.

2.12 The 1996 review (see paragraph 2.10 above) noted that:

“Any credible review of the use of seclusion must consider other, more routine and therapeutic approaches to aggression that might forestall or replace the practice.”

Definition of “time out”

2.13 Time out is a procedure whereby the service user is separated temporarily from the current environment as part of a planned and recorded therapeutic programme to modify his/her behaviour. The breadth of its definition is open to misuse to encompass what is, in fact, seclusion. Although a distinction is made between it and seclusion, in practice it is less readily separable. This potential for confusion is open to abuse. The widespread use of time out, particularly with certain service user groups, such as children or those with a learning disability, makes it difficult to regulate to the same extent as seclusion. It has been recommended that the term ‘time-out’ be avoided in preference to a clear description of the procedure that is actually proposed. Such an approach inevitably raises the issue of consent, which should underwrite all therapeutic processes. **The term 'time out', or another comparable term, must state explicitly exactly what this entails within the practice of the unit and procedures regarding consent etc for its use. Policies should also provide for ensuring that the understanding of service users is clearly recorded and the action monitored and reported to a senior staff member as soon as possible: in the case of children, parents or those with parental responsibility should also be informed at the earliest possible opportunity.**

Nature and types of physical interventions

2.14 There are three broad categories of physical interventions as described by Harris et al (1996):

- **direct physical contact** between a member of staff and services user;
 - **the use of barriers** to limit freedom of movement;
 - **materials or equipment which restrict or prevent movement.**
- 2.15 **Physical intervention skills** are described by McDougall (1996) as a set of techniques that are designed and taught to momentarily prevent or curtail a behaviour which is deemed to be dangerous to that individual or others.
- 2.16 No physical intervention, whether planned or emergency, should ever intend or knowingly be allowed to cause pain.

Planned physical interventions

- 2.17 The planned use of physical interventions involves the use of an agreed strategy which includes the possible use of physical intervention to intervene in a sequence of behaviours with the aim of avoiding or reducing injury/injuries.
- 2.18 Planned physical interventions, including restraint for the purposes of medical interventions, should be part of a broader therapeutic strategy. It is envisaged that there may be rare occasions when restraint might be necessary, in someone's best interests, to facilitate urgent medical treatment. Where medication may be used to facilitate restraint in the management of disturbed or violent behaviour, reference should be made to the recent NICE guidance "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments".
- 2.19 Planned physical interventions are normally used as a last resort. Strategies designed to manage aggressive/violent behaviours should include:
- i. ecological strategies and the environment of the service user;
 - ii. early intervention and de-escalation;
 - iii. emergency use of physical intervention.
- (i) ***Ecological strategies and the environment of the service user (primary prevention)***
- 2.20 Ecological Strategies involve providing environments likely to reduce the likelihood of aggressive or violent behaviours occurring. It involves changing aspects of an individual's personal environment to minimise situations arising that are known precursors to the service user displaying behaviours which have implications for the safety of him/herself or others.
- 2.21 It is the context in which violence occurs that is of most importance when considering measures to limit the use of restraint and/or seclusion. Violence may reflect the expectations of the staff, low levels of staffing or changing staffing. The emphasis is moving from the control of violence to its prevention

by measures such as an improved environment and staffing, both in levels and skills. Crucial to this are staff attitudes, training, good communications and supervision.

- 2.22 Children are particularly responsive to their surroundings. Special attention needs to be paid to creating a safe environment for disturbed and violent children. A designated safe area or safe room may be helpful, but this should reflect normal domestic living space as far as possible. Children and adults with certain disabilities, such as autism, benefit from routine, regularity and predictability in their lives which in turn makes disturbed and violent behaviour less likely to occur. People of all ages are less likely to show such behaviour if they are provided with choices or are kept active with relevant challenges.
- 2.23 In a designated safe area, it is necessary to minimize the risk of self injury or of serious damage to property. In achieving this aim, it is important to balance the service user's need to be cared for in an environment which reflects normal living space (in terms of decoration and furnishings, where appropriate) with the need to ensure his/her safety.
- 2.24 Trusts and other providers in constructing operational guidance for the use of seclusion and/or restraint need to consider how they can manage the service users' environment or care setting to limit the potential for violent and/or aggressive behaviour. Environment, in this context, includes both the physical environment and the level and qualification of staff. A comprehensive understanding of how setting, staff and service users can interact is necessary to ensure preventative as well as reactive strategies are in place to deal with service users with complex and at times challenging needs.
- (ii) *Early intervention and de-escalation (secondary prevention)*
- 2.25 Plans for early intervention and de-escalation are instigated after it becomes clear that an aggressive episode of behaviour is likely to occur. They seek to prevent the escalation of such behaviours and in all cases they should be individualised to the service user concerned. These approaches focus on communication, negotiation, use of staff body language, personal space etc. with the overall aim of maintaining safety.
- 2.26 The use of physical interventions generally raises a number of serious issues for service users, staff and service providers alike. The following are some issues which should be considered more fully, with each organisation regularly providing clear guidelines and advice to staff.
- Consent of service users issues as covered in DHSSPS Guidance “Good Practice in Consent”, particularly where there are issues relating to children and the competence of other service users to provide valid consent.
 - Assessment for benefit and risks associated with the procedure.

- Legal, ethical and professional issues.
- Physical health status of the service user.
- Impact on individual of intervention.
- Least restrictive physical intervention.
- Particular vulnerability of service users taken into account.
- Staff requirements.
- Method of recording, reporting and reviewing.

(iii) Emergency use of physical interventions

2.27 Emergency physical interventions may be required in response to unexpected episodes of aggressive or violent behaviours. Physical interventions can be justified to maintain the safety of the service user or others. However, the amount of force used must be proportionate to the level of threat presented by the service user - staff should use the minimum amount of force for the least amount of time required with the aim of maximising the safety of everyone involved.

2.28 Following the use of emergency physical interventions, procedures should be followed which entail recording/reporting the incident and the updating of the service user's individual care plan to include assessment of risk, preventative strategies and a programme of planned responses to any such future behaviour. (See paragraphs 3.9-3.18 on Post-Incident Management Monitoring).

3. QUALITY ASSURANCES, COMPLAINTS AND ADVOCACY ARRANGEMENTS AND POST INCIDENT MANAGEMENT AND MONITORING

Quality assurances

- 3.1 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables service users, regardless of age or need, maximum opportunity for personal growth and emotional wellbeing.
- 3.2 In care settings, good practice in the use of restraint and seclusion described in this guidance will be monitored as part of HSS Trusts' compliance with the Duty of Quality requirements established by the HPSS Order 2003, which commenced in April 2003. The establishment of the HPSS Regulatory and Improvement Authority (HPSSRIA), which is scheduled to become operational in 2005, will also ensure that standards of practice and levels of compliance in these areas will be regulated on an independent basis across the statutory and independent sectors. It is also expected that local policies and procedures explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restraint and/or seclusion.
- 3.3 Under health and safety legislation, employers are responsible for the health safety and welfare of their employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of restraint and seclusion. Employers should establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about service users with whom they are working.
- Leadbetter and Trewartha (Leadbetter, D and Trewartha, R (1995) A question of restraint, *Care Weekly*, 18 May, 10-11) noted that employers have to give equal priority to the safety of staff and service users. Under Health and Safety legislation (Health and Safety at Work Act 1974), they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This obligation has been reinforced by civil cases successfully brought by employees against their employers. Leadbetter and Trewartha cite the case of Walker v. Northumberland County Council (1994) where the judgement hinged on the council's failure in their duty of care in that they had not taken action to avoid or mitigate 'reasonably foreseeable' risks to their employee's health.
 - Lindsay and Hosie (Lindsay, M and Hosie, A (2000) *The Edinburgh Inquiry - Recommendation 55. The Independent Evaluation Report*.

University of Strathclyde and the former Centre for Residential Child Care) state that in the case of litigation employers would have to demonstrate that the method of restraint they chose best suited the needs and circumstances of their clients and, on the basis of the best available advice, was likely to address the demands of day to day practice. The problem is that there is a striking absence of evidence about the respective merits of the various techniques.

- 3.4 Commissioning authorities will need to ensure that provider agencies' policies and procedures follow this guidance where restraint and/or seclusion is used. Registration and Inspection staff will also monitor the implementation of the resulting policies and procedures in the course of their work across the statutory and independent sectors.

Complaints and advocacy arrangements

- 3.5 Complaints arrangements should follow policies developed for Trusts in response to the “Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services (April 2000)” and Children Order (Article 45(3)) requirements in respect of complaints and representations made in relation to children's social services.
- 3.6 Trust staff should ensure that complainants are easily able to make a complaint, that this process is simple and aimed at satisfying the complainants' concerns. Where necessary staff should provide information on the Advocacy Service available. Responses to complainants should be timely and emphasise early resolution. Staff should be informed of the existence of a complaint and appropriate staff involved in the investigatory process. Staff should also be informed of the outcome of any complaints made in respect of them.
- 3.7 Discussions should take place on the investigatory process and feedback from complaints should inform any review of complaints at team meetings.
- 3.8 Training and awareness building should usually be managed within the organisation, with lessons emerging from complaint case studies used to promote the development of good practice. To this end, Trusts and other providers should annually monitor complaints received in relation to the use of restraint and seclusion. This annual review should be used to inform, where necessary, the revisions of policies and procedures and the design of staff training and support processes.

Post-Incident Management and Monitoring

General

- 3.9 It is recognised that Post- Incident Management and Monitoring (PIM&M) is critical where restraint or seclusion are used. Some Trusts may regularly audit the use of these processes as this is considered good practice. Auditing and

monitoring should be carried out on a multi-disciplinary basis, where appropriate.

3.10 The PIM&M procedure will have the following elements clearly itemised within it:

- feedback to those with parental responsibility/carers that does not infringe on the service user's right to confidentiality;
- debriefing the service user after the incident;
- providing information on how to make a complaint;
- service users who are injured will always be examined by a doctor following the incident;
- Trust accident/incident form will be completed as soon as possible after the incident, stating exactly what happened – **no assumptions: facts only** (examples of incident forms are given at Annex I (a) - Restraint Report Form - and Annex I (b) (Seclusion Report Form – organisations will develop their own format to cover their particular circumstances);
- details of all/incidents are recorded in service users' files. In some instances, this record is required even where a separate monitoring form is in use.
- Reports to outside agencies (Mental Health Commission, HPSSRIA etc).

3.11 If staff are injured – a statement must be completed to include as a minimum the following information:

- place where injury happened;
- number of staff on duty and their location at the time of the incident;
- number of service users in the area.

Staff

3.12 Where staff are injured the following actions are required:

- refer staff to Occupational Health Department or Accident and Emergency Department if injured. If they decline, advise them to contact their own GP and record this advice;

- accident report form to be completed according to Trust policy requirements.

3.13 It is important that staff are made aware of the potential emotional shock that may follow on from an assault or injury. Managers/peers need to be supportive, recognising that even minor incidents, such as verbal abuse/comments, can be traumatic. Staff should be given the opportunity to talk and express how they feel. A de-briefing discussion after an incident can assist those involved. Relevant areas for discussion include:

- identification of cause/trigger factors to incident;
- ascertaining what exactly occurred;
- identifying staff's role in the incident;
- ascertaining the feelings of staff involved;
- what learning experiences and/or training needs can be identified from incident.

Staff Support

3.14 Employers have responsibilities to support all staff. To this end, individual members of staff involved in an incident must be given an opportunity to discuss their feelings. This will include:

- individual/group discussion with the line manager;
- access to confidential counselling from Occupational Health Department through self-referral or line management referral;
- awareness of professional body or Trade Union role/support;
- multidisciplinary review/debriefing discussion of incident with colleagues/peers to allow staff to review, reflect and talk about their views following the occurrence;
- access to confidential staff care or support system.

Monitoring Arrangements

3.15 Effective monitoring procedures are essential and must be comprehensive and timely. Monitoring includes:

- the risk of violence being regularly assessed by appropriate senior staff which will vary according to the setting;

- assessing the effectiveness of the implementation of existing policies and procedures, identifying any gaps or need for updating;
- reassessing the effectiveness of countermeasures introduced and disseminating good practice examples;
- discussions at staff meetings, senior staff meetings etc. to raise issues arising with a view to improving safeguards for both service users and staff. This should include ensuring staff are aware of whistle blowing policy and feel confident in using it;
- recording and analysis of complaints made, ensuring that reports are regularly brought to the attention of the Trust's Chief Executive under Clinical and Social Care Governance arrangements.

Audit

3.16 Audit mechanisms should focus on a number of factors which can give managers a baseline assessment on the effective implementation of policy, such as:

- number of incidents of physical injuries sustained by service users as a result of a violent episode;
- number of incidents of physical injuries sustained by staff as a result of a violent episode;
- number of incidents of verbal/threatening behaviour to staff/service users;
- number of occasions that physical restraint, "time out" or equivalent was carried out in a setting, identifying any possible explanation for peaks and troughs in its usage over time.

3.17 It can be helpful to use audit information to compare levels of violence, restraint or seclusion across similar service areas to ascertain if there are any environmental factors (see paragraphs 2.20-2.24) which are either serving to reduce or increase levels in any setting.

Where service users are injured

3.18 If a service user is injured as a consequence of the use of restraint, the following action is required:

- ensure the service user receives appropriate and timely medical assistance;

- notify carer, parent or those with parental responsibility immediately of the injury and the steps taken to deal with the injury, securing appropriate consent for treatment where necessary;
- make a detailed record of the event and the consequences in the service user's case file;
- complete an accident report form and inform the Trusts Risk Management Unit which will make any other necessary notifications;
- complete a Physical Intervention Monitoring/Restraint Report Form (example attached at **Annex I(a) – organisations will develop their own forms to cover their particular circumstances**);
- senior managers review incident on discussion with staff and ascertain if there are any training, support or supervisory matters which require to be addressed;
- inform service user, carer, parent or those with parental responsibility of the Trust's complaints arrangements and how to access them.

4. LEGISLATIVE CONTEXT

General

- 4.1 Generally, primary legislation makes little explicit reference to the use of restraint and seclusion, with the issue being dealt with in most areas by Guidance and Regulation. The exception to this is the education sector where the use of restraint in schools by authorized persons is regulated by primary legislation and by detailed guidance. There is, however, no uniformity of approach across different sectors and no standard threshold indicating when restraint or seclusion can be used legally. Legislatively and in terms of best practice, restraint and seclusion in relation to the care of service users should only be used in exceptional circumstances and it must be ensured that all techniques used are approved, safe and in compliance with international rights standards. The DHSSPS has issued guidance on consent (Good Practice in Consent) with which staff should acquaint themselves.
- 4.2 The remainder of this section considers **the European Convention on Human Rights (ECHR)** and **the United Nations Convention on the Rights of the Child (UNCRC)** before outlining some case decisions to assist with identifying situations where the use of restraint or seclusion is potentially open to challenge under these international conventions. It concludes with comment on the legislative context for specific groups of service users who are identified as particularly vulnerable.

The European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998

- 4.3 Many of the following paragraphs use children's cases for illustrative purposes. This reflects the expertise of the legal issues sub-group whose remit was to specifically address the issue in respect of children. The messages emerging have, however, wider application and the working group has edited the sub-group's contribution and extended parts of the material to the wider field.
- 4.4 The Human Rights Act 1998, which came fully into force in October 2000, enables most of the rights enshrined in the ECHR to be pursued in the domestic courts rather than through the European Court of Human Rights (ECtHR). All public authorities are obliged to discharge their functions in accordance with the rights sets out in the ECHR and the courts must take Convention rights into account when deciding cases. These rights apply to both children and adults.
- 4.5 In the context of the use of restraint and seclusion the following articles of the ECHR should be taken into consideration.

Article 3 ECHR

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

Article 5 ECHR

- 4.7 Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
- (a) the lawful detention of a person after conviction by a competent court;
 - (b) the lawful arrest or detention of a person for non compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
 - (c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority;
 - (d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purposes of bringing him before the competent legal authority;
 - (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, and of drug addicts or vagrants;
 - (f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

Article 8 ECHR

- 4.8
1. Everyone has the right to respect for his private and family life, his home and his correspondence.
 2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The United Nations Convention on the Rights of the Child (UNCRC)

- 4.9 The UNCRC is an international treaty on children's rights, which all countries have signed with the exception of U.S.A. and Somalia. The key relevant provisions of the UNCRC are set out below.

Article 1 UNCRC

- 4.10 For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2 UNCRC

- 4.11 States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
- 4.12 States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members.

Article 3 UNCRC

- 4.13 In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
- 4.14 States Parties undertake to ensure the child such protection and care as is necessary for his or her well being, taking into account the rights and duties of his/her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end shall take all appropriate legislative and administrative measures.
- 4.15 States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff as well as competent supervision.

Article 12 UNCRC

- 4.16 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 19 UNCRC

- 4.17 States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child.

Article 25 UNCRC

- 4.18 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 37 UNCRC

- 4.19 States Parties shall ensure that:
- (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.
 - (b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.
 - (c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which take account of the needs of a person of his/her age. In particular every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

- (d) Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 UNCRC

- 4.20 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self respect and dignity of the child.

The United Nations Committee on the Rights of the Child

- 4.21 The implementation of the UNCRC is monitored by the United Nations Committee on the Rights of the Child. In the “Concluding Observations of the United Nations Committee on the Rights of the Child, United Kingdom of Great Britain & Northern Ireland”, October 2002¹ the Committee expressed concern about figures indicating that children had sustained injuries as a result of the use of restraints and control in prison. In addition, the Committee expressed concern about the frequent use of physical restraint in residential institutions and in custody as well as the placement of children in solitary confinement in prisons.
- 4.22 The Committee recommended the review of the use of restraint and solitary confinement in relation to children and young people in custody, education, health and welfare institutions to ensure compliance with the UNCRC in particular articles 25 and 37 UNCRC (paragraphs 4.18 and 4.19 respectively of this Guidance).
- 4.23 The Committee also expressed concern that the principle of primary consideration for the best interests of the child is not consistently reflected in legislation and policies affecting children and recommended that the principle of the best interests of the child as a paramount consideration should be enshrined in all legislation and policy affecting children.

Restraint and seclusion: human rights issues and the key caselaw

- 4.24 Seclusion is described in the Department of Health (England and Wales) Code of Practice (1999) as:

¹ The Concluding Observations of the UN Committee on the Rights of the Child published on 9 October 2002 and available online at www.unhcr.ch/tbs/doc.nsf

“the supervised confinement of a patient in a room, which may be locked for the protection of others from significant harm.”

- 4.25 In practice, seclusion is a form of solitary confinement which can be used for therapeutic, containing or punitive purposes. The purpose of restraint has been described by the Department of Health as the use of physical force against a patient to minimise unacceptable behaviour. Both seclusion and restraint in relation to the care of service users raise potential human rights issues. A number of these issues have been raised in the domestic courts and further guidance can be obtained from the case law of the European Court of Human Rights (ECtHR).
- 4.26 The leading domestic authority on the use of restraint in the mental health context remains the House of Lords decision in *Pountney v Griffiths* [1976] AC 314 where it was held that hospital staff had “powers of control over mentally disordered patients, whether admitted voluntarily or compulsorily, though the nature and duration of the control varies with the category of patient to which the patient belongs.” The ECtHR decision in *Herczegfalvy v Austria* [1992] has placed the concept of medical necessity at the core of any intervention of this type. The ECtHR stated that:
- “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.....The established principles of medicine are admittedly 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.” (Highlighting added.)
- 4.27 The question of the burden of proof in relation to whether a medical necessity has been “convincingly shown” was examined in *R v Dr M and others ex parte N* [2003] 1 WLR 562 where the Court of Appeal held that while the requirement was not equivalent to a criminal burden of proof it still required a high standard of proof. The decision in this case is an important one in that the Court of Appeal reviewed the common law authorities on consent to treatment. Simon Brown LJ found that the “therapeutic necessity” test applied both to patients with and without capacity. This decision would appear to indicate that where treatment of questionable therapeutic benefit is administered to a patient who strongly opposes it, and which will, if administered, involve the use of physical force with possible detrimental effects to the patient’s health, that this will constitute a violation of Article 3 of the Convention. This approach should, therefore, apply to the use of restraint and seclusion of all service users who have capacity and to those whose capacity may be questioned as a consequence of their age or other impairment.
- 4.28 In order to breach the terms of Article 3 of the Convention the treatment in question must reach a particular threshold of severity. (See *S v Airedale NHS*

Trust [2002] EWHC 1780). Brief periods of seclusion and proportionate instances of restraint are, therefore, unlikely to reach the requisite threshold to constitute a breach of a Convention Right.

- 4.29 There is the possibility that restraint and seclusion could be argued as a breach of Article 5 of the ECHR. In the context of adult mental health the developing jurisprudence has held that Article 5 protections are restricted to the determination of whether detention is lawful or not. (See *R v Governor of Parkhurst Prison ex parte Hague* [1992] 1 AC 58.) Where detention of a child or adult takes place on a non-statutory basis then the possibility of an Article 5 breach arising from the use of either seclusion or restraint is a real one.
- 4.30 Similarly, treatment that falls short of medical necessity may constitute a breach of Article 8 of the ECHR. However, the broad justifications available in Article 8(2) are likely to render many interventions with service users to be in accordance with the ECHR.
- 4.31 The decision in *Herczegfalfy* found that there was no breach of Article 8 where the individual was restrained and force fed in circumstances where he was “entirely incapable of taking decisions for himself.” It remains to be determined whether differential treatment of service users deemed to lack capacity because of age or intellectual impairment will fall foul of the anti-discrimination provisions of Article 14 of the Convention. It should be noted that a mere assertion of differential treatment is not enough to ground an Article 14 point. (See Carswell LCJ’s discussion in *Re Jean McBride* [2003]).

Impact of legislation for specific service users

Professional guidance relating to medical settings

- 4.32 The British Medical Association in a recent publication set out a number of considerations in relation to the use of restraint in respect of the care of children in medical settings:²
1. Restraint should only be used where it is necessary to give essential treatment or to prevent a child from significantly injuring him/herself or others.
 2. Restraint is an act of care and control, not punishment.
 3. Unless life prolonging or other crucial treatment is immediately necessary, the approval of a court should be sought where treatment involves restraint or detention to override the views of a competent

² British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People*, BMJ Books, 2001.

young person, even if the law allows doctors to proceed on the grounds of parental consent.

4. All steps should be taken to anticipate the need for restraint and to prepare children, their families and staff for its use.
 5. Wherever possible, the members of the health care team involved should have an established relationship with the child and should explain what is being done and why.
 6. Treatment plans should include safeguards to ensure that restraint is the minimum necessary to achieve the clinical therapeutic aim, and that both the child and parents have been informed what will happen and why the use of restraint is considered necessary.
 7. Restraint should only be used in the presence of other staff, who can act as assistants and witnesses, unless there is no other means of protecting the service user or others.
 8. Any use of restraint or detention should be recorded in the medical case records. These issues are appropriate subject for clinical and social care audit.
- 4.33 The Royal College of Nursing has issued Guidance on the use of restraining and preventing children from leaving a medical setting.³

Children's residential care services

- 4.34 The relevant provisions on children's residential care services are to be found in the Children (Northern Ireland) Order 1995, regulations made under the Order and in Volume 4 (Residential Care) of the associated series of volumes of "Guidance and Regulations". There is no reference at all in the 1995 Order to the use of restraint or isolation. The Children's Homes Regulations (Northern Ireland) 1996, made under the Children Order, make provision at regulation 8 in relation to control and discipline. Regulation 8 (2) sets out measures which should not be used on children in a children's home; and regulation 8 (3) gives measures which the regulations do not prohibit, including "the taking of any action immediately necessary to prevent injury to any person or serious damage to property".
- 4.35 These provisions are considered under 'Good Order and Discipline' in Chapter 4 of Volume 4 of the Guidance and Regulations. In particular, the following areas are set out and dealt with:
- Disciplinary Measures – general (Paragraph 4.14)

³ The Royal College of Nursing. *Restraining, Holding Still and Containing Children: Guidance for Good Practice*. London: RCN, 1999.

- Permitted disciplinary measures (Paragraphs 4.15 – 4.19)
- Prohibited measures (paragraph 4.20)
 - Corporal punishment
 - Deprivation of food and drink
 - Restriction or refusal of visits/communications
 - Requiring a child to wear distinctive or inappropriate clothing
 - The use or withholding of medication or medical or dental treatment
 - The use of accommodation to physically restrict the liberty of any child
 - Intentional deprivation of sleep
 - Imposition of fines
 - Intimate physical searches
- General principles governing interventions to maintain control (Paragraph 4.21)
- Methods of care and control of children which fall short of physical restraint or the restriction of liberty (Paragraph 4.42)
- Use of physical presence of staff (Paragraphs 4.43 – 4.24)
- Holding (Paragraphs 4.2.5 – 4.25)
- Touching (Paragraphs 4.27 – 4.28)
- Physical restraint (Paragraphs 4.29 – 4.34)
- Restriction of liberty (Paragraphs 4.35 – 4.39)
- Monitoring (Paragraph 4.40)

4.36 The Children Order guidance provides specific guidance on the use of restraint and the restriction of liberty. Paragraph 4.13 specifically prohibits the locking of children in their bedroom at night "whatever their age and competence". The Guidance outlines permissible forms of care and control and establishes a comprehensive list of general principles governing interventions to maintain control.

Foster care

4.37 The Foster Placement (Children) Regulations (NI) 1996 provide for the approval of Foster Parents (Regulation 3), the Review and Termination of Approval (Regulation 4), Placements (Regulation 5) and Termination of Placements (Regulations 7).

- 4.38 Regulations 3(6)(b) provides that an authority shall not place a child with an approved foster parent unless he enters into a written agreement with it covering the matters specified in Schedule 2 (Matters and obligations to be covered in foster care arrangements). Pursuant to Paragraph 5 of the Schedule each foster carer must specifically agree "Not to administer corporal punishment to any child placed with him".
- 4.39 Under the Guidance issues in respect of the Children (NI) Order 1995 (Volume 3 Family Placements and Private Fostering) at paragraph 4.31 (Assessment and approval of foster carers) there is a duty placed on the social worker to 'ascertain the applicant's views on discipline with particular regard to the issue of corporal punishment which is not regarded as an appropriate means of correcting children'. The term "corporal punishment" is then defined to cover 'any intentional application of force as a form of punishment, including slapping, pinching, squeezing, shaking, throwing objects and rough handling. It would also include punching or pushing in the heat of the moment in response to violence from young people. It does not prevent a person taking necessary physical action where any other course of action would be unlikely to avert immediate danger of physical injury to the child or to another person, or to avoid immediate danger to property. Verbal abuse, derogatory remarks and pointed jokes can cause psychological harm to a child and should be avoided'.
- 4.40 In relation to children who are privately fostered, the Trust does not approve or register private foster parents but must satisfy itself that the arrangements are satisfactory that the private foster parents are suitable. The responsibility for safeguarding and promoting the welfare of the privately fostered child rests with the parents. Regulation 2(2)(j) of The Children (Private Arrangements for Fostering) Regulations 1996 places a duty on the Trust to satisfy itself that the private foster parent is being given any necessary advice. Pursuant to Chapter 15 (Suitability of the foster parent) of the Guidance Volume 3 there is reference to discipline with particular regard to the issue of corporal punishment (paragraphs 15.13-15.14). The definition of corporal punishment is provided and there is requirement that a child should not be refused meals or drink as punishment nor restricted from visiting or being visited by family and friends as a means of punishment. The UK National Standards for Foster Care requires policies to be in place on corporal punishment to ensure that each child in foster care is protected from all forms of corporal punishment (smacking, slapping shaking) and all other humiliating forms of treatment or punishment.⁴

There is no legislative provision in relation to the use of restraint and isolation for the child who is in foster care – either under the Children (NI) Order 1995 itself or any regulations issued thereafter. There is similarly, no specific guidance in relation to restraint and isolation. However the Trust is under a duty to assess foster carers (and give advice to private foster carers) and in this context these issues may be addressed by the individual Trusts. Guidelines are

⁴ Published by the National Foster Care Association on behalf of the UK Joint Working Party on Foster Care.

issued by the National Foster Care Association on the Care and Control of Children in Foster Homes.

Secure accommodation

- 4.41 Article 44 of the Children (NI) Order 1995 sets out the criteria by which a child can be placed or kept in secure accommodation. The associated regulations are the Children (Secure Accommodation) Regulations 1996. This statutory provision permits the restriction of liberty of children but also ensures that any such decisions taken by the Trust or others are scrutinised and endorsed by the Court. A child cannot be placed or kept in secure accommodation unless it appears that
- (a) (i) he has a history of absconding and is likely to abscond from any other description of accommodation; and
 - (ii) if he absconds, he is likely to suffer significant harm; or
 - (b) that if he is kept in any other description of accommodation he is likely to injure himself or other persons." (Article 44)
- 4.42 The criteria must apply and once it no longer applies then the child must not continue to have his liberty restricted (even if there is a court order authorising the restriction currently in existence). The definition of "restriction of liberty" is a matter which is to be determined by the Court and may include any practice or measure which prevents a child from leaving a room or building of his own free will. This is a measure of last resort and will only be permitted when it is evidenced that there is no appropriate alternative. The onus is therefore on the Applicant to show that everything else has been comprehensively considered and rejected. The secure placement should only be for as long as is absolutely necessary (and not for the duration of the Court Order itself). The Trust have a duty to take reasonable steps to avoid the need for children to be placed in secure accommodation (The Children (NI) Order 1995; Schedule 2 paragraph 8(c)).
- 4.43 There is one unit in Northern Ireland which provides secure accommodation for children at Lakewood in Bangor.

Services provided under the mental health legislation

- 4.44 The use of restraint and seclusion in respect of service users is not referenced in the primary legislation, the Mental Health (NI) Order 1986. The Code of Practice, which accompanies the Mental Health (NI) Order 1986, does, however, provide limited guidance on the use of restraint and seclusion generally.⁵ Section 5.33 requires every Unit of Management (i.e HSS Trust) to have a policy on the use of all forms of physical restraint (physical restraint in

⁵ 1992, Belfast, HMSO

the context of this guidance includes locked ward doors, time out and seclusion). Sections 5.32 – 5.53 of the Code of Practice gives guidance on restraint, locked doors on open wards, time out and seclusion. Within this Guidance there is, however, no specific reference to children and young people.⁶

- 4.45 In the case of *S v Airedale NHS Trust* a young person who was a mental health in-patient challenged his detention in seclusion by the NHS Trust while they sought a more suitable placement to meet his needs. S was being held in a locked room at night because a bed was not yet available for him at a secure unit. He argued that the NHS Trust was obliged to follow the Mental Health Code of Practice (1999) and that there had been a breach of Article 3 ECHR in relation to the conditions he was held under and a breach of Article 8 ECHR. The High Court rejected the application stating that the conditions he was held under were not poor enough to constitute a breach of Article 3 ECHR. It was concluded that the NHS Trust had acted lawfully, but S appealed to the Court of Appeal, which considered his case alongside the case of Colonel Munjaz who was challenging the policy at Ashworth Hospital not to follow the Mental Health Code of Practice when patients were secluded for more than three days.⁷
- 4.46 Seclusion is defined in paragraph 19.16 of the 1999 Code of Practice as the supervised confinement of a patient in a room, which might be locked to protect others from significant harm. The Code states that seclusion should be used as a last resort and for the shortest period of time; that a decision to seclude should be taken by a doctor or nurse in charge and that the continued need for seclusion should be reviewed every two hours by a nurse and every four hours by a doctor. The question before the Court of Appeal was whether seclusion was capable of infringing Articles 3, 5 and 8 of the ECHR as incorporated by the Human Rights Act 1998. It was no longer argued that in these particular cases a breach of Article 3 had occurred.
- 4.47 The Court of Appeal accepted that there was an implied power for the authorities to seclude a person who was compulsorily detained under the Mental Health Act within a hospital setting as a “necessary ingredient flowing from the power of detention for treatment”. In addition, seclusion could amount to medical treatment. The Court was of the view that there was no doubt that seclusion could potentially amount to inhuman and degrading treatment or punishment prohibited under Article 3 ECHR, but segregation from other detained patients did not itself constitute such treatment. Seclusion also infringed Article 8 (2) ECHR unless it could be justified under Article 8(2) ECHR. However, the further seclusion of a detained patient did not amount to a deprivation of liberty for the purposes of Article 5 ECHR which was concerned

⁶ See also the Mental Health Act 1983, Revised Code of Practice (1999) which applies in England and provides more detailed guidance on restraint, seclusion, locked wards and also contains a detailed section on children and young people.

⁷ The Court of Appeal gave judgment in both cases in *R (Munjaz) v Mersey Care NHS Trust and R(S) v Airedale National Health Service Trust and others* [2003] EWCA Civ 1036 (16 July 2003)

with the lawfulness not the conditions of detention, although there would be a breach of Article 5 (1) ECHR if a person was detained in a type of institution which was inappropriate to meet the purpose of his detention.

- 4.48 Where issues relating to a patient's human rights were engaged, the Code of Practice should be followed by all hospitals unless there was good reason to depart from it in individual cases. In the *Munjaz* case, the Court held that the wholesale departure from the Code of Practice in certain groups of cases based on the length of time spent in seclusion was unlawful. In the case of *S*, on the facts the Court found his seclusion (which was in breach of the Code of Practice and used on the basis that there was no other more suitable placement available for him) to be unjustified.

Other areas of interest

- 4.49 Although not directly related to the HPSS sector, the following examples of interpretation of the law in other sectors are of interest and knowledge of them may assist staff working in settings which interface with either the education or youth justice sectors.

Education sector

- 4.50 Article 4 of the Education (NI) Order 1998 came into force on 21 August 1998 and authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

- 4.51 Non teaching staff are also authorised to use reasonable force in these circumstances provided they have been authorised by the Principal to have lawful control or charge of pupils.

- 4.52 Detailed guidance for schools is contained in "Guidance on the Use of Reasonable Force to Restrain or Control Pupils", DE Circular 1999/9 and is included in "Pastoral Care in Schools; Child Protection". A copy of this guidance is attached at **Annex J** for reference.

Youth justice

- 4.53 The use of restraint and seclusion of children in a custodial youth justice setting is regulated by the Juvenile Justice Centre Rules (NI) 1999. Regulation 29 allows for the use of "forms of control" approved by the Secretary of State in

dealing with “unruly children”.⁹ Regulation 30 allows for the use of temporary confinement of a child for up to 24 hours. These Rules must be interpreted in light of the ECHR as incorporated by the Human Rights Act 1998.

- 4.54 In a recent case taken by the Howard League for Penal Reform in England¹⁰ an 18 year old applicant (who was 17 at the time complained of) argued that his segregation on two periods for five and four days respectively in a segregation unit in a young offenders centre and the conditions under which he was detained there amounted to a breach of the Young Offender Institution Rules 2000 (“the Rules”) and a breach of his rights under Article 3 and Article 8 of the European Convention On Human Rights. The judge held that there had been a breach of the Rules, but on the facts no breaches of Articles 3 and 8 of the Convention. It is of note, however, that the judge stated that, although he was not making a finding under Article 3 in this particular case, he was prepared to accept that solitary confinement of a child (in other words, someone under 18) could amount to a breach of Article 3 in circumstances where it would not in relation to an adult. In respect of Article 8 he stated:

“ I hope I may be permitted merely to utter this warning: there are clear dangers in placing young people in segregation units in relation to their rights enshrined in Article 8”.

Conclusion

- 4.55 The legal issues relating to the use of restraint and seclusion are complex. The discussion above has, therefore, sought to highlight issues which staff and their employers need to take into account in using these procedures with any service user. The use of restraint and seclusion are measures of last resort. Staff in making use of either procedure should have a clear understanding of the rights of service users and when it is appropriate for them to employ either restraint or seclusion and the safeguards that should be in place to ensure they are not subject to legal challenge. Employers have a duty to provide key staff with training on human rights considerations under ECHR and other relevant international instruments, and that their policies and procedures ensure that work in these difficult areas is of a high professional standard. There is, therefore, a clear link between this section of the guidance and those relating to policy, training, complaints and management and monitoring arrangements.

⁹ This is the wording of Regulation 29

¹⁰ *The Queen on the Application of BP v The Secretary of State for the Home Department* [2003] EWHC 1963 Admin

5. PRINCIPLES INVOLVED

General

- 5.1 This section discusses some of the key principles relating to the use of restraint and/or seclusion and ends with a statement of principles which should underpin the use of these interventions.
- 5.2 Important principles regarding the protection of individuals from abuse by State organisations or the staff working within them are set out in the Human Rights Act 1998. In addition, it is a criminal offence to use physical force, or to threaten to use force, unless the circumstances give rise to a ‘lawful excuse’ or justification for the use of force. Similarly, it is an offence to lock a service user in a room without a court order (even if they are not aware that they are locked in) or the consent of the service user, except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. For children, rules are specified in the regulation 6 of the Children (Secure Accommodation) Regulations (NI) 1996 (“the 72 hours rule”). Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.
- 5.3 The use of restraint and seclusion should always be designed to achieve outcomes that reflect the best interests of the individual service user whose behaviour is of immediate concern and others immediately affected by the behaviour.
- 5.4 The decision to use restraint or seclusion must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing either restraint or seclusion as a method of intervention.
- 5.5 Efforts to minimise the use of restraint or seclusion should be in place. This may require the adoption of primary and secondary preventative strategies.
- 5.6 Primary prevention is achieved by:
- ensuring that the number of staff deployed and their level of competence corresponds to the needs of service users and the likelihood that physical interventions will be needed. Staff should not be placed in vulnerable positions;
 - helping service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities;
 - developing care plans, which are responsive to individual needs and include current information on risk assessment;

- creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement;
- developing staff expertise in working with service users who present challenging behaviours;
- talking to service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some service users prefer withdrawal to a quiet area to an intervention which involves bodily contact.

5.7 Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing ‘defusion’ techniques to avert any further escalation. Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of interventions at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective, and
- the risks associated with *not* acting are greater than the risks of using restraint or seclusion; and
- other appropriate methods, which do not involve restraint or seclusion, have been tried without success.

5.8 All prevention strategies should be carefully selected and reviewed to ensure that they do not, except through necessity, either constrain opportunities or have an adverse effect on the welfare or the quality of life of service users (including those in close proximity to the incident) . In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities, which might provoke challenging behaviours compared with the impact on the person’s overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment.

5.9 Particular regard should be had to service users’ attitudes towards physical contact, physical stature, age, gender and previous life experiences when restraint is being used. Restraint and seclusion should be used as measures of a last resort and in a way that is sensitive to, and respects the cultural expectations of service users. Any physical intervention used in restraint should avoid contact that might be misinterpreted as sexual.

5.10 Where restraint is employed staff must ensure that they only employ a reasonable amount of force, that is, the minimum force needed to avert injury or serious damage to property, applied for the shortest possible period of time.

Planned physical interventions should only be used as part of a holistic strategy where the risks of employing an intervention are judged to be lower than the risks of not doing so.

Proactive use of restrictive physical interventions

- 5.11 In most circumstances, restraint or seclusion will be used reactively. Occasionally, it may be considered in the best interests of the service user to accept the possible use of an intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to ‘shadow’ the child and to adjust the level of any physical intervention needed according to the child’s behaviour. Similarly, staff might be sanctioned to use restraint, if necessary, as part of an agreed strategy to help a person who is gradually learning to control his/her aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.
- 5.12 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate.

Emergency use of restrictive physical interventions

- 5.13 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence shows that injuries to staff and to service users are more likely to occur when restraint is used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions is used.
- 5.14 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restraint to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property.
- 5.15 Even in an emergency situation, any force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restraint in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences, which might have occurred without the use of a physical intervention.

5.16 There must be a written protocol, which includes:

- a description of behaviour sequences and settings which may require the use of restraint or seclusion;
- the results of any assessment which has determined any contra-indications for the use of physical interventions;
- a risk assessment which balances the risk of using physical intervention against the risk of not using a physical intervention;
- a record of the views of the service user or those with parental responsibility in the case of children, and family members in the case of adults not deemed competent to make informed choices;
- a system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages;
- a record of previous methods which have been tried without success;
- a description of the specific physical intervention techniques which are sanctioned, and the dates on which they will be reviewed;
- details of staff who are judged competent to use these methods with this person;
- the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

5.17 An up-to-date copy of this protocol must be included in the service user's individual care plan.

5.18 The use of a restraint or seclusion should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. See paragraphs on Post-Incident Management and Monitoring (paragraphs 3.9-3.18).

STATEMENT OF PRINCIPLES

5.19 **The following principles should underpin the use of restraint and seclusion with service users across the range of client groups.**

- **The philosophy of care is the least restrictive and controlling possible for the individual service user.**
- **Prevention strategies are in place to minimise the need to use either of these interventions.**
- **Institutions or settings employing either restraint and/or seclusion have clearly defined policies for the management of violent service users.**
- **Restraint and seclusion are interventions of last resort, used for the minimum time necessary to protect life, to safeguard from harm or to prevent serious damage to property.**
- **The management of disturbed and violent behaviour requires a multidisciplinary approach to planning for the care and treatment of the service user.**
- **The principles for the management of disturbed and violent behaviour which poses a risk to the individual or other service users are the same whatever the institution or setting.**
- **Planned use of these interventions is based on a risk assessment and is part of the care plan for the individual service user, of which they are informed.**
- **The risk assessment specifies if there are reasons why a specific intervention should not be employed with an individual service user.**
- **The age, gender, personal characteristics of the service user and setting specific factors are all drawn together to inform the use of any approach designed to manage or control behaviours.**
- **The use of these interventions is recorded in a standardised manner as soon as possible after the incident.**
- **Post incident monitoring is carried out at a senior level within the service to:**
 - **ensure compliance with human rights requirements;**
 - **ensure compliance with the *last resort* principle;**

- **ensure that the minimum amount of force was used for the shortest possible period of time;**
 - **compliance with the policies and procedures;**
 - **that staff involved were appropriately trained; and**
 - **determine what lessons can be extracted to inform future practice, training or staff support.**
-
- **Staff employing these interventions are appropriately trained to ensure they use the procedures to promote the well being and best interests of service users and in a manner consistent with the Human Rights Act and the European Convention on Human Rights.**
 - **Staff working with children ensure that their practice is consistent with the United Nations Convention on the Rights of the Child and that complaint procedures are available in a child friendly format.**
 - **Staff and service users have opportunities for de-briefing after the use of these interventions.**
 - **Management strategies for disturbed and violent behaviour should be regularly monitored and audited.**
 - **Service users and their families are aware of how to complain if they are dissatisfied about the way they were managed prior to, during and after the incident.**

6. REFERENCE/BIBLIOGRAPHY

Physical Interventions – Definitions and Purpose

“Physical Interventions. A Policy Framework.” Harris. J. et al (1996) British Institute of Learning Disabilities (BILD).

“Physical Restraint. A Review of the Literature”. McDougall. T. (1996). Psychiatric Care, 3 (4) 132-136

“Guidance for Restrictive Physical Interventions. How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder.” Department of Health

“Legal Issues Arising from the Care and Control of Children with Learning Disabilities who also present Sever Challenging Behaviour. A Guide for Parents and Carers.” The Mental Health Foundation

“Mental Health (Northern Ireland) Order 1986 Code of Practice” H.M.S.O.

“Restraining, Holding Still and Containing Children and Young People 2003. Guidance for Nursing Staff.” Royal College of Nursing

Restraint and Isolation in Mental Health

Law

Mental Health Act 1983 and Revised Code of Practice (England)

The Mental Health (NI) Order 1986 and Code of Practice for the Mental Health (NI) Order 1986

Cases

R (Munjaz) v Mersey Care National Health Service Trust and Others

R (S) v Airedale National Health Service Trust & Others [2003] EWCA Civ 1036

Hutchison Reid v UK (50272199) 14 BHRC 41 (EHCR)

R (on the application of KB) v Mental Health NHS Trust Exp. L Times, Dec 8 1997
CCA

Johnson v UK 1999 27 EHRR 296

R v Secretary of State for Scotland 1989 SCLR 784

Case of Paul and Audrey Edwards v the UK

Journals

“Uncomfortable truths” Hewitt D, NLJ 2003 153 (7078) 661-2

“False imprisonment in mental health cases” Canal S, NJL 1999 149 (6887) 6867

Articles

“Why aren’t mentally ill children getting the support they need?” 19/6/01 *BBC Newsonline*

“Hospitals wrong to disregard Code of Practice, Appeal Courts rules”

<http://www.mind.org.uk>

“Psychiatric patients denied basic rights”

<http://www.society.guardian.co.uk>

“Seclusion room interventions in Acute Care Psychiatry”

<http://www.crpnm.mb.ca/seclude.html>

Newspapers

“Mentally ill will not be held in cells” Nelson F, *The Times*, Nov 18 2000, 13

“A room of one’s own-seclusion is at last lawful” Hewitt D, *The Times* Nov 26 2002

“Non offenders to be locked up indefinitely”- Goodchilds, *Independent* Sunday June 23, 2002, 10

“Thousands of NHS Patients being detained illegally” Dyer C, *Guardian* Feb 5 1998

“Voluntary Patient held unlawfully” Patton *Guardian* Oct 30 1997^B

Policy

“Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments”. The National Institute for Clinical Excellence (NICE) February 2005. (Developed by the National Collaborating Centre for Nursing and Supportive Care) www.nice.org.uk

“Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units.” The Royal College of Psychiatrists and the Royal College of Nursing, March 1996 www.rcpsych.ac.uk/publications/cr/cr41 - Cases cited in the context of this publication are:

Department of Health (1992) *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*. London: HMSO.

- (1993) *Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients: “Big, Black and Dangerous”*. London: HMSO.

Department of Health and Social Security (1980) *Report of the Review of Rampton Hospital*. London: HMSO.

- (1985) *Report to the Secretary of State for Social Services Concerning the Death of Mr Michael Martin at Broadmoor Hospital on 6th July 1984*. London: HMSO

Disruptive Pupils

Cases

Purvis v Buckinghamshire CC [1999] ELR 231

Tyrer v UK 1978

R(on the application of L,A Child) v J School Governors Feb 27 2003

Newspapers

“Classrooms ban detention after pupil cites human rights” Kielbie P, *Independent*, Jan 7 2003, 9

“Greater protection urged for accused teachers” Fern D, *Financial Times* 25 Aug 2003

“Teachers want training in restraint techniques” Fri 2 April 1999 *BBC Newsonline*

Policy

Pastoral Care in Schools. Child Protection

Pastoral Care: Guidance on the use of reasonable force to restrain or control pupils.

A structured framework for the development of a policy the use of reasonable force/safe handling all school sectors

Westminster City Council

Policy audience for schools on the use of physical restraint.

Denver Public Schools Student Services Manual

Section 10: Policies and Procedures regarding Student Restraint

Toronto Catholic District School Board

Physical restraint-A guideline for the use of physical restraint

Children In Custody

Law

Juvenile Justice Centre Rules (NI) 1999

Cases

R (on the application of the Howard League for Penal Reform) v Secretary of State
July 2003

Articles

“Fighting for the rights of children” Crook F, Sun Nov 10 2002

<http://observer.guardian.co.uk/comment/story/069038370500.html>

“Government reported to UN for breaching rights of children in Prison” Howard
League, Thurs 19 Sept 2002

<http://web.ukonline.co.uk/howard.league/press/2002/19902.htm>

“Blunkett faces high court challenge for failure to protect children in prison” Howard
League, July 2002

<http://web.ukonline.co.uk/howard.league/press/2002/29762.htm>

Newspapers

“Segregation of teenage inmates is child abuse” Bernetto J, *Independent* Feb 11
“Prisoners could sue over degrading jail conditions”. Burns, *Guardian* Dec 11 2002
“Court upholds rights of jailed youngsters” Dyer C, *Guardian* Nov 30 2002

Children In Care

Law

Statutory Instrument 2001 No3967
The Children’s Homes Regulations (NI) 1996
The Children’s Order Guidance & Regulations, Volume 4, Residential Care

Cases

X v Brown [2003] EWCA Civ 181 CA

Articles

“Measuring Competence in Physical Restraint Skills in Residential Child Care.” Bell L and Stark C,
<http://www.scotland.gov.uk/cru/documents/refin21.htm>

“Physical restraint: Important information for residents and families”
<http://www.nchcfa.org/restrain.asp>

“Physical restraint-Part 1: Use in Acute and Residential Care Facilities. Best Practice” Vol. 6 Issue 3 2002

“Physical Restraint in Acute and Residential Care.”
David Evans, Jackie Wood, Leonnie Lambert and Mary Fitzgerald

“Learning from Each Other: Success stories and ideas for reducing restraint/Seclusion in Behavioural Health” - American Psychiatric Association

“Children’s rights and the use of physical force” Fortin J,
Child and Family Law Quarterly, Vol.113 No 3 2001

Policy

Clear Expectations, Consistent Limits. The Centre for Residential Child Care
Physical Restraint-Practice, Legal, Medical & Technical Considerations. The Centre for Residential Child Care

“Restraining, holding still and containing children” - Guidance for Good Practice-
Royal College of Nursing.

“Children’s Views on Restraint” Dr Roger Morgan OBE, Children’s Rights Director,
Commission for Social Care Inspectorate

Miscellaneous

The Government of the United Kingdom of Great Britain & N. Ireland. Response to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment-Visit to N. Ireland-Dec 1999

“Connecting Mental Health and Human Rights”: Gavin Davidson, Maura McCallion and Michael Potter, on behalf of the Northern Ireland Human Rights Commission.

“Independent Inquiry into the death of David Bennett”: report of enquiry set up by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

“Good Practice in Consent” – a handbook for DHSSPS, 2003.
www.dhsspsni.gov.uk/publications

“A question of restraint”. Leadbetter, D and Trewartha, R (1995), Care Weekly, 18 May 10-11.

“The Edinburgh Inquiry – Recommendations 55. The Independent Evaluation Report”. Lindsay M and Hosle, A (2000). University of Strathclyde and the former Centre for Residential Child Care.

“Guidance on Handling HPSS Complaints: Hospitals and Community Health and Social Services” (April 2000).

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

OUTLINE TERMS OF REFERENCE

Restraint and seclusion can be used in a variety of health and social care settings eg. residential/nursing homes, children's homes, hospitals and facilities accommodating people with a learning disability and mental health problems. There are possible implications for Articles 3, 5 and 8 of the ECHR. The purpose of this piece of work is to develop guidelines for staff to ensure that any restraint or seclusion is reasonable, proportionate and justifiable in the circumstances and that appropriate documentation is completed.

Methodology

- Examine current policies and procedures.
- Examine current practices, including local audits, work in progress, research reports - is there evidence of best practice anywhere?
- Examine current documentation and recording mechanisms.
- Examine complaints in this area to identify weaknesses and areas for action.
- Examine existing case law to identify issues and guiding principles.

Product

User-friendly, practical guidelines which:

- (a) are human rights compliant and which have been validated by the appropriate professions, legal advisors, the NIHR, the Equality Commission;
- (b) have been quality assured; and
- (c) are capable of incorporation into training for new and existing staff, where relevant.

Accountability

Boards, Trusts etc. will be asked to report on progress on implementation of the guidelines within the framework of Priorities for Action and the Health and Well-being Investment Plans. It is not envisaged that this piece of work will be issued as a Departmental circular as the objective is to support and encourage staff to develop a human rights culture within their organisations and their own policies and procedures to implement the guidance. This approach recognises that different organisations will be at different stages of applying practice and have varying needs depending on their client group and whether they are residential or community based services.

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

MEMBERSHIP

Mrs Marion Reynolds (Chair)	Social Services Inspectorate, DHSSPS
Ms Tara Caul	Children's Law Centre
Mr Arthur Dick	Down Lisburn HSS Trust
Ms Heather Ellis	Human Rights Liaison Group
Mrs Roisin Gallanagh	School of Nursing, University of Ulster
Mr Gene Gillease	Western Equality & Human Rights Forum
Dr Joan McGuinness	Armagh & Dungannon HSS Trust
Mr Clinton Stewart	North & West Belfast HSS Trust
Ms Alison Wilson	Secure Units, Lakewood
Ms Linda Wilson	Barnados
Mr Cecil Worthington	Ulster Community and Hospitals HSS Trust
Mr Niall Young	Homefirst HSS Trust
Mr Stewart Love	Human Rights Unit, DHSSPS

MEMBERSHIP OF SUB-GROUP ON LEGISLATIVE CONTEXT

Tara Caul

Prof Tony McGleenan

Henry Tower QC

Carol Sholdis BL

Denise Hunt BL

Marion O'Neill, Solicitor

Hilary Wells, CSA

**EXAMPLE OF HSS TRUST
MANAGEMENT OF
AGGRESSION POLICY**

TABLE OF CONTENTS

- 1.0 Policy Statement and Trust's Principles
- 2.0 Definition of Aggression
- 3.0 Responsibilities
 - 3.1 Staff Responsibilities
 - 3.2 Management Responsibilities
 - 3.3 Special Responsibilities
- 4.0 Arrangements for Managing Aggression
 - 4.1 Organisational Risk Assessment
 - 4.2 Individual Risk Assessment
 - 4.3 Communication of Risk Assessment
 - 4.4 Recruitment and Selection
 - 4.5 Staff Learning and Development
 - 4.5.1 Induction
 - 4.5.2 Monitoring and Supervision
 - 4.5.3 Training and Development
 - 4.5.4 Performance Management and Redeployment
 - 4.6 Managing an Incident
 - 4.6.1 Reporting, Investigation and Monitoring
 - 4.6.2 Post Incident Support
 - 4.6.3 Post Incident Review
 - 4.6.4 Learning from Incidents
 - 4.6.5 Arrangements to Assist Staff Returning to Work Following an Incident
 - 4.6.6 Contact with External Organisations
- Appendix 1- Committees and Groups with Management of Aggression Responsibilities
- Appendix 2 - Other Relevant Trust Documents
- Appendix 3 - Relevant Legislation
- Appendix 4 - Sources of Further Information

1.0 POLICY STATEMENT AND TRUST'S PRINCIPLES

It is the policy of this Trust to promote an organisational culture and develop associated structures that prevent aggression in the workplace. The Trust seeks to equip all staff with the appropriate attitudes, knowledge and skills to work with service users in those situations which critically challenge how they are supported. This will enable management of aggression to be achieved in a caring manner by the implementation of training and policy initiatives that promote best practice.

This approach must fit with the wider quality issues of clinical and social care governance and controls assurance. Each service should develop, where appropriate, local procedures reflecting the ethos of this policy.

The existing law requires that individuals do not interfere with the rights of others, eg the use of physical intervention techniques. Such action can, however, be defended if it is intended to prevent harm to the service user or others. Members of Trust staff must be able to demonstrate clearly that they act at all times in the best interests of the individual.

The following are the Trust's principles underpinning the policy.

- Service users and carers should be treated with respect at all times and their dignity maintained.
- Person centred approaches, sensitive to the needs of the individual and promoting effective communication between service users and staff, should be practised to help reduce the likelihood of aggressive incidents.
- Prevention of aggression is preferable to intervention at a later stage.
- The use of physical intervention techniques, may on occasions be necessary to fulfil a duty of care. However, these should be kept to an absolute minimum and carried out within local service guidelines. Physical intervention techniques when used will take full account of the service user's need for respect, privacy and dignity as well as social and cultural considerations.
- The personal safety of staff, service users, carers, students on placement and other persons carrying out authorised tasks on behalf of the Trust is of paramount importance to this Trust. Personal safety takes priority over damage to property.
- The Trust recognises its legal and moral responsibility to reduce risk to staff, service users, carers, students on placement and others to the lowest level practicable.

- Trust staff have individual and collective responsibility for ensuring that aggressive incidents are kept to a minimum and effective risk management procedures are in place to secure this aim. The safety of service users is everyone's responsibility.
- The training and support provided to Trust staff will recognise these principles and will provide staff with a tool-kit of skills that will enable them to manage difficult situations in a person-centred manner.

2.0 DEFINITION OF AGGRESSION

The Trust defines aggression as behaviour resulting in damaging or harmful effects (physical or psychological) on another person or persons. This includes:

- verbal abuse
- non verbal abuse (eg stalking)
- threats of physical abuse
- physical abuse
- threats of sexual abuse
- sexual abuse
- damage to property

The above definition includes behaviour directed at staff, service users, carers, students on placement and other persons carrying out authorised work on behalf of the Trust.

3.0 RESPONSIBILITIES

[Describe the relevant responsibilities within the Trust]

The Trust Board has the responsibility for overseeing the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. The Chief Executive in conjunction with his colleagues on the operational Management Team is charged with meeting these responsibilities. The Operational Management Team, which includes the Heads of Service in the Trust, directs all Trust initiatives to reduce the risks of aggression whilst providing person-centred services to service users. The Operational Management Team is accountable through the Chief Executive to the Trust Board.

3.1 Staff Responsibilities

All staff have a responsibility to ensure that their behaviour towards service users and their carers reflect a person-centred approach. Staff should be aware of the impact of their own behaviour and how this could precipitate or increase the severity of an incident of aggression. All staff who work directly with service users should endeavour to be aware of the risk factors for aggressive

behaviour. Trust training will reinforce the value of appropriate communication skills. Staff are obliged to adhere to this policy and associated training at all times.

While it is the legal responsibility of the Trust to provide safe systems of work, individuals have a personal responsibility to follow safe working practices.

3.2 Management Responsibilities

Chief Executive

The Chief Executive carries overall responsibility for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. He is responsible to:

- ensure that appropriate arrangements are in place within the Trust to manage aggression;
- ensure that those systems that are in place are in line with clinical and social care governance;
- ensure that effective monitoring systems are in place to quality assure these arrangements

Heads of Service

- Ensure that their staff are aware of the policy and that its relevance to their work is recognised
- Ensure any additional local procedures in a particular service area fits with the Trust-wide approach.
- Allocate resources (time, people and financial outlay) according to areas of highest risk.
- Ensure staff are adequately trained.
- Provide High level monitoring of the level and effectiveness of training.
- High level monitoring of incident patterns.
- Develop systems which will support staff and service users following an aggressive incident.
- Communicate, where appropriate information, information about significant known risks to ensure remedial action is taken to address these.

Service Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Implement Trust recruitment and selection procedures to ensure that applicants are fully aware of the roles and inherent risks associated with

the job. This should facilitate the selection of an appropriate person for the post.

- Ensure staff are adequately trained.
- If necessary draw up service specific local procedures to support and underpin the Trust-wide policy and approach.
- Ensure that appropriate risk assessments of aggressive behaviour associated with use of Trust's services have been carried out in conjunction with staff, service users and carers and using a multi-disciplinary approach. This should occur within the annual service-planning cycle.
- Fully implement the Trust's incident reporting policy
- Ensure that any risks identified are managed appropriately through an action-plan approach. These risks should be reviewed within an agreed timescale
- Ensure arrangements to support and supervise staff are implemented and monitor their effectiveness.
- Ensure that managers have a system for investigating any aggressive incidents in their area.
- Monitor and implement lessons learned from incidents and provide feedback and information to staff and the Risk Management Unit.
- Inform their Service Head of areas of significant risk to ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

First Line Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Provide Induction Training for new staff.
- Implement Trust recruitment and selection procedures to ensure that persons applying are fully aware of the roles and inherent risks associated with the job. This should facilitate the selection of an appropriate person for the post
- Ensure appropriate management of aggression and the provision of learning and skills development. This should include, as appropriate, training in a multi-disciplinary and at times multi-agency fashion.
- Ensure all training given to their staff is formally recorded and staff's training is kept up to date.
- Ensure that appropriate risk assessments are carried out and remain up to date.
- Involve other disciplines, as appropriate, in the management and assessment of risk of aggressive incidents.

- Ensure all incidents are reported promptly to the Trust's Incident Reporting Centre.
- Carry out investigation of any incidents occurring, supported by their Service Manager and the Risk Management Unit for significant incidents.
- Arrange for appropriate and comprehensive support for employees following an incident.
- Promote team-working.
- Monitor practice (formally and informally) and ensure the best standard by ongoing supervision.
- Use manpower planning skills to release staff for training.
- Keep Service Manager informed of any significant risks or implementation problems and ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

Supervisory Management

- Promote best practice by example and on the job training for staff.
- Assist in implementing risk assessment procedures.
- Ensure that all incidents are reported promptly.
- Inform first-line manager of significant risks or problems and the arrangements required to reduce risk.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

3.3 Special Responsibilities

Consultants and Lead Clinicians/Social Care Professionals

- Responsible to ensure adequate and appropriate assessment of the service user presenting a risk because of aggressive behaviour. Although this process may initially start with one discipline it will in many cases involve a multi-disciplinary approach and may also require involvement from other Trusts and agencies as appropriate.
- Following assessment, development of management/care/treatment plans.
- Monitor, review and adjust these plans following re-assessment of the service user.
- Ensure that known risks are communicated where appropriate to staff and others to ensure other decisions are properly informed.
- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.

- Ensure that their staff receive appropriate induction and updated training, and support and supervision.
- Implement the Trust's Incident Reporting Policy.
- Ensure that their staff are aware of arrangements for post-incident staff support and that these are readily available when required.
- Lessons learned from incidents should be effective in changing practice in the workplace. Any information from this process should be passed on to the relevant staff and the Risk Management Unit.
- Promote team-working.

Head of Operational Support

- Chairs the Health and Safety Committee
- Provides quarterly reports to the Operational Management Team about aggressive incidents including learning points.
- Senior manager responsible for risk management advice, as member of the strategic Operational Support Team.
- Manages the Service Manager responsible for the Risk Management Unit.
- Responsible for alerting other senior managers to significant risk issues to ensure timely, appropriate responses.

Risk Manager

- Service manager responsible for managing the Risk Management Unit.
- Provides professional advice on Trust-wide management of risk.
- Devises, develops and reviews policies and procedures to reduce risk.
- Devises and manages risk assessment processes.
- Manages the process of reporting and monitoring incidents ensuring that managers are kept informed about incidents reported in their area and any significant implications for work practices.
- Responsible for analysing trends and providing managers with quarterly information about lessons to be learnt.
- Manages the training function for the reduction of risk.
- Advises managers at every level on targeting high risk areas.
- Provides assistance to managers to find risk solutions, leading to action plans.
- Ensures that the Trust minimises the risk of civil and criminal liability and that there is appropriate legal defence where cases are filed against the Trust.

Head of Human Resources

- Senior manager responsible for Occupational Health Services, learning and development and all other human resource issues.

- Sets high-level recruitment and selection procedures.
- Responsibility for redeployment and disciplinary issues.
- Provides high-level specialist advice to the Trust in the above areas.
- Establishes processes and protocols and makes arrangements for post-incident staff support and monitors its effectiveness.

Occupational Health Sister

- Manages the process of pre-employment health assessments.
- Provides a service for pre-employment risk assessment.
- Provides specialist advice to managers on employee's health.
- Advises managers and employees on return to work following an incident.
- Provides approved courses for Trust is First-Aiders.
- Organises appropriate health surveillance.
- Provides a work-place assessment service for managers

Human Resources Managers

- Provide advice on managing the processes of recruitment and selection.
- Advise managers on performance management issues.
- Assist and advice managers in implementing disciplinary procedures etc..

Trade Union Health and Safety Representatives

- May investigate hazards and dangerous occurrences in the workplace.
- May investigate complaints relating to health, safety and welfare at work by the staff they represent.
- May make appropriate representations to Trust Management in respect of the above issues.
- May carry out inspections in respect of the above issues.
- May represent appropriate staff in consultations with Trust Management, or inspectors of any enforcing agency.
- May attend meetings of safety committees, as appropriate, in connection with the above functions.

4.0 ARRANGEMENTS FOR MANAGING AGGRESSION

4.1 Organisational Risk Assessment

Information from the individual assessments of service users and risk factors regarding the working environment must feed into a process. This will help inform the broader assessment of risk of a ward, Trust facility/department or caseload. It is important that a collective view of risk is formed, as this is the way risk can best be managed and high-risk areas can be appropriately targeted.

The process is as follows:

- first-line managers of the ward/department/Trust facility have responsibility to initiate the process;
- risk issues from individual risk assessments are drawn together and patterns of risk are identified;
- consideration of any factors which may increase or decrease risk in any place where staff are at work;
- assessments should result in the production of action plans to prioritise and manage high risk and significant risk issues;
- information from this assessment should be used to inform their line manager so that a picture of risk emerges. This will enable the Service Manager to make plans to manage risk through the annual service-planning cycle and also on a day-to-day basis;
- finally, this process should inform the Heads of Service and the Operational Management Team about significant Trust-wide risks.

The organisational assessment of the risk of aggression will include:

- the actual number of incidents;
- the service user groups involved;
- the perceived risks associated with the work situation and procedures;
- staff perceptions of risk;
- the use of preventative strategies;
- the appropriateness of support and supervision arrangements provided by the Trust;

4.2 Individual Risk Assessment

Appropriate professionals should routinely carry out suitable and sufficient risk assessments in conjunction with staff, service users and carers. These assessments must be completed and reviewed at appropriate regular intervals and should include consideration of the risk of aggressive behaviour associated with the use and provision of Trust services.

The individual service user's risk assessment must address the following areas:

- harm to self or others;
- past history of aggression, its pattern, frequency and seriousness;
- likelihood of any possible incident;
- individuals who may potentially be at risk;
- precautions that already exist;
- any further actions that need to be taken to reduce risk.

Following risk assessment a reasoned judgement must be reached and recorded regarding the assessed degree of risk. Appropriate action and communication must then be taken on the basis of that judgement. The initial risk assessment will be reviewed and may change to reflect the ongoing management of the service user's care. Where there is disagreement between professionals regarding the proposed strategy of managing risk, decisions should be taken to a more senior level.

4.3 Communication of Risk Information

Managers and staff must consider their responsibility to provide information about significant risks which may affect other departments/services within the Trust. This should include sharing information about measures in place to address the risks. Information should be exchanged with all people who may be at risk in a timely and easily understood manner. Care must be taken to preserve the confidentiality of service user's information. Serious and imminent danger to others will however on rare occasions form a reasoned basis for the sharing of confidential information.

In addition, all managers have a legal responsibility (under Health and Safety legislation) to inform other persons not employed by the Trust who may be at risk due to the actions, or failure to act, of the Trust.

4.4 Recruitment and Selection

Recruitment and selection documentation should be explicit about the nature of the work, and any foreseeable risks in handling challenging behaviours. Profiles of facilities should be used and reviewed regularly. Recruitment panels, where appropriate, may assess staff's ability, (or potential ability) to deal with situations where aggressive behaviours may occur. At recruitment the pre-employment risk assessment process developed by Occupational Health should be followed.

4.5 Staff Learning and Development

4.5.1 Induction

Managers must ensure that all new staff attend the organisational induction programme. They must agree a personal development plan for the next twelve months for all new staff. New staff will be required to read and understand their responsibilities within the Management of Aggression policy. Line managers should discuss any questions and clarify issues so that new staff have a clear idea of what to expect and how best to manage the different situations.

Training courses should be available, if possible before service commences, or as soon as possible thereafter.

4.5.2 Monitoring and Supervision

People responsible for staff must assist staff with their professional development. They are also responsible for assisting with the development of a competent staff team by identifying training needs.

Ongoing monitoring of compliance with the requirements of the Management of Aggression policy and staff performance will be included in the supervision process.

4.5.3 Training and Development

All staff will have the opportunity to develop their knowledge and skills in a person-centred approach to managing aggression. Appropriate learning and development initiatives currently within the Trust will facilitate this process. The need for staff development will be identified as part of the process of risk assessment. Learning and development will be targeted to address assessment of actual risks and will include the use of information from previous incidents or potential incidents.

The experience and knowledge of service users and carers will be incorporated when staff development resources are being produced and implemented.

Overseeing learning and skills development will be the responsibility of the first line manager and should, where appropriate, include training in a multi-disciplinary and at times multi-agency fashion.

Management of Aggression learning and development objectives will be evaluated in terms of how effectively the knowledge and skills learned have been applied to the workplace by staff. This training should be service specific.

4.5.4 Performance Management and Redeployment

Managers have a responsibility to constantly monitor the performance of staff in managing aggression. If managers or staff are aware of any performance issues this should be addressed using some or all of the following options:

- counselling;
- further training;
- job advice;
- redeployment options;
- disciplinary action.

Where staff have experienced a particularly traumatic incident/s the manager has special responsibility to consider how best to support staff in the working environment.

4.6 Managing an Incident

4.6.1 Reporting, Investigating and Monitoring

Information is essential to assist in the reduction and prevention of incidents, the need for staff development and evaluation of the efficacy of training or other interventions.

The Trust's Incident Reporting Procedure must be implemented throughout Divisions as follows:

- all incidents of aggression must be reported as soon as possible to the person in charge of the relevant area/department by the person(s) directly involved;
- all staff must use the Trust's Incident Report Form to report all significant incidents of aggression (as defined in this policy) and forward immediately to the Incident Reporting Centre at Trust Headquarters;
- major incidents must be reported to the Incident Reporting Centre within 24 hours or as soon as possible. This is a legal requirement under the Reporting of Injuries Diseases and Dangerous Occurrences, (Northern Ireland), Regulations 1997. The responsibility for reporting under these regulations lies with the Risk Management Unit. Managers and staff discharge their responsibility once they have reported to the Incident Reporting Centre.

Line managers must investigate every incident that occurs within their business areas. However, serious or highly significant incidents must involve the Risk Management Unit.

These reporting and investigatory arrangements do not detract from the legal responsibilities placed upon the Trust to formally investigate and report on individual incidents where injury has occurred.

The significance of aggressive incidents will vary within the differing service areas in the Trust. It is the responsibility of the Service Manager to define which incidents are significant for their particular area.

The importance of reporting incidents should be promoted more positively by demonstrating how effective information collection and analysis can contribute to the implementation of appropriate change measures eg training initiatives, resource strategies etc..

Managers should monitor the frequency and severity of incidents in their business areas. The Risk Management Unit will produce reports at agreed intervals for managers to assist them in this task. Areas most at risk need to be clearly identified and remedial measures put in place.

4.6.2 Post Incident Support

The Trust wishes to promote a culture of support that permeates the total organisation. Each service should demonstrate a commitment to providing support to staff, service users and carers involved in an incident.

Service managers are responsible for ensuring that the individual receives the appropriate form of support.

The form of support should be responsive to individual need and the following options should be offered:

- support immediately after the incident within the department/unit (Group or individual);
- opportunity to go off duty;
- contact relative, friend or Trade Union representative;
- taxi Home/Transport arrangements;
- assistance and accompaniment to hospital;
- ongoing managerial contact with individual in a considerate/supportive manner;
- long-term support eg staff care, occupational health.

Managers should be aware of the potential long-term effects of an incident and the incremental effects of a series of incidents on their staff's well-being and performance.

If a member of staff feels it is necessary to pursue legal action against an aggressor in the context of their work the Trust will, where appropriate, offer emotional support to staff through the resulting legal process.

4.6.3 Post Incident Review

Each service should have an Incident Review Procedure. Service managers must demonstrate that their service reviews individual incidents within a prescribed time period from the incident occurrence, (ideally 4-7 days post incident).

It is the manager's responsibility to investigate all incidents of significance within their area of responsibility.

The process of incident review should involve consultation with those involved; ie staff, service user, carer or any other person involved in the incident. Each incident should be examined in terms of:

- antecedents – actions, stressors, behaviour etc that may have contributed to the incident;
- nature of incident;
- how it was handled – identify positive and negative staff interactions and strategies adopted that influenced the effectiveness with which the incident was handled.

4.6.4 Learning from Incidents

Incident Review should be regarded as an opportunity:

- to learn from experience;
- to obtain information to prevent/reduce the risk of further incidents;
- to improve services/resources where necessary;
- to promote a learning culture.

It is important that lessons are learned and conclusions drawn from each and every experience. Managers should promote learning from experience and team working throughout their business areas. Opportunities to share learning across the Trust should be maximised to prevent the reoccurrence of similar incidents in other Trust facilities/departments. These may include: management of aggression training sessions, team meetings, and manager's meeting.

4.6.5 Arrangements to Assist Staff Returning to Work Following an Incident

Every effort will be made to provide support to staff in returning to work following an incident. This will include:

- advice from Occupational Health;

- advice from Personnel Services;
- supportive return to work interview with the line manager;
- implementation as soon as possible, of any organisational learning from the incident;
- provision of any required training in management of aggression.

It is primarily the line-manager's responsibility to provide all possible positive support in re-integrating the member of staff back into the workplace.

4.6.6 Contact with External Organisations

Health and Safety Executive (Northern Ireland)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997, require that certain incidents of aggression must be reported to the Health and Safety Executive. In certain circumstances these reports must be made within 24 hours of the incident occurring. This is a legal requirement and failure to meet this requirement constitutes a criminal offence. The Risk Management Unit is responsible for making these reports and it is the responsibility of persons reporting incidents to report them promptly to the Incident Reporting Centre, Trust Headquarters. In cases of death or serious injury these reports should be made by telephone with the form sent on by post, as soon as possible.

Mental Health Commission

It is the responsibility of the Trust to immediately notify the Commission of the following:

- the death of any service user not resulting from natural causes in both the hospital and community settings;
- suspected suicides in both settings;
- sexual assaults in both settings;
- actual or alleged physical assaults by members of staff in both settings.

Where any of the above incidents have occurred within the community, the Commission would not normally require a report on service users who have not received care or treatment for a mental disorder for more than two years.

Written reports of incidents must be submitted to the Mental Health Commission within six weeks of the incident occurring and must include the following information:

- a brief account of the circumstances of the incident;
- information on the mental state of the service user, particularly at the time of the incident;
- information regarding any other person involved in the incident indicating whether staff, other service user or member of the public;
- a copy of the minutes of the multi-disciplinary review meeting.

Where there was no multi-disciplinary involvement with the service user the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action taken as a result of the investigation.

The Commission expects that the Trust will record, monitor and review all incidents and will inspect records and review management's policies and procedures regarding all untoward events.

Registration and Inspection Unit (R&I Unit)

The same reporting requirements for the Mental Health Commission apply for this external agency. The R&I Unit only requires reports with regard to Trust's residential facilities.

Office of Care and Protection

Where any person suffering from a mental disorder has been referred to the Office of Care and Protection, and has been the victim of mishaps or accidents and suffered injury/loss/damage to property which might entitle him/her to compensation, then the Office of Care and Protection needs to be notified. This is to ensure the rights of such persons are protected.

Police Involvement

The Trust recognises the legal right of employees and others to be protected by the police. The Trust may in exceptional cases instigate legal proceedings for those situations in the interests of Trust staff and the community. This may be against the wishes of individuals who have suffered the consequences of aggression but it may be necessary for the protection of others.

The Trust's training programme and service specific procedures should include guidance for staff on the recognition of those situations when it would be appropriate to call for the assistance of the police.

APPENDIX 1 Committees and Groups with Management of Aggression
Responsibilities

APPENDIX 2 OTHER RELEVANT TRUST DOCUMENTS

For example:

Health and Safety Policy

Untoward Incident Reporting Policy

Managing Diversity Policy

Confidentiality Policy

Managing Attendance Policy

Special Observation Policy

APPENDIX 3 RELEVANT LEGISLATION

Mental Health (Northern Ireland) Order 1986, *ISBN 0-11-066595*

Children (Northern Ireland) Order 1995, *ISBN 0-337-92257-8*

The Northern Ireland Health and Personal Social Services Order 1991

Health and Safety at Work Order (Northern Ireland) 1978 *ISBN 0-11-084039-9*

Management of Health and Safety (Northern Ireland) Regulations (1992) *ISBN 0-337-90359-X*

**RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences
Regulations (1997) *ISBN 0-337-93043-0***

APPENDIX 4 SOURCES OF FURTHER INFORMATION

B.I.L.D, Physical Interventions, a policy framework, 1996, *ISBN 1-873791-86-0*

Dealing with Violence against Nursing Staff, an RCN Guide for Nurses and Managers, 1998, order code 000837

Violence at Work, UNISON

The Management of Aggression and Violence in Places of Care. An RCN position statement, 1997, order code 000 713

Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*

Violence and Aggression to Staff in the Health Services. Guidance on Assessment and Management. Health and Safety Commission, Health Services Advisory Committee, 1997, *ISBN 0-7176-1466-2*

Management of Imminent Violence, clinical practice guidelines to support mental health services. Occasional paper, 1998, Royal College of Psychiatrists Research Unit.

Trainers in the Management of Actual or Potential Aggression. Code of Professional Conduct and Minimum Training Standards RCN Institute 1997

Practitioner-Client relationships and the Prevention of Abuse, UKCC, 1999

Code of Professional Conduct, UKCC, June 1992

Protecting the Public, UKCC, July 1997

Guidelines for Mental Health and Learning Disabilities Nursing, UKCC, April 1998

Guidelines for Records and Record-keeping, UKCC, October 1998.

EXAMPLE OF HSS TRUST

**Protocol on the Use of Physical
Restraint**

**Mental Health Hospital Services and
Adolescent Psychiatric Inpatient Services**

TABLE OF CONTENTS

- 1.0 Introduction**
- 2.0 When should physical restraint be used?**
- 3.0 Training**
- 5.0 Best Practice in the Use of Physical Restraint**
- 5.0 Weapons**
- 6.0 Involvement of Police Service of Northern Ireland**
- 7.0 Management of Physical Restraint**
- Appendix 1 Physical Intervention Monitoring Form**

1.0 Introduction

This policy underpins the Trust's "*Management of Aggression Policy*" and should be read in conjunction with it. It is specifically written for Mental health Hospital Services and Adolescent Psychiatric Inpatient Services, it is not applicable to any other business area of the Trust.

The law requires that individuals do not unnecessarily/arbitrarily interfere with the rights of others, e.g. the use of physical intervention techniques. However, such action may be defended *if it is intended to prevent harm to the service user or others*. Trust staff must be able to demonstrate that they have acted at all times with regards to the best interest of the individual. All physical restraint must be carried out in accordance with the principles and ethos taught in the Management of Aggression training provided by the Trust.

Since staff have a responsibility for the health and safety of themselves and others, they must give assistance in managing aggression where and when necessary. This does not mean that all staff will become involved directly with the physical restraint of a service user, but that they may be able to provide other supporting assistance in meeting the needs of the situation.

In compliance with Section 75 of the Northern Ireland Act 1998, this policy/protocol has been drawn up, with the underlying principle, that this course of action should not adversely impact any of the 9 equality groups set out in Section 75 of the above Act.

2.0 When should physical restraint be used?

Physical restraint is designed to take control of a dangerous situation, limiting the person's freedom for no longer than necessary to end or reduce the potential harm to self or others.

Staff should attempt to remain calm and use de-escalation techniques before, and during, the use of physical restraint. Physical restraint should only be used when all other approaches at de-escalation have failed and/or physical aggression is actual or imminent.

The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All physical restraint should be applied in a manner that attempts to defuse, rather than provoke, further aggression.

Physical restraint should only be employed as a proportionate response to aggression likely to harm the service user or others. Damage to property does not usually warrant the use of restraint, unless the act in itself is going to cause danger to others or the service users themselves.

The number of staff required to safely employ physical restraint will depend on the situation. If alone and faced with real or potential violence staff should attempt to escape from the situation, then summon assistance by the most appropriate means e.g. use of alarm systems, shout for help etc..

3.0 Training

[Provide information on any training available to staff.]

4.0 Best Practice in the use of Physical Restraint

There are basic principles that should be borne in mind when using physical restraint. These principles and practical guidance for their implementation are contained within the Trust's Management of Aggression training courses. Staff attending these courses will be provided with this knowledge and skill.

- Service users should be treated with respect at all times and their dignity maintained.
- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users' co-operation and a return to voluntary control as soon as is safely possible.
- Well-briefed, trained and a co-ordinated staff response will be the most effective means of dealing with restraint situations.
- The aim is to restrain the service user safely in a low stimulus environment. This may mean moving the service user or asking others to leave.
- Preferably staff taking the lead in restraint situations should be those who have received training within the Trust as they will be able to provide advice and guidance to others.

5.0 Weapons

For the purpose of this document a weapon is defined as:

“Any object that is made, adapted or intended to be used to cause physical injury to a person”

*A concise dictionary of Law (1192) pp 282
Oxford University Press, Oxford*

Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgements must be made using professional knowledge and

experience, risk assessment and management of aggression training. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police.

6.0 Involvement of Police Service of Northern Ireland

There may be times when the level of threat posed or the nature of the attack means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the nurse in charge of the unit to action appropriate assistance. The use of the police for assistance will trigger the completion of an untoward incident review.

7.0 Management of physical restraint

1. One person should take the lead in the restraint and nominate others to assist him/her.
2. In a team restraint situation the person taking care of the head should co-ordinate the restraint. The rest of the team should take their instruction from the co-ordinator.
3. The service users' co-operation should be sought and encouraged at all times.
4. Communication with the service user is imperative throughout and he/she should be kept informed of what is happening to encourage his/her co-operation.
5. All persons not involved in the restraint should be asked to leave however, other staff should be available to provide additional assistance if required.
6. The doctor should be called to see the service user as soon as possible after commencement of restraint in the adult wards. Young People's Centre staff should refer to the procedure for restraint of an individual in their unit.
7. A full account of the incident must be documented clearly and concisely in the service user's notes and on the incident form and a physical intervention monitoring form must be completed (see Appendix 1).
8. If physical restraint is employed for more than half an hour a review must be carried out by the nurse manager/duty nurse manager at that time, and every half-hour thereafter to ensure that only intermittent restraint is used. This review must be fully documented in the service user's notes.

9. Following restraint the nursing team must review their interventions. The multi-disciplinary team must review the interventions as soon as possible.

Appendix 1
Physical Intervention Monitoring Form - Sample

Trust
PHYSICAL INTERVENTION MONITORING FORM

Service User's Name	Service User's Number	Unit/Ward	Date of Incident
Exact time commenced and exact location am/pm		Exact time discontinued and exact location am/pm	
Staff action(s) immediately PRIOR to using physical intervention (please tick			
1. None-insufficient time	<input type="checkbox"/>	4. Administration of PRN medication	<input type="checkbox"/>
2. Told the service user to stop	<input type="checkbox"/>	5. Counselling	<input type="checkbox"/>
3. Attempts to de-escalate the situation (specific in comments section)	<input type="checkbox"/>	6. Other (specify in comments section)	<input type="checkbox"/>
Why did you first intervene? (tick one box only)			
Aggressive behaviour in progress			
1. Towards others	<input type="checkbox"/>		
2. To self	<input type="checkbox"/>		
3. Other (specify)	<input type="checkbox"/>		
Details of all people involved			
Name	Job title	Role/Responsibility	Method used*
*Key			
1. Looking after the head			
2. Immobilisation of the legs			
3. Immobilisation of an outstretched arm			
4. Immobilisation of a bent arm			
5. Immobilisation of the hand			
6. Taking over from a colleague			

Breakaway (please indicate point of contact eg wristgrab, method used to breakaway and subsequent actions.)

Service User's position during the restraint

Column 1 – Please indicate all positions that the service user was held in during the restraint process. Number from 1 accordingly.

1st position – 1,
2nd position – 2 etc

Column 2 – Please indicate the SINGLE position that was maintained the most throughout the restraint process

1. Sitting on a chair/sofa	<input type="checkbox"/>	<input type="checkbox"/>
2. Sitting on a bed	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting on the floor	<input type="checkbox"/>	<input type="checkbox"/>
4. Kneeling on the floor	<input type="checkbox"/>	<input type="checkbox"/>
5. Lying on a bed – face up	<input type="checkbox"/>	<input type="checkbox"/>
6. Lying on a bed – face down	<input type="checkbox"/>	<input type="checkbox"/>
7. Lying on the floor – face up	<input type="checkbox"/>	<input type="checkbox"/>
8. Lying on the floor – facedown	<input type="checkbox"/>	<input type="checkbox"/>
9. Walking to another area	<input type="checkbox"/>	<input type="checkbox"/>
10. Standing	<input type="checkbox"/>	<input type="checkbox"/>

Use of protective clothing or other equipment by staff

Not used	<input type="checkbox"/>	Plastic apron	<input type="checkbox"/>
Latex gloves	<input type="checkbox"/>	Cut-resistant gloves	<input type="checkbox"/>
Ligature cutters	<input type="checkbox"/>	Eye wear	<input type="checkbox"/>

Injuries occurring during the intervention process

<i>Service User</i>	<i>Injury</i>	<i>Staff</i>
<input type="checkbox"/>	No visible injury	<input type="checkbox"/>
<input type="checkbox"/>	Reddening/bruising	<input type="checkbox"/>
<input type="checkbox"/>	Swelling	<input type="checkbox"/>
<input type="checkbox"/>	Lacerations/Cuts	<input type="checkbox"/>
<input type="checkbox"/>	Scratches	<input type="checkbox"/>
<input type="checkbox"/>	Friction burns	<input type="checkbox"/>
<input type="checkbox"/>	Thermal burns/Scalds	<input type="checkbox"/>
<input type="checkbox"/>	Other – Please specify	<input type="checkbox"/>
	In the 'comments' box	

Subsequent Action
'As required' medication given

No Further Action Required Orally Injection Time administered

Comments: Further details of actual behaviour preceding restraint, and attempts made to prevent the situation escalating any injuries sustained, use of protective clothing or equipment and any other relevant points.

Date of Completion	Name of person leading	Signature
For administration use only Incident form no.....		Copies to: Incident Report Centre

TO BE COMPLETED BY THE PERSON IN CHARGE AT THE TIME OF THE PHYSICAL INTERVENTION TAKING PLACE

ANNEX F

EXAMPLE OF HSS TRUST POLICY ON SECLUSION

Definition for Seclusion

The forcible denial of the company of other people by constraint within an enclosed environment.

(Code of practice Mental Health NI Order 1986)

The objective of seclusion is the short term safe containment of patients who are displaying severely disturbed behaviours which are likely to cause harm to themselves or others. It is an emergency management procedure, used only when all other reasonable steps/measures have been exhausted.

Seclusion facilities

Seclusion should be in a safe, secure and clearly identified room which offers maximum opportunity for observation. The room should have adequate heating, lighting and ventilation. Patients should be asked regularly if they require to use the toilet and be escorted to and from the toilet. Staff must make a careful judgement as to what the patient is permitted to take into the room. The patient must always be clothed when placed in seclusion but all belts, ties and shoe laces that could cause harm must be removed. Safety must always be a priority.

The decision to authorise any visit to a patient in seclusion rests with the patients consultant or a medical officer acting on the consultants behalf.

Courtyards should not be used for seclusion. Where patients wish to access a Courtyard the door must remain unlocked, permitting the patient to re-enter the unit.

Procedure for the use of seclusion

The initial decision to place a patient in seclusion can be taken by:

The Medical Officer
The Nurse-In-Charge of the unit
The Nurse Duty Officer

Where the decision is taken by someone other than a doctor the medical officer should be contacted immediately. The patient should be constantly observed by a designated nurse until the authorisation is obtained from the medical officer.

If not involved in the decision to seclude a patient the nurse duty officer should be informed as soon as possible.

Where seclusion is required frequently or for extended periods, the patient must be referred to the multi-disciplinary team for consideration of their legal status, if not subject to detention.

A nurse should be present and observe the patient from outside the seclusion room door when:

- A. the patient has been sedated prior to being secluded.
- B. The patient is on constant supervision.

The purpose of seclusion should be explained to the patient, where possible.

Observation

The objective of observation is to assess the condition of the patient, ensure his/her well-being and to determine whether seclusion can be terminated.

The patient should be directly observed at least every 15 minutes and more frequently if individual circumstances demand. A documented report must be made every 15 minutes. This should include information on the patients mood, behaviour, appearance and any request made by the patient. In the case of continued seclusion a review should take place every two hours by the nurse in charge and every four hours by a doctor.

If seclusion continues for more than eight hours consecutively or 12 hours in total over a period of 48 hours, the responsible consultant should be informed by the nurse in charge, to ascertain if a review is necessary.

Record keeping

Detailed records should be maintained in the patients care plan of any use of seclusion, this will include:-

- The reasons for its use
- Time commenced
- Medical staff involved and time of notification
- Nurse Duty Officer and time of notification
- Nurse in charge of unit
- Staff to patient ratio
- Staff allocated for observation
- Reports on observation and reviews
- Time terminated

In addition to recording in the patient care plan, the information will also be forwarded via the day/night report to Nursing Administration for central recording/audit purposes.

Patient requested "Seclusion"

Seclusion is not regarded as a treatment technique. However there may be times when a quiet period in a room may help to reduce agitation or alleviate distress. Individual patients may request time separated from the presence of others. This is not regarded as seclusion unless the door is locked.

Occasionally the patient may request/insist that the door be locked. Where the patient can open the door from inside the room this is not defined as seclusion, however where a patient request time alone in a locked room and cannot open the door from inside this should in all circumstances be regarded as seclusion. The patient should be observed every 15 minutes as per policy and asked if they wish to leave the seclusion room. Seclusion must be terminated immediately on request by the patient.

Use of unlocked seclusion room

There may be occasions where the seclusion room is accessed by a patient with the door unlocked, this does not meet the definition of seclusion. In all cases it should be authorised by the Nurse-In-Charge, discussed with the multi-disciplinary team and recorded in the patients care plan and day/night report.

QUESTIONNAIRE AND SUMMARY OF FINDINGS

1. To assist in establishing the current position, a questionnaire was issued in June 2003 to all HSS Trusts and to a range of other service providers.
2. The questionnaire issued to providers is attached as an Appendix to this annex.
3. A total of 81 responses were received, greater than the number of organisations approached as in some cases corporate responses were received from units within organisations while others gave a single response. 54 responses were received from HSS Trusts, including Hospital HSS Trusts and Community HSS Trusts, and 27 from voluntary or private organisations and both adult and children's services were covered.
4. The questionnaires asked about restraint and seclusion policies and practices under four main headings:

Policies and Procedures
Monitoring Arrangements
Training
Complaints Procedure

Policies and Procedures

5. Most of the organisations responding indicated that some policies and procedures on restraint and seclusion were in place: for restraint of adults – 46; restraint of children – 13; seclusion of adults – 6; and seclusion of children – 5. There were 17 organisations which said they did not have or did not need these policies or procedures – however, some of these were in the process of developing a policy. Of those with policies and practices, a number were high level policies, and others were by reference to standards and guidance of professional organisations, eg Royal College of Nursing. Some were detailed documents for the particular organisation and others were relatively brief guidelines. In some instances, although lacking a policy on restraint or seclusion, training was provided on management of violence and aggression.
6. A few organisations (9 in total) said they had facilities for seclusion.

Monitoring Arrangements

7. 15 organisations indicated they had conducted a local audit of practice in relation to restraint and 5 in relation to seclusion.

8. Proformas were available in 32 organisations for recording restraint and in 9 organisations for seclusion.
9. Arrangements were in place to review each client group in the use of restraint in 42 organisations and on the use of seclusion in 8 organisations.

Training

10. For restraint, 53 organisations provided information to their staff of policies and procedures and 39 provided training to staff. For seclusion, 9 organisations indicated that they provided information and 5 training.
11. On the inclusion of human rights implications in training, 33 organisations indicated that it was included for restraint and 7 for seclusion.

Complaints

12. The response to the questionnaire indicated that 45 organisations had mechanisms in place to scrutinise complaints on restraint and 7 had mechanisms in place for seclusion.

Outcome

13. The responses to the questionnaires and the accompanying papers provides very useful background to the working group in establishing the current positions and considering the extent and content of the guidance required.

HSS TRUST/OTHER SERVICE PROVIDER

QUESTIONNAIRE ON RESTRAINT & SECLUSION

(Please return completed Questionnaires by 27 June 2003)

Name of Trust/Other service provider:

Name of Member of staff responsible for completing this questionnaire:

Position in Organisation:

Business area/programme of care

Contact telephone number:.....

E-mail address:

Policies & Procedures

1. Do you have policies and procedures, which inform, across all client groups, the use of:

- restraint of adults Yes No
- restraint of children Yes No
- seclusion of adults Yes No N/A
- seclusion of children Yes No N/A

If you have answered **Yes** to any of the above please forward copies of the policies and procedures when returning the completed questionnaire.

If you have answered **No** please outline below what arrangements are in place to regulate the use of **both** restraint and seclusion.

2. Do you have a definition of:

- restraint Yes No
- seclusion Yes No N/A

If **Yes** please forward a copy of these with the completed questionnaire.

3. Do you have facilities for seclusion: Yes No

If **Yes** please provide details on the facility and any other information which you feel would be helpful to us in understanding your provision.

Monitoring Arrangements

4. Has your organisation conducted a local audit of practice in relation to:

- the use of restraint with any client group Yes No
- the use of seclusion Yes No N/A

If **Yes** please forward a copy of the audit report with the completed questionnaire.

5. Do you have pro forma for each client group to record use of:

- restraint Yes No
- seclusion Yes No N/A

If **Yes** please forward a copy of the pro forma with the completed questionnaire.

6. Do you have arrangements in place to review each client group the use of:

- restraint Yes No
- seclusion Yes No N/A

If **Yes** please provide copies of any pro formas used **or** outline below these arrangements.

Training

7. Do you have arrangements in place to inform staff across all professional groups and programmes of care of your policies and procedures regarding the use of:

- restraint Yes No
- seclusion Yes No N/A

If **Yes** please outline the arrangements below

8. Do you provide training to staff on the use of:

- restraint Yes No
- seclusion Yes No N/A

If **Yes** please attach a sheet detailing the **range** of training provided, the **frequency** at which it is provided and the **number** of staff trained each year. If you have a written training programme on restraint and/or seclusion, please enclose it with the completed questionnaire.

9. Please name the type of training provided, indicating, where appropriate, the accrediting body.

10. Does your training include consideration of the human rights implications of using:

- restraint Yes No
- seclusion Yes No N/A

If you have answered **Yes** please outline the issues covered.

Complaints Procedures

11. Do you have mechanisms in place to scrutinize complaints to identify weaknesses and areas for action in respect of the use of:

- restraint Yes No
- seclusion Yes No N/A

If you have answered **Yes** please provide details below, including how you have specifically addressed restraint and seclusion issues in this process.

12. If you have any other comments, which you feel would assist us in this area please outline these.

Completed Questionnaires should be returned **by 27 June 2003 to:**

Mrs Heather Humphries
Room C4.22
Castle Buildings, Stormont
BELFAST BT4 3SQ
Email heather.humphries@dhsspsni.gov.uk

Many thanks for your assistance

DRAFT GUIDANCE ON RESTRAINT AND SECLUSION IN HEALTH AND PERSONAL SOCIAL SERVICES

EQUALITY IMPACT ASSESSMENT: EQUALITY SCREENING

1. BACKGROUND

1.1 Section 75 of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- **between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;**
- **between men and women generally;**
- **between persons with a disability and persons without; and**
- **between persons with dependants and persons without.**

1.2 In addition, without prejudice to the above obligation, public authorities must also, in carrying out their functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

1.3 Schedule 9 of the Act requires public authorities to prepare Equality Schemes, which should state, among other things, the authorities' arrangements for assessing the likely impact of policies adopted, or proposed to be adopted, by the authority on the promotion of equality of opportunity. Schedule 9 also requires a public authority, in publishing the results of an assessment, to give details of any consideration given to measures which might mitigate any adverse impact of the policy on the promotion of equality of opportunity and alternative policies which might better achieve the promotion of equality of opportunity.

1.4 Equality Schemes are in place for the Department of Health, Social Services and Public Safety and all Health and Social Services Boards and Trusts. The Department and its associated bodies are committed to promoting equality of opportunity.

2. PROPOSALS

- 2.1 The proposed guidance on Restraint and Seclusion in Health and Personal Social Services (HPSS) is intended to assist HPSS bodies in developing and implementing policies on restraint and seclusion. The purpose is to protect and promote the human rights of anyone in their care who may be subject to such procedures. It is designed to help ensure compliance with, and respect for, the provisions of the Human Rights Act, which gives effect to the European Convention on Human Rights, and other human rights conventions.
- 2.2 Restraint and seclusion issues, as defined in the guidance, may arise in a range of care settings, such as residential homes for the elderly, children or disabled people, in hospitals, in day-care centres, health centres and where people are being cared for in their own homes.

3. EQUALITY IMPACT ASSESSMENT SCREENING

- 3.1 Specific areas of concern in relation to the issues of restraint and seclusion may arise for young people, older people and persons with a disability who are in a position of being cared for, whether in a residential setting or otherwise. It is therefore possible that these proposals could differentially impact on **persons of different age** and **persons with or without a disability**. However, no quantifiable evidence is available on the groups subject to restraint and seclusion procedures in HPSS.
- 3.2 There is no indication of any differential impact in terms of the other seven Section 75 distinctions:
- **between men and women generally;**
 - **persons of different marital status;**
 - **persons of different religious belief;**
 - **persons with/without dependants;**
 - **persons of different political opinion;**
 - **persons of different racial group;**
 - **persons of different sexual orientation.**
- 3.2 These proposals are intended to inform the development of policies by Health and Social Services Trusts, Boards and other agencies. All public authorities designated as such for the purposes of Section 75 will in any event have to screen these policies as they are developed, to determine whether a full Equality Impact Assessment is desirable. This fact affords a double safeguard regarding equality of opportunity.

4. CONCLUSION

- 4.1 The proposals are intended to be entirely beneficial in protecting and preserving the human rights of the people affected. There is no adverse impact on other people. Accordingly, it is considered that the proposals do not have an adverse impact in terms of any of the Section 75 distinctions.
- 4.2 It is also considered that these proposals will have no effect on good relations between persons of different religious belief, political opinion or racial group.

HSS TRUST

RESTRAINT REPORT FORM

This form should be completed if physical restraint is used in the management of any incident or accident.

Physical restraint refers to any method of responding to aggressive or violent behaviour which involves some degree of direct physical force to limit or restrict movement or mobility, ie the actions of one person which restricts the movements of another person. Physical restraint implies the restriction of a person's movement which is maintained against resistance. It is therefore qualitatively different from other forms of physical contact such as manual prompting, physical support or guidance.

Physical Restraint may involve:

1. **Direct physical contact between a member of staff and a client** eg holding a client's hand to prevent him hitting etc.
2. **The use of barriers, such as locked doors, to limit freedom of movement,** eg placing someone in a chair with a table in front so that he/she cannot easily stand up or move away, locking doors, etc.
3. **Materials or equipment which restrict or prevent movement,** eg strapping someone into a wheelchair, having a person wear a helmet to reduce the effects of head banging, placing splints on a person's arms to restrict movement, etc.

(A) Form Reference Number

(B) Type of Restraint used: Physical Contact Barriers Equipment

(C) Outline the reasons why restraint was used

(D) Outline details of the method of restraint used (who was involved in the restraint procedure; what procedure was used; who carried out different elements of the procedure; what areas of the body were in contact etc).

(E) Time restraint started: (24 hr clock) Time restraint stopped: (24 hr clock)

(F) Outline the individual's response to the restraint procedure being applied.

(G) Was a body check of the individual completed following the restraint procedure?

Check completed

Check refused

Delayed as may have caused
Further aggression

Outline details of any injury noted

(H) Outline the tasks completed in recording and reporting this incident (eg IRI form completed; reported incident to carer, manager etc)

(I) Outline any issues arising from this incident which may influence future contact with this individual.

Name of person
Completing form _____

Signature _____

Date _____

Please return to _____

by _____

HSS TRUST
SECLUSION REPORT FORM

Ward No. _____

Date: _____

Patient's Name _____

Status and Reg No. _____

Description of Incident _____

Alternative Measures Tried Prior to Seclusion _____

Patient checked for harmful objects/clothing

Yes/No

Nurses present _____

Authorisation for seclusion given by _____

Ward Doctor/Duty Doctor informed _____ At _____

Visited by Doctor _____ At (time) _____

Senior Nurse Manager _____ Notified at (time) _____

Duration of Seclusion: From _____ To _____

Monitor Chart Completed

Yes/No

2 Hourly Review by Nurses _____

4 Hourly Review by Doctor _____

Signed: _____
(Nurse in Charge)

CLINICAL SERVICES MANAGER'S REPORT

Signed: _____

ANNEX J

DENI CIRCULAR NUMBER 1999/9 –

**PASTORAL CARE: GUIDANCE ON THE USE OF
REASONABLE FORCE TO RESTRAIN OR CONTROL
PUPILS**



Subject:

Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils

Circular Number:

1999/9

Date of Issue:

8 March 1999

Audience:

- Principals and Boards of Governors of all grant-aided schools;
- Education and Library Boards;
- Council for Catholic Maintained Schools;
- Association of Governing Bodies of Voluntary Grammar Schools;
- Northern Ireland Council for Integrated Education; and
- Teachers' Unions.

Summary of Contents:

This Circular provides clarification and guidance on the use of reasonable force, by teachers and other authorised staff, to restrain or control pupils in certain circumstances. It gives guidance about who can use reasonable force, when it is appropriate to use it, and the procedures for recording incidents where reasonable force was used. It also advises that schools should have a written policy about the use of reasonable force which should be made known to parents.

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Mr Jackie Simpson (Tel: 01247-279247)
Pupil Support Branch
Department of Education
Rathgael House
Balloo Road
BANGOR
BT19 7PR

Status of Contents:

Advice

Information for schools

Related Documents:

Circular 1999/10

(Pastoral Care in Schools:

Child Protection)

Superseded Documents:

None

Expiry Date:

Not applicable

DENI Website:

This Circular is also available on

<http://www.deni.gov.uk>



**PASTORAL CARE: GUIDANCE ON THE USE OF
REASONABLE FORCE
TO RESTRAIN OR CONTROL PUPILS**

1. All schools have a pastoral responsibility towards the pupils in their charge and should therefore take all reasonable steps to ensure that the welfare of pupils is safeguarded and that their safety is preserved. The Board of Governors and the Principal of each school also have a duty to promote and secure good behaviour and discipline on the part of pupils at the school.

2. Article 4 of the Education (Northern Ireland) Order 1998, which came into force on 21 August 1998, clarifies powers which already exist under common law. It enables a member of staff of a grant-aided school to use, in relation to any pupil at the school, such force as is reasonable in the circumstances to prevent a pupil from:

- a. committing an offence;
- b. causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- c. engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils, whether during a teaching session or otherwise.

3. The right of a member of staff to use such force as is reasonable to restrain or control a pupil applies:

- where the member of staff is on the premises of the school; or
- elsewhere at a time when he/she has lawful control or charge of the pupil concerned;
- to teachers at the school, and to any other member of staff who with the authority of the principal has lawful control or charge of pupils.

4. **The need to use reasonable force to restrain or control a pupil should be rare.** This Circular and the attached Appendix provide clarification and guidance on a number of issues relating to the use of “reasonable force” by teachers and others to restrain or control pupils. **However, it is emphasised that corporal punishment remains unlawful, and that neither Article 4 nor this Circular, in any way, authorise teachers or others to use any degree of physical contact which is deliberately intended to cause pain or injury or humiliation.** The application of reasonable force to restrain or control a pupil is to be used as a last resort, only when other behaviour management strategies have failed, and when the pupil, other pupils, members of staff, or property are at risk, or the pupil is seriously compromising good order and discipline.

Article 4 does not however prevent any person from exercising his/her right under common law to defend themselves against an attack provided he/she does not use a disproportionate degree of force to do so. The purpose of Article 4 is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.



Need for Schools to Have a Written Policy

5. The use of reasonable force is only one of the strategies available to schools and teachers to secure pupils' safety and well being and also to maintain good order and discipline. All those who may have to use reasonable force with pupils must clearly understand the options and strategies open to them, and they must know what is regarded as acceptable action on their part and what is not. It is important, therefore, that schools have a clear written policy about the use of reasonable force to restrain or control pupils. This should be understood by teachers, authorised staff, pupils and parents and should form part of the school's policy on discipline and child protection within its overall pastoral care policy.

6. In drawing up a written statement of the school's disciplinary policy, as required in Article 3 of the 1998 Order, it is recommended that the Board of Governors, in consultation with the Principal, should:

- include a statement setting out the school's policy and its guidelines on the use of reasonable force to restrain or control pupils;
- discuss these with staff who may have to apply them; and
- issue or make them known to parents and pupils.

Boards of Governors should also have regard to any advice issued by Education and Library Boards and, where appropriate, the Council for Catholic Maintained Schools.

7. The Department has asked a Working Group, comprising representatives from the Education and Library Boards, CCMS and schools, who are already drafting best practice guidelines for schools on a wide range of disciplinary matters, to draft a model policy for schools on the use of reasonable force based on the guidance in this Circular. This will be available later this year. Schools may wish to draw up their own policies in the meantime in order to provide guidance to staff and others on the use of reasonable force and its place in the school's strategies for maintaining good behaviour and discipline.

8. A statement of the school's policy on the use of reasonable force to restrain or control pupils should be included with the information the school gives parents about its overall policy on discipline and standards of behaviour.

9. The Department considers that it would also be useful if schools designated an experienced senior member of staff (the Principal or a senior teacher, or perhaps the designated teacher for child protection) as having special responsibility for providing guidance to other staff on the use of reasonable force. This teacher should also assume responsibility for notifying parents about incidents where reasonable force has had to be used and for dealing with any complaints which may emerge. This will help to ensure a consistent approach within the school to the use of reasonable force and the reporting arrangements.

C JENDOUBI (MRS)
School Effectiveness Division



GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Who may use reasonable force?

Teachers

1. Article 4 of the 1998 Order authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

Non-teaching staff

2. Other members of staff at the school are also authorised to use reasonable force in the circumstances described at 1. above, provided they have been authorised by the Principal to have lawful control or charge of pupils. This might, for example, include classroom assistants, midday supervisors, and escorts. In addition the authorisation could extend to education welfare officers and educational psychologists.

3. In determining which non-teaching staff to authorise, Principals will wish to have regard to the roles and responsibilities of the staff concerned. In particular they should consider whether the staff have a responsibility to supervise pupils as part of their normal duties or whether, from time to time, they may have to take on that responsibility when a teacher is not present.

Volunteers

4. Suitably vetted volunteers normally work only under the direction and supervision of a teacher or other member of staff and should not be expected to assume sole responsibility for the safety and well-being of pupils. Where a situation arises, therefore, where the use of reasonable force may need to be exercised, the volunteer should alert the member of staff in charge and defer to his/her judgement as to the appropriate means of handling the situation.

There may, however, be circumstances in which the Principal may need to authorise a volunteer to use reasonable force in exceptional circumstances. These might include school visits, holidays and residential activities where some degree of delegated responsibility may have to be given to the volunteers in the organisation of activities; where a member of school staff may not be readily available to deal with an incident; and where it is possible that significant harm will occur if action



is not taken immediately. Where volunteers are so authorised, it is essential that they receive appropriate training and guidance.

5. **The key issue is that all non-teaching staff and volunteers must be identified and specifically authorised by the Principal to be in control of or in charge of pupils.** The Principal should clearly inform all persons concerned and ensure that they are aware of and understand what the authorisation entails. Principals may find it helpful to arrange for training or guidance to be provided by a senior member of the teaching staff who has been designated as having special responsibility for this matter and who has already received suitable training on the use of reasonable force. Principals should also keep an up to date list of authorised non-teaching staff and others who are so authorised and ensure that teachers know who they are, for example, by placing a list on the staff room notice board.

Where can reasonable force be used?

6. The right of a teacher or other person to use reasonable force applies where the pupil concerned is on the school premises **and** when he/she has been authorised to have lawful control or charge of the pupil concerned elsewhere e.g. supervision of pupils in bus queues, on a field trip, or other authorised out of school activity such as a sporting event or educational visit.

What is meant by reasonable force?

7. There is no precise legal definition of “reasonable force” so it is not possible to state, in fully comprehensive terms, when it is appropriate to use physical force to restrain or control pupils or the degree of force that may reasonably be used. It will always depend on the circumstances of each case. However, there are three relevant considerations to be borne in mind:

- the **use of force** can be regarded as reasonable **only** if the circumstances of the particular incident warrant it. The use of any degree of force is unlawful if the particular circumstances do not warrant the use of physical force. Therefore physical force could not be justified to prevent a pupil from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force;
- the **degree of force** employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. Any force used should always be the minimum needed to achieve the desired result;
- whether it is reasonable to use force, and the degree of force that could reasonably be employed, might also depend on the age, level of understanding and sex of the pupil, and any physical disability he/she may have.

Is it appropriate to use reasonable force in every situation?

8. **Reasonable force should not be used automatically in every situation nor should it be used as a form of discipline. In a non-urgent situation, reasonable force should only be used when other behaviour management strategies have failed.** That consideration is particularly appropriate in situations where the aim is to maintain good order and discipline, and there is no



direct risk to people or property. Any action which could exacerbate the situation needs to be avoided, and the possible consequences of intervening physically, including the risk of increasing the disruption or actually provoking an attack, need to be carefully evaluated. The age and level of understanding of the pupil is also very relevant in those circumstances - physical intervention to enforce compliance with staff instructions is likely to be increasingly inappropriate with older pupils and **should never be used as a substitute for good behaviour management.**

9. Staff may not always have the time to weigh up the possible courses of action and it would be prudent therefore for them to have considered in advance the circumstances when they should and should not use reasonable force. Staff should, whilst taking due account of their duty of care to pupils, always try to deal with a situation through other strategies before using reasonable force. All teachers need to be aware of strategies and techniques for dealing with difficult pupils and situations which they can use to defuse and calm a situation. Best practice guidelines on successful discipline policies are currently being drawn up by a Working Group comprising representatives from schools, the Education and Library Boards and CCMS. These will be circulated to all schools shortly.

When might it be appropriate to use reasonable force?

10. In a situation where other behaviour management strategies have failed to resolve the problem, or are inappropriate (eg in an emergency), there are a wide variety of circumstances in which reasonable force might be appropriate, or necessary, to restrain or control a pupil. They will fall into three broad categories:

- a. where action is necessary in self-defence or because there is an imminent risk of injury;
- b. where there is a developing risk of injury, or significant damage to property;
- c. where a pupil is behaving in a way that is compromising good order and discipline.

11. Examples of situations that fall into one of the first two categories are

- a pupil attacks a member of staff, or another pupil;
- pupils are fighting;
- a pupil is causing, or at risk of causing, injury or damage by accident, by rough play, or by misuse of dangerous materials, substances or objects;
- a pupil is running in a corridor or on a stairway in a way in which he/she might have or cause an accident likely to injure him- or herself or others;
- a pupil absconds from a class or tries to leave school (NB **this will only apply if a pupil could be at risk if not kept in the classroom or at school.**)



12. Examples of situations that fall into the third category are:
- a pupil persistently refuses to obey an order to leave a classroom;
 - a pupil is behaving in a way that is seriously disrupting a lesson.
13. However, some practical considerations also need to be taken into account:
- Before intervening physically a member of staff should seek to deploy other behaviour strategies. Where these have failed, the member of staff should, wherever practicable, tell the pupil who is misbehaving to stop, and what will happen if he/she does not. The member of staff should continue attempting to communicate with the pupil throughout the incident, and should make it clear that physical contact or restraint will stop as soon as it ceases to be necessary. A calm and measured approach to a situation is needed and staff should never give the impression that they have lost their temper, or are acting out of anger or frustration, or to punish the pupil.
 - Sometimes a member of staff should not intervene in an incident without help (unless it is an emergency), for example, when dealing with an older pupil, or a physically large pupil, or more than one pupil, or if the teacher believes he/she may be at risk of injury. In those circumstances the member of staff should remove other pupils who might be at risk, and summon assistance from a colleague or colleagues, or where necessary telephone the Police. The member of staff should inform the pupil(s) that he/she has sent for help. Until assistance arrives the member of staff should continue to attempt to defuse the situation orally, and try to prevent the incident from escalating.
 - Situations where a pupil refuses to obey an order to leave a classroom need to be handled carefully as they can be a prelude to a major confrontation, especially if reasonable force is used to eject older pupils. Where a pupil persistently refuses to leave a classroom and the teacher believes that the use of reasonable force will endanger the teacher or other pupils, the school should have an emergency response procedure whereby assistance can be summoned quickly, for example a trusted pupil is sent for help.
 - If a school is aware that a pupil is likely to behave in a disruptive way that may require the use of reasonable force, it will be sensible to plan how to respond if the situation arises. Such planning needs to address:
 - managing the pupil (eg reactive strategies to de-escalate a conflict, holds to be used if necessary);
 - involving the parents to ensure that they are clear about the specific action the school might need to take;
 - briefing staff to ensure they know exactly what action they should be taking (this may identify a need for training or guidance);



- ensuring that additional support can be summoned if appropriate.

What might be regarded as constituting reasonable force?

14. Physical intervention can take a number of forms. It might involve staff:

- physically interposing between pupils;
- blocking a pupil's path;
- holding;
- pushing;
- pulling;
- leading a pupil by the arm;
- shepherding a pupil away by placing a hand in the centre of the back; or
- (in extreme circumstances) using more restrictive holds.

15. In exceptional circumstances, where there is an immediate risk of injury, a member of staff may need to take any necessary action that is consistent with the concept of "reasonable force", for example, to prevent a young pupil running off a pavement onto a busy road, or to prevent a pupil hitting someone, or throwing something. **However, staff should never act in a way that might reasonably be expected to cause injury, for example by:**

- holding a pupil round the neck, or by the collar, or in any other way that might restrict the pupil's ability to breathe;
- slapping, punching, kicking or using any implement on a pupil;
- throwing any object at a pupil;
- twisting or forcing limbs against a joint;
- tripping up a pupil;
- holding or pulling a pupil by the hair or ear;
- holding a pupil face down on the ground.

16. Staff should also avoid touching or holding a pupil in any way that might be considered indecent.



What action can be taken in self-defence or in an emergency situation?

17. Neither Article 4 nor the guidance contained in this Circular can cover every possible situation in which it might be reasonable for someone to use a degree of force. For example, everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of force to do so. Similarly, in an emergency, for example if a pupil is at immediate risk of injury or on the point of inflicting injury on someone else, any member of staff would be entitled to intervene whether or not specifically authorised by the Principal to do so. The purpose of Article 4 and this Circular is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Is physical contact with pupils appropriate in other circumstances?

18. The Code of Conduct for staff which has been issued to all schools makes it clear that, although physical contact with pupils should generally be avoided, there can be occasions when physical contact with a pupil may be proper or necessary other than those situations covered by Article 4. For example, some physical contact may be necessary to demonstrate exercises or techniques during PE lessons, sports coaching, music or technology and design, or if a member of staff has to give first aid. Young children and children with special educational needs may also need staff to provide physical prompts or help. Touching may also be appropriate where a pupil is in distress and needs comforting. Teachers should use their own professional judgement when they feel a pupil needs this kind of support. Guidance on these issues can be found in the Code of Conduct, and also in paragraphs 73 and 74 of the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

19. There may be some children for whom touching is particularly unwelcome, because, for example, they have been abused. Physical contact with pupils becomes increasingly open to question as pupils reach and go through adolescence, and staff should also bear in mind that even innocent and well-intentioned actions can sometimes be misconstrued.

Should incidents where reasonable force is used be recorded?

20. It is extremely important that there is a detailed, contemporaneous, written report of any occasion (except minor or trivial incidents) where reasonable force is used. This may help prevent any misunderstanding or misrepresentation of the incident, and it will be helpful should there be a complaint. Schools should keep an up-to-date record of all such incidents, in an incident book. Immediately following any such incident the member of staff concerned should tell the Principal or a senior member of staff and provide a short written factual report as soon as possible afterwards. That report should include:

- the name(s) of the pupil(s) involved, and when and where the incident took place;
- the names of any other staff or pupils who witnessed the incident;
- the reason that force was necessary (eg to prevent injury to the pupil, another pupil or a member of staff);



- briefly, how the incident began and progressed, including details of the pupil's behaviour, what was said by each of the parties, the steps taken to defuse or calm the situation, the degree of force used, how that was applied, and for how long;
- the pupil's response, and the outcome of the incident;
- details of any obvious or apparent injury suffered by the pupil, or any other person, and of any damage to property.

At least annually, the Chairman of the Board of Governors and the Principal should review the entries in the incident book. Records of incidents should be kept for 5 years after the date they occurred.

21. Staff may find it helpful to seek advice from a senior colleague (eg the Principal or senior member of staff who has been designated to provide training and guidance on the use of reasonable force), or a representative of their professional association when compiling a report. They should also keep a copy of the report.

22. Incidents involving the use of force can cause the parents of the pupil involved great concern. It is always advisable to inform parents of an incident involving their child (other than a trivial incident), and give them an opportunity to discuss it. The Principal, or a member of staff to whom the incident is reported, will need to consider whether that should be done straight away or at the end of the school day, and whether parents should be told orally or in writing.

Are complaints about the use of reasonable force likely to occur?

23. Involving parents when an incident occurs with their child, and having a clear policy about the use of reasonable force that staff adhere to, should help to avoid complaints from parents. It will not, however, prevent all complaints, and any complaint from a parent about the use of reasonable force on his/her child should be dealt with in accordance with the procedures set out in the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

24. The possibility that a complaint might result in a disciplinary hearing, or a criminal prosecution, or in a civil action brought by a pupil or parent, cannot be ruled out. In these circumstances it would be for the disciplinary panel or the court to decide whether the use and degree of force was reasonable in all the circumstances. In doing so, the disciplinary panel or court would have regard to the provisions of Article 4. It would also be likely to take account of the school's policy on the use of reasonable force, whether that had been followed, and the need to prevent injury, damage, or disruption, in considering all the circumstances of the case.

Will suitable training and supporting advice on the use of reasonable force be provided for teachers and other authorised staff?

25. Education and Library Boards are being asked to arrange suitable training courses for a senior teacher in each school who will then be responsible for providing "cascade" training and advice to other staff in the school. Boards are being asked to place an emphasis on and cover behaviour management strategies which seek to avoid the need to use reasonable force to restrain or control pupils. Such training will be in the context of schools' behaviour and child protection



policies. Arrangements are also being made for suitable training to be included as part of INSET and initial teacher training courses.

26. The Education and Library Boards are also establishing multi-disciplinary Behaviour Support Teams, to offer professional advice and practical support to schools on a range of behavioural and disciplinary matters, including the use of reasonable force.

