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Means of Restraint in Residential Care when there is no Acute Danger. Time for the European Committee on the Prevention of Torture to Set the Standard

HIGHLIGHTS

- Using means of restraint in residential care is often only considered permissible if there is an acute danger.
- This is also the approach taken in the standards of the European Committee for the Prevention of Torture.
- However, during visits to member states, the committee has also tolerated the use of means of restraint for preventive and protective reasons.
- The committee rarely discusses the conditions for applying means of restraint and the relevant safeguards.
- It would be desirable to pay more attention to the other reasons for using means of restraint.

ABSTRACT

This contribution analyses the approach of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) to means of restraint in residential psychiatric and disability care. Generally, the CPT states that means of restraint can only be applied in cases of acute danger, or if all alternatives have failed. Detailed and strict conditions apply, including for the duration (usually minutes rather than hours). However, an analysis of the CPT's country reports shows that sometimes longer-term use is implicitly accepted, first to preventively maintain order and safety in a care facility and second, to protectively safeguard the interests of the patient. Based on country reports and general human rights principles, this contribution tries to provide the clearest possible picture of the conditions for applying means of restraint and the required legal guarantees in these cases. Nevertheless, many loose ends remain. To safeguard the rights of patients, it is desirable that the CPT is more explicit concerning means of restraint when there is no acute danger.

KEYWORDS: means of restraint, seclusion, European Committee for the Prevention of Torture, psychiatric and disability care

1. Introduction

1.1. Means of restraint: more than just a tool to tackle acute danger

Means of restraint (physical restraint, mechanical restraint, chemical restraint and seclusion) are often associated with the bare isolation cells used in mental health care to deal with acute cases of aggression.

There is a wealth of information on how to use means of restraint in these cases of acute danger, as well as how to prevent and avoid their use (Bak. et al., 2019; Chieze et al., 2019; Nielson et al., 2020).

Their application is not only tackled from a clinical perspective (Sailas & Fentopn, 2012; Bowers et al., 2015; Borckardt et al., 2011; Putkonen et al., 2013); the human rights point of view is also of relevance, as they could interfere with the right to private life, and may amount to a deprivation of liberty or even to inhuman treatment (Kumble & McSherry, 2010; Lyons, 2015).[1] The human rights consensus, supported by most organs of the United Nations and the Council of Europe, is that restraint may only be applied for the shortest time possible as a last resort to protect the patient or others in case of acute danger.[2] If applied, this should be done within the boundaries of a clear legal framework and policy at the level of the care facility.[3] Foreseeability, proportionality and controllability are important touchstones. At the same time, this consensus is under pressure: means of restraint are often applied without consent, leading the UN Committee on the Rights of Persons with Disabilities to consider them contrary to the UN Convention on the Rights of Persons with Disabilities (McSherry, 2017). That debate is not addressed in the current contribution.

What is addressed here, however, is the fact that this same human rights consensus states that using means of restraint for any reasons other than acute danger (e.g., punishment, lack of staff or as part of therapy) should be prohibited.[4] That does not correspond to reality, at least not in our home

[1] See for example on the level of the European Court of Human Rights: ECtHR 18 October 2012, nr. 37679/08, Bureš/Czech Republic, §90; ECtHR 27 February 2014, nr. 31974/11, Koroviny/Russia, § 65; ECtHR 19 February 2015, nr. 75450/12, M.S./Croatia (n° 2), § 102; ECtHR 14 June 2016, nr. 60103/11, Stepanian/Romania, § 65; ECtHR 14 February 2012, nr. 13469/06, D.D./Lithuania, § 173; EHRM 24 September 1992, nr. 10533/83, Herczegfalvy/Austria, § 83.

[2] Art 27.1 Recommendation Rec(2004)10 of the Committee of Ministers of the Council of Europe Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004), CM/Rec(2004)10; General comment No. 24 Committee on the Rights of the Child, 2019.

[3] Report of the Special Rapporteur on the Question of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (3 July 2003), *UN Doc.* A58/120 (2003), § 49.

[4] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, 1.4; Art. 27.1 Recommendation Rec(2004)10 of the Committee of Ministers of the Council of Europe Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004), CM/Rec(2004)10; ECtHR 18 October 2012, nr. 37679/08, Bureš/ Czech Republic, § 56; Visit to Bulgaria, CPT/Inf(2002)1, § 182-183.

country, Belgium. For example, enter a ward for people with intellectual disabilities or dementia and one immediately encounters means of restraint that are used for other reasons (to avoid the risk of falling and wandering, to curb disruptive behaviour or avoid potential aggression, to facilitate care, etc.). In human rights literature, as well as clinical research, these other reasons for using means of restraint are – if mentioned (e.g. Day, et al., 2010; Weisbrodt et al., 2012; Lyons, 2015) – rarely separately evaluated (e.g. Cannella-Malone, et al. 2008; Weeden, et al., 2015; Scheithauer, et al. 2015). Human rights bodies also rarely note them.[5] For those who do not see them with their own eyes, they remain under the radar.

From that perspective, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has a privileged position. The CPT is a human rights body of the Council of Europe that conducts visits to, among other places, psychiatric facilities and social care homes in the member states.[6] In other words: they see things that happen with their own eyes. This contribution therefore focuses on how the CPT, as a privileged witness, deals with the application of means of restraint when there is no acute danger. This is not always as consistent as one would expect it to be.

1.2. The Committee for the Prevention of Torture

The CPT draws its *raison d'être* from the European Convention for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment. It proactively monitors locations where people may be deprived of their liberty. For this purpose, the CPT makes periodic (and, if necessary, ad hoc)

[5] Recommendation CM/Rec(2014)2 of the Committee of Ministers to member States on the promotion of human rights of older persons, CM/Rec(2014)2, § 41; Report of the Independent Expert on the enjoyment of all human rights by older persons, *UN Doc.* A/HRC/33/44, § 48.

[6] Art. 2 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 26 November 1987.

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on-site visits in the member states.[7] Visits are not exclusively to prisons, but include a wide range of places, such as psychiatric facilities and social care homes. After each occasion, the CPT sends a visit report to the relevant member state, containing its findings and recommendations. If the member state agrees, the report is made publicly available.

Although their recommendations are not binding, the CPT is an important voice in the human rights debate concerning residential care. After all, the CPT and other binding and authoritative bodies within the Council of Europe are communicating vessels. From that perspective, the CPT plays an important role in the interpretation of articles of the European Convention on Human Rights, in particular Article 3 on torture and inhuman and degrading treatment.[8]

The CPT's reporting system leads to a multitude of reports, often containing similar recommendations. Because of the great similarities between the various country reports, the CPT has developed 'standards', in which it presents its main recommendations on a given theme.[9] The CPT country reports and standards mutually enrich one another. The standards are fuelled by the recommendations in the country reports, but are also referred to in the country reports to clarify the CPT's position.

1.3. The standardized approach to means of restraint

The CPT has a long tradition of making recommendations on means of restraint. Its stance is reflected in a detailed CPT standard on the use of restraint in psychiatric establishments for adults.[10]

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[7] Art. 2 European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 26 November 1987.

[8] For example: ECtHR 18 October 2012, nr. 37679/08, Bureš/Czech Republic, §88-106 refers to the CPT visit. In the other direction the Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, §2 refers to the case of Bureš.

[9] For example Standards of the CPT on Imprisonment, CPT/Inf(92)3-part2; and on Juveniles deprived of their liberty under criminal legislation, CPT/Inf(2015)1-part rev1.

[10] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6.

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Although this standard appears to have a limited scope — psychiatric care (including forensic) for adults — the CPT also refers to it when visiting social care homes.[11] Accordingly, this standard appears to be a response to the use of means of restraint throughout care situations.

The CPT standard distinguishes between four means of restraint: physical restraint (i.e., staff holding or immobilising a patient by using physical force – 'manual control'); mechanical restraint (i.e., applying instruments of restraint, such as straps, to immobilize a patient); chemical restraint (i.e., forcible administration of medication for the purpose of controlling a patient's behaviour); and seclusion (i.e., placement of a patient alone in a locked room, potentially against their wishes).[12]

The core of the CPT standard is — in line with the human rights consensus — that restraint can only be used for one reason: to exceptionally and briefly restrain violent patients who endanger themselves or others, when all alternatives have failed.[13] Other motives for means of restraint (for example, punishment, the mere convenience of staff, staff shortages or proper care or treatment) are out of the question.[14] Moreover, the use of means of restraint is accompanied by very strict conditions and high safety standards listed in the CPT standard, and repeated and further explored in the country reports. For example:

> Every patient who is subjected to mechanical restraint or seclusion should be subjected to continuous supervision. In the case of mechanical restraint, a qualified member of staff should be permanently present in the

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[11] Factsheet 'persons deprived of their liberty in social care establishments', 21 December 2020, 21 December 2020 CPT/Inf(2020)41, §27.

[12] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, definitions.

[13] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, esp. introduction and 1.1 and 4.1; The same criterion is applied in Art 27.1 Recommendation Rec(2004)10 of the Committee of Ministers of the Council of Europe Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder, 22 September 2004, CM/Rec(2004)10.

[14] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, esp. introduction and 1.1 and 4.1; see e.g. Visit to Montenegro, CPT/Inf(2010)3, §127.

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room in order to maintain a therapeutic alliance with the patient and provide him/her with assistance. 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.[15]

For a full overview, we refer to the standard on means of restraint in psychiatric establishments for adults.

1.4. Beyond the standards

The CPT standard and the vast majority of country reports suggest — again in line with the human rights consensus — that restraint should only be used very briefly if violent patients endanger themselves or others, and all alternatives have failed. This raises questions. In Belgium, the country the authors are most familiar with, policy documents,[16] inspection reports[17] and case law[18] demonstrate that means of restraint are also used in situations other than these acute examples: First, preventively to ensure the order and safety in care facilities. For example, in some psychiatric facilities, bedroom doors are locked at night. According to the CPT definition, this amounts to seclusion. Second, in some types of care facilities, means of restraint are applied protectively to safeguard the interests of the patient. This seems especially the case in facilities for people with intellectual disabilities and psychogeriatric disorders. The use of restraint in the context of fall prevention is a clear example.

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[15] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, § 7.

[16] For example, Superior Health Council of Belgium in advice 9193 on the use of coercive measures in psychiatry on page 19 (see https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/hgr_advies_9193_dwanginterventie.pdf. In Dutch).

[17] For example Department WVG, *Syntheserapport inspecties vrijheidsbeperkende maatregelen binnen de gehandicaptenzorg voor kinderen en minderjarigen*, July 2019 (https://www.departementwvg.be/sites/default/files/media/Syntheserapport%20Vrijheidsbeperkende%20maatregelen%20in%20de%20gehandicaptenzorg%20voor%20kinderen%20en%20minderjarigen.pdf).

[18] For example Criminal Court Bruges 2 May 2005, published in Tijdschrift voor Gezondheidsrecht, 2007-08, 228.

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The question arises as to how the CPT would assess the preventive and protective application of means of restraint. It is obvious that they do not correspond to the conditions of application in the CPT standard. However, are there indications that according to the CPT they are permissible after all? If so, what are the conditions of application and the required legal safeguards?

2. Methods

This contribution examines whether the CPT considers the application of means of restraint to be acceptable in non-acute cases and what possible conditions of application could apply. To do so, we examine the country reports of the CPT, the case law of the European Court of Human Rights and the general principles applied by the Council of Europe in residential care. In this way, the aim is to give the clearest possible CPT-based picture of their application.

The current contribution is primarily based on CPT country reports on psychiatric hospitals and social care homes published between May 2013 and May 2021. These reports were analysed in terms of whether they dealt with the use of means of restraint that were not mentioned in the CPT standard and if so, what conditions for application and legal guarantees were stipulated. As there is a dialogue between the CPT and the ECtHR, the case law on means of restraint in care settings was also analysed (up to May 2021). However, the CPT country reports (and the ECtHR case law) offer limited guidance on the application of means of restraint in non-acute situations. Therefore, they are supplemented with sources from the Council of Europe (CPT, ECtHR, Committee of Ministers and Commissioner for Human Rights). These do not specifically deal with means of restraint, but give broader guidance on related themes (order and safety in care, coercive treatment, substitute decision making, etc.). For this broader human rights framework, we used sources that were previously collected for a dissertation on restrictions on freedom in residential care (Opgenhaffen, 2020a). That research dealt with restrictions in the external and internal legal position of residential care users from the perspective of legal capacity, movement, private life and (in)humane treatment. It involved the perspective of both the United Nations and the Council of Europe.

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3. Results and discussions

Except for cases involving means of restraint used as a punishment (which is never permitted), the analysis provides a mixed picture. There are cases where the CPT explicitly prohibits the use of means of restraint in non-acute situations, but also cases where their use is (often implicitly) accepted. After dealing with means of restraint as a punishment (3.1), we first tackle the preventive application of its use to ensure order and safety in a care facility (3.2), and second, deal with protective application of means of restraint to safeguard the interests of patients (3.3).[19]

3.1. Punishment

Punishment turns out to be a potential motive for applying restraint. According to the CPT standard, means of restraint should never be applied (or experienced[20]) as a punishment in a care context. This is confirmed by all the country reports. A care context differs from a detention context, where seclusion may be used as a punishment for a breach of the internal order.[21]

Forensic psychiatry should also be labelled as a care context, rather than as a detention context. Consequently, the use of seclusion as a punishment is also prohibited in these settings. The reason for this is not that forensic psychiatric patients lack a sense of guilt, but instead that punishments do not belong in facilities aimed at care and treatment.[22] A report on a forensic psychiatric facility in Portugal made this clear, as the facility applied the disciplinary rules applicable to prisoners insofar as a forensic psychiatric patient had a sense of guilt. Therefore, if the behaviour was related to a psychiatric disorder, the patient could not be disciplined. This practice was condemned by the CPT, as

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[19] The distinction into preventive and protective stems from a human rights evaluation framework made for restrictions on freedom in care in Opgenhaffen. T. (2020). *Vrijheidsbeperkingen in de zorg*. Antwerp-Cambridge, Intersentia.

[20] Visit to Russia, CPT/Inf(2019)26, § 66 ; Visit to Poland, CPT/Inf(2018)39, § 134.

[21] Solitary Confinement of Prisoners, CPT/Inf(2011)28-part2.

[22] Visit to Portugal, CPT/Inf (2020) 33, § 114 ; Visit to Poland, CPT/Inf(2018) 39, § 136 ; Visit to Germany, CPT/Inf(2017)3, § 125.

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a breach of internal order is often likely to be related to a psychiatric disorder, and thus should be approached from a therapeutic rather than a punitive standpoint.[23]

3.2. Prevention

3.2.1. The standard and its deviations

Means of restraint also seem to be applied preventively to ensure order and safety in a care facility. The standardized answer is that means of restraint may not be used in such a preventive manner, and this is confirmed by most of the country reports. For example, the CPT opposes the systematic locking of bedroom doors at night.[24] The CPT also refers to the use of seclusion to avoid tensions between patients, as representing inadequate care and a poor approach to safety.[25] The suggestion that means of restraint should not be used in a preventive manner is also confirmed in the judgements of the ECtHR in the examples of Bureš and Aggerholm, amongst other cases. In the case of Bureš, the Czech Republic was condemned on the basis of Article 3 of the ECHR — which protects against torture and inhuman and degrading treatment — for mechanically restraining a patient for hours to prevent him from attacking members of staff. The Czech Republic could not prove that the patient would have behaved violently and that alternatives would have been unsuccessful.[26] The fact that the patient resisted the application of mechanical restraint did not prove that he would have been violent if not restrained.[27] Similarly, in the case of Aggerholm, Denmark was convicted on the basis of the same article because of an episode of mechanical restraint that persisted while the risk of violence was no longer imminent but merely potential.[28]

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[23] Visit to Portugal, CPT/Inf (2020) 33, § 114.

[24] Visit to Germany CPT/Inf (2017) 13, §129.

[25] Visit to Italy, CPT/Inf (2017) 23, §115.

[26] ECtHR 18 October 2012, nr. 37679/08, Bureš/Czech Republic, §98.

[27] ECtHR 18 October 2012, nr. 37679/08, Bureš/Czech Republic, §99; Repeated in ECtHR 19 February 2015, nr. 75450/12, M.S./Croatia, §107-109.

[28] ECtHR 15 September 2020, nr. 45439/18, Aggerholm/Denmark, §111.

At the same time, there are a series of country reports in which the CPT observes preventive application of means of restraint, but is less explicit in rejecting them. For example, in a Danish psychiatric hospital, some of the residents' rooms are locked either all day or for a significant part of the day. These residents have the right to spend one or two hours a day outdoors and can receive visitors and make telephone calls. The measure was reassessed by doctors on a monthly basis (weekly for some patients). The CPT does not oppose this type of seclusion in difficult populations where no alternative exists, provided it is used only in highly exceptional circumstances and for the shortest possible time.[29] Another example is a report on a Lithuanian facility for persons with disabilities that applies seclusion to calm down agitated residents. The CPT notes that there is a legal basis and that the care facility has a clear policy that includes a time limit (4 hours). The CPT agrees with this practice if the decision is taken by a medical doctor and executed by trained medical staff. For registration and supervision, the CPT refers to its standard on Means of Restraint in Psychiatric Establishments for adults.[30] A last (non-exhaustive) example is a report on an Irish care facility for persons with intellectual disabilities that applies walking restraints to some of its patients. There is a legal basis and protocol for their use (which is also provided to the residents), the staff are trained, there is a registration mechanism and the situation is evaluated every three months. The CPT does not object to this practice.[31]

Together with other reports, these demonstrate that the CPT apparently accepts the preventive use of means of restraint in some cases but is rarely explicit about the conditions of application. Using

[29] Visit to Denmark, CPT/Inf(2019)35, §169-176; see similarly in Visit to Sweden, CPT/Inf(2021)20, § 72; see earlier Visit to Denmark, CPT/Inf(2014)25, §142-146.

[30] Visit to Lithuania, CPT/Inf (2018) 2, §118-119; Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, § 7.

[31] Visit to Ireland, CPT/Inf (2020)37, §§158-160; walking restraints are also mentioned in e.g. Visit to Denmark, CPT/Inf(2019)35, §169-176.

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the available reports and general principles, we try to give more guidance on these alternative forms of application. In doing so, we distinguish between coercive application and application with consent.

3.2.2. Coercive application

Means of restraint can only be used coercively (that is, without consent of the patient or their representative) in highly exceptional circumstances. This can be concluded from the CPT standard and the prohibition of degrading treatment in Article 3 of the ECHR, as understood by the ECtHR.[32] Following from the country reports, the preventive application of means of restraint can amount to the criterion of 'highly exceptional' if restraining a *specific* patient is the only way to ensure order and safety in a facility that is best suited for *this* patient. The safety risk should thus be inherent to a certain context and a certain target group, and should always be assessed at the level of the individual patient.[33] Using means of restraint in a preventive manner in a facility that is not adapted to the type of problem the patient faces is in no way permissible.[34] It goes without saying that even if such a highly exceptional situation arises, a legal basis is still required to proceed with restraining the patient.

As with the standardized use of means of restraint, additional safeguards are necessary. With regard to these safeguards, it is noteworthy that when dealing with the preventive application of means of restraint, the CPT regularly refers to safeguards from the standard on means of restraint in psychiatric establishments for adults, although in principle this only applies to acute situations.[35] The CPT standard should therefore be applied by analogy as far as possible. At the same time, the analogy stops at some points. For example, if a bedroom door is locked at night, the previously mentioned requirement for continuous and mutual visual contact between the patient and a staff member seems unfeasible and undesirable (see 1.3). In general, the goals to be reached with the

[32] ECtHR 15 September 2020, nr. 45439/18, Aggerholm/Denmark, §83.

[33] Visit to Portugal 2012, CPT/Inf (2013) 4, §110; Visit to Denmark, 2019, CPT/Inf (2019) 35, §169-176.

[34] ECtHR 23 May 2020, nr. 38067/15, L.R./North Macedonia, § 81.

[35] Examples: Visit to Lithuania, CPT/Inf (2018) 2, §118-119; More implicit in Visit to Denmark, CPT/Inf (2019) 35, §169-176.

preventive use of restraint differ from acute situations and would therefore be better if accompanied by specific and customized recommendations.

The CPT only recently gave the first impetus for such customized recommendations in a report on a Russian forensic psychiatric hospital. That facility — accommodating high-risk patients — used seclusion in a preventive manner but did so in an inhumane way. The CPT acknowledges that preventive long-term seclusion in high-security wards may exceptionally be permissible, particularly when seclusion has been applied previously for serious and acute danger. However, apart from a clear legal basis (that was apparently available in this case[36]), eight safeguards must be respected.[37] First, the application has to be assessed medically on an individual basis by a multi-disciplinary team. The assessment should be part of the patient's file and care plan, and should also deal with therapies during seclusion. Second, a plan on how to reintegrate the patient in the facility should be drafted. Third, regular (at least daily) meaningful human contact should be provided. Contact with the outside world (through visits and telephone) is required and meaningful daytime activities should be offered. With regard to the latter, previous country reports have already emphasized that the patient must in any event be able to spend one hour a day in the open air.[38] Fourth, the patient's state of health has to be monitored daily, and a weekly multidisciplinary consultation is required to judge the necessity of the measure. Fifth, if the application is long-term — the CPT is talking about several months here — the patient should also be followed up by independent care providers and alternatives are to be sought for outside of the care facility. Sixth, the patient has the right to appeal against the measure. Seventh, a separate register is required. And eighth, the measure should be accompanied by a clear policy that the patient is informed of.[39]

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[36] See a contrario Report on Russia, CPT/Inf(2019)26, § 109.

[37] Report on Russia, CPT/Inf(2019)26, § 60.

[38] Report on the United Kingdom, CPT/Inf(2017)9, § 158; Report on Germany, CPT/Inf(2017)3, § 130.

[39] Report on Russia, CPT/Inf(2019)26, § 60.

These recommendations are far more concrete than those in previous country reports on similar situations,[40] but pale into insignificance against the detailed standard on means of restraint in acute cases. Moreover, they are drafted for a specific situation: long-term seclusion in high-risk forensic psychiatric care. The question arises of how other cases of using preventive restraint should be dealt with (for example locking the room doors at night[41] or mechanically restraining a disruptive patient with intellectual disabilities[42]) and to what extent the recommendations dealt with here can be transposed. If so, the further question is whether they offer sufficient protection, for example, using mechanical restraint for a longer period of time if a patient is disruptive in the context of care for persons with intellectual disabilities.

3.2.3. Consensual application

The preceding paragraphs demonstrate that the coercive application of means of restraint in a preventive manner is only permissible in highly exceptional situations, where there is also a legal basis. This leads to the question of whether the patient's consent (or that of their representative) can also give rise to the preventive use of means of restraint, and if so, what the conditions would be.

The country reports do not provide an answer, as there are no reports where consent is the basis for a preventive application. However, it is the CPT standard itself that creates an opening for this, by stating that patients themselves may sometimes ask to be subjected to means of restraint. The standard on means of restraint in psychiatric establishments for adults states that if alternatives have been assessed, means of restraint are allowed in these cases. The measure should be terminated as soon as the patient asks to be released.[43] This is also in line with general human rights principles; free

[40] Report on the United Kingdom, CPT/Inf(2017)9, § 150-158; Report on Germany, CPT/Inf(2017)3, § 129-130; Report on Norway, CPT/Inf(2011)33, § 94.

[41] Which is for example the case in Report on Germany, CPT/Inf(2017)3, §129 and Report on Portugal, CPT/Inf(2013)4, §110.

[42] Which is for example the case in Visit to Lithuania, CPT/Inf (2018) 2, §118-119.

[43] Standards of the CPT on Means of Restraint in Psychiatric Establishments for adults, 21 March 2017, CPT/Inf(2017)6, § 9

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and informed consent precludes a restriction of the right to private life within the meaning of Article 8 of the ECHR, and ensures that the measure does not amount to a deprivation of liberty within the meaning of Article 5 of the ECHR.[44] Moreover, consent precludes the application of Article 3 of the ECHR, which protects patients from inhuman treatment, at least if the measure does not involve a serious risk to a patient's health and is not generally considered to be inhumane.[45]

Although consent is the basis, there is no clarity on additional safeguards. By analogy, one could apply the CPT standard, or the conditions described in section 3.2.2 here, but there is no clear obligation to do so. It could be imagined that when specific legal guarantees are lacking, it becomes a slippery slope. Two examples make that tangible. First, what about facilities that ask residents on admission to agree to a policy on the preventive use of means of restraint in the event of agitation? One immediately feels that a clause in an agreement wherein a patient is asked to waive the right to oppose the use of means of restraint contravenes the principle of informed consent.[46] However, in the light of the existing power imbalances, it is doubtful whether this principle is sufficiently precise to protect the patient. Second, what about patients who lack the competence to give consent? This is a very vulnerable group, which the UN Convention on the Rights of Persons with Disabilities has brought into sharp focus (Arstein-Kerslake & Flynn, 2016). While the UN Committee on the rights of Persons with Disabilities strongly resists the fact that legal capacity must not be based on mental capacity and rejects substitute decision-making by a representative, the bodies of the Council of Europe still adhere to the idea that in case of mental incapacity a representative may make decisions

[44] For example: ECtHR 14 February 2012, 13469/06, D.D./Lithuania, § 181 ECtHR 15 June 2005, nr. 61603/00, Storck/Germany, § 143; ECtHR 19 July 2012, nr. 2452/04, M/Ukraine, § 78-79; ECtHR 19 June 2012, nr. 22883/05, Cristian Teodorescu/Romania, § 57; ECtHR 3 July 2012, nr. 34806/04, X/Finland, § 212

[45] For example ECtHR 6 November 2014, nr. 12927/13, Dvořáček /Czech Republic, § 96.

[46] Art. 5 Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (4 April 1997), ETS N° 164; also see Visit to San Marino, CPT/Inf(2008)9, §57 (in case of a protective application).

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on a patient's behalf (Opgenhaffen, 2020b).[47] There are no indications that according to the CPT this would not be the case for decisions on the preventive application of means of restraint. However, without clear guidelines and additional safeguards, the patient is vulnerable. These safeguards are currently limited to principled considerations. For example, it can be concluded from the case law on Article 5 of the ECHR that if representation is not carried out in a careful manner (e.g., the facility itself acts as the representative) or if the patient persistently opposes the decision of a representative, means of restraint amount to a deprivation of liberty.[48] However, it is doubtful whether these broad principles sufficiently guarantee the patient's legal position. The same applies to patients who are able to give consent on admission (and who do so), but are subsequently not mentally competent to confirm or withdraw that consent.

3.3. Protection

3.3.1. The standard and its deviations

Safeguarding the interests of the patient can also be a motive for applying restraint. In this regard, the CPT standard states that means of restraint do not have a therapeutic justification. However, as mentioned, the CPT standard relates to responses to violence; when there is no aggression, some country reports lead to different conclusions on the protective use of restraint.

First, there are several country reports on mechanical restraint being applied to facilitate medical interventions.[49] For example, the CPT observes that in a high-security mental health facility in the UK,

[47] Examples at the ECtHR: ECtHR 27 March 2008, nr. 44009/05, Shtukaturov/Russia, § 86; EHRM 13 October 2009, nr. 36500/05, Salontaji-Drobnjak/Serbia, § 141; ECtHR 21 June 2011, nr. 46185/08, Krušković/Croatia, § 30; ECtHR 17 July 2014, nr. 47848/08, Centre for Legal Resources on behalf of Valentin Câmpeanu/Romania, § 132.

[48] Examples: ECtHR 16 September 2014, nr. 50131/08, Atudorei/Romania, § 133-136; ECtHR 26 February 2002, nr. 39187/98, H.M./Switserland, § 46. ECtHR 22 January 2013, nr. 35939/10, Mihailovs/Latvia, § 134; ECtHR 17 March 2015, nr. 25820/07, Stefan Stankov/Bulgaria, § 89; ECtHR 5 June 2014, nr. 12317/06, Akopyan/Ukraine, § 68; EHRM 5 October 2004, nr. 45508/99, H.L./UK, § 91.

[49] For example: Visit to Ireland, CPT/Inf (2020)37, §§158-160; Visit to Lithuania, CPT/Inf (2018) 2, §118-119.

a patient was restrained when taking a (necessary) blood sample and treating a head wound. The CPT did not oppose this measure (for which a legal basis exists), but did oppose the disproportionate use of power in its implementation, as the measure was carried out by nine security officers.[50] Another example is the aforementioned Irish facility for persons with intellectual disabilities. In that facility, physical interventions are used to enable medical tests and treatment to be carried out. There is a legal basis and a protocol (which is also provided to the patient). Moreover, staff are trained, and the measure is properly registered.[51]

Second, there are country reports on the application of mechanical restraint in the context of fall prevention, and the risk of wandering or escape.[52] For example, a home for the elderly in San Marino uses bed rails and abdominal belts as part of fall prevention if a doctor prescribes it and the family agrees in writing. The measure is regularly reviewed and is subject to registration. The CPT accepts this practice, but warns that the use of mechanical restraint in this case should not be approved by the 'family' and requires the consent of either the resident or (if the resident is incapacitated) their legal representative.[53]

As in the case for the preventive application of means of restraint, the CPT apparently accepts the use of means of restraint in a protective manner, but is rarely explicit about the exact conditions of application. Sometimes reference is made by analogy to the CPT standard that is to be applied.[54] However, the analogy stops at some point. In a similar way to the previous part, we try to give more

[50] Visit to the United Kingdom, CPT/Inf (2017)9, §171

[51] Visit to Ireland, CPT/Inf (2020)37, §§158-160;

[52] For example: Visit to Ireland, CPT/Inf (2020)37, §§158-160; Visit to Norway, CPT/Inf(2019)1, §138-139; Visit to Armenia 2015, CPT/Inf(2016)31, §128-129;

[53] Visit to San Marino 2013, CPT/Inf (2014)33, §57; see other examples on elderly homes: Visit to Liechtenstein, CPT/Inf (2017) 21 §80-8; Visit to France 2015, CPT/Inf (2017) 7, §173-174.

[54] For example implicit in Visit to Norway, CPT/Inf(2019)1, §138-139; Visit to Armenia 2015, CPT/Inf(2016)31, §128-129;

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guidance here, based on the reports that are available and on general principles. Again, we distinguish between coercive and consensual application.

3.3.2. Coercive application

As already stated (see section 3.2.2), means of restraint can only be used coercively (that is, without the consent of either the patient or their representative) in highly exceptional situations. Although the CPT is not explicit about this, it seems obvious that when means of restraint are applied protectively, 'highly exceptional' coincides with the criteria for coercive medical treatments. After all, the protective use of means of restraint is a medical act with the aim of achieving a health benefit.

The conditions for coercive treatment have been listed by several human rights bodies within the Council of Europe. Coercive treatment is only allowed if the patient has a psychiatric disorder and constitutes a serious danger to their own health or that of others. The treatment is the last resort and can only be applied if the patient (and eventually their representative) has been heard. Such coercive treatment is only possible if there is a clear legal basis, containing sufficient procedural safeguards.[55] Important safeguards include the fact that the decision is taken by or under the supervision of an independent body, and the fact that the patient is consulted and has a right to appeal.[56] In addition, care facilities themselves play an important role: they must conduct a policy on

[55] Within the Council of Europe see for example art. 18 and 20 Rec(2004)10 of the Committee of Ministers of the Council of Europe Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 september 2004), CM/Rec(2004)10; Art. 7 Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (4 April 1997), ETS N° 164; Report by Nils Muižnieks, the Commissioner for Human Rights of the Council of Europe following his visit to Norway from 19 to 23 Januari 2015 (18 May 2015), CommDH(2015)9, § 31. Explicit in a country report on seclusion: Visit to the Netherlands, CPT/Inf(2002)30, §59.

[56] Art. 21 Rec(2004)10 of the Committee of Ministers of the Council of Europe Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004), CM/Rec(2004)10; CPT Checklist for Visits in Social Care Institutions where Persons may be Deprived from their Liberty (22 May 2015), CPT/Inf(2015)23, G;

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coercive treatment and make it part of individual care and treatment plans.[57] In addition, registration,[58] the requirement for a second (independent) opinion[59] and an effective enforcement mechanism if a facility disobeys the rules[60] should protect patients against unlawful application.

The CPT also devotes extensive attention to coercive treatment in psychiatric and (to a lesser extent) disability care, but does so in a different section of the country reports to the one on means of restraint. It is not made explicit that the recommendations on coercive treatment also apply to the coercive and protective application of means of restraint. In other words, there is a steady framework, especially when — in addition — the CPT standard is applied by analogy as best as possible. Nevertheless, it would be desirable for the CPT to further clarify and confirm the application of that framework.

Resolution 1460 (2005) of the Parliamentary Assembly of the Council of Europe on Improving the Response to Mental Health Needs in Europe (24 June 2005), PA/Res1460(2005), § 14.

[57] For example Visit to Latvia, CPT/Inf(2013)20, § 167; Art. 19, § 1-2 Rec(2004)10 of the Committee of Ministers of the Council of Europe Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder (22 September 2004), CM/Rec(2004)10; Rec(2006)5 of the Committee of Ministers of the Council of Europe on the Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015 (5 April 2006), CM/Rec(2006)5, action line 3.9.

[58] Rec 1245 (1994) of the Parliamentary Assembly of the Council of Europe on Psychiatry and Human Rights (12 April 1994), PA/Rec1235(1994), § 7.2.c; CPT Checklist for Visits in Social Care Institutions where Persons may be Deprived from their Liberty (22 May 2015), CPT/Inf(2015)23, G.

[59] For example in Report by Nils Muižnieks, the Commissioner for Human Rights of the Council of Europe following his visit to Finland from 11 to 13 June 2012 (25 september 2012), CommDH(2012)27, § 68; Report by Nils Muižnieks, the Commissioner for Human Rights of the Council of Europe following his visit to Norway from 19 to 23 Januari 2015 (18 May 2015), CommDH(2015)9, § 43..

[60]Report by Nils Muižnieks, the Commissioner for Human Rights of the Council of Europe following his visit to Finland from 11 to 13 June 2012 (25 September 2012), CommDH(2012)27, § 68.

3.3.3. Consensual application

Consent (either by the patient or their representative) can also serve as a legal basis. Given the fact that the protective application of means of restraint should be considered as a medical act, informed consent seems a self-evident legal basis for their use. This is confirmed by country reports that refer to consent as the legal basis for protective restraint.[61] These same reports state (often implicitly) that consent in itself is not enough; several safeguards are required, for example, a clear policy, registration and training. It is moreover self-evident that consent should be freely given and can be revoked at all times.[62] The conditions, safeguards and reservations discussed in the section on preventive application of means of restraint (3.2.3) can be repeated here.

In the case of preventive restraint, it is unclear whether the CPT considers consent to be subject to substitute decision-making by a legal representative. In the protective application of means of restraint, it clearly does.[63] That makes sense from a legal point of view (the protective use of restraint is a medical act and medical acts are subject to representation), but leads to precarious situations in a long-term care context. The protection of the patient's rights heavily depends on the quality of the representation and the extent to which the outcome is the one the patient would have wanted.

In this regard, the principles in Recommendation R(99)4 of the Committee of Ministers of the Council of Europe serve as a starting point: legal capacity should be safeguarded as much as possible, what the person would have wanted should be respected as much as possible and effective safeguards should be put in place (for example, the right to be heard and an adequate right to appeal).[64] These

[61] Visit to Liechtenstein, CPT/Inf (2017) 21 §80-8; Visit to San Marino 2013, CPT/Inf (2014) 33, §57.

[62] Visit to San Marino, CPT/Inf(2008)9, §57.

[63] Visit to Liechtenstein, CPT/Inf (2017) 21 §80-8; Visit to San Marino 2013, CPT/Inf (2014) 33, §57; Visit to France 2015, CPT/Inf (2017) 7, §173-174.

[64] R(99)4 of the Committee of Ministers of the Council of Europe on principles concerning the legal protection of incapable adults (23 February 1999), CM/R(99)4.

principles are not only further operationalized by the abundance of ECtHR jurisprudence,[65] but are also covered in the CPT country reports themselves. These country reports give a clear view of how to deal with the issue of representation in long-term care. Without giving an exhaustive overview (see Opgenhaffen, 2020a) it is clear that the CPT pays particular attention to the independence and active involvement of the representative.[66] The CPT therefore treats (personnel of) care facilities acting as representatives with notable suspicion,[67] especially if this occurs automatically.[68] In addition, the representation must be effective, meaning that the representative must be involved in the decision-making process.[69] The facility has the task of reporting ineffective representatives — for example, if a representative is no longer fulfilling their duties — to the competent authority.[70] In addition, representatives should be under the supervision of the relevant member state, which has a duty to protect individuals against the arbitrary actions of representatives. This protection must go beyond an (often theoretical) right to independent access to justice; periodic review and automatic revision should be in place.[71]

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[65] For example: ECtHR 22 November 2012, nr. 23419/07, Sýkora/Czech Republic.

[66] Examples: Visit to Lithuania, CPT/Inf(2009)22, § 127; Visit to Latvia, CPT/Inf(2009)35, § 135; Visit to Poland, CPT/Inf(2011)20, § 167; Visit to Bulgaria from 18 to 29 October 2010 (15 maart 2012), CPT/Inf(2012)9, § 206.

[67] Examples: Visit to Lithuania, CPT/Inf(2009)22, § 127; Visit to Latvia, CPT/Inf(2009)35, § 135; Visit to the Slovak Republic, CPT/Inf(2006)5, § 77; See specifically in a country report on restraints: Visit to Bosnia and Herzegovina, CPT/Inf(2009)25, §136; Also see on the level of the ECtHR: ECtHR 22 January 2013, nr. 33117/02, Lashin/Russia, § 117 and ECtHR 17 January 2012, nr. 36760/06, Stanev/Bulgaria, § 214.

[68] Visit to Lithuania, CPT/Inf(2009)22, § 127; Visit to Armenia, CPT/Inf(2011)24, § 165.

[69] Visit to Kosovo, CPT/Inf(2011)26, § 91.; See specifically in a country report on restraints: Visit to the Czech Republic (CPT/Inf(2007)32, §136.

[70] Visit to the Republic of Macedonia, CPT/Inf(2012)4, § 145; Visit to the Republic of Macedonia, CPT/Inf(2016)8, § 184. Visit to Kosovo, CPT/Inf(2009)3, § 132; Visit to Serbia, CPT/Inf(2009)1, § 132.

[71] Visit to the Republic of Macedonia, CPT/Inf(2012)4, § 145; Visit to the Republic of, CPT/Inf(2016)8, § 183; Also see ECtHR 22 November 2012, nr. 23419/07, Sýkora/Czech Republic, § 67; ECtHR 22 JanuarY 2013, nr. 33117/02, Lashin/Russia, § 79.

The section on legal capacity and substitute decision making in CPT reports is, however, different from that on the use of means of restraint. The link between the two sections is rarely made,[72] which again leads to a situation in which the framework is clear but the link between this framework and the application of means of restraint is not clear. One can imagine that the CPT's recommendations on legal capacity and substitute decisions should be combined with the CPT standard as far as possible, but precisely what that means remains unclear. Some (but by no means the only) examples of this are how often the measure should be reassessed, how monitoring should take place and to what extent the patient's resistance to the measure plays a role.

4. Conclusions

This contribution has analysed the CPT's approach to means of restraint in psychiatric and disability care in cases without acute danger. We took the CPT standard on the use of means of restraint in psychiatric care as the starting point. This standard specifies that means of restraint may only be applied exceptionally and briefly if violent patients endanger themselves or others, and if all alternatives have failed. Other criteria for application (for example, punishment or the convenience of staff) as well as prolonged application are rejected. This standardized approach, in which means of restraint may only be used in cases of acute danger, does not correspond to practices where restraint is also used for other reasons.

The CPT is rarely explicit about this, but seems to accept the use of restraint under certain conditions. What these conditions are, is not fully clear from the country reports. Using clues from the country reports and general principles of human rights applied by the bodies of the Council of Europe, this contribution has tried to assess as far as possible what criteria and legal safeguards could apply. To do so, we made a distinction between the preventive application of means of

[72] For rare but still implicit examples see Visit to Bosnia and Herzegovina, CPT/Inf(2009)25, §136 and Visit to the Czech Republic (CPT/Inf(2007)32, §136; Visit to Liechtenstein, CPT/Inf (2017) 21 §80-8.

restraint (in the interest of order and safety in the facility) and the protective application of means of restraint (in the interest of patients' health). For each of them, we distinguished between use under coercion and use with consent.

Except in the case of preventive use with consent, it was always possible to formulate some recommendations. In the case of preventive coercive application, the recommendations are taken from the country reports themselves; in the case of protective coercive application, they are taken from the rules on coercive medical treatment; in the case of protective application of means of restraint with consent, the rules on informed consent served as a guideline. With regard to the latter, representation and substitute decision-making in case of mental incapacity deserve special attention.

We note that there are several sources that can give some direction, and that when supplemented with broader human rights principles, some guidance is possible. However, the CPT approach remains a patchwork, in which the level of detail appears to vary from one country report to another and no general recommendations are given. As a consequence, patients subject to means of restraint for other reasons than mentioned in the CPT standard are far less protected. The CPT standard seems to suggest that these uses are not allowed, while the CPT country reports implicitly approve them, while seldom being explicit about the criteria and safeguards. Moreover, if reports are explicit, the question arises of whether they can be generalized. Not only is the variety of use within preventive and protective application of means of restraint greater than in acute situations, but also each observation on site is different and the composition of the visiting panel is not always the same. With a view to generalization, the broader human rights framework can provide some direction, but often does not lead to practical recommendations. To safeguard the rights of patients, it is desirable for the CPT to be more explicit regarding other reasons for the application of restraint and the criteria and safeguards that apply, both in country reports and in the CPT standards.

Lastly, we would like to emphasize that in addition to this call to the CPT, a more fundamental debate looms on the horizon: to what extent are means of restraint acceptable at all? That debate — which

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is not the subject of this contribution — is driven by the UN Convention on the Rights of Persons with Disabilities. Indeed, it goes without saying that the principles used by the CPT are contrary to the UN Convention as interpreted by the UN Committee on the rights of persons with disabilities; not only when they are applied under coercion, but also when the application takes place based on the decision of a representative (McSherry, 2017; Opgenhaffen, 2020b).

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References

**Human rights documents are cited in footnote.

Arstein-Kerslake, A. & Flynn, E. (2016) The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: a roadmap for equality before the law. *The International Journal of Human Rights*, 20(4), 471-490, DOI: 10.1080/13642987.2015.1107052.

Bak, M., Weltens, I., Bervoets, C., De Fruyt, J., Samochowiec, J., Fiorillo, A., Sampogna, G., Bienkowski, P., Preuss, W. U., Misiak, B., Frydecka, D., Samochowiec, A., Bak, E., Drukker, M., & Dom, G. (2019). The pharmacological management of agitated and aggressive behaviour: A systematic review and meta-analysis. *European psychiatry : the journal of the Association of European Psychiatrists*, *57*, 78–100. https://doi.org/10.1016/j.eurpsy.2019.01.014.

Borckardt, J. J., Madan, A., Grubaugh, A. L., Danielson, C. K., Pelic, C. G., Hardesty, S. J., Hanson, R., Herbert, J., Cooney, H., Benson, A., & Frueh, B. C. (2011). Systematic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital. *Psychiatric services (Washington, D.C.)*, *62*(5), 477–483. https://doi.org/10.1176/ps.62.5.pss6205_0477.

Bowers, L., James, K., Quirk, A., Simpson, A., SUGAR, Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International journal of nursing studies*, 52(9), 1412–1422. https://doi.org/10.1016/j.ijnurstu.2015.05.001.

Cannella-Malone, H. I., O'Reilly, M. F., Sigafoos, J., & Chan, J. M. (2008). Combined Curricular Intervention with Brief Hands Down to Decrease Hand Mouthing and the Use of Arm Splints for a Young Boy with Profound Disabilities. Education and Training in Developmental Disabilities, 43(3), 360–366.

Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review. *Frontiers in psychiatry*, 10, 491. https://doi.org/10.3389/fpsyt.2019.00491.

Day, A., Daffern, M. & Simmons, P. (2010) Use of Restraint in Residential Care Settings for Children and Young People. *Psychiatry, Psychology and Law*, 17(2), 230-244. https://doi.org/10.1080/13218710903433964.

Kumble, S. & McSherry, B. (2010). Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective. *Psychiatry, Psychology and Law*, 17(4), 551-561. https://doi.org/10.1080/13218719.2010.482917.

Lyons, D. (2015). Restraint and Seclusion of Students with Disabilities, *The International Journal of Children's Rights*, *23*(1), 189-239. https://doi.org/10.1163/15718182-02301009.

McSherry, B. (2017). Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities. *International journal of law and psychiatry*, *53*, 39–44. https://doi.org/10.1016/j.ijlp.2017.05.006.

Nielson, S., Bray, L., Carter, B., & Kiernan, J. (2021). Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. *Journal of Child Health Care*, 25(3), 342–367. https://doi.org/10.1177/1367493520937152.

Opgenhaffen, T. (2020a). *Vrijheidsbeperkingen in de zorg*. Intersentia.

Opgenhaffen, T. (2020b). Deprivation of Liberty in Care. An ECHR and CRPD Approach and its Consequences for Belgium. European journal of health law, 27(2), 147–167. https://doi.org/10.1163/15718093-BJA10003.

Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O. P., Kautiainen, H., & Tiihonen, J. (2013). Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. *Psychiatric services (Washington, D.C.)*, *64*(9), 850–855. https://doi.org/10.1176/appi.ps.201200393.

Sailas, E., & Fenton, M. (2000). Seclusion and restraint for people with serious mental illnesses. *The Cochrane database of systematic reviews*, *2000*(2), CD001163. https://doi.org/10.1002/14651858.CD001163.

Scheithauer, M., O'Connor, J., & Toby, L. M. (2015). Assessment of self-restraint using a functional analysis of self-injury. *Journal of applied behavior analysis*, *48*(4), 907–911. https://doi.org/10.1002/jaba.230.

Weeden, M., Mahoney, A., & Poling, A. (2010). Self-injurious behavior and functional analysis: where are the descriptions of participant protections?. *Research in developmental disabilities*, *31*(2), 299–303. https://doi.org/10.1016/j.ridd.2009.09.016.

Weissbrodt, Madeira, W., Stewart, D., & Dikel, W. (2012). Applying International Human Rights standards to the restraint and seclusion of students with disabilities. *Law & Inequality*, 30(2), 287.

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