

**Mental Health Units – Use of Force Policy**

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| Services | Applicable |
| Trustwide | X |
| Mental Health and LD |  |
| Community Health Services |  |

**Version Control**

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| 1.0 | New draft policy created | 05/2022 | New policy in line with Use of Force Act |

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# Executive Summary

* 1. This policy sets out the Trust’s responsibilities in connection with the Mental Health Units (Use of Force) Act 2018.
  2. The policy sets out how roles should be allocated, where and how information should be recorded and how reporting requirements are managed.
  3. The policy should be read in accordance with the Mental Health Units (Use of Force) Act 2018, the Mental Health Units (Use of Force) Act 2018 Statutory guidance for NHS organisations in England, the Mental Health Act Code of Practice 2015 and Trust policies that cover restrictive practices such as isolation/seclusion and physical, mechanical and chemical restraint.

# 2 Introduction

2.1 The Mental Health Units (Use of Force) Act 2018 (‘the Act’) was enacted on 1st November 2018 having been introduced via a Private Members Bill following the death of Olaseni Lewis, who was restrained by 11 police officers in the Bethlem Hospital in 2010. As such, the Act is sometimes referred to as ‘Seni’s law’.

2.2 The purpose of the Act is to make provision about the oversight and management of the appropriate use of force in relation to service users in mental health units.

2.3 East London Foundation trust is committed to providing safe and positive care and ensuring the wellbeing of all its patients, service users, carers and staff. We will ensure our care is the least restrictive, the most positive and takes account of human rights, choice, engagement, and collaboration. We aspire to utilise the least restrictive approach and where we do use force will ensure safe and positive practice in collaboration with service users, their families/carers and are supported by best practice, a clinical model and sit within the framework of trauma informed care and human rights.

2.4 The Care Quality Commission are likely to take account of the Trust’s compliance with the requirements of this Act.

# 3 Linked Policy’s

3.1 This policy should be read in conjunction to the following policies;

3.1.1 Seclusion policy

3.1.2 Physical Holds Policy

3.1.3 Management of Medicines Policy

3.1.4 Rapid Tranquillisation policy

3.1.5 Complaints Policy

3.1.6 Deprivation of Liberty Safeguards Policy

3.1.7 Education, Training and Development Policy

3.1.8 Observation Policy

3.1.9 Search Policy

3.1.10 Safeguarding Adults Policy

3.1.11 Safeguarding Children Policy

3.2 The Trust also recognises it has an obligation under the Health and Safety at Work etc. Act (1974) and the Management of Health and Safety at Work Regulations (1999), for the health, safety and welfare at work of its staff.

# 4 Definitions

* 1. “Use of Force” refers to;
     1. the use of physical, mechanical or chemical restraint; or
     2. the isolation of a patient
     3. ‘Physical restraint’ means physical contact which is intended to prevent, restrict or subdue movement of any part of a patient’s body.
  2. ‘Mechanical restraint’ means the use of a device which is intended to prevent, restrict or subdue movement of any part of a patient’s body and which has the primary purpose of behavioural control.

4.3 ‘Chemical restraint’ is the use of medication which is intended to prevent, restrict or subdue movement of any part of a patient’s body. Please refer to Trust guidance on use of rapid tranquilisation

4.4 The Mental Health Units (Use of force) Act defines the use of force as:

4.4.1 The use of physical, mechanical or chemical restraint on a patient, or

4.4.2 The isolation of a patient

4.5 The Act introduces the following definitions of use of force:

4.5.1 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.

4.5.2 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.

4.5.3 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 tranquilisation.

4.6 The act states that isolation is any seclusion or segregation that is imposed on a patient however the definitions for these are those provided in the Mental Health Act Code of Practice 2015:

* + 1. 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.

4.6.2 (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 multidisciplinary 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.

4.7 Negligible use of force

4.7.1 Negligible does not mean irrelevant to a person’s experience of care or treatment and it is expected that negligible use of force will only apply in a very small set of circumstances.

4.7.2 The use of force can only be considered negligible where it involves light or gentle and proportionate pressure. Any negligible use of force must meet all of the following criteria:

a) is the minimum necessary to carry out therapeutic or caring activities (e.g., personal care or for reassurance)

b) it forms part of the patient’s care plan

c) valid consent to the act in connection with care and treatment has been obtained from the patient, or where appropriate a member of their family or carer has been consulted, particularly a person with parental responsibility if this is in relation to a child and the child is not Gillick competent. Where the patient lacks capacity, a Best Interest Decision would need to be made

d) And only if they are outside of the circumstances in which the use of force can never be considered

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

* + 1. Any use of rapid tranquilisation
    2. Any form of mechanical restraint
    3. The patient verbally or physically resists the contact of a member of staff
    4. Where the use of force involves the use of a wall, floor (or other flat surface) and the use of force is disproportionate.
    5. Someone other than ELFT staff (who may be the patient, another patient, a visitor, or a carer) witnesses use of force, and has capacity to validly appraise and comment on the use of force, complains about the use of force that they witnessed
    6. The use of force causes an injury to the patient or a member of staff (including any type of injury or other physical reaction including scratches, marks to the skin and bruising)
    7. The use of force involves more members of staff than is specified in the patient’s care plan
    8. During or after the use of force a patient is upset or distressed
    9. The use of force has been used to remove an item of clothing or a personal possession

# 5 A Human rights-based approach to the use of force

5.1 The use of force must be lawful and compliant with the articles of the European Convention on Human Rights as incorporated into domestic law via the Human Rights Act 1998. The Trust will ensure that it has an established mechanism that enables patients to report any potential breaches of human rights.

5.2 The [Mental Health Act 1983: code of practice](https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983) 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](https://www.legislation.gov.uk/ukpga/1983/20/contents).

It defines restrictive interventions (use of force), 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:

* + 1. 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;
    2. end or reduce significantly the danger to the patient or others.
    3. 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:
    4. be used for no longer than necessary to prevent harm to the person or to others;
    5. be a proportionate response to that harm, and;
    6. be the least restrictive option

# 6 Being Trauma Informed

6.1 Trauma, personal and/or caused by the system, whether historical or current is a real issue for us to tackle as part of improving safe and positive care and reducing restrictive practices. We will work to deliver care that is trauma aware and sensitive to the impact of actual, potential, and vicarious trauma on the lives of everyone who encounters services, including those who work within it.

6.2 We will work to ensure that our processes and pathways do not re-enact peoples’ experiences of trauma, but promote safety and recovery. We will build and maintain cultures and atmospheres where both services users and staff feel supported, validated, and included.

6.3 Where the behaviour of an individual indicates their level of risk cannot be managed safely using the Trust standard approved MAPA techniques staff should refer to the MAPA Team for a more bespoke risk management plan. In circumstances where techniques have had to be adapted by the MAPA Team, these must be approved by the “responsible person” under the Mental Health Units (Use of Force) Act

6.4 Care Plans and Positive Behavioural Support Plans Care Plans and Positive Behavioural Support Plans should, with the patient’s consent take into account how patients, their families and carers are involved in care planning which should set out the preventative strategies to the use of force. However, it is important to remember that there may be circumstances where it could be harmful to a patient to involve their family or carers (i.e., survivors of domestic abuse or violence so the patient’s wishes and preferences must be taken into account.

# 7 Duties

7.1 All staff working in Mental health settings will have due regard of this policy and its procedural arrangements

7.2 Both the ‘responsible person’ and staff working in mental health units ‘must have regard’ to the specific guidance related to the Use of Force Act (2018). 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.

7.3 Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective.

7.4 The Responsible Person is the Chief Medical Officer..Functions delegated by the Responsible Person to officers of the Trust in accordance with section 10 of the Act. Deputy Responsible Person for each Mental Health Unit is the local clinical director. The Chief Medical officer is

1. Clinical Directors are responsible for ensuring that all managers in their areas are aware of this policy and linked policies where the implementation of the use of force Act is outlined. Support its implementation and that ongoing leadership and co-ordination. The Director of Patient Safety must to ensure that the Trust complies with the requirements of the Act.
   1. The Chief Medical officer will ensure that staff groups with responsibility will have the knowledge and skills required of the roles, the support of the executive team.
   2. Management of violence and aggression trainers are responsible for delivering training (as appropriate to job role requirements) within ELFT. Trainers will meet all the requirements as set out by the Restraint Reduction Network (RRN) and are assessed on a yearly basis. They also support into clinical ward areas in support of the view to reducing restrictive practice.
   3. Matron for restraint practices and Lead MAPA trainer will keep the training provision under on-going review in order to be consistent with current national policy, new developments, best practice guidance and evidence.
   4. Ward/Team/Department Managers are responsible for:
      1. Ensuring that this policy (and linked policies) is fully implemented within the ward environment/the team/the department that they manage.
      2. Ensuring that this policy is readily available to all staff at all times.
      3. Ensuring that the recording and auditing of incidents of physical intervention is completed in line with this policy.
      4. Responding appropriately to any concerns regarding the attitude of staff members around issues of the use of force, aggression, violence or restrictive practice.
      5. Ensuring that there is a regular and comprehensive general risk assessment to ensure the safety of the environment
      6. Maintaining training and equipment levels in their ward/team/department. This will include ensuring that are staff appropriately trained to monitor physical health.

7.9 Education, Training & Development Department. Will maintain a database of all staff who have undergone MAPA Training. This will specify via risk assessment the level of training different groups of staff require and the frequency of training and updates (NICE 2005).

7.10 All Staff members are responsible for ensuring that their practice is safe. Clinical staff have a Duty of Care to ensure that they act in ways that are consistent with any codes of practice relevant to their profession. The Trust also has a Duty of Care towards its employees and towards service users, which is fulfilled by the implementation of this policy.

# 8 Training

8.1 All staff with responsivities for the use of force agenda will have access to training in relation to the Use of Force Act and its impact on practice and care provision.

* 1. Management of violence and aggression training will include;
     1. Involving service users in planning and development of reducing restrictions within inpatient services
     2. Safe environments
     3. Dealing with Crisis and de-escalation
     4. Strategies to minimise risk
     5. Least restrictive
     6. Integrated ethical, trauma informed and Human rights care.
     7. Post incident De-brief

# 9 Reporting

9.1 All uses of force must be recorded in an incident form. ELFT have set up the incident reporting system to ensure that we adhere to the formal reporting systems that satisfy the legal requirements but also contractual reporting requirements with NHSEI.

9.2 Staff must complete the incident report in full, further guidance can be found in the Incident Management Policy and Procedure.

9.3 Below are some of the key requirements that must be detailed into the incident form and this will be pulled through to their care record.

* + 1. the reason and type of the use of force
    2. the place, date and duration of the use of force
    3. whether the type or types of force used on the patient formed part of the patient’s care
    4. plan and if notifiable persons (if any) were contacted following use of force as described in the care plan
    5. a description of how force was used
    6. the name and job title of any member of staff who used force on the patient
    7. whether the patient has a learning disability or autistic spectrum disorder
    8. a description of the outcome of the use of force
    9. whether the patient died or suffered any serious injury as a result of the use of force
    10. any efforts made to avoid the need for use of force on the patient

9.4 Incident data will be utilised to develop anonymised dashboards for each ward to ensure staff are able to analyse and consider their use of force/restrictive practices and measure improvement in reduction of use. Trust wide reporting will take place through high level anonymised dashboards and into the Quality committee.

9.5 The Use of Force Act includes the requirement to investigate all deaths and serious injuries in a mental health unit. ELFT will utilise the Serious Incident investigation process for any inpatient deaths and adhere to the principles of Section 9 of the Use of Force Act.

9.6 Section 12 of the act relates to police use of body cameras. 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. 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 officers to determine in line with current College of Policing guidance on the use of body cameras whether special circumstances apply.

# 10 **Communications**

10.1 The trust will develop co-produced information for patients and carers about the use of force this will be accessible at the point of care. Staff will take reasonable practicable steps to ensure that the patient and/or carer is aware of the information and understands it.

# 11 Complaints

11.1 Complaint made against staff as a result of a violent incident including what the service feels was an inappropriate use of force or where too much force was applied will be investigated through the appropriate ELFT procedure including complaints, safeguarding, performance and disciplinary procedures.

11.2 Service Users and Carers will be supported through this process.

11.3 Data around complaints related to use of force will be evaluated for themes and link to patient safety forum.

# 12 Audit, Monitoring and Review

12.1 Compliance with the requirements under the Use of force Act 2018 will be monitored through the Patient Safety Forum chaired by the Executive medical officer and reports to the board through Quality committee.

* 1. The patient’s safety forum will;
     1. To oversee development, dissemination and implementation of the Trust-wide strategy on restrictive practice.
     2. To oversee the development, implementation and regular review of policies and procedures related to restrictive practices and de-escalation to support the delivery of the Trust’s strategy on restrictive practice.
     3. To ensure the Trust discharges its duties in the use of restrictive practices in line with legislation as articulated within Human Rights, Mental Health Act, The Mental Capacity Act and The Mental Health Units (Use of Force) Act 2018 and Trauma informed care.
     4. To oversee and critically reflect on the use restrictive practice across all care pathways within the Trust, including oversight of evaluation of embedding the clinical model application.
     5. To enable the voice of lived experience to influence the policy and development of practice within the Trust through appropriate representation
     6. To receive reports from the Operational Restrictive Practice Forum including analysis of restrictive practice data across the Trust, considering themes and ensuring shared learning from incidents.
     7. Ensure data is being used effectively at patient, team, and strategic level
  2. A quarterly report will be presented to the Quality Committee to;

12.3.1 Scrutinize output from patient safety forum

12.3.2 Review incident trends,

12.3.3 Areas for improvement and learning,

12.3.4 Analysis of information

12.4 Trust, Directorate and team dashboards are available in order to support learning, identify themes and any areas for address or improvement.

12.5 Safer staffing information is reported through E-roster and can be triangulated with incident reporting data and Clinical Establishment Reviews as part of the Directorate Performance Reviews.

* 1. An audit programme is available to support audit and review of the standards related to restrictive practice and the Use of force, specifically to seclusion, restraint and rapid tranquilisation. Audits will be performed as per schedule agreed and reports are available to establish if standards are being met.
  2. ELFT have a responsibility to consider the detail behind the data to evaluate if our 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.

12.8 This data and its analysis will be vital in informing the ELFT plan to reduce the use of restrictive interventions.

# 13 Audit, Monitoring and Review

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| --- | --- | --- | --- | --- | --- | --- |
| **Monitoring Compliance Template** | | | | | | |
| Minimum Requirement | Process for Monitoring | Responsible Individual/ group/committee | Frequency of Monitoring | Review of Results process (e.g. who does this?) | Responsible Individual/group/ committee for action plan development | Responsible Individual/group/ committee for action plan monitoring and implementation |
| Monitor use of force and  reduction relevant standards related to Statutory guidance and this policy | Incident reporting Dashboards Thematic Analysis Complaint and concerns  Audit  Training Compliance on Use of Force | Patient Safety Forum  Chief medical officer | On event for use of restraint, seclusion and RT  Quarterly for incident data and complaints | Patient Safety Forum | Patient safety forum | Patient Safety Forum  Mental Heath Act committee  Quality Committee (Monitoring) |

*Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. Review date: April 2024*

# 14 I**m**plementation Plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Action/Task** | **Responsible Person** | **Deadline** | **Progress Update** |
| Upload new policy onto intranet and remove old version | Chief Medical Officer | 05/2022 |  |
| Make teams aware of revised policy | Clinical Directors  Comms Lead | 06/2022 |  |
| Integrate policy into linked policies and MAPA training | Matron for Restrictive Practices  Directors of Nursing | 08/2022 |  |
| Training on use of force for all staff | Lead Nurses | 08/2022 |  |
| Develop co-produced leaflet for Use of Force at point of care | Matron for Restrictive Practices  Director of People Participation | 8/2022 |  |

# Appendix A – Links to Other Policies, Standards (Associated Documents)

The policy is set out to meet the requirements from;

* The Mental Health Units (Use of Force) Act 2018 as set out in the Mental Health Units (Use of Force) Act 2018 statutory guidance for NHS organisations in England and police forces in England and Wales (2021) and fully supports the recommendations of Violence prevention and reduction standard (2020),
* Positive and Proactive Care: reducing the need for restrictive interventions (2014),
* Restraint Reduction Network (RRN) Training Standards (2019),
* NICE - Violence and aggression: short-term management in mental health, health and community settings (2015),
* Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings (2016).

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# Appendix B – Human Rights

The Articles of the Human Rights Act 1998 which are pertinent to the use of restraint in Mental Health settings are:

**Article 2: Right to Life.**

This obliges the Trust to protect anyone under its care from risk to that person’s life, whether self-inflicted or by another, whether by act or omission.

Article 2 imposes a procedural obligation on the Trust to conduct an investigation in circumstances including: where the person has attempted suicide while so detained and has sustained serious injury (or potentially serious injury); where the Trust owed a duty to take reasonable steps to protect the person’s life because the person was under the Trusts control or care and the Trust knew (or ought to have known) there was a real and immediate risk to the person’s life.

This can also include voluntary patients.

**Article 3: Prohibition of torture, inhuman or degrading treatment.**

No restrictive intervention should be used unless it is absolutely necessary to do so in all the circumstances of the case. Action that is not proportionate or necessary may well breach a patient’s rights under article 3.

‘Inhuman or degrading treatment’ does not have to be deliberate and can be unintentional. To avoid this all the individual circumstances of the service users’ case should be factored into any application of force.

**Article 8: Respect for private and family life.**

Restrictive intervention may breach a patient’s article 8 rights if it has a sufficiently adverse effect on the patient’s private life, including their moral and physical integrity.

**Article 14: protects from discrimination.**

**In addition** to what is set out above as in the Mental Health Units (Use of Force Act (2018) statutory guidance:

**Article 5: Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR (the right to liberty).**

ELFT and its staff are legally obliged to respect patient’s rights and take reasonable steps to protect those rights. 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.

# Appendix C - Additional Clinical Guidance

**Showing respect for diversity generally includes the following:**

* creating and sustaining inclusive environments where every patient feels valued, listened to and supported.
* 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.
* 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 inequality experienced by groups with different protected characteristics.
* how to demonstrate respect for individual beliefs, values, cultures and lifestyles and appreciating the differences.

**Avoiding unlawful discrimination, harassment and victimisation includes 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).

**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

**The use of techniques for avoiding or reducing the use of force includes the following:**

* understanding the challenges and constraints experienced 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)
* 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 ethnic and minority backgrounds
* creating positive physical environments
* person-centred care, including preventative approaches such as Safewards and where applicable Positive Behaviour Support
* 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 (see the section on training to understand the effect of a threat to use force and coercion)

**The risks associated with the use of force includes the following:**

* preparing care plans which identify individual risks associated with the use of force, and how these risks are minimised (including by not using force)
* physical, psychological and emotional effects on those subject to the use of force
* 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 – to include vital signs monitoring and response, 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 impact of trauma (whether historic or otherwise) on a patient’s mental and physical health**

**includes the following:**

* 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
* considering 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

**The impact of any use of force on a patient’s mental and physical health includes the following:**

* the impact of use of force in further traumatising or re-traumatising patients whose mental ill health may already have been exacerbated by forms of trauma
* 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
* the impact of the use of force in relation to the person’s health condition or impairment
* The impact of any use of force on a patient’s development includes the following:
* risk of 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

**How to ensure the safety of patients and the public includes 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

**The principal legal or ethical issues associated with the use of force includes the following**

**principles (from Positive and Safe Care 2014):**

* 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 and 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
* the rights of service users and staff to be in a safe environment

**Trauma Informed Card and Practice**

* Trauma, both personal or caused by the system, whether historical or current is an area of care and practice for us to address as part of improving safe and positive care and reducing restrictive practices. We will strive to be increasingly trauma aware and sensitive to the impact of actual, potential, and vicarious trauma on the lives of everyone who encounters services, including those who work within it. This will involve the integration of trauma informed care into all of our training and specific training in teams to support this.
* Therapeutic environments and activity and dedicated space for calming, soothing and de-escalation
* A therapeutic environment provides the best opportunity for recovery and wellbeing.
* Meaningful Activity is essential to this, and a key component in reducing restrictive practice, a purposeful admission, enhancing health and wellbeing and making the stay of service users more positive.

**Activity, and the way it is delivered provides, (amongst other things):**

* A meaningful conduit for therapeutic engagement and developing therapeutic relationships
* Can be used to cope with symptoms and the challenges that living on an inpatient ward can bring
* Promotes maintenance and development of individual’s skills, roles and routines. The ward is a place where people can discover or rediscover skills and values that can be taken forward into the community
* Offer people an opportunity to take an active role in promoting their own recovery and mental wellbeing
* Can alleviate boredom and supports the model of recovery and wellbeing
* A programme of activities will be available throughout the day and week and be a key component of the service users care and treatment: It will be seen as routine and as essential as medication.
* Activity will be embedded in the ward culture, owned by all and be routinely and consistently offered as part of the therapeutic model of care.

**To support this there needs to be**

* Identified spaces and rooms both on and off the ward (in and outdoors) that 1:1 and group activities can take place
* A range of resources and equipment: leisure, creative, educational etc.

**Staff Knowledge, Skills and Training**

* Staff education and training are essential 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 people are treated with dignity and respect and their views and feelings are understood and their specific needs are met.
* Training provided will support an overall human right- based approach, which is focussed on the minimisation of the use of force and ensures any use of force is rights respecting.
* Training will focus on creating a positive environment for care which pre-empts, takes active steps to avoid, or de- escalate distress and conflict.
* Staff will be skilled and knowledgeable to know when they can and should use appropriate and proportional force, as well as be able to recognise what is inappropriate or excessive use force.
* Training will be co-designed and delivered with those with live experience.
* The training is certified with NAVIGO as part of the Restraint Reduction Network and is also supported by the Safewards implementation programme.

**Collaboration and care planning**

* Service users and their families/carers (where relevant) will be involved in the planning, development and delivery of care and treatment.
* This will show respect for service users past and present wishes and feelings.
* Response to distress will be included, as part of knowing the person, and will form part of the care plan.
* Crisis response plans and Positive Behaviour support plans will also be part of this.
* Where force has been used or is predicted to need to be used, the care plan will set out ways of supporting future prevention as well as post situation follow up and care.

**Safewards**

* The clinical model of safewards is to be implemented and embedded across all inpatient services as a way of improving safety and harmony between staff and services users by working together on the interventions, which support the reduction of flashpoints and conflict and support the non-use of force.
* The Safewards Model depicts six domains of originating factors: the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework.
* These domains give risk to flashpoints, which have the capacity to trigger conflict and/or containment. Staff interventions can modify these processes by reducing the conflict-originating factors, preventing flashpoints from arising, cutting the link between flashpoint and conflict, choosing not to use containment, and ensuring that containment use does not lead to further conflict.
* The Trust is adopting the implementation of the interventions from Safewards in a structured, supported way.
* The interventions are included within the Respect training and are as follows:
* Clear Mutual Expectations
* Soft Words
* Talk Down
* Positive Words
* Bad News Mitigation
* Know Each Other
* Mutual Help Meeting
* Calm Down Methods
* Reassurance
* Discharge Messages
* These interventions also reflect the process of approaching managing behaviours of concern through primary, secondary and tertiary strategies.