IN OUR increasingly informed, litigious and rights-based society, there is an ever-growing need for all practising nurses to undergo training on the fundamental medico-legal concepts that impact upon their daily interaction with patients/service users and on their profession as a whole.

When it comes to the encroachment of the law into their daily lives, the list of concerns of mental health professionals continues to grow. In this article, we will examine a number of the issues presently causing concern in mental health circles, focusing on patient restraint and seclusion under the Mental Health Act 2001.

There are legal safeguards in place for the protection of individuals who are placed in restraint, either physical or mechanical. Under rules made by the Mental Health Commission in accordance with section 69 of the Mental Health Act 2001, a person may not be placed in bodily restraint or seclusion unless it is absolutely necessary or as a last resort.

Restraint
Restraining a patient presents healthcare professionals with a potential legal pitfall but if the restraint is performed correctly, ie. with the use of reasonable force and applied by a trained individual and only when necessary. Under such circumstances, provided the patient is monitored carefully during the restraint period, there are few legal challenges that could successfully be brought against the healthcare provider and/or hospital or approved centre.

If the decision to restrain is prompted by a real emergency and by the need to protect the safety of the patient/service user, there should be no liability for the use of a restraint device provided it is administered or applied in accordance with the relevant policy on restraint and procedures.

It is also essential that the restraints are only used for as long as is necessary and that the patient is monitored carefully throughout the duration of his restraint. Under no circumstances can a restraint device ever be used to punish a patient and they are only to be used where it is absolutely necessary and in the patient’s best interests.

In fact, not protecting a patient’s safety and wellbeing by not using a restraint device when such measure is clinically necessary could result in potential liability for the healthcare provider and the facility in question. As to whether a failure to restrain could amount to medical or professional negligence, the test applied by a court would be whether the relevant healthcare professional breached their duty to the patient by not applying a restraint device when other ordinary, prudent, and reasonable healthcare providers would have done so in the same or similar circumstances.

Also, where possible, the consent of the next of kin should be obtained to the use of restraint as if the family consents to the use of a restraint device and if it is administered correctly many of the legal challenges that could be brought would be effectively eliminated.

Any nurse using restraint and/or seclusion must adhere to the Mental Health Commission rules regarding same without deviation. The law of false imprisonment that protects any patient, including a psychiatric patient, from an illegal restriction in his or her freedom of movement, only applies to unlawful restraint of liberty.

This cause of action could be alleged by a patient but, again, it is unlikely that he or she would be successful in their claim if the staff can show that they abided by the relevant policy on the use of restraints, the action taken was necessary, they accurately documented their actions and that they obtained authorisation from the appropriate quarter.
Section 69 – theory and practice

Section 69(1) of the Mental Health Act 2001 provides that a person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under section 69(2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless seclusion or restraint complies with such rules.

Section 69(2) obliges the Mental Health Commission to make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient. A ‘patient’, under section 69(4) of the Act, refers to a person to whom an admission or renewal order relates, a child in respect of whom an order under section 25 is in force and a voluntary patient as defined by the Act.

The key principle underpinning the use of seclusion and/or mechanical means of bodily restraint is that they shall only be used as a last resort when all other options have been considered and shall not be prolonged beyond the period of time that is necessary for their purpose.

The Mental Health Act 2001 provides for deprivation of liberty by means of seclusion and mechanical means of bodily restraint for voluntary patients as well as involuntary patients. The Mental Health Commission is strongly of the view that the use of seclusion and mechanical means of bodily restraint on a voluntary patient must involve a consideration of whether involuntary admission of the patient on the grounds of mental disorder is warranted, and if so, the appropriate procedures must be followed.

Prosecutions in respect of any person who contraves section 69 may be brought by the Mental Health Commission. Prof Harry Kennedy, clinical director of the Central Mental Hospital, has commented on the concern that these rules have generated among healthcare professionals on how they may operate to deter hospitals from admitting challenging or disruptive patients in order to avoid altogether the use of seclusion, thus leading to discrimination against vulnerable patients.

At particular risk of discrimination as a result of this heightened awareness of the potential difficulty regarding restraint are young males suffering from psychosis. Prof Kennedy further observed that such an attitude may deprive vulnerable persons of timely mental health treatment and lead to increased criminalisation and imprisonment of such persons.

Case law on use of restraint

In the leading European Court of Human Rights case on the issue of restraint, Herczegfalvy versus Austria, the court had no difficulty holding that the use of a security bed and handcuffs in order to forcibly administer medication and feeding, reached the threshold of Article 3 of the Convention on Human Rights and constituted inhuman and degrading treatment.

However, the court also held that the administration of treatment which was ‘medically’ or ‘therapeutically’ necessary did not contravene Article 3. Therefore, so long as the treatment provided to the unwilling patient is medically necessary, it is unlikely to contravene Article 3 of the Convention/the patient’s human rights to be free from inhuman and degrading treatment.

The medical necessity to restrain the patient must be ‘convincingly shown’ to exist. It is questionable whether the system in place under the Mental Health Act, whereby the treating consultant must choose a second consultant to back up their opinion before the restraint can be applied, would be described as ‘convincing’ proof of necessity, if a case were to be taken to challenge the lawfulness of the use of mechanical restraints in Ireland.

Seclusion

The Act also provides that the Mental Health Commission shall make rules in relation to the use of seclusion. Seclusion is defined as: ‘the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving’. However, a patient locked in his or her bedroom at night in the National Forensic Service (Central Mental Hospital) as part of his or her individual risk assessment and management plan for the purposes of enhanced security, does not constitute seclusion under these rules.

Seclusion must be authorised in writing by a registered medical practitioner following consultation with the consultant psychiatrist responsible for the care and treatment of the patient, or the duty consultant psychiatrist.

In addition to recording the matter in the clinical file, the seclusion register must be completed by the registered medical practitioner and the consultant psychiatrist responsible for the care and treatment of the patient or the duty consultant psychiatrist, as soon as is practicable, and in any event within 24 hours.

A seclusion order shall remain in force for a maximum period of eight hours from the time of its making and then shall expire. The authorisation to seclude must only be made following an examination of the patient concerned by the registered medical practitioner, where such an examination is practicable. A record of the examination must be entered into the patient’s clinical file. In an emergency situation the following rules apply:

1. Seclusion may in addition be initiated by a registered nurse or care officer (National Forensic Service)
2. If a registered nurse or care officer (National Forensic Service) initiates seclusion, a registered medical practitioner must be notified immediately of the initiation of seclusion
3. The relevant sections of the seclusion register relating to the details surrounding seclusion must be completed by the registered medical practitioner, registered nurse or care officer (National Forensic Service) who initiated the seclusion as soon as is practicable, and no later than three hours after the commencement of seclusion, a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the patient or the duty consultant psychiatrist, must authorise seclusion in writing.

Exclusion orders may be renewed but a patient must not be secluded for longer than 24 hours. If the period must be renewed after a continuous period of 24 hours, the treating consultant psychiatrist must examine the patient. If a period of 72 hours is reached and it remains necessary to keep the patient in seclusion, the inspector of mental health services and/or the Mental Health Commission must be notified.

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Source material