CONSULTATION - RESPONSE BASED ON STAFF AND PATIENT FOCUS GROUPS

Mental Health Unit (Use of Force) Act 2018, Seni’s Law: statutory guidance for NHS organisations in England and police forces in England and Wales -

Introduction

1. Colourful Minds is a volunteer led Charitable Association, founded to be an ambassador for mental wellbeing and mental health in and on behalf of Black and Minority Ethnic communities throughout England.

2. The charity became involved in the statutory guidance consultation for the Mental Health Units (Use of Force) Act 2018 (Seni's Law), after meeting Ajibola Lewis, the mother of Seni Lewis a 23-year-old black male graduate, who died after been restrained by up to 11 police officers. This happened whilst he was under the care of a mental health unit, as a voluntary patient. Mrs Lewis and her family have campaigned tirelessly since Seni's death, to reduce the use of force in mental health units and avoid future deaths and serious injuries.

3. As an ambassador for black and ethnic minority communities, it was also important that Colourful Minds undertook research to respond to the consultation since Black or Black British people; People of mixed heritage and People of other ethnic groups (non-South Asians) are four, three and two times more likely respectively, to be subjected to restrictive interventions (i.e. use of force) in NHS funded mental health units than white people according to the NHS data.[1]

4. To prepare this response to the guidance, we undertook two separate 2.5-hour focus groups. One with eight people with lived experience of use of force in a mental health unit and a second with ten members of staff, who have either used force or witnessed the use of force in a mental health unit. The people with lived experience focus group was funded by the Department of Health and Social Care whilst the staff focus group was funded by the South London and Maudsley NHS Foundation Trust.

5. The aims of the focus groups were to hear first-hand the experiences of service users and staff regarding the use of force in mental health units, to garner their opinions on the various elements of the statutory guidance and see how it can be improved.

6. We would like to thank the focus group participants for their time and for sharing their experiences. We acknowledge that this may have been traumatising to relive, but we do hope to see an improvement in mental health care and a reduction in the use of force in mental health units, as a result of their bravery and candour.

Overall view of the guidance

1. Providing greater detail and SMART guidance

7. We do not believe the draft guidance provides enough detail in some areas. This will allow organisations to interpret the guidance in very different ways. This may lead to poor and ineffective implementation of the guidance and a postcode lottery in terms of use of force. Specifically, disproportionate use of force.

8. The guidance requires the involvement of patients, families and people with lived experience in the development and review of policies, in the design of patient information, in staff training and in defining negligible use of force. However, there is no SMART guidance available regarding this, there are no examples of how these groups should be

[1] Mental Health Bulletin 2019-20 Annual report

involved or a clear definable pathway by which patients and people with lived experience can hold organisations accountable, should they fail to engage in good faith and in meaningful consultation.

9. We recommend that each part of the guidance is robustly tested to ensure that the guidance provided are SMART (i.e. Specific, Measurable, Achievable, Relevant and Timely).

2. Setting National standards for use of force

10. The guidance states, “It is essential that all policies reflect the needs of the patient population using the service,” and that the responsible person “Must consult with whoever they consider it appropriate to consult. This should include….any relevant local third sector organisations”.

11. We are concerned that the guidance does not set national standards and devolves a number of decisions about the definition, training, design and other policy responses to each organisation. We consider this to be a problem because we recognise that patients are sometimes placed out of area and staff, particularly bank staff, work across units. This exposes patients to a postcode lottery in terms of the standard of care they receive. A lack of national standards allows organisations to opt out of taking appropriate action on the use of force and increases the risk of disproportionate use of force against people with protected characteristics because of the organisations’ local demographics.

12. Throughout our response we have recommended areas where national standards should be set and applied. This is to ensure that patients can be assured that they will receive the same standard of care, regardless of which mental health service they are under the care of in England or which police force they find themselves in contact with, in England and Wales.

3. Addressing disproportionate use of force against people of colour

13. We do not believe the guidance properly addresses the over representation of people with protected characteristics, specifically black men, in the existing data regarding the use of force. This is particularly concerning as research shows that these groups are at greater risk of being involved in use of force that results in serious injury or death[2].

4. Use of ‘Must’ and ‘Should’ in the guidance

14. We recommend the guidance considers identifying more actions as “must” as opposed to “should”; (“should” meaning actions or policies that are good practice that it is expected organisations will follow and apply to their mental health units and “must” meaning actions or policies that are a legal or regulatory requirement or duty under the use of force act, or other regulations that relate to the use of force in mental health units). This will hopefully facilitate greater compliance with the guidance and will mean that organisations will be required to give a robust and justifiable reason should they make decisions to the contrary.

5. Making the guidance accessible to service users

15. The guidance, like the Act, will put in place some important changes to patients’ rights to information, their involvement in designing their own care and will raise the expectation

---

[2] Report of the Independent Review of Deaths and Serious Incidents in Police Custody

for positive changes in the way staff interact with and care for patients. It is therefore important that this guidance is particularly clear, concise and easy to follow by lay people, in a manner that may not be the case for other statutory guidance.

16. In preparation for our focus groups with people with lived experience and with staff, we identified that the guidance in its current format refers to other documents, guidance and regulations not within the guidance itself. This makes the guidance hard to follow for lay people who may not be familiar with, or may find it difficult to follow the other related guidance and regulations referred to in the guidance.

17. A person with lived experience said:

> *"One can only know something, if they have the knowledge. If you don't have the knowledge of the new guidance, how can you ensure that it's implemented, that it's used in your best interest so you can challenge the system? So we need to find ways to talk about how are black and minority ethnic communities being informed about the new guidance."*

18. We recommend that the guidance is restructured to bring all the information needed to comply with the Act into one concise guidance document, without links to external documents or resources.

6. The culture that leads to use of force in mental health units

19. We are concerned that in its current form, the guidance focuses only on a policy response i.e. to train staff, provide information on use of force to patients, collect data and prepare use of force plans. This may lead to the wrong impression that use of force by staff is an individual action rather than recognising that use of force, including the higher incidences of force against ethnic minority patients, happens for many different and complex reasons, such as the organisational structure and culture.

20. We heard from people with lived experience that use of force was often rooted in enforcing an unequal power dynamic between patients and staff, which favours mental health unit staff. This can lead to patients being stripped of agency to make their autonomous decisions, even where patients pose no threat and would be perfectly capable of making decisions for themselves. A woman with lived experience shared the following:

> *"I was forcibly medicated for about eight weeks because I did not want to be medicated at the time. It didn't matter that at some points there were six males and only one female, whilst they were injecting me in my bottom or in my thigh, which obviously involves moving your clothing. That stayed with me forever and I found that humiliating."*

21. We heard from staff that there is a desire to see change and a realisation which sometimes after force has been used, that there may have been better ways to handle the situation. However, they do not feel that staff have the right organisational support to create lasting change that would lead to a reduction in appropriate use of force. One mental health unit staff member said:

> *"I work on a PICU ward and I suppose one of the reasons that I'm here is that this conversation has happened on and off for a long time and I get the feeling that nothing really changes, certainly where I am…it would be nice to be part of something that changes that."*

22. At our focus groups we heard from both people with lived experience and staff, that there are several factors which contribute to the risk of the use of force. These include:
    - staff shortages - 75% of staff agreed or strongly agreed that there is more risk of use of force when staff are short of time or when units are short of staff
    - we heard from both staff and people with lived experience that the ward environment and having activities for patients to do were important determinants in whether force will be used
    - poor communication skills on the part of some staff members
    - distance and a lack of therapeutic relationship between patients and staff – where staff do not know patients or their triggers.

23. Regarding the question as to whether the focus group participants, believe there is a culture of using force to get patients to comply, 100% of people with lived experience and 67% of staff agreed or strongly agreed that this was indeed the case, whilst 8% of staff disagreed and 25% neither agreed nor disagreed.

24. The guidance needs to support and encourage a move towards a culture of consent where possible in mental health units. This will allow patients to trust staff and to feel empowered to exert agency and control regarding their own care.

25. Therefore, any policy response to reduce the use of force in mental health units must tackle the institutional conditions which allow and sometimes promote the excessive use of both appropriate and inappropriate use of force in mental health units. This can result in people from ethnic minorities, particularly black men, being subjected to more incidents of use of force and/or the most excessive and restrictive practices.

26. We therefore recommend that as well as focusing on the patients' human rights, the guidance should also provide detailed instruction on the systemic changes organisations need to make, in order to create long term cultural changes in the relationship and power dynamic between patients and staff. This can be done by requiring units to prepare a Use of Force Reduction Action Plan, which addresses all aspects and factors that lead to the use of force.

Definitions:

7. The definition of appropriate and inappropriate use of force

27. The terms "appropriate use of force" and "inappropriate use of force" are used in the guidance, but these terms are not defined in an unambiguous way.

28. It is encouraging that the guidance does discuss specific forms of use of force such as punishments, threats and coercion as well as related concepts such as the least restrictive approach principle. However, we believe guidance needs to set clear national standards and guidelines as to what constitutes appropriate and inappropriate use of force.

29. Clear national standards and guidelines regarding the use of force would enable staff and patients to understand what constitutes acceptable and unacceptable behaviour, thus making it easier for staff and patients to challenge wrongdoing and for the focus to be placed on reducing appropriate use of force and eliminating inappropriate use of force.

30. During both focus groups we heard stories which suggested a culture of the use of force, and/or coercion in mental health units to get patients to comply with basic instructions where nobody was at risk. When asked "Do you think there is culture of using force to

get patients to comply?" 100% of people with lived experience agreed or strongly agreed that this was indeed the case whilst 75% of staff agreed or strongly agreed. Only 8% of staff disagreed.

As an example, we heard a story from a member of staff about a patient being denied his Section 17 leave by a deputy nurse in charge, to go out for a cigarette, unless the patient had a shower. We heard similar stories from patients, who expressed the traumatising nature of this form of force and the importance of this being recognised and addressed within any guidance on use of force.

31. Any definition of appropriate and inappropriate use of force, needs to be both specific in parts, but nuanced enough to capture coercive practices that seek to enforce psychological control over patients. It will therefore have to capture specific types of restraints, actions and types of coercion and set out specific principles of what constitutes inappropriate use of force (by virtue of its nature), the context in which the force is used, the proportionality of the force used and the danger posed to the patient themselves and others.

32. We heard from one person with lived experience that:

> *"Covert restraint is one you don't see, being threatened that you're going to stay in hospital longer or the people calling the police on you. These are very covert restraints carried out by people who are not part of your team or involved in your mental health, but can instigate restraints on you. That's happened to me about five times… it's very unpleasant because you have to comply or matters get worse."*

33. When we asked staff about the difference between appropriate and inappropriate use of force, we received various examples or definitions of appropriate use of force, but very few were able to define inappropriate use of force.

34. We recommend that within the definitions section of the guidance, a clear national definition is given of appropriate and inappropriate use of force. We recommend that the definition of inappropriate use of force includes, psychological control, coercion and the forms of physical restraint identified in the draft guidance.

35. We asked staff and people with lived experience of the use of force "Do you think patients with lived experience should be involved in defining what is appropriate and inappropriate use of force?" 100% of people with lived experience and 100% of staff, agreed or strongly agreed that this should be the case.

8. Where the guidance applies

36. We disagree that the guidance should not apply in accident and emergency departments, outpatient clinics, in 136 suites or to Section 135. This is because the physical and psychological trauma of use of force would be the same wherever it is experienced.

37. Whilst we understand the Act excludes these parts of hospitals and contexts, mental health units, mental health professionals and police should be encouraged and expected to apply the same standards of care to mental health patients wherever they are on the organisation's premises or under their care.

38. We recommend that at the very least that the guidance should recommend that training, permitted techniques, information provision and the definitions of appropriate and

Colourful MINDS ®

inappropriate use of force, are applied throughout each organisation. This is to provide certainty to patients and staff about acceptable behaviour and conduct.

39. We also recommend that the requirement to record use of force and analyse performance be extended to these settings so that organisations have a better understanding about the culture of use of force in these settings and can begin to enact appropriate changes and training to reduce use of force on mental health patients across its estate.

Section 2: mental health units to have a responsible person

40. We welcome the guidance's recognition that Trust boards have a legal, professional and ethical obligation to minimise harm to service users, staff and others and must therefore be accountable for the use of force within their organisation.

41. However, we feel that the guidance is not explicit about what the Trust board and responsible person must do to reduce inappropriate use of force. It does not recognise the complex institutional factors that need to be addressed to deliver a meaningful change that would make the stay of patients in mental health units safer.

42. We recommend the guidance be explicit in how the Trust board and the responsible person are legally and professionally responsible and accountable for:
    - the organisational culture and working environment that leads to the eradication of inappropriate use of force and a reduction in the appropriate use of force.
    - continual improvements in care, care environment and staff working conditions that leads to a reduction in the appropriate use of force within the organisation, as well as the eradication of inappropriate use of force.
    - ensuring there are not disproportionate incidents of use of force against people with a protected characteristics within their organisation.

9. Delegation of responsibility

43. Whilst the Board or a Trust may appoint a named responsible person, who delegates some of their responsibilities for implementation and monitoring, the feedback from staff and people with lived experience alike expressed the need for senior involvement.

44. We recommend that some parts of the policy response are not delegated, particularly around understanding why use of force happens in the Trust and developing a wider action plan to reduce the appropriate use of force and eradicate inappropriate use of force.

45. We also recommend the annual review of the organisation's performance in use of force be performed by the Board.

10. Other recommended interventions

46. We note there are studies in the scientific literature which have looked at the effectiveness of restraint reduction programmes and have produced recommendations of actions that work, which we would like to see included in the guidance. Two such studies include:

    1. Marie-Hélène Goulet et al (2017), Evaluation of seclusion and restraint reduction programs in mental health: A systematic review

Colourful MINDS ®

2. CQC (2017), A focus on restrictive intervention reduction programmes in inpatient mental health services

47. Included within the CQC paper is the use of quality improvement methodologies, such as the setting of clear use of force reduction targets within a fixed period of time. We believe if Trusts are required to set, monitor and report on performance against such targets, the local community will be able to hold the Trust and the responsible person properly accountable.

48. Included in the Goulet et al (2017) paper was the idea of having champions locally within a unit or service with the responsibility for reducing the use of force. Tellingly, 84% of staff agreed or strongly agreed, that it would help if there was a use of force champion based in the unit. Staff felt that the role could be involved in ongoing training to change and reduce use of force, mediate between patients and staff before force is used or carrying out debriefs and investigations after force has been used.

49. People with lived experience said they would like the role to be akin to that of a peer support worker role. The role should be:

> *"A ground level role…we want people to have compassion…and then that person is the bridge between policy makers, change makers and the patients and the staff…so they kind of then feed into the system."*

50. Although not part of our prepared questions, when people with lived experience were asked about the idea of a champion for reduction in use of force, there was overwhelming support that this would be a good idea, that this individual would be a neutral arbiter to resolve situations and help lead a change in culture.

    People with lived experience expressed that it is important the champion has the trust of patients and have lived experience to be able to understand and empathise with any complaints or concerns raised by patients.

11. Training for the responsible person

51. We welcome the requirement for the responsible person to undertake the same training as staff on use of force. However, we identified in our focus groups that the reasons why and how force is used in mental health units is complex and multi-factorial. We believe that the entire Board should be required to demonstrate a full understanding of the culture within their organisation that leads to the use the of force. Without a clear understanding, the Board cannot give due consideration to the impact of their wider decisions on reducing or increasing the risk of use of force and the disproportionate incidence of use of force on people with protected characteristics.

52. We asked the staff focus group what they think the responsible person needs to be required to do, in order to gain a good understanding of why force is used in mental health units. The consensus from the responses was the importance of having a good understanding of the patients and staff environment from frontline ward experience and a good contextual understanding of the data on use of force incidents in the mental health unit.

53. We asked staff if they know who the responsible person is for force reduction at their Trust and their role and responsibility for reducing use of force. 42% disagreed or strongly disagreed that they knew, compared with the 58% who agreed and strongly agreed that

they knew. This suggests more work may be needed to improve visibility of the responsible person amongst staff to ensure the confidence of the staff.

54. We recommend that the whole Trust Board is required to have training about use of force including:
   - why use of force happens
   - the impact of risk of use of force on patients
   - the difference between appropriate and inappropriate use of force
   - the impact of operations and service design on the risk of use of force in mental health units
   - unconscious bias training, focusing on anti-racism and presentation of the national data showing the disproportionate incidence of use of force on people from ethnic minorities

Section 3: policy on use of force

12. The Required policy commitment

55. We asked both focus groups if they thought the policy statement has the right emphasis. Interestingly, 67% of the lived experience group agreed or strongly agreed that this was the case compared with the 91% for staff respondents. We also saw that 33% of the lived experience group neither agreed nor disagreed that this was the case whilst this was 9% for the staff group. The rest of the respondents did not answer the question.

56. Regarding the policy statement, one of the patients stated in their comments that the wording needs to be stronger with “zero tolerance for unnecessary use of force”, which we agree with. The testimony we got from both staff and those with lived experience suggests that there is inappropriate use of force occurring, which is not being challenged.

57. A person with lived experience shared the following story of their experience of use of force in a mental health unit.

“I was restrained and pushed into my bathroom and there was quite a lot of them. I can't remember how many and because they were so tough on my arm, I got a dead arm and I couldn’t do much myself anymore, which is obviously what they wanted. So, I sort of slipped down the wall near the shower and I literally saw the nurse or whoever, support worker, press the shower button because it wasn't a sensor-controlled shower. This one was a button and controlled and the shower started and they all carried on. They didn't try and get me away. They're quite happy for me to be soaking wet..and they finally…they dragged me out after a period of time and put me onto my bed and left me there.”

58. Having a clear national definition and standards of what constitutes inappropriate use of force within the guidance, then supporting this with training and a commitment to zero tolerance of inappropriate use of force, would set a clear expectation that would begin to change the culture and encourage staff to reflect on the impact of both appropriate and inappropriate use of force.

59. We recommend the guidance includes a zero-tolerance approach to the inappropriate use of force within the policy commitment.

60. We recommend having clearer national guidance on appropriate and inappropriate use of force. This guidance should seek to restrict the circumstances in which physical restraints, chemical restraints and seclusion are permitted across all mental health units, regardless of age, gender, race or ethnicity.

61. We believe this is important to allow both staff and non-mental health professionals (e.g. police) coming onto mental health units, to be appropriately trained and to know what is expected of them wherever they work. Furthermore, the guidance will permit patients to be able to understand their rights. All of this would empower staff, patients and police to challenge and intervene when they see inappropriate use of force taking place.

13. Allowing different use of force techniques within different services

62. We are concerned that parts of section 3 of the guidance would allow services to continue applying different types and levels of force to different groups of patients. We are particularly concerned with the acknowledgment that "specific techniques which the organisation may use, which may be different in services for children and young people, adults or older people".

63. We acknowledge that different techniques may be needed in different mental health settings, however the principles and threshold for the use of force should be the same across all settings. If force is to be used, the least amount of force necessary should be used.

64. We believe there should not be too much variation between local areas regarding the techniques used by services, otherwise this might give the impression that there are different safety and endurance thresholds for different patient groups, which would only perpetuate unconscious bias and discrimination.

65. Our focus groups were particularly concerned that black men may be restrained simply because they are more likely to be perceived as dangerous. We also heard from patients that the psychological trauma from use of force is one of the lasting traumas from their stays in mental health units.

66. We recommend the guidance makes it clear that different techniques do not mean there should be different thresholds or principles in the use of force between services. Where there are differences, these should be transparent and evidence-based. We do not wish to see patients with certain mental health conditions or demographic characteristics being labelled either as a threat or as able to tolerate greater levels of force.

67. We heard from a person with lived experience that:

> *"Having been restrained a number of times, I thought they were restraining the stereotype of me. They weren't restraining me as an individual and I think this is something that goes on for unfortunately, the overrepresentation of black men being restrained."*

68. We also do not believe using different techniques in different services is in the best interest of staff, some of whom work across different services. As this may lead to confusion and an inconsistent standard of care being provided. As stated previously, any differences in types of force/restraint used across services, should be kept at a minimum and the reasons for these differences should be transparent and evidence based (e.g.,

young children generally tend to be of smaller stature so restraint x may be more appropriate).

69. We asked staff, if they thought guidance will be difficult to follow if different types of force and specific techniques differ across services depending on whether they are for children and young people, adults or older people. We saw that 83% agreed or strongly agreed that this would be the case, whilst only 17% disagreed or neither agreed nor disagreed.

14. Consultation and involvement of patients and people with lived experience

70. As stated above we recommend clearer guidance is given on elements of the policy (including definition of appropriate and inappropriate use of force, training and analysis of data on use of force) to avoid post code lotteries in terms of care. This is of particular importance since patients may be referred to mental health units outside their local area.

71. Where the policy needs to reflect local circumstances, we welcome the requirements to consult and involve both current and former patients, their families and carers, bereaved families, any relevant local third sector organisations and staff.

72. We believe the guidance should be more specific about the role the patient population and people with lived experience should play in the development of the policy and consultation about the draft policy before it is published.

73. We feel the guidance does not give sufficient weight to the importance of the voice of staff in explaining how to change the culture and environment that leads to the use of force.

74. However, we would like to see more guidance provided on when to consult i.e.:
    - the duration of consultation exercises
    - clarity of scope and impact of the consultation
    - accessibility of consultation exercises
    - feedback to participants on the consultation exercises
    - consultation responses should be analysed carefully, and clear feedback should be provided to participants following the consultation.
    - the mechanisms for consultation participants to hold the responsible person accountable if they are not happy with the policy or other policies which may impact the use of force

75. As part of the best practice guidance on implementation, we recommend that lived experience/patient and staff focus groups, such as the ones conducted for our response, are conducted to obtain the input of experts by experience.

15. Analysis of data to identify themes

76. The final paragraph of section 3 of the guidance starts, “it is good practice...” and in the same paragraph states “it may be useful to analyse the data to identify themes emerging across patient groups which could be used to update the policy and reduce any disproportionate use on people sharing protected characteristics.”

77. We are concerned that the language used in this section gives organisations the opportunity to opt out. If the language was changed to “must” (with “must” clearly defined as stated in section 4 of this document) it would add the compulsion needed to protect patients from ethnic minority backgrounds who are more at risk of being subjected to use of force and restrictive practices.

Colourful MINDS®

78. Existing data collected by the NHS shows clear patterns and groups that are at a disproportionate risk of being subjected to use of force and restrictive practices. Therefore, the easiest way to reduce the overall incidence of use of force within units, would be to understand which groups are at most risk and why. This should be followed by the implementation of operational and cultural changes to reduce the risk and disproportionality. This would likely lead to a reduction in use of force in all patient groups.

79. When we asked the patients focus group, 100% agreed or strongly agreed and 92% of the staff focus group either agreed or strongly agreed, that identifying themes from data of groups disproportionately affected by use of force should be a requirement. 8% of our staff group neither agreed nor disagreed.

80. We recommend that each service “use 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]” to update operational procedures.

81. At the policy level, trusts and mental health units should analyse the data to identify themes emerging across patient groups which could be used to update the policy and reduce any disproportionate use of force on people sharing protected characteristics. This should be used to drive and develop training to address and reduce the disproportionate use of force. We heard from both staff and patients with lived experience that cultural barriers, stereotypes and “not fitting in” plays a role in the risk of being subjected to use of force.

16. Other policy responses

82. We heard from people with lived experience and staff alike about the impact unit environment, staffing levels and most importantly staff skill set has on the risk of incidences of use of force. People with lived experience talked about the impact the lack of activities have on patient staff relationships, whilst staff talked about the impact of the design of the unit on patient staff interactions. It was also highlighted that having staff know how to interact empathically with patients, may potentially reduce the risk of use of force.

83. We heard overwhelmingly from people with lived experience that they would like to see more done by mental health units in “pre-escalation”

> *“There's de-escalation obviously, which is what people should be focusing on, but then also there's pre-escalation, which is obviously the prevention of anything escalating in the first place. You can include things like just the ward environment in general, what we've spoken about, there not being activities to keep people occupied and [being] therapeutic to help them on their journey of recovery."*

84. We recommend it would be best practice for mental health units to be required to conduct a use of force impact assessment on other existing policies and future policies. This will allow an understanding to be had on what impact the policy and operational changes have had on the risk of both appropriate and inappropriate use of force happening in mental health units.

85. We also heard that having people with lived experience involved in developing the organisations operational model, staff competency frameworks and the staff interview and recruitment process, would help to ensure the right people are working on the ward.

86. This ensures that due regard is given throughout the organisation, on the consequences of operational decisions being taken out of the control of frontline staff, and the impact this has on patient safety and protection of their human rights.

Section 4: information about use of force

17. Quantity of information to be provided to patients

87. Both people with lived experience and staff welcomed the provision of information on use of force to patients.

88. However, we are concerned about the quantity of information to be provided. In the guidance there are a minimum of 16 bullet points of information to be provided.

89. We are concerned that this is a lot of information for patients to take in and comprehend, particularly if the information "must be provided to the patient as soon as reasonably practicable" after they are admitted to the mental health unit.

18. Where information on use of force is provided

90. The draft guidance states *"The responsible person (or delegated members of staff) must ensure the information about the use of force is provided to each patient, and to any person whom the responsible person (or delegated members of staff) considers it appropriate to provide the information to in connection with the patient, such as a family member or carer. However, the duty to provide patients and others with the information does not apply if the patient or other person refuses the information. There may be legitimate reasons for patients refusing information, such as they find it causes further distress, or they feel they do not require it. If the patient initially refuses the information, the responsible person (or delegated members of staff) should make further attempts at reasonable intervals to provide them with the information in an appropriate format… The responsible person should also record whether the information was accepted or refused by the patient."*

91. We are concerned that this would lead to linear information provision, particularly in busy ward situations, with the duty and responsibility to provide information being discharged as soon as the information has been provided once to the patient or after several failed attempts. We heard from people with lived experience that it is not realistic to expect patients to understand and retain information when they are very sick or medicated (e.g. sedated). The concern is that these patients would then not actually be aware of their rights regarding the use of force.

92. One person with lived experience stated:

"[the information should be provided] if and as when you need it while you're on the ward…because sometimes you're not very well or you've totally forgotten.

"I've been told before that the nurse went through [some information] with me… and I absolutely could not remember any of it. I would be sure it hasn't happened, but maybe it did. But then when I asked to get [the

information] again, I was told, 'oh, it already happened ...it's done'. [It is] irrelevant if I wasn't with it or if I didn't understand...if I wanted it [provision of information] to happen again, then it should happen again. So I think sometimes it's a bit too rigid as well and it doesn't take into consideration how unwell you might be at the time."

93. We heard from patients that information should be provided continually, to ensure that the information can be fully processed and retained. Regarding the lived experience group, 55% stated that information on use of force should be provided in the community before admission, 22% stated it should be provided on admission to hospital and 22% stated it should be provided in both the community and on admission. Regarding the staff focus group, 45% thought the information should be provided in the community prior to arriving in hospital, 18% felt it should be on arrival to the ward and 45% felt it should be provided when it is most appropriate for the individual patient.

94. We recommend, as was the general sentiment from the focus groups, that general education for patients and their families, about their rights in relation to use of force, is provided through community groups. This is particularly important for groups that are disproportionately affected by use of force and restrictive practices.

95. For this to be effective, we recommend that there would need to be a set of national standards on use of force, which can be turned into a patient's charter of rights. This charter would be short, clear and easy to understand. As stated elsewhere in our response, more guidance should be given on standards in relation to appropriate and inappropriate use of force and less devolved to individual organisations. This would have the following additional advantages as it would:
    - support wider information campaigns.
    - enable patients to understand information when they are healthier.
    - reduce the quantity of information mental health units have to provide when patients arrive to hospital
    - hopefully allow patients to feel empowered
    - hopefully reduce the postcode lottery of care and rights

19. The duty to provide information to patients

96. We are concerned that "the duty to provide patients and others with the information does not apply if the patient or other person refuses the information." This is of particular concern as when we asked people with lived experience to rank their preferred method to receive information on use of force, the "in person explanation from staff" was ranked third out of the four options. People with lived experience expressed that they preferred leaflets, posters and in person information provided by family members, carers or advocates.

97. We also heard elsewhere in the lived experience focus group, about the lack of trust patients have in staff, which may make receipt of this information difficult.

98. We recommend it would be good practice for Trusts to find independent advocates or peer support workers (such as a use of force reduction champion that is not a staff member) to provide this information empathetically and be on hand to answer patients' questions. We heard from people with lived experience about the importance of confidence in the peer support worker role, in that it should be:

Colourful MINDS ®

"..somebody that you feel confident that, you know, you can trust, they can be in the middle [between staff and patients] and they're going to hear you and they're going to want to achieve something positive for you as well as a patient."

Section 5: training in appropriate use of force

99. We heard from staff and people with lived experience alike that some of the reasons force is used is due to poor communication skills on part of some of the staff, unconscious bias, lack of trust between patients and staff and lack of empathy and care on part of some of the staff.

100. One patient stated:

"For me personally it was 99% bad communication that led to me being restrained. I also see the same things happening with patients I work with. The way patients are ignored is so frustrating. It is so often unmet need that leads to agitation…etc. The way someone talks to you can make a huge difference. Even during my psychotic episode I still knew the way people were talking to me was rude and dismissive"

101. Staff were asked if they believed that language or cultural barriers affect the chance that force would be used and whether it will escalate. All who answered agreed this was the case. We also asked staff if good or bad communication between staff and patients, plays a role in the risk of use of force and the chance force would escalate. Again, the majority agreed that this was the case.

102. When asked "Do you think the training does enough to reduce the risk of use of force for particular communities?" 75% of people with lived experience disagreed or strongly disagreed that this was the case whilst 50% of staff strongly disagreed or disagreed. Regarding those who agreed or strongly agreed, this was 42% of staff whilst 12% of those with lived experience strongly agreed.

103. We welcome the inclusion of de-escalation training as this was heavily featured in responses from staff. However, one staff response was as follows:

"There is emphasis, but staff do not always then practice this when in clinical areas. The training can be exemplary but if this is not employed within the clinical setting then it was worthless. Staff need to be monitored to ensure that they are delivering the training as taught and don't start taking short cuts, making things up or just resorting to use of force as the quickest and easiest option."

104. Any training undertaken by each service or units should be data led and based on a thorough understanding of the causes of escalating behaviours and the groups most at risk of use of force.

105. We heard from people with lived experience of positive interactions with staff and what positive de-escalation looks like. One person with lived experience shared their story:

"There was an occasion when I was in the secure garden, having a cigarette and I refused to come back in. I staged a protest and they got a

nurse and a support worker to come down and try and get me to come in and I just sort of was having a bit of a meltdown.

She said, 'right, let's sit on the floor'. So we sat down on the floor and then the other support worker sat down and she said to the other one, 'go and get a cup of tea, let's have a chat'. We sat there for an hour and we laughed and I cried. It was the fact that she came to my level, we had a nice chat. She was very kind and I felt like someone was actually listening to me and it felt like a normal situation rather than she was a nurse. The other lady was a support worker and we sat there for an hour just chatting rubbish. I always think to myself, you know, how thankful I was for that lady, because it broke the barrier down of 'you against me, against them'. That was the beginning of me starting to trust them again, but it was just literally just sitting on the floor."

106. The importance of empathy, patience and positive body language were repeated themes in avoiding situations which lead to use of force or disputes in mental health units. One person with lived experience mentioned the importance of patients being humanised, rather than being treated as a stereotype of their condition or colour. A person with lived experience stated:

"Something I worked on a lot is developing trust across the colour line, which is for me quite crucial and I tried to see beyond race as well, but I find that quite challenging. But when I get to that stage, I think that's some of the best relationships I've had when I've been in a mental health ward."

107. We also recommend that all training provided by organisations for staff should include the following as areas of specific focus:
   - **staff communication, listening skills, care provision and empathy training –** as part of general de and pre-escalation training and trust building with patients.
   - **unconscious bias training –** focusing on anti-racism, the presentation of the national data showing disproportionate incidence of use of force on people from ethnic minorities and perceptions about mental health and mental illness.
   - **appropriate and inappropriate use of force training –** the difference between appropriate and inappropriate use of force.
   - **appropriate and inappropriate use of force reduction/eradication training –** how to effectively intervene where inappropriate force is being used, including an understanding of every staff member's responsibility to eradicate inappropriate use of force and reduce appropriate use of force.

108. We heard from people with lived experience and staff alike, that the training on use of force should be provided to all staff regardless of their role or authorisation to use force.

109. People with lived experience believe that the use of force is so widespread, that it is sometimes practiced by members of staff who are not authorised to use it.

110. When asked "do you think that all staff in a mental health unit should be trained regardless of their role or authorisation in use of force?" 92% of staff agreed or strongly agreed that this should be the case, whilst only 8% of staff disagreed. On the other hand, 100% of people with lived experience agreed or strongly agreed that this should be the case.

111. We are concerned that in the guidance, "requirement to train members of staff does not apply where the responsible person considers previous training in the appropriate use of force was both sufficiently recent and of an equivalent standard to that required under the Act". This does not recognise the nature of use of force as described above. Therefore, to ensure that staff are embedded into a health culture with a zero tolerance for inappropriate use of force, undertaking training again should be mandatory before staff are allowed to use force or engage in the mental health unit's communication and restrictive practice procedures. This is of particular importance if members of staff move to mental health units where local demographics may differ from where they have previously worked.

112. We believe that by not making this a mandatory requirement, patients are potentially left unnecessarily exposed to being subjected to use of force, especially in services or units with a high staff turnover or an overreliance on bank staff.

113. We recommend training is continually provided to **all staff** and must be based on feedback from staff, patients and data on use of force. The data in particular should identify specific factors or groups that are subject to use of force. This is important to help all staff understand their roles and responsibilities in preventing inappropriate use of force and reducing appropriate use of force. This will also hopefully help empower staff to speak out when they witness inappropriate use of force taking place.

114. We heard from people with lived experience about the importance of having people with lived experience involved in use of force training design and delivery. This will allow staff to have a deeper and nuanced understanding on how the use of force happens and how to reduce it.

115. We also believe it is important that the board has annual training on use of force and the progress being made on reducing use of force.

20. Patient care plans.

116. With regards to having a care plan, 75% of people with lived experience and 74% of staff, agreed or strongly agreed that having a care plan that covers use of force would help them feel safer in the mental health unit. On the other hand, 9% of staff and 12% disagreed.

117. Additionally, we heard from staff that while having a clear care plan would be helpful, this would only work if staff use the information. There was a concern that this may be another "box-ticking exercise" if not implemented well, as staff could end up being overwhelmed with other tasks leading the care plan to fall by the wayside.

118. Whilst we think implementation of care plans such as this would be a step forward in helping to identify special accommodations needed by patients to avoid use of force or escalation, we are concerned that care plans would not help to address poor or inappropriate treatment of patients.

119. We heard from both people with lived experience and staff, that continuity of care is very important as it allows staff to build mutual trust and understanding of the patients needs. This demonstrates the importance of wider policies and operational procedures on the effectiveness of use of force reduction measures implemented under the Use of Force Act. This also highlights why it is important that organisations understand why use of force occurs and undertakes Use of Force Impact Assessments when introducing new policies and procedures.

Section 6: recording of use of force

21. Definition of negligible use of force

120. We are concerned about the concept of negligible use of force within the guidance, as this could potentially exclude psychological coercion or threats of use of force, which we heard from staff and people with lived experience often happens in mental health units.

121. We recommend that the guidance provides further clarity and detail on the definition of negligible use of force, rather than what is not negligible use of force. This is to ensure that the appropriate and accurate record keeping takes place.

22. Patient trust in data accuracy

122. We discussed data collection on use of force with patients with lived experience and staff. We heard from people with lived experience that they would have problems trusting the data without the opportunity of independent audit by a neutral party or patients themselves.

123. We asked people with lived experience "Do you feel that you know your rights and you would feel safe to complain if you were subjected to or saw others subjected to inappropriate use of force?" 50% said they were unlikely to report, 33% said they were likely to report and 17% were neither likely nor unlikely. The reasons given were related to fear of repercussions.

124. We heard from staff regarding their concerns about the process being a paper filling exercise with poor quality data capture. We are particularly concerned as there are over 20 data points to be recorded.

125. We are concerned that the guidance as it is currently written, disincentivises accurate reporting of information which is required to drive real change. We believe that the guidance will encourage only the reporting of serious incidents with low level and inappropriate use of force continuing to go under the radar, especially if there is no evidence of serious injury.

126. We are also concerned that there are no provisions in the guidance to verify the accuracy of full recording of use of force, or to protect staff and patients who make well founded allegations of use of force.

127. We recommend the guidance includes mechanisms to encourage accurate reporting and recording, to drive improvements in services.

128. We believe the use of independent patient advocates or peer support workers, would help to give wider context and act as a cross check to the themes and information coming from official data on use of force. We heard from people with lived experience about a charity in Croydon doing such work; listening to service users, some of whom tell the charity volunteers things that they would not share with staff on the mental health unit. The charity hears a lot of stories about patients being restrained and advocates on their behalf until it sees changes.

129. We recommend the guidance includes training on the importance of accurate and timely reporting as well as the importance of detailed and contemporaneous record keeping on the use of force.

Section 9: investigations of deaths and serious injuries

130. We are concerned that section 9 does not define serious injuries, which may lead to under reporting in this category. Again, we are concerned that this only focuses on the physical impacts of use of force and not the psychological trauma that may result from it.

23. Investigation of and learning lessons from use of force incidents

131. By only requiring investigations after deaths or serious injuries, we are concerned that lessons that could be learnt from low level incidents will be missed until it is too late and a death or serious injury has occurred. We also believe that investigations of some other incidents of use of force is needed to give context to the data collected on use of force and support training of staff, if there is to be successful continued reduction in use of force.

132. We recommend it should be good practice to investigate a proportion of use of force incidents and produce a 'Lessons Learned' report which feeds into staff training and other organisational improvements. Such investigations should be broad in scope to allow a better understanding on the wider factors that lead to the use of force.

Section 12 of the Mental Health Unit (Use of Force) Act 2018.

133. We heard from staff who did not attend the focus groups, about the power dynamic and the ability of staff to intervene to stop police, if they see inappropriate use of force by the police called to assist with patients. We heard that there is a fear to intervene because to do so, may lead to police withdrawing or the police would not follow the direction of staff, some of whom may be junior.

134. We are concerned that non mental health staff, such as police and security staff, may not be trained in the organisation's use of force protocols, meaning that the risk of the employment of inappropriate use of force may be more likely. Therefore, this should be taken into consideration by staff before escalating and involving non-mental health professionals such as the police. It is important that staff exhaust all other avenues before involving external professionals. For example, utilising patients support network to intervene if available and appropriate.

135. We heard from a family member with lived experience of use of force:

> *"One of my sons had an episode of psychosis some years ago and we were referred to the accident emergency. Because he was so agitated, the staff actually called for the security men to restrain him. I was literally terrified and he actually ended up with his older brother having to get him in a choke lock, to stop him from leaving the hospital.*
>
> *But I, I stood on helpless. We were all in tears because I didn't know what to do. All I wanted was for him to get help, but because the staff were taking so long and he was getting agitated, they was [sic] worried about him absconding and not getting the help.*
>
> *They said 'if he runs off, we'll call the police' and that's 10 times worse. So it's I think in terms of having the sort of tools or having something else that*

Colourful MINDS

could be done or said, or a body language or something that would have made that situation different because I had to decide, do we allow the older brother to restrain him or two big burly security men, the worst of two evils?"

136. We note the guidance is not clear about the chain of command and direction when non-mental health professionals are called in to assist with a patient, nor is it clear about the rights and responsibility of staff to intervene or patient safeguarding in such instances.

137. We recommend:

138. It should be recommended practice that a multi-disciplinary team (MDT) discussion takes place before the non-mental health staff are called in to assist with a patient, with a senior mental health professional being responsible and accountable for the decision.

139. That there is clear guidance on the role of non-mental health staff (e.g. police or security) in mental health units, if called upon to assist with patients.

140. There should be an assumption that unless a crime has been committed, that the mental health team remain responsible for the safety of the patient and that the police are acting under direction of mental health staff.

141. Training and guidance on the consequences of involvement of external agencies should be mandatory and emphasised. It should be made clear that the involvement of external agencies such as the police should only be used as a last resort.

142. The guidance should make clear and provide training on who has ultimate responsibility for giving directions, when it comes to use of force by non-mental health professionals.

143. Guidance be provided on training for police, with regards to following the directions of mental health unit staff.

144. Training on how to intervene, if mental health unit staff have a suspicion that the restraint techniques being used are inappropriate or the types of restraints used are contrary to the patient's care plan and their use cannot be justified by the level of risk posed by the patient.

145. A requirement by police to notify staff and record and explain why body cameras are not worn or on while in the mental health unit.

The Colourful Minds team would again like to extend our gratitude the participants of the focus groups. We would also like to acknowledge South London and Maudsley NHS Foundation Trust and The Department of Health and Social Care for funding of this piece of work. We hope that this contributes positively to meaningful and lasting change in use of force in mental health settings and beyond. It has been a privilege to have these stories shared with us. It has been an honour to be able to provide a platform for the stories to be shared more widely.

Colourful - MINDS - ®