POLICY TITLE:	Use of Force in Mental Health Units
Policy Number:	H128
Version Number:	02
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Policy Owner:	Paul Cowans, Specialist Director
Ratified by:	Colin Quick, Chief Quality Officer
Responsible Signatory:	David Watts, Director of Risk Management

Outcome:	This policy:
	• Aims to inform all staff of the requirements of the Mental Health Units Use of Force Act
	• Ensures that the legal requirements of the act are met
	• Includes guidance on:
	  ○ Responsibilities
	  ○ Implementation
	  ○ Monitoring

Cross Reference:	H37 Prevention and Management of Behaviour that Communicates Distress in Adults

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

POLICY TITLE

CONTENTS

1 SCOPE

1.1 This policy applies to all sites across England. Where there are differences between nations, this will be clearly highlighted.

1.2 The policy applies to all Mental Health Units in England.

2 PURPOSE

2.1 The Mental Health Units (Use of Force) Act 2018 and statutory guidance requires Priory Healthcare to have a written policy to clearly set out the measures which are needed to both reduce the use of force and ensure accountability and transparency about the use of force in the mental health units.

2.2 The implementation of this policy underpins the work of the Reducing Restrictive Practice Committee and the Healthcare Reducing Restrictive Intervention Training (RRIT) to reduce the number of restrictive intervention.

3 POLICY CREATION

3.1 This policy was created in consultation with the Patient Reference Group, RRP Committee, Service Networks and clinicians across services.

4 RESPONSIBILITIES, ACCOUNTABILITY & DUTIES

4.1 **Priory Board -** The Priory Board has a legal, professional and ethical obligation to minimise harm to patients, staff and others and is accountable for the use of force within the company.

4.2 It is committed to minimising the use of force, through the promotion of positive cultures, relationships and approaches which understand the trauma history and triggers of patients which will prevent escalation and any need to use force. It will:

- understand why force is used across services and implement a strategy for violence reduction and the use of force
- regularly review the services performance in reducing the use of force
- monitor the use of force on people who share protected characteristics under the Equality Act 2010 and take action on the inappropriate or disproportionate use of force where this is identified
- be aware of the types of force and specific techniques which are used and ensure that these are risk assessed prior to use
- appoint a "responsible person" whose role it is to ensure that the Organisation complies with the requirements of the Act.

4.3 **Chief Quality Officer -** The Chief Quality Officer is appointed as the "responsible person" whose role it is to ensure that the organisation complies with the requirements of the Mental Health Unit (Use of Force) Act:

- That a "responsible person" is appointed and that the requirements of the act are carried out
- Publish a policy regarding the use of force by staff who work in the service.
- Publish information for patients about their rights to the use of force by staff who work in the service.
- Ensure that staff receive appropriate training in the use of force
- Keep records of any use of force on a patient by staff who work in the service, including demographic data across the protected characteristics in the Equality Act 2010
- Where a patient dies or suffers serious injury, have regard to any relevant guidance in relation to investigations of deaths or serious injuries
- Where appropriate, delegate any or all of these functions, and keep records of what and who these have been delegated to.

4.4 **Specialist Director -** The Specialist Director will:

- Act as the "deputy responsible person" to carry out the responsible person's functions within the Trust
- Promote awareness and support implementation of the Mental Health Units Use of Force Act within the service.
- Chair the Reducing Restrictive Practice Committee for Priory Group
- Collaborate with the RRIT Team, managers and senior clinicians to promote reducing the use of force within services
- Review monthly datix data on restrictive interventions and the number of uses of force taking place across all services
- Provide regular feedback to the responsible person

4.5 **Hospital Directors** - Hospital Directors or equivalent will:

- Make arrangements for the effective implementation and monitoring of the policy
- Promote a culture, which focuses on openness and transparency about the use of force.
- Facilitate and monitor the attendance of staff on mandatory RRIT training
- Review datix data on the use of force by wards/service type and protective characteristics at monthly clinical governance meetings.
- Promote a positive reporting and learning culture to facilitate continuous improvement with regard to reducing the use of force in the hospital

4.6 **Directors of Clinical Services –** Directors of Clinical Services or equivalent will:

- Advise and instruct staff on the policy requirements via local induction arrangements and on-going communication mechanisms
- Facilitate an understanding of the legal and practice requirements, which must be implemented as set out in this policy.
- Facilitate and monitor the attendance of staff on mandatory RRIT training
- Maintain accurate staff training records
- Promote a culture which focuses on openness and transparency about the use of force
- Ensure all incidents are reported via the Electronic Incident Reporting System (Datix) and that incidents involving the use of force are reviewed at each MDT patient review and at Clinical Governance regarding trends.
- Promote a positive reporting and learning culture to facilitate continuous improvement with regard to reducing the use of force and restrictive interventions.

4.7 **All Colleagues -** All staff are required to:

- Promote a culture, which focuses on reducing restrictive interventions, including the use of force by early recognition, prevention and de-escalation of potential aggression,

using techniques, and therapeutic approaches that support patients in line with their preferences, needs and abilities and that minimise the risk of its recurrence.
- Operate in a trauma informed care approach, where this appropriate to the service that they work within.
- Ensure that all patients have a Keeping Safe care plan & where required a Positive Behaviour Support plan in place
- Comply with the Managing Behaviours that Communicates Distress Policies (Adult & YP) to protect themselves and others from harm
- Report all incidents using the Datix system and participate in post-incident team incident reviews
- Attend mandatory training on RRIT
- Seek advice and support as required in a timely manner

5 IMPLEMENTATION

5.1 All uses of force must be rights-respecting, lawful and compliant with the Human Rights Act

5.2 **What is the Use of Force? -** The Mental Health Units (Use of force) Act defines the use of force as:

a) The use of physical, mechanical or chemical restraint on a patient, or
b) The isolation of a patient The Act introduces the following definitions of use of force:
   i. 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.
   ii. 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.
   iii. 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. 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:
   iv. 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.
   v. (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.

5.3 Use of force should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation. Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

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

5.4 **Where does the Act apply?** - A Mental Health Unit is described as a health service hospital or independent hospital in England that provides treatment to inpatients for a mental disorder. An Independent hospital will only be a 'mental health unit' if its purpose is "to provide treatment to inpatients for mental disorder", and "at least some of that treatment is provided, or is intended to be provided, for the purposes of the NHS."

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

- Acute mental health wards for adults of working age and psychiatric intensive care units
- CAMHS wards
- Eating Disorder wards
- Rehabilitation mental health & learning disability wards for working age adults
- Forensic inpatient or secure wards (low & medium) including learning disability
- Wards for older people with mental health problems

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

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

5.7 **Negligible Force -** The use of force can never be considered negligible in any of the following circumstances:

- Any use of rapid tranquilisation
- Any form of mechanical restraint
- The patient verbally or physically resists the contact of a member of staff
- Where the use of force involves the use of a wall, floor (or other flat surface) and the use of force is disproportionate
- Someone other than Priory 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, and complains about the use of force that they witnessed.
- 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)
- 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 personal possession

5.8 **Data Collection Requirements -** Any use of force that meets the above criteria must be recorded appropriately via Datix and must include the following:

a) The reason for the use of force
b) The place, date and duration of the use of force
c) The type or types of force used on the patient
d) Whether the type or types of force used on the patient formed part of the patient's care plan
e) Name of the patient on whom force was used
f) Description of how force was used
g) The patient's consistent identifier
h) The name and job title of any member of staff who used force on the patient
i) The reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
j) The patient's mental disorder (if known)
k) The relevant characteristics of the patient (if known) –
    i. The patient's age
    ii. Whether the patient has a disability, and if so, the nature of that disability
    iii. The status regarding marriage or civil partnership
    iv. Whether the patient is pregnant
    v. The patient's race
    vi. The patient's religion or belief

vii. The patient's sex
viii. The patient's sexual orientation
ix. Gender reassignment – whether the patient identifies with a different gender to their sex registered at birth

l) Whether the patient has a learning disability or autistic spectrum disorder
m) A description of the outcome of the use of force
n) Whether the patient died or suffered any serious injury as a result of the use of force
o) Any efforts made to avoid the need for the use of force on the patient
p) Whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan.

5.9 All the above data requirements on the use of force will either be collated from Datix or Care Notes so there are no additional data collection requirements for staff

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

5.11 Information leaflets have been developed for each Ward to share with patients/carers. This information will be discussed with all patients on admission, or as soon as is reasonably practicable after admission, so that patients understand what constitutes restricted interventions and the restraint techniques which may be used during their stay. If the patient initially refuses to receive the information, staff should make further attempts at reasonable intervals to provide them with the information in an appropriate format. (HG15 Patient Information Leaflet & HG16 Use of Force Poster). Staff should record a clinical note as to whether the information was accepted or refused by the patient

5.12 **Requests for Police Assistance -** In circumstances where Police Officers have been called into mental health units to assist staff on that unit, Police Officers must wear and operate a body camera at all times when reasonably practicable.
This applies to English Police Officers, a member of the Special Constabulary or Special Constable and the British Transport Police.

5.13 However, it is recognised that there may be special circumstances that justify not wearing or operating a camera, it is for the Police Officer(s) to determine in line with current College of Policing Guidance on the use of body cameras whether special circumstances apply. Images from these cameras will be the responsibility of the data controller i.e., the person that takes them - the Police

5.14 **Post Incident Reviews -** Tertiary prevention recognises the need for thorough post-incident review procedures in order to ensure that lessons are learned from incidents and that action is taken to prevent the risk of re-occurrence.

5.15 Following any use of force, the patient, and where appropriate family or carers will be involved in post incident reviews where the impact both physical and emotional will be reflected upon.
Debrief must:

- Evaluate the physical and emotional impact on all involved including witnesses
- Identify if there is a need, and if so, provide counselling or support for any trauma that might have resulted
- Help patients and staff to identify what led to the incident and what could have been done differently to ensure lessons are learnt from each incident
- Determine whether alternatives including less restrictive interventions were considered
- Determine whether service barriers or constraints make it difficult to avoid the same course of action in future

- Where appropriate, recommend changes to the service philosophy, policy, care environment, treatment approaches, staff education and training.
- Patients should not be compelled to take part in debrief, they should be offered the right to talk about the incident independently.

5.16 **Raising concerns about the use of force -** Any concerns about the use of force witnessed by colleagues should be reported to your line manager or direct to the Director of Clinical Services/Hospital Director

6 TRAINING

6.1 All clinical staff will receive RRI Training appropriate to their role. The training will be compliant with the Restraint Reduction Network Standards.

6.2 RRIT training will be a minimum of 2 days for new staff and 3 days in specific services who need additional learning on specific restrictive interventions, i.e. Seclusion, Rapid Tranquilisation.

6.3 Related service specific theoretical training will be provided face to face via Induction, i.e. Safewards/PBS/Working with Young People/NG Feeding, etc.

6.4 The core physical intervention holds taught to staff are shown in Appendix 1.

6.5 The RRIT training required for specific sites/services is based on an RRIT Training Needs Analysis, looking at incident data over the previous two years and the assessed needs of current patients. (See Appendix 2 - Individual RRIT Risk Assessment)

6.6 Training delivered can and is adapted to suit the needs of each patient group served.

7 MONITORING ARRANGEMENTS

7.1
- Performance in Reducing Restrictive Interventions (Including restraint) – Annual report to Board
- Performance in Monitoring Equality – Annual Report to Board
- Monitoring of training on the Use of Force – Annual Report to Board
- Monitoring of the recording of the Use of Force on patients – Monthly data to RRP Committee Monitoring restrictive interventions – Monthly report to RRP Committee and Quality Assurance Committee

8 REFERENCES

8.1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038727/Government-response-to-consultation-Mental-Health-Units-Use-of-Force-Act-2018-statutory-guidance.pdf
Equality Act 2010
Mental Health Act 1983 Page 15 of 16
Mental Health Act Code of Practice 2015

9 ASSOCIATED FORMS/GUIDANCE/PROTOCOLS

9.1 HG15 Use of force - A Patient Guide
HG16 Use of Force in Mental Health Units Poster

9 EQUALITY IMPACT ASSESSMENT

9.1 **How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?**

Protected Characteristic (Equality Act 2021)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	None	Equally applies to all	
Disability	None	Equally applies to all	
Gender re-assignment	None	Equally applies to all	
Marriage or civil partnership	None	Equally applies to all	
Pregnancy or maternity	N/A		
Race	None	Equally applies to all	
Religion or beliefs	None	Equally applies to all	
Sex	None	Equally applies to all	
Sexual orientation	None	Equally applies to all	
Other, please state:			
EIA completed by:			
Name: **Role/Job Title:**	Paul Cowans		
Date completed:	05/07/2022		

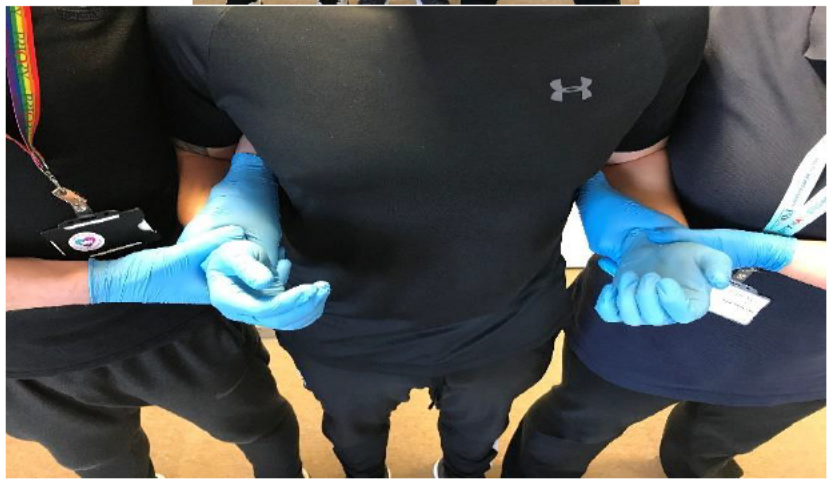
10 APPENDICIES

10.1 Appendix 1 - Physical Intervention – 4 Core Holds.
Appendix 4 – RRIT Individual Assessment

APPENDIX 1 – PHYSICAL INTERVENTION – 4 CORE HOLDS

Double Wrist Hold

In the example below immobilisation and restriction is achieved by the service user's arms being held back and high with their elbows tucked under the member of staff's armpits.

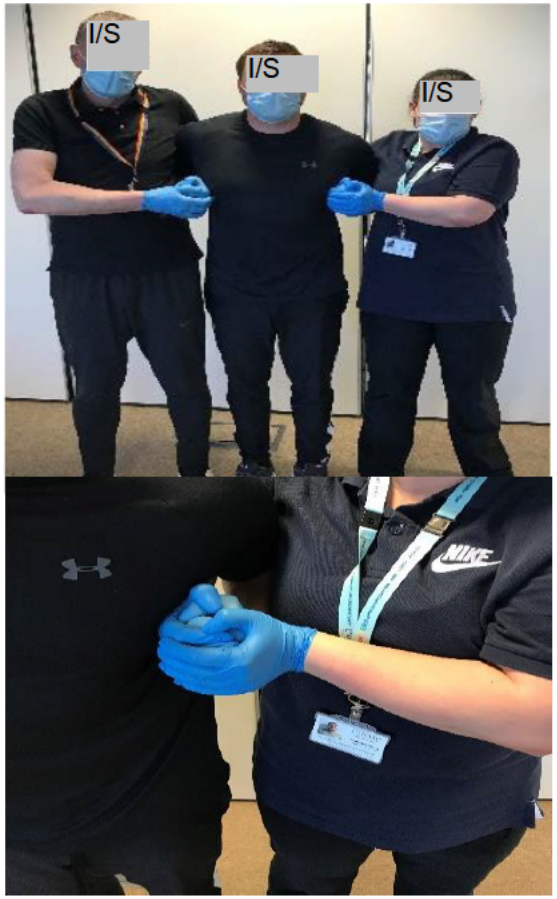


Straight Arm Hold

Some service users, especially young people, will struggle and wriggle during an intervention which can result in them extending their arms out in-front of them with their elbows 'locked-out' in an attempt to break free of the intervention. By going with this movement, it reduces the need for colleagues to struggle against the service user and control can be achieved by simply stepping back and holding the arms as shown. **Note the position of the staff**, which is slightly to the rear supporting the service user's back.

Cupped Fist Hold

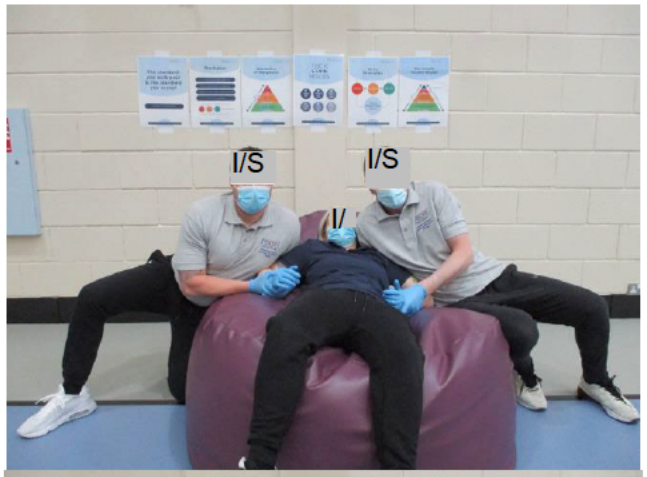
A 'Cupped Fist' hold provides us with a firmer low-level intervention. In this case we 'cover' the fist by 'cupping' it as shown. This allows continual immobilisation without too much restriction, and without discomfort, harm and / or pain.

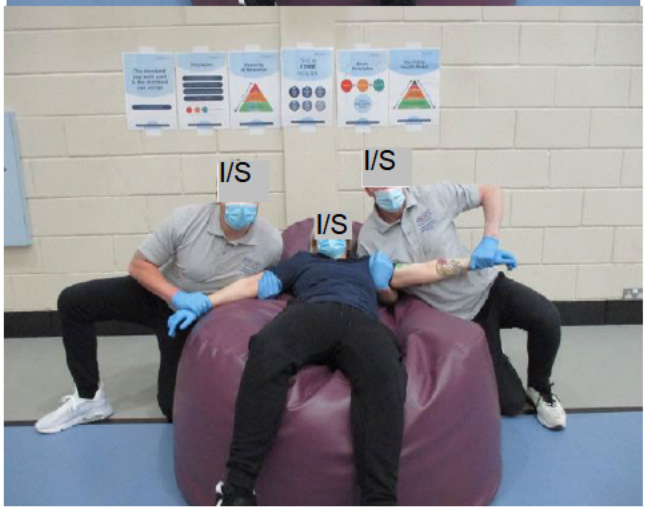


Cupped Wrist Hold - Only to be used in a life threatening/changing situation

There may be exceptional circumstances when colleagues have no option but to use a more restrictive technique in order to control a service user. The cupped wrist-hold has been approved but within a clear legal context, addressing concepts of reasonable force, absolute necessity and proportionality.
The hold is achieved by colleagues holding and supporting the end of the forearm (the radius and ulna bones) in a cupped way. At no time should colleague's hands rise up towards or above the knuckles of the service user. This technique would be used when the other 3 core holds have failed and there is an extreme risk of violence, more commonly used in seclusion.

All **4 core** holds can be used in a safety pod, seated position or kneeling position.





PROTECTING RIGHTS, REDUCING RESTRICTIVE PRACTICE

APPENDIX 4 – RRIT INDIVIDUAL ASSESSMENT (*THIS IS FOR INFORMATION ONLY ASSESSMENT MUST BE COMPLETED ON CARENOTES***)**

Individual Risk Assessment When Specifying Individualised Restrictive Interventions

The risk assessment for each individual must be informed as a minimum by the information set out below.

This assessment must include anything the service user themselves or their advocate wishes to include in each of the categories.

Name:	
Date:	

About the person (please include things that are important to know about this person) Age, gender, cultural heritage, family background, strengths, current mental health difficulties, likes & dislikes.

Risk Factors
Any known physical characteristics or health problems that may elevate the risk of harm to the person if a restrictive intervention is used.

Sensory Factors
Any known sensory processing issues that may elevate the risk of harm to the person if a restrictive intervention is used.

Developmental Factors
Any known developmental issues that may elevate the risk of harm to the person if a restrictive intervention is used

Emotional & Psychological Factors
Any known emotional or psychological characteristics or current and potential issues and problems that may elevate the risk of harm to the person if a restrictive intervention is used. This should include, if known, reference to any past trauma

About the behaviour(s) of concern
Any accurate description of the behaviour of concern. Based on data that has been collected:

- Frequency
- Duration
- Severity (impact)
- Most likely locations that the behaviours of concern occurs in

Summary of the risks posed to self and others by the behaviour of concern:

Current responses to the behaviour of concern
Are there any advanced directives or protocols agreed with the person or their family? Please include date of last review of these

Please summarise or attach copy to this risk assessment documentation:

Any successful primary strategies that are used to prevent the behaviour(s) of concern from arising in the first place

Any successful secondary interventions that are currently used to prevent the behaviour(s) from escalating if there are warning signs that the behaviour of concern may occur

Any successful non-restrictive tertiary interventions (PBS / Advance statements) that are currently used when the actual behaviour of concern is occurring that help to bring resolution and a return to safety

Any restrictive tertiary interventions that are currently used when the actual behaviour(s) of concern is occurring that help to bring resolution and a return to safety? How often are they used?

Restrictive intervention reduction plan currently in place and when last reviewed

Yes / No Date…….

Has the service user been consulted with and contributed to this assessment?

Yes/No Date…….

Are there any other restrictive interventions not named above that are now being considered for use?

Has the person consented to the interventions being considered for use?

Yes / No