Human rights and restraints

The principles set out in the Universal Declaration of Human Rights, the European Convention on Human Rights and similar instruments encourage fairness, respect, equality, dignity and autonomy for all. In the UK the Human Rights Act 1998 makes these rights legally binding. The principles underpinning these rights reflect basic needs that enable us all to live full lives with maximum dignity and respect. These core societal values are at the heart of high quality health and social care. People should be put at the centre of all decisions about their care in a person-centred way. In doing so people's experiences of care, the quality of their lives, health and wellbeing can be improved.

The Human Rights Act 1998 places a legal obligation on services to respect human rights. All health services need to be attuned to human rights and should ensure its principles are meaningfully integrated into the routines of practice. There are some human rights that are particularly relevant to the health and hospital context. These include:

- The right to life
- Freedom from torture inhuman and degrading treatment and punishment
- The right to liberty
- The right to no punishment without law
- The right to respect for private and family life.

Additional conventions – such as the United Nations (UN) Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities – while not legally enforceable, the UK has nevertheless committed to implementation.

Restraint

Clearly, restraint has the potential to infringe people's human rights and international conventions. In its broadest sense restraint is about preventing people from doing something they wish to do, including placing limits on people's will or freedom. There are a host of definitions of restraint stemming from professional guidance, research and governments and all with reference to a wide range of care settings, client groups and challenging situations. Definitions need to encompass legal considerations of restraint as well as defining practices that place restrictions on people's lives in hospital. A broad definition can help to recognize the ways in which restrictions are placed on people's freedom to live as they want but may be too general to recognize more subtle forms of restraint. Conversely, narrow definitions risk encouraging precision in practice.

The British Institute of Learning Disabilities (2008) policy framework on physical interventions focuses on the use of direct physical force to some degree that restricts people's mobility. The British Institute of Learning Disabilities categorizes physical interventions into direct physical contact (i.e. an individual person is physically controlled by another person, such as holding someone), the use of barriers (e.g. locked doors) and the use of materials or equipment (e.g. splints on people's arms to prevent movement).

Types of restraint

In the literature, restraint commonly refers to physical restrictions. However, when considering the use of restraint across a wide range of health-care contexts, it is important to take a broad view on the ways in which freedom may be curtailed. Different forms of restraint are not mutually exclusive and a broad understanding of restraint will include:

- Physical restraints – tying or securing someone so he/she cannot move freely
- Physical interventions – moving someone against his/her will, pushing someone, the use of holding techniques (e.g. prone, supine and basket holds) or 'distraction'
- Covert medication and chemical restraint – the use of drugs to control behaviour or limit freedom in ways that is not treating a clinical condition
- Medical restraints – preventing a person from interfering with clinical or medical interventions that are designed to assist him/her and may compromise his/her clinical care and outcomes (e.g. the use of hand mittens)
- Environmental restraints – the design and make up of environments can limit people's abilities to move freely, such as locked doors, 'baffle' locks, complicated door handles or disguised entrances and exits (e.g. using mirrors)
- Seclusion – locking someone in a room
- Aversive care practices – behaviour may be controlled by lights being turned off to discourage certain forms of activities or threatening or dominant tones of voice to manage behaviour in some way (e.g. 'where do you think you are going?')
- Surveillance – tagging and tracking technology has been proposed as part of a wider debate about the monitoring of people, especially people with dementia (prone to 'wandering') and people with learning difficulties.

Any form of restraint has the potential to infringe people's human and civil rights. Most seriously, physical interventions, including prone restraints, have been implicated in a number of restraint-related deaths (Ball, 2005).

Physical intervention may also use 'distraction' techniques, which involve the infliction of pain on various parts of the body. Physical interventions that involve or rely on the use of pain as a means of control are a form of corporal punishment and arguably a breach of individuals' human and civil rights (Lord Carlile of Berriew, 2006). The UN has criticized the UK on its use of these kinds of techniques with children and young people and is expected to raise further concerns in its forthcoming 2008 report (Children's Rights Alliance for England/National Society for the Prevention of Cruelty to Children, 2007).

The use of tranquillizers and other drugs to restrain people via inappropriate pro re nata (PRN) prescriptions and 'anticipatory' prescribing to prevent problems from arising rather than dealing with issues as and when they arise has been a major concern in the care of people with dementia. A recent parliamentary committee, for example, heard that up to 70% of neuroleptic prescribing was inappropriate for people

with dementia (All Party Parliamentary Group on Dementia, 2008).

Some people who use services, especially those who are viewed by society as 'vulnerable', 'challenging' or whose voices are seldom heard or listened to can be seen as people or problems to be managed. Whether people are in hospital or receiving other health- or social-care services, there is a risk that they may be treated differently and have their human and civil rights ignored. These different practices may be justified because of people's conditions and behaviour.

People with dementia, for example, are one such group. There is a tendency for people with the advanced stages of the illness to be regarded by society as 'non-persons' without the rights and attributes that full citizenship implies. The human rights 'lens' shows how these kinds of views are unfair and discriminatory. When people use health services, they have the right to total freedom, to do what they want and to go where they want, unless their liberties are restricted by law (for example being detained under the Mental Health Act 1983).

Human rights practice seeks to reduce, and ultimately remove, unfair treatment, discrimination of individuals and structural inequalities in communities. Human rights therefore are not just legal issues but are a tool for more broader social and cultural change. A human rights perspective can help to challenge social and cultural understandings about practice and policies and the discourses that shape the care and treatment people receive.

A concern raised in the literature about the use of restraint is that people are not being fully involved in decisions about their care, including when restraints are applied. For example, children and young people have emphasized that they did not know they would be restrained until it actually happened (Children's Rights Director, 2004). A human rights approach supports the deep and meaningful involvement of individuals in decisions about their own care as well as people taking steps to influence policies and practices more widely (Department of Health, 2007).

Conclusions

Commentators have argued that there is not yet a culture of respect for human rights in the UK (Economic and Social Research Council, 2007). They call for human rights to be mainstreamed within services and for the public to be more aware of these rights. Commentators have also criticized the UK's narrow approach to human rights as serving only to protect civil and political rights.

Broader social, cultural and economic rights – as set out by the UN International Covenant on Economic, Social and Cultural Rights – also need to be covered. These broader rights emphasize that people should have the opportunity to enjoy high standards of health and wellbeing and this requires high quality health and social services. The quality of a service is likely to play an important determining role in how difficult situations that might give rise to the use of restraint are handled and – crucially – whether therapeutic approaches take precedent over restraining ones. BJHM

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KEY POINTS

- Human rights promote fairness, respect, equality, dignity and autonomy for all.
- Restraints place limits on people's will or freedom.
- Restraints commonly refer to physical restrictions; however, it is important to recognize a wide range of ways in which people's freedom may be curtailed (e.g. covert medication, seclusion, surveillance).
- Unless limited by law everyone has the right to total freedom and this means that therapeutic approaches should take precedence over restraint.
- The use of restraints constitutes health-care practice of the last resort.