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Mental Health Units (Use of Force) Act 2018: Statutory guidance for NHS organisations in England and police forces in England and Wales

On 1 November 2018, the Mental Health Units (Use of Force) Act 2018 (“the Act”) received Royal Assent , however a commencement dated for the full implementation date of the Act has not yet been provided.

16 June 2021

Statutory guidance for NHS organisations in England and police forces in England and Wales - draft for consultation.

On 1 November 2018, the Mental Health Units (Use of Force) Act 2018 (“the Act”) received Royal Assent [1], however a commencement dated for the full implementation date of the Act has not yet been provided. The government has now issued draft statutory guidance for consultation which closes on 17th August 2021, suggesting we may see this legislation fully implemented sooner rather than later.

The Act is also known as ”Seni’s Law” after Olaseni Lewis who died in 2010, aged 23, after being restrained on a mental health ward by police officers. At the inquest the restraint used was deemed to be excessive, unreasonable and disproportionate. Since that time concerns have been raised about the number of deaths in detention following the use of force. The campaign for Seni’s Law noted there had been more than 5,600 deaths in custody since 1990, the majority of which involved individuals with mental health problems.

The Act will require mental health units to publish a policy setting out the steps being taken to reduce the use of force by staff who work in that unit, and information about patients' rights in relation to the use of force. It will also require mental health units to provide training for staff including:

- showing respect for patients' past and present wishes and feelings
- 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 and force (whether historic or otherwise) on a patient's mental and physical health

Each mental health unit will be required to keep a record of any use of force by staff who work in that unit where the use of force is not "negligible". Some of the information that must be included is:

- the place, date, duration and reason for the use of force
- the type or types of force used on the patient
- the name and job title of any member of staff who used force on the patient
- the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
- the patient's mental disorder and if they have a learning disability or autistic spectrum disorders
- the relevant characteristics of the patient for example race, whether pregnant or sexual orientation
- the outcome of the use of force
- any efforts made to avoid the need to use force on the patient

At the end of each year the Secretary of State must ensure that statistics relating to the records collected are analysed and published.

In addition where a police officer attends a mental health unit to help staff the officer will be required to take a body camera.

The government has now published draft statutory guidance ("the Guidance") to accompany the Act, setting out guidance as to how the Act should be implemented. This is currently open for consultation. The consultation closes on 17th August 2018. To read more and contribute to the consultation click here.

Throughout the Guidance, the following key themes emerge in relation to care planning, the use of restraint, the production and provision of documentation (information, policy and records), and training:

1. The need to respect, understand and reflect patient diversity (at the individual and group level) including disabilities, race, religion, cultural sensitivities and neuro-diversity

2. The importance of involving those close to the patient (including family, those who care and advocate for them) in care planning and ensuring they are aware of their rights and how to exercise them

3. That the use of force must not be in pursuit of unlawful discrimination, harassment or victimisation

4. The importance of ensuring collaborative learning about the lived experiences of restraint. This includes its impact on the individual (such as trauma) as well as those close to them and those who have observed the use of force

5. The importance of maintaining a caring and therapeutic environment for the patient at all times, such that the use of force is care-planned and minimised;

6. The need for a commitment to using proportionate restraint only as an informed last resort to manage a patient, where all practical attempts at de-escalation are unsuccessful; and

7. The need for a commitment to equality and respecting a patient's human rights (referred to the Human Rights Act 1998 and other United Nations human rights treaties which are relevant to the use of force). Particular reference is made to Article 2 (right to life), Article 3 (freedom from torture, inhuman and degrading treatment), Article 8 (respect of private and family life) and Article 14 (protection from discrimination).

What does the Guidance say?

Section 2: Responsible person (RP)

The RP must be of appropriate seniority and ensure the organisation complies with the requirements of the Act. To reflect the need for accountability and appropriate oversight of the Act's requirements, the Guidance indicates that this may be someone at Executive Director level or equivalent such as the Chief Nurse or Medical Director. The Trust Board should ensure their competency and fully support their duties. The RP should be fully conversant with the techniques used by staff and the impact the use of force has on others. The name of the Responsible Person should also be published in the same way that members of the Trust Executive Board are published.

Section 10: Delegation of the RP's functions

The Guidance provides a reminder that whilst the RP can delegate their duties to a person with an appropriate level of seniority, they retain overall accountability for the duties being carried out on their behalf. They can also still perform the duty themselves. The Guidance suggests that the RP keeps a record of what functions have been delegated, to whom and why. They should also ensure person has the relevant skills and experience to perform the task.

Section 3: Policy

The Guidance has much to say about the publication of the policy by the RP and its contents (setting out how the organisation intends to reduce the use of force in its mental health units). The key recommendations regarding the policy's contents are that it should:

1. Be the result of 'co-production' and the use of local management information. The RP must consult with appropriate persons (families, patients and those with lived experiences relevant to the policy), organisations (e.g. third sector) and groups (e.g. networks, user groups and forums) when writing or substantively amending the policy. Details of this process should be included within the policy also.

2. Reflect (and set out) the needs of the patient population and be tailored to the specific service being provided

3. Confirm the types of force used (and techniques), provide examples of when it may and may to be used, explain how use is monitored across persons with shared protected characteristics, and steps taken where inappropriate force is used

4. Confirm how a patient's family, carers, advocates can be involved in the care planning of preventative strategies to reduce the risk of force being used, as well as post-incident reviews

5. Provide details of staff training, how staff will use and follow the care plans, and how the use of force will be recorded and reported

6. Details of how policies communicated to family, carers and advocates.

The policy should be signed off at Board level, before being published on the website and in hard copy. It should be accessible in different formats, and reviewed annually.

Section 4: Information about use of force

The Responsible Person must publish and review information about the use of force and their rights regarding staff use of force, and what support is available if needed. Such information must be needs-specific to the patient population and service provision. Patients, and where appropriate, families and carers should be provided with this information. The appropriate consultations must take place prior to any substantive publication or amends, which must be signed off by the organisation or Trust Board.

The Guidance also sets out the minimum requirements of the information, which includes:

1. Confirmation that any use of force will be proportionate and as a last resort (without intention to cause pain or humiliate), the types of force (techniques and approaches) that may be used and by whom, and how the use of force will be avoided;

2. How patients, families, carers and advocates are to be involved in care planning (to avoid the use of force) and post-incident review;

3. The provision of accessible and understandable information to patients and other relevant persons (including those who witness restraint), in particular, being sensitive to how such approaches should be made and when. There is an emphasis in the guidance to do this in a way that minimises the risk of distress and to ensure that information is disseminated appropriately to any given patient (including the monitoring of persistent refusals to receive information)

4. Patients' rights regarding the use of force, their rights to advocacy services and how these can be accessed, and how to raise complaints and concerns about breaches of human rights

5. Details about record keeping and records reviews, as well as the review of more general information about restraint

The information should also be published on the organisation's website and in hard copy (e.g. leaflet available on the wards or in a patient's welcome pack). It should also be kept under regular review (being reviewed annually at least) and reflect any relevant changes to the restraint policy.

Section 5: Training

The Guidance confirms that training and education is central to supporting a calm and respectful environment. It also confirms that trainers must be certified as compliant with Restraint Reduction Network Training Standards. This training covers also the threat of the use of force and coercion (which are not included in meaning of use of force covered by the Act). Training is the foundation for the culture of restraint use within any organisation. The RRN Training Standards aim to facilitate culture change and not just technical competence.

Section 5 of the Act provides a non-exhaustive list of training topics to be covered by those for whom the use of restraint is an anticipated part of their role. The Guidance goes on to provide a detailed list of examples of what should be included as a minimum for each training topic. Through these examples, the Guidance emphasises the following regarding training and the use of force:

1. It is embedded within the human rights framework so that it's application is minimal and its application is respectful of the patient's

rights

2. It should reflect the therapeutic nature of care organisations and promote minimal reliance on the use of force by staff

3. It must be informed by understanding the impact of restraint and reasons for patient's behaviour. This should be explored with the patients themselves, their carers, families and advocates where possible

4. It should result in staff feeling confident with de-escalation skills and restraint techniques

Revisions to documentation and refresher training should be regular, and at least on an annual basis.

Section 6 Recording of use of force

The Guidance highlights the need to (and the benefits of) recording open, transparent and reliable data regarding the use of force and reasons why it was deployed. However, such reporting must be proportionate to the aims of the Act. Therefore, the Guidance helpfully confirms the distinction between negligible and non-negligible use of force. Where the use of force is negligible then it need not be recorded or reported. 'Negligible' is defined as a contact or touch (activities) that are the minimum necessary in order to carry out daily therapeutic or caring activities. The Guidance provides an example of a negligible use of force being the use of a flat (not gripping) guiding hand by a staff member to provide reduction or support to prevent harm to a person, the contact being so light that the patent can override or reject the direction and exert their autonomy.

The Guidance also discusses data analysis and reinforces the need to consider the detail behind the data. The data itself provides only part of the story and other factors should also be considered when reviewing the incident figures, including staff reporting behaviours, and the patient composition of the ward. The Guidance recommends that when the organisation or Trust Board analyses its data to assess whether its compliance with the Act is effective, they should consider:

1. When force was used, did it meet the justification threshold of imminent or immediate risk of harm to self or others;

2. Was the level of force used proportionate in all cases;

3. Has there been a reduction in aspects that may be said to measure effectiveness: duration of force applied; the use of physical restraint especially prone and supine positions; the number of injuries to patients and staff following the use of force; the number of complaints from patients, families and carers.

The above analysis should inform the unit's planning and policy reducing the use of force.

Section 9 Investigation of deaths or serious injuries

Section 9 places a duty on the RP to investigate deaths and serious injuries in the mental health unit for which they are responsible, and not just those that were the result of using force.

In addition to an organisation's own internal reporting and recording requirements for serious incidents, the Guidance also confirms that:

1. There is an ongoing duty to adhere to the reporting requirements of external bodies, including the CQC, NHS Digital Mental Health Services Data Set, NHS England and NHS Improvement, and HM Coroner where the reporting criteria are met; and

2. The Act does not affect the organisation's duty of candour under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Therefore, where there has been a death or a serious injury, the patient or their family (or carer) should be communicated with in an open, honest and compassionate manner. They should also be advised of how they can participate in the investigation process and be informed of progress.

Status of the Guidance

Following consideration of the consultation responses the guidance will be finalised, following which a commencement date for both the legislation and the guidance will be provided.

Once the Act and Guidance are in force, the RP and staff working in mental health units will be required to have regard to the Guidance, which is intended to sit alongside pre-existing guidance applicable to mental health units. Any departure from the Guidance may be subject to legal challenge, for. Therefore, clear and cogent reasons for departing from the Guidance should be recorded.

Conclusion

The intention is that the Act and Guidance will mark a change in the way force is used and considered in mental health settings, starting a conversation about alternative less restrictive ways of managing risk.

It is important to note that the Act does not authorise the use of force, to which legal frameworks such as the Mental Health Act 1938 and the Mental Capacity Act 2005 should be referred as well as their associated Codes of Practice.

Should you have any questions or queries, we have a national team of specialists available to support your organisation.

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[1] The Act applies to all patients being assessed or treated for a mental health disorder in a mental health unit (NHS and independent hospitals providing NHS-funded care), whether they are detained under the Mental Health Act 1983 or as an informal or voluntary patient.

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