Department of Health & Social Care

Mental Health Units (Use of Force) Act 2018 statutory guidance

Government response to the consultation

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Ministerial foreword

As Minister for Care and Mental Health, I am committed to ensuring that every individual in a mental health unit is treated with dignity and in a caring therapeutic environment free from abuse. For too long the use of force has been accepted as the norm in many mental health services. We know that there is an over-reliance on the use of force in mental health units and that certain groups, such as people from black and minority ethnic groups, are more likely to have force used against them.

We are committed to ensuring that everyone, regardless of their background, has access to the right mental health support and the Mental Health Units (Use of Force) Act 2018 represents a significant step towards in addressing these inequalities. It is clear the focus needs to shift to one which respects all patients' rights, provides skilled, trauma-informed, person-centred care, follows the principle of least restriction and promotes recovery. While we continue to make progress in improving the patient experience within mental health services, we know that more needs to be done to reduce the use of force.

The Mental Health Units (Use of Force) Act 2018 (the Act), also known as Seni's Law, is named after Olaseni Lewis, who tragically died as a result of being forcibly restrained whilst he was a voluntary patient in a mental health unit. Whilst nothing can ease the pain of Seni's family and friends, I am determined that we learn the lessons from these tragic events to ensure that no other family need experience the same devastating loss.

The purpose of the Act is to clearly set out the measures which are needed to both reduce the inappropriate use of force and ensure accountability and transparency about the use of force in mental health units.

The statutory guidance sets out how we expect mental health units to meet the requirements of the Act. Commencing the Act, and publishing the statutory guidance is part of the Government's wider reform agenda to improve support for individuals with severe mental illnesses, including our work in reforming the Mental Health Act 1983, which will ensure that people have greater control over their treatment and receive the dignity and respect they deserve.

Development of the statutory guidance has involved extensive engagement across a wide range of stakeholders, including Aji Lewis and Seni's family. Through this consultation and policy work we have also engaged with people who have personal experience of being an inpatient in a mental health unit, their families and carers, the voluntary and charitable sector, regulators, the NHS and professional bodies.

Responses to the consultation were largely positive, and I would like to thank all those who have taken the time to respond.

I am pleased that alongside the publication of this government response to the consultation, we are making commencement regulations and publishing the final statutory guidance. The majority of the provisions within the Act will then come into force in March 2022.

Gillian Keegan

Minister of State for Care and Mental Health

Executive summary

Overview

The Government is clear that the use of force should only ever be proportionately and as a last resort, when all attempts to de-escalate a situation have been employed.

The Mental Health Units (Use of Force) Act gained Royal Assent in November 2018. Commonly known as Seni's Law, it is named after Olaseni Lewis who died in September 2010 as a result of being forcibly restrained whilst he was a vulnerable voluntary patient in a mental health unit.

The aim of Seni's Law is to clearly set out the measures which are needed to both reduce the inappropriate use of force and ensure accountability and transparency about the use of force in our mental health units. This must be in all parts of the organisation, from Executive Boards to staff directly involved in patient care and treatment.

The statutory guidance issued by the Department of Health and Social Care is intended for use by NHS hospitals and independent hospitals (providing NHS funded care) in England who provide care and treatment to patients with a mental disorder. It provides the information they need about how they should meet the legal obligations placed on them by the Act, in addition to best practice advice. The guidance also covers the obligations on police officers when in mental health units in England.

We ran a public consultation on the draft statutory guidance, and all responses were welcomed, especially from those who have personal experience of the use of force in a mental health unit. This response to the consultation sets out what respondents have said about the draft statutory guidance.

Public consultation

We ran a 12-week public consultation, receiving more than 400 responses. In parallel to the consultation, Colourful Minds and the Restraint Reduction Network (RRN) held workshops and webinars to get richer insights from service users, clinicians, and those with personal experience of the use of force in mental health units, about the clarity, content and approach of the draft statutory guidance.

Overall, there was broad agreement that the statutory guidance clearly sets out the requirements of the Act for mental health units and the majority of respondents agreed that the guidance seeks to reduce and minimise the use of force in mental health units. Some of the questions regarding the development of the guidance are complex issues, and we

are grateful for the constructive and insightful input we have had from stakeholders.

Some respondents raised concerns around the type of settings the Act applies to and made suggestions that the Act should apply to Accident and Emergency (A&E) departments and Section 135/136 suites. We understand the concerns raised with the use of force in different settings, however, they remain out of scope of the Act, which only applies to mental health units that provide inpatient treatment.

The majority of respondents agreed with the appointment of a ‘responsible person’ who will ensure that mental health units comply with the requirements of the Act, but some concerns were raised about accountability and monitoring of this person.

Additionally, some respondents asked for a stronger focus on learning disabilities and autism, in particular with regards to training for staff in this area. We are aware that there are particular considerations and sensitivities involved in caring for autistic people and people with learning disabilities. We will work closely with NHS England and NHS Improvement to ensure services are ready to implement the new guidance and reduce the inappropriate use of force.

The majority of individual respondents disagreed that the duty to keep a record should not apply if the use of force is considered negligible within the circumstances set out in the draft statutory guidance. Many respondents felt that all instances in which force is used should be recorded for the protection of both patients and staff. Several respondents felt that the term ‘negligible force’ lacks clarity and is open to a variety of interpretations, with many not certain on what constituted ‘negligible use of force’.

Lastly, the majority of respondents agreed that the statutory guidance emphasises the importance of involving patients, their families and carers in decisions about their own care in mental health units. Several felt that there was insufficient detail on how to implement this guidance, such that it could be open to interpretation. We have revised the guidance to provide the further detail respondents required, details of which are set out in this response.

Next steps

Alongside the publication of the government response to the consultation, we are making commencement regulations in December 2021. In line with administrative good practice, the provisions specified within this legislation will subsequently be brought into force on 31 March 2022, to allow reasonable time for services to prepare for the provisions in the Act. We will continue to work with the Home Office, British Transport Police, the Care Quality Commission, NHS Digital and NHS England and NHS Improvement to finalise system readiness for the final set of requirements to be commenced in May 2022.

The consultation response represents an important step in developing the statutory guidance and ensuring that mental health providers have the necessary directions to applying the Act and thus, the tools to reduce the inappropriate use of force. The aim of the Act is to reduce the use of force on all patients, but in particular, we aim to reduce the disproportionate use of force on groups who share protected characteristics under the Equality Act 2010.

This Act, in parallel with the work being undertaken through the NHS Long Term Plan to expand and transform mental health services, and to invest an additional £2.3 billion a year by 2023/24, will see people receive the right mental health support in the community, and improvements to patient experience where admission to hospital is required.

This Act also represents an integral part of our wider reforms to the mental health system. In addition to commencing the Mental Health Units (Use of Force) Act 2018, we are working to reform the Mental Health Act 1983, to give people greater control over their treatment and help ensure they receive the dignity and respect they deserve. We will work to build the necessary infrastructure to support the roll out of a number of reforms, and work to promote practical and cultural change across the system, through such initiatives as the Quality Improvement Programme and the Patient and Carer Race Equality Framework.

Introduction

The Government is committed to ensuring every individual admitted to a mental health unit is treated with dignity and respect and in a caring therapeutic environment which is free from abuse.

We know that for people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. The Government is clear that the use of force should only ever be used proportionately and as a last resort, when all attempts to de-escalate a situation have been employed.

The purpose of the Mental Health Units (Use of Force) Act 2018 is to reduce the inappropriate use of force and increase the oversight and management of the use of force in mental health units. The Government will also publish statutory guidance on the use of force in mental health settings for NHS organisations in England, and police forces in England and Wales to ensure that mental health trusts are able to reduce instances of inappropriate use of force.

We ran a public consultation on the draft statutory guidance and worked closely with stakeholders who held workshops and focus groups on the guidance. We have carefully considered all responses received, especially from those who have personal experience of the use of force in a mental health unit.

This response sets out what we heard from the consultation on the draft statutory guidance, our response to the points raised, and how we have taken on board feedback as we developed the final statutory guidance, published alongside this consultation response. We will continue to engage stakeholders as we commence the Act and work closely with NHS England and NHS Improvement to ensure services understand their duties and responsibilities in relation to the use of force in mental health units.

How we consulted

This section sets out how we consulted on the Mental Health Units (Use of Force) Act 2018 draft statutory guidance, who responded and who we consulted. The public consultation ran for 12-weeks.

It comprised of:

- an online consultation, open to anyone of any age
- an easy read version of the consultation, open to anyone of any age
- workshops run by Colourful Minds consulting staff working in mental health services, and those with personal experience of mental health services and the use of force from black and minority ethnic backgrounds

We would like to thank everyone who participated in the consultation for their time and thoughtful input. We would also like to thank the Restraint Reduction Network (RRN) for facilitating a webinar with their membership (including people with personal experience, patients, carers and families, and health professionals) to discuss the negligible use of force.

Who responded?

We received an excellent response to the public consultation from individuals and organisations, totalling 421 responses overall. This was made up of 378 responses (90%) received through the main online consultation and 43 responses (10%) to the easy read consultation. We also received 8 email responses and, as a result of not following the same format as the main consultation, these have not been included in the percentage figures.

For the main online consultation and easy read, around a quarter of all respondents left blank or empty responses, with 87 (21%) left blank overall.

The easy read version of the consultation asked questions in a similar enough way to the main consultation and responses from both sources have been combined across most questions in the analysis. The majority of email responses have not followed the main consultation standard format and so were considered separately from the main consultation.

Each response is taken on face value in that there is no weighting to account for where a response might reflect multiple individuals or organisations.

Totals of percentages may not sum to 100% due to rounding. Additionally, percentages have been based on completed responses, to which blank responses have been removed.

In parallel to the consultation, Colourful Minds ran two separate 2.5 hour focus groups: one with eight people with personal experience of use of force in a mental health unit and a second with ten members of staff, who have either used force or witnessed the use of force in a mental health unit. The RRN also ran a webinar that was attended by 156 people.

Summary of responses

Response type	Number	Percentage
Main response, complete	275	65%
Main response, blank	81	19%
Main response, individual or organisation only*	22	5%
Easy read, complete	36	9%
Easy read, blank	6	1%
Easy read, individual or organisation only*	1	0%

Summary of responses by format

Response format	Number	Percentage
Main response	378	90%
Easy read	43	10%

Summary of all responses, by completeness

Response type	Number	Percentage
Total complete responses	311	74%
Total blank, or individual or organisation only*	110	26%

* only answered the question on if the response was from an individual or organisation

Who did we consult?

The consultation was published on GOV.UK. We drew the consultation to the attention of individuals, organisations and groups that we expected would have an interest in the statutory guidance.

We received 334 online responses from individuals. The majority of online individual respondents were female (70% of individual responses). Nearly 15% of the responses were from black, Asian and ethnic minority groups and 25% of respondents considered themselves to be disabled. Of the online responses received, 26% of respondents indicated they had personal experience of the use of force in a mental health unit.

We also received 63 online and email responses from various organisations. These organisations spanned a wide range of sectors including charity and non-Government, experts in the field of restrictive interventions, people with personal experience and regulators. More information on the breakdown of respondents is included in the annex of this response.

What you said

Overview

The following sections provide a summary of how people responded to the Mental Health Units (Use of Force) Act 2018 draft statutory guidance consultation questions. We have grouped the comments we received from people who responded to our consultation and we have presented these as broad themes for each consultation question. This section will largely follow the structure of:

- consultation question relating to a particular section of the statutory guidance
- responses to consultation question
- next steps

For the majority of questions in this consultation, the overall response was the same whether responding as an individual or organisation. Where there are differences between responses received from individuals compared to organisations, we have presented this. We have not assigned a weighting where a response might reflect multiple individuals or organisations. Please note that percentages reported in this section will not always add up to 100% due to rounding.

Key definitions (section 1)

Consultation question 1

The statutory guidance sets out some of the key terms used in the Act and explains that the Act applies to mental health units, including both NHS and independent hospitals providing NHS funded care.

The terms in the Act which are defined in the guidance include:

- ‘Mental Disorder’
- ‘Mental Health Unit'
- ‘Use of force’
- ‘Physical restraint’

- ‘Mechanical restraint’
- ‘Chemical restraint’
- ‘Seclusion’
- ‘(Long-term) segregation’

Is the guidance clear on what is meant by each of the terms?

What you told us in the consultation

The majority of respondents agreed that the guidance was clear on each of the terms specified in section 1 of the statutory guidance, whether responding as an individual or as an organisation.

68% of individuals and 55% of organisations agreed that the guidance was clear on each of the terms. Overall, 66% of responses agreed with the definitions of the terms; while 10% disagreed; and 8% were not sure.

Points raised from those who commented included:

'Mental Disorder':
Some responses detailed the need to have further clarity on what is meant by ‘Mental Disorder’ as they felt it can be too broadly interpreted. Points were raised in relation to whether autism and learning disabilities were covered as part of ‘Mental Disorder’. It was highlighted that this should be made clearer in the statutory guidance.

'Mental Health Units':
A few responses highlighted that they felt the definition of ‘Mental Health Units’ was unclear and should have been signposted sooner in the guidance.

'Use of Force':
Responses which focused on the definition of ‘use of force’ wanted better clarity around application of the concept. It was emphasised that it would be helpful to define appropriate force and widen the application of ‘use of force’ to different settings.

“Members feel that the definition of ‘use of force’ would benefit from the inclusion of direction around the ‘type of force' used, in relation to the age and cognitive development of the person.”

Royal College of Nursing

Restraint types:
Individuals found it challenging to distinguish between physical, chemical and mechanical restraint. It was stated that the definitions of the restraint types (physical, chemical and mechanical) were clear for clinicians but needed to be more accessible to a wider audience, including support workers. More specifically, some respondents felt confused by the distinction between chemical and mechanical as actions in relation to these restraints can overlap. Some respondents felt this section would benefit from having specific examples, so individuals are able to differentiate between the two restraint terms and to understand what restraint methods are permitted. Additionally, several respondents recommended defining ‘rapid tranquilisation’.

“Trusts have made some suggestions as to how to clarify some of the terms used in the Act. These include defining chemical and mechanical restraint in greater detail to better illustrate all the forms these take, for example, rapid tranquilisation, night-time sedation, and hypnotic medication. Some have suggested it might also be helpful to add ‘short-term' segregation to this section of the guidance, and that the definition of seclusion' can include ‘open-door' seclusion.”

NHS Providers

'Seclusion' and '(Long-term) Segregation':
Many respondents felt there needs to be a better distinction between seclusion and segregation, with many querying when seclusion becomes segregation and what timeframe is indicative of each.

On seclusion, it was highlighted that the definition of ‘seclusion’ should include ‘open-door’ seclusion which is currently used and recorded by providers.

On segregation, it was stated that ‘short-term’ segregation is also currently being used as a form of isolation which is recorded as restrictive practice. Additionally, given children’s developmental needs, it was also recommended that the guidance distinguishes between children and adults in its definition of ‘long-term’ in ‘(long term) segregation’.

Next Steps

We have sought to incorporate the feedback received from the consultation where appropriate to ensure definitions are sufficiently clear to enable the practical application of the Act. We have added to the definitions of the restraint types in the guidance and provided references to other laws and guidance which look to further illustrate the

definitions. We have also included more detail on the settings which are or are not within the scope of the Act, such as Section 135/136 suites where they are located within a mental health unit.

Consultation question 2

Is the guidance clear about what settings the Act applies to?

What you told us in this consultation

The majority of respondents agreed that the guidance was clear about what settings the Act applies to, whether responding as an individual or as an organisation.

68% of individuals and 40% of organisations agreed that the guidance was clear about what settings the Act applies to. Overall, 63% of responses agreed the guidance was clear; while 7% disagreed; and 10% were not sure.

Points raised from those who commented included:

Independent settings:
Some respondents were unclear as to whether the Act applied to independent hospitals, particularly highlighting the ambiguity around whether the Act applies to the entire inpatient population where NHS-funded care is provided, or only to a cohort of patients specifically funded by the NHS.

Special educational settings:
Some respondents were unclear if special education settings, like residential schools, were included in the scope of the Act. There was a strong indication that respondents wanted this setting added if not already included. It was recommended that the guidance should make it clear if this setting is included or not.

Acute hospitals and A&E:
Many respondents felt the guidance did not make clear how and if the Act applied in acute hospital settings. It was requested that A&E departments are added to the settings the Act applies to.

Concerns raised about the exclusion of A&E departments and why it should be included were detailed as:

- it is a place of safety under the Mental Health Act 1983

- the UK Government proposes to extend Mental Health Act 1983 section 5 holding powers to A&E departments

It was emphasised that the exclusion of places of safety (like A&E) from the Act would have a disproportionate impact. It was detailed this is because black people are more likely than white people to come into contact with services via the police.

Mental Health Act 1983 Section 135/136 Suites:
A large proportion of respondents highlight that the use of force is often used in Section 135/136 suites and questioned why these were omitted from the Act or guidance. Many respondents felt it was unfair to exclude this setting and requested a "whole system approach" by asking for the addition of Section 135/136 suites.

> "We would like to see the guidance be expanded outside of the defined Mental Health Units to cover 135 and 136 and A&E for example as we experience the Use of Force, at times, in these areas of care delivery."
>
> Sheffield Health and Social Care NHS Foundation Trust

Care homes:
Some respondents were not clear if the Act applied to those living in residential settings or care homes. If not applicable, respondents would value knowing the reason behind the decision to omit this setting from the Act or guidance.

Next Steps

All responses have been carefully considered in relation to the inclusion and addition of further settings.

As the Act has already been passed and we are confined by its terms, it will remain legally applicable to only Mental Health Units which fall within the definition set out in the Act and as described in the statutory guidance as a health service hospital or independent hospital in England (or part thereof) that provides treatment to inpatients for a mental disorder.

Section 135/136 suites that are outside of a mental health unit are excluded from the Act as they do not come within the definition of providing treatment to inpatients for mental disorders. However, this would not rule out any unit that does meet the definition under the Act of a 'Mental Health Unit' that is also being used for suite 135/136 assessments in addition to its purpose to provide treatment to inpatients for mental disorders.

Other settings such as care homes and residential settings are out of scope of the Act as they do meet the definition set out in the Act.

Mental health units to have a responsible person (section 2)

Consultation question 3

The Act states that a health organisation operating a mental health unit must appoint a 'responsible person' to ensure that the organisation complies with the requirements of the Act.

The statutory guidance specifies that:

- this must be a member of staff at an appropriate level of seniority
- the responsible person should attend appropriate training in the use of force
- where the health organisation or trust operates more than one mental health unit, the same responsible person must be appointed in relation to all of the mental health units

Is it clear what the role of the “responsible person” is?

What you told us in this consultation

The majority of respondents agreed that the guidance was clear about the role of ‘responsible person’, whether responding as an individual or as an organisation.

66% of individuals and 58% of organisations agreed that the guidance was clear about the role of ‘responsible person’. Overall, 64% of responses agreed the role was clear in the guidance; while 8% disagreed; and 8% were not sure.

Points raised from those who commented included:

Training or experience:
Respondents have strongly agreed that the ‘responsible person’ should receive appropriate training on the use of force. It was suggested that the nature of the training should be standardised. Some respondents felt that the use of ‘appropriate training’ is vague and the guidance should make clear what training is required.

Respondents also have stated that it would be useful to have specific examples detailing what level of experience is required, relevant clinical background and what qualification or professional membership the ‘responsible person’ should have. Moreover, respondents felt that a competency framework should be developed for this role, one that is specific to the type of unit, patient population and community which the ‘responsible person’ will be accountable for.

"The guidance would be strengthened by specifying that the responsible person should have a relevant clinical background, be a member of the appropriate professional organisation and have experience of working in clinical care roles where restraint had been used. It would also be helpful to include more on the skills and experience necessary in the role and to require a cultural understanding of the community served by the provider."

The Care Quality Commission

More detail:
Many comments related to requesting additional detail on the accountability of the 'responsible person' and how this will be monitored. Several respondents felt the guidance should include clearer parameters of the role of the 'responsible person', including job details and specific responsibilities. It was also highlighted that it would be beneficial to include what the consequences would be if organisations and the 'responsible person' are failing to comply with the Mental Health Units (Use of Force) Act 2018 and statutory guidance or if they did not follow the duty to have a 'responsible person'.

"It should be clearer what the consequences of not following the Use of Force Act and statutory guidance is for the responsible person and staff throughout the organisation."

The Challenging Behaviour Foundation and Mencap

Next Steps

We have acknowledged requests for further guidance on the role and training of the "responsible person". We have included further details in the guidance on the skills and experience required by the responsible person, such as experience in clinical roles where the use of force has been used, and requiring the responsible person to have previous experience in children and young people's services if they work in a children and young people's mental health unit. However, we believe there should be flexibility for mental health units to tailor the role of their "responsible person" in line with their services, community and patient population.

Consultation question 4

Is it clear the level of seniority the "responsible person" must have?

What you told us in this consultation

The majority of respondents agreed that the guidance was clear about the level of seniority that the responsible person must have whether responding as an individual or as an organisation.

48% of individuals and 55% of organisations agreed that the guidance was clear about the level of seniority that the ‘responsible person’ must have. Overall, 49% of responses agreed the guidance was clear; while 23% disagreed; and 9% were not sure.

Points raised from those who commented included:

Level of seniority:
Many respondents agreed that the ‘responsible person’ must be of an ‘appropriate level of seniority’. However, of those who disagreed some felt that the ‘level of seniority’ was unclearly defined in the guidance. It was specified that the guidance would benefit from explicitly stating what is meant by ‘appropriate’ and a definition of ‘level of seniority’.

Some respondents felt that the ‘responsible person’ should be appointed on the basis of relevant clinical experience as opposed to the ‘level of seniority’.

Delegation of role:
Respondents have welcomed the clarification in the guidance that, where a ‘responsible person’ delegates some of their functions, they retain overall accountability for all the functions. However, there are some concerns around the tasks associated with the ‘responsible person’ being primarily delegated down instead of being mainly kept at a senior level, and that the delegated tasks are not upheld to the same standard. It has been recommended that the guidance makes clear the accountability of the ‘responsible person’ and person’s delegated to, and that they are responsible for upholding required standards for the delegated tasks.

Moreover, some respondents have highlighted that the delegated staff should be required to attend the same training as the ‘responsible person’ and receive the same guidance surrounding their role and responsibilities.

> “We recommend that some parts of the policy response are not delegated. Particularly understanding why use of force happens in the Trust and developing a wider action plan to reduce the appropriate use of force and irradicate inappropriate use of force”
>
> Colourful Minds

Next Steps

All comments have been welcomed and have been carefully considered in relation to the Act and its application. The statutory guidance has been amended to explicitly state that the “responsible person” must be an Executive board member, and as previously noted have included further detail in relation to the required skills and experience.

We have made it clear in Section 10 of the guidance that the delegation of a function does not affect the responsibility of the responsible person for the exercise of the functions under the Act.

Policy on use of force (section 3)

Consultation question 5

The statutory guidance sets out that the responsible person must publish and keep under review a policy regarding the use of force on patients by staff who work in the mental health units run by that organisation. The guidance specifies what the policy should include (as a minimum) and the considerations should be taken into account when drafting and publishing the policy, including the importance of consultation with people with lived experience.

Does the guidance clearly explain what a policy on use of force should include?

What you told us in this consultation

The majority of respondents agreed that the guidance clearly explained what a policy on use of force should include whether responding as an individual or as an organisation.

55% of individuals and 49% of organisations agreed that the guidance clearly explained what a policy on the use of force should include. Overall, 54% of responses agreed the guidance was clear; while 13% disagreed; and 11% were not sure.

Points raised from those who commented included:

Policy:
Many respondents welcomed that the guidance noted that it is essential that all policies reflect the needs of the patient population using the services and are tailored precisely to the services provided.

Text changes:
A number of respondents requested that the wording on section 3, relating to the 'responsible person' needing to only "consult with whoever they consider it appropriate to consult", be changed or removed. This is because respondents felt that this wording leaves room for the 'responsible person' to neglect consulting widely with patients, their families and carers on the policy if not deemed appropriate.

De-escalation:
Many respondents felt that the guidance should state that organisational policies must place emphasis on diversion techniques and de-escalation to avoid the use of force. It was suggested that de-escalation examples should be signposted in organisational policies on the use of force.

Co-production:
Many respondents have welcomed the inclusion of measures to co-produce the policy with patients, their families and carers. However, some respondents felt this wasn't clearly set out in the guidance. These respondents suggest that a stronger emphasis should be placed in the statutory guidance to ensure those with personal experience and their families are involved in the co-production of policies, but also play a key role in providing feedback through the lifetime of the policy. Additionally, it has been suggested that patient safety committees or groups are considered when reviewing the policy to ensure patient voices are captured.

> "We're concerned that, despite the content about the importance of coproduction, the guidance leaves latitude for the responsible person not to consult with current and former patients, bereaved families, and any relevant local third sector organisations."
>
> MIND

Additions to the policy:
Many respondents have felt the guidance should include how often policies on the use of force should be reviewed and what the consequences are for inappropriate use of force. Additionally, some respondents also felt it would be beneficial to have a universal standard template for the policy in order to have consistency across units. Likewise, a small number of respondents specified that it would be useful to state in the guidance that policies on the use of force should include instructions on complaints procedures for patients, carers and independent advocates to raise issues.

Furthermore, some respondents stated the guidance should be changed to make it a requirement, instead of "good practice", for post-incident review data, investigation and

inquest findings and coroner's prevention of future death reports to be analysed to regularly update the policy on use of force.

Moreover, respondents have also requested that it should be made explicit that policies should be tailored to people from black and minority ethnic backgrounds needs.

Next Steps

Appeals for clarity have been factored into the revised statutory guidance, and requests for additional requirements for the policies on the use of force have been considered.

We have included more detail on things which should be included within the policy, such as ending the disproportionate use of force and discrimination against people sharing certain protected characteristics under the Equality Act 2010, and that staff have a duty to be alert to abuse and the misuse of force and report it. In addition, we have explicitly referenced that the policy should acknowledge the impact the use of force has on staff and how they can be supported, and that the policy should include details of the roles and responsibilities of staff and the police if the police are called into a mental health unit to assist staff in the management of a patient. In addition, organisations have a duty under the Mental Health Act 1983: Code of Practice to support patients and their nearest relative to make complaints. Therefore, we have looked to explicitly state in the guidance that the policy on the use of force must include the organisation's complaints procedure.

We welcome the fact that the majority of respondents agree that policies on the use of force should be reflective of the patient population, service provider and the community where it resides. Though we are unable to provide specific sections under each heading relating to different patient populations, we have been clear that all policies should be inclusive and tailored to its users.

Information about use of force (section 4)

Consultation question 6

The statutory guidance sets out the statutory duty to publish and provide patients, and other people considered appropriate, with information about the use of force and the patient's rights in relation to the use of force which may be used by staff in a mental health unit. This section of the guidance sets out what this information is expected to include (as a minimum), who should be consulted in its development and how it should be disseminated. This includes the expectation for responsible persons to take whatever steps are reasonably practicable to make sure patients are aware of the information and understand it.

Does the guidance clearly explain what information should be given to patients on the use of force?

What you told us in this consultation

The majority of respondents agreed that the guidance clearly explains what information should be given to patients on the use of force, whether responding as an individual or as an organisation.

54% of individuals and 56% of organisations agreed the guidance clearly explains what information should be given to patients on the use of force. Overall, 54% of responses agreed the guidance was clear; while 13% disagreed; and 11% were not sure.

Points raised from those who commented included:

Use of standard templates:
A few respondents highlighted that it would be beneficial to have a national standard template for the information that needs to be shared with patients to avoid variability in how and what information is provided.

Patient accessibility and modes of delivery:
Several respondents expressed their concerns about how the information on the use of force would be delivered to patients, as it was not explicitly addressed in the guidance. Many relayed that the information must be provided in various accessible formats in order to ensure the information was accessible and correctly understood by patients. It was requested the information is accessible in multiple languages, including British Sign Language and Makaton; have multiple modes of delivery, including verbal communication and written communication through printed hardcopies and online accessible versions; and should be age and developmentally appropriate, particularly for children and young people. Some respondents also suggested that there should be a stronger focus in the guidance on the role of an independent advocate, particularly in the communication of information on the use of force to patients.

“Support people's communication and information needs in line with NHS England's Accessible Information Standard. This could also include:

- Seeking advice from, or referring people to, a speech and language therapist whenever needed.

- Providing an independent interpreter (that is, someone who does not have a relationship with the person) so that people can communicate in their first language.

- Finding out before an appointment how the person prefers to communicate and receive information.

- Extending appointment times to give more time for discussion.

- Giving people written information (such as appointment letters and reminders) in different languages or in an accessible format of their choice, for example Easy Read, audio books, films or by using online resources such as specialist learning disability websites."

National Institute for Health and Care Excellence

Additions to the information provided to patients:
Some respondents expressed that it would be advantageous for the guidance to indicate that information should be provided to patients about what to expect post-incident from clinicians.

Moreover, respondents felt that as part of the regular review of information provided about the use of force, a process of collecting, analysing and acting on patient and public feedback about the information should be detailed as part of the guidance.

Additionally, the complaints process should be clearly highlighted to patients during the process of communicating information on the use of force. Respondents felt that the guidance should make clear that information should be provided about the role of local authorities and Safeguarding Adults Boards in responding to a concern that an incident of use of force may involve abuse or neglect, and about how to refer an adult safeguarding concern to the relevant local authority. Likewise, respondents felt it would be beneficial to, in addition to the organisation's complaints procedure, add reference to the whistleblowing process and Freedom to Speak Up Guardians.

"It might be beneficial to add a reference to whistleblowing processes and Freedom to Speak Up Guardians. This would be in addition to an organisation's complaints procedure in order to be more robust and help to mitigate cultures of poor practice in isolated services."

NHS Providers

Next Steps

The Department of Health and Social Care will not be providing a standardised template for the information that should be provided to patients and their carers on the use of force. Flexibility is needed to allow mental health units to tailor and to co-produce, with those with

personal experience and their families and carers, the information provided to patients on the use of force, in accordance with its services and its patient population.

We are encouraged that respondents have highlighted important points on the deliverability and accessibility of information on the use of force to patients. We strongly encourage mental health units to factor these comments into their planning and highly recommend organisations produce information that is accessible in various modes of delivery, for example, British Sign Language, written communications and easy reads.

We have also provided further detail on the role of advocates in helping to communicate the information to patients, and that it is important to collect continual feedback from patients, and their families and carers about the information, and how this should be used to update and review the information about the use of force.

Training in appropriate use of force (section 5)

Consultation question 7

The responsible person must arrange for training to be provided to staff about the use of force by staff who work in the mental health unit. For each of the topic areas which must be included in staff training the statutory guidance sets out examples of what should be covered in each of those topic areas (as a minimum). The guidance also sets out training requirements for new members of staff and refresher training requirements.

Does the guidance clearly explain the requirements for training on the use of force?

What you told us in this consultation

The majority of respondents agreed the guidance clearly explains the requirements for training on the use of force whether responding as an individual or as an organisation.

57% of individuals and 45% of organisations agreed the guidance clearly explains the requirements for training on the use of force. Overall, 55% of responses agreed the guidance is clear; while 14% disagreed; and 8% were not sure.

Points raised from those who commented included:

Delivery of training and guidelines:
Some respondents have stated that organising adequate orientation and training can be difficult, particularly for temporary or agency staff, and often the training shows no tangible improvement to staff behaviour. It was suggested that it would be beneficial to develop a

competency framework that has to be achieved by those that attended training, allowing a more practical way to assess the development of the skills learnt on the training course.

Respondents felt that the guidance should detail what “adequate standard” of training is and should list training types that are licenced and approved under the Act. Additionally, several respondents requested clarity surrounding when the training should be delivered: annually or as a one-off. Respondents have requested that the guidance should include a deadline for introducing training, interim measures whilst staff are awaiting training and specify the regularity of training.

Many respondents have welcomed that the guidance has made clear that training on the use of force must use a training provider who is certified as being compliant with RRN National Training Standards.

Additions to the training:
Many respondents felt that training for staff should include specific training on autistic people and those with learning disabilities, their sensory needs and why they struggle to express their thoughts and feelings. Respondents felt training must cover the range of health needs that people may have which may put the person at additional risk of harm from the use of force.

Additionally, several respondents specified that there should be specific training on the needs of individuals from black and minority ethnic backgrounds.

> “We are concerned that the training of staff only needs to be provided ‘as soon as reasonably practicable'. The guidance should include a deadline for introducing training, and there should be interim measures in place for staff working while awaiting training. There should also be a requirement in the guidance for staff to take refresher courses in training. Finally, we share concerns with colleagues in the sector that the standards of training should be independently monitored, rather than being monitored by the responsible person in a mental health trust. There should be further detail in the guidance on what the ‘adequate standard' of training is."
>
> Agenda Alliance

Next Steps

NHS England and NHS Improvement has been working with NHS providers and the RRN to ensure all training providers are compliant with the RRN National Training Standards. The RRN National Training Standards have been developed to ensure coverage of all the requirements set out in the Act and statutory guidance. We have looked to clarify the requirements of training in the statutory guidance, including what the reasonable

timeframe is for delivering training to staff. All staff starting a new role should complete training as part of their induction and before working on the ward. Staff should not be involved in the use of force on patients if they have not been trained.

Recording of use of force (section 6)

Consultation question 8

The statutory guidance sets out the requirements for the responsible person to keep a record of any use of force on a patient by staff who work in the mental health unit. The requirements are set out in detail in the Act and cover the information which must be recorded locally (as a minimum).

The duty to keep a record does not apply if the use of force is negligible. The statutory guidance sets out the very small set of circumstances in which the negligible use of force would apply.

Does the guidance clearly explain what information should be recorded when force is used on a patient?

What you told us in this consultation

The majority of respondents agreed the guidance clearly explains what information should be recorded when force is used on a patient whether responding as an individual or as an organisation.

57% of individuals and 49% of organisations agreed the guidance clearly explains what information should be recorded when force is used on a patient. Overall, 55% of responses agreed the guidance is clear; while 12% disagreed; and 11% were not sure.

Points raised from those who commented included:

Comments under this section were mainly around the recording of negligible force, and the staff commitment necessary to record the use of force. For clarity, this has been reflected under question 11. We also received comments around ensuring that the guidance is clear on the recording of serious injuries within mental health units.

Next Steps

Next steps have been detailed alongside comments under question 11 for clarity. The guidance now provides more clarity on what constitutes a serious injury for the purposes of recording under the Act.

Consultation questions 9 and 10

The draft statutory guidance set out that the use of force can never be considered as negligible in the following circumstances:

- any form of chemical or mechanical restraint is used
- the patient verbally or physically resists the contact of a member of staff
- a patient complains about the use of force either during or following the use of force
- someone else complains about the use of force
- the use of force causes an injury to the patient or a member of staff
- more than one member of staff carried out the use of force

We asked whether you agree or disagree with the list of circumstances in which the use of force can never be considered as negligible, and whether there is anything else that should be added to the list.

What you told us in this consultation

On question 9, the majority of respondents agreed with the list whether responding as an individual or as an organisation.

50% of individuals and 40% of organisations strongly agreed or agreed with the list. Overall, 49% of responses strongly agreed or agreed with the list; while 14% strongly disagreed or disagreed; 7% were not sure.

On question 10, 20% of individuals indicated something should be added to the list; while 30% were not sure; and 20% indicated 'No'. 22% of organisations indicated something should be added to the list; while 16% were not sure; and 25% indicated 'No'.

Points raised from those who commented included:

Level of detail:
Whilst overall most respondents agreed with the list of circumstances in which the use of force can never be considered negligible, some who commented thought that the list needs to be more detailed to minimise subjectivity and ambiguity, and to factor in a range of specific contexts, such as the age and ethnicity of the patient and whether they have previously experienced violence or abuse. Several respondents felt that the list needed to

be clearer about the use of force for personal care, including where the patient has requested it.

> “We don’t think that “negligible force” is a helpful or even valid concept. The words are incompatible, and the term almost invites those exercising force to underestimate what force is and negates the experience of those subject to force – who, in the end, are the only arbiters of what is and isn’t negligible.”
>
> MIND

Respondents also gave specific examples of uses of force or situations that they felt should be included in the list, such as where the use of force results in the patient experiencing pain or distress, further examples of physical restraint (e.g. use of any flat surface as part of the restraint), threats to use force, cases where the patient asks not to be touched before the use of force happens, any use of force carried out by a male staff member on a female patient, withholding privileges, segregation and seclusion, and sleep deprivation.

Patient experience:
There was strong support for putting emphasis on the patient’s own experience and the impact on them in deciding whether the use of force is negligible, but some felt that the list did not sufficiently factor this in. For example, some thought that the list should take into consideration that some patients may not outwardly express their distress, may be non-verbal or have specific ways of communicating. Several responses were concerned about how this list may be used in cases where the patient lacks capacity.

> “Guidance should explicitly note the need to take into account a patient's communication needs when establishing whether a “patient complains about the use of force either during or following the use of force” or whether “the patient verbally or physically resists the contact of a member of staff”. Given the communication needs of patients with learning disabilities and autistic patients, it may not be sufficient to note only whether they complain or verbally resist, and employment of a more complete behavioural and communicative assessment may be needed to establish whether behaviour is used to communicate discomfort.”
>
> The Challenging Behaviour Foundation and Mencap

Next Steps

The negligible use of force section of the guidance has been revised to reflect the consultation comments and reach a compromise position with regards to recording the

negligible use of force. Further detail has been added on when the use of force could be considered negligible and sets out the specific criteria, and further clarity has been added to the list of circumstances when the use of force could never be considered negligible.

Any use of force which meets the criteria for negligible use of force set out in the statutory guidance must be included within the patients care plan and be recorded proportionately. If the same routine negligible use of force is identified in relation to a patient, this must be subject to a restraint reduction plan, which should include the justification for the continued use of the routine negligible use of force.

Consultation question 11

We asked whether you agree or disagree that the duty to keep a record should not apply if the use of force is negligible, as defined in the guidance.

What you told us in this consultation

The majority of individual respondents strongly disagreed or disagreed that the duty to keep a record should not apply if the use of force is negligible, as defined in the guidance. Among organisations, there was an even split between whether they strongly agreed, agreed or strongly disagreed or disagreed.

50% of individuals and 24% of organisations strongly disagreed or disagreed that the duty to keep a record should not apply if the use of force is negligible. Overall, 21% of responses strongly agreed or agreed that the duty to keep a record should not apply if the use of force is negligible, as defined in the guidance; while 46% strongly disagreed or disagreed; 10% were not sure.

Points raised from those who commented included:

Negligible use of force:
Whilst overall responses agreed the guidance was clear, several respondents felt that the term ‘negligible force’ lacks clarity and is open to a variety of interpretations, with many not certain what constituted as ‘negligible use of force’.

Some respondents felt that the guidance should make clearer what is meant by the ‘use of force’, particularly in relation to the ‘negligible use of force’. It was suggested that examples should be included in this section to reduce the risk of inconsistent approaches across mental health units.

"A definition and clarity surrounding terminology is essential. Well defined restrictive practice terminology is frequently misunderstood. We have heard examples of obvious

uses of restrictive practices being misrepresented and given euphemisms e.g. removal rooms and calming rooms instead of seclusion or long-term segregation. Negligible force must be clearly defined and the definition as easily understandable as possible."

Restraint Reduction Network

All uses of force should be recorded:
Many respondents felt that all instances in which force is used should be recorded for the protection of both patients and staff. It was recognised that this may put extra burden on staff, though it was suggested this would be minimal. Concerns were raised that if negligible uses of force as defined in the guidance were not recorded, this could open a loophole through which cases may be missed that should have been recorded. Examples given by respondents included: purposeful omission by staff; cases that may be open to interpretation; cases where the patient's view of the situation differs from that of staff; cases where the patient is unable to communicate their distress either due to the patient's difficulties with communication or fear of retaliation.

Several respondents felt that recording all uses of force could also be useful for other reasons such as: building up an understanding of the patient and what they are and are not comfortable with; for referring to if the patient complains about the incident later; for spotting patterns in the 'negligible' use of force; and for staff training.

"We remain concerned that negligibility remains a loophole through which staff and services could potentially avoid scrutiny for the use of force. Rethink Mental Illness recommends amendment to the Mental Health Units (Use of Force) Act to remove the negligibility loophole."

Rethink Mental Illness

Burden on staff:
Some respondents thought that there could be negligible uses of force that are not recorded in order to minimise time spent on paperwork rather than caring for patients, for example in cases where the use of force has been pre-agreed. Several respondents who disagreed or were unsure felt that the negligible use of force should be recorded but that this could be included in the patient's notes as a minimum rather than in a more formal report.

"Given the wide definitions in some cases, members have raised concerns around the significant amount of increased administrative burden caused by more detailed record keeping, especially if the definition of restraint is so broad and includes regular and routine activities. This could impact on time available to provide quality care to individuals."

The Royal College of Psychiatrists

Next Steps

We acknowledge that several respondents requested that all force should be recorded, even when considered ‘negligible’. We took on board this feedback and agreed with proposals put forward following stakeholder engagement work. As noted under question 9 and 10, any use of force which meets the criteria for negligible use of force set out in the statutory guidance must be included within the patients care plan and be recorded proportionately. If the same routine negligible use of force is identified in relation to a patient, this must be subject to a restraint reduction plan, which should include the justification for the continued use of the routine negligible use of force.

Investigation of deaths or serious injuries (section 9)

Consultation question 12

The statutory guidance sets out that (where appropriate) deaths and serious injuries which occur in a mental health unit, are investigated thoroughly with the involvement of the family in a transparent manner (regardless of there being any use of force or not). Investigations should be independent of those involved in the incident, timely and of good quality and ensure that lessons are learned to drive improvements in patient safety and prevent such incidents from happening again.

The responsible person must have regard to existing relevant guidance on what should happen when a patient dies or suffers a serious injury in a mental health unit that is published by the following organisations:

- Care Quality Commission
- Monitor
- NHS Commissioning Board
- NHS Trust Development Authority
- a person prescribed by regulations made by the Secretary of State

We asked you whether the guidance clearly explains what should happen following a serious injury or death in a mental health unit.

What you told us in this consultation

The majority of respondents agreed that the guidance clearly explains what should happen following a serious injury or death in a mental health unit whether responding as an individual or as an organisation.

61% of individuals and 51% of organisations agreed that the guidance clearly explains what should happen following a serious injury or death in a mental health unit. Overall, 59% of responses agreed the guidance is clear; while 8% disagreed; and 9% were not sure.

Points raised from those who commented included:

Accountability and transparency:
Some respondents felt that the guidance could be clearer with regards to accountability and consequences. Several stressed the importance of avoiding a culture of blame, as this may prevent reports from being filed and hinder learning. There was general support for a transparent process that closely involves the patient's family.

Independent investigations:
Respondents also felt that the guidance could include more details of how independent investigations should be carried out, by whom, and how to ensure that the investigation is sufficiently independent and thorough. Several respondents specifically stated that investigations should be independent from the institution and NHS Trust or independent provider where the injury or death happened, otherwise they will be investigating their own staff.

> "The current guidance needs to be much more robust in ensuring that an investigation following a death is done so with a level of hierarchical independence from the care trust or provider associated with the death. This would improve public confidence, the quality of the investigation and the breadth of future learning."
>
> Independent Advisory Panel on Deaths in Custody

Links to other guidance:
Some requested that the guidance go beyond signposting to other legislation and guidance, for example around workplace deaths and safeguarding, and explain the procedures more clearly. Several respondents specifically asked for an explanation of how the guidance works alongside Learning from lives and deaths – People with a learning disability and autistic people (LeDeR), a service improvement programme that looks at the lives of people with learning disabilities and autistic people who died and finds out about the health and social care services that they received throughout their lives.

> “Overall, we feel that further explanation of the investigative process, including reference to the potential outcomes and redress that could be expected, would be more helpful. Flowcharts or visual explanation of these separate processes could also be of some use in further clarifying the distinct processes for lay audiences.”
>
> Rethink Mental Illness

Next Steps

All comments have been considered and suggested additions have been carefully considered. The Department of Health and Social Care will continue to work with partners across government to improve how the NHS learns from serious incidents and deaths.

Summary Questions

The following questions were set out as a series of statements which requested respondents to answer how far they agreed with each statement.

Consultation question 13

> We asked you whether the guidance clearly sets out the requirements of the Act for mental health units.

What you told us in this consultation

The majority of respondents agreed that the guidance clearly sets out the requirements of the Act for mental health units whether responding as an individual or as an organisation.

61% of individuals and 55% of organisations strongly agreed or agreed that the guidance clearly sets out the requirements of the Act for mental health units. Overall, 60% of responses strongly agreed or agreed that the guidance clearly sets out the requirements of the Act for mental health units; while 11% strongly disagreed or disagreed; 5% were not sure.

Points raised from those who commented included:

More detail and clarity:
As noted throughout this consultation response, there are several areas that respondents generally felt there could be more detail and clearer definitions. For example, several respondents asked for clearer definitions of ‘chemical restraint’ and ‘restrictive practices’ and were concerned about misinterpretation of the term “negligible use of force”.

> “It would be useful if case studies could be included to illustrate when the use of restraint is justified and appropriate. Guidance should ensure the principles of STOMP/STAMP are followed and include information on what is considered 'least restrictive'. For instance, chemical restraint could be considered less restrictive because it requires less consistent physical force to be applied to someone. However, it could also be considered more restrictive because it not only limits someone's movement but also limits their ability to communicate or may have side effects. This requires clarification. These issues would be best resolved through training that explains these terms as well as setting out possible decision-making procedures to weigh these different factors up.”
>
> The National Autistic Society

Links to other laws and guidance:
Some thought that it could be clearer how the guidance interacts with non-statutory guidance as well as other legislation and common law.

Context of the individual:
Many respondents said that the guidance should more explicitly factor in patients’ individual circumstances, including ethnicity, sex, age, whether the person is autistic or has a learning disability, and the importance of trauma-informed responses.

Implementation:
Many who agreed that the guidance was clear also stressed the need to ensure that it is followed in practice, backed up by regular, high-quality training for all relevant staff. Linked to this, people commented that several elements of the guidance, such as trauma-informed and human rights approaches, should be explained in a more practical way and use case studies to help illustrate this.

Next Steps

Many of these comments have been reflected by respondents in earlier questions and, where possible, we have taken on board recommendations to ensure the statutory guidance provides the clarity necessary for organisations to comply with the Act accordingly.

Consultation question 14

> We asked you whether you thought that the guidance seeks to reduce and minimise the use of force in mental health units.

What you told us in this consultation

The majority of respondents agreed that the guidance seeks to reduce and minimise the use of force in mental health units whether responding as an individual or as an organisation.

58% of individuals and 51% of organisations strongly agreed or agreed that the guidance seeks to reduce and minimise the use of force in mental health units. Overall, 57% of responses strongly agreed or agreed that the guidance seeks to reduce and minimise the use of force in mental health units; while 12% strongly disagreed or disagreed; 8% were not sure.

Points raised from those who commented included:

For this section, many respondents chose to reiterate some of the points raised in previous questions. This includes references to training and accountability, de-escalation and negligible use of force. All comments have been accounted for and reflected under other relevant sections.

Next Steps

For specific points raised around training and accountability see consultation question 7 in section 5, for de-escalation and negligible use of force see consultation questions 9 and 10 in section 6.

Consultation question 15

We asked you whether the guidance makes it clear that force should only be used proportionately as a last resort.

What you told us in this consultation

The majority of respondents agreed that the guidance makes it clear that force should only be used proportionately as a last resort whether responding as an individual or as an organisation.

58% of individuals and 55% of organisations strongly agreed or agreed that the guidance makes it clear that force should only be used proportionately as a last resort. Overall, 57% of responses strongly agreed or agreed that the guidance seeks to reduce and minimise the use of force in mental health units; while 14% strongly disagreed or disagreed; 5% were not sure.

Points raised from those who commented included:

Earlier reference:
Whilst respondents generally agreed with the statement, some felt that this intention needs to be made more explicit earlier in the guidance.

Clearer definitions and context:
Others felt that the terms ‘last resort’ and ‘proportionate’ should be defined in more detail, factor in the patient’s perspective and personal context, and be backed up by case studies.

Alternatives to force:
Some respondents also felt that there needs to be a greater focus on alternatives to the use of force.

"When restraint or seclusion is used, there is often no verbal de-escalation. No alternative measures were used to support the patient, before resorting to restraint. The policy on the use of force should emphasise putting the patient first and how to help them feel safe. The policy could include practical examples and suggestions which calm situations. These are things which can help:

- Thinking about how the child or young person communicates;
- Using sensory experiences, i.e. experiences related to the senses of touch, smell, taste, sight and hearing;
- Offering to go for a walk outside with a patient;
- Offering to go for a one-to-one to discuss what the patient is feeling at that moment;
- Thinking about what the children and young people would enjoy; what might make them happy;
- Having environments which are welcoming and comfortable."

Article 39

Next Steps

All comments have been welcomed and considered against the application of the Act. We have included a greater emphasis that the use of force should only be used as a last resort and should be proportionate to the risk posed.

Consultation question 16

We asked you whether the guidance appropriately explains the different approaches required when caring for children and young people and adults.

What you told us in this consultation:

The majority of respondents agreed that the guidance appropriately explains the different approaches required when caring for children and young people and adults whether responding as an individual or as an organisation.

48% of individuals and 35% of organisations strongly agreed or agreed that the guidance appropriately explains the different approaches required when caring for children and young people and adults. Overall, 46% of responses strongly agreed or agreed that the guidance appropriately explains the different approaches required when caring for children and young people and adults; while 15% strongly disagreed or disagreed; 16% were not sure.

Points raised from those who commented included:

Approach for children and young people:
Several respondents commented that the guidance is clear that there should be different approaches for children and young people, but that it does not go into enough detail about how the approach should be different. Some thought that there should be separate guidance to explain this more clearly. It was recommended that the guidance is amended to explain the implications of the use of force for children and how the legislation applies to them.

> “The guidance clearly states that different approaches should be considered for children but does not suggest what that would mean in practice. For example, the guidance could have been used to delineate forms of restraint that shouldn't be used on children, or to recommend additional procedural safeguards.”
>
> Care Quality Commission

Person-centred approach:
Some felt that the guidance should focus on taking a person-centred approach rather than an age-based approach, whilst others supported an age-sensitive approach alongside this, noting the long-term effects that use of force can have on everyone, especially children and young people.

Next Steps

We acknowledge that some respondents would value having separate guidance for children and young people and, on the other hand, some believe that the guidance should shift to a person-centred approach versus being aged-based.

We are strongly of the belief that the focus needs to shift to one which respects all patients' rights, provides skilled, trauma-informed, person-centred care, follows the principle of least restriction and promotes recovery. Policies, training and information provided to patients should be inclusive and reflective of the patient population of each mental health unit and its services, including providing guidance specific for children and young people where the approach is different.

Consultation question 17

We asked you whether the guidance clearly outlines the need to consider those with protected characteristics under the Equality Act 2010 when fulfilling the requirements of the Act.

What you told us in this consultation

The majority of respondents agreed that the guidance clearly outlines the need to consider those with protected characteristics under the Equality Act 2010 when fulfilling the requirements of the Act whether responding as an individual or as an organisation.

53% of individuals and 55% of organisations strongly agreed or agreed that the guidance clearly outlines the need to consider those with protected characteristics under the Equality Act 2010 when fulfilling the requirements of the Act. Overall, 54% of responses strongly agreed or agreed that the guidance clearly outlines the need to consider those with protected characteristics under the Equality Act 2010 when fulfilling the requirements of the Act; while 10% strongly disagreed or disagreed; 12% were not sure.

Points raised from those who commented included:

Proactive commitments:
Several respondents felt that the guidance needs to go further to make more general and specific commitments to tackling disproportionality and discrimination. Some felt that the guidance could require remedial action to address evidence of disproportionate use of force and discrimination.

"We recommend that the guidance also includes inclusion health groups, a term used by NHS England to describe all people who are socially excluded. Considering both protected characteristics and inclusion health groups would provide a more comprehensive list of groups who may be more likely to experience use of force and subsequent harm as a result of the restraint procedure."

The Association for Young People's Health

Next Steps

We strongly believe that mental health units can play a key role in tackling disproportionality and discrimination. Particular to Seni Lewis' experience and evidence from data, we know that certain groups who share protected characteristics under the Equality Act 2010 are more likely to experience the disproportionate use of force. The reasons for this are multiple and complex and we recognise that we have further work to do in order to understand them better. We have been clear in the guidance that all mental health units are expected to set out what steps will be taken to reduce the use of force, which in turn will also tackle the disproportionate use of force on all patients and in particular those who share protected characteristics under the Equality Act 2010.

Consultation question 18

We asked you whether you think that the guidance emphasises the importance of involving patients, their families and carers in decisions about their own care.

What you told us in this consultation

The majority of respondents agreed that the guidance emphasises the importance of involving patients, their families and carers in decisions about their own care units whether responding as an individual or as an organisation.

62% of individuals and 53% of organisations strongly agreed or agreed that the guidance emphasises the importance of involving patients, their families and carers in decisions about their own care units. Overall, 60% of responses strongly agreed or agreed that the guidance emphasises the importance of involving patients, their families and carers in decisions about their own care units; while 10% strongly disagreed or disagreed; 7% were not sure.

Points raised from those who commented included:

More detail:
Several respondents felt that there was insufficient detail on how to effectively involve patients, families and carers in decisions. There were many concerns that this will not happen in practice, and that the language is not strong enough to ensure that this happens. Related, some respondents agreed but felt that the guidance did not sufficiently address how to deal with situations in which it may not be possible to involve these groups, such as in urgent decisions.

> "We believe the guidance needs to be stronger in ensuring patients' families are consulted on the policy on the use of force and on the published information regarding use of force. We believe the guidance should remove the wording that the RP need only "consult with whoever they consider it appropriate to consult"."
>
> INQUEST

Next Steps

All comments have been welcomed and considered. After careful review, we believe the statutory guidance currently reflects our strong position in relation to the importance of the involvement of patients and their family and carers in decisions about their own care, but we have provided further clarity where appropriate. For example, we have made it clear that the policy developed by each organisation should include details on how to involve families or carers of the patient, whilst at the same time, recognising that there may be circumstances where it could be harmful to involve families or carers (e.g. for patients who are survivors of domestic abuse).

Annex A: consultation demographics

1. Overview of responses

Overall, there were 421 responses to the main consultation: 378 (90%) from the main consultation and 43 (10%) from the easy read version. We also received 8 email responses and, as a result of not following the same format as the main consultation, these have not been included in the percentage figures.

Around a quarter of all respondents were blank/empty responses: 87 (21%) were blank overall and a further 23 (5%) only indicated they were an individual or organisation.

The easy read version of the consultation asked questions in a similar enough way to the main consultation and responses from both sources have been combined across most questions in the analysis. The majority of email responses have not followed the main consultation standard format and so considered separately from the main consultation.

Each response is taken on face value in that there is no weighting to account for where a response might reflect multiple individuals or organisations.

Totals of percentages may not sum to 100% due to rounding. The breakdown of responses by questionnaire type is as follows:

Summary of responses

Response type	Number	Percentage
Main response, complete	275	65%
Main response, blank	81	19%
Main response, individual/organisation only*	22	5%
Easy read, complete	36	9%
Easy read, blank	6	1%
Easy read, individual/organisation only*	1	0%

Summary of responses by format

Response format	Number	Percentage
Main response	378	90%
Easy read	43	10%

Summary of all responses, by completeness

Response type	Number	Percentage
Total complete responses	311	74%
Total blank or individual/organisation only*	110	26%

* only answered the question on if the response was from an individual or organisation

1.1 Are you responding as an individual or an organisation?

Of 421 responses received, 87 (21%) were totally blank. Of the remaining 334: 277 (83%) were from an individual; 55 (16%) were from an organisation; and 2 (1%) were not stated.

The 2 'not stated' responses have been combined with the individual responses in subsequent analyses, giving 279 responses treated as from individuals.

Number of responses by individuals and organisations

Respondent type	Number	Percentage of responses
Individual	277	83%
Organisation	55	16%
Not stated	2	1%

2. Individual demographics

The demographics of the respondents are presented below. These mainly pertain to those responding as individuals.

2.1 Age of respondent

Of the 279 individual responses, 9 responses (2%) were received by people aged under 25; 53 were from people aged 25-39 (20%); 57 from people aged between 40-49 (14%); 79 from people aged between 50-59 (19%), and 64 from people aged 60 or over (15%). 17 respondents did not specify age.

Number of respondents by age group

Age group	Number	Percentage
18 to 24	9	2%
25 to 29	18	4%
30 to 39	35	8%
40 to 49	57	14%
50 to 59	79	19%
60 to 69	49	12%
70 and above	15	4%
Missing	17	4%

2.2 Sex of respondent

In terms of sex of the respondents, of the 279 individual responses, 195 respondents (70%) were female; 67 were male (24%) and 17 did not specify (6%).

Number of respondents by sex

Sex	Number	Percentage
Male	67	24%
Female	195	70%
Missing	17	6%

2.3 Is the gender you identify with the same as your sex registered at birth?

Respondents were also asked whether the gender they identified with was the same as their sex registered at birth. Of the 279 individual responses, 256 respondents (92%) indicated yes their gender was the same as their sex registered at birth, 3 indicated it wasn't (1%), and 20 did not specify (7%).

Number of respondents by response to the question: Is the gender you identify with the same as your sex registered at birth?

Response	Number	Percentage
Yes	256	92%
No/other	3	1%
Missing	20	7%

2.4 Ethnicity of respondent

In terms of ethnicity of the respondents, of the 279 individual responses, 211 respondents (76%) indicated 'white/white British'; 6 were 'Asian/British Asian' (2%); 20 were 'black/African/Caribbean/black British' (7%); 15 indicated 'Mixed/Multiple ethnic groups' (5%); and 8 indicated 'prefer not to say' (3%); a further 19 did not specify (7%).

Number of respondents by ethnicity

Ethnicity	Number	Percentage
white/white British	211	76%
Asian/British Asian	6	2%
black/African/Caribbean/black British	20	7%
Mixed/Multiple ethnic groups	15	5%
Prefer not to say	8	3%
Missing	19	7%

2.5 Disability

In terms of disability, of the 279 individual responses, 189 respondents (68%) did not consider themselves to be disabled; 71 (25%) indicated they were; and 19 did not specify (7%).

Number of respondents by response to the question: Do you consider yourself to be disabled?

Response	Number	Percentage
Yes	71	25%
No	189	68%
Missing	19	7%

2.6 Whether responding as a healthcare professional or not

Of the 279 individual responses, 183 respondents (66%) indicated they were not responding as a healthcare professional; 81 indicated they were (29%); a further 15 did not specify (5%).

Number of respondents by response to the question: Are you responding as a healthcare professional?

Response	Number	Percentage
Yes	81	29%
No	183	66%
Missing	15	5%

2.7 Whether the respondent works for the NHS

Of the 279 individual responses, 202 respondents (72%) indicated they did not work for the NHS; 61 indicated they did (22%); a further 16 did not specify (6%).

Number of respondents by response to the question: Do you work for the NHS?

Response	Number	Percentage
Yes	61	22%
No	202	72%

Missing	16	6%

2.8 Whether the respondent has lived experience of use of force in a mental health unit

Of the 279 individual responses, 171 respondents (61%) indicated they did not have lived experience of use of force in a mental health unit; 17 indicated not applicable or preferred not to say (6%); 73 (26%) indicated they did have lived experience of use of force in a mental health unit and/or being a patient in a mental health unit; a further 18 did not specify (6%).

Number of respondents by response to the question: Do you have lived experience of being subject to the use of force in a mental health unit and/or being a patient in a mental health unit?

Response	Number	Percentage
Yes	73	26%
No	171	61%
Prefer not to say	12	4%
Not applicable	5	2%
Missing	18	6%

3. Responses from organisations

3.1 Organisations

Responses were received from the following types of organisation:

- voluntary and charitable sector – representing people from black and minority ethnic groups, children and young people, women and girls, faith groups, and people with autism and learning disabilities
- NHS and NHS Foundation trusts
- Health regulator
- Local Healthwatch

- independent government advisory panels
- professional bodies
- The Royal Colleges

4. Lived experience

26% of the 279 individuals responding indicated they had lived experience of use of force; while 67% indicated they did not or prepared not to say; 6% were missing.

The sex and ethnic profiles of those with lived experience of use of force were broadly similar to all individual respondents.

About three quarters were female (73%) and one quarter male (26%); 1% didn't specify. This was similar to those without lived experience (or preferred not to say) female (74%), male (26%); 0% didn't specify.

There was a similar profile by ethnicity amongst those with lived experience of use of force or not.

Ethnicity distributions of those with lived experience of use of force and those without

Ethnicity	Percentage of respondents (sample that reported lived experience)	Percentage of respondents (sample that did not report lived experience)
white/white British	79%	81%
Asian/British Asian	0%	3%
black/African/Caribbean/black British	5%	9%
Mixed/Multiple ethnic groups	8%	5%
Prefer not to say	4%	3%
Missing	3%	0%

The main difference in ages for those in the lived experience group or not was among 30-39-year olds as shown below.

Age distributions of those with lived experience of use of force and those without

Age group	Percentage of respondents (sample that reported lived experience)	Percentage of respondents (sample that did not report lived experience)
18 to 29	8%	11%
30 to 39	22%	10%
40 to 49	19%	23%
50 to 59	26%	31%
60 and over	23%	24%
Missing	1%	1%

There are some differences in whether individuals considered themselves disabled or not.

A higher proportion of individuals responding with lived experience of use of force considered themselves to be disabled (44%) than those without lived experience (21%).

Distribution of responses to the question: Do you consider yourself to be disabled? for those with lived experience and those without

Response	Percentage of respondents (sample that reported lived experience)	Percentage of respondents (sample that did not report lived experience)
Yes	44%	21%

No	55%	78%
Missing	1%	1%