Royal College of Nursing Response to the Department of Health and Social Care: Mental Health Units (Use of Force) Act 2018 statutory guidance

With a membership of over 450,000 registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Introduction

The Mental Health Units (Use of Force) Act 2018 (the Act) received Royal Assent (when a bill is made into an Act of Parliament) on 1 November 2018.[1] This consultation only covers the sections of the Act which require action by the 'responsible person' or a 'mental health unit'. These are sections 2, 3, 4, 5, 6, 9 and 10. Sections 7, 8 and 11 impose duties on the Secretary of State for Health and Social Care[2].

As the main professional group implementing and delivering care within inpatient mental health services, alongside patients and service users', it is vital that the voice of nursing staff is heard throughout this consultation and beyond. This response has been developed in collaboration with a range of RCN members and staff.

1. Section 1: key definitions

1.1. Members responding to the consultation believe the guidance is clear on what the terms "mental disorder" and "mental health unit" mean.

1.2. Members feel that the definition of "use of force" would benefit from the inclusion of direction around the 'type of force' used, in relation to the age and cognitive development of the person.

[1] Mental Health Units (Use of Force) Act 2018

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

1.3. Concerns were raised for the inclusion of the dementia example in "*what is the use of force, why and when it can be used*". Someone with dementia refusing personal care is not an obvious example of when force will be required. Therefore, section 6 of the Mental Capacity Act[3] must be explicitly referred to within the guidance:
   a) restraint should only be used when the clinician/carer "*reasonably believes that it is necessary to do the act in order to prevent harm*" to the service user;
   b) "*the act is a proportionate response the likelihood of P's suffering harm, and the seriousness of that harm*".

2. Section 2: mental health units to have a responsible person

2.1. Some members felt the definition of the "responsible person" is unclear.
2.2. There was some confusion around 'responsible person' and the statutory role of 'responsible clinician', as outlined within the Mental Health Act[4].
2.3. The guidance is not clear what a responsible person must do in order to fulfil this role, the reporting requirements and other key tasks that this person would be expected to undertake.
2.4. Training for the responsible person must include the relevant level of safeguarding and Mental Capacity Act awareness.

3. Section 3: policy on use of force

3.1. Members felt that the statutory guidance clearly explains what a policy on use of force should include. Further considerations for what should be included within the policy section of the guidance are outlined in the following subsections (3.2–3.8).
3.2. Through the principals of co-production[5], care staff and service users must be involved in the governance, discussion, publication and dissemination of policy created for mental health units.
3.3. Nurses, nursing associates and support workers are the care staff most likely to use force within mental health units.
3.4. The duty to consult nursing staff is only inexplicitly referenced once within the guidance: "staff representatives" should be consulted. However, without making this more explicit, policies could easily be produced without consulting a nurse, nursing associate or a support work.

[3] Mental Capacity Act 2005
[4] Mental Health Act 2007
[5] Co-production in mental health

3.5. There is no acknowledgment of the potential psychological harm caused by those carrying out or witnessing the use of force . These omissions could negatively impact the equality the document is trying to achieve. Health and care workers involved in using force are likely to be junior staff and many from ethnic minority backgrounds.

3.6. Psychotropic medication is often used as a way to manage behaviour that is seen by clinicians as challenging. People with a learning disability, autism or both are more likely to be given these medicines than other people[6]. It is vital that policies on the use of force include concerns of 'over-medicating' people within mental health units.

3.7. Organisational policies must place emphasis on diversion techniques and de-escalation process to avoid the use force.

3.8. The recommendation about the policy setting out the plan "the organisation is taking to reduce the use of force within their mental health units" needs further consideration. Organisational and unit-level targets for restraint reduction may not sufficiently address the experiences of individual service users. The information captured post restraint must enable data to be examined closely enough to identify trends and take individual cases into account.

3.9. There may also be times when unexpected and new situations arise, resulting in the use of force. Organisations must have appropriate policies in place to protect nurses whom may deem it necessary (in line with the MCA) to respond with force in an unexpected situation.

3.10. Policies on the use of force must include the principals of **staffing for safe and effective care**: having the right number of registered nurses and nursing support workers with the right knowledge, skills and experience in the right place at the right time is critical to the delivery of safe and effective care for all those who use health and care services.[7]

3.11. Low levels of staff, unstable teams, and poor working conditions can lead to compassion fatigue and poor practice. Low staffing levels have been shown to increase the occurrence of restrictive practices, while negatively affecting service user outcomes[8].

3.12. We continue to call for the expansion of accountability for workforce planning and funding in law and investment into nursing higher education in England. A commitment in law is critical to provide assurance to our nursing community that our workforce shortages will be tackled.

[6] Stopping over medication of people with a learning disability, autism or both (STOMP)
[7] RCN Workforce Standards
[8] Discrimination in mental health services

4. Section 4: information about use of force

4.1. The majority of members felt that the guidance clearly explains what information should be given to service users on the use of force. However, further additions must be considered (see 5.2-5.4).

4.2. Nursing staff must be seen by service users as carers not custodians. There must be a commitment from the nursing team to rebuild rapport and resolve potential trauma to the service user following any use of force.

4.3. Members would like to see some indication in the information for service users about what to expect post restraint from their clinicians. The guidance only mentions service user/family/carer involvement in post incident reviews.

4.4. There is also the need to provide information around who can make a complaint on behalf of a child and/or young person (CYP), i.e. the CYP themselves, their parents/carers, their advocate and/or all of the above.

5. Section 5: training in appropriate use of force

5.1. Training for nursing staff must include: basic life-support and person-centred risk assessments (e.g. not to use force on service users with cardiac problems and other serious physical health co-morbidities).

5.2. There must be an emphasis on training around conditions such as dementia/frailty as well as 'diagnostic over-shadowing'.

5.3. The emphasis of training must be underpinned by the latest evidence-based approaches. Training content within the guidance should include:

a) Person-centred care planning
b) Techniques for avoiding/reducing use of force
c) De-escalation versus coercive approaches
d) Consideration of the risks associated with use of force
e) Safeguarding training at the appropriate level
f) Impact of any use of force on a patient's mental and physical health
g) Involvement of service users, carers, and significant others when planning, developing, and delivering care plans

5.4. Providing de-escalation techniques alone will not be sufficient in tackling a culture of restrictive practices; a comprehensive approach is necessary. Our members believe that certified training for the use of force must comply with a set of good practice standards, i.e. the Restraint Reduction Network Training Standards[9].

[9] Training Standards 2019 - Restraint Reduction Network

5.5. Diversity training should be included as evidence has shown that individuals from Black and Minority Ethnic (BAME) groups especially black men are more likely to have experienced the use of force in mental health settings.
5.6. Some mental health services are focusing on delivering race and diversity training packages to improve awareness of this issue. More emphasis is needed within the guidance to highlight this area of need.
5.7. The responsible person who provides training should be suitably qualified to deliver the programme that meets the requirements for all age groups. Co-production with those that have lived experience must be core to the planning, delivery and evaluation of training in the use of force.

6. Section 6: recording of use of force

6.1. Members believe that the guidance clearly explains what information should be recorded when force is used on a service user. Case studies with good examples of how to record this vital information would be helpful for those not familiar with the process.
6.2. Although agreeing with the list setting out the circumstances where the use of force can never be considered as negligible, there were concerns amongst members with the use of the term "negligible force".
6.3. The term "negligible", whilst defined within the Act, can be misinterpreted. Further clarity within the guidance is needed.
6.4. Force only occurs when stopping someone from doing something they want to do or making them do something they don't want to do, thus implying there will be resistance. If there is no resistance from the service user, then by definition, there should be no force occurring.

7. Section 9: investigation of deaths or serious injuries

7.1. The guidance clearly explains what should happen following a serious injury or death in a mental health unit.
7.2. Members believe there needs to be more clarity about what is meant by "independent" in this context. An employee in an organisation from another department may be considered "independent", yet their investigation will go through the same non-independent senior management review processes.
7.3. There is no mention of the UN Conventions on the Rights of the Child (UNCRC)[10] within the guidance. The UNCRC imposes duties on the state

[10] UN Convention on the Rights of the Child (UNCRC)

similarly to the European Convention of Human Rights (ECHR) and must be included.

8. Section 10: delegation of responsible person's functions

8.1. There is general agreement with the summary questions outlined in section 10.

8.2. It was felt that the trauma informed, human rights and age/developmental approaches to reducing the use of force could be explained in more a more practical way, i.e. case studies of such situations where the approaches should be used.

8.3. The guidance emphasises the importance of involving service users, their families and carers in decisions about their own care. Clarity on when it may not be possible or could be harmful to involve people and their families must be included.

8.4. How the delegated responsible person feeds back to the Responsible person should be made explicit.

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