Department of Health & Social Care

Mental Health Units (Use of Force) Act 2018

Statutory guidance for NHS organisations in England, and police forces in England and Wales

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Ministerial foreword

The commencement of the Mental Health Units (Use of Force) Act 2018 and publication of this statutory guidance represents a significant moment towards improving the care and treatment of the most vulnerable patients in our care. We have heard from people with lived experience of mental health services about how the use of force can be a frightening, traumatising and humiliating experience which can have a lasting impact long after the incident.

Every patient has the right to be treated with dignity and respect, in a caring and therapeutic environment where their rights are upheld, their needs are met, and they feel supported and listened to. The use of force must always be used proportionately, in accordance with the law, and only ever as a last resort. It must never be used with the intention of causing pain, suffering or humiliation to a patient.

We must remember why the Mental Health Units (Use of Force) Act 2018 is needed. The use of force can have serious and sometimes fatal consequences, as was the case of Olaseni (Seni) Lewis, a young black man who lost his life following the disproportionate and inappropriate use of force in a mental health unit. After the tragic loss of their son, Aji and Conrad Lewis and the wider Lewis family campaigned tirelessly for change to ensure no other family need suffer in the way they did. The act is a testament to the hard work of the Lewis family and other families who have lost loved ones following the use of force in mental health services.

We must also acknowledge that the use of force is often disproportionately used on people who share certain protected characteristics under the Equality Act 2010, such as people from black and minority ethnic backgrounds, and women and girls. Through the introduction of the act we must see an end to this; this is an opportunity to make changes to promote positive ward cultures which support recovery, engenders trust between patients and staff, and protects the safety and wellbeing of all our patients and people using our mental health services.

The use of force can also have a negative impact on staff who witness and use force on patients themselves. It is important to recognise that staff often have a difficult job to do in challenging circumstances, and that there are many caring staff providing excellent care and support to patients. Where there is good practice in reducing the use of force, we must learn from this and share their experience and success. It is right that staff are held accountable for their actions, but they should also be equipped and supported to work safely in the least restrictive way and contribute to positive ward culture's. When patients are cared for in what feels like a safe and positive environment, organised around their needs and individual requirements, situations should not arise where the use of force is

needed. There are services who work in this way and have reduced their use of force significantly.

In developing this statutory guidance, we have consulted widely with patient's, people with lived experience and their families and carers, the voluntary and charitable sector, mental health staff, professional bodies, and regulators of services. It has been important to hear from all those who will be impacted by the act and the statutory guidance, and I would like to thank those people with lived experience and staff who shared their personal experience of the use of force. The guidance provides the detail of how we expect mental health units to implement the requirements of the act and will provide patients with the information they need about what to expect from mental health units when they are in their care.

The act and this statutory guidance must be the catalyst for change that the system has been calling for. We must see an end to the disproportionate use of force on all patients and provide a better experience of mental health services for all patients and their families and carers. We must support staff to provide person-centred and trauma-informed care, where the emphasis is on prevention and understanding the individual's needs. Most importantly we must ensure that what happened to Seni and others who found themselves in similar situations doesn't happen to anyone else.

Gillian Keegan

Minister of State for Care and Mental Health

1. Introduction

The need for the act and statutory guidance

Every individual has the right to be treated with dignity and in a caring therapeutic environment which is free from abuse. The use of force (which refers to physical, mechanical or chemical restraint, or the isolation of a patient) can sometimes be necessary to secure the safety of patients and staff. The use of force always comes with risk and can be a traumatic and upsetting experience for patients when they are at their most vulnerable and in need of safe and compassionate care. The use of force can also be upsetting for those who witness it, such as other patients or visitors. For too long the use of force has been accepted as the norm in many mental health services. This must change. Whilst there has been guidance in recent years which has aimed to reduce the reliance on the use of force, there are still too often reports of its misuse and abuse which reminds us there is still work to do.

Data from the NHS Digital Mental Health Bulletin shows that the use of force is at an all-time high. Whilst there are many reasons for this rise, such as improved recording and reporting and more patients using services, there is still an over-reliance on the use of force. While the reasons behind this may be complex, this data also shines a light on the often, disproportionate use against some groups who share a protected characteristic under the Equality Act 2010 such as people from black and minority ethnic backgrounds, women and girls, and people with autism or a learning disability.

Whilst there is good practice in many of our mental health units, there is still a greater focus on managing behaviour rather than working to prevent situations from escalating to the point at which the use of force is seen to be the only solution. Poor staff communication with patients due to language or cultural barriers, and not understanding the reasons for a patients' behaviour also create an environment where escalation and force is more likely.

This 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.

A former child patient said:

"When a restraint takes place, it really takes a toll on you, emotionally and mentally. That effects your mental health even more."

Aim of the act and statutory guidance

The aim of the Mental Health Units (Use of Force) Act 2018 and this statutory guidance is to clearly set out the measures which are needed to both reduce the 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.

It is also widely recognised that there are inconsistencies nationally in the way mental health units record and report data on the use of force, the quality of staff training, and the way in which investigations are carried out when things go wrong. The requirements of the act and this statutory guidance provide a much-needed opportunity to embed a consistent approach across services nationally.

The guidance also promotes and encourages the use of a human rights-based approach to the use of force, working with patients in a trauma-informed, person-centred way, and developing therapeutic environments which ensure that force is used proportionately and only ever as a last resort. The use of force should be rare and exceptional, rather than a common experience for patients and staff.

Through compliance with the act and statutory guidance we must see:

- an end to the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age, and disability
- services which meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point
- services which understand the negative impact of the use of force of patients with histories of trauma and abuse
- services which involve the individual, their families and carers in the planning and delivery of their care
- positive relationships between those receiving care and those providing it

An NHS staff member said:

"I work on a PICU ward, and I suppose one of the reasons that I'm here, is that this conversation has happened on an off for a long time and I get the feeling that nothing really changes, certainly where I am. And then it would be nice to be part of something that changes that."

What is the use of force, why and when it can be used

The Mental Health Units (Use of Force) Act 2018 introduces the following definitions of use of force.

Use of force includes physical, mechanical or chemical restraint of a patient, or the isolation of a patient (which includes seclusion and segregation).

The act defines the different types of force as:

- physical restraint: the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection

- mechanical restraint: the use of a device which is intended to prevent, restrict or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control

- chemical restraint: the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation (see NICE guideline (NG10) Violence and aggression: short-term management in mental health, health and community settings)

The act states that isolation is any seclusion or segregation that is imposed on a patient. However, it does not define these terms. The definitions of these are provided in Annex A of the Mental Health Act 1983: Code of Practice, which applies to any patient in a mental health unit detained under that act, which defines them as:

- seclusion: the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. This can include seclusion where the door to a room is open, but the patient is still prevented from leaving, for example, by a staff member either in or next to the doorway

- (long-term) segregation: a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis

It is important to acknowledge that there are circumstances where it may be difficult to avoid the use of force to ensure the safe care and treatment of the patient, and the safety

of other patients and staff. For example, nasogastric feeding for patients with eating disorders or a need to restrain a patient who is resisting or refusing help with personal care and support. Even within these situations it is still essential that the relevant legal principles are applied and that the use of force is proportionate.

'Chapter 26: Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice provides further statutory guidance in relation to the use of force which staff are under a statutory duty to have regard to in relation to patients in mental health units detained under the Mental Health Act 1983.

In particular paragraphs 26.36 and 26.37 provide further guidance on the meaning of any use of force that amounts to restrictive interventions, as:

"…deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and;
- end or reduce significantly the danger to the patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

- be used for no longer than necessary to prevent harm to the person or to others;
- be a proportionate response to that harm, and;
- be the least restrictive option."

Human rights-based approach to the use of force

All uses of force must be rights-respecting, lawful and compliant with the Human Rights Act 1998. Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away; but some rights can be restricted in specific circumstances for a legitimate reason, as long as that restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment are absolute and can never be restricted.

The Human Rights Act 1998 incorporates into domestic law the rights enshrined in the European Convention on Human Rights (ECHR). Articles 2 (right to life), 3 (freedom from torture, inhuman and degrading treatment), 8 (respect for private and family life) and 14 (protection from discrimination) of the ECHR are those which relate to the use of force in mental health settings. It means all public authorities and organisations carrying out public functions (including the provision of mental health units) are legally obliged to respect patient's rights and take reasonable steps to protect those rights.

Alongside the Human Rights Act 1998, the UK Government has signed and ratified other United Nations (UN) human rights treaties which are relevant to the use of force. Organisations should ensure that all staff are aware of, and understand their duties under this statutory guidance which reflects their obligations under the Human Rights Act 1998 and other relevant UN human rights treaties. These include:

- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- International Covenant on Civil and Political Rights (ICCPR)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- Convention on the Rights of the Child (CRC)
- Convention on the Rights of Persons with Disabilities (CRPD)

The following documents provide further detailed guidance on human rights:

- Chapter 26: Safe and therapeutic responses to disturbed behaviour - Mental Health Act 1983: Code of Practice
- Equality and Human Rights Commission; Human rights framework for restraint
- Equality and Human Rights Commission; Human rights framework for people in detention
- Mental Health, Mental Capacity and Human Rights: A practitioner's guide – the British Institute of Human Rights

It is important that staff and senior managers ensure that the legislative framework is applied in a way which is compatible with ECHR rights and freedoms. The Human Rights Act 1998 is the foundation on which other laws and duties are implemented.

There are legal frameworks including those under the Mental Health Act 1983 and the Mental Capacity Act 2005 that are designed to ensure that any use of force is applied only after a proper process has been followed. Such legal frameworks require any force used to be necessary and proportionate, and the least restrictive option.

The principle of least restriction would involve the least restrictive method, using the least amount of force (proportionate to the risk posed) and for the minimum amount of time.

Below is a list (not exhaustive) of legislation relevant to the use of force.

- Human Rights Act 1998
- The Mental Health Act 1983 (as amended 2007)
- Mental Capacity Act 2005
- Equality Act 2010
- The Children Act 1989
- The Children Act 2004
- The Children and Families Act 2014
- The Care Act 2014
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

What the act covers and who it applies to

The Mental Health Units (Use of Force) Act 2018 (the act) received Royal Assent (when a bill is made into an act of Parliament) on the 1st November 2018.

The requirements set out in the act are:

- section 2 - mental health service providers operating a mental health unit to appoint a 'responsible person' who will be accountable for ensuring the requirements in the act are carried out

- section 3 - the responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit. The written policy will set out the steps that the unit is taking to reduce (and minimise) the use of force by staff who work in the unit

- Section 4 - the responsible person for each mental health unit must publish information for patients about their rights in relation to the use of force by staff who work in that unit

- Section 5 - the responsible person for each mental health unit must ensure staff receive appropriate training in the use of force. This statutory guidance sets out what that training should cover

- section 6 - the responsible person for each mental health unit must keep records of any use of force on a patient by staff who work in that unit, which includes demographic data across the protected characteristics in the Equality Act 2010

- section 7 - the Secretary of State for Health and Social Care must ensure that at the end of each year statistics are published regarding the use of force by staff, using the relevant information recorded under section 6

- section 8 - the Secretary of State for Health and Social Care must conduct an annual review of any reports made under paragraph 7 of schedule 5 to the Coroners and Justice Act 2009, and may conduct a review of any other findings or determinations made relating to the death of a patient as a result of the use of force in a mental health unit. The Secretary of State for Health and Social Care must then publish a report that includes conclusions arising from the review

- section 9 – if a patient dies or suffers serious injury in a mental health unit, the responsible person must have regard to any relevant guidance relating to investigations of deaths or serious injuries

- section 10 – explains that the responsible person may delegate their functions where appropriate to do so

- section 11 – the Secretary of State for Health and Social Care must publish guidance which sets out in more detail how to implement the requirements of the act

- section 12 – if a police officer is going into a mental health unit on duty to assist staff who work in that unit, the police officer must wear and operate a body camera at all times when reasonably practicable

The act applies to all patients being assessed or treated for a mental health disorder in a mental health unit, this applies equally to both NHS and independent hospitals providing

NHS funded care. For independent hospitals providing NHS funded care the act applies to all patients in their care not just those who are receiving treatment through NHS funded services. The act also applies whether a patient is detained under the Mental Health Act 1983 or as an informal or voluntary patient. When we refer to patients in this guidance, we mean everyone including children and young people (under the age of 18), working age adults, older people, and both sexes. Where information relates specifically to one group of patients this will be clearly set out.

As set out above, this statutory guidance (produced under section 11 of the act) provides detail about how to implement the requirements of the act. It only covers the sections of the act which require action by the responsible person or a mental health unit. These are sections 2, 3, 4, 5, 6, 9 and 10. The guidance does not set out specific actions to be taken in all circumstances, nor does it recommend or prohibit specific uses of force.

Sections 7, 8 and 11 impose duties on the Secretary of State for Health and Social Care.

Section 7 requires the Secretary of State to publish annual statistics about the use of force in mental health units. The national statistics will use some of the information which will be collected under section 6 (recording of use of force) of the act, using systems which are already in place for recording and reporting the use of force. The use of force will continue to be reported through the NHS Digital Mental Health Services Data Set on a monthly basis, whilst the annual national data required under section 7 of the act will be reported in the annual NHS Digital Mental Health Bulletin. The annual statistics will provide a breakdown of patient demographic information using the protected characteristics as set out in the Equality Act 2010, and details of the types of force used.

Section 8 requires the Secretary of State to conduct an annual review into any coroners' reports. The Secretary of State may also conduct a review into, other relevant organisations' findings, of deaths that occurred as a result of the use of force by staff in a mental health unit. The Secretary of State must then publish a report of the review and include conclusions arising from the review.

Section 12 of the act relates to police use of body cameras. If a police officer is going into a mental health unit on duty to assist staff who work in that unit, the police officer must wear and operate a body camera at all times when reasonably practicable.

The act applies in England only. Section 12 applies to English police officers, a member of the special constabulary or special constable, the British Transport Police, and Welsh police officers if they are called to assist in a mental health unit in England.

Whenever the police are called to assist mental health unit staff they are required to wear and operate a body camera at all times when reasonably practicable. This could be any of the officers noted in the paragraph above. If the police officer has a body camera they

must wear and keep it operating (recording) at all times. However, there may be special circumstances that justify not wearing or operating a camera, it is for the police officer(s) to determine in line with current College of Policing guidance on the use of body cameras whether special circumstances apply.

The Home Office and College of Policing will consider whether current guidance on the police use of body cameras requires further update to ensure it is in line with the requirement of the act.

Legal status of this statutory guidance

This statutory guidance issued by the Secretary of State for Health and Social Care under section 11 of the act provides guidance to a 'responsible person' (see section 2) and 'relevant health organisations' (mental health units) about how they exercise their functions under the act.

Both the 'responsible person' and staff working in mental health units 'must have regard' to this guidance. It is important that, the responsible person ensures that they and other staff are familiar with its requirements, as departures from the guidance could give rise to legal challenge. There should be clear and cogent, documented reasons for departing from the guidance as courts will scrutinise such reasons to ensure that there is a sufficiently convincing justification in the circumstances. Organisations or trusts should have a process in place to ensure that the reason(s) for any departure(s) from the guidance are clearly documented.

This guidance is not intended to override other guidance which already applies to mental health units but sits alongside it. For example, the Mental Health Act 1983: Code of Practice in relation to restrictive interventions will still apply to patients in mental health units who are detained under the Mental Health Act 1983. Where relevant this guidance will refer directly to other legislation, guidance and information.

This guidance will be kept under review and updated as necessary. Any substantial changes to the guidance will be consulted on with appropriate persons before being published in accordance with section 11(6) of the act.

Compliance with the act and statutory guidance

Role of the health regulator

The Care Quality Commission (CQC) will have regard to this statutory guidance when carrying out its regulatory functions and determining whether registered persons are

complying with relevant requirements. If CQC considers the requirements of the Mental Health Units (Use of Force) Act 2018 and this statutory guidance are not being met, it may take action as appropriate in accordance with its statutory powers and policies.

Role of commissioners

NHS England and NHS Improvement commissioners will need to assure themselves that organisations or trusts (the providers) of the services they commission have the necessary knowledge, skills and competencies to effectively support all patient groups and have arrangements in place to promote positive environments, reduce risk, and minimise any inappropriate or disproportionate use of force. This includes assuring themselves that providers of mental health services meet the needs of the patient population they are serving and are tailored to the specific services they are providing (for example, children and young people).

Through contract management providers are regularly and rigorously reviewed, and failure to comply with contractual obligations will lead to prompt action to safeguard and promote the welfare of all patient groups. Organisations or trusts and those who commission services should ensure that the services they commission are consistent with the contents of this statutory guidance.

The NHS Standard Contract necessitates providers of mental health services to submit data and information to commissioners on a quarterly basis as part of reporting requirements.

2. Requirements of the act

The requirements set out in the rest of this guidance are applicable to mental health units (both NHS and independent where providing NHS funded care).

Section 1: key definitions

This section explains some of the important terms used in the act.

Mental Disorder has the same meaning as in the Mental Health Act 1983 which is “any disorder or disability of the mind”. This includes people with a learning disability, although a learning disability is not always considered to be a mental disorder for the purpose of the Mental Health Act 1983, and as set out in that act, in some situations is only included where the disability is associated with abnormally aggressive or seriously irresponsible conduct.

Learning Disability also has the same meaning as in the Mental Health Act 1983 which means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning. Chapter 2: Mental Disorder Definition of the Mental Health Act 1983: Code of Practice details the list of clinically recognised conditions which could fall within the definition of a mental disorder for both the Mental Health Act 1983 and this act.

Mental Health Unit is described as a health service hospital or independent hospital in England (or part thereof) that provides treatment to inpatients for a mental disorder. An independent hospital (or part thereof) will only be a 'mental health unit' if its purpose is “to provide treatment to inpatients for mental disorder”, and “at least some of that treatment is provided, or is intended to be provided, for the purposes of the NHS.”

The types of inpatient service which would be considered within the definition of a mental health unit (this is not an exhaustive list) include:

- acute mental health wards for adults of working age and psychiatric intensive care units
- long stay or rehabilitation mental health wards for working age adults
- forensic inpatient or secure wards (low, medium and high)
- child and adolescent mental health wards
- wards for older people with mental health problems

- wards for people with autism or a learning disability
- specialist mental health eating disorder services
- inpatient mother and baby units
- acute hospital wards where patients are "detained under the Mental Health Act 1983 for assessment and treatment of their mental disorder"

The following services are considered to be outside of the definition of a mental health unit (this is not an exhaustive list) and therefore not covered by the requirements of the act:

- accident and emergency departments of emergency departments
- section 135 and 136 suites that are outside of a mental health unit
- outpatient departments or clinics
- mental health transport vehicles

Please refer to the 'What is the use of force, why and when it can be used' section of this guidance for the definitions of the use of force introduced by this act.

Section 2: mental health units to have a responsible person

It is essential that there is accountability and responsibility for the use of force at the highest level within an organisation. Organisation or trust boards have a legal, professional and ethical obligation to minimise harm to service users, staff and others, and therefore must be accountable for the use of force within their organisation. Organisation or trust boards should have a good understanding of why force is used within their services, develop wider action plans for reducing the use of force, and regularly review the organisation or trusts performance in reducing the use of force.

A relevant health organisation (NHS trust, NHS Foundation trust or independent hospital providing NHS funded care) operating a mental health unit must appoint a 'responsible person' whose role it is to ensure that the organisation complies with the requirements of the act.

The role of the responsible person does not require a new appointment, but it must be a permanent member of staff within the organisation and be a member of the organisation or trust board. The role may be undertaken by, for example, the Chief Nursing Officer or Medical Director. Organisation or trust boards should ensure that whoever is appointed has the relevant skills and experience to undertake the responsibility of this role, this

should include a relevant clinical background with experience of clinical care roles where the use of force is used, and an understanding of the needs of the patient population being served. This could for example include specific skills and knowledge in supporting people with autism or a learning disability, or a cultural understanding of the needs of the local patient population.

Where the organisation or trust is providing services mainly or wholly for children and young people, the responsible person should have the knowledge, skills and experience of working with children and young people, and/or managing children's services.

Organisation or trust boards should ensure the responsible person has the support of all senior management in performing their role and has the necessary resources available to them. This should include support to challenge practice across the organisation or trust and across disciplines, for example, the Chief Nursing Officer should be able to challenge medical staff.

The responsible person should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in. It is important they are guided by the impact of trauma on their patients and the potentially re-traumatising impact of the use of force. See section 5 for further detail on staff training requirements.

A former female patient said:

"I want therapeutic support with my current difficulties and past traumatic experiences including bereavement, sexual abuse and domestic violence."

Where the organisation or trust operates more than one mental health unit, the act requires that the same responsible person must be appointed in relation to all the mental health units. This is to ensure a consistency of approach to the use of force across the organisation or trust.

The relevant health organisation (NHS trust, NHS Foundation trust or independent hospital providing NHS funded care) operating a mental health unit may also appoint a deputy responsible person to carry out the responsible person's functions that are delegated to them. This may assist larger NHS and independent organisations or trusts who operate several mental health units or services spread out geographically across the country.

The responsible person may delegate some of their functions under the act to other suitably qualified members of staff within the organisation, including the deputy responsible person. Refer to section 10 of this guidance for further detail on delegation. It

is important to state that whether the responsible person delegates any of the act's functions or not, they retain overall accountability for these functions being carried out.

The name of the responsible person should be published in the same way that other members of the organisation or trust executive board are published.

Section 3: policy on use of force

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 or trust. Where there is more than one mental health unit within the organisation, one single organisation wide policy should be produced and shared across the organisation. This will ensure there is a consistent approach across the organisation.

Where the organisation or trust has an existing policy on use of force this may be updated to ensure it complies with the requirements set out in the act and this guidance. The responsible person must ensure it is produced, published and consulted on as set out in this section of the statutory guidance.

It is essential that all policies reflect the needs of the patient population using the services and are tailored to the specific services being provided. Where an organisation or trust is providing different types of services across several units the policy should clearly set out the different needs or considerations that may be relevant for particular patient groups, for example, children and young people, adults, women and girls, patients with autism or a learning disability, people from black and minority ethnic backgrounds and people who share protected characteristics under the Equality Act 2010.

It is also important that policies reflect the differences in approach required to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the patient population being served. This should include understanding of cultural identity and heritage, and the discrimination faced by many people from black and minority ethnic backgrounds, in particular by black men.

A former male patient said:

"Having been restrained a number of times, I thought they were restraining the stereotype of me. They weren't restraining me as an individual. I think this is something that goes on for unfortunately the over-representation of black men being restrained."

Healthcare services are also encouraged to consider the needs of inclusion health groups which is a 'catch all' term to describe people who are socially excluded, this could for example include people who experience homelessness, people with drug and alcohol

dependence, or victims of modern slavery. They typically experience multiple overlapping risk factors and poor health (such as poverty, violence and complex trauma), experience stigma and discrimination. For more information please see Inclusion Health: applying All Our Health.

The policy should include a statement which sets out the organisation's commitment to minimising the use of force, through the promotion of positive cultures, relationships and approaches which understand the trauma history and triggers of individuals which will prevent escalation and any need to use force.

A former child patient said:

"For a patient who has experienced physical abuse, if you're restrained, it can bring back a lot, it can bring back flashbacks about the physical abuse you have experienced. Also, domestic violence, if you've seen your parents who've been physically violent with each other it brings back trauma. I really don't feel that's recognised enough."

The policy should set out the plan or approach the organisation or trust is taking to reduce the use of force within their mental health unit(s). The policy should include (but is not limited to) the following:

1. the organisation or trust's commitment to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds, women, girls and disabled people

2. the organisation or trust's commitment to minimising the use of force, and eliminating the inappropriate use of force, recognising the potentially traumatising impact the use of force can have

3. the preventative action the organisation or trust is taking to minimise use of force

4. information about how the organisation or trust will monitor the use of force on people who share protected characteristics under the Equality Act 2010

5. what action the organisation or trust will take if the inappropriate or disproportionate use of force is identified. Healthcare staff, managers and independent advocates have a professional responsibility to be alert to the disproportionate use of force, to know what they must do if they witness or suspect the abusive use of force, and to take action. Organisations or trusts must ensure staff understand their safeguarding responsibilities and are familiar with the organisation or trust's safeguarding policies and procedures

6. details of the types of force and specific techniques which the organisation or trust may use, which may be different in services for children and young people, adults or older people. This should include information about the risk assessments undertaken prior to the techniques being approved by the organisation or trust board, and an assessment of the training needs of staff in using these techniques

7. set out how children's rights will be protected when they are separated from others within the unit or ward. This should cover, for example, the physical environment, personal possessions, stimulating activities, support and meaningful contact with staff, as well as notifying parents or others with parental responsibility

8. examples of the circumstances in which the use of force may or may not be used, and when a use of force is considered negligible (in accordance with this guidance - see section 6)

9. information on how the risks associated with the use of force will be managed

10. details of relevant staff training programmes and how learning and knowledge will be transferred into the workplace. This should also include the importance of all training being provided by certified training providers as complying with Restraint Reduction Network National Training Standards (section 5 for further details on the training standards)

11. details of how patients, their families, carers, and independent advocates will be involved in care planning which sets out the preventative strategies to the use of force, through for example advance statements. It is important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account

A former female patient said:

"I think often care plans are not understanding enough if there is a history of abuse and how using prone restraint could affect a person. Staff should always realise they could have a long-lasting impact on someone."

12. information about how staff will use and follow individualised patient plans, such as Positive Behavioural Support Plans (or equivalent). See Positive and Proactive Care: reducing the need for restrictive interventions 2014 for further detail on Positive Behavioural Support

13. details of how patients, their families, carers, and independent advocates can raise concerns about the use of force, and how they will be involved in post incident reviews following the use of force, and how the impact (physical or emotional) will be reflected in the patients' follow up care. The NICE Quality Standard (QS154), Quality Statement 5 provides further information on post incident debrief

A former child patient said:

"I think I probably had 3 debriefs in the 3 years that I was in and out of hospital. I hardly ever got any support after my own restraint or after seeing a friend being restrained."

14. clear information on the expectations for recording and reporting of the use of force within the organisation or trust

15. detail on how analysis of local management information will be used to inform development and review of the policy

16. details on how the organisation or trust will work to co-produce policies with their local patient populations to reflect their needs and experiences

17. details of how the policy will be publicised and communicated to patients, families, carers and independent advocates

18. detail of the principles of staffing for safe and effective care: having the right number of staff with the right knowledge, skills and experience in the right place at the right time, and the impact this can have on reducing the use of force

19. recognition of the emotional impact the use of force has on staff and how they will be supported

20. details of how healthcare staff and the police will work together to manage incidents of use of force if (in exceptional circumstances) the police are called to assist in the management of a patient. This should refer to The College of Policing 'Memorandum of Understanding' – The Police Use of Restraint in Mental Health and Learning Disability Setting (see second link listed in 'Mental Health' section)

21. details of how often the policy will be reviewed and by whom, this should include the role for patients, their families and carers in providing ongoing feedback for the life of the policy to inform any changes

For (6) in the list above, the Mental Health Act 1983: Code of Practice sets out the following in relation to physical restraint where restrictive intervention is required:

- patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered there should be no pressure to the neck region, rib cage and/or abdomen

- unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor

Positive and Proactive Care 2014: reducing the need for restrictive interventions also states:

- if exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible

- staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation

A former child patient said:

"For some reason my hospital always did prone restraints even though it's more dangerous. I would be face down and someone would be shouting at me to calm down. Who shouts calm down? Like it's going to help. Just shouting at you when you are clearly already very distressed.

Before publishing the policy on use of force, the responsible person must consult with whoever they consider it appropriate to consult. This should include both current and former patients, their families and carers, bereaved families, any relevant local third sector organisations and Local Healthwatch (as a statutory body for patients and the public). Because of the disproportionate impact of the use of force on women and girls, people from black and minority ethnic backgrounds, and disabled people, this should also include these groups. This may be carried out through existing networks, user groups and forums such as patient safety committees or groups. Staff who have not been involved in the development or co-production of the policy on use of force should also be consulted. The policy on use of force should also include details of who or which groups were consulted. General feedback for those who participated in the consultation should be provided so that they can understand how their contributions or experiences were considered and included.

It is important that staff working in mental health units recognise the valuable contribution people with personal experience can have in the design and improvement of services. The responsible person should ensure that the policy on use of force is co-produced with

people with personal experience of mental health services, along with their families and carers. Meaningful co-production in service design is critical to ensuring services respond to the needs of patients using their services, and that they are trauma-informed and person-centred.

A person with personal experience told us:

"Our lived experience is our first-hand valuable experience that could be used in a positive way to influence positive change."

Good co-production means drawing together people with personal experience and health professionals and treating them as equal and reciprocal partners. It requires everyone to value one another's opinions, views and expertise. Understanding and learning from their experiences (good and bad) should lead to more person-centred approaches to care, and improved relationships between service users and staff, and can help break down barriers and assumptions people may have. Good co-production means that everyone involved will be able to recognise their input into the policy on use of force. However, the policy on use of force remains the responsibility of the responsible person who will have the final say over its contents.

The policy on use of force should also be signed off by the organisation or trust board.

The policy on use of force must be published; this should be on the organisation or trust's website and in hard copy format, and any other way that the organisation or trust usually makes information available and accessible for patients and service users. The policy should be made available in different formats (such as EasyRead) as appropriate to the type of service being provided and in line with the duty to make reasonable adjustments. It is good practice to publish all available formats on the organisation or trust's website.

The act requires the responsible person to keep the policy on use of force under regular review. This should be done on an annual basis to ensure it is up to date with current practice and evidence, and to allow for local management information to inform the review. Patients should also be involved in the review process; again, this could be through existing networks, user groups and forums such as patient safety committees or groups. If the review suggests changes to the policy which are considered to be a substantial change, the act requires that the responsible person must again consult on the changes and re-publish the policy.

Local management information (such as learning from post incident review data, deaths (specifically Coroner's Preventing Future Deaths reports) or serious injuries, complaints data and records of force used in the previous year) should be used to update the policy on use of force. For example, post incident review data should include information on ways

in which to prevent or reduce the use of force in the future for a patient, such as those who share a protected characteristic under the Equality Act 2010. Data should be analysed to identify themes emerging across patient groups which could be used to update the policy on use of force and reduce any disproportionate use of force on people sharing protected characteristics. This should also be used to update the information about of force and staff training programmes. If a review of current practice and local management information identifies that the organisation is not achieving the principles set out in the policy on use of force, then the policy on use of force should be reviewed and updated.

The responsible person should ensure that all staff within the organisation or trust are aware of the policy on use of force and that it applies to all staff working within the organisation or trust who will be involved in the use of force. This includes NHS employees, contractors, and temporary or bank or agency staff.

Section 4: information about use of force

It is important that patients, and where appropriate their families and carers, are provided with information about the use of force and their rights in relation to any use of force which may be used by staff in a mental health unit. The information will help patients and their families and carers understand what might happen to them whilst they are an inpatient in a mental health unit, what their rights are, and what help and support is available to them should they need it.

As with the policy on use of force, the responsible person must publish and keep under review information about the rights of patients as it relates to the use of force. It is important the information being provided reflects the age and needs of the patient population using the service and is tailored to the specific service being provided. Where an organisation or trust is providing different types of services across several units the information should be specific to the type of service being provided.

The information provided should include (but is not limited to) the following:

- a clear statement that the use of force is only ever used proportionately and as a last resort and that it can never be used to cause pain, suffering, humiliation or as a punishment

A former female patient said:

"I was forcibly medicated for about eight weeks because I did not want to be medicated at the time. It didn’t matter that at some points there were 6 males and only 1 female, whilst

they were injecting me in my bottom or in my thigh, which obviously involved moving your clothing. That stayed with me forever and I found that humiliating."

- which staff may use force and in what limited circumstances, and what approaches and steps will be taken to avoid using it
- details of the types of force (techniques and approaches used) which staff may use with a distinction between children and young people, adults and older people and sex
- details of how patients, their families, carers, and independent advocates must be involved in care planning which sets out the preventative strategies to the use of force, through for example advance decisions

A former female patient said:

"I can take back control of my own life, be involved in my care and am able to discuss a range of options, which are personally suited to me, including alternatives to medication."

- details of how patients, their families, carers, and independent advocates must be involved in post incident reviews following the use of force, including information on the process and what to expect
- what action the organisation or trust will take if the inappropriate or disproportionate use of force is identified
- the patient's rights in relation to the use of force; this includes rights protected by the Human Rights Act 1998, the Mental Health Act 1983, Mental Capacity Act 2005, and the Equality Act 2010 (including the duty to make reasonable adjustments). Patients must understand that during any use of force their human rights will be respected, and the least restrictive intervention will be used
- the patient's legal rights to independent advocacy and how to access organisations who can provide this service (including contact details of relevant local and national organisations), and the role of the Independent Mental Health Advocate and Independent Mental Capacity Advocate (if applicable)
- the organisation or trust's complaints procedure and the help available from an independent advocate to pursue a complaint in relation to the use of force. This should include details of who can make a complaint and to whom

A former child patient said:

> "Now I have realised this happened to me, it probably happened to other people. At the time it was far too complicated to put in a complaint. So, I didn't. So, things kept happening to everyone. It should be easier and simpler to put in a complaint, or no one will ever say anything."

- the process for raising concerns about abuse and breaches of human rights, and the help available from independent advocates
- clear information on what will be recorded and reported on the use of force
- details on how the organisation or trust will work to co-produce policies and information with their local patient populations
- a glossary of the terms used by staff and the organisation or trust in relation to the use of force
- details on where the policy on the use of force can be found
- details of how often the information about use of force will be reviewed and by whom, this should include the role for patients, their families and carers in providing ongoing feedback on the information provided to patients to inform any changes

The Equality and Human Rights Commission have produced information for patients, their families and carers about their rights under the Mental Health Act 1983, Human Rights Act 1998 and Equality Act 2010. The information covers much of what is required by the act and this statutory guidance and could be used to assist in producing the information about use of force. Your rights when detained under the Mental Health Act in England

Before publishing the information about use of force, the responsible person must consult with whoever they consider it appropriate to consult. This should include both current and former patients across the protected characteristics under the Equality Act 2010 (including women and girls, people from black and minority ethnic backgrounds and disabled people), their families and carers, bereaved families, staff representatives, any relevant local third sector organisations, and Local Healthwatch (as a statutory body for patients and the public). Staff who have not been involved in the development of the information should also be consulted. This may be carried out through existing networks, user groups and forums. General feedback for those who participated in the consultation should be provided so that they can understand how their contributions or experiences were considered and included.

As with the policy on use of force, it is important to recognise the valuable contribution people with personal experience can have. The responsible person should ensure that the information on the use of force is co-produced with people with personal experience of

mental health services, along with their families and carers and the staff involved in providing the care. See section 3 policy on use of force for more on co-production.

The information about the use of force should be signed off by the organisation or trust Board.

The responsible person (or delegated members of staff) must ensure the information about the use of force is provided to each patient, and to any person whom the responsible person (or delegated members of staff) considers it appropriate to provide the information to in connection with the patient, such as a family member or carer. However, the duty to provide patients and others with the information does not apply if the patient or other person refuses the information. There may be legitimate reasons for patients refusing information, such as they find it causes further distress, or they feel they do not require it. If the patient initially refuses the information, the responsible person (or delegated members of staff) should make further attempts at reasonable intervals to provide them with the information in an appropriate format.

The responsible person should guard against patients being routinely said to refuse information about their rights. They should actively monitor take-up of information, and ensure strategies are in place to encourage positive dissemination of the information. The responsible person should also record whether the information was accepted or refused by the patient.

The information must be provided to the patient as soon as reasonably practicable after they are admitted to the mental health unit. The responsible person (or delegated members of staff) within the unit will need to use their professional judgement about when it is an appropriate time to provide the information to patients. Individual approaches may be required and will be dependent on each patient. Staff will need to be sensitive to the timing of approaches to inform some patients (for example children and young people or survivors of abuse) about their rights in relation to the use of force, so as not to cause alarm or distress.

It can be traumatic for other persons within the unit to witness force being used on others. It is recommended that other persons who may witness force being used, be offered the information about use of force to avoid any distress and confusion this may cause them. It would be good practice to offer the other person who may have witnessed the use of force the opportunity to debrief with a member of staff not involved in that use of force. This should be seen as a further opportunity to learn and take action if required.

The responsible person (or delegated members of staff) must take whatever steps are reasonably practicable to make sure the patient is aware of the information about use of force and understands it, whilst having regard to the interests of the patient who has the right not to discuss the information if they do not want to. This means that staff must

explain the information set out in an accessible and easily understandable way. Staff may need to talk to patients more than once about the information, using tailored approaches which are appropriate to the patient to ensure they are aware of and understand the information they are being provided with.

A former child patient said:

"I'm autistic and at times I become non-verbal. A lot of staff in hospital tended to take the approach that non-verbal means they have nothing to say. But the best staff would work out a way to communicate with you despite that."

It is important that the information about use of force is presented positively to patients, their families and carers, and that the use of force is not presented as a means of managing 'bad behaviour', or used to scare patients into compliance. Staff should also recognise that the information about use of force could be re-traumatising for survivors of abuse and violence.

For patients with a neurodiversity, learning or intellectual disability written or verbal information alone may be of limited use. Tailored approaches will be required to ensure patients are given the best opportunity to truly engage with the information they are being presented with. This may require a range of approaches and techniques to be considered.

Additionally, where patients may lack mental capacity (to make relevant decisions) (including temporarily), it is important that the responsible person follows the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice, including applying the principles of that act as applicable and providing information about the use of force that is appropriate to the patients circumstances (such as simple language, visual aids or any other means).

The responsible person may also want to consider whether it would be appropriate to involve an independent advocate who can also play a vital role in assisting patients to understand their rights in relation to the use of force. An independent advocate may also be of assistance where there is a lack of trust in staff which may make the receipt of the information difficult.

The information about use of force must be published. This should be on the organisation or trust's website as well as in hard copy. It could be as a leaflet available on the wards, or in a patient's welcome pack. Patients and others should know where the information is located and be able to easily access it themselves. The information about use of force should be accessible to all patients reflecting the population using the service. This may mean producing the information in different formats and languages. As with the policy on

use of force, it is good practice to publish all available formats on the organisation or trusts website.

Under the Equality Act 2010 organisations or trusts have a duty to make reasonable adjustments, which means that the information about use of force must be provided in accessible formats for disabled people. This duty is anticipatory, so organisations must think in advance of the needs of patients and not wait until the need arises to provide foreseeable adjustments. NHS organisations are also legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients.

The act requires the responsible person to keep the information about use of force under regular review. This should be done on an annual basis to ensure it is up to date and in the relevant formats for patients. Patients should also be involved in the review process; again this could be through existing networks, user groups and forums. If the review suggests changes to the information being provided which are considered to be a substantial change the responsible person must again consult on the changes and re-publish the information. The information about use of force may also require updating following any revisions to the policy on use of force.

Section 5: training in appropriate use of force

Staff education and training are central to promoting and supporting calm, safe and respectful environments where the use of force is kept to a minimum. It is essential that staff are properly trained to provide safe, trauma-informed, person-centred care, where children and young people, adults, women and girls and older adults are treated with dignity and respect and their views and feelings are understood and their specific needs are met.

A former child patient said:

"My key nurse was fantastic. She had a very calming approach. We used to be able to have a laugh. That allowed me to open up a lot more with her. When it was a bad day, I could communicate with her. She actually cared about me getting better."

The training provided should support an overall human rights-based approach which is focussed on the minimisation of the use of force and ensures any use of force is rights-respecting. Human rights apply to all patients receiving care and treatment, and all training must be informed by the legal duties of staff to respect and protect those human rights.

The emphasis of any training programme should be on creating a positive environment for care, which promotes the patient's best interests and reduces the reliance on the use of force; through understanding the impact of trauma and the reasons for a patient's behaviour, it is possible to pre-empt, take active steps to avoid, or de-escalate distress or conflict. Organisation or trust boards should ensure that training and workforce development reflects the therapeutic nature and purpose of health and care settings and ensure that it has been appropriately developed for use in health and social care rather than for other purposes.

People with personal experience told us:

"We would like to see more pre-escalation. There is de-escalation obviously, which is what people should be focussing on. But then there's pre-escalation, which is obviously the prevention of anything escalating in the first place.

On the rare occasions where the use of force is needed, patients, their families and carers must feel confident that staff have been properly trained in the safe use of the techniques they are using.

It is also important that training is done in a manner that is respectful of staff's legitimate concerns to be able to protect the safety of the patient, and others against potential violence from another patient. The training should aim to provide staff with the confidence to know when they can and should use appropriate and proportionate force as well as being able to recognise what is inappropriate or excessive force. There should be clear plans in place to ensure that knowledge gained during staff training is transferred to the workplace and applied in practice, and that staff should only use techniques they have been appropriately trained to use.

An NHS member of staff told us:

"The training can be exemplary but if this is not employed within the clinical setting then it was worthless. Staff need to be monitored to ensure they are delivering the training as taught and don't start taking short cuts, making things up or just resorting to the use of force as the quickest and easiest option."

As with the policy on use of force and information about use of force it is important to ensure the experiences of people with personal experience inform the development of training materials and delivery of the training through meaningful co-production. This could involve presentations from people with personal experience talking to staff about how the use of force impacts patients. Good co-production should involve respectful communication, listening to everyone's perspectives, getting to know patients and

breaking down barriers between patients and staff. Training programmes should also be relevant to the patient population using the services and cover the different approaches which will be needed for children and young people, women and girls, people with autism or a learning disability or patients from black and minority ethnic backgrounds.

The responsible person must provide training for staff about the use of force by staff who work in the mental health unit. The definition of staff is included within section 13 of the act. For the purposes of complying with the act staff means any person (whether as an employee or contractor) who works for an organisation or trust that operates a mental health unit who either:

- may be authorised to use force on a patient
- may authorise the use of force on a patient
- has general authority for the use of force

This means that all staff (including temporary, bank or agency staff) involved in using force on a patient or involved in the authorisation of the use of force must undertake training which is appropriate to the role they are undertaking. For example, executive board members (or equivalent) who authorise the use of force in their organisation or trust should undertake appropriate training to ensure they are fully aware of the approaches and techniques (prevention or otherwise) their staff are being trained in. It should also include training on why force is used and the impact and risks the use of force has on patients. They would not be expected to complete the full training programme given to staff who are directly involved in patient care.

Section 5 sets out, as a minimum, the list of training topics which must be covered. The list in the act is not exhaustive. For each of the topic areas which must be included in staff training the following sections set out examples of what should be covered in each of those topic areas.

A. How to involve patients in the planning, development and delivery of care and treatment in the mental health unit

This should cover the following:

- taking the time to get to know each patient’s means of communicating their wishes, preferences (this could include the option to choose the sex of staff directly involved in their care), feelings, and their past experiences of trauma, including abuse. Staff will need to consider alternative methods of communication, for example drawing or writing things down, to both allow patients to communicate their needs and understand what is being communicated to them

A former child patient said:

"One health care assistant in one hospital helped me. I couldn't talk at the time. He let me write down how I was feeling. That is how I communicated. The other staff members made it into a joke. But he let me write it down and that really stuck with me and really helped me."

- how discussions between staff and patients should include what makes them feel distressed, scared or out of control and how staff can avoid such situations. This should focus on triggers and the sensory needs of some patients (for example with autism or a learning disability) to prevent the patient becoming overwhelmed

- how families and carers should be involved in the agreement and development of (for adults, this will be subject to the consent of the patient where they are capacitous or competent to make this decision) person-centred care planning and delivery. Again, it is important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers for example, for survivors of domestic abuse or violence. The patients' wishes and preferences must be taken into account

- ensuring conversations and decision-making processes are inclusive and sensitive to the patient's age, understanding, mental capacity and circumstances

- ensuring patients are aware of their legal rights to independent advocacy, the important role of Independent Mental Health Advocates and Independent Mental Capacity Advocates (if applicable) in protecting their rights to be heard and involved

- ensuring all patients, including children and young people and their parents (or those with parental responsibility) are involved in making decisions on the unavoidable use of force, and in the use of least restrictive option as part of their treatment plans. Some patients may need additional support to make their own decision, this could be through accessible information or support from their family or carer, and/or an independent advocate. For others, who are found to lack capacity, there must be a Best Interests decision. It is important their preferences, and all the information that family and others know about them, is used to inform decisions about their care and treatment

- understanding the value of positive engagement with patients in order to provide a trauma-informed, person-centred approach to their care and treatment. It is important that staff show empathy, patience and use positive body language when communicating with patients; the patient should feel confident that they will be listened to. Good communication can play a major part in helping to reduce the need to use force

A former patient said:

"For me personally it was 99% bad communication that led to being restrained. I also see the same things happen to patients I work with. The way patients are ignored is so frustrating. It is often unmet need that leads to agitation etc. The way someone talks to you can make a huge difference. Even during a psychotic episode, I still knew the way people were talking to me was rude and dismissive."

B. Showing respect for patients' past and present wishes and feelings

This should cover the following:

- the different ways in which patients (for example children and young people or those with autism or a learning disability) communicate, including in times of stress and distress. Staff will need to adapt the way they communicate with autistic people to cater for some autistic people's sensory needs. The Core Capabilities Framework for Supporting Autistic People provides guidance on how to implement adjustments

- an understanding of a patient's evolving and changing maturity, an understanding of capacity drawing on the Gillick competence and principles set out in the Mental Capacity Act 2005

- how factors such as past and present wishes and feelings (in particular, any relevant written statement made when the patient had capacity) and beliefs and values that would be likely to influence the person's decision if they had capacity should be given consideration when determining what is in the patient's best interests

- working with families and carers, and others who know the patient well (for adults, this will be subject to the consent of the patient where they are capacitous or competent to make this decision), again noting previous comments about when it might not be appropriate to involve family members or carers

- how to support the patient to express what they want to happen in a particular event. This should consider what might be effective in avoiding or de-escalating a situation through better understanding a person's triggers and individual needs

- how patients (if they wish to) can be supported to be involved in the post-incident review process to reflect and learn from what happened

- an understanding of the patient's past experiences of trauma and abuse and how this should be reflected in their care plan. Staff working with girls and young women in

particular should understand that girls' and young women's mental health, experiences of trauma, discrimination and inequality are interlinked and that a trauma-informed approach to working with girls and young women should be sensitive to both age and sex

A former female patient said:

"For most of my life I've been on the radar of one support service or another. Starting with the care system and a host of child psychologists and social workers. Not one of them took enough interest in me to see past my behaviour and recognise me as a very damaged child."

C. Showing respect for diversity generally

This should cover the following:

- creating and sustaining inclusive environments where every patient (child, young person or adult) feels valued, listened to and supported

A former female patient said:

"I am treated with respect and given the time to express how I feel and am not made to feel a burden when seeking help."

- recruiting and supporting diverse staff groups which reflect the local community
- positively challenging practices and behaviour which have the potential to cause patients or staff to feel degraded and/or excluded
- understanding of the range of factors that can affect staffs' responses to the people they support
- an outline of the law covering all the protected characteristics under the Equality Act 2010; this should recognise the distinct experience of abuse, discrimination and disparities experienced by groups with different protected characteristics
- how to demonstrate respect for individual beliefs, values, cultures and lifestyles and appreciating the differences

A former female patient said:

> "Services work together to consider how best to support me in a way that is culturally appropriate and understanding of my sexuality."

- how to demonstrate a trauma-informed approach which strengthens cultural understanding. Language and cultural barriers can increase the risk of an incident escalating. The risk of force being used, and an incident escalating may not be simply due to the difference in cultures but the lack of cultural understanding between patients and staff

- an outline of inclusion health groups, recognising the distinct experience of abuse, discrimination and inequality experienced by socially excluded groups. Inclusion Health: applying All Our Health provides more information on this.

D. Avoiding unlawful discrimination, harassment and victimisation

This should cover the following:

- as with 'Showing respect for diversity generally' an outline of the law covering all the protected characteristics under the Equality Act 2010; this should recognise the distinct experience of discrimination, harassment and victimisation experienced by groups with different protected characteristics. This should cover in particular:

    - direct discrimination (for example on the basis of disability, race, age, or sex)

    - indirect discrimination

    - reasonable adjustments, and how they are relevant to use of force (for example environmental changes), and how they can prevent the use of force by reducing the likelihood of situations escalating

    - The Public Sector Equality Duty

    - how use of force monitoring and data can identify themes and issues which affects those involved (patients, staff and managers) and in turn, how this should be acted upon

    - the important role of independent advocates in helping patients to challenge the inappropriate use of force

E. The use of techniques for avoiding or reducing the use of force

This should cover the following:

- understanding the challenges and constraints experienced by children, young people and adults living in mental health units (for example the impact of living under blanket restrictions, sensory issues, missing family and friends, being away from familiar surroundings, or feeling unsafe)

A former child patient said:

"Try other things first even if it's something you think is silly. Like one staff member brought in a guitar onto the unit and was playing the guitar. Everyone had such a good time. Just think out of the box, it doesn't have to be something you'd see on paper. It's thinking about the person in front of you and what would help them."

- recognising the high levels of trauma amongst patients in mental health units, particularly among women and girls, people with autism or a learning disability, and people from black and minority ethnic and backgrounds
- creating positive physical environments
- trauma-informed, person-centred care, including preventative approaches such as Positive Behaviour Support (or equivalent). This should include the use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating
- the use of individualised de-escalation techniques, including verbal strategies such as using a calm tone of voice or non-verbal techniques which include an awareness of self and body language

A person with personal experience told us:

"There was an occasion when I was in a secure garden having a cigarette and I refused to come back in. I staged a protest and they got a nurse and a support worker to come down and try and get me to come in. I was just sort of having a meltdown. And she said right let's sit on the floor. So we sat down on the floor and the other support worker sat down and said lets get a cup of tea and have a chat. We sat there for an hour and we laughed, and I cried. I felt like someone was actually listening to me and it felt like a normal situation rather than she was a nurse. I always think to myself how thankful I was for that lady, because it broke the barrier down of, you against them. That was the beginning of me starting to trust them again, but it was just literally sitting on the floor."

- conflict avoidance and resolution (within inter-personal relationships and groups)
- staff clinical supervision, reflective practice, and development and mentoring

- understanding of the difference between coercion or threatening to use force and de-escalation so that staff understand that trying to gain compliance through coercion or threats is not ethical or in line with the least restrictive approach

F. The risks associated with the use of force

This should cover the following:

- preparing person-centred care plans which identify individual risks associated with the use of force, and how these risks are minimised (including by not using force particularly on patients with cardiac problems or other serious physical health co-morbidities)

- physical, psychological and emotional effects on those subject to the use of force

A former child patient said:

"The restraint only lasts a minute but the memory of it lasts forever."

- physical, psychological and emotional effects of witnessing the use of force

- physical, psychological and emotional effects on staff applying the use of force

- the risk of deaths and serious injuries caused by, or connected to, the use of force

- medical emergency procedures or basic life-support – to include vital signs monitoring and response, including pulse, respiration and complexion. Staff should know how to monitor the patient's airway and physical condition throughout the use of force to minimise the potential of harm or injury, and raising the alarm if concerned about a patient’s health

- roles and responsibilities during an incident – in the exceptional event of the police being called to assist staff in the management of a patient, it is important that everyone is aware of the role of the police and the healthcare staff in managing the incident properly and safely, and the procedures to be followed. The College of Policing 'Memorandum of Understanding' – The Police Use of Restraint in Mental Health and Learning Disability Setting (see second link listed in 'Mental Health' section) sets out detailed guidance on the clinical oversight expected during an incident. As noted above we expect the police to be called to assist in exceptional circumstances when all other responses have been considered. It is important that healthcare staff understand that they retain overall responsibility for the patient and their safety and wellbeing and must intervene if they consider there is a risk to the patient

G. The impact of trauma (whether historic or otherwise) on a patient's mental and physical health

This should cover the following:

- the impact of sexual, physical and emotional abuse on children's sense of who they are and what they can expect from adults

> A former child patient said:
>
> "If you've gone through something worse, you know you've seen horrible stuff happen, it can really affect you. I think also for me it made me feel like I've done something wrong, or I was a bad person. It also made me feel less of a human. Especially like when it's done almost blasé.

- the impact of sexual, physical and emotional abuse on survivors' experience of the use of force
- coping with loss, fear and anxiety
- strategies for building self-esteem and regaining a sense of control
- modelling non-violent, healthy relationships
- understand the meaning of 'trauma' and how it can impact on people's experience of use of force
- how the use of force can trigger a trauma memory
- understanding that the use of force can be traumatic for patients experiencing it and the staff applying it
- consider how the sex of the person applying the use of force could trigger trauma memories for certain patients, particularly women and girls who are disproportionately likely to have experienced violence and abuse from male perpetrators
- recognition of potential symptoms of trauma and how behavioural symptoms can be linked to trauma
- an understanding of trauma through a developmental perspective that applies to all ages, not just children

H. The impact of any use of force on a patient's mental and physical health

This should cover the following:

- the impact of use of force in further or re-traumatising patients whose mental ill health may already have been exacerbated by forms of trauma

A former child patient said:

"I don't think they take into consideration how much it [restraint] does affect your mental health. You're already struggling with your mental health when that happens. It's bound to have a big impact.

- ensuring use of force is never applied as a punishment or as a means of causing pain, suffering or humiliation
- the impact of the sex of the person applying the use of force to the patient and the sex of the patient subject to the use of force
- the impact of the use of force in relation to the age of the patient, particularly for children and young people and older adults
- the impact of the use of force in relation to the person's health condition or impairment

I. The impact of any use of force on a patient's development

This should cover the following:

- risk of child's (or adult's) unmet or misunderstood needs being conceived as wilful, challenging behaviour (leading to coercive and punishment-based interventions)
- preventing institutionalisation and preparing patients for family life and relationships within the community
- an understanding of the difference in size, physiology, psychological and emotional development of children

J. How to ensure the safety of patients and the public

This should cover the following:

- the process by which patients and their families or carers are informed of the approaches and techniques which may be used
- the process by which patients and their families or carers are involved in agreeing their own care plan and arrangements to take active steps to prevent and pre-empt distress and conflict arising
- the impact of the use of force on staff's mental and physical health whether this is caused by a patient's physical aggression or by observing the use of force and how this is mitigated within the organisation
- the role of observers in any use of force incidents
- the role of independent advocates in assisting patients and their families or carers in agreeing plans and raising concerns about the use of force
- Duty of Candour in regulation 20 of the 2014 Regulations in respect of the use of force – see section 9 for further detail on the Duty of Candour
- the organisation's approach to the inappropriate use of force and action which will be taken where it is identified
- whistleblowing and 'Freedom to Speak Up Guardians' procedures

K. The principal legal or ethical issues associated with the use of force

This should include the following principles (from Positive and Safe Care: reducing the need for restrictive interventions 2014**Error! Bookmark not defined.**):

- the use of force must never be used to punish or be for the sole intention of inflicting pain, suffering or humiliation
- there must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
- the nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
- any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
- any restriction must be imposed for no longer than absolutely necessary

- what is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
- use of force must only ever be used as a last resort
- the involvement of people who use services, carers and independent advocates is essential when reviewing plans for the use of force
- understanding of human rights and discrimination legislation and how this interacts with other mental health, and health and social care legislation

This should also cover the following:

- the (very limited) circumstances in which the use of force is appropriate and what are the reasons for its use or not; The legal framework for use of force but, in particular circumstances justifying the use of force (Mental Capacity Act 2005 and Mental Health Act 1983)
- the rights of service users and staff to be in a safe environment

For existing members of staff, the act requires that training must be provided as soon as reasonably practicable after section 5 comes into force. For new members of staff training must also be provided as soon as reasonably practicable after they have become a member of staff. In practice all staff starting a new role should receive training as part of their induction, and they should complete this before working clinically on a ward. If there are new members of staff who have not received training in accordance with the act and this guidance, but are working on a ward, they should receive their training within one month of starting their new role. Staff should not be involved in using force on a patient if they have not received their training. The responsible person should provide regular reports to the organisation or trusts board on staff training. The report should include, for example, details of the numbers of staff trained, which staff have been trained, and what level of training they have received.

The requirement to train members of staff does not apply where the responsible person considers previous training in the appropriate use of force was both sufficiently recent and of an equivalent standard to that required under the act. It is for the responsible person to determine if previous training is of an adequate standard and covers the detailed requirements set out in the act. It is important this is properly considered as decisions around individual staff training needs, and this act's requirements, may come under scrutiny during inspections and monitoring activity, complaints investigations and safeguarding reviews. If the responsible person is finding it difficult to assess whether the member of staff's previous training was adequate, they should err on the side of caution

and provide further training. Where prior training related to adults only, and the member of staff is now working with children, new training must be provided (and vice versa).

Refresher training must be provided at regular intervals to ensure staff have received relevant, up to date training. This should be on an annual basis as a minimum. The training is aimed at refreshing skills, but it should also include some element of new learning or development.

The responsible person must ensure that temporary, bank or agency staff have received training which is of an equivalent standard to the training requirement under the act before they are allowed to use force on patients when working in the mental health unit. Temporary, bank or agency staff should also be familiarised with the organisation or trusts policy on the use of force.

For the safety of both patients and staff, it will also be important for the responsible person to ensure that all staff, whether employed or contracted, temporary, bank or agency staff have been trained in the use of the same techniques.

This requirement does not extend to voluntary staff as they are not expected to be involved in the use of force on patients under any circumstances. Only staff working in a professional capacity who are appropriately trained should use force on a patient. However, it would be good practice to ensure voluntary staff are aware of how to avoid the use of force, what to do if a situation escalates, and are familiar with the organisation or trusts policy on the use of force.

In addition to the requirements under Section 5 of this act, under the Management of Health and Safety at Work Regulations 1999 employers have a legal duty to assess any risks to employees and others from exposure to reasonably foreseeable violence and aggression relating to their work. This assessment should identify appropriate control measures to protect workers, which may include training in the prevention and management of violence or aggression. For further information please see Health Services - Workplace violence: What you need to do. If workers have concerns about their own health and safety, they can Contact the Health and Safety Executive.

Restraint Reduction Network training standards and certification

The Restraint Reduction Network (RRN) were commissioned by Health Education England, working with NHS England and NHS Improvement to develop national standards for training in the prevention and, where necessary, use of restrictive interventions, in line with the requirements of the act. The RRN training standards provide a national benchmark for training and have been endorsed by a wide range of professional bodies, charities and government arm's length bodies.

The Training Standards aim to facilitate culture change, not just technical competence and are designed to:

- protect people's fundamental human rights and promote person-centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

Training providers must be certified as complying with the RRN Training Standards. Certification bodies must be accredited by the UK Accreditation Service (UKAS) as complying with the ISO standards for certification. UKAS is the government recognised national accreditation body for the United Kingdom. UKAS ensure the competence, impartiality & integrity of the certification scheme. A list of certified training organisations can be found on the RRN website.

Certified training that complies with the RRN Training Standards became a requirement of NHS commissioned services for people with learning disabilities, autism or mental health conditions in April 2020. Recognising the time required to achieve certification for training providers and then for service providers to complete all staff training, NHS commissioners were asked to agree Service Development Improvement Plans with service providers, giving assurance that action is underway to deliver on this new contractual requirement within the agreed timeframe. The Care Quality Commission will expect services across health and social care to have certified training that complies with the RRN Training Standards from April 2021.

When commissioning a training provider, NHS trusts and commissioned services therefore need to ensure that training is certified (by a UKAS accredited body) as complying with the RRN Training Standards. This will help to ensure training complies with the requirements of section 5 of the act.

It is important that staff receive the training they need to help prevent the need for reactive restrictive practices (for example Positive Behaviour Support or Safewards) ahead of receiving training in the use of force. Training in the use of force must be proportional to the needs of patients and be delivered by competent and experienced training

professionals with relevant experience who can evidence knowledge and skills that go far beyond the application of physical restraint or other use of force. Certified training ensures this is the case. Certified training also ensures training complies with all the requirements of the act.

Training to understand the effect of a threat to use force and coercion

The threat to use force and coercion are not included within the definition of the use of force covered by the act. However, the threat to use force is included within the meaning of control or restraint set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The RRN Training Standards**Error! Bookmark not defined.** set out that training needs to cover the legal circumstances in which use of force can be lawfully used. As part of this the standards set out clearly that the use of force must never be used as a threat or as punishment, or in a way that curtails the rights and freedoms of the individual.

It is also important that staff and patients recognise the difference between de-escalation and coercion.

The RRN Training Standards define coercion as: any action or practice undertaken which is inconsistent with the wishes of the person in question (undertaken without the person's informed consent).

Examples of coercion or psychological restraint (as defined within the RRN Training Standards) can include constantly telling the person not to do something, or that doing what they want to do is not allowed or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example mobile phones, favourite toys or comforting objects, or keeping the person in nightwear with the intention of stopping them from leaving.

Blanket restrictions are another form of control which can have a negative impact on how patients behave, and their care and recovery. Examples of blanket restrictions could include a lack of access to outdoor spaces or the internet. There may be circumstances where there will be restrictions on all patients that are necessary for their safety or for the safety of others. Any blanket restrictions imposed should have a clear justification, and organisations or trusts should have a policy in place to ensure the reasons for the restriction are communicated to patients, family members and carers.

De-escalation (verbal and non-verbal) aims to prevent an escalation in potential or actual challenging behaviour or conflict. De-escalation involves different approaches which are specifically tailored to the patient; the specific techniques should be discussed with the

patient as part of the care planning process. De-escalation relies on staff providing good interventions and working in the best interests of the patient.

Training which is certified as compliant with the RRN training standards covers the above. As previously noted certified training that complies with the RRN Training Standards became a requirement of NHS commissioned services for people with autism or a learning disability, or mental health conditions in April 2020.

Section 6: recording use of force

It is important that there is openness and transparency within mental health units about how often they use force, and the reasons why. Robust data collection has many organisational advantages, such as informing restraint reduction plans and identifying issues at an individual patient level. Recording use of force also helps public authorities to meet their obligations under the Public Sector Equality Duty, by demonstrating that they understand how they use force on different groups sharing protected characteristics under the Equality Act 2010. They can then take action to reduce any disproportionate use of force identified.

It is important that organisations or trusts have the necessary systems in place to record any use of force and that staff have the training, knowledge and skills to do so correctly. The responsible person (or members of staff to whom the responsibility for keeping a record has been delegated to) must ensure that all staff involved in the use of force understand the relevant definitions and terminology, and guidance about what must be recorded.

Since the publication of Positive and Proactive Care in 2014, there has been a lot of work to improve the quality of information recorded about the use of force. Changes to NHS Digital's Mental Health Services Data Set, and the continuing work across NHS Digital, the Care Quality Commission and NHS England and Improvement to address issues with under reporting, has led to an improvement in the quality of submissions and an increase in the number of organisations submitting data. However, it is still the case that, despite these improvements there are still too many organisations or trusts and independent hospitals who are not submitting data in the way that they should.

It is already mandatory for NHS organisations or trusts and independent hospitals (where they are providing NHS funded care), to submit data on the use of force to the NHS Digital Mental Health Services Data Set. Through the implementation of the act we can expect to see an increase in compliance in relation to the submission of data, and the number of organisations or trusts submitting data in order to meet their obligations under the act.

This section sets out the requirements for the responsible person (or delegated members of staff) to keep a record of any use of force on a patient by staff who work in the mental health unit. The information which is recorded by mental health units and submitted to NHS Digital will be used to form the national statistics which the Secretary of State must publish as set out in section 7 of the act.

Positive and Safe Care Programme – Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

The use of data to inform the reducing restrictive interventions agenda is a central part of the trust's restrictive practice reduction programme. In particular, the ability to use data to inform and promote individualised person-centred approaches to reduce the use of restrictive interventions has proven crucial.

It supports clinical teams to target interventions and resources where they can be of most help, promoting environments that better meet the needs of the people that live and work within them.

One patient said: "looking at my incidents helps me understand I am not a bad person, bad things have happened to me and that's why I have incidents at certain times and I need more support during those times."

Guidance on the negligible use of force

The duty to keep a record of the use of force does not apply if the use of force is negligible. The inclusion of this distinction within the act is to ensure that the recording of the use of force remains proportionate within the aims of the act, which are to:

- introduce transparency and accountability about the use of force, and
- require mental health units to take steps to reduce their use of force

Negligible does not mean irrelevant to a person’s experience of care or treatment. We expect that negligible use of force will only apply in a very small set of circumstances. Whenever a member of staff makes a patient do something against their will, the use of force must always be recorded. If a member of staffs’ contact with a patient goes beyond the minimum necessary in order to carry out therapeutic or caring activities, then it is not a negligible use of force and must be recorded.

The use of force can only be considered negligible where it involves light or gentle and proportionate pressure.

Any negligible use of force for the purpose of this section must also meet all of the following criteria:

- it is the minimum necessary to carry out therapeutic or caring activities (for example, personal care or for reassurance)

- it forms part of the patient's care plan

- valid consent to the act in connection with care and treatment (which may include the use of force) as part of the delivery of care and treatment has been obtained from the patient and where appropriate a member of their family or carer has been consulted, particularly a person with parental responsibility if the child is not Gillick competent. Where the patient lacks capacity to consent to the relevant act a Best Interest decision would need to be made and s5 and s6 Mental Capacity Act 2005 should be complied with to the extent applicable

- and only if they are outside of the circumstances in which the use of force can never be considered negligible as set out below

Any use of force that meets the above criteria must be included in the patient's care plan and be recorded proportionately. This could mean a weekly summary and will not be of the same level of detail required for non-negligible force which must be reported to the NHS Digital Mental Health Services Data Set.

The use of force can never be considered as negligible in any of the following circumstances:

1. any use of rapid tranquillisation

2. any form of mechanical restraint

3. the patient verbally or physically resists the contact of a member of staff. For example, telling a member of staff to get off them, to stop touching them or to take their hands off them. It would also include a patient struggling to regain control over their body. It will be important to consider the communication needs of patients with autism or a learning disability and the employment of a more complete behavioural and communication assessment may be needed to establish whether behaviour is used to communicate discomfort

A former child patient said:

"If you're not speaking it doesn’t mean you don’t have anything to say or that you don’t have any feelings. Staff should be trained to understand the patient's perspective and understand their personal circumstances to support them in the best way they can."

4. where the use of force involves the use of a wall, floor, (or other flat surface) and the use of force is disproportionate. In practice, it will be unlikely that such a surface would be used where a patient is not resisting

5. a patient complains about the use of force either during or following the use of force. For example, telling a member of staff they are hurting them

6. someone else complains about the use of force. This does not have to be a formal complaint and can include another patient telling a member of staff they are hurting a patient

7. the use of force causes an injury to the patient or a member of staff. In this context, this would include any type of injury or other physical reaction including scratches, marks to the skin and bruising

8. the use of force involves more members of staff than is specified in the patient’s care plan

9. during or after the use of force a patient is upset or distressed

A former child patient said:

"They say you need to calm down, you need to stop kicking and punching. But how would you react if you're not well and multiple people come and grab you? Of course, you're going to kick out."

10. the use of force has been used to remove an item of clothing or a personal possession

One example of a negligible use of force is: the use of a flat (not gripping) guiding hand by one member of staff to provide the minimum necessary redirection or support to prevent potential harm to a person. Using this example, it is important to note that the contact is so light or gentle that the person can at any time over-ride or reject the direction of the guiding hand and exercise their autonomy. It is essential that the guiding hand does not cause distress to the person.

As noted above one of the criteria for the use of force to be considered negligible is that the use of force forms part of a patient’s care plan. This is because it is important for care teams and the organisation or trust to understand what physical contact is being made

with patients, including whether the care plan allows for frequent use of negligible force and if so in what circumstances. It may be that care plans or methods of communication need to be reviewed if they allow for repeated use of negligible force. It is important to guard against microaggressions and a negative cumulative effect of force. Where a patient's therapeutic care allows for the negligible use of force, that should be recorded in a patient's care plan.

If the same routine negligible force (which is the minimum necessary to carry out therapeutic or caring activities) is used on the same patient on a regular basis then it must be subject to a restraint reduction plan which includes the justification and the proportionality of the measures taken. The minimum information that should be included in the restraint reduction plan is:

- why it is necessary to use this type of force and what other less restrictive options have been considered or already tried
- what the use of force consists of (a clear operational description)
- how frequently the force is likely to be used and in what circumstances
- what is the outcome for the patient if the activity that uses negligible force isn't carried out
- whether the patient consented to the negligible use of force
- how much discomfort it causes the patient
- any special health consideration, for example sensory issues, frailty, or limited communication which makes the patient more vulnerable to the use of any force
- any measures that are being implemented to reduce the need for force to be used
- how the patient subject to the use of force (and where appropriate their families or carers) are involved in actively finding a solution to the need for the use of force
- how often the reduction plan will be reviewed and by who
- what training is needed by staff to implement the negligible use of force safely and competently

After applying the above guidance, if healthcare staff are still unsure as to whether the use of force was negligible or not, they should seek advice from a more senior member of staff. If there is still uncertainty the incident should be recorded.

Negligible use of force is excluded only from the duty to record in accordance with section 6 of the act. Other parts of the act and guidance apply to all uses of force.

Organisation or trusts are additionally encouraged to include examples of what they, after the requisite co-production, consider to be negligible use of force within their published policy on use of force**.**

Use of force information to be recorded

The act requires that the record of the use of force used on a patient by a member of staff must include the following:

a. the reason for the use of force

b. the place, date and duration of the use of force

c. the type, or types of force used on the patient

d. whether the type or types of force used on the patient formed part of the patient's care plan

e. name of the patient on whom force was used

f. a description of how force was used

g. the patient's consistent identifier

h. the name and job title of any member of staff who used force on the patient

i. the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient

j. the patient's mental disorder (if known)

k. the relevant characteristics of the patient (if known)

l. whether the patient has a learning disability or autistic spectrum disorder

m. a description of the outcome of the use of force

n. whether the patient died or suffered any serious injury as a result of the use of force

o. any efforts made to avoid the need for use of force on the patient

p. whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan

For (k) in the above list the patient's relevant characteristics are:

a. the patient's age

b. whether the patient has a disability, and if so, the nature of that disability

c. the status regarding marriage or civil partnership

d. whether the patient is pregnant

e. the patient's race

f. the patient's religion or belief

g. the patient's sex

h. the patient's sexual orientation

i. gender reassignment – whether the patient identifies with a different gender to their sex registered at birth.

Gender reassignment is a protected characteristic under the Equality Act 2010 and information about whether a patient has transitioned from one gender to another should also be collected.

For (d) and (p) in the list above references to care plans may also include Positive Behavioural Support Plans (or equivalent).

For (k) in the list above proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.

For (m) in the above list of recording requirements (a description of the outcome of the use of force) the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

For (n) in the above list (whether the patient died or suffered any serious injury as a result of the use of force) the injuries the patient suffered should be recorded.

Serious injuries to a patient should also be reported to the Care Quality Commission if the patient was seriously injured while a regulated activity was being provided or their injury may have been a result of the regulated activity or how it was provided. Guidance on Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of Other Incidents provides further detail on the types of incident and injuries that should be considered for the purposes of recording under this act's requirements. For example, any injury to a service user which, in the reasonable opinion of a health professional, requires treatment by a health professional to prevent death, or if left untreated would lead to permanent damage to, for example, bones, muscles, or tendons.

NHS and independent organisations (where providing NHS funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. The death must also be reported to the local Coroner (including voluntary or informal patients). It is for the Coroner to determine the cause of death. The requirement to record whether the patient died as a result of the use of force will need to be recorded once the Coroner has provided their conclusion. The responsible person must ensure that this is added into the record of the incident. It would also be good practice to notify the Care Quality Commission of the Coroner's conclusion.

For (o) in the above list (any efforts made to avoid the need for use of force on the patient) this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.

For (p) in the list above (whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan) this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

A notification should be sent to the person or persons (families, carers or independent advocates) identified in the patients care plan or positive behavioural support plan (or equivalent) following every use of force. Further guidance can be found in Chapter 26 – 'Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice on notifications following the use of force.

The act requires that the responsible person must keep the record of any use of force for 3 years from the date it was made. It is not permitted to record anything which would otherwise breach the Data Protection Act 2018 or the common law duty of confidence. This is intended to preserve the patient's rights in relation to their information.

Most mental health units record the use of force within their internal incident reporting systems. It is current good practice to include the record of the use of force within the patient's electronic record.

Further considerations when analysing use of force data

Openness and transparency about the use of force within an organisation or trust is essential, but it is also important to recognise that the data only tells part of the story. There are many factors which can impact the number of incidents reported such as staff reporting behaviours or the nature, range and complexity of needs of patients in the unit.

Organisations or trusts have a responsibility to consider the detail behind the data to evaluate if their wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone. Organisations or trust boards should also consider the following:

- when force is used does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force
- what steps have been taken to reduce the use of force for all patients, and in particular those sharing protected characteristics under the Equality Act 2010

This data and its analysis will be vital in informing the unit's plan to reduce the use of force. It should also feed into reviews of the policy on use of force and training in appropriate use of force.

It would be good practice to investigate and interrogate a sample of use of force incidents to produce a lesson's learned report. This report should feed into updates to staff training programmes and reviews of the policy on use of force.

Section 9: investigation of deaths or serious injuries

Unlike other sections of the act which are relevant to the use of force only, section 9 relates to all deaths and serious injuries in a mental health unit, not just those which were as a result of the use of force.

When death or serious injury occurs within a mental health unit, it can indicate that something has gone wrong in the care and treatment provided to an individual. Where there is evidence that problems in care and treatment have occurred and those problems may have led to the death or serious injury then it is important that organisations or trusts understand why things may have gone wrong and how to reduce the risk in the future. Where a full investigation is required by relevant guidance (see below), that process must involve those affected, including the family members or carers of the patients. Any investigation should be conducted by people who are independent of those involved in the incident, be timely and of good quality and ensure that lessons are learned to drive continuous improvements in patient safety and reduce the risk of similar incidents from happening again.

A former child patient said:

"I think sometimes it's overlooked, for example if a patient is injured, so there needs to be stricter boundaries on what's investigated and the consequences of that. They [staff] kind of think this is a mental health unit, this is bound to happen. But that shouldn’t matter."

When a patient dies or suffers a serious injury in a mental health unit the responsible person must, under the act, have regard to guidance relating to the investigation of deaths and serious injuries that is published by the following organisations:

- Care Quality Commission
- Monitor
- NHS Commissioning Board
- NHS Trust Development Authority

Monitor and the NHS Trust Development Authority merged to become NHS Improvement in April 2016, and the NHS Commissioning Board was renamed NHS England in 2013. NHS England and NHS Improvement have now merged to become NHS England and NHS Improvement.

At the time of publication, the existing guidance on the investigations of such incidents are listed below (this is not an exhaustive list):

- National Guidance on Learning from Deaths; National Quality Board – March 2017
- Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers; NHS Improvement – July 2018
- Serious Incident Framework; NHS England, updated March 2015
- Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services – November 2015
- Convention on the Rights of the Child (CRC)

Current NHS guidance sets out clear guidelines on the timescales for investigations and the types of skills and experience investigation team members will need or require access to. All investigators must have expertise in systems-based investigation.

Following any death or serious injury the patient themselves, or patient's family or carer should be communicated with in an open, honest and compassionate manner. They should be informed of how they can be involved in any investigation process and kept informed of progress at every stage. It is fundamental that they are involved from the very beginning of the process and that their needs are assessed to ensure they are appropriately supported.

The NHS Duty of Candour set out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 means that NHS organisations have a legal duty to ensure they are open and transparent with the people using their services. The legislation sets out some specific requirements organisations or trusts must follow when things go wrong with care and treatment, which includes informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. All staff must be aware of the Duty of Candour and what it means for them in practice.

Article 2 of the European Convention of Human Rights (ECHR) investigations

Article 2 of the Human Rights Act 1998 protects a person's right to life. Above mentioned guidance published in 2015 by the Department of Health and Social Care provides detail for NHS organisations on the factors to be taken into account when deciding whether an independent investigation needs to be carried out to satisfy (in whole or part) the State's obligations under Article 2 of the ECHR. For the purposes of Article 2, NHS organisations are considered agents of the State. This guidance should be read in conjunction with the current NHS England Serious Incident Framework.

Article 2 imposes a procedural obligation on the State to conduct an investigation in circumstances including:

- where the person has died while detained (for example under the Mental Health Act 1983); or has attempted suicide while so detained and has sustained serious injury (or potentially serious injury)

- where the State owed a duty to take reasonable steps to protect the person's life because the person was under the State's control or care and the State knew (or ought to have known) there was a real and immediate risk to the person's life. This could include voluntary psychiatric patients (e.g Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2)

- where the person was killed by an agent of the State

To satisfy this procedural obligation, the State must initiate an investigation that is prompt, effective, carried out by a person who is independent of those implicated, provides a sufficient element of public scrutiny and involves the next of kin to an appropriate extent.

A Coroner's inquest is the means by which the State ordinarily discharges the procedural obligation – inquests often go beyond the strict requirements of Article 2.

Section 10: delegation of responsible person's functions

The responsible person for the mental health unit can delegate any of their functions detailed in this guidance to someone who works in the organisation or trust who is of an appropriate level of seniority. The deputy responsible person or relevant person who has been delegated a function under the act by the responsible person must be a permanent member of staff within the organisation. The responsible person should ensure that the relevant person who has been delegated a function under the act has the relevant skills and experience to undertake the responsibility of the task which has been delegated to them.

The responsible person may delegate their functions under the act to more than one relevant person within the organisation or trust.

If the responsible person delegates any of their functions under the act, they must ensure they are acting in line with relevant professional standards set by the relevant professional body. For example, the Nursing and Midwifery Council Code (Standard 11) provides details of when it may or may not be appropriate to delegate tasks to others. It is important that the responsible person ensures that the outcome of any delegated function meets the required standard.

The responsible person may also delegate some of their functions to the deputy responsible person. The deputy responsible person does not necessarily need to be a member of the organisation or trust board but must have the relevant skills and experience to undertake the responsibility of this role as set out in Section 2 of this guidance.

The deputy responsible person or relevant person who has had a function under the act delegated to them must attend the same training as the responsible person.

There should be a process in place for regular feedback by the deputy responsible person or relevant person who has had a function under the act delegated to them to the responsible person on progress against their delegated function.

If the responsible person has delegated a function to a deputy responsible person or relevant person, they can still perform this function themselves. Whether the responsible person delegates any of the act's functions or not, they retain overall accountability for the functions being carried out on their behalf.

If the responsible person delegates any of their functions to others within the organisation, they should keep a record of what they have delegated and to whom.

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