



NORTHERN
IRELAND
HUMAN
RIGHTS
COMMISSION

**Submission to DoH on the Regional Policy on the
use of Restrictive Practices in Health and Social
Care Settings**

8 October 2021

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Summary of Recommendations

- 3.4** The Commission recommends amending the definition of restrictive practices at paragraph 5. from 'those that limit a person's movement, day to day activity or function' to 'deliberate acts on the part of other person(s) that restrict a person's movement, liberty and/or freedom to act independently'.
- 3.5** The Commission recommends it is made explicit that the human rights framework underpinning the lawful and appropriate use of restrictive practises in health and care settings incorporates the full range of internationally accepted human rights standards ratified by the UK.
- 3.6** The Commission recommends the use of practical examples throughout Standard 1 to illustrate how the actions of health and social care staff might engage ECHR Articles 2, 3, 5 and 8 across the range of restrictive practises identified.
- 3.7** The Commission recommends setting out a clearly defined list of general principles that apply to the use of all restrictive practices in accordance with human rights standards. This should include:
- Initial attempts of restraint should as far as possible be non-physical;
 - Restrictive practices should never be used to punish, to inflict pain or humiliation, or to replace proper care or treatment;
 - There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken;
 - The nature of the technique used must be proportionate to the risk of harm and the seriousness of that harm and be the least restrictive option that will meet the need;
 - Any restriction should be imposed for no longer than absolutely necessary.
- 4.3** The Commission advises that, in order to ensure a robust human rights-based approach, the 'Three Steps to Positive Practice Framework' should explicitly incorporate human rights considerations at each stage.
- 4.6** The Commission recommends that adequate resources are

allocated to ensure that staff within health and social care settings are adequately trained so that they understand the human rights implications of the use of restrictive practices, restraint and seclusion, including alternative measures to minimise or avoid their use. This training should be a mandatory and regular requirement.

4.10 The Commission recommends that the guidance clearly sets out how and when input will be proactively sought from the individual concerned, family members, caregivers or advocates, in all consultation, decision-making and monitoring processes regarding the use and minimisation of restrictive practices.

5.6 The Commission recommends that, in accordance with Concluding Observations of the UN CRPD Committee, it is made explicit that practices of restraint and seclusion should not be used for reasons related to disability.

5.11 The Commission recommends that specialised guidance is produced for the use of restrictive practices for children and young people, which makes it explicit that only techniques proven to be safe for children should be used, and only as a matter of last resort in circumstances where a child is at risk of harming themselves or someone else, and never for disciplinary purposes.

6.3 The Commission recommends that Standard 6 sets out the minimum reporting requirements for the use of any restrictive practice in health and social care settings in NI. This should include:

- the type of restrictive practice employed**
- the date and the duration of the intervention**
- the names of the staff and people involved**
- reasons for using the type of restrictive practice employed (rather than an alternative less restrictive approach)**
- whether the person or anyone else experienced injury or distress**
- the person's views of the incident (if appropriate, through family, caregiver or advocate)**
- what follow-up action was taken**

6.6 The Commission recommends that the Department of Health

publishes an annual report on the use and governance of restrictive practices, restraint and seclusion in health and social care settings across NI, which contains disaggregated data on the frequency and impact of the restrictive practices in use and monitors the effectiveness of minimisation strategies.

7.3 The Commission recommends that the guidance clearly sets out at para 11.23 that the seclusion room must allow for staff to be able to continuously observe and hear the person within the designated room, and that the latter can fully see the staff member. It should be made explicit that video surveillance cannot replace staff presence.

1.0 Introduction

1.1 The Northern Ireland Human Rights Commission (the Commission), pursuant to Section 69(1) the Northern Ireland Act 1998, reviews the adequacy and effectiveness of law and practice relating to the protection of human rights in Northern Ireland (NI). In accordance with this function, the Commission provides this submission to the Department of Health in relation to the public consultation on the draft Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion.

1.2 The Commission bases its advice on the full range of internationally accepted human rights standards, including the European Convention on Human Rights, as incorporated by the Human Rights Act 1998, and the treaty obligations of the Council of Europe (CoE) and United Nations (UN). The relevant regional and international treaties in this context include:

- European Convention on Human Rights 1950 (ECHR);¹
- UN International Covenant on Civil and Political Rights 1966 (UN ICCPR);²
- UN International Covenant on Economic, Social and Cultural Rights 1966 (UN ICESCR);³
- UN Convention Against Torture 1984 (UN CAT);⁴
- UN Convention on the Rights of the Child 1989 (UN CRC);⁵
- UN Convention on the Rights of Persons with Disabilities 2006 (UN CRPD);⁶

1.3 In addition to these treaty standards, there exists a body of 'soft law' developed by the human rights bodies of the CoE and UN. These declarations and principles are non-binding, but provide further guidance in respect of specific areas. These include:

- UN Committee on the Rights of Persons with Disabilities (UN CRPD Committee) 2017 Concluding Observations to the UK;
- UN Committee on the Rights of the Child (UN CRC Committee) 2016 Concluding Observations to the UK

¹ Ratified by the UK in 1951

² Ratified by the UK in 1976

³ Ratified by the UK in 1976

⁴ Ratified by the UK in 1988

⁵ Ratified by the UK in 1991

⁶ Ratified by the UK in 2009

- UN Committee on the Convention Against Torture (UN CAT Committee) 2013 Concluding Observations to the UK;
- UN Principles for Older Persons 1991;⁷
- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991;⁸
- Council of Europe Recommendation (2004)¹⁰ concerning the protection of the human rights and dignity of persons with mental disorder.⁹
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), The CPT Standards (2002)¹⁰

1.4 The Commission welcomes this opportunity to provide evidence on the use of restrictive practices and seclusion in health and social care settings. This submission highlights relevant human rights standards and principles underpinning the use of restrictive practices to inform the development of this policy.

1.5 The Commission notes that the Department of Education is currently undertaking a review of the use of restraint and seclusion practices in educational settings. The Commission is a member of the Reference Group involved in the oversight of that process. In February 2021, the Commission provided a submission to the Committee for Education on the human rights implications of the guidance relating to restraint and seclusion in educational settings, making a number of recommendations for change.¹¹ The Commission highlights the overlap between work on this policy and the Department of Education’s ongoing review and encourages collaboration between the Departments to ensure a degree of consistency across all settings.

2.0 Human Rights Framework

2.1 The use of restrictive practices, restraint and seclusion in health and social care settings can interfere substantially with an individual’s human rights. Human rights standards do not prevent all forms of restrictive interventions in all circumstances but do require that all interventions are subject to appropriate procedural safeguards. In particular, a fair balance

⁷ Adopted by General Assembly Resolution 46/91, 16 December 1991.

⁸ Adopted by General Assembly Resolution 46/119, 17 December 1991.

⁹ Adopted by the Committee of Ministers, 22 September 2004.

¹⁰ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2002) ‘The CPT Standards’, Council of Europe, Strasbourg [Revised 2011]: see also, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), ‘Means of restraint in psychiatric establishments for adults’ (2017) Council of Europe, Strasbourg.

¹¹ NI Human Rights Commission, ‘Submission to the Northern Ireland Committee for Education on the Human Rights Implications of Current Guidance Relating to the Use of Restrictive Practices in Schools’ February 2021

must be struck between the severity and consequences of the interference for the individual being restrained and the aim of the restraint, the main purpose of which is to ensure the safety of the individual and others. The relevant standards and principles are examined below.

Domestic standards

ECHR rights overview

2.2 In some circumstances, the use of restraints has the potential to result in injury and death. The use of restraint clearly engages a number of articles of the ECHR.¹² In particular: Article 2 ECHR (the right to life)¹³; Article 3 ECHR (the right not to be subjected to torture, inhuman or degrading treatment or punishment)¹⁴; Article 5 (the right to liberty and security) and Article 8 (the right to private and family life, which includes the right to bodily integrity) are engaged but not necessarily breached in all instances of the use of restraint techniques. Those rights are considered in more detail below.

Articles 2 and 3

2.3 The combination of Articles 2 and 3 places upon public authorities a strict duty to refrain from intentional and unlawful taking of life and causing injury, abuse or ill-treatment and a positive obligation on the State and its public authorities “to take appropriate steps to safeguard the lives of those within its jurisdiction”.¹⁵ Integral to protection of the Articles 2 and 3 substantive rights, is the corresponding duty to investigate. The State bears an obligation to carry out an effective investigation into alleged breaches.

2.4 Article 3 ECHR states that, “no one shall be subjected to torture or to inhuman or degrading treatment or punishment”. It is an absolute right from which there can be no derogation. Jurisprudence from the European Court of Human Rights (ECtHR) identifies a positive obligation on the state to take measures to prevent breaches and “provide effective protection, in particular, of children and other vulnerable persons”.¹⁶ Moreover, there is required to be in place appropriate procedures to identify and thereafter

¹² Incorporated into domestic law by the Human Rights Act 1998.

¹³ The right to life applies, short of death, if the use of force places a person at serious risk. See e.g., *Makaratzis v. Greece* [GC], § 55; *Soare and Others v. Romania*, §§ 108-109; *Trévalec v. Belgium*, §§ 55-61

¹⁴ See e.g., *Kurt v Turkey* (1998) ECHR 44, which held that a defect in the procedural action required of the State under Article 2 may additionally amount to a breach of Article 3 in respect of the impact on the family of the person whose right to life has been violated.

¹⁵ *LCB v UK* (9 June 1998) 27 EHRR 212 at para 36

¹⁶ *Z and others v the United Kingdom* (2001) ECHR, at paras 70 and 73.

address suspected instances of abuse or ill treatment. This duty is more than merely passive.

- 2.5 A minimum threshold of severity is required before Article 3 ECHR bites. In deciding if treatment reaches the 'threshold' of being inhuman or degrading, the court has stated "it depends on all the circumstances of the case, such as the nature and context of the treatment or punishment, the manner and method of its execution, its duration, its physical or mental effects and, in some instances, the sex, age and state of health of the victim".¹⁷ In other words, in assessing whether treatment comes within Article 3 it is the impact of the treatment on the individual concerned which is measured. For example, the ECtHR has held that "degrading treatment" may well include situations where a person is humiliated in his or her own eyes, even if not in the eyes of others.¹⁸

Right to liberty and security of the person, Article 5

- 2.6 Article 5 ECHR states that "everyone has the right to liberty and security of person".¹⁹ As a qualified right, limitations are allowed if they are lawful, proportionate, and necessary for the protection of one of the objectives set out in the text of Article 5(1) ECHR. The ECtHR has identified three essential components: (i) confinement in a restricted place for a not negligible period of time; (ii) a lack of valid consent; and (iii) the confinement is attributable to the state.²⁰ The UK Supreme Court has indicated that compliance should not be assumed to be consent.²¹ For rights under Article 5 to be engaged it is not necessary for an individual to be held under locked conditions. Preventing their movement, whether by use of physical, chemical or environmental restraints, for a period of time may engage an individual's right to liberty.²²

- 2.7 There is a difference between deprivation of liberty and restriction upon liberty. The ECtHR observed however it is "one of degree or intensity" and "account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question".²³

¹⁷ Soering v UK (1989) ECHR at para 100. See also: Ireland v. the United Kingdom, 18 January 1978, Series A no. 25.

¹⁸ Costello-Roberts v UK (25 March 1993) Application No 13134/87.

¹⁹ See also article 9 of the ICCPR, 'Everyone has the right to liberty and security of person'; article 37(b) of the UN CRC, 'No child shall be deprived of his or her liberty unlawfully or arbitrarily'; and article 14 of the UN CRPD, 'States Parties shall ensure that persons with disabilities... enjoy the right to liberty and security of person'.

²⁰ Storck v Germany (2005) 43 EHRR 6, at paras 74-89

²¹ P v Cheshire West and Chester Council [2014] UKSC 19, at para 35.

²² Novotka v Slovakia (4 November 2003) Unreported, Application No 47244/99

²³ Guzzardi v Italy: ECHR 6 Nov 1980

Respect for private and family life, Article 8

- 2.8 Article 8 ECHR protects against arbitrary interferences with private and family life, home, and correspondence by a public authority. Article 8 is a qualified right, which means that departure from the strict requirements may be permissible in certain limited circumstances.
- 2.9 Conditions upon which a State may interfere with the enjoyment of a protected right are set out in Article 8(2) of the ECHR. Limitations are allowed if they are “in accordance with the law” or “prescribed by law” and are “necessary in a democratic society” for the protection of one of the objectives set out in Article 8(2) of the ECHR. Even if there is a legitimate reason for imposing a restriction, the restriction must be the least restrictive option available.²⁴
- 2.10 In order to determine whether a particular infringement of Article 8 ECHR is necessary in a democratic society, the ECtHR balances the interests of the State against the right of the individual. The ECtHR has clarified that “necessary” in this context does not have the flexibility of such expressions as “useful”, “reasonable”, or “desirable”, but implies the existence of a “pressing social need” for the interference in question.²⁵
- 2.11 It is notable in the current context that, although the right to a private life includes a right to privacy, it is much broader. It also addresses the infringement of the individual’s well-being and dignity;²⁶ moral, physical and psychological integrity;²⁷ the circumstances in which it is permissible to provide personal care or medical treatment without an individual’s consent;²⁸ and the power of an individual to make decisions as to personal risk.²⁹ In, for example, the case of *Pretty v the United Kingdom*, the ECtHR considered “that the notion of personal autonomy is an important principle underlying the interpretation of [Article 8] guarantees”.³⁰

Equality and non-discrimination, Article 14

- 2.12 Article 14 of the ECHR provides for the enjoyment of ECHR rights:

²⁴ *Huang v Secretary of State* [2007] 2 AC 167 at [19]; *Kurnaz v Turkey* (Application no. 36672/97) at [56].

²⁵ *The Sunday Times v United Kingdom* (1979) 2 ECHR 245.

²⁶ *Beizaras and Levickas v. Lithuania*, §§ 109 and 11

²⁷ *X and Y v Netherlands* (26 March 1985) 8 EHRR 235, para 22; and *Pretty v The United Kingdom* (2002) ECHR 427, at para 61.

²⁸ *Storck v Germany* (16 June 2005) 43 EHRR 96.

²⁹ *X v Belgium* (6 February 1968) 18 DR 225.

³⁰ *Ibid*, at para 62.

“...without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

2.13 This is not a freestanding right to protection from discrimination but a right to protection from discrimination in the enjoyment of other ECHR rights. For example, the right not to be discriminated against in the enjoyment of family life. Importantly, the grounds of discrimination contained in (and prohibited by) Article 14 are not exhaustive. Discrimination on other grounds have been found by the ECtHR to be unlawful under Article 14 such as age³¹ and disability.³² This is because they come within “other status” for the purposes of Article 14.

International standards

2.14 The International Covenant on Civil and Political Rights (ICCPR) guarantees rights to all people within the jurisdiction of a State Party. Many of the human rights contained in the ICCPR are particularly relevant to the provision of health and social care. For example the right to life (Article 6), the right not to be subjected to cruel, inhuman or degrading treatment (Article 7) and the right to private and family life (Article 17).

2.15 The UN Convention on the Rights of Persons with Disabilities (UN CRPD) is also relevant in the context of health and social care settings. Article 1 sets out its purpose, “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.” Article 16 UN CRPD requires States to take all appropriate measures to protect people with disabilities from exploitation, violence and abuse. Other relevant provisions include the right to the highest attainable standard of health without discrimination on the basis of disability (Article 25) and the right to respect for physical and mental integrity on an equal basis with others (Article 17).

2.16 Children and young people, particularly in health and social care settings, require specific protection and safeguarding in accordance with the UN Convention on the Rights of the Child (UN CRC). Article 3 UN CRC requires that the best interests of the child must be a primary consideration in all

³¹ [Schwizgebel v. Switzerland \(Application no. 25762/07\)](#)

³² [Glor v. Switzerland \(Application no. 13444/04\)](#)

matters affecting them. Moreover, Article 19 UN CRC provides that “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”. Article 37 provides that “no child shall be subjected to torture or other cruel, inhumane or degrading treatment or punishment”.

2.17 Alongside the legal protections contained in the domestic and international human rights frameworks, a number of soft law standards, which are often used to aid interpretation of substantive rights, are relevant. While these ‘soft law’ standards are not legally binding in the sense that a person cannot rely on a breach directly in local courts, they are extremely useful in providing clarity on the standards that are legally binding. They should be considered by States Parties in the development of domestic law, policy and practice.

2.18 The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care³³ contain useful guidance for States, including the general principles of least restriction and the requirement for regular review. Principle 9(1) states:

“[E]very patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to [their] health needs and the need to protect the safety of others.”

2.19 Principle 9(2) requires that treatment and care are based upon individually assessed needs and follow a prescribed plan that is reviewed regularly. Principle 11(11) requires that physical restraint or involuntary seclusion of a person in care is only applied to prevent immediate or imminent harm and shall not be prolonged beyond the period which is strictly necessary for this purpose.

2.20 The UN Principles for Older Persons³⁴ provide guidance to States on how the rights of older people can best be protected. The principles are centred on five core areas: independence, participation, care, self-fulfilment and dignity. Principle 14 states, “Older persons should be able to enjoy human

³³ Adopted by General Assembly Resolution 46/119, 17 December 1991.

³⁴ Adopted by General Assembly Resolution 46/91, 16 December 1991.

rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.”

2.21 Article 8 of the Council of Europe Recommendation (2004)³⁵ concerning the protection of the human rights and dignity of persons with ‘mental disorder’ applies the principle of least restriction. The Recommendation sets out general standards relating to the training of staff involved in the provision of mental health services (Article 11) and general principles regarding treatment, including the requirement for regular review (Article 12). Article 27 sets out standards for the use of restraint and seclusion, which again requires compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed. Measures of restraint should only be used under medical supervision and appropriately documented. In addition, the reasons for and duration of restraint should be recorded in the person’s records. All instances of physical restraint should also be recorded in a register so that the use of restraint can be appropriately monitored. The Explanatory Memorandum notes that there may be higher levels of risk for older people where restraint is used and therefore additional safeguards may be advisable.

2.22 The European Committee on the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) provides specific standards addressing the use of restraint in psychiatric establishments.³⁶ The CPT’s standards set out the following requirements:

- that restraint is subject to a clearly defined policy
- initial attempts of restraint should as far as possible be non-physical
- physical restraint should in principle be limited to manual control
- staff should receive training on the use of non-physical and manual restraint, and
- all instances of physical restraint should be recorded in a specific register and in the person’s file.

2.23 In addition, the CPT is clear that the use of physical restraint as a

³⁵ Adopted by the Committee of Ministers, 22 September 2004.

³⁶ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2002) ‘The CPT Standards’, Council of Europe, Strasbourg [Revised 2011]: see also, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), ‘Means of restraint in psychiatric establishments for adults’ (2017) Council of Europe, Strasbourg.

punishment or for a period of days is likely to constitute ill treatment.³⁷ The CPT also requires that the use of “chemical restraint” i.e., sedating by medication, should be governed by clear rules and subject to the same oversight as any other means of restraint.³⁸

3.0 Standard 1: Definitions

- 3.1 Identifying which practices amount to restrictive practises, restraint and/or seclusion, is necessary if health and social care staff are to act lawfully and apply relevant guidance. The Commission welcomes the range of definitions contained within Standard 1, which provide a standardised approach across all health care settings by using consistent language to identify and describe restrictive practice.
- 3.2 While there are no internationally agreed definitions for restrictive practices and seclusion, the Commission considers it imperative that the guidance is firmly within a comprehensive, international human rights framework. This will help to ensure that human rights obligations translate into practice.³⁹ Furthermore, current UK Government guidance on the use of restrictive interventions in health care⁴⁰ and the CPT Standards on means of restraint⁴¹ both establish a set of general principles that apply across all restrictive practices. In doing so, it clarifies appropriate safeguards for the ethical and legal use of such practices in accordance with international human rights obligations.
- 3.3 The Commission suggests rewording the overall definition provided for restrictive practices (at para. 5), to align it more accurately with the key human rights implications identified above. The definition proposed below is consistent with the definition for ‘acts of restraint’ in the Mental Capacity Act (NI) 2016 and current UK Government guidance.⁴²

3.4 The Commission recommends amending the definition of restrictive practices at paragraph 5. from ‘those that limit a person’s movement, day to day activity or function’ to ‘deliberate

³⁷ Ibid at para 48.

³⁸ Ibid at para 41.

³⁹ For examples see: Equality and Human Rights Commission, ‘Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions’ March 2019; and Royal College of Nursing, ‘Let’s talk about restraint: Rights, risks and responsibility’ 2008

⁴⁰ UK Government, Department of Health, ‘Positive and Proactive Care: reducing the need for restrictive interventions’ (2014) at para 58.

⁴¹ CPT Standards (2002) at para 47, and Revised CPT Standards (2017) at para 1.

⁴² See: S.12, Mental Capacity Act (Northern Ireland) Act 2016; and UK Government, Department of Health, ‘Positive and Proactive Care: reducing the need for restrictive interventions’ (2014) at para.17.

acts on the part of other person(s) that restrict a person's movement, liberty and/or freedom to act independently'.

- 3.5 The Commission recommends it is made explicit that the human rights framework underpinning the lawful and appropriate use of restrictive practises in health and care settings incorporates the full range of internationally accepted human rights standards ratified by the UK.**
- 3.6 The Commission recommends the use of practical examples throughout Standard 1 to illustrate how the actions of health and social care staff might engage ECHR Articles 2, 3, 5 and 8 across the range of restrictive practises identified.**
- 3.7 The Commission recommends setting out a clearly defined list of general principles that apply to the use of all restrictive practices in accordance with human rights standards. This should include:**
- Initial attempts of restraint should as far as possible be non-physical;**
 - Restrictive practices should never be used to punish, to inflict pain or humiliation, or to replace proper care or treatment;**
 - There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken;**
 - The nature of the technique used must be proportionate to the risk of harm and the seriousness of that harm and be the least restrictive option that will meet the need;**
 - Any restriction should be imposed for no longer than absolutely necessary.**

4.0 Standard 2: Three Steps to Positive Practice Framework

- 4.1** The Commission welcomes the explicit commitment to a human rights-based approach. In particular, the Commission is encouraged by the framing of restrictive practises in terms of relevant ECHR Articles⁴³ and the FREDA principles⁴⁴, which together help to ensure restrictive practices are used lawfully and proportionately with appropriate, person-centred

⁴³ Para 6.7 identifies relevant protections under the European Convention on Human Rights (ECHR), including Article 2 (Right to life); Article 3 (Prohibition of torture); Article 5 (Right to liberty and security); Article 8 (Right to respect for private and family life); Article 14 (Non-discrimination).

⁴⁴ Para 6.7 – 6.11; Fairness, Respect, Equality, Dignity and Autonomy

safeguards.

4.2 However, it is notable that the 'Three Steps to Positive Practice Framework' only applies a human rights-based approach in relation to the second step on implementing safeguards. As observed above, it is the Commission's view that the human rights implications of each decision must be fully considered and justified before applying a potentially restrictive practice. Judgements as to the legitimacy of an interference with a person's ECHR rights will be based on all presenting circumstances.⁴⁵ Therefore, acknowledging human rights considerations during the 'review and reflect' stage is important.

4.3 The Commission advises that, in order to ensure a robust human rights-based approach, the 'Three Steps to Positive Practice Framework' should explicitly incorporate human rights considerations at each stage.

4.4 In addition, it is imperative that health and social care professionals receive adequate practical guidance and training on how to apply a human rights-based approach to their decision-making. For instance, health and social care staff must be able to identify and assess the risks associated with each restrictive intervention in order to address complex questions of proportionality. This requires making a human rights-based assessment to strike a fair balance between the severity and consequences of the interference for the individual being restricted and the aim of the intervention. Of note is the Council of Europe Committee Ministers recommendation that mental health staff should have mandated training, not just on how to apply physical practices of restraint, but also on:

- protecting the dignity, human rights and fundamental freedoms of persons with mental disorder;
- understanding, prevention and control of violence;
- measures to avoid the use of restraint or seclusion;
- the limited circumstances in which different methods of restraint or seclusion may be justified, taking into account the benefits and risks entailed, and the correct application of such measures.⁴⁶

4.5 The Commissioner for Older People for Northern Ireland has stated

⁴⁵ UK Government, Department of Health, 'Positive and Proactive Care: reducing the need for restrictive interventions' (2014) at para.18

⁴⁶ Committee of Ministers (2004) Recommendation Number Rec 2004(10) (Strasbourg: Council of Europe), at art 11(2)

previously that “human rights should be an essential component of practitioner dialogue” and that “all staff in care settings, commissioners of care, social care workers, and regulators must receive training on the implications of human rights for their work”.⁴⁷ It is vital that appropriate funding is available to provide training on the practical application of these principles.

4.6 The Commission recommends that adequate resources are allocated to ensure that staff within health and social care settings are adequately trained so that they understand the human rights implications of the use of restrictive practices, restraint and seclusion, including alternative measures to minimise or avoid their use. This training should be a mandatory and regular requirement.

4.7 The Commission welcomes the inclusion of advocacy at para 6.21, however it is not clear from the guidance how advocates, the individual, parents or caregivers are proactively involved in the planning and review processes. Of particular concern is that organisations are advised to involve an independent advocate “if there is an advocate available”. The Committee is reminded that active and informed participation, individual autonomy and the freedom to make one’s own decisions in matters that affect one’s life is not only central to a human rights-based approach but embedded in core treaty obligations.⁴⁸

4.8 In accordance with the UN CRPD and UN CRC, the Department must ensure the direct involvement of persons with disabilities, children and young people, and children and young people with disabilities, in all processes regarding the use (and minimisation) of restrictive practices. Where appropriate, participation through a trusted representative must be ensured, i.e., family members, caregivers, or advocate.

4.9 Given the nature and potentially traumatic implications associated with the use of restrictive practises this advocacy role becomes particularly important in all discussions about care planning and behavioural support; implementing preventative approaches and, where unavoidable, restrictive practices; and, involvement in post-incident reviews and monitoring procedures.

⁴⁷ Commissioner for Older People for Northern Ireland ‘Home Truths’, June 2018, at 30.

⁴⁸ Articles 12 and 23(1), UN CRC; and Articles 4(3) and 33(3), UN CRPD

4.10 The Commission recommends that the guidance clearly sets out how and when input will be proactively sought from the individual concerned, family members, caregivers or advocates, in all consultation, decision-making and monitoring processes regarding the use and minimisation of restrictive practices.

5.0 Standards 3 -5: Preventative Strategies

- 5.1 The Commission welcomes the alternative approaches and preventative strategies set out in Standards 3 to 5, which aim to eliminate or minimise the use of all restrictive practises, restraint and seclusion across health and social care settings in NI. Furthermore, where lawful interventions must be applied, it is emphasised it should only be a measure of last resort, using the least-restrictive means, which is consistent with the key human rights based principles of proportionality and 'least restriction', as set out above.⁴⁹
- 5.2 However, as any restrictive practice can pose the risk of harm to the person subjected to its use, whether physical or psychological, assessing the severity of that harm requires careful consideration of why an individual may be particularly vulnerable, such as their age, experience of trauma, health conditions or disabilities. The Commission notes its concern that guidance does not explicitly address the disproportionate impact of these practises on those with particular vulnerabilities, in terms of appropriate mitigation measures and safeguards.
- 5.3 In 2013, the UN Special Rapporteur on torture observed that seclusion and restraint in healthcare settings fell under the scope of the UN Convention Against Torture, particularly when used against people with disabilities.⁵⁰ The report highlighted the importance of additional measures to protect persons with disabilities:

“...the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed “best interests”, and where serious violations and discrimination

⁴⁹ See ECHR; UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care; UN Principles for Older Persons, and; Council of Europe Recommendation (2004)10

⁵⁰ A/HRC/22/53, UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013

against persons with disabilities may be masked as “good intentions” of health professionals.”⁵¹

5.4 The report recommends that State parties,

“Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application.”⁵²

5.5 In its initial report on the UK in 2017, the UN CRPD Committee raised concerns about “the continued use of physical, mechanical and chemical restraint” on persons with disabilities in health care settings, as well as practises of segregation and seclusion.⁵³ The Committee called for the adoption of appropriate measures to “eradicate the use of restraint for reasons related to disability within all settings...as well as practises of segregation and isolation that may amount to torture or inhuman or degrading treatment”.⁵⁴

5.6 The Commission recommends that, in accordance with Concluding Observations of the UN CRPD Committee, it is made explicit that practices of restraint and seclusion should not be used for reasons related to disability.

5.7 When deciding whether and how to use a restrictive practise on a child, their best interests must be the primary consideration (Article 3, UN CRC). Children are developing physically and psychologically which makes them particularly vulnerable to harm.⁵⁵ To that end, the person responsible for applying a restrictive intervention on a child should robust justification.

5.8 In 2006, the UN CRC Committee acknowledged “that there are exceptional circumstances in which teachers and others, e.g. those working with children in institutions and with children in conflict with the law, may be confronted by dangerous behaviour which justifies the use of reasonable

⁵¹ Ibid at 61.

⁵² Ibid at para 89.

⁵³ CRPD/C/GBR/CO/1 Committee on the Rights of Persons with Disabilities, ‘Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland’ 3 October 2017, at para 36

⁵⁴ Ibid at para 37(a)

⁵⁵ R (C) v Secretary of State [2009] QB 657 at [58]; in Equality and Human Rights Commission, ‘Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions’ March 2019

restraint to control it.”⁵⁶ The Committee stated, however, that “[t]he principle of the minimum necessary use of force for the shortest necessary period of time must always apply.”⁵⁷

5.9 In 2016, the UN CRC Committee recommended that the UK and NI: (a) abolish all methods of restraint against children for disciplinary purposes in all institutional settings; (b) ensure that restraint is used against children exclusively to prevent harm to the child or others and only as a last resort, and; (c) systematically and regularly collect and publish disaggregated data on the use of restraint and other restrictive interventions on children in all settings.⁵⁸ This recommendation was later supported by the UN CAT Committee.⁵⁹

5.10 In 2017, the UN CRPD Committee recommended the State “set up strategies, in collaboration with monitoring authorities and national human rights institutions, in order to identify and prevent the use of restraint for children and young persons with disabilities”.⁶⁰ In a joint response to the Committee against Torture, the Commissioners for Children and Young People from Scotland, Wales and NI noted that, despite these calls by international human rights mechanisms, “the UK and devolved governments are still not fulfilling their responsibilities in relation to restraint and seclusion of children in all settings”.⁶¹ It reminds that, “only techniques proven to be safe for children should be used and pain should never be deliberately inflicted in order to restrain a child.”

5.11 The Commission recommends that specialised guidance is produced for the use of restrictive practices for children and young people, which makes it explicit that only techniques proven to be safe for children should be used, and only as a matter of last resort in circumstances where a child is at risk of harming themselves or someone else, and never for disciplinary purposes.

⁵⁶ UN Committee on the Rights of the Child, General Comment No. 8: The Right of the Child to Protection from Corporal Punishment and Other Cruel or Degrading Forms of Punishment (Arts. 19; 28, Para. 2; and 37, inter alia) (Forty-second session, 2006), U.N. Doc. CRC/C/GC/8 (2006), para. 18.

⁵⁷ Ibid at para 15.

⁵⁸ CRC/C/GBR/CO/5, Committee on the Rights of the Child, Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland, 12 July 2016 at paras 39 and 40.

⁵⁹ CAT/C/GBR/CO/5 Committee against Torture, Concluding observations on the fifth periodic report of the United Kingdom, adopted by the Committee at its fiftieth session, 6-31 May 2013, at para 28.

⁶⁰ Ibid at para 37(b)

⁶¹ NICCY, CYPCS and the Children’s Commissioner for Wales, ‘Joint submission to the United Nations Committee Against Torture 66th session on the sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland’, at para 6.1.

6.0 Standard 6: Governance

6.1 The Commission frequently highlights the need for transparent monitoring and data collection as essential aspects of human rights compliance and government accountability. Therefore, the inclusion of a dedicated standard on governance to standardise a regional approach to reporting is welcome. However, the Commission would emphasise the importance of ensuring consistency in reporting arrangements at every level. It is noted that Standard 6 does not set out the minimum requirements for recording the use of restrictive practices at the individual level, such as those contained at paras 11.54 – 11.57 in respect of seclusion.

6.2 Whether planned or unplanned, any use of a restrictive practice within any health and social care setting in NI should be recorded and reviewed to ensure learning and continuous safety improvements. The CPT Standards state that an entry should include:

“...the times at which the measure began and ended, the circumstances of the case, the reasons for resorted to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.”⁶²

6.3 The Commission recommends that Standard 6 sets out the minimum reporting requirements for the use of any restrictive practice in health and social care settings in NI. This should include:

- **the type of restrictive practice employed**
- **the date and the duration of the intervention**
- **the names of the staff and people involved**
- **reasons for using the type of restrictive practice employed (rather than an alternative less restrictive approach)**
- **whether the person or anyone else experienced injury or distress**
- **the person’s views of the incident (if appropriate, through family, caregiver or advocate)**
- **what follow-up action was taken**

6.4 The Commission notes the consultation document does not outline any plans for developing a publicly accessible report. In its most recent

⁶² European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2002) ‘The CPT Standards’, Council of Europe, Strasbourg [Revised 2011] at para 50.

Concluding Observations to the UK, the UN CRC Committee recommended that the state should:

“Systematically and regularly collect and publish disaggregated data on the use of restraint and other restrictive interventions on children in order to monitor the appropriateness of discipline and behaviour management for children in all settings, including in education, custody, mental health, welfare and immigration settings.”⁶³

6.5 In addition, current UK Government guidance to health and social care services states:

“Services must also publish a public, annually updated, accessible report on their increased behaviour support planning and restrictive intervention reduction, which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions. These should be included within annual quality accounts (or equivalent publications).”⁶⁴

6.6 The Commission recommends that the Department of Health publishes an annual report on the use and governance of restrictive practices, restraint and seclusion in health and social care settings across NI, which contains disaggregated data on the frequency and impact of the restrictive practices in use and monitors the effectiveness of minimisation strategies.

7.0 Standard 7: Seclusion

7.1 At the outset, the Commission emphasises that the ultimate objective should always be to prevent the use of seclusion as far as possible. The Commission notes the view of the CPT that seclusion has no therapeutic justification and can cause lasting damage without strict and person-centred safeguards:

“As regards seclusion, this particular measure is not necessarily a proper alternative to the use of mechanical, chemical or other means

⁶³ NI Human Rights Commission, ‘Submission to the UN Committee on the Rights of the Child 88th Session on the Sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland on compliance with the UN Convention on the Rights of the Child’ (NIHRC, 2020), at para 16.6.

⁶⁴ UK Government, Department of Health, ‘Positive and Proactive Care: reducing the need for restrictive interventions’ (2014) at para. 111

of restraint. Placing a patient in seclusion may produce a calming effect in the short term, but is also known to cause disorientation and anxiety, at least for certain patients. In other words, placement in a seclusion room without appropriate, accompanying safeguards may have an adverse result.”⁶⁵

7.2 To that end, the Commission welcomes the development of a detailed regional operating procedure for seclusion as a last resort intervention, which promotes a number of proactive steps to adopt alternative measures and ultimately eliminate its use. It is welcomed that the use of seclusion is limited to a hospital setting or a purpose-built suite that must comply with the number of procedural safeguards at paras at 11.22 – 11.25. However, in accordance with the CPT Standards, the Commission would like to stress the need for staff to be especially attentive and to have this clearly defined in guidance:

“If patients are held in seclusion, the staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous staff presence.”⁶⁶

7.3 The Commission recommends that the guidance clearly sets out at para 11.23 that the seclusion room must allow for staff to be able to continuously observe and hear the person within the designated room, and that the latter can fully see the staff member. It should be made explicit that video surveillance cannot replace staff presence.

7.4 Finally, the Commission reiterates the recommendation above, that the guidance should provide explicitly that seclusion should never be used if the *reason* for use is related to disability. The use of seclusion for persons or children and young people with disabilities will only be justified in very limited circumstances when deemed necessary to prevent serious harm to the person or others.

⁶⁵ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2002) 'The CPT Standards', Council of Europe, Strasbourg [Revised 2011] at para.42.

⁶⁶ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 'Means of restraint in psychiatric establishments for adults' (2017) Council of Europe, Strasbourg, at para.7.

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