

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

|  |  |
| --- | --- |
| Version: | Draft 1.2 |
| Ratified by: |  |
| Date ratified: |  |
| Name of originator/author: | Claire McKenna, Director of NursingKenneth Muzongondi, Matron for Restrictive Practice & MAPA TrainingPaul McLaughlin, Lead for Advanced Roles |
| Name of responsible committee/individual: | Quality Committee |
| Circulated to: | Operational management group, Borough Lead nurse group |
| Date issued: | 1st September 2022 |
| Review date: | 1st September 2023 |
| Target audience: | All staff |

|  |  |
| --- | --- |
| Services | Applicable to |
| Trustwide | √ |
| Mental Health and LD |  |
| Community Health Services |  |

**Version Control and Amendment Log**

|  |  |  |  |
| --- | --- | --- | --- |
| **Version No.** | **Type of Change** | **Date** | **Description of change(s)** |
| 1.0 | New draft policy created | 05/2022 | New policy in line with Use of Force Act |

**Contents**

|  |  |  |
| --- | --- | --- |
| **Section** |  | **Page** |
|  | Version Control and Amendment Log |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Contents**

[1. Executive Summary 4](#_Toc114745143)

[2. Introduction 4](#_Toc114745144)

[3. A Human rights-based approach to the use of force 6](#_Toc114745145)

[4. Being Trauma Informed 7](#_Toc114745146)

5. 'Responsible Person'…………………………………………………………………………………………………………………………………8

[6. Duties of Staff 9](#_Toc114745147)

7. Training………………………………………………………………………………………………………………………………………………….11

[8. Reporting 12](#_Toc114745148)

[9. Communications 15](#_Toc114745149)

[10. Complaints 15](#_Toc114745150)

[11. Audit, Monitoring and Review 17](#_Toc114745151)

[**12.** **Implementation Plan** 18](#_Toc114745153)

[Appendix 1 – Links to Other Policies, Standards (Associated Documents) 19](#_Toc114745154)

[Appendix 2 – Human Rights 20](#_Toc114745155)

[Appendix 3 - Additional Clinical Guidance 21](#_Toc114745156)

Appendix 4 - Police Use of Restraint in Mental Health & Learning Disability Settings……………………………………….26

# Executive Summary

* 1. This policy sets out the Trust’s and all staff’s responsibilities in connection with the Mental Health Units (Use of Force) Act 2018.
	2. The Trust is committed to ensuring that our staff and services should:
* respects all patients’ rights
* provide skilled, trauma-informed and person-centred care
* follow the principle of least restriction
* promote recovery
	1. Through compliance with the act and statutory guidance the intention is to see:
* an end to the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age and disability
* services that meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point
* services that understand the negative impact of the use of force on patients with histories of trauma and abuse
* services that 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
	1. East London NHS Foundation Trust is committed to these principles and will review and report regularly on progress.
	2. Patient and carer information about the use of force has been co-produced with our service users and carers. We recognise the valuable contribution that people with personal experience can have in the design and improvement of services. Meaningful co-production in service design is critical to ensuring services respond to the needs of patients using our services, and that they are trauma-informed and person-centred.
	3. 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. If the review suggests substantial changes to the policy, the act requires that the responsible person must again consult on the changes and re-publish the policy.
	4. Data should be analysed to identify themes emerging across patient groups that 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 use of force and staff training programmes.
	5. The policy should be read in conjunction 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 (rapid tranquilisation).

# 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 in the media as ‘Seni’s law’.

2.2 The purpose of the Act, and this policy, is to clearly set out measures intended to reduce the use of force, prevent the inappropriate use of force, and ensure accountability and transparency about the use of force in all services in the Trust.

2.3 East London NHS 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, we will only do so as a last resort and will ensure safe and positive practice in collaboration with service users, their families/carers, supported by best practice and a clinical model that sits within the framework of trauma informed care and human rights.

2.4 Positive and Proactive Care (DoH, 2014) sets out recommendations for services to avoid and reduce the use of restrictive interventions. This Trust has pledged to reduce the use of restrictive practices across it services.

2.5 Definitions:

2.5.1 “Use of Force” refers to;

- the use of physical, mechanical or chemical restraint; or

* the seclusion or isolation of a patient

 2.5.2 ‘Physical restraint’ means physical contact which is intended to prevent, restrict or subdue movement of any part of a patient’s body.

2.5.3 ‘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, e.g. handcuffs.

2.5.4 ‘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 the Trust’s Rapid Tranquilisation Policy.

2.5.5 ‘Seclusion’ is 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 that 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.

2.5.6 ‘(Long-term) segregation’ is 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.

2.6 The use of force should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

Where staff use (or threaten 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.

2.7 Linked Policies

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

Seclusion policy

Use of Physical Holding Policy

Handcuff Protocol – Forensic directorate

Incident reporting policy

Resuscitation policy

Manual handling policy

Management of Medicines Policy

Rapid Tranquillisation policy

Complaints Policy

Deprivation of Liberty Safeguards Policy

Education, Training and Development Policy

Observation Policy

Search Policy

Safeguarding Adults Policy

Safeguarding Children Policy

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

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

3.1 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 that 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.

3.2 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 that 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.

3.3 Alongside the Human Rights Act 1998, the UK government has signed and ratified other United Nations (UN) human rights treaties 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
* International Covenant on Civil and Political Rights
* Convention on the Elimination of All Forms of Discrimination against Women
* Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
* Convention on the Rights of the Child
* Convention on the Rights of Persons with Disabilities

3.4 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
* Human rights framework for restraint – Equality and Human Rights Commission
* Human rights framework for people in detention – Equality and Human Rights Commission
* Mental Health, Mental Capacity and Human Rights: A practitioner’s guide – the British Institute of Human Rights

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

3.6 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.

3.7 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.

3.8 The following is a list (not exhaustive) of legislation relevant to the use of force:

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

# 4. Being Trauma Informed

4.1 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.

4.2 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.

4.3 ELFT will reduce its Use of Force by implementing and embedding the Least Restrictive Practice Strategy work plan supported by the Clinical and Social Care Strategy with its primary focus on prevention. Knowing services users, their strengths and needs and recognising trauma is key to this. De-escalation is a major factor necessary to prevention and reducing impact on service users and staff.

4.4 Trauma informed care is an approach to health and social care that seeks to realise the widespread impact of trauma and understand paths for recovery, recognise the signs and symptoms of trauma in service users, families, and staff, integrate knowledge about trauma into policies, procedures, and practices, and actively avoid re-traumatisation. Inpatient services across ELFT have been adopting and developing a trauma informed approach, in particular with regard to the reduction of restrictive interventions and the use of force. This policy endorses the adoption of this approach and encourages services and service leaders to further develop this approach to the provision of care and treatment and reduction of restrictive practices, and to staff training and development.

4.5 ELFT is committed to minimising the use of force through the promotion of positive cultures, relationships and approaches that understand the trauma history and triggers of individuals, and that will prevent escalation and any need to use force.

**5. ‘Responsible Person’**

5.1It is essential that there is accountability and responsibility for the use of force at the highest level within an organisation. 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.

5.2 The Trust board should:

- have a good understanding of why force is used within their services

- develop wider action plans for reducing the use of force

- regularly review the Trust’s performance in reducing the use of force

5.3 The Trust is required to appoint a ‘responsible person’ whose role it is to ensure that the organisation complies with the requirements of the Act.

5.4 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 Trust board. The role may be undertaken by, for example, the Chief Nursing Officer or Medical Director.

5.5 Skills, experience, support and training of the responsible person

The Trust board 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.

5.6 Where the 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 managing children’s services.

5.7 The Trust board 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.

5.8 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.

5.9 Where the 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 Trust.

5.10 Deputy responsible person and delegation of duties

The Trust may also appoint a deputy responsible person to carry out the responsible person’s functions that are delegated to them.

5.11 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. 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.

5.12 Transparency

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.

5.13 In ELFT the Responsible Person will be the Chief Medical Officer. The deputising role would normally be carried out by the Directors of Nursing.

# 6. Duties of Staff

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

6.2 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.

6.3 All staff should contribute to a culture where the use of force is avoided and minimised.

6.4 Any force that is used must be used as a last resort, when other less restrictive options have been tried and exhausted, and be reasonable.

6.5 In relation to prone restraint, it is the position of the Trust that staff should do everything possible to avoid the use of prone restraint, and techniques exist to administer rapid tranquilisation as a last resort whilst still avoiding prone restraint. If exceptionally a patient 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.

6.6 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.

6.7 Staff must take into account the different needs and 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
* people who share protected characteristics under the Equality Act 2010

Debrief following any use of force should be used as an opportunity for staff to reflect on and

think about these different needs and considerations and they should inform all staff training.

6.8 Staff should also 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
* victims of modern slavery

6.9 Additional guidance on specific patient groups and the use of force is provided in policies related to the use of force, e.g. Physical Holding Skills Policy and MAPA Training covers these issues in detail.

6.10 Any use of force, unless the use of force is ‘negligible’, must be recorded and documented by staff.

6.11 Clinical and Service 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 ongoing leadership and co-ordination.

6.12 ELFT will ensure that staff groups with responsibility will have the knowledge and skills required of the roles, and the support of the executive team.

6.13 The responsible person retains overall accountability for any delegated duties being carried out.

6.14 ELFT will publish the name of the responsible person on ELFT intranet.

6.15 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 providesupport to clinical teams to foster the reduction of restrictive practice.

6.16 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.

6.17 Ward/Team/Department Managers are responsible for:

* Ensuring that this policy (and linked policies) is fully implemented within the ward environment/the team/the department that they manage.
* Ensuring that this policy is readily available to all staff at all times.
* Ensuring that the recording and auditing of incidents of physical intervention is completed in line with this policy.
* Responding appropriately to any concerns regarding the attitude of staff members around issues of the use of force, aggression, violence or restrictive practice.
* Ensuring that there is a regular and comprehensive general risk assessment to ensure the safety of the environment
* Maintaining training and equipment levels in their ward/team/department. This will include ensuring that - staff are appropriately trained to monitor physical health.

6.18 Education, Training & Development Department will maintain a database of all staff who have undergone Safety Intervention 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). The training levels are outlined in the Use of Physical holding poilicy

6.19 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.

6.20 Seni’s Law is named after Olaseni Lewis who died after being restrained by police officers who attended an incident on a mental health unit in South London. All staff should be familiar with the document and guidance called Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings, which can be found in Appendix 4.

# 7. Training

7.1 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.

7.2 All staff working in mental health services will have access to training in relation to the Use of Force Act and its impact on practice and care provision.

7.3 The training provided should support an overall human rights-based approach that is focused 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.

7.4 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.

7.5 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.

7.6 Any training related to the use of force should include:

* Co-production and involvement of patients and carers
* Showing respect for patients’ past and present wishes and feelings
* Showing respect for diversity generally
* Avoiding unlawful discrimination, harassment and victimisation
* The use of techniques for avoiding or reducing the use of force
* The risks associated with the use of force
* The impact of trauma (whether historic or otherwise) on a patient’s mental and physical health
* The impact of any use of force on a patient’s mental and physical health
* The impact of any use of force on a patient’s development
* How to ensure the safety of patients and the public
* The principal legal or ethical issues associated with the use of force
* Understanding coercion and psychological restraint

7.7 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.

7.8 Inpatient nursing staff also receive Management of Actual and Potential Aggression (MAPA) Training to include:

* Involving service users in planning and development of reducing restrictions within inpatient services
* Safe environments
* Identification of levels of risk and responding appropriately to de-escalate situations
* Non-restrictive and Restrictive Strategies to minimise risk and maximise safety
* Least restrictive
* Awareness of risks associated with use of force interventions and corrective actions
* Integrated ethical, trauma informed and Human rights care.
* Post incident Debrief - guided by the COPING model (Appendix 1)

7.9 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 2019 provide a national benchmark for training, and have been endorsed by a wide range of professional bodies, charities and government arm’s length bodies. 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 UK. UKAS ensure the competence, impartiality and integrity of the certification scheme. 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, The CQC will expect services across health and social care to have certified training that complies with the RRN Training Standards from April 2021.

# 8. Reporting

8.1 All uses of force must be recorded using a DATIX incident reporting 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.

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

8.3 Below are some of the key requirements that must be detailed into the incident form:

* the reason and type of the use of force
* the place, date and duration of the use of force
* whether the type or types of force used on the patient formed part of the patient’s care plan and if notifiable persons (if any) were contacted following use of force as described in the care plan
* a description of how force was used
* the name and job title of any member of staff who used force on the patient
* whether the patient has a learning disability or autistism
* a description of the outcome of the use of force
* whether the patient died or suffered any serious injury as a result of the use of force
* any efforts made to avoid the need for use of force on the patient
* if the police were involved, details of how they managed the situation

If there are any concerns about police management of the situation, this should be escalated immediately to a senior manager or the senior manager oncall.

8.4 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. Trustwide reporting will take place through high level anonymised dashboards and into the Quality committee.

8.5 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
* 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. It is expected 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.

8.6 If a member of staff’s 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.

8.7 Any negligible use of force 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 section 5 and section 6 of the 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.

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

* Any use of rapid tranquillisation.
* Any form of mechanical restraint.
* The patient verbally or physically resists the contact of a member of staff – for example, telling a member of staff to get off them, stop touching them or 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.
* Where the use of force involves the use of a wall or 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.
* 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.
* 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.
* 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.
* The use of force involves more members of staff than is specified in the patient’s care plan.
* During or after the use of force, a patient is upset or distressed.
* 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 override 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.

8.9 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 that includes the justification and proportionality of the measures taken.

8.10 NHS Trusts must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the CQC 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 CQC of the coroner’s conclusion.

8.11 A notification should be sent to the person(s) (families, carers or independent advocates) identified in the patient’s 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.

8.12 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 that 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. It is current good practice to include the record of the use of force within the patient’s electronic record.

# 9. **Communications**

9.1 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.

9.2 The Trust will ensure that all staff are kept up to date with any changes or updates to this policy or wider learning from the use of force data and reviews.

# 10. Complaints

10.1 Complaints made against staff as a result of any use of force including what the patient feels was an inappropriate use of force will be investigated through the appropriate ELFT procedure including complaints, safeguarding, performance and disciplinary procedures.

10.2 Advice should be sought from senior management and People and Culture as soon as possible.

10.3 The service user is free to report any concern to the police at any point they wish, and will be supported to do so if they need advocacy or assistance from staff to do this.

10.4 At any point the investigating managers may decide to involve the police depending on the nature of the allegation and the initial evidence. The investigation may then need to be temporarily stopped pending a police investigation.

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

10.6 The member(s) of staff who are the subject of the complaint or allegation should also be supported through the investigation process.

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

# 11. Audit, Monitoring and Review

11.1 Compliance with the requirements under the Use of force Act 2018 will be monitored through the Patient Safety Forum chaired by the Deputy Responsible Person and reports to the board through the Responsible Person and the Quality Committee.

11.2 The Patient Safety Forum will:

* Oversee development, dissemination and implementation of the Trust-wide strategy on restrictive practice.
* 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.
* 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.
* 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.
* Enable the voice of lived experience to influence the policy and development of practice within the Trust through appropriate representation
* 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.
* Ensure data is being used effectively at patient, team, and strategic level

11.3 A quarterly report will be presented to the Quality Committee to:

* Scrutinize output from patient safety forum
* Review incident trends
* Identify areas for improvement and learning
* Enable analysis of information

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

11.5 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.

11.6 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.

11.7 ELFT has 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.

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

# 11. Audit, Monitoring and Review

|  |
| --- |
| **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 relevant standards related to Statutory guidance and this policy | Incident reporting Dashboards Thematic Analysis Complaint and concernsAudit | Patient Safety ForumDeputy Responsible Person | On event for use of restraint, seclusion and RTQuarterly for incident data and complaints | Mental Health Legislation Committee | Patient Safety Forum | Patient Safety Forum |

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

1. **I**m**plementation Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Action / Task** | **Responsible Person** | **Deadline** | **Progress update** |
| *Upload new policy onto intranet and remove old version* | *Executive Medical officer* | *09/2022* |  |
| *Make teams aware of revised policy* | *Team manager**Comms Lead* | *06/2022* |  |
| *Integrate policy into linked policies and MAPA training* | *Matron for restrictive practices/ Directors of nursing**Directors of Nursing* | *09/2022* |  |
| *Training on use of force for all staff* | *Directors of Nursing* | *09/2022* |  |
| *Develop co-produced leaflet for Use of Force at point of care* | *Matron for Restrictive practices* | *09/2022* |  |

# Appendix 1 – 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).

#

# Appendix 2 – 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 3 - 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.

**Appendix 4 - Police Use of Restraint in Mental Health & Learning Disability Settings**

**Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings**

**In Summary**

* This Memorandum of Understanding (MoU) between National Police Chief’s Council, Mind, Royal College of Psychiatrist, RCN and Faculty of Forensic and legal Medicine provides clarity on the role of the police service in responding to incidents within mental health and learning disability settings.
* Health providers have a duty to undertake, implement and review risk assessments for all the services they provide. The police do not have specific powers to restrain a patient for the purposes of medical treatment regardless of whether the treatment is in the patient’s best interests.
* Police services and health providers should develop or review existing protocols to take account of this MoU. There should be timely joint reviews of incidents where the police use force or where the police did not attend an incident despite the agreed local protocol being properly used.

**Over-Arching Ethos**

* Each situation should be properly judged on its individual merits.
* Police officers should NOT be called to undertake restrictive practices, connected to purely clinical interventions (e.g. taking of fluid samples, injections, etc.) unless exceptional factors apply.
* The police service should ensure an appropriate response to allegations of crime and to requests for immediate support in connection with risks of serious injury or damage, where healthcare providers’ internal mechanisms have been unsuccessful and safety is then compromised.

**Examples Requiring a Police Response**

* An immediate risk to life and limb
* Immediate risk of serious harm
* Serious damage to property
* Offensive weapons
* Hostages

**Police Attendance Protocol**

**Step 1 – Decide RVP**

At the time healthcare staff request the police to attend, a suitable rendezvous point (RVP) should be agreed. This is where the most senior police officer present can meet with the most senior member of health staff before police deployment onto the ward takes place. Depending on the circumstances and urgency of the situation, an RVP may not be suitable.

**Step 2 – Incident explained**

Police and health staff meet at the RVP. Health staff will explain the incident, which should include any specific risks associated with the patient (e.g. the patient’s legal status; whether the patient has already been restrained by healthcare staff; whether tranquilisation has been administered and the effect this has had; highlighting any dangers and relevant health related issues). An assessment of available/sufficiently trained staff should also be made.

**Step 3 – Police/Health roles established**

If further deployment is necessary both Health care/Police leads will work together to decide how best to resolve the incident. Police will consider the use of specialist officers/public order trained/hostage negotiator etc., where relevant. Throughout the incident health staff will remain responsible for the patient’s health and safety.

**Step 4 – Police handover**

Police will regain control of the ward/patient/situation using appropriate tactics. If police restraint is used, police will hand-over the patient to healthcare staff as soon as control is regained. There should be sufficiently trained healthcare staff to enable this to happen (unless exceptional circumstances, e.g. health staff injured/unavailable).

**Step 5 – Determine need for Criminal Investigation**

If a criminal act is alleged or the police determine that a criminal offence has been committed, a police investigation should be instigated. If a patient is suspected to be responsible for a crime, it will be an exceptional set of circumstances where police will consider arresting and removing the patient from the health setting. The crime will be recorded by police and a statement obtained from relevant witnesses. A short statement/CPS approved pro-forma will also be obtained from a suitably qualified health practitioner in relation to the patient’s mental state at the time of the offence.