Restraint Reduction Network

# Ensuring hospital care is safe and supportive

This is part of a set of information about the **Use of Force Act**. There is a:

- Booklet called, '**Ensuring hospital care is safe and supportive**'. It explains the care that you can expect in a lot of detail. It has practical examples and lots of checklists. This information leaflet was created by and for people with lived experience. The document aims to be accessible, using preferred language. This document was signed off by the NHS England Restrictive Practices Oversight Group (RPOG).
- Summary called, '**How I should be cared for in a mental health hospital**'. It has some key points that you should know about the care you might experience. It also tells you about the restrictive practices that might be used and what your rights are.
- Evaluation checklist called, '**Am I getting good care?**'. It can help you see whether your care is good and assess whether restrictive practices are being used correctly.

# What is in this booklet?

# Ensuring hospital care is safe and supportive

## Introduction

You are in hospital to get the care doctors think you need. You might also be in hospital to keep you and/or other people safe. However, it might be worrying and unsettling to be away from home. The hospital environment is likely to be new to you and you may not know the people you are with. You might find the laws the people caring for you need to follow complicated. This can make it hard to understand your rights.

This booklet has been written by people who have been in hospital and understand what it might be like for you. It explains some of the laws that tell staff how they must care for you. It tells you what might happen so that you know what you can expect.

Some of the words that are used in the booklet might be new to you or tricky to understand. These words have been highlighted in **bold** and are explained on pages 31–32. Other words might conflict with your culture and/or feel overly medical. We appreciate these words can be triggering and we have tried to use non-medical, everyday language where possible.

The Restraint Reduction Network (RRN) hope that this booklet helps you to feel safe and supported while you are in hospital.

# The care and treatment you should expect

Hospital staff caring for you while you are in hospital must respect the laws (eg Mental Health Act, Equality Act, Human Rights Act, Use of Force Act) throughout your care and treatment. They should also follow 'good practice' guidance. This means they should only do the things that have been shown to be helpful and effective.

# Things that MUST happen

Staff caring for you must respect your rights and follow the law. You might find it helpful to look at this list to see the examples of **good practice** you think staff are doing well.

## Do staff make sure the following are done?

You are safe and your life is protected. Yes ☐ No ☐

You are never treated in an inhumane or degrading way. Yes ☐ No ☐

Your privacy is respected. Yes ☐ No ☐

You have regular contact with your friends and family (if you want it). Yes ☐ No ☐

You can have, and express, your opinions, and be who you want to be. Yes ☐ No ☐

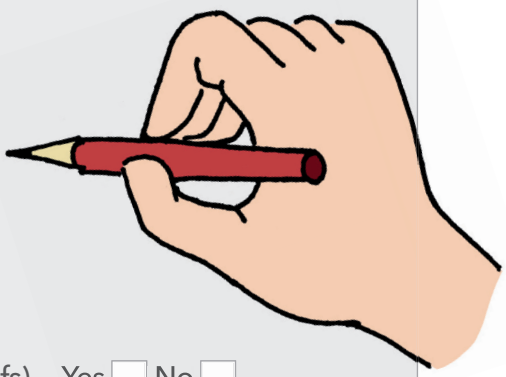
You can practice your religion. Yes ☐ No ☐

You can access education. Yes ☐ No ☐

You can enjoy the things that are yours. Yes ☐ No ☐

You are treated fairly. Yes ☐ No ☐

You are able to access advocacy and legal representation (see pages 28–30). Yes ☐ No ☐



Your care meets your personal needs and characteristics (eg gender, ethnicity, age, sexuality, disability, religion, beliefs). Yes ☐ No ☐

Staff make **reasonable adjustments** to meet your needs. Yes ☐ No ☐

Staff respect your personal characteristics (eg gender, ethnicity, age, sexuality, disability, religion, beliefs). Yes ☐ No ☐

You understand your legal status and the reasons for you being in hospital. Yes ☐ No ☐

You understand your rights in hospital. Yes ☐ No ☐


If the above things are not happening, it is important that you tell your **Independent Mental Health Advocate** (IMHA – see page 28) and/or a person you trust (eg a family member) so they can help make sure the people caring for you follow the law in future.

# Things that SHOULD happen

These things are not written in law but are thought to be **good practice**. You might find it helpful to go through this list to see what staff are doing well or not so well.

## Good practice examples

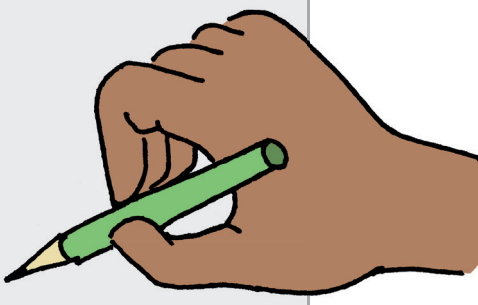
You are supported with compassion, dignity, and kindness. Yes ☐ No ☐

You are seen as a person and not a diagnosis/risk. Yes ☐ No ☐

You are given plenty of opportunities to talk with staff and feel listened to. Yes ☐ No ☐

You are involved in all decisions about your care. Yes ☐ No ☐

Your family, carers and/or partner are involved in your care (if you give permission). Yes ☐ No ☐



There is **positive risk-taking** in your care. This means your care should focus on what you can do, rather than what you cannot do. Yes ☐ No ☐

The hospital is a calm and therapeutic environment. Yes ☐ No ☐

You can find your room and other areas of the ward easily. Yes ☐ No ☐

You are allowed outside and have access to fresh air. Yes ☐ No ☐

You have regular opportunities for exercise and leisure activities. Yes ☐ No ☐

Your culture, ethnicity and heritage are respected by staff. Yes ☐ No ☐

Talking therapies are there to help you. Yes ☐ No ☐

Staff avoid situations that might upset you or that could lead to restraint (see page 11). Yes ☐ No ☐

The doors in the communal areas of the ward are open unless it is necessary for them to be locked. Yes ☐ No ☐

If staff are not following **good practice**, you can speak with your **IMHA** or a trusted person (eg a family or staff member). You can also look at the information on page 26 to find out more things you can do to improve your care.

# Planning your care and making decisions

Staff should help you to plan your care and decide on the support that might work best for you. It's important that staff make sure you have read and understand your care plan and that you get answers to any questions you may have. Staff should also involve you in working out what is going well and if anything could be better (eg by taking part in any evaluations).

## What you should expect

You have an equal say in your care – your views are listened to as much as the professionals. Yes ☐ No ☐

You are listened to. Yes ☐ No ☐

You can change your mind. Yes ☐ No ☐

Your views are respected. Yes ☐ No ☐

You make your care plan with staff. Yes ☐ No ☐

Your plan focuses on you as an individual person. Yes ☐ No ☐

You feel your care and treatment meets your needs and is helping you. Yes ☐ No ☐

Your care plan takes account of your past history (eg any traumatic events that have happened to you). Yes ☐ No ☐

Your care plan considers your ethnic, cultural and race related needs. Yes ☐ No ☐

Staff talk to you about what you might find upsetting (eg your triggers) and support you to understand why. Yes ☐ No ☐

Your care plan explains your triggers and how staff might help you to prevent distress and stay calm. Yes ☐ No ☐

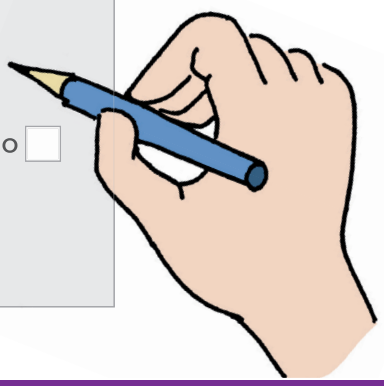
Your care plan explains clearly how to calm things down (de-escalation) and how to keep things safe and respectful if you are distressed. Yes ☐ No ☐

Your care plan outlines ways to make restrictive practices (see below) less distressing. Yes ☐ No ☐

Your care plan is regularly reviewed. You and your care givers read it often and it is changed as your needs change. Yes ☐ No ☐

You have a plan to leave hospital and have opportunities to talk about the future. Yes ☐ No ☐

If any of these things are not happening, show the list to the nurse in charge of your care and ask what they can do to help. You should also speak with your **IMHA** or a person you trust (eg someone from your family) so they can make sure you are getting the right care in the future.



# Restrictive practices

Restrictive practices happen when staff make a person do something they don't want to do or stop them from doing something they want to do (Skills for Health, 2014).

Restrictive practices should only be used to keep people safe. For example, staff might lock doors because they think it is necessary to prevent serious harm. On most hospital wards, doors are locked to the outside and people have key cards for their bedrooms.

There are different types of restrictive practices, including:

# Why does restraint happen?

Staff should do everything they can to avoid restraint. However, there are some reasons that make restraint more likely to happen. Understanding the reasons can help you and staff avoid restraint.

## Poor ward culture

Sometimes the culture of the ward (the beliefs, values and behaviour of staff, and the way the ward is organised) can create situations where distress and restraint are more likely to happen. Poor practice can result in a person feeling distressed, making restraint more likely. This could include the following reasons:

- Staff not listening, resulting in a person not agreeing with their care and treatment.
- Staff not understanding what a person is saying or how they prefer to communicate.
- Staff not understanding people's culture or religion and/or have not taken account of ethnic legacy/needs.
- A ward environment that is difficult for a person to manage, eg it is too busy, the lights are too bright, or it is too noisy.
- **Blanket restrictions** (see page 22) that are not fair, eg not having Wi-Fi or being able to go out.
- Being far away from home and/or not being able to connect with family/friends as much as a person would like.

## Unconscious bias

Unconscious thoughts – thoughts we are not aware of – can influence how we think about certain groups of people and how we relate to them. This is called unconscious bias. It can lead to stereotyping, prejudiced views and restraint.

Nobody should be restrained because of their race, culture, gender, ethnicity, age, sexuality, disability, religion, or beliefs.

If any of these things apply to you, speak with a senior member of staff (eg the ward manager). They might help change the situation. If you are not comfortable doing this yourself, you can ask a trusted person (eg your **IMHA** and/or family member) to speak to them with you.

## Not agreeing with care and treatment plans

If a person doesn't understand and agree with their care and treatment, they might understandably feel anxious and become distressed. It is therefore important for staff to listen to your views and take time to explain your treatment options. This is especially true when medicalised approaches to care might conflict with people's culture and ethnic preferences.

**If you are a 'voluntary' patient**, you cannot be given a treatment unless you agree with it. It is important that staff discuss your options with you so that you can make the right decisions together. You should be given time to think about your options, change your mind or choose another option you feel happier with.

**If you are detained under the Mental Health Act**, staff can make you have a treatment even if you do not agree with it. It is therefore even more important for staff to help you to understand your treatment, why it is needed and how it will be given to you. If staff take time to explain and make **reasonable adjustments**, this can prevent distress and restraint.

### If a person is restrained so that staff can give treatment:

- ✔ The treatment must be given in a way that is **least restrictive**.
- ✔ Staff must not force a person to have more treatment than they absolutely need. It must be **proportionate** to their situation and condition.
- ✔ Staff should try to reduce a person's fear and distress throughout the treatment.

# Physical restraint

Staff might use their body to make you do something or stop you from doing something. This is known as physical restraint. It might also be called physical intervention, safe holding, friendly come along or manual restraint.

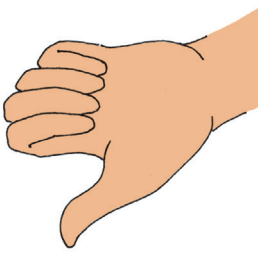
Physical restraint can happen in several ways. These include the following:

- Guiding – when staff guide a part of a person's body (eg their hand) to complete a task that the person is struggling with or does not want to do.
- Keeping someone in a seated or standing position – when staff sit or stand either side of a person and hold them still.
- Holding someone against a flat surface – when staff members hold a person against something (eg the floor) so that they cannot move.

## What should happen if a person is physically restrained?


- Staff should only restrain a person when it is absolutely necessary. They should have tried everything they can to help the person to stay calm (eg using strategies from their 'Positive Support Plan' or 'My Safety Plan'). This can be found on the RRN website (restraintreductionnetwork.org/).
- Staff should never restrain a person as a punishment or to humiliate them.
- Staff should make sure they talk to people in a way they prefer and understand.
- Staff must ensure that a person is able to see, hear, speak, and breathe while they are being restrained.
- Staff should only restrain a person for the shortest time possible and not for longer than ten minutes (for exact wording see National Institute for Health and Care Excellence (NICE) NG10, 2015, 1.4.29).

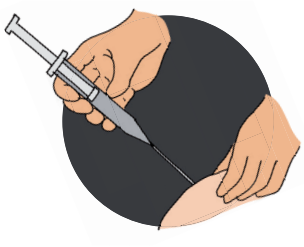
If any of these happen to you, you should tell your **IMHA** and/or a trusted person (eg a family member).



**You should not be restrained face down (also called prone restraint).**

**Staff must not press on your rib cage, neck, or abdomen.**

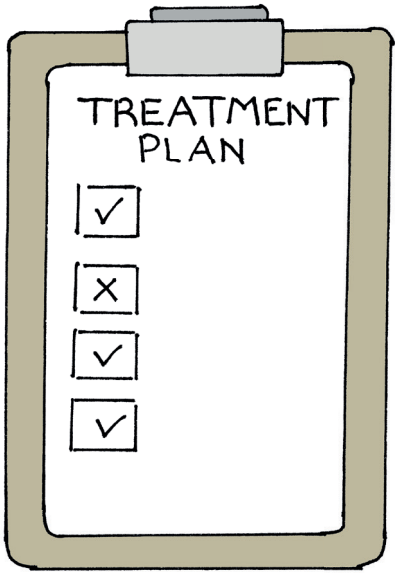
**Staff must not stop the blood circulating to any part of your body.**



# Chemical restraint

Chemical restraint is where medication is used to make a person do something they don't want to do or to stop them from doing something they do want to do. The reason staff might use medication as a restraint is to reduce the risk of harm. This is because the medication will make the person sedated (feel sleepy/calm) if they become very distressed.

Staff should only offer medication if they think there is no better way to stop the person harming themselves or someone else. In that situation the person should first be offered the medication as a tablet (or sometimes a liquid) that they can swallow.

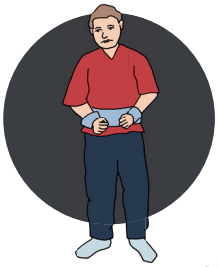



If it is too difficult for the person to do this, and they need to be helped to calm down urgently, they might be given an injection. This is also called rapid tranquillisation. If the person does not agree to have an injection, staff can use physical restraint to hold them while they inject them.

Before chemical restraint is used, the person should be involved in deciding if they want to take medication to help calm them down. Staff should discuss which medication they might prefer. This is because some medications work better for some people than others and there can be **side effects**.

You should be able to discuss with staff your experience of medication, and any problems you have had.

**Chemical restraint is different to when you agree to take medication to help with a physical or mental illness.**



# Mechanical restraint

If a person becomes extremely distressed and there is a high risk of them or others being hurt, they might be mechanically restrained if there is no other way to keep people safe. Examples of mechanical restraint are cuffs, straps, or a specially designed beanbag to stop people from doing something.

If this happens to you, you can speak to your **IMHA** or to a trusted person (eg a family member).

**Mechanical restraint should only be used in exceptional circumstances. For example, to manage extreme distress directed at other people or to limit self-injury that happens a lot and that is intense.**

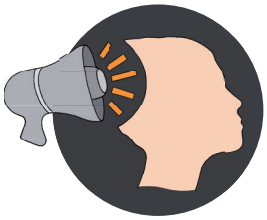
# Psychological restraint

It is important that staff say and do things that help people to understand their care and treatment. For example, praising a person when they are doing well, or giving them time to think things through before giving an answer, if this is helpful for them. If a person has communication differences or learning differences, staff should use the strategies in their communication passport.

However, staff should never say or do anything to force a person to do or not do something. This kind of controlling and coercive behaviour is known as psychological restraint. This could include the following:

- Waiting and looking at a person intensely for a long time until they do what they've been asked.
- Giving a person too much information and talking to them for longer than is necessary or helpful, so that they feel pressured to do something.
- Using complicated/medical language to make a person think they know best and have the authority to influence decision making.
- Leaving out information – not giving a person important information so that they agree to do something (eg not telling them the side effects of medication).
- Negotiating with a person so that they behave in a certain way (eg saying, *"When you take your medication, you can go for a walk."*).
- Preventing a person from expressing their views and doing things that are important to them, their values, ethnicity, and culture to make them feel inferior and humiliated. This is also known as cultural restraint.
- Using threatening and abusive language (eg saying, "You'll regret doing that" or swearing) or intimidating gestures (eg pointing) to force a person to do something.
- Making a person fearful – giving a person too much information about the bad things that might happen if they do not do what staff say.

If you think staff might be abusing or neglecting you, it is important to tell someone you trust (eg your **IMHA** or a family member). You can also tell (or ask the person you trust to tell) your local authority safe-guarding team.



# Cultural restraint

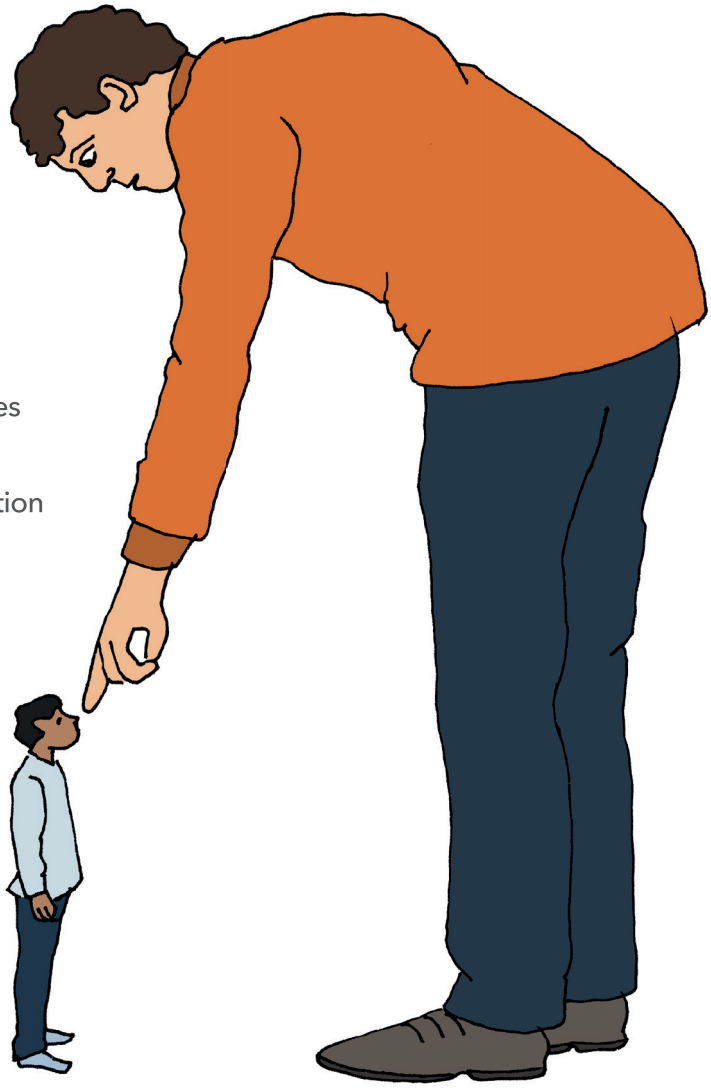
Cultural restraint is using cultural norms to make a person do something they don't want to do or stopping them from doing something they do want to do.

This might include:

- stopping a person from expressing their cultural views
- stopping someone doing something that is important to them, their values, ethnicity and/or culture
- making someone feel ashamed, inferior and/or humiliated because they are different to someone else

For example:

- Mocking a vegan person and not giving them suitable food options.
- Not allowing someone their prayer mat to pray.
- Mocking someone's personal offerings to the deity.
- Asking an autistic person to use eye contact.
- Taking a person's yarmulkes (skull cap).
- Not adjusting communication for people with a learning disability.



# Seclusion

If a doctor or a nurse on the ward thinks that a person is so distressed that they pose a risk to themselves or others, they might decide that the person needs to be secluded. If this happens, staff take the person away to another space, away from other people and do not allow them to leave. Seclusion might also be called time-out, isolation or segregation.

Examples of seclusion could include:

- keeping a person in a caged area in an ambulance
- making a person stay in a place (eg a bedroom, sensory room, or garden)
- keeping a person locked away from others in a ward or seclusion room

## What should happen if someone is secluded?

A person should only be secluded if staff have already tried everything to help them stay safe. Staff must follow the law. This includes the following:

- A person must only be secluded for the shortest time possible, while staff manage the emergency.
- Staff must check every two hours that seclusion is still needed (Mental Health Act, Code of Practice, 26.112).

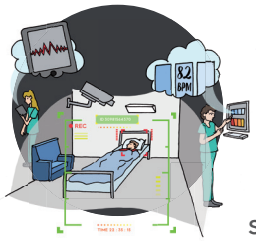

**Staff can only seclude a person if they are detained under the Mental Health Act and/or if they think their distress has become an emergency. If a *voluntary patient* is secluded, staff must ask for a *Mental Health Act assessment*.**

## Segregation

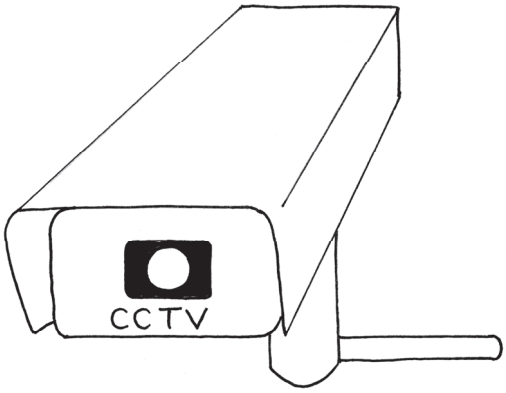
If a person is kept in one space for longer than 48 hours, they are no longer being secluded; they are being **long-term segregated** (CQC, 2019, 2020).

### What must happen if a person is segregated?

- Staff must tell the Care Quality Commission.
- The person must be able to communicate with other people.
- The person must still be able to go outside and breathe fresh air.
- The person must still be able to do things they enjoy and have the therapy they need.
- The person must have plenty of space to live in, including a bathroom, a bedroom and a lounge area.




# Surveillance

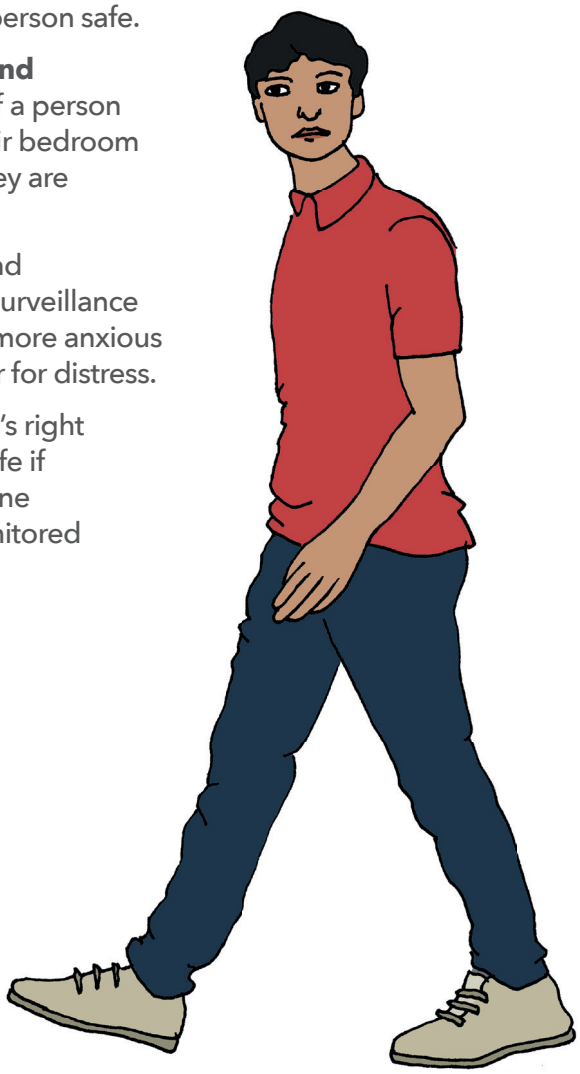



**Surveillance** is when staff use observations, cameras, microphones, or other technology such as GPS trackers to watch and listen to people, places, and property.

Lawful surveillance can help make sure that people, places, and property are safe and cared for. However, surveillance must only be used for a specific purpose – staff should be able to tell you the reason. If a hospital wants to use surveillance in a person's private bedroom area, they must check that the person agrees, and the person should sign a form.

Being under surveillance can affect a person's **human rights** in the following ways:

- Surveillance might be a **blanket restriction** (see page 22) if it is not the only way to keep a person safe.
- It might be **inhumane and degrading treatment** if a person is being recorded in their bedroom all the time (eg when they are getting undressed).
- It might be inhumane and degrading treatment if surveillance causes a person to feel more anxious or if it becomes a trigger for distress.
- It could breach a person's right to privacy and a family life if their conversations, phone calls and emails are monitored all the time.



## What should happen if surveillance is used?

Right to respect for private and family life, home and correspondence *(Article 8)*

Hospitals should not use surveillance unless all other **least restrictive** ways to keep a person safe have been tried (eg observations by staff, rather than continuous video recording).

If a person is under surveillance, staff must do all they can to protect their human rights. The more that surveillance affects a person's privacy and dignity (eg if they are being recorded in their bedroom or bathroom), the stronger the reason must be for it to be used.


## Questions you can ask if you are worried about surveillance.

- What is the reason for the surveillance?
- How long do I have to be monitored?
- Are there any other alternatives that do not breach my rights?
- When will the use of surveillance be reviewed?

If you prefer, you can ask your **IMHA** or a trusted person (eg a family member) to ask these questions for you.

## Blanket restrictions

Blanket restrictions are rules that everyone must follow. Some blanket rules are needed because they are the law (eg no weapons or illegal drugs on the ward). Other rules might be there to keep people safe on the ward (eg no alcohol or sharp objects). However, some ward rules (eg not having Wi-Fi, computer/mobile phone access or being locked out of a bedroom or kitchen) might not be fair if you behave in a safe and responsible way.

### Questions you can ask if you are worried about blanket rules

- What are the rules I am being asked to follow?
- Does this rule impact my rights and wellbeing without good reason?
- What is the reason why I am being asked to follow this rule?
- Do staff regularly check there is still a need for the rule I am being asked to follow?
- Is this rule just for me, or is everyone having to follow this rule?
- Is it fair?

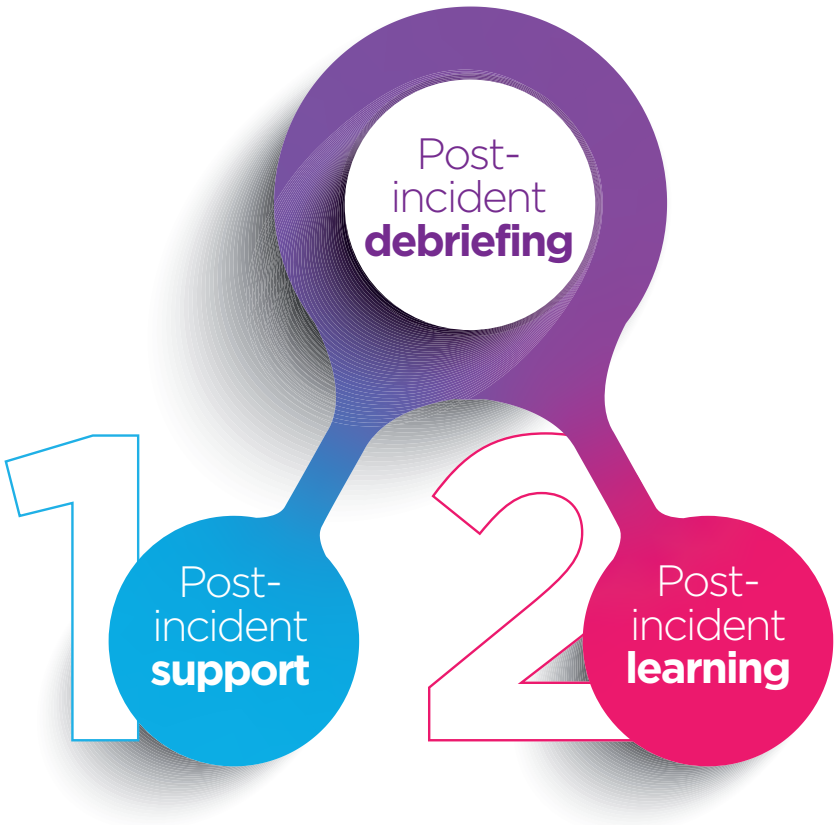
There must be a good reason that the rule is needed for it to be legal.

# Post-incident debriefing good practice guidance

Restrictive practices can be distressing for people to experience or see happening. It could also be important for people to receive support if they have experienced a restraint or seen a distressing event (eg someone else getting restrained).

Post-incident debriefing is not about blaming or being judgemental. It involves thinking about what happened so that the distressing thing is less likely to happen again.

There are two parts to post-incident debriefing.



## 1 Post-incident support

Post-incident support should happen soon after the incident or distressing event.

Staff should:

- help you feel safe
- talk to you in a kind, calm and gentle way
- check you feel physically ok
- check if you have any injuries/pain
- comfort you
- respect your individual needs (eg cultural)

## 2 Post-incident learning

Post-incident learning should happen a few days or a week after the incident. This is because people need to feel calm and settled enough to be able to think about what happened.

The aim of post-incident learning is for people to learn from each other about what happened and think about how to stop the same thing happening again. This may also involve thinking about how staff might meet your cultural needs. Your family/carers and/or IMHA should be involved (if you want them to be).

# Post-incident debriefing checklist

**Before you became distressed:**

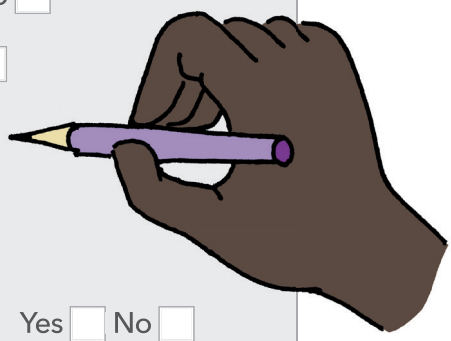
Did you feel able to tell staff that you were feeling upset? Yes ☐ No ☐

**When you were distressed and being restrained:**

Did staff help you when you were distressed? Yes ☐ No ☐

Did staff do what you needed them to do? Yes ☐ No ☐

Did staff follow your care plan? Yes ☐ No ☐



**Support you received in the hours after you were distressed and restrained:**

Did staff spend time with you after the distressing event? Yes ☐ No ☐

Did staff listen to your needs and experiences? Yes ☐ No ☐

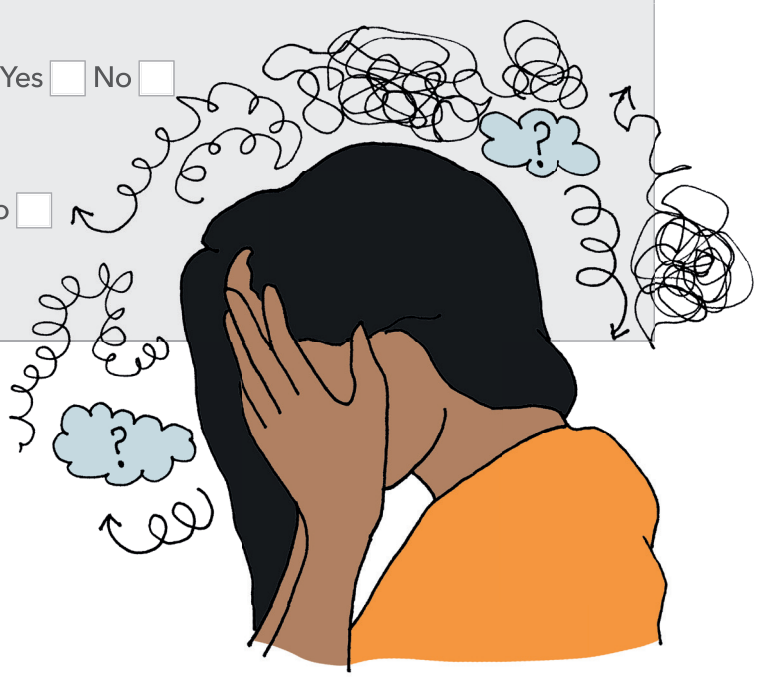
**One week after you had the distressing event:**

Have you been able to discuss the reasons you became distressed? Yes ☐ No ☐

Did staff understand why you became distressed? Yes ☐ No ☐

Did staff understand your perspective and respect it? Yes ☐ No ☐

Is there a plan to reduce your distress that you understand? Yes ☐ No ☐



# What if you have worries about your care and treatment?

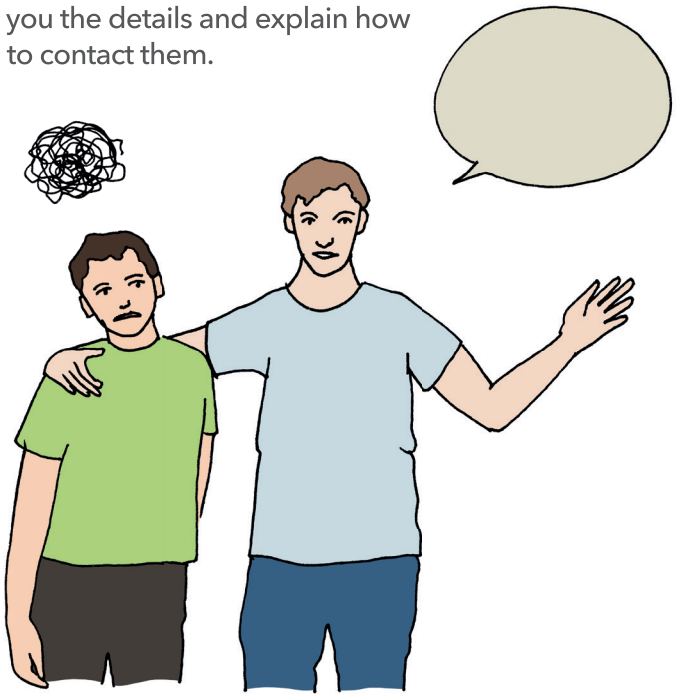
If you think that you are not getting the right care and support or you have been abused or neglected, it is important to tell someone you trust.

## People you can tell

- Family members, loved ones and/or friends.
- Your **Independent Mental Health Advocate** (IMHA, see page 28).
- Cultural advocates (eg black advocacy).
- The nurse who is in charge of your care.
- The ward manager (person in charge of the nurses and care assistants on the ward).
- Your **responsible clinician** (the doctor that is in charge of your care).
- Your care coordinator (the nurse in the community responsible for your care).
- Your social worker.
- Your solicitor (if you are sectioned/ detained you should have one to help you with any legal challenges).
- Peer support workers (if your ward has them). These are people who have had similar experiences to yours (eg mental health illness), who are employed to support people on the ward.
- A spiritual or religious leader (eg the hospital chaplain).
- Your local Member of Parliament (MP). Your MP can offer you support and raise concerns on your behalf in many ways. For example, they can make private enquiries about your care and raise any serious issues in the House of Commons.

## Services and organisations that can help

- **Patient Advice and Liaison Service (PALS)**
  A member of staff in your ward can give you the details and explain how to contact them.



- **Care Quality Commission (CQC)**. You can report your concerns via this link: https://www.cqc.org.uk/contact-us/how-complain/complain-about-service-or-provider

- **The police** – if there has been a serious offence or if you are in immediate danger or harm

# Independent Mental Health Advocacy and why it is important

An **Independent Mental Health Advocate** (IMHA) is a professional who has been trained in the law (eg the Mental Health Act) whose role is to help you to understand your rights in hospital. The IMHA service is free and available to people who are detained under the Mental Health Act.

IMHAs are independent. This means they do not work for the NHS or the hospital you are in. They are not involved in deciding whether you should stay in hospital or what treatment you should have. However, they are there to support you to understand your care and treatment, and to sort out any problems that might come up. If you have any worries, it is important to tell your IMHA so they can help.

**An IMHA should:**

- ✔ help you express your views and wishes to staff
- ✔ discuss care and treatment options with you
- ✔ explain your rights and other information about being detained in a way that you can understand
- ✔ speak to staff (if you want them to)

# My Independent Mental Health Advocate

**The name of my IMHA:**

**The contact information of my IMHA:**

Phone number:

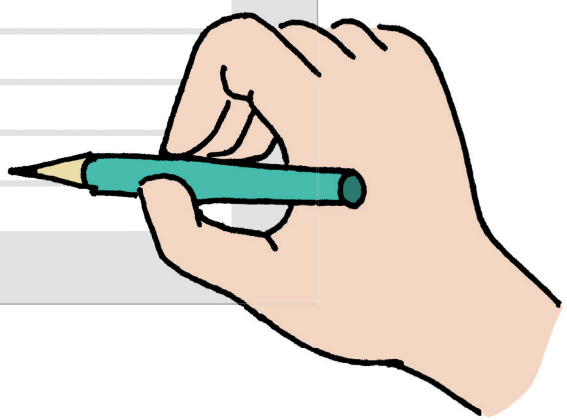
Email:

Address:

**Things that I need:**

**The treatment I would prefer:**

**Other things I am worried about:**



# Independent Mental Health Advocate Checklist

**When you arrived in hospital:**

Were you and your nearest relative told about your right to Independent Mental Health Advocacy? Yes ☐ No ☐

Were you given written information about how to contact the IMHA? Yes ☐ No ☐

Were you able to contact the IMHA as soon as you wanted to? Yes ☐ No ☐

**When meeting with your IMHA:**

Are you able to meet in private (eg in a space where no one else can hear you)? Yes ☐ No ☐

Are your meetings confidential (ie hospital staff do not know what you talked about)? Yes ☐ No ☐

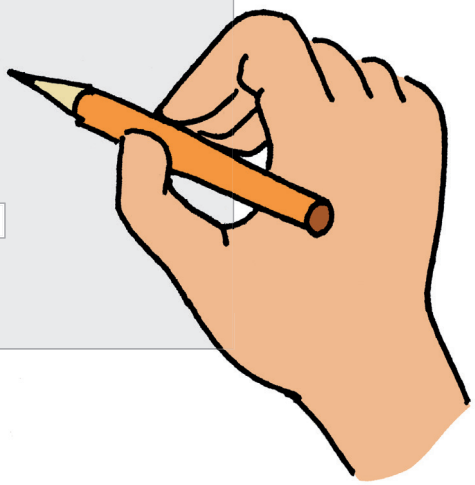
**Does your IMHA:**

Understand and respect your needs? Yes ☐ No ☐

Treat you fairly and respectfully? Yes ☐ No ☐

Communicate with you in a way you prefer and understand? Yes ☐ No ☐

Understand the treatment you prefer and make sure staff give it to you? Yes ☐ No ☐



# Glossary

### Abuse

When someone does something on purpose to hurt your body or your feelings.

### Advanced statement

This is a document that tells staff the things a person likes and does not like about their health, care, and treatment.

### Blanket restrictions

Blanket restrictions are rules that everyone must follow. Some blanket rules are needed because they are the law (eg no weapons or illegal drugs on the ward). Other rules might be there to keep people safe (eg no alcohol or sharp objects on the ward).

### Care Quality Commission (CQC)

The Care Quality Commission (CQC) makes sure that the health and social care services (eg hospitals) are safe and give good care. The CQC does this by inspecting services and listening to people's concerns.

### De-escalation

This is when staff help a person to calm down by trying to make a stressful situation better (eg helping them to move to a quieter space or helping them to use the strategies in their support plan).

### Detention

This is when a person is made to stay in a place (eg a hospital), even if they do not want to be there. A person can only be detained in a hospital if they have had a Mental Health Act assessment.

### Force

This is the use of power and/or control to make someone do something or not do something against their will.

### Good practice

Support given by staff which has been shown to be helpful and effective. This might also be referred to as 'best practice'.

### Human rights

Human rights are the basic rights and freedoms that belong to every person in the world. These include the right to life, to being safe from serious harm, to freedom, to respect for private and family life and to be treated fairly.

### Independent Mental Health Advocate (IMHA)

An Independent Mental Health Advocate (IMHA) is a professional who is not employed by the NHS or the hospital and is there to help people understand their care, treatment and their rights.

### Inhumane and degrading

When a person is treated as less than human or as if they don't have worth.

### Last resort

This means that staff must have tried everything they can to support a person before that person is restricted.

### Least restrictive

This means that a person's human rights should be restricted as little as possible.

### Mechanical restraint

If a person becomes extremely distressed and there is a high risk of them or others being hurt, staff may decide they need to use equipment to keep the person and others safe. It should only be used in exceptional circumstances.

### Mental Health Act assessment

This is when a doctor and another specially trained professional (eg a social worker, nurse, or psychologist) speak to a person, their family and other professionals so they can decide if the person needs to be in hospital.

### Patient Advice and Liaison Service (PALS)

This is an NHS service that gives advice and support about hospital care and treatment. PALS can help people with any concerns or complaints they may have. There should be a PALS in every hospital.

### Positive risk-taking

This is care that focuses on what a person can do, rather than what they cannot do. This means staff should look at any risks there may be and see what they can do to make them smaller.

### Post-incident debriefing

This is the support and learning a person should get from staff after something distressing (eg a restraint) has happened.

### Prone restraint

This is a type of restraint where a person's face is held against a surface (eg facing down with their tummy on the floor). It is not considered good practice as it can be dangerous.

### Proportionate

When the staff support is equal to what you need, eg staff support should be the right amount. Not too little. Not too much.

### Psychological restraint

This happens if staff say or do something to force a person to do or not do something. This is not OK.

### Reasonable adjustments

If a person has a disability, staff must by law make changes so that the disabled person can use the service just as easily as everyone else.

### Responsible clinician

This is the doctor (usually a psychiatrist) who oversees a person's care while they are in hospital.

### Restraint

Restraint happens when staff members stop a person from moving their body, or part of their body, if there is no reasonable or less harmful way of keeping that person safe.

### Restrictive practices

Restrictive practices happen when staff make a person do something they don't want to do or stop them from doing something they want to do. Restrictive practices should only be used to keep people safe, when there is no other way of doing so.

### Seclusion

This happens if staff take the person away to another space, away from other people and do not allow that person to leave. Staff can only do this if a person is detained under the Mental Health Act and/or if a person's distress has become an emergency. Seclusion should only happen for the shortest time possible and if staff have tried everything else they can to help the person stay safe.

### Segregation

This happens if a person is kept in one space for longer than 48 hours.

### Side effects

Unwanted undesirable effects that might happen to a person because of a medication.

### Surveillance

Surveillance is when staff use observations, cameras, microphones, or other technology to watch and listen to people in order to keep them safe.

### Therapeutic

When the environment and the staff help a person to feel better and recover from their distress or ill health.

### Voluntary patient

If a person agrees to be in hospital for their treatment and have not been detained under the Mental Health Act, they are called a voluntary patient.

# References


Care Quality Commission (2019) *Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism*. Download from https://bit.ly/44SBmXP.

Care Quality Commission (2020) *Out of sight – who cares?: Restraint, segregation and seclusion review*. Download from https://bit.ly/3O2LvuY.

Skills for Care (2014) *A Positive and Proactive Workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*. Download from: https://bit.ly/38jGDPE

National Institute for Health and Care Excellence (NICE) (2015) (NG10 Guideline) *Violence and Aggression: Short-term management in mental health, health and community settings*. Download from: https://bit.ly/3UzWVGQ