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

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 “ *b* *b* ”. 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 “ *b* *b* ” to the service user;
b) “ *b* *f* ”.

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 cl1 2673tr4(e)-3( )-93(guplica(in)4s-94(th4(h)3

3.5.

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 cont

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

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.

Stephen Jones, Professional Lead Mental Health
Stephen.jones@rcn.org.uk

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