Use of Force Policy
(OP-004)

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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

A proportion of people who need the support of mental health and learning disabilities services require on occasions to be cared for under conditions that are viewed as restrictive interventions. Even when restrictive interventions are used as an appropriate response to maintain safety, it is accepted that the potential negative outcomes, including physical and psychosocial trauma, can lead to fragmented therapeutic relationships and inequalities of care and support.

Humber Teaching NHS Foundation Trust is committed to reducing the use of restrictive interventions. Where restrictive interventions are used to prevent harm to the patient or others, services will ensure that they are used:

- Safely and effectively;
- As a last resort;
- With the least possible force; and
- For the shortest possible duration.

These commitments are met by staff training, working collaboratively with patients and their families, ensuring good leadership of services, maintaining appropriate environments, availability of meaningful therapies and activities, individualised care (which includes crisis and risk management plans), support and engagement, and the involvement and empowerment of patients.

This overarching policy outlines the statutory responsibilities of all staff in relation to the management of violence and aggression of patients under our care and the subsequent possibility of use of force. There are a number of associated policies that relate specifically to the restrictive intervention and the patient safeguards required when implementing the use of such restrictions. Details can be found in section 11.

The policy should be read in conjunction with Chapter 26 of the MHA 1983 Code of Practice (2015) on safe and therapeutic responses to disturbed behaviour, and also the Mental Health Units (Use of Force) Act 2018 and the accompanying statutory guidance.

The guiding principles related to the Mental Health Act are:

Least restrictive option and maximising independence Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery.

Empowerment and involvement Patients must be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2. SCOPE

This policy applies to all staff working within the organisation or trust who will be involved in the use of force who work within mental health and learning disability inpatient units. This includes NHS employees, and temporary or bank or agency staff.

All Mental Health and Learning Disability staff should be familiar with the Mental Health Act 1983, Mental Capacity Act 2005, the Human Rights Act 1998 and Equality Act 2010.

All patient leaflets and information regarding the use of force, and personal plans will be provided in easy read documents.

3. POLICY STATEMENT

All staff have a statutory obligation to follow the standards and processes set out within the Mental Health Act (1983) Code of Practice 2015 and the Mental Health Units (Use of Force) Act 2018. The procedures outlined in this Policy are in line with the requirements of the Code and the statutory guidance to the Mental Health Units (Use of Force) Act 2018. There must be no exceptions.

Humber Teaching NHS Foundation Trust recognise the potentially traumatising impact the use of force can have on people. The Trust 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 individuals which will prevent escalation and any need to use force.

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.

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.

We will prioritise creating safe spaces where teams are able to reflect on their own emotional responses to the work and process the experiences that can leave people feeling overwhelmed, stressed or distressed. In this way we can build and maintain teams that are compassionate, can work together consistently and take therapeutic risks and are able to put service users at the centre of their care planning.

Creating consistent psychological safety requires leaders who are themselves fully supported. Leaders have the biggest influence in creating and maintaining a psychologically safe culture within a staff group; they are in the best position to role model respectful compassionate relationships, valuing differences of opinions, challenging with thoughtful

responses and making difficult decisions in compassionate ways. They can ensure that the expectations around team values and ethos can be held to account, and they can ensure that the team processes that need to be in place are given priority. If a service has compassionate leaders, the team feels connected and engaged with each other and with service users/patients.

Humber Teaching NHS Foundation Trust are committed to preventing closed cultures and to promote and support the commitment to reduce and limit the use of restrictive interventions across all healthcare settings. The aim is to promote an open culture which delivers care to enhance the quality of life and lived experience of those in receipt of Trust services.

By a closed culture we mean **a poor culture that can lead to harm, which can include human rights breaches such as abuse.** Any service that delivers care can have a closed culture, and features of a closed culture include:

- staff and/or management no longer seeing people using the service as people
- very few people being able to speak up for themselves. This could be because of a lack of communication skills, a lack of support to speak up, or fear of abuse.

This may mean that people who use the service are more likely to be at risk of harm. This harm can be deliberate or unintentional. It can include abuse, human rights breaches or clinical harm.

People using services that have closed cultures, are more likely to be exposed to risks of abuse, avoidable harm and breaches of their rights under the Human Rights Act 1998 and the Equality Act 2010.

This policy aims to:

- ensure the physical and emotional safety and wellbeing of the patient
- ensure the voices of people who use services are sought, listened to and acted on
- ensure that the patient receives the care and support rendered necessary should any restrictive interventions be unavoidable
- ensure that any necessary use force takes place where possible in a designated suitable environment that takes account of the patient's dignity and physical wellbeing
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of force and any follow-up action

4. DUTIES AND RESPONSIBILITIES

4.1. Chief Executive

The chief executive has overall responsibility to ensure that policies and processes are in place for the treatment of the patients subject to seclusion.

4.2. Deputy Chief Executive and Chief Operating Officer

As the named Responsible Person for the Mental Health Units (Use of Force) Act 2018 the Deputy Chief Executive and Chief Operating Officer is accountable for ensuring the requirements in the act are carried out.

The responsible person:

- must publish a policy regarding the use of force by all staff of any profession who work in each individual unit

- must publish information for patients about their rights in relation to the use of force by staff who work in each individual unit
- must ensure staff receive appropriate training in the use of force
- must keep records of any use of force on a patient by staff who work in each individual unit,
- should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in
- may delegate some of their functions under the act to other suitably qualified members of staff within the organisation, including the deputy responsible person

(Whether the responsible person delegates any of the act's functions or not, they retain overall accountability for these functions being carried out).

4.3. Director of Nursing, Allied Health & Social Care Professionals/Caldicott Guardian
The Director of Nursing has responsibility to ensure that this policy is understood and adhered to by nursing staff and that all the processes are in place to ensure the policy is fully implemented.

4.4. Medical Director
The Medical Director is responsible for ensuring that this policy is understood and carried out by medical staff involved in the implementation of this intervention.

4.5. General Managers and Divisional Clinical Leads
General Managers and Divisional Clinical Leads have responsibility for ensuring that all clinical and professional staff within the care group are familiar with the requirements of the policy and are able to implement them.

4.6. Modern Matrons/Service Managers
The modern matrons have the responsibility to ensure that all staff working within inpatient areas comply with the policy and ensure it is implemented effectively and safely.

4.7. Responsible Clinician
The responsible clinician has specific responsibilities for the commencement, review and termination of seclusion and long-term segregation, and has ultimate responsibility for the care and treatment of the patient.

4.8. Charge Nurses/Registered Staff/Other Clinical Staff
Charge nurses/registered staff/other clinical staff must be aware of and comply with their responsibilities to work within the safeguards and requirements of this policy; and to be aware of and follow associated policies where restrictive interventions are clinically appropriate to support the management of violent and aggressive incidents.

5. PROCEDURES

5.1. Individualised Assessments
Individuals supported by the Trust should be assessed for risk of behavioural distress and disturbance (as described in the Act). Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person's behaviour, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.

While previous history is an important factor in assessing current risk, staff should not assume that a previous history of behavioural disturbance means that a person will necessarily behave in the same way in the future.

Care should be taken to ensure that negative and stigmatising judgements about certain diagnoses, behaviours or personal characteristics do not obscure a rigorous assessment of the degree of risk which may be presented, or the potential benefits of appropriate treatment to people who are assessed as liable to present with behavioural distress or disturbance. Providers should consider the accuracy of assessments of risks as part of routine audit arrangements and put training in place to learn lessons. Cultural awareness is particularly important in understanding behaviour and responding appropriately; assessments should be carried out in a way that takes account of the individual's communication abilities and any cultural issues.

Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the impact of the individual's social and physical environment, considering the needs of those who are neurodiverse and the broader context against which behavioural distress or disturbance occur. There may be times where an individual feels angry or anxious for reasons not associated with their mental disorder and this may be expressed as behaviours that challenge services. Assessments should seek to understand the underlying function of the behaviour in its broader context and not presume behavioural distress to be a manifestation of a mental disorder.

Assessments should be carried out where possible in collaboration with patients and their families, carers and advocates about why an individual might be behaving in a particular way, including any historical accounts of behaviour and possible reasons for that behaviour. This is particularly important because they can provide useful strategies, interventions and insights regarding individual responses to distressed states that have been tried in the past.

The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance quality of life outcomes for the individual and others who care for and support them.

When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviour serves or the outcomes they achieve for the individual. These assessments should inform the patient's care programme approach (CPA) care plan and/or positive behaviour support plans (or equivalent).

Factors which may contribute to behavioural disturbance and which should be considered within assessments include:

- poorly treated symptoms of mental disorder
- unmet social, emotional or health needs
- excessive stimulation, noise and general disruption
- excessive heating, overcrowding and restricted access to external space
- boredom, lack of constructive things to do, insufficient environmental stimulation
- lack of clear communication by staff with patients
- the excessive or unreasonable application of demands and rules
- lack of positive social interaction
- restricted or unpredictable access to preferred items and activities
- patients feeling that others (whether staff, friends and/or families) are not concerned with their subjective anxieties and concerns
- exposure to situations that mirror past traumatic experiences
- a sense of personal disempowerment
- emotional distress
- frustrations associated with being in a restricted environment
- antagonism, aggression or provocation on the part of others

- inconsistent care
- difficulties with communication
- the influence of alcohol or drugs intoxication and/or withdrawal
- a state of confusion, and physical illness.
- not having a sense of sexual safety
- fear of not being in control or somebody having control over them
- seeking reassurance of care

This is not an exhaustive list.

Where it can reasonably be predicted on the basis of risk assessment, that the use of force / restrictive interventions may be a necessary and a proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Plans should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient.

In regard to restrictive interventions for older people, as with all restrictive interventions, this needs to be only considered as last resort and to provide appropriate interventions to maintain a person's safety and dignity. When this is considered this should be planned with the multi-disciplinary team taking into consideration physical and psychological needs and frailty.

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalents). Patients eligible for support from an independent mental health advocate (IMHA) should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan (or equivalent). The preparation of positive behaviour support plans (or equivalents) also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. For example, on occasion, family members may wish to be notified if the patient is becoming anxious and to contribute to efforts to de-escalate the situation by speaking to the individual on the phone. People must consent to the involvement of families or advocates if they have capacity to give or refuse such consent.

It is important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account.

5.2. Individual Positive Behaviour Support Plans/Care Plans

Positive Behavioural Support Plans and Individualised Care Plans are developed following assessment. They consist of a description of the functions of the behaviours that might be seen at times of distress, the proactive strategies that may reduce the risk of the individual becoming distressed, and the de-escalation and the reactive strategies that have been agreed will be used if needed. They should also include arrangements for review and de-briefs with the patient, engaging individuals in all aspects of positive behaviour support plans / care plans. Staff must follow individualised plans at all times.

5.3. Intervention Strategies

5.3.1. Primary Preventative Strategies

Positive Behaviour Support demands that in addition to responding to distressed behaviour when it occurs (reactive strategies), we must also develop and introduce approaches that reduce the chances of the person becoming distressed and promote change over time.

Primary preventative strategies include ensuring there is a supportive and therapeutic culture in the care environment for all patients, whilst also ensuring that the individual's assessed needs are catered for in a proactive way. The Trust uses Safewards as a framework for monitoring use of restrictive interventions and practice, and as a tool for continuous improvement.

Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), the care environment should typically include the following:

A: The care environment:

- providing predictable access to preferred items and activities
- avoiding excessive levels of environmental stimulation
- organising environments to provide for different needs, for example, quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air giving each patient a defined personal space and a safe place to keep their possessions
- ensuring an appropriate number and mix of staff to meet the needs of the patient population
- ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, sensory impairments, and
- ensuring care is individualised, and not based on service-based routines or adherence to 'blanket rules'

B: Engaging with individuals and their families:

- ensuring that individuals are able to meet visitors safely in private and welcoming environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors
- engaging individuals, supporting them to make choices about their care and treatment and keeping them fully informed, and communicating in a manner that ensures the individual can understand what is happening and why
- involving individuals in the identification of their own trigger factors and early warning signs of behavioural or emotional disturbance and in how staff should respond to them
- engaging individuals in all aspects of care and support planning
- ensuring that meetings to discuss an individual's care occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates
- with the individual's consent (if they have the capacity to give or refuse such consent), involving their nearest relative, family, carers, advocates and others who know them and their preferences in all aspects of care and treatment planning, and
- promptly informing patients, families, carers and advocates of any significant developments in relation to the individual's care and treatment, wherever practicable and subject to the patient's wishes and confidentiality issues

C: Care and support:

- opportunity for individuals to be involved in decisions about a therapeutic programme that is relevant to their identified needs, including evening and weekend activities
- delivering individualised patient-centred care which takes account of each person's unique circumstances, their background, priorities, aspirations and preferences
- supporting individuals to develop or learn new skills and abilities by which to better meet their own needs.

- developing a therapeutic relationship between each patient and care workers, including a named key worker or nurse identified as the patient's primary contact at the service
- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, desirable staff attitudes and values, and training in the implementation of models of care including positive behavioural support plans
- having the right number of staff with the right knowledge, skills and experience in the right place at the right time, and the recognition of the impact this can have on reducing the use of force and for safe and effective care: (escalated where necessary via safer staffing process)
- ensuring that individuals' complaints procedures are accessible and available and that concerns are dealt with quickly and fairly
- ensuring that physical and mental health needs are holistically assessed and that the person is supported to access the appropriate treatments, and
- developing alternative coping strategies in response to known predictors of behavioural disturbance

Primary strategies also include personalised interventions that are known to help keep the patient emotionally well and reduce the risk of them becoming distressed. These strategies will be identified from the assessment as described in 5.1 and may include specific actions that help the individual feel safe, have a greater sense of control, ensure they have regular time with family, opportunities for specific relaxation and mindfulness strategies, regular 'check-in' times with staff, etc, dependent on their identified needs.

5.3.2. Secondary Preventative Strategies

Secondary strategies are the strategies to be employed where a warning sign has been identified that the patient may be becoming distressed.

De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance or a behaviour of concern.

De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy, alliance and validation; demonstrating that you have not only listened but taken on board, understand and communicated back in a simple form what that person is communicating. When employing de-escalation strategies one staff member should take the primary role in communicating with the patient. This staff member should assess the situation for safety, seek clarification with the patient and negotiate to resolve the situation in a non-confrontational manner. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the individual's positive behaviour support plan (or equivalent). In some instances it may be feasible for families to contribute to de-escalation approaches, e.g., by speaking to their relative on the telephone.
Staff should ensure that they do not exacerbate behavioural disturbance, e.g. by dismissing genuine concerns or failing to act as agreed in response to requests, or through the

individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

De-escalation training is included in the Trust-approved DMI and PATs and conflict resolution training to prevent escalation of behavioural disturbances. This training is compliant with Restraint Reduction Network National Training Standards, which is BILD accredited.

5.3.3. Supportive Engagement

The Trust has a specific Supportive Engagement Policy for use within mental health and learning disability inpatient settings. Staff must ensure they are fully aware of the policy and receive local training on implementation and recording.

Enhanced engagement can be used as a therapeutic intervention or as required for the short-term management of behaviours that challenge with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their distress constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc.)

Occasionally restrictions on activity may be needed to ensure an individual's safety. Such interventions should always be individualised, and subject to discussion and review by the whole MDT. Any restrictions should be reasonable and proportionate to the risks associated with the behaviour being addressed and consistent with the guiding principles of the Mental Health Act 1983 and Mental Capacity Act. Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted or used as a 'reward' or 'privilege'.

5.3.4. Tertiary Interventions: Restrictive Interventions

Tertiary interventions are those that take place at the time of a patient becoming distressed, violent or aggressive, in order to manage the immediate risk. These interventions may include restrictive interventions.

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

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

Restrictive interventions should not be used to punish or for the intention of inflicting pain, suffering or humiliation or establishing dominance. Where a person restricts a patient's movement, or uses (or explains the choice between demonstrating de-escalation and the impending need 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

The most common reasons for needing to consider the use of restrictive interventions are:

- current and ongoing physical assault by the patient
- dangerous, threatening or destructive behaviour

- self-harm or risk of physical injury by accident
- attempts to escape or abscond (where the patient is detained under the Act or deprived of their liberty under the MCA)

The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- the patient's wishes and feelings, if known (e.g. by an advance statement)
- what is necessary to meet the needs of the individual based on a current assessment and their history
- degree of frailty
- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- obligations to others affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff

Where an individual has a history of trauma, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. This highlights the importance of obtaining peoples' wishes around restrictive interventions.

Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected where possible.

There will be people admitted to our units with undisclosed history of trauma so all patients should have the same level of consideration regarding any physical intervention. This would work towards a trauma informed environment in all cases.

The following tertiary restrictive interventions are approved for utilisation in line with the Code of Practice 2015 and in line with guidance laid out in this policy:

- Physical restraint
- Seclusion and long-term segregation
- Rapid tranquilisation
- Mechanical restraint (Forensic Services only)

Each restrictive intervention has policy guidance, documentation and training that must be adhered to at all times by staff. It is the responsibility of staff to ensure that they are fully familiar and trained in the application, monitoring and post care of patients subject to utilisation of restrictive interventions.

The Mental Health Act 1983: Code of Practice (2015) sets out the following in relation to physical restraint where restrictive intervention is required:

- patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered there should be no pressure to the neck region, rib cage and/or abdomen
- unless there are cogent (convincing) reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor, i.e. administering parenteral medication.

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

- if exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible
- staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation

5.3.5. Informal patients with capacity to leave

Any use of force or restraint under the powers to hold or return patients needs to be justifiable as both necessary and proportionate to the risks.

Adopting a common sense approach to restraining at risk patients will almost always be lawful and the right thing to do.

Staff need to be familiar and comfortable with the Trust's Physical Restraint Policy and should feel confident to use restraint where required. The alternative, of letting someone harm themselves and / or others, would result in very serious consequences, which can include:

- A civil law claim of negligence;
- An inquest;
- A Health and Safety Executive investigation;
- CQC involvement;
- Reputational damage;
- And, importantly, the human cost of such an incident (to the victim as well as the staff involved).

<u>Preventing a patient from leaving</u>

- If you have concerns that a patient presents an immediate and serious risk of harm, **AND NEITHER THE MHA OR MCA IS AVAILABLE**, it is generally safer in legal and practical terms to restrain a patient on a precautionary basis (even if this needs to be on a "common sense" basis until further assessment is completed) rather than to allow the patient to come to harm because of uncertainty about the legal basis on which a patient could be detained or fear of the possibility of legal action.
- Verbal de-escalation techniques and persuasion should be used wherever possible as a first steps before restraint, which should always be a last resort.
- Any use of restraint needs to be necessary in the circumstances and proportionate to the risk of the patient (or someone else) coming to harm. It should be the least restrictive option available.
- The Trust's physical restraint policy should be well known to all members of staff and followed carefully.
- Incidents and claims commonly arise where patients are inappropriately restrained. Inappropriate use of restraint can result in serious injury and death.
- Restraint should continue for no longer than necessary and formal steps should be put in place as soon as possible for ongoing detention or deprivation of liberty. Failure to do this may result in a claim of unlawful detention.

<u>Powers to hold patients</u>

- As set out above, as a general rule if you "common sense" feeling is that a patient presents an immediate and serious risk of harm to themselves or

others, it is safer in legal and practical terms to restrain a patient on a precautionary basis so that further assessment can be completed as soon as possible.

- Alongside powers under the Mental Health Act and Mental Capacity Act to detain patients who present a risk of immediate and serious harm, there are criminal law powers and "common law" powers and which can be used when there has been little opportunity to form a judgment about a patient's capacity or mental disorder where urgent intervention is required to prevent serious consequences. However, these powers should be used for the shortest amount of time possible and if it's going to be for a more significant period then you need to consider whether that constitutes a deprivation of liberty.

What is the legal holding power?	Who can it be used for?	What is the criteria for detention?	How does it work?
Common law power of restraint to prevent breach of the peace or control person who is a potential danger to themselves or others	Capacitous or non-capacitous patients where there is a risk of harm to themselves or others or property. On or outside the Trust's premises (both private and public property) **–** including in A&E.	Words or behaviour lead staff to believe imminent violence is expected.	Allows staff to physically restrain a patient whose words or behaviour lead staff members to believe that imminent violence is expected. To address violence occurring at the time, prevent breach of peace from re-occurring or to prevent new breach of peace.
s3(1) Criminal Law Act 1967	Capacitous or non-capacitous persons. On or outside the Trust's premises.	1) needs to be an immediate risk to other members of the public if patient is discharged or allowed to leave. 2) The risk will most obviously be harm to others but could be damage to property.	Use of "such force as is reasonable in the circumstances" against a person assessed as being an immediate risk to other members of the public if discharged or allowed to leave.

5.4. Reporting of Incidents Involving Violence and Aggression

All incidents of challenging behaviour, violence and aggression, physical or non-physical, and near misses to incidents will be reported using the Trust reporting system Datix via the internet.

Physical assaults on NHS staff are now defined as:

> *"The intentional application of force to the person of another without lawful justification, resulting in physical injury or personal discomfort".*

Non-physical assaults on NHS staff are now defined as:

> *"The use of inappropriate words or behaviour causing distress and/or constituting harassment".*

Employees will be supported in the incident reporting procedure and advised to complete requests as soon after the incident or near miss as possible. They will be offered timely support based upon their individual need or preference. Support methods can include:

- Practical help with transport or accessing medical help
- Signposting to specific victim support or individual counselling
- Access to Occupational Health Services
- Critical incident analysis/guided reflection
- Counselling or psychological therapies
- Assistance in making requests and incident reports
- Information and assistance in relation to criminal justice procedures
- Training opportunities – refresher or additional as required
- Access to staff representation and buddy systems, where appropriate
- Professional and line management supervision which must be documented
- Capability policy
- Staff wellbeing

All employees are advised to contact the local police force, using the emergency 999 or 101 number, if they are involved in challenging behaviour, a violent or aggressive situation that cannot be de-escalated or managed by the range of clinical procedures and interventions available or have been injured. This is particularly important if a violent incident is provoked or initiated by those who are not in receipt of clinical services and are not known to employees.

Each incident must be considered on a case by case basis in light of all the available facts i.e. capacity/clinical condition. If the police are involved and attend an incident, every effort should be made to ascertain if the police intend to take action against the assailant, along with obtaining the details of the police officers involved so that these can be passed onto the Local Security Management Specialist (LSMS) to assist in their role in monitoring the progress and/or providing assistance. Where the police decline to investigate the incident, the LSMS will consider investigating further to see whether or not a private prosecution or other action, such as a Criminal Behaviour Order (CBO) or civil injunction is necessary. Irrespective of whether a sanction is pursued or not, management should consider whether "warning letters" about future conduct should be sent (advice and a range of templates – warnings, responsibilities agreements, withholding treatments, Acceptable Behaviour Orders are available from the LSMS – Vickie Shaw 01482 477861 vickie.shaw@nhs.net and/or Paul Dent 01482 477859 pdent@nhs.net) along with adding an alert on to the service users (if known) medical records to warn other employees of the potential risks.

5.4.1. Post Incident Review

As part of learning from all incidents of violence and aggression, a post incident Review should be undertaken.

The post incident review with a patient involved in the violence should be undertaken by an appropriate member of staff, as soon as it is deemed clinically appropriate and should be recorded in their electronic records.

Patient's families, carers, and independent advocates should be involved in post incident reviews following the use of force, and how the impact (physical or emotional) will be reflected in the patients' follow up care (with the patient's prior consent - Trust policy sharing information with carers). Patient's families, carers, and independent advocates can raise concerns about the use of force separately if required.

A post incident review with any patient who witnessed the violence and aggression should be undertaken by an appropriate member of staff, as soon as it is deemed clinically appropriate and should be recorded in their electronic records.

A post incident review with staff involved in the violence and aggression should be undertaken by an appropriate member of the team, this could be straight after the event or maybe at another appropriate time and should be part of staff reflection and learning from events. There should also be recognition of the emotional impact the use of force has on staff and how they will be supported.

5.4.2. Use of Force Information to be recorded

The Mental Health Units (Use of Force) Act 2018 requires that the record of the use of force used on a patient by a member of staff must include the following:

a. the reason for the use of force
b. the place, date and duration of the use of force
c. the type, or types of force used on the patient
d. whether the type or types of force used on the patient formed part of the patient's care plan / Positive Behavioural Support Plans (or equivalent)
e. name of the patient on whom force was used
f. a description of how force was used
g. the patient's consistent identifier
h. the name and job title of any member of staff who used force on the patient
i. the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
j. the patient's mental disorder, mental health condition or difficulty (if known)
k. the relevant characteristics of the patient (if known) – proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.
l. whether the patient has a learning disability or autistic spectrum disorder
m. a description of the outcome of the use of force – the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.
n. whether the patient died or suffered any serious injury as a result of the use of force (the injuries the patient suffered should be recorded)
o. any efforts made to avoid the need for use of force on the patient – this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.
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 / Positive Behavioural Support Plans (or equivalent) – this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

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

a. the patient's age
b. whether the patient has a disability, and if so, the nature of that disability
c. the status regarding marriage or civil partnership
d. whether the patient is pregnant
e. the patient's race

f. the patient's religion or belief
g. the patient's sex
h. the patient's sexual orientation
i. gender reassignment – whether the patient identifies with a different gender to their sex registered at birth.

A record of the use of force must be reported via the adverse incident on the electronic record in order for the data be reported to the NHS Digital Mental Health Services Data Set.

5.4.3. Negligible use of force

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

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

Negligible does not mean irrelevant to a person's experience of care or treatment. 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. If a member of staffs' contact with a patient goes beyond the minimum necessary in order to carry out therapeutic or caring activities, then it is not a negligible use of force and must be recorded.

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

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

- it is the minimum necessary to carry out therapeutic or caring activities (for example, personal care or for reassurance)
- it forms part of the patient's care plan
- valid consent to the act in connection with care and treatment (which may include the use of force) as part of the delivery of care and treatment has been obtained from the patient and where appropriate a member of their family or carer has been consulted, particularly a person with parental responsibility if the child is not Gillick competent. Where the patient lacks capacity to consent to the relevant act a Best Interest decision would need to be made and s5 and s6 Mental Capacity Act 2005 should be complied with to the extent applicable
- and only if they are outside of the circumstances in which the use of force can never be considered negligible as set out below

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

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

1. any use of rapid tranquillisation
2. any form of mechanical restraint
3. the patient verbally or physically resists the contact of a member of staff. For example, telling a member of staff to get off them, to stop touching them or to take their hands off them. It would also include a patient struggling to regain control over

their body. It will be important to consider the communication needs of patients with autism or a learning disability and the employment of a more complete behavioural and communication assessment may be needed to establish whether behaviour is used to communicate discomfort

4. where the use of force involves the use of a wall, floor, (or other flat surface) and the use of force is disproportionate. In practice, it will be unlikely that such a surface would be used where a patient is not resisting
5. a patient complains about the use of force either during or following the use of force. For example, telling a member of staff they are hurting them
6. someone else complains about the use of force. This does not have to be a formal complaint and can include another patient telling a member of staff they are hurting a patient
7. the use of force causes an injury to the patient or a member of staff. In this context, this would include any type of injury or other physical reaction including scratches, marks to the skin and bruising
8. the use of force involves more members of staff than is specified in the patient's care plan
9. during or after the use of force a patient is upset or distressed
10. the use of force has been used to remove an item of clothing or a personal possession

In accordance with the Mental Health Units (Use of Force) Act 2018 statutory guidance, one example of a negligible use of force is: the use of a flat (not gripping) guiding hand by one member of staff to provide the minimum necessary redirection or support to prevent potential harm to a person. Using this example, it is important to note that the contact is so light or gentle that the person can at any time over-ride or reject the direction of the guiding hand and exercise their autonomy. It is essential that the guiding hand does not cause distress to the person.

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

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

5.5. Managing Children and Young People Under 18

Management of violence and aggression in children and young people will follow this policy with staff taking into account:

- The child or young person's level of physical, intellectual, emotional and psychological maturity
- That all safety plans should be co-produced with young people and their parents/carers (where appropriate)
- The Mental Capacity Act 2005 applies to young people aged 16 and over. For young people under 16 staff should assess for competency as described in the Trust's Consent Policy.
- CAMHS staff should be familiar with the Children Act 1989 and 2004, the Mental Health Act 1983, the Human Rights Act 1998 and the United Nations Convention on the Rights of the Child.

In the case of children and young people under the age of 18, the use of restrictive interventions may require modification to take account of their stage of development.

A standard operating procedure has been developed by the Trust to support identified wards who would accept emergency admissions of young people under the age 18; in addition policies for specific restrictive interventions also include guidance related to young people. The CAMHS service will support any young person admitted to an adult inpatient ward and contribute to the development of the treatment and care plan.

Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.

Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

5.6. Use of force with consideration of individuals with a history of trauma (including use of force specific to women and girls)

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.

Staff must show respect for patients' past and present wishes and feelings, have an understanding of the patient's past experiences of trauma and abuse and how this should be reflected in their care plan. Staff should understand that ''patients' mental health, experiences of trauma, discrimination and inequality are interlinked and that a trauma-informed approach to working with these patients should be sensitive to both age and sex recognising the high levels of trauma amongst patients in mental health units. Staff must consider how the sex of the person applying the use of force could trigger trauma memories for certain patients.

5.7. Use of force specific to autistic people or people with a learning disability

Management of violence and aggression in people with a learning disability and / or autistic people will follow this policy with staff taking into account:

- The person's diagnosis and / or any comorbid physical / mental health problems
- The person's level of social or adaptive functioning and ability to understand new or complex information

- Potential for diagnostic overshadowing – This occurs when the symptoms of physical ill health are incorrectly either attributed to a mental health/behavioural problem or considered inherent to the person's learning disability or autism diagnosis
- The person's past experiences of use of force in any environment
- The person's communication skills and the staff ability to communicate in ways that they understand and is meaningful to them
- The person's sensory needs and as documented in sensory assessments if available / completed
- Making reasonable adjustments in the immediate environment to meet individual sensory needs where possible to do so
- All positive behavioural support plans should be co-produced with individuals where possible and with their family / carers (where appropriate and with consent) and will have specific regard to include person's views and wishes detailing when and how to use physical restraint
- All plans and information about use of force will be provided in easy read documents

5.8. Use of force specific to people from black and minority ethnic backgrounds and people who share protected characteristics under the Equality Act 2010

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

5.9. Police support and Section 136 assessments

The police may be required to support the Trust in the management of violence and aggression on inpatient wards and within the 136 suite. The police are trained in different violence and aggression management techniques and training. All staff should be trained in DMI when working on an inpatient ward and should follow the Trust-approved techniques. Staff should be aware of their responsibilities and that the police are in Trust wards. Trust staff should always ensure that patient safety is paramount and should address any concerns with the police who are on the ward.

If the risk is high or if the patient is in possession of a weapon, the staff member must consider the potential consequences of taking action and if there is a need to request police presence to assist with use of force; as outlined in the 'The College of Policing 'Memorandum of Understanding' – The Police Use of Restraint in Mental Health and Learning Disability Setting MH and LD services' should be prepared for known eventualities and only call the police if it is a very dangerous situation and there is a risk of serious harm to others.

Each situation where the police are called for emergency assistance should be properly assessed on its merits. There will be no assumption that police cannot be involved because the patient is either detained under the Mental Health Act (MHA) or in hospital. The police role is the prevention of crime and protection of persons and property from criminal acts.

The Trust's role and responsibilities when restraint is used by the police

- Throughout the incident health staff will remain responsible for the service user's health and safety as well as to highlight any past trauma that may be relevant. This will require active monitoring of the service user's vital signs.
- Trust staff to be aware that if a police officer is going into a mental health unit on duty to assist staff who work in that unit, the police officer must wear and operate a body

camera at all times when reasonably practicable (section 12, Mental Health Units (Use of Force Act) 2018).

- Health staff **must** alert police officers regarding any concerns as to the service user's welfare during any period of restraint.
- Allocate a lead member of staff to co-ordinate the incident and instruct and inform attending police.
- Trust staff should record details of all incidents, including details/rationale of the restraint and complete a Datix.

5.10. Advanced Decisions

Patients should be involved in all decisions about their care and treatment, and offered the opportunity to jointly develop care and risk management plans. If a patient is unable or unwilling to participate, they should be offered the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

Staff should check whether patients have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example during admission to an inpatient psychiatric unit).

Staff should ensure that patients understand that during any restrictive intervention their human rights will be respected and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Staff should identify and reduce any barriers to a patient exercising their rights and, if this is not possible, record the reasons in their notes.

It is essential that carers are involved in decision-making whenever possible, if the patient agrees, and that appropriate carers are involved in decision-making for all service users who lack mental capacity, in accordance with the Mental Capacity Act 2005.

It is also important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account.

Definitions

Advance decision: a written statement made by a person aged 18 or over that is legally binding, if valid and applicable to the circumstances arising, and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance statement: a written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Patients detained under the Mental Health Act (MHA) 1983

Encouraging patients to set out their wishes in advance is often a helpful therapeutic tool, encouraging collaboration and trust between patients and professionals. It is a way in which effective use can be made of patients' expertise in the management of crises in their own conditions.

Whenever expressing a preference for their future treatment and care, patients should be encouraged to identify as precisely as possible the circumstances they have in mind. If they are saying that there are certain things that they do not want to happen, e.g. being given a

particular type of treatment, or being restrained in a particular way, they should be encouraged to give their views on what should be done instead.

Patients should be made aware that expressing their preference for a particular form of treatment or care in advance like this does not legally compel professionals to meet that preference. However, professionals should make all practicable efforts to comply with these preferences and explain to patients why their preferences have not been followed.

Where patients express views to any of the professionals involved in their care about how they should be treated or ways they would not wish to be treated in future, the professional should record those views in the patient's notes. If the views are provided in a written form, they should be kept with the patient's notes.

Whether the patient or the professional records the patient's views, steps should be taken, unless the patient objects, to ensure that the information:

- is drawn to the attention of other professionals who ought to know about it, and
- it is included in care plans and other documentation which will help ensure that the patient's views are remembered and considered in situations where they are relevant in future

The Trust has updated guidance for staff supporting mental health service users to prepare an advance statement/decision available on the intranet or seek advice from the MH Legislation Department.

5.11. Respecting Human Rights

The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds, women, girls and disabled people.

Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

Action that is not medically necessary may well breach a patient's rights under article 3, which prohibits inhuman or degrading treatment.

Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless 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.

Unless a patient is detained under the Act or is subject to a deprivation of liberty authorisation or Court of Protection order under the MCA, providers and their staff must be careful to ensure that the use of restrictive interventions does not impose restrictions which amount to a deprivation of liberty.

5.12. Identification of inappropriate or disproportionate use of force

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

they should immediately raise their concerns with the staff involved in the first instance and then escalate for example via datix / safeguarding/ line management etc.

To help reduce potential of these incidents occurring staff are able to access relevant training such as safeguarding and DMI. The Trust also have robust processes in place regarding Freedom to Speak up and Closed Cultures.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

This Policy, procedures and guidelines ensure that all people are in receipt of services that are safe, effective and led by the needs of the person. The standards within the policy will be applied equally to all patients irrespective of the protected characteristics of the Equality Act 2010. Where individuals are being detained or receiving treatment under the terms of the Act no community group will be treated less favourably.

The impact assessment has identified that the trends in the use of the Mental Health Act will be monitored by the Mental Health Act Legislation Committee against National Equality and Diversity data to identify any impacts on the target groups.

Where patients' legal status is affected we have a clear duty to inform them of their rights regardless of their main language or communication difficulties. DVDs are available in 28 languages (other than English) with the rights of detained patients.

When patients are detained with any impairment to understanding, clinical staff must identify this need as soon as possible and access appropriate interpreter support (e.g. Language specialist, BSL interpreter, Independent Mental Health Advocate). All staff will ensure that patients are repeatedly advised of their rights using these methods of interpretation.

Religious beliefs will be respected and the Trust Chaplain will support access to relevant faith leaders and information. All clinical settings (wherever possible) should accommodate individual prayer/meditation space with appropriate access facilities.

7. IMPLEMENTATION/TRAINING

This policy will be disseminated by the method described in the Document Control Policy.

The Policy will also be available on the staff intranet and the use of force web page. The final version will be communicated to the groups initially involved in the co-production of the policy.

The policy will be reviewed annually by the authors and those involved in the Trust's reducing restrictive interventions group, and this will include the involvement of patients, their families, and carers in providing ongoing feedback for the life of the policy to inform any changes.

All staff must receive appropriate and relevant induction and training appropriate to their place of work and use of restrictive interventions and minimising the need for the use of force.

Additional training will be identified by the ward manager but will likely include DMI as a mandatory requirement on inpatient mental health and learning disability wards. Training will include focus on de-escalation and preventing escalation of potentially violent situations.

8. MONITORING AND AUDIT

Compliance against the requirements of this policy will be monitored by individual Divisions via their clinical governance arrangements. All restrictive interventions are monitored on a monthly basis via the Reducing Restrictive Interventions Group. Additionally there are individual audit requirements for each episode of seclusion, long term segregation, CAFO (Care Away From Others) and rapid tranquilisation.

All reported instances of restraint involving Trust patients are reviewed by the corporate safety huddle on a daily basis by a multi-disciplinary team including senior nurse representation and clinical staff from each of the Trust's divisions. The incidents are considered by the group to confirm that all required information regarding the means of restraint used, length of restraint and appropriate monitoring / review of the patient following the restraint has been appropriately recorded on the Trust DATIX system.

Any instances of prone restraint will also be considered by the huddle, and the nature and length of these restraints will also be confirmed with the reporting team. In addition, where an incident of prone restraint is confirmed, a briefing report will be commissioned by the daily huddle to explore the incident in further detail. Completed prone restraint briefing reports are considered by the Trust's Clinical Risk Management to ensure that appropriate actions have been taken and that there is sufficient assurance in place around the maintenance of patient safety during and following the instance of restraint.

Data will be collated via the adverse incident form around the use of force on people who share protected characteristics under the Equality Act 2010 in order to enable the Trust to monitor any disproportionate practice against such groups.

This information is reported to the Mental Health Legislation Committee within its six monthly reporting cycle (RRI report), and where required associated actions should be agreed as part of the quarterly committee meeting. Any identified actions will be used to inform the development and review of this policy.

Local management information (such as learning from post incident review data, deaths (specifically Coroner’s Preventing Future Deaths reports) or serious injuries, complaints data and records of force used in the previous year) should be used to update the policy on use of force. For example, post incident review data should include information on ways in which to prevent or reduce the use of force in the future for a patient, such as those who share a protected characteristic under the Equality Act.

Compliance with DMI training monitored via ESR and presented at monthly RRI Group. RRI training facilitated by Matrons is also monitored via ESR.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Department of Health (2014) Positive and proactive care: reducing the need for restrictive interventions London DH.
DoH (2015) The Code of Practice, Mental Health Act 1983 London, TSO.
NICE (2015) Violence and aggression: short-term management in mental health, health and community settings, London, NICE.
NLAG (Northern Lincolnshire and Goole NHS Foundation Trust) Guidance on absconding patients
Sheffield Health and Social Care NHS Foundation Trust Use of Force Policy

10. GLOSSARY

MHA	Mental Health Act
MCA	Mental Capacity Act
DMI	De-escalation Management Intervention
PATS	Personal and Team Safety
BILD	British Institute of Learning Disabilities
MDT	Multi-Disciplinary Team
ALSMS	Accredited Local Security Management Specialist
RRI	Reducing Restrictive Interventions
QpaS,	Quality and Patient Safety Group
CAMHS	Child and Adolescent Mental Health
Gillick competent	Refers to the ability of the child (under the age of 16) to give consent following assessment of whether they have enough understanding to make up their own mind about the benefits and risks of a certain issue.

11. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Seclusion and Long-Term Segregation Policy
Mental Health Act Policy
Supportive Engagement and Observation Policy
Mental Capacity Policy
Being Open and Duty of Candour Policy and Procedure
Rapid Tranquilisation Policy
Physical Intervention Policy
Guidance for Staff Supporting Mental Health Service Users to Prepare an Advance Statement/Decision

APPENDIX 1: DOCUMENT CONTROL SHEET

This document control sheet, when presented for approval/ratification must be completed in full to provide assurance. The master copy of the document is to be held by the Policy Management Team.

Document Type	Policy		
Document Purpose	This overarching policy outlines the statutory responsibilities of all staff in relation to the management of violence and aggression of patients under our care and the subsequent possibility of use of force. There are a number of associated policies that relate specifically to the restrictive intervention and the patient safeguards required when implementing the use of such restrictions. Details can be found in section 11.		
Consultation:	Date:	Group / Individual	
list in right hand columns consultation groups and dates -	10 December 2024	Reducing Restrictive Interventions Group	
	11 December 2024	Humber Centre Patient Council Meeting	
	19 December 2024	Circulated to RRI Group for comments	
	19 December 2024	Inpatient Voice Group	
	15 January 2025	Recirculated to Inpatient Voice Group	
	16 January 2025	Circulated to MHL Steering Group for comments	
	11 November 2025	Reducing Restrictive Interventions Group	
	19 November 2025	Circulated to Service User Involvement Group	
	19 November 2025	MHL Steering Group	
Approving Body:	QPaS	Date of Approval:	22 January 2026
Date of Board Ratification:	N/A (minor amends)		
Training Impact Analysis:	None [x]	Minor [ ]	Significant [ ]
Financial Impact Analysis:	None [x]	Minor [ ]	Significant [ ]
Capacity Impact Analysis:	None [x]	Minor [ ]	Significant [ ]
Equality and Health Inequalities Impact Assessment (EHIIA) undertaken?	Yes [x]	No [ ]	N/A [ ] Rationale:

Document Change History:			
Version Number	*Type of Change (full/interim review, minor or significant change(s))*	*Date*	*Details of Change and approving group or Executive Director* ***(if very minor changes as per the document control policy)***
P199 Management of Viloence and Aggressive Behaviours Policy (Reference updated to N-049 2017)			
1.00	*New policy*	*March 2014*	*New policy. Merged and replaced P059 Violence & Aggression policy and P164 Challenging Behaviour Policy.*
2.00	*Legislation*	*January 2017*	*Updated policy in line with Code of Practice 2015.*
2.01	*Review*	*March 2017*	*Amendments relating to other policies page 10*
2.02	*CAMHS review*	*July 2019*	*Policy Reference updated to N-049 (transfer to HealthAssure system)* *Addition of text in section 5.5 Managing Children and Young People Under 18*
2.03	*Review*	*November 2019*	*Minor amendments to section 5.2 and 5.3*
OP-004 – replacing N-049 due to legislation			
1.00	*New Policy*	*March-22*	*This policy has replaced the Management of Violence and Aggression Policy in response to the requirements of the Mental Health Units Use of Force Ac 2018.*
1.1	*Review*	*27 March 2023*	*Full review – Added "considering the needs of those who are neurodiverse" under individualised assessments (page 6), added factors which may contribute to behavioural disturbance (page 7), added safewards framework under primary preventative strategies (page 8), consideration of those people admitted with undisclosed history of trauma (page 11), amended title of 5.6 to emphasise history of trauma is not limited to women and girls (page 17), addition of the requirement for police to wear body cameras (page 18), expanded monitoring and audit section (page 21). Approved at EMT (27 March 2023).*
1.2	*Review*	*March 2024*	*Page 13 – inclusion of narrative regarding informal patients with capacity to leave.* *Page 4 - inclusion of narrative regarding being trauma informed.* *Page 8 – Inclusion of narrative for use of restrictive interventions with older people.* *Approved at EMT (27 March 2024) and ratified at Board (29 May 2024).*

1.3	*Review*	*January 2025*	*Full review* *Discussed in December 2024 RRI Group – circulated 19.12.24 for comments – none received.* *Presented to patient council meeting at the Humber centre on 11.12.24. There were 4 service users present. They didn't have any other comments other than a suggestion of an easier read guide as the policy is written more for staff. However they were then reminded about the available use of force leaflets and presented with these again and they were happy with these as easy read version of policy.* *Policy circulated to inpatient voice group in December 2024. Leaflets also shared a few times, last time October 2024 - no feedback received for either.* *The Use of Force leaflets were also shared with LD engagement lead to review the easy read versions. Co-production stamp request form can be submitted for both the use of force leaflets and the policy.* *Approved at QPaS (23 January 2025).*
1.4	*Review*	*January 2026*	*Full review* *Discussed in November 2025 RRI Group – no comments received.* *Policy circulated to inpatient voice group 19 November 2025 – no comments received. Approved at QPaS (22 January 2026).* *Review date set to March 2027 as requested, as legally required to review annually.*

APPENDIX 2 – EQUALITY AND HEALTH INEQUALITIES IMPACT ASSESSMENT (EHIIA) TOOLKIT

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Use of Force Policy
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Legislation Lead
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service This overarching policy outlines the statutory responsibilities of all staff in relation to the management of violence and aggression of patients under our care and the subsequent possibility of use of force. There are a number of associated policies that relate specifically to the restrictive intervention and the patient safeguards required when implementing the use of such restrictions. Details can be found in section 11. The policy should be read in conjunction with Chapter 26 of the MHA 1983 Code of Practice (2015) on safe and therapeutic responses to disturbed behaviour, and also the Mental Health Units (Use of Force) Act 2018 and the accompanying statutory guidance.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Positive = evidence of positive impact (Blue) Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	How have you arrived at the equality impact score? • Who have you consulted with? • What have they said? • What information or data have you used? • Where are the gaps in your analysis? • How will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	Staff should always ensure that any use of force is used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including disabled people. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Sex	Man/Male, Woman/Female.	Neutral	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including women and girls.

Marriage/Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to marriage/civil partnership.
Pregnancy/Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.	Neutral	Staff should always ensure that any use of force is used only after having due regard to the individual's maternity status and having taken full account of their physical, emotional and psychological wellbeing.
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds. It is acknowledged that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender identity related preferences, needs or requirements. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, genderfluid or agender people.

Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of income or living standards.
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. Easy read versions of the Use of Force patient information leaflets are available.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. It is acknowledged that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of digital skills or access.
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of inclusion health group.
	• people who experience homelessness	Neutral	This policy is consistent in its approach regardless of housing status.
	• drug and alcohol dependence	Neutral	This policy is consistent in its approach regardless of drug / alcohol dependence.
	• vulnerable migrants	Neutral	This policy is consistent in its approach regardless of the person's country of origin / migration status.
	• Gypsy, Roma and Traveller communities	Neutral	This policy is consistent in its approach regardless of ethnic background or community.
	• sex workers	Neutral	This policy is consistent in its approach regardless of the person's occupation.
	• people in contact with the justice system	Neutral	This policy is consistent in its approach regardless of the person's contact with the justice system.
	• victims of modern slavery	Neutral	This policy is consistent in its approach regardless of the person's experience with modern slavery.
Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of geographical location.

Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of geographical location.
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy actively seeks to involve carers and families of patients where consent is given.
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of parent/carer status.
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of veteran status.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA. This policy is consistent in its approach regardless of the person's neurodivergent status. Reasonable adjustments will be made where necessary to support patient's understanding.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above.

It is felt that this policy and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs.

The policy takes significant consideration of the protection of all service users and their carers under the Equalities Act 2010 and the Human Rights Act. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.

Healthcare staff, managers and independent advocates have a professional responsibility to be alert to the disproportionate use of force, to know what they must do if they witness or suspect the abusive use of force, and to take action. Staff must ensure they understand their safeguarding responsibilities and are familiar with the trust's safeguarding policies and procedures. If staff witness or suspect the inappropriate or disproportionate use of force, they should immediately raise their concerns with the staff involved in the first instance and then escalate if necessary.

EIA Reviewer: Michelle Nolan	
Date Completed: 07.01.26	Signature: M Nolan