

Restraint and the 'least restrictive environment'? Legal and ethical issues in the management of aggression and violence in health care.

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Introduction

Health care workers in the UK as elsewhere are expected to exercise mature professional judgement and formulate rational decisions for which they may be professionally, ethically and legally accountable while working in care environments which can change extremely rapidly. This paper will focus on of a sensitive and complex area of practice namely the legal issues surrounding the practice of restraint. Restraint is often interpreted as synonymous with physical holding but the laws interpretation of what may constitute restraint is in fact much wider.

A number of recent legal initiatives notably, the incorporation of the European Human Rights Act into Scottish and subsequently English law, a series of decided cases involving the Human rights act and the introduction of the Adults with Incapacity Act into Scottish law have recently changed the legislative environment significantly. The impact of such changes can however, can only be fully understood against the backdrop of the existing legal and ethical framework surrounding the application of force towards, and/or the restriction of liberty of, patients who present with aggressive and violent behaviour which will therefore, of necessity be explored.

Learning Outcomes

Reading this paper and completing the associated learning activities should enable you to

Identify and discuss the two criteria which Gostin suggests must be met if the use of force is to be considered legitimate.

Describe the four key sections of the European Convention on Human rights of relevance to the use of force with people with a mental disorder.

Discuss the five lawful excuses for the use of force

Define the two categories of patients who may be considered as 'de facto' detained

Discuss the legal basis for the practice of seclusion for people with mental disorder

The Legal basis for practice

In both the US and the UK in certain circumstances society legitimatises a range of medical interventions, where patients are unable and/or unwilling to grant informed consent. However, the law can view an intervention forced on patients without their informed consent, and/or against their expressed wishes as a crime or a civil wrong.

Amongst the most likely criminal charges which might result from the unlawful use of force may be;

False imprisonment
Assault and Battery

False imprisonment has been defined as ‘an act of the defendant which directly and intentionally or negligently causes the confinement of the plaintiff within an area delimited by the defendant’ (Brazier Law of Torts p 28 cited by Lyon 1994 p76). Using this definition a variety of measures used which are the subject of professional controversy such as ‘Buxton’ or tilt back chairs (which restrict an individuals freedom of movement) cot sides, ‘strong’ clothing, arm splints, seclusion and some forms of medication could all technically be considered ‘false imprisonment’. Crucially the meaning of ‘confinement’ in this context is not restricted to physical confinement such as by locked doors and an individual,

‘can be imprisoned if instead of a lock and key or bolts and bars, he is prevented from, in fact exercising his liberty by guards and warders.... They serve the same purpose’

(Meering v Grahame- White Aviation Co Ltd (1920) 122 Lt 44 at 53-54:)

Thus almost any means, in any situation where an individual is prevented from leaving a building of any type, a hospital including its grounds, a vehicle, specific areas (such as a patients or patients bedroom) or even a chair, might constitute unlawful detention. For ‘confinement’ to be considered to have occurred the restriction on liberty must however, be ‘total’ such that the patient would risk injury if they tried to escape or it would be unreasonable to expect the patient to try to escape such was their position.

Assault and Battery

In English Law an assault is defined as ‘any act of the defendant which directly and either intentionally or negligently causes the plaintiff immediately to apprehend a contact with his person’ Battery is defined ‘as any act of the defendant which directly and intentionally or negligently causes some physical contact with the plaintiff without the plaintiff’s consent.’ (Brazier 1989 cited by Lyon 1994 p79). In both instances the type of contact whether actually experienced or apprehended must clearly go beyond that liable to be experienced in everyday life. Many acts of care could however, in certain circumstances easily constitute assault and battery and/or false imprisonment. The administration of medicine without valid consent for example whether this is achieved by

coercion, physical force or surreptitiously via concealment might in certain circumstances constitute both an assault and a form of false imprisonment (Nursing and Midwifery Council 2001) . The US Health Care Financing Administration (HCFA) regulations on restraints suggest that,

“a drug used as a restraint, is a medication used to control behaviour or to restrict a patients freedom of movement and is not a standard treatment for the patients medical or psychiatric condition.” (HCFA 1999:482) .

Scots law and Assault

In Scots law assault is an attack on the person of another. It is a crime of intent. The slightest amount of force is enough and there need be no actual injury. It cannot be committed recklessly or negligently. Unintentional infliction of personal injury is in certain circumstances criminal, but it is not an assault (Wilkinson et al 1990). Section 122 of the Mental Health (Scotland) Act 1984 has been suggested to offer a degree of protection to staff against criminal charges or civil suits arising from their practice. Such protection applies only to those working with patients detained under the Act and is negated by any demonstration of bad faith (i.e. the staff member knew what they were doing was wrong and and/or acted with malice) or failure to act with reasonable care.

However both the Mental Health Act 1983 and Mental Health (Scotland) Act 1984 provide some statutory protection for those experiencing mental disorder. Section 105 of the 1984 Act makes it an offence for anyone responsible for the custody or care of a person with a mental disorder to either ill treat or willfully neglect him or her. The Adults with Incapacity (Scotland) Act 2000 also contains similar provisions, with Section 8.3 of the Act making it an offence for anyone exercising powers under the Act to ill-treat or willfully neglect a person with mental incapacities in his or her care.

The European Convention on Human Rights

The European Convention on Human Rights or to give it its full title the Convention for the Protection of Human Rights and Fundamental Freedoms of the Council of Europe. The Council of Europe is an entirely separate entity from the European Union with which the Convention's origins are often mistakenly associated. Since the Conventions inception citizens of countries which are members of the Council of Europe have had the right to pursue cases under the Convention. However, prior to the conventions incorporation into domestic law in Scotland and then latterly England Wales and Northern Ireland such cases could ultimately involve taking the case to the European Court of Human rights in Strasbourg in a lengthy and potentially costly process. The convention contains numerous provisions of potential significance in mental health but the key articles relevant to the issue of restraint are perhaps those of;

Article 3 . Prohibition of torture. Which requires that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 5. Right to liberty and security. This gives a right to liberty and security of the person,

Article 8. Right to respect for private and family life. This gives a right to personal privacy and respect for the privacy of family life.

Article 11. Freedom of assembly and association. This provides the right to to freedom of peaceful assembly and to freedom of association with others,

Lawful Excuse

Essentially in order for the application of force and/or restriction of liberty with adults to be considered legitimate the practitioner must be able to offer a justification in law why their actions do not constitute an offence. Gostin 1986 suggests that two criteria must be met. It must be noted however, that the overarching principle is always that no practicable alternative to the use force was available. The two principle criteria identified by Gostin (1986) are;

- A lawful excuse in terms of a legitimate reason to use force and/or restrict the liberty of an individual must exist.

and

- The force and/or restriction utilised must be demonstrably reasonable.

Legitimate Reasons

According to Hogget (1985, 1990) there are five main categories of lawful excuse for the use of force and/or the restriction of an individuals liberty.

The prevention of a crime

The English Criminal Law Act (H.M.S.O. 1967) states explicitly that ' A person may use such force as is reasonable in the circumstances in the prevention of a crime '. (reasonableness is examined later in this paper) This would include potentially any statutory offence although for very minor offences any use of force may be considered unreasonable.

The Prevention of a breach of the peace

Lyon (1994, p89) defines a breach of the peace as a situation where ' harm is done or likely to be done to a person or in his presence, to his property: or harm is feared through an affray, riot, assault or other disturbance '. Harm does not need to be done, a patient loudly threatening harm, e.g. to assault another patient or to damage property, may cause a practitioner to apprehend that harm is potentially likely, and permit action to avert such harm before it occurs.

Self defence

Whilst the law imposes a duty on any potential victim to retreat and escape it also recognises that it may not always be possible to disengage. In the latter circumstances, the use of force and/or restriction of liberty, in self defence, are likely to be considered legitimate. (Martin 1990)

The restraint of a dangerous lunatic

Under common law in both Scotland and England it may be legitimate to use force to detain the 'insane' if their behaviour places their own or others safety at risk. There is no suggestion that this archaic terminology is appropriate, a modern interpretation of these concepts would generally include those individuals covered under the term mental disorder used in both the Mental Health Act (1983) and the Mental Health Act (Scotland) 1984. This includes both those experiencing mental ill health and/or people with learning disabilities. (Lyon 1994, p87; Hogget 1990). However, there are suggestions that in Scotland the common law power to detain persons of unsound mind who are a risk to themselves or others is restricted firstly, by time, any restriction of liberty being legitimate only until a warrant can be obtained and secondly, that previous cases have indicated that this power may be unavailable to those individuals or agencies who possess statutory powers of detention. (B v Forsey 1988 SLT 572(HL)). Thus if detention is considered clinically necessary the nurse or doctor must use statutory provisions where they possess them or the detention may be unlawful.

Exercise of Statutory Powers/Duties

In certain contexts the authority to use restrict individual liberty may be derived from specific statute legislation. In some cases the power may be 'explicit' that is clearly outlined and defined in the statutory legislation e.g. 'Nurses Holding Power'. The Mental Health Act (1983) allows that a voluntary patient in hospital receiving treatment for a mental disorder can be legally detained by a nurse registered with NMC (only to those nurses registered in Mental Health or Learning Disability) for up to a maximum of 6 hours which cannot be extended, subject to two conditions.

- It appears to the nurse that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving the hospital;

and

- It is not practicable to secure the immediate attendance of a medical practitioner for the purpose of furnishing a report under Section 5(2).

The nurse simply has to record in writing that the conditions are met. This written record must however be conveyed to the identified Mental Health Act Managers (or a member of staff acting on their behalf) as soon as possible. The section expires at the end of six hours or ends when a doctor who is entitled to impose a Section 5(2) arrives. Should the doctor decide to use Section 5(2), this authorises the continued detention of the patient for 72 hours but from the time that the original Section 5(4) report was made by the nurse not the time the doctor examines the patient. The Mental Health Act (Scotland) 1984 provides almost identical powers with the proviso that the power to detain pending medical assessment is restricted to a maximum of two hours and should the doctor choose to detain the patient under section 25 (2) of the Act the 24 hour period starts from the time they complete the certificate.

Detention of patient for long enough to carry out an assessment for detention

Neither the Scottish or English Act clarify however, where the authority to detain the patient while they are being assessed by the doctor stems from. The Mental Welfare Commission for Scotland (2000:470) report however, that legal advice to the Commission is to the effect that

‘Parliament is deemed not to have legislated to make unworkable provisions. A purposive interpretation of the act would be to the effect that there is an implied power to detain the patient for a reasonable length of time, in order to assess the need for formal detention and to attempt to fulfil the requirement for consent under the act’.

These considerations noted apply to any situation where a patient deemed to be at risk is wishing to leave and the doctor has to assess the need for emergency intervention.

Both the 1983 Act and its predecessor the 1959 Act however,

‘leave unspoken many of the necessary incidents of control flowing from a power of detention for treatment including; the power to restrain patients, to place them in seclusion, (cf. R v Deputy Governor of Parkhurst prison ex p Hague (1992) 1 AC 58 HL) to deprive them of their personal possessions for their own safety and to regulate the frequency and manner of visits to them’

(Auld LJ 1998 cited by the Honourable Stanley Burnton in S v Airedale National Health Service Trust p 16 of the HTML Transcript).

A body of case law has however, developed which has gone some way to clarify the powers implicit to the 1959 and 1983 Acts. Much of this has originated in the context of challenges to the legitimacy of practices such as seclusion, the searching of both the person and the property of detained patients and the physical restraint of patients. The use of both Restraint and Seclusion have been challenged under Article 3 of the Convention which proscribes torture and requires that no one should be subject to inhuman and degrading treatment. In *Heczegfalvy v Austria* 1992 18 BLMR, a patient complained

that the 'treatment' administered, he was handcuffed to a bed for two weeks in isolation, breached Article 3. The court found however, that while aspects of his care were worrying, particularly the duration of the security measures used, the evidence heard was insufficient to refute the suggestion that the treatment given, in the circumstances, was not justified by medical necessity.

The use of seclusion outside the immediate management of an emergency situation was challenged in the case of *A v United Kingdom* 1974. 'A' an in-patient in Broadmoor who had been secluded for five weeks with limited sanitation and access to exercise challenged the legality of his detention in such circumstances under Article 3. The case was settled without any admission of liability by the UK government, which, however, agreed the adoption of new guidelines covering the use of seclusion at Broadmoor. These preceded the development of National Guidelines for the use of seclusion in England and Wales under the Code of Practice for the 1983 Act. The use of seclusion was however, recently challenged again in *S v. Airedale National Health Services Trust*. S an in-patient, spent a considerable period of time in seclusion, partly it was acknowledged, because a shortage of secure beds meant he was being cared for in an open ward rather than being transferred to a more appropriate secure environment. Although the circumstances in which S was secluded were considered to have breached the Mental Health Act Code of Practice, the court adopted the view that a breach of the Code of practice does not necessarily give rise to unlawfulness. Any departure from the Code must however, be justifiable in terms of necessity or it could be unlawful.

Justice Mr Stanley Burnton (*S v. Airedale National Health Services Trust* 79.) found that,

'seclusion is not necessarily contrary to Article 3: it may be imposed for a very short time, in good conditions and with no negative impact on the patient. In such a case it is not arguable that it reaches the level of severity involved in an infringement of Article 3'

However, while seclusion may be used lawfully in certain circumstances this does not necessarily preclude a finding in other circumstances that,

'the duration and conditions of seclusion, the reason for it and its effects on the patients may be such as to constitute an infringement of Article 3'.

(*S v. Airedale National Health Services Trust* 79). The Council of Europe Steering Committee on Bioethics (CDBI) Working Party on Psychiatry has published (for consultation purposes with a view to drawing up guidelines to be included in a new legal instrument of the Council of Europe) a White Paper on 'The Protection Of The Human Rights And Dignity Of People Suffering From Mental Disorder, Especially Those Placed As Involuntary Patients In A Psychiatric Establishment' (Strasbourg, 3 January 2000 DI R/JUR (2000). The Working Party has specifically examined both seclusion and other means of physical restraint within the wider framework of compulsory placement and/or treatment. They,

‘considered that the use of short periods of physical restraint and of seclusion should be in due proportion to the benefits and the risks entailed’

Only in ‘exceptional’ cases might seclusion and mechanical or other means of restraint be used for prolonged periods. In such cases the individual's behavior must pose a significant risk to themselves or others in the environment and there must be no other means of remedying the situation. It is however, also important in a practice context that practitioners recognise that seclusion can take other forms than that traditionally recognised ie placing the patient in a designated room with the door locked. Fassler and Cotton (1992) have described what are perhaps the most common variants of seclusion, any of which might, in certain circumstances, unless the practice can be justified, constitute a breach of human rights ;

- Placing a patient in a room with the door locked
- Placing a patient in a room with the door held shut
- Placing a patient in a room which his or her ability to leave is somehow restricted eg by suggesting that any attempt to leave the room will result in physical restraint or compulsory medication
- Separating a patient from the group although not necessarily by physical walls

Article 11 of the Convention provides for Freedom of Assembly and Association. Admission in and of itself, if the patient is prevented from leaving by whatever means, will significantly restrict the patient in his or her exercise of these rights. However, in some practice areas seclusion may be used to manage the difficult and dangerous behaviour which may be associated with the individual mental disorder. In secluding the patient their liberty is restricted severely and it might be suggested that this additional restriction of liberty breaches both Article 11 and Article 5 because the decision to seclude as opposed to the decision to detain is not specifically regulated by any ‘lawful procedure’. The decision to seclude is instead one of ‘clinical judgement’. However, in *Ashingdane v United Kingdom* 1985 7 E.H.R.R. 528 (paragraph 55) the Court concluded that subject to the patient's initial detention being lawful, Article 5,

‘is not in principle concerned with suitable treatment or condition’.

Seclusion is seen as representing simply a variation of the conditions of detention not a materially separate form of detention. Its justification legally is therefore found in the patient's original detention as,

‘the power of detention and treatment necessarily carried with it a power of control and discipline’

(Auld LJ 1998 cited by the Honourable Stanley Burnton in S v Airedale National Health Service Trust p 16 of the HTML Transcript).

Learning activity

List the four forms that seclusion may take identified by Fassler and Cotton (1992) . How many of those have you experienced or used?

Are any of these used in your service?

If one or more of the forms of seclusion identified above is used what procedures are in place to safeguard patients rights?

The legitimacy of random and routine searches of patients belongings for security purposes in Broadmoor Hospital was challenged in R v. Broadmoor Hospital Authority. Article 8. of the convention provides for the Right to Respect for Private and Family Life. This article in effect enshrines in law the principle of autonomy not just of the individual but of the family unit. Any interference in an individuals private or family life may thus constitute a breach of this article. The Court of Appeal judgement however supported the practice of routine searches on security grounds as a ‘necessary’ exercise of control by reason of the persons mental disorder compatible with the 1983 Act in seeking to safeguard the welfare of the patient and others in the environment (R v. Broadmoor Hospital Authority.)

As previously noted Article 5. of the convention provides for The right to the liberty and security of the person. In general this requires that ‘No one shall be deprived of his liberty’. A number of exceptions to this general proviso are however, made and the Convention provides for the ‘*the lawful detention, of persons of unsound mind, alcoholics or drug addicts*’. Such individuals may be detained in the interests of their health and safety or that of others if informal admission is refused or impractical and admission the only means of preventing harm. Such detention must however, be in ‘in accordance with a procedure prescribed by law’ and unsound mind must be determined by ‘objective’ medical opinion. An improvement in the patients condition, if significant, may thus nullify the power to detain (Winterwerp v the Netherlands (1979) 2 E. H. R. R. 387). It may however, be reasonable in some circumstances, for example, where previous experience of the patient suggests their condition may rapidly fluctuate, for practitioners to ensure that the improvement is ‘sustained’.

Concerns have however, been expressed about the ‘de facto’ detention of a number of groups of patients whose legal position has seemed somewhat ambiguous.

- The patient who can consent to treatment including admission and does so apparently willingly

Such patients may not immediately seem to be detained being nominally both accepting of treatment and free to leave. However, some research suggests that many ‘informal’ patients report a high level of perceived coercion in the process of admission and

treatment (Eriksson and Westrin 1995). Many report that they are informed that their legal status will remain informal only as long as they agree to stay and/or comply with medication. There is however, a delicate balancing act in such cases in which the presence of an independent advocate is strongly desirable. The health care practitioner may be required to inform the patient of the consequences of their actions. Where the patient is declining treatment but the worker believes treatment is necessary and may need to be given compulsorily if the patient refuses consent in order to reduce the likelihood of seriously dangerous behaviour. The practitioner is arguably obliged to inform the patient of their opinion and the potential consequences of the patient's continued refusal to accept treatment voluntarily. These may ultimately include that the practitioner may liaise with other members of the clinical team to seek their detention in order to effect treatment. The patient fearful of the potential consequences of detention in terms of further restrictions on their liberty may understandably comply but their compliance has in fact only been obtained under duress. The resulting situation is a form of effective detention thus 'de facto', albeit a wholly undesirable one in which paradoxically the patient in 'choosing' informal status may have fewer rights than if they were detained under the relevant statutory provisions.

Learning Activity

Place yourself in the position of a patient admitted informally on the basis of informed consent to an in-patient psychiatric unit. You have found the unit frightening and stressful and after two days express a wish to leave to your primary nurse who you have only talked to very briefly since your admission. He informs you that he has serious concerns about your mental health and would very much like you to reconsider and stay, if you don't, he says he may have to detain you and ask a doctor to review your case with a view to continued detention.

How would you feel?

What factors might influence your decision?

What information would you want in order to inform your decision making?

How much of that information is available to the patients you work with ?

Hoggett (1996:9) describes a further and perhaps much larger group of patients who might also be considered as 'de facto' detained;

- *'those elderly or severely disabled patients who are unable to exercise any genuine choice but do not exhibit the active dissent which provokes professionals to invoke the compulsory procedure'* .

The legal position of such patients in England has been extensively explored in the context of the 'Bournewood Case (R v Bournewood Community and Mental Health NHS Trust ex parte L (Secretary of State and others Intervening). L who had a profound learning disability and autism had previously been an in-patient in Bournewood hospital for more than thirty years. He had however, been discharged to a home care setting where after a trial period he had lived successfully for three years. Following an episode of acutely disturbed behaviour while attending a local day centre and the inability of day centre staff to contact his home carers, L was taken to the local A&E Unit and from there to the behavioural mental health unit at the hospital. The responsible consultant decided that L required to be admitted but considered that detention under the Act was unnecessary because L appeared compliant. The 'Bournewood' case as it has come to be known actually comprised three separate hearings which will be discussed in the order in which they occurred .

Bournewood 1

L's carers were subsequently unable to persuade the trust to release him to their care as the responsible consultant considered he required continuing medical care and treatment. L's carers went to court however, making two specific allegations. In an initial hearing they complained that L,

- had in fact been detained, in that, the trust refused to discharge him to their care
- his detention was unlawful as he had not been detained under the appropriate statute i.e. the Mental Health Act 1983

On the basis of these arguments they demanded his immediate release to their care. The case was dismissed because the judge who heard the case concluded that L was not detained but rather admitted, as the trust contended, informally, under the provisions of section 131(1) of the 1983 Act. This reproduces verbatim the Section 5(1) of the 1959 Act;

'Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under the Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained'

The initial hearing considered that such informal admission does not necessarily require informed consent. Section 5(2) of the 1983 Code of Practice suggests that,

'An informal patient for the purposes of this section is one who has understood and accepted the offer of a bed, who has freely appeared on the ward and who has co-operated in the admission procedure'

Jones (1996:340) however, has observed, given that the wording of the 1983 Act does not in fact, support such a strict interpretation, that a more appropriate definition might be that,

‘an informal patient in-patient for the purposes of this section is one who has arrived at the ward and who has offered no resistance to the admission procedure’

Where a patient is admitted informally, is incapable of giving consent, and offers no resistance a lawful excuse for the administration of treatment which might otherwise constitute an assault is thus *‘found in the common law doctrine of necessity’* (R v Bournwood Trust ex parte L (Secretary of State and others intervening)).

Bournewood 2

L’s carers however, appealed against this judgement and the Court of Appeal effectively reversed the decisions of the previous hearing. They concluded that ‘L’ was effectively detained,

‘because those who had control over the premises had the intention that he should not be permitted to leave those premises, and had the ability to prevent him doing so’

(R v Bournwood Community and Mental Health NHS Trust ex parte L (Secretary of State and others intervening) Butterworth Medico Legal Reports 44 BMLR: 2.)

They further concluded that his detention in such circumstances was unlawful reasoning,

‘that the right of a hospital to detain a patient for treatment for mental disorder is to be found in, and only in, the 1983 Act, whose provisions apply to the exclusion of the common law principle of necessity’

(R v Bournwood Trust ex parte L (Secretary of State and others intervening Butterworth Medico Legal Reports 44 BMLR: 19). The effective detention of a patient in hospital for the purposes of administering treatment who had been admitted informally was unlawful because, where the 1983 act covers the situation, no 'necessity' to act outside the statute can arise. The 'doctrine of necessity' might still apply in circumstances where immediate restraint was need to prevent an individual with a mental disorder experiencing or inflicting serious harm but it could not be used to effect prolonged detention in order to ensure treatment. The implications of Bournewood 2 were however, enormous with regard to the numbers of patients admitted informally who might have to be subject to compulsory measures. Consequently the decision of the Court of Appeal was itself subject to an appeal which was heard by the House of Lords.

Bournewood 3

On this occasion the decision of the Court of Appeal judgement, was itself, reversed. Counsel for the Department of Health observed that patients admitted to hospital in order to receive treatment for a mental disorder fall into two main categories;

- A Those patients subject to compulsory measures who are detained either against or with no regard to their will
- B Those patients not subject to compulsory measures

However, it was argued that ‘patients not subject to compulsory measures’ represent two distinct groups, firstly, ‘voluntary patients’ i.e. those who have the capacity to consent and choose to do so voluntarily and secondly, ‘informal patients’ i.e. those who lack the capacity to consent but do not object to its offer or imposition. Both forms of non-statutory admission are permitted under section 131(1) of the 1983 Act. In reaching this conclusion reference was made to the Report of Royal Commission on the Law Relating to Mental Illness and Deficiency (Cmnd 169 1954-1957) (The Percy Commission) whose recommendations formed the basis of the 1959 Act. The Commission recommended the abandonment of the,

‘Assumption that compulsory powers must be used unless the patient can express a positive desire for treatment, and replacing this by the offer of care without deprivation of liberty, to all who need it and are not unwilling to receive it. All hospitals providing psychiatric treatment should be free to admit patients for any length of time without any legal formality....’

‘L’s behaviour immediately preceding his admission constituted an emergency in which intervention was immediately necessary in the circumstances. The responsible consultant could have chosen to detain L under the provisions of the 1983 Act but the decision not to do so did not automatically render the actions, which were taken unlawful. They were justified under common law by the ‘*doctrine of necessity*’. There was some disagreement between the Law Lords as to whether L had actually been imprisoned, however, they were in unison that his subsequent treatment as an in-patient (whether he was detained or not) in the absence of consent under the provisions of section 131(1) was not unlawful because again,

‘his treatment was plainly justified on the basis of the common law doctrine of necessity’

(R v Bournwood Trust ex parte L (Secretary of State and others intervening Butterworth Medico Legal Reports 44 BMLR :32). The effect of the decision by the House of Lords is however, as acknowledged by Lord Steyn to

‘leave compliant incapacitated patients without the safeguards enshrined in the 1983 Act’

(R v Bournwood Trust ex parte L (Secretary of State and others intervening Butterworth Medico Legal Reports 44 BMLR :40).

The conclusions of Bournwood 3 are, by default, that the profound question of the legality of enforcing treatment on non consensual patients who are mentally incapacitated and cannot give valid and informed consent, where the provisions of the mental health act 1983 are not used is reduced to a question of professional opinion. This situation as Lord Steyne observed is wholly unsatisfactory and consultation on incapacity legislation in England has recently commenced (R v Bournwood Trust ex parte L (Secretary of State and others intervening Butterworth Medico Legal Reports 44 BMLR :40).

A very different position has applied in Scotland since April 2002. Section 17(2) of the Mental Health Scotland 1984 contains similar provisions to that of Section 131(1) of the 1983 Act. The legal position in Scotland has however, been substantially altered by the introduction of the Adults with Incapacity (Scotland) Act 2000 whose provisions came into force in April 2002. The Act provides a new more flexible and comprehensive legal framework in respect of adults experiencing both mental disorder and for those with severe physical impairment whose competency in decision making and/or communication is impaired.

Learning Activity De facto detention

Differentiate by definition, 'voluntary patients', and 'informal patients'

Provide examples from your own experience of patients for both categories

Who was L in the Bournemouth case

Reasonable Force

However even when a legitimate reason to use force to enforce treatment exists this does not legitimise any action by practitioners. In R v. Bracknell J.J, ex parte Griffiths p318 E-G Lord Widgery found

'the staff at the hospital, ... can and indeed must, use reasonable force in order to ensure that control is exercised over the patients'.

The crucial word in the preceding sentence is however, 'reasonable'. Even where the law provides a potentially legitimate reason for the use of force any force and/or restriction of an individual's liberty must be able to meet a further criteria if it is to be lawful, 'reasonableness'. (Gostin 1988) The notion of reasonableness is complex and can only in any given instance be absolutely determined by a court of law. (Lyon 1994) Reasonableness in this context has however been defined as;

" the force used should be no more than was necessary to accomplish the object for which it is allowed (so retaliation, revenge and punishment are not permitted) and secondly, the reaction must be in proportion to the harm which is threatened, in both degree and duration ". (Dimond 1990)

The CDBI Working Party on Psychiatry (2000) emphasize that any,

' response to violent behavior by the patient should be graduated, i.e. that staff should initially attempt to respond verbally; thereafter, only insofar as required, by means of manual restraint; and only in a last resort by mechanical restraint. It was also under lined that physical restraint must always be used within the framework of the treatment. In other words, when it is used, physical restraint should be seen as being a part of the treatment'.

Where physical restraint was employed,

'Thorough training in techniques of physical restraint should be provided to staff'.

Good practice guidance suggests that restraint, where violence is foreseeable, should be subject to risk assessment such that the risks involved are considered against the risks of alternatives (Harris et al. 1996). Identified risks should be discussed with the patient, carers relatives and advocates where appropriate, so that where possible restraint is based on a consensus of opinion which has involved the scrutiny and testing of alternative interventions based on the principle of the least restrictive environment (Aitken and Tarbuck 1995) and the importance of primary and secondary prevention (Allan 2000)

Sometimes, a potentially violent situation involves a process of escalating behaviour. Consequently, it is desirable that approaches to the care and treatment of the patient offer a range and hierarchy of responses in which the extent and nature of the restriction of liberty or restraint used can be matched to the patient's behaviour. The aim of any intervention must be to promote a safe environment and maintain a dialogue with the patient.

The underlying principles that any force used must be 'reasonable' and by definition the minimum necessary attract little debate. However, such principles require interpretation and it is likely that any court in seeking to judge the reasonableness or otherwise of a particular application of force would seek the advice of 'experts' in the given field i.e. the management of disturbed behaviour. This approach however, begets its own problems a recent review carried out by the American medical Association. (Brown et al 2000) concluded that the literature on,

'restraint is far too limited particularly on its use in children and adolescents to establish scientific guidelines on its use, on the training necessary for

administering these methods and on the methods most appropriate for individual patients and particular situations”

‘Expert’ opinion in this area is actually rife with debates these include ,

- Is pain-based restraint ethically justifiable in some practice situations?
- Is it ‘better’ in some situations to restrain a patient on the floor or in some other e.g. standing sitting or kneeling position
- How long does it take to ‘train’ direct care staff and what exactly should they be trained in?
- Is mechanical restraint where the patient might be secured via wrist straps or other device preferable to prolonged physical restraint

Unfortunately research to date has failed to provide definitive or authoritative answers. to such questions. One crucial judgement involves the question of whether to take the subject to the floor or to restrain them in a standing position or sitting position. It is probable that with a strong or very resistant person floor restraints may offers a greater degree of security and thus a reduced risk of injury to staff. However, taking the person to the floor against resistance can be experienced by patients as more aversive than alternatives and may be associated with an increased risk of sudden death in certain situations (Paterson et al 2003).

Conclusions

Nurses and their employers are increasingly concerned to ensure that they are fully aware of what the law requires and allow them to do when faced with an aggressive or violent patient. Ensuring good practice in this difficult and demanding area requires knowledge of the legal principles which underpin professional practice. Utilising these principles, a framework can be devised, which practitioners can use to assess any potential use of any force. This paper has focused on the legal issues involved in the use of force including the restriction of liberty in adult patients experiencing mental disorder and has excluded the legal situation involving children. Nurses should of course also be aware of the ethical dimensions of their practice and the need to ensure their practice is not just lawful but ethical (Paterson and Tringham 1999)

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particularlry the implications of calls for

based on the principle of the least restrictive environment (Aitken and Tarbuck 1995)
This paper aims particularlry to consider both the actual and potential implications of these initiatives however in order to place their impact in context