Restraint Reduction Network

Implementing Seni's law

Guidance for developing a policy to comply with Section 3 of the Statutory Guidance of the Mental Health Units (Use of Force) Act 2018

Please note that this document does not, and is not intended to, constitute legal advice. The RRN strives to provide accurate, well-researched information that is helpful to practitioners, professionals and people with lived experience.

All links to resources were correct at the time of publication.

Contents

About this guidance

The Restraint Reduction Network (RRN) is a registered charity with an ambitious vision to eliminate the unnecessary use of restrictive practices in health, social care and education. We seek to create a culture of respect for human rights so that services are safe, dignified and respect people's autonomy and wellbeing.

As a network of committed organisations and individuals, the RRN works towards this mission by sharing learning, developing quality standards and practical tools to support restraint reduction, and by working across sectors to promote culture change.

This document was created by the RRN to support providers in developing their restraint reduction policies. The document share examples of good restraint reduction policy to help providers shape their own.

The aim of the Mental Health Units (Use of Force) Act 2018 and the accompanying statutory guidance is to set out the measures that are needed to prevent the inappropriate use of force in mental health units in England and to ensure accountability and transparency about the use of force when it is used. Under the Act, 'use of force' means the physical, mechanical or chemical restraint of a person, and/or the isolation of a person, including seclusion and segregation.

Section 3 of the Act and statutory guidance requires providers to publish a written policy which will set out the steps that the mental health unit is taking to reduce (and minimise) the use of force by staff who work in the unit. Where there is more than one mental health unit within the organisation, one single organisation-wide policy should be produced and shared across the organisation. Where an organisation or trust is providing different types of services across several units, the policy should clearly set out the different needs or considerations that may be relevant for particular groups of people.

This guidance and policy template has been created to support service providers to comply with the Mental Health Units (Use of Force) Act 2018 (section 3), and the accompanying statutory guidance. There is an expectation that providers will have due regard to the statutory guidance and policies will include (but not limited too) the 21 elements as described within this document.The Act identifies 21 specific elements that must be covered in the policy, which are detailed in this guidance.

https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018

https://www.legislation.gov.uk/ukpga/2018/27

This guidance is in three parts:

1. A brief introduction to the Act.
2. The key principles providers should take account of when developing their policy.
3. Looking at each required element of the policy, making suggestions for key considerations and offering signposts to any good practice or links that might be useful.

This guidance was developed by a team of people who had the right expertise and experience to inform the document. These people include those with lived experience, family members and carers and professionals. We also consulted a wider group of specialist networks.

Particular emphasis was placed on the ideas and insight from people with lived experiences of the use of force and restraint in health settings. These are the very people whose rights the Act is designed to protect, so we have incorporated the reflections they have made about the use of respectful language, accessibility and transparency within the creation and implementation of this policy template. Further, we agree with the emphasis they placed on the need to ensure there is meaningful coproduction in the development of the policy. As such, the result reflects many different people's aspirations of what this policy should aim to achieve.

The final sign off for this guidance rightly went to Ajibola (Aji) Lewis, the mother of Seni Lewis for whom the Act is named.

Introduction

The Mental Health Units (Use of Force) Act 2018 is known as Seni's Law. It was named after Olaseni 'Seni' Lewis – a young, healthy, 23-year-old black man from South London who had recently graduated and was looking forward to starting his PhD. Seni was admitted to the Bethlem Royal Hospital on 31 August 2010 on a voluntary basis. Within a few hours of seeking help, he was tragically killed as a result of prolonged prone restraint[1]. Seni's family have campaigned ever since for a change in law to prevent a similar tragedy.

The Use of Force Act (UoF Act) does not endorse or advocate the use of force. It aims to prevent it. Restraint is not inevitable and is not therapeutic. We know it can be traumatising and dangerous. The Act requires those responsible for providing mental health units in England to produce a policy to ensure it is implemented in practice. This guidance aims to help policy makers[2] with the difficult job of producing a policy that is not only compliant with the requirements in section 3 of the UoF Act, but that will also improve practice and ultimately reduce and minimise the use of force.

1. Prone restraint comes under the definition of 'physical restraint' under the Act and so is a 'use of force'. The Mental Health Act (2015) Code of Practice and NICE guideline NG10: Violence and aggression both advise the restriction and minimisation of the use of prone restraint due to increased risk of physical and psychological harm and injury. The jury at the coroner's inquest into Seni's death concluded the prone restraint he experienced had been 'prolonged, disproportionate and unreasonable', and tragically caused the hypoxic brain injury from which he died.

2. and more specifically the 'responsible person' required under section 2. of the UoF Act.

Aji says:

> *What is needed is a living policy that changes cultures and continually motivates staff to use kinder, inclusive alternatives to restraint when working with people in distress. People deserve better. Care is not restraint.*

Aji Lewis, Seni's mother, does not want policies to be limited to a tick box exercise that simply describe *"increased protections and oversight on use of force in mental health settings – we have to do better than that!"*

Instead, Aji hopes policymakers are inspired by Seni's story and those of countless others who have experienced restraint. She wants to see care and safety, prevention and humanising cultures as the foundation of the principles of policy and guidance.

Policies should not focus simply on using force in better ways but on how to work in more humane ways that reduce the distress and trauma people are experiencing and prevent the need for restraint. In this way, policies can contribute to an overall reduction in restrictive practices. For example, data on the reduction of restraint in practice is required as the key measure of successful policy implementation.

This document seeks to realise this vision. It provides guidance to policymakers and responsible persons regarding the Use of Force Act, highlighting key principles that policymakers must take into account.

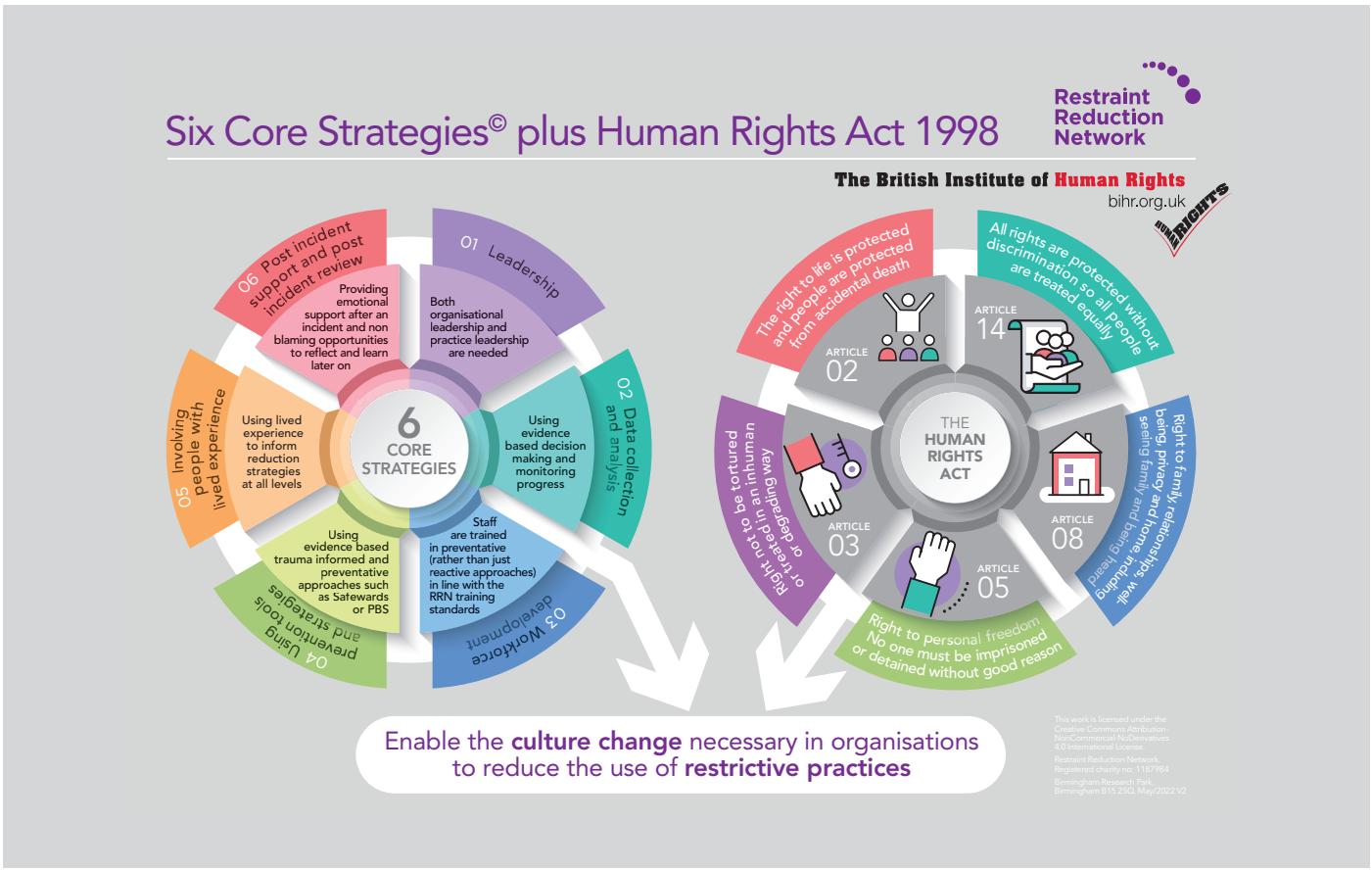
Six Core Strategies

The Six Core Strategies© are a set of evidence-informed approaches that have been widely adopted and have been shown to be effective in reducing the unnecessary use of physical restraint and seclusion.

It is a whole system approach and was originally developed in the United States by the National Association of State Mental Health Program Directors (NASMHPD). It is also used in the United Kingdom, Canada, Australia and Finland. All six strategies should be implemented. Leadership is key to drive the change needed.

The six core strategies are:

- Leadership towards organisational change (includes senior leadership and practice leadership).
- Full inclusion and coproduction with people with lived experience at all levels.
- Use of data to inform practice.
- Workforce development planning – ensure staff are well supported and trained in prevention skills.
- Use of reduction tools – evidence-based approaches.
- Non blaming post incident support and learning for all who have been involved in incidents.



The infographic above shows how the six core strategies interact with human rights and together they promote positive non restrictive cultures in which people can thrive.

If you follow this link you can access a simple Restraint Reduction Network checklist for the six core strategies: https://bit.ly/46Wyn17

Key principles

There are six overarching principles we would ask providers and responsible persons to consider when developing and implementing the policy.

These six principles include:

1. Be **coproductive**.
2. Ensure you use **inclusive and empowering language**.
3. Focus on the **prevention and support of distress**.
4. Cultivate a **safe and inclusive environment**.
5. Be **culturally attuned**.
6. Ensure transparency and **accountability in policy development, implementation and improvement.**

Below we provide more detail of the principles.

1. **Be coproductive:**

   - The policy should be coproduced by a 'team' comprising representatives of all those with a key interest in preventing, reducing and minimising the use of force. This must include a 'responsible person' (see statutory guidance, section 2) who is 'employed by the relevant health organisation' and is 'of an appropriate level of seniority'.

   - The team should be diverse and include 'professionals' andthose with lived experience, such as those subjected to the use of force and restraint (current and former patients), their families and carers, bereaved families, any relevant local third-sector organisations and local Healthwatch (as a statutory body for patients and the public). According to the statutory guidance, women and girls, people from black, racially and ethnically minoritised backgrounds and disabled people should also be involved because of the disproportionate impact of the use of force on them. Staff at various organisational levels should be involved, with the perspective of those who directly support people listened to. People who are in positions of governance and strategic oversight within the service or organisation should also be involved.

   - There should be equity between team members. The team must be facilitated in a way that enables everyone to contribute to the policy development.

   - For more information see the NHS England (2023) An introduction to co-production and NDTi (2016) Embedding co-production in mental health: A framework for strategic leads, commissioners and managers.

2. **Ensure you use inclusive and empowering language:**

   - The language we use and the way we describe other people reflects our prejudices, assumptions and values and influences our attitudes and behaviour.

   - The policy should be written in plain English so that most staff, the people they support and their families can understand it.

- Language should be neutral, inclusive, promote human rights and dignity. It must avoid prejudicial, biased or discriminative terms and concepts that are, for example, racist, ableist, sexist, homophobic, or otherwise offensive and stigmatising.
- Language should reflect a commitment to prevention, reduction and elimination of force, as well as people's liberation and emancipation and rights to the care, dignity and support they require.
- Language should reflect what is most beneficial and not simply the principle of least restriction (Department of Health, 2015).
- The policy should ensure that people are always informed of their rights and entitlements to support, information and advocacy in an accessible and timely manner[3].

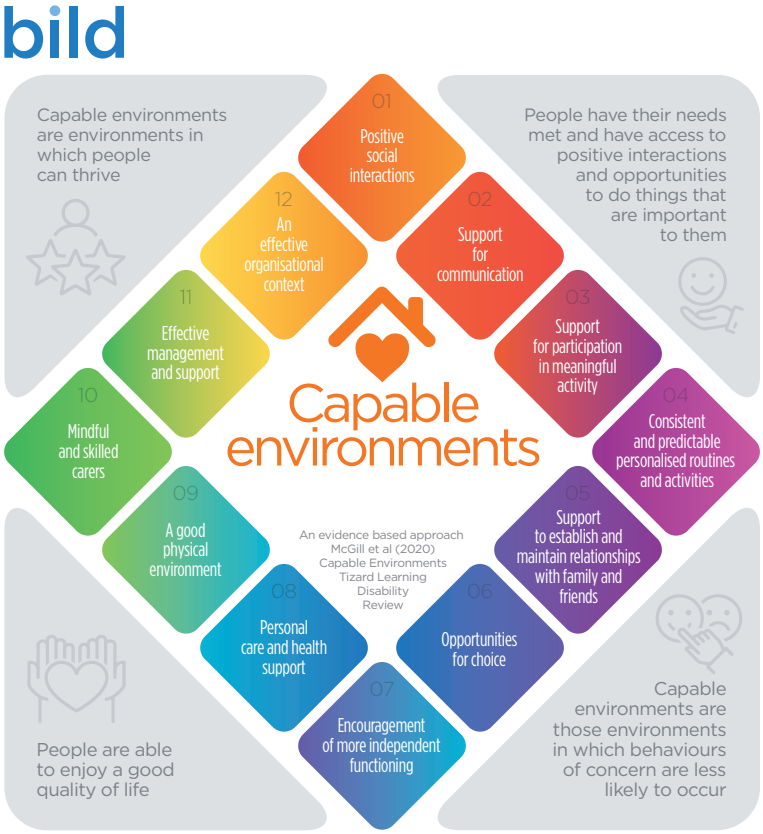
Examples

Often used	Alternatives
Service user/patient/client	Person
Violence and aggression	Distress that harms or behaviour(s) of concern
Challenging behaviour	The way the person responds to me/the situation…
Manage the person or their behaviour	Support the person
Least restrictive…'intervention/ practice'	Most beneficial form of support

3. For more information see: Department of Health (2015) Mental Health Act 1983: Code of Practice; Mental Health Act 1983; The Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008; Mental Capacity Act 2005; The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006; Care Act 2014; Local Government and Public Involvement in Health Act 2007; The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

3. **Focus on the prevention and support of distress:**

- The policy should focus on promoting person centred approaches that address people's individual needs and support them through experiences of distress.
- The policy should state that the starting point is to understand each person's individual causes of distress and the impacts of trauma which are experienced in different ways by different people.
- The policy should set out that each person requiring support should have an individualised formulation that helps everyone understand them as a person and the causes or reasons for their distress. This should include situations and actions that might escalate their distress, retraumatise or harm them.
- The policy should suggest that each person have an individualised support plan informed by the formulation.
- The person, their family and supporters must be involved in the formulation and deciding the content of the support plan.
- The support plan should focus on improving quality of life and wellbeing and reducing the likelihood that distress will occur. The support plan should clearly state what staff and others should do to achieve this, including how to interact and support them on a daily basis. The support plan should detail what is needed for that person to be able to thrive. These are the elements of a capable and supportive environment.
- The support plan must provide opportunities for the person to do things that are meaningful and enable them to develop or maintain relationships that are important to them.
- The support plan should contain personalised strategies that help a person to feel calmer when distressed and actively promote de-escalation.
- The support plan must contain the least restrictive interventions possible to keep the person safe. It is to be acknowledged that any application of a restrictive practice is a form of control/management over that person – use of force and control are only to be considered in unsafe situations to prevent harm and injury.
- The support plan should also consider nonrestrictive options to manage crisis situations and prevent the use of force.



- The policy must require each person to receive individualised post incident support that reduces their distress and trauma. This would include reflections on the possible physical and/or psychological trauma resulting from restrictions or uses of force and any subsequent traumatisation from medical procedures or hospitalisation relating to the uses.
- The policy should draw on the duty of candour (Health and Social Care Act 2008, Regulations 2014) to act in an open and transparent way with people and their families or carers about situations where a person's distress was escalated due to a mistake on the part of the service of a staff member, or where restraint has been used inappropriately and caused harm.
- Staff should have sufficient training, supervision and support to use strategies that enable them to manage and lower their own distress and arousal and develop skills to regulate themselves in the face of a person's crisis and distress.

4. **Cultivate a safe and inclusive environment:**

   - The policy should address physical and psychosocial environmental issues, ensuring that people have access to safe environments, to the things and activities that are important to them and that improve their wellbeing.
   - Environmental barriers that remove people's dignity and prevent people from having a good quality of life should be considered a risk factor regarding people's wellbeing, the support of their distress and a contributing factor to escalations resulting in a potential threat of, or actual use, of force. These might include the use of blanket restrictions.
   - Consideration should be given to the ways in which existing service environments and structures might increase distress and promote escalations, including wards and staff prioritising physical or mechanical restraints, containments and/or safety measures to ensure the separation of stigmatised or marginalised people.

5. **Be culturally attuned:**

   - The policy should seek to promote equality and nondiscrimination and actively protect people's human rights (Human Rights Act 1998; Equality Act 2010) and uncover, report and address inequalities and human rights infringements to the relevant internal and external authorities.
   - The policy should address cultural and power differentials between staff and people in services and how these might give rise to the use of force or escalate people's distress.
   - This should include an understanding of the potential for relational retraumatisation of staff and people in services, through preventable and avoidable crises, escalations, threats and actual uses of force. This would also involve an assessment of staff ability/capacity for improved relational working and using this as the basis of supporting people in distress.
   - The policy should require the organisation and staff to critically reflect on what constitutes the least restrictive practice on a service-wide and individual basis, on a regular basis.
   - The policy should ensure that staff provide socially and culturally attuned aware and appropriate care, which is sensitive to people's cultural identity and heritage and personal identities.

6. **Ensure transparency and accountability in policy development, implementation and improvement:**

    - The process of policy development should be deliberately iterative to facilitate creativity and freedom to explore alternatives to identified policies and practices that are not working.
    - To ensure openness, transparency and continuous learning, a record should be made of how the policy came about, the assumptions that underpin the policy, who was involved in the creation or improvement, any assets and resources required to implement it, conscious reflections and evaluations on the development and implementation and an assessment of how evidence from data on the extent that key outcomes were achieved or not was used to amend further iterations.
    - The policy should be dynamic, kept under regular review and be easily amended and updated based on its operational effectiveness. It may therefore be different from other existing organisational policy formats and development processes rather than be required to be restricted and conform to them.
    - It should further the development of an open, curious and learning culture, that recognises and builds on success, learns from failures and views post incident debriefs and support as learning opportunities to improve future support.
    - As required by the statutory guidance, all policy should be reviewed, reported upon and discussed by senior management and the governance body of the organisation ensuring the full support of the responsible person.

Key considerations for each element

The aim of the policy is prevention and ultimately to reduce, minimise and end the use of force in the organisation. Below we have provided key considerations and further links and resources relating to each of the 21 specific elements described within the statutory guidance.

Requirement A:

The organisation or trust's commitment to protect human rights and freedoms and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds, women, girls and disabled people.

Key considerations:

- Applying the principles and duties of human rights and equality legislation and statutory guidance to the policy and to the prevention, minimisation and actual use of force in the organisation.
- Reflecting the intended principles of any reform of the Mental Health Act (1983) as set out by the Government's White Paper:
    - Choice and autonomy – ensuring service users' views and choices are respected;
    - Least restriction – ensuring the Act's powers are used in the least restrictive way;
    - Therapeutic benefit – ensuring patients are supported to get better, so they can be discharged as quickly as possible;
    - The person as an individual – ensuring patients are viewed and treated as individuals.
- Articulating commitments to protections from prejudice and discrimination and promoting people's human rights in ways that underpin all the work of the organisation and in relation to the specific duties and requirements under the Mental Health Units (Use of Force) Act 2018.
- Ensuring the policy guidelines on human rights are clear, concise and outline the accountability to the range of lived experiences in relation to the use of force.
- Outlining specific considerations around the promotion of equality, culturally-sensitive practice and the prevention of discrimination of all those with a protected characteristic under the Equality Act 2010 and especially those from racially and ethnically minoritised groups (including those from black and Asian backgrounds), women and girls and those with a disability. These groups are specifically mentioned by the statutory guidance and in relation to race and ethnicity are mandatory parts of the Parent and Carer Race Equality Framework.

Further links and resources:

- Mental Health Act 1983: code of practice (chapter 26: safe and therapeutic responses to disturbed behaviour). https://www.gov.uk/government/publications/code-of-practice-. mental-health-act-1983
- Equality and Human Rights Commission, Human rights framework for restraint. https://www.equalityhumanrights.com/sites/default/files/2022/our-work-human-rights-framework-restraint-2019.pdf
- The British Institute for Human Rights, Mental health, mental capacity and human rights: a practitioner's guide. https://www.bihr.org.uk/media/cczlt3l5/guide_mental-health-capacity-human-rights-practitioners-guide.pdf
- Care Quality Commission, Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition. https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf
- Reforming the Mental Health Act (white paper). https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act
- Patient and carer race equality framework (PCREF). NHS England » Patient and carer race equality framework
- Department of Health, Positive and proactive care: reducing the need for restrictive interventions. https://assets.publishing.service.gov.uk/media/5a7ee560e5274a2e8ab48e2a/JRA_DoH_Guidance_on_RP_web_accessible.pdf

See also the articles of the:

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). https://rm.coe.int/16807001c3
- International Covenant on Civil and Political Rights. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights
- International Convention on the Elimination of All Forms of Racial Discrimination. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial
- Convention on the Elimination of All Forms of Discrimination against Women. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women
- Convention on the Rights of Persons with Disabilities. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities
- Convention on the Rights of the Child. https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

Requirement B:

The organisation or trust's commitment to minimising the use of force and eliminating the inappropriate use of force, recognising the potentially traumatising impact the use of force can have.

Key considerations:

- Whether to designate a board-level director as the statutory 'responsible person' for the minimisation and elimination of inappropriate use of force under the Act.
- Providing a statement outlining the organisation's commitment to the reduction, minimisation and elimination of inappropriate use of force.
- Providing clear descriptions of how this commitment will be translated into actions and practices (and action plan), for example, how minimisation and elimination of inappropriate use of force will be included in mandatory training and induction of new staff and a description of the required monitoring, reporting and reviews of use of force under the Mental Health Units (Use of Force) Act 2018. This action plan should be developed in collaboration with people with lived experience and a description should be made about this collaboration and how it will evolve in the subsequent implementation and reviews of the policy and action plan.
- Ensuring the action plan is underpinned by realistic targets and meaningful monitoring and evaluation and specific assessments of care planning, lived experience charters and the impacts of use of force on the lives of people with lived experience, their families, carers and staff involved, resulting from people's experiences of structural discrimination, admission, ward experience and discharge.
- Ensuring that the commitment enables clear accountability and transparency and sets out how patients and families will be involved in governing progress towards the minimisation and elimination of inappropriate use of force.
- Clarifying what is meant by the following terms (use of force - including the different forms defined under the Act), minimisation, elimination of unnecessary or inappropriate in ways that are accessible to those with lived experiences of the use of force and restraint and especially those who are at higher risk of its use, including young and disabled people, girls and women (1) and those from black, and racially and ethnically minoritised communities.

(1) When developing their policy it is for each provider to consider the impact of the UK Supreme court decision about the definition of women within the equality act.
https://www.supremecourt.uk/cases/uksc-2024-0042

Key considerations (continued):

- Including a specific statement recognising and acknowledging the potentially traumatic (physical and psychological) impacts of the use of force. Ensuring that this statement is supported with a commitment to minimising and addressing the traumatic impacts of the use of force and that this commitment is translated into specific trauma informed principles, actions and practices (action plan). This would also include a clear process for post incident debriefing and learning and access to trauma related physical, psychological, psychotherapeutic and counselling support for people who are subject to the use of force. Ethical considerations here should be made about the appropriateness of involving people who authorise or are involved in the use of force in any support for people who are traumatised / retraumatised by the experience.
- Providing an overview that explains possible links to post traumatic stress disorder (PTSD), referring to NICE guidance of how to support trauma and retraumatisation.
- Drawing on an intersectional understanding of trauma, traumatisation and retraumatisation and the ways in which systems can exacerbate or address historic and contemporary trauma for people from black, and racially and ethnically minoritised communities.

Further links and resources:

- NICE, Post-traumatic stress disorder [NG116]. https://www.nice.org.uk/guidance/NG116
- Department of Health, Positive and proactive care: reducing the need for restrictive interventions. https://assets.publishing.service.gov.uk/media/5a7ee560e5274a2e8ab48e2a/JRA_DoH_Guidance_on_RP_web_accessible.pdf
- Mental Health Europe, Short guide to ending coercion and restraint in mental health service. https://www.mhe-sme.org/wp-content/uploads/2021/06/Short-Guide-on-Alternatives-to-Coercion.pdf
- Mental Health Act 1983: code of practice (chapter 26: safe and therapeutic responses to disturbed behaviour). https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
- Restraint Reduction Network (RRN), Training standards. https://restraintreductionnetwork.org/wp-content/uploads/2023/10/RRN_standards_v9_accessible_PDF_updated.pdf
- Te Pou (NZ), The six core strategies service review tool. https://www.tepou.co.nz/initiatives/least-restrictive-practice/the-six-core-strategies-service-review-tool

Requirement C:

The preventative action the organisation or trust is taking to minimise use of force.

Key considerations:

- Including in the action plan mentioned above specific commitments, actions and practices aimed at preventing the use of force in the organisation. These might include the removal of blanket policies, the incorporation of coproduced de-escalation planning within care plans, or structural changes to service delivery to minimise the potential of threats of use of force, or physical changes to the service environment to promote the support of distress, or how practices that promote the prevention and support of distress are incorporated into mandatory training.
- Incorporating the promotion of person centred care as a preventative measure (as proposed by the Care Quality Commission).
- Proactively integrating the prevention and minimisation of the use of force into strategic organisational level, wider quality improvement, commitments, oversight, monitoring and reporting.

Further links and resources:

- See above.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents
- HM Government, Reducing the need for restraint and restrictive intervention. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-intervention.pdf
- Care Quality Commission, Restrictive practice — a failure of person-centred care planning? https://carequalitycomm.medium.com/restrictive-practice-a-failure-of-person-centred- care-planning-b9ab188296cf
- Restraint Reduction Network, Reducing the use of blanket restrictions. https://restraintreductionnetwork.org/wp-content/uploads/2021/10/RRN_SL_tool.pdf

Requirement D:

Information about how the organisation or trust will monitor the use of force on people who share protected characteristics under the Equality Act 2010.

Key considerations:

- Ensuring the information is accessible and written from a lived experience perspective, reflecting the needs of those with protected characteristics under the Equality Act.
- Outlining the intersectional relationships between this requirement at other relevant duties under the Equality Act, including the Public Sector Equality Duty taking positive action under the Equality Act 2010.
- Requiring information to meet as a minimum the Accessible Information Standards, and coproduced with people who have relevant lived experience.
- Providing accessible information through the use of a lived experienced dashboard where monitoring could be available for those subject to the use of force and especially those who have protected characteristics under the Equality Act.

Further links and resources:

- NHS England, Accessible information standard.
  https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/
- Patient and carer race equality framework (PCREF).
  NHS England » Patient and carer race equality framework
- Equality and Human Rights Commission, Equality Act 2010 code of practice – services, public functions and associations statutory code of practice.
  https://www.equalityhumanrights.com/sites/default/files/servicescode_0.pdf
- Equality and Human Rights Commission, Public sector equality duty.
  https://www.equalityhumanrights.com/guidance/public-sector-equality-duty-psed

Requirement E:

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

Key considerations:

- Ensuring all core training enables staff, independent advocates and hospital managers (as defined under the Mental Health Act) to identify a use of force and understand the signs of inappropriate and disproportionate use. These would draw on the Restraint Reduction Network (RRN) Training standards relating to the threat and use of force.
- This will include an understanding of all relevant NICE and clinical guidance, for example, on encountering violence and aggression (NG10). It would also include an understanding of a patient's rights and those of their family/carer or appointed representative. And be underpinned by a trauma informed approach.
- Cultivating an organisational system and environment where staff are there to embrace the duty of candour, raise concerns and make disclosures to the responsible person (under the Act) in relation to the inappropriate and disproportionate use of force. Ensuring these are underpinned by effective reporting and safeguarding policies and procedures in the organisation.
- Promoting respect, dignity and distress support within organisational policies and behavioural standards expected of employees.
- Requiring all staff to understand the recording requirements under section 6 of the Mental Health Units (Use of Force) Act 2018 and outlining how the workforce shall be informed, trained and supported in recording of inappropriate use of force.
- Monitoring professional standards and raising concerns with any relevant professional body.

Key considerations (continued):

- Describing how the organisation will communicate, publicise and inform communities about the actions that will be taken if inappropriate or disproportionate use of force is identified. These actions should extend to healthcare staff, managers and independent advocates if inappropriate use of force is identified.
- Detailing the support available to staff and independent advocates if they witness inappropriate use of force.
- Ensuring effective integration of this policy with existing safeguarding responsibilities, policies and procedures and for these to be described in care plans.
- Explaining how the person who has experienced the inappropriate use of force will be supported and kept informed in relation to any subsequent investigation and conclusions or apologies.

Further links and resources:

- Department of Health, Mental Health Act 1983: code of practice (see advocacy). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- The Mental Health Act 1983 (independent mental health advocates) (England) regulations 2008. https://www.legislation.gov.uk/uksi/2008/3166/made
- Office of the Public Guardian, Mental Capacity Act 2005: code of practice. https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf
- The Mental Capacity Act 2005 (independent mental capacity advocates) (general) regulations 2006. https://www.legislation.gov.uk/uksi/2006/1832/contents/made
- Health and Social Care Act 2008 (regulated activities) regulations 2014: regulation 16. https://www.cqc.org.uk/guidance-providers/regulations/regulation-16-receiving-acting-complaints
- Health and Social Care Act 2008 (regulated activities) regulations 2014: regulation 20. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20
- HM Government, Working together to safeguard children. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Department of Health, Care and support statutory guidance. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#using-the-care-act-guidance

Further links and resources (continued)**:**

- Public Interest Disclosure Act 1998 (PIDA) guidance. https://www.gov.uk/government/publications/guidance-for-auditors-and-independent-examiners-of-charities/the-public-interest-disclosure-act--2
- NHS England, Freedom to speak up policy for the NHS. https://www.england.nhs.uk/wp-content/uploads/2022/06/PAR1245i-NHS-freedom-to-speak-up-national-Policy-eBook.pdf
- Restraint Reduction Network (RRN), Training standards. https://restraintreductionnetwork.org/wp-content/uploads/2023/10/RRN_standards_v9_accessible_PDF_updated.pdf
- NICE, Violence and aggression [NG10]. https://www.nice.org.uk/guidance/ng10/chapter/1-recommendations

Requirement F:

Details of the types of force and specific techniques which the organisation or trust may use, which may be different in services for children and young people, adults or older people. This should include information about the risk assessments undertaken prior to the techniques being approved by the organisation or trust board and an assessment of the training needs of staff in using these techniques.

Key considerations:

- Providing a more detailed description and explanation of the different types of use of force, as defined by the Mental Health Units (Use of Force) Act 2018 and Chapter 26 Mental Health Act code of practice of the Mental Health Act 1983: code of practice (for the purposes of isolation, seclusion and segregation.
- Undertaking an impact assessment of the risks associated with applying these different types of the use of the force to different populations (related to the services that the organisations provide, for example, for children and young people or older adults).
- Giving particular attention in the assessment to the impacts on: A. black and minoritised racial and ethnic communities, B. children, and young people, C. girls and women, adults and older people. This would include a consideration of how specific forms of the use of force might be inappropriate given a person's lived and cultural experiences and considering the specific trauma(s) they have experienced.
- Ensuring that the assessment is informed by coproducing guidance for the assessment of risk and drawing on evidence and insight from people with lived experiences of the use of force in mental health settings.
- Using the assessment to inform the types of force that are deemed to be permissible for different service populations and how the organisation will ensure that any risks are managed in relation to these specific groups of people.
- Ensuring this assessment is undertaken prior to the techniques being approved by the organisation or trust board.

Key considerations (continued):

- Undertaking an audit of staff (under the meaning of the Act) training needs relating to the use of force, meeting as a minimum, the requirements set out in section 5 (list of training topics that must be covered under a through to k) of the Mental Health Units (Use of Force) Act 2018 statutory guidance.
  This audit should identify training needs and use a training plan to explain how the training needs will be met and over what time period. In line with other specific requirements of the Mental Health Units (Use of Force) Act 2018 this training plan should provide information about the ways in which training will contribute to the reduction, minimising and/or ending of the use of force in the organisation.

- Ensuring the needs identified under the training plan are met by appropriately qualified training providers with relevant and certified experience in the area of use of force and mental health provision. These might include training certified under the Restraint Reduction Network (RRN) Training standards.

- Ensuring that any certified training to meet identified needs incorporatesthe risks and impacts of different uses of force on different groups of people (i.e., those from black, racially and ethnically minoritised groups, children and young people, older adults).

- Assuring the board, the responsible person and/or any delegated persons who becomes responsible, embed training requirements into team and individual staff training plans, to ensure there is consistency in all practices; from a person's assessment to their discharge and any aftercare (i.e., section 117 of the Mental Health Act 1983).

Further links and resources:

- Department of Health, Mental Health Act 1983: code of practice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- Restraint Reduction Network (RRN), Training Standards. https://restraintreductionnetwork.org/wp-content/uploads/2023/10/RRN_standards_v9_accessible_PDF_updated.pdf

Requirement G:

Set out how children's rights will be protected when they are separated from others within the unit or ward. This should cover, for example, the physical environment, personal possessions, stimulating activities, support and meaningful contact with staff, as well as notifying parents or others with parental responsibility.

Key considerations:

- Providing a clear statement of the consideration of the use and removal of blanket policies and the preventative measures that are in place to avoid the use of isolation, seclusion and segregation.
- Acknowledging that the current legislative framework is complex and so staff will need to have sufficient understanding of these interacting frameworks to ensure they protect the rights of the child. These include the legal interactions between the Children Act 1989, Children and Families Act 2014, Mental Health Act 1983, Mental Capacity Act 2005 and Human Rights Act 1998. In addition to these, children's rights are protected under the European Convention on Human Rights (ECHR), UN Convention on the Rights of the Child and UN Convention on the Rights of Persons with Disabilities.
- Striving to ensure that children's rights and protections are pursued irrespective of whether they are admitted on an informal basis or detained under the Mental Health Act 1983.
- Implementing existing requirements for children's care and treatment to take place in environments and accommodations (including for the purposes of separation, seclusion and segregation) that are appropriate for their age and circumstances (s.31, Mental Health Act 2007), Chapter 19, 26 MHA code of practice).
- Setting out the ways in which the physical environment could be therapeutic, be made to be as homely as possible and considering any reasonable adjustments required for the person's disability (e.g., sensory issues), needs for simulation and the person's cultural needs.
- Ensuring continuous reviews of the use of segregation and seclusion of children and young people to prevent avoidance isolation and proactively explore less restrictive methods of support.
- Detailing how the therapeutic relationships with the child or young person will be maintained while in segregation or seclusion and how this will be reviewed and monitored and reflected in their care planning.

Key considerations:

- Providing for a child and young person's right to the continuity of education and engagement in meaningful activities, exercise, social contact and stimulation (reflecting the SEND and Mental Health Act codes of practice).
- Considering how personal possessions will be managed and risk assessed while children are secluded or segregated. Any risk assessments should involve direct discussions with the child or young person and those with parental responsibility and reviewed regularly.
- Setting out clear guidance requiring the provision of age, developmentally and need appropriate communication with children subject to the use of isolation, seclusion and segregation. This would include informing them of their rights and any access to statutory and non statutory advocacy or advice services, including in conversations with the child about communication with family. This would include a consideration of Gillick competence and the conditions under which a child might consent to seclusion and segregation without parental consent.
- Setting out clear guidance requiring the provision of accessible information for the parent(s), family member(s), carer(s) and/or those with parental responsibility for the child or young person. Within these considerations of the inclusion of children in communications with parent(s), family and those with parental responsibility in regard to consent. Further, an outline of how proactive ongoing meaningful communication with parent(s), families, carer(s) and those with parental responsibility will be managed by staff.
- Ensure communication and contact with parent(s), carer(s) and family is focused on the reduction of the child's or young person's distress and maintaining their contact with the world beyond the organisation. Within this, specific consideration (in line with safeguarding requirements) should be given to identify and manage concerns arising from contact with those with parental responsibility, where it would exacerbate the child's or young person's experiences of adversity within the familial context and increase their distress. This should also be the case in a situation where the parent (or those with parental responsibility) have consented to the admission and treatment of children under the age of 16 and where it conflicts with their own wishes (building on the recommendation of the independent Mental Health Act review).

Further links and resources:

- Convention on the Rights of the Child. https://www.unicef.org.uk/what-we-do/un-convention-child-rights
- Statement of the Committee on the Rights of the Child on Article 5 of the C onvention on the Rights of the Child. https://www.ohchr.org/sites/default/files/documents/hrbodies/crc/statements/CRC-Article-5-statement.pdf
- Convention on the Rights of Persons with Disabilities. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities
- Council of Europe, European Convention on Human Rights. https://www.echr.coe.int/documents/d/echr/convention_ENG
- Department of Health, Mental Health Act 1983: code of practice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- The Mental Health Act 1983 (independent mental health advocates) (England) regulations 2008. https://www.legislation.gov.uk/uksi/2008/3166/made
- Office of the Public Guardian, Mental Capacity Act 2005: code of practice. https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf
- The Mental Capacity Act 2005 (independent mental capacity advocates) (general) regulations 2006. https://www.legislation.gov.uk/uksi/2006/1832/contents/made
- Health and Social Care Act 2008 (regulated activities) regulations 2014: regulation 16. https://www.cqc.org.uk/guidance-providers/regulations/regulation-16-receiving-acting-complaints
- HM Government, Working together to safeguard children. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Gillick v West Norfolk and Wisbech AHA [1986] AC 112.
- Department for Education / Department of Health Special educational needs and disability code of practice: 0 to 25 years. https://assets.publishing.service.gov.uk/media/5a7dcb85ed915d2ac884d995/SEND_Code_of_Practice_January_2015.pdf
- Independent Review of the Mental Health Act 1983, Modernising the Mental Health Act, increasing choice, reducing compulsion. https://assets.publishing.service.gov.uk/media/5c6596a7ed915d045f37798c/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf
- NDTi, It's not rocket science", considering and meeting the sensory needs of autistic children and young people in CAMHS inpatient services. https://www.ndti.org.uk/assets/files/Its-not-rocket-science-V6.pdf
- Restraint Reduction Network, Reducing the use of blanket restrictions. https://restraintreductionnetwork.org/wp-content/uploads/2021/10/RRN_SL_tool.pdf
- NHS England, What are restrictive practices? https://www.england.nhs.uk/wp-content/uploads/2022/07/Restrictive-Practices-easy-read-Email-Verison.pdf
- NHS England, My rights magazine. https://www.england.nhs.uk/wp-content/uploads/2023/08/B0137-my-rights-magazine-full.pdf

Requirement H:

Examples of the circumstances in which the use of force may or may not be used and when a use of force is considered negligible (in accordance with this guidance − see section 6).

Key considerations:

- Providing a more detailed description and explanation of the different types of use of force, as defined by the Mental Health Units (Use of Force) Act 2018 and Chapter 26 of the Mental Health Act 1983: code of practice (for the purposes of isolation, seclusion and segregation).
- Undertaking an impact assessment of the risks associated with applying these different types of the use of the force.
- Ensuring that the assessment is informed by coproducing guidance for the assessment of risk and drawing on evidence and insight from people with lived experiences of the use of force in mental health settings.
- Using the assessment to inform the types of force that are deemed to be permissible to use under specific circumstances. Within this, explaining the definition of 'negligible' within the Mental Health Units (Use of Force) Act 2018 and giving specific circumstances and examples that illustrate this.
- Ensuring this assessment is undertaken prior to the techniques being approved by the organisation or trust board.
- Undertaking periodic reviews of practice and recording of the use of force to ensure that the thresholds and criteria for 'negligible use of force' remain consistent with the statutory guidance and meaning under the Mental Health Units (Use of Force) Act 2018.

Further links and resources:

- Department of Health, Mental Health Act 1983: code of practice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- Mental Health Units (Use of Force) Act 2018 statutory guidance. https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales

Requirement I:

Information on how the risks associated with the use of force will be managed.

Key considerations:

- Embedding in the commitments, assessments, planning and auditing referred to above. There should be specific consideration given to the risks arising from the different forms of the use of force and as applied to different groups of people (i.e., those who are black, racially or ethnically minoritised, disabled or children).
- Incorporating an assessment of risk in relation to the serious harm and trauma (psychological and physical) that can arise from the use of force and balancing this with any assessment under the Mental Health Act 1983 or NICE guidance relating to risk of serious harm to self or others.
- Coproducing risk assessments with people who have lived experience of the use of force, their families, carers and representatives. As should any planning relating to the reduction, management and mitigation of risk.
- Ensuring that risk planning and management are transparent and be held at a sufficient level of seniority (director and governance level) to ensure that the organisation and its staff can be held to account.

Further links and resources:

- Department of Health, Mental Health Act 1983: code of practice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- NICE, Violence and aggression [NG10]. https://www.nice.org.uk/guidance/ng10/chapter/1-recommendations
- Department of Health, Positive and proactive care: reducing the need for restrictive interventions. https://assets.publishing.service.gov.uk/media/5a7ee560e5274a2e8ab48e2a/JRA_DoH_Guidance_on_RP_web_accessible.pdf
- HM Government, Reducing the need for restraint and restrictive intervention. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-intervention.pdf
- Restraint Reduction Network (RRN), Training standards. https://restraintreductionnetwork.org/wp-content/uploads/2023/10/RRN_standards_v9_accessible_PDF_updated.pdf
- Social Care Institute for Excellence, Managing risk, minimising restraint. https://www.scie-socialcareonline.org.uk/managing-risk-minimising-restraint/r/a11G00000017yFWIAY

Requirement J:

Details of relevant staff training programmes and how learning and knowledge will be transferred into the workplace. This should also include the importance of all training being provided by certified training providers as complying with Restraint Reduction Network National Training Standards (section 5 for further details on the training standards).

Key considerations:

- Undertaking an audit of staff (under the meaning of the Act) training needs relating to the use of force, meeting as a minimum, the requirements set out in section 5 (list of training topics that must be covered under a through to k) of the Mental Health Units (Use of Force) Act 2018 statutory guidance. This audit should identify training needs and use a training plan to explain how the training needs will be met and over what time period. In line with other specific requirements of the Mental Health Units (Use of Force) Act 2018 this training plan should provide information about the ways in which training will contribute to the reduction, minimising and/or ending of the use of force in the organisation. The audit and plan should further explore the individual and collective staff learning needs around the specific and cultural needs of people that use the organisation's service(s) who they work with.
- Ensuring the needs identified under the training plan are met by appropriately qualified training providers with relevant and certified experience in the area of use of force and mental health provision. These would comply with the Restraint Reduction Network (RRN) Training standards and may be training certified under them.
- Ensuring the learning programme will be coproduced with those with lived experiences of the use of force, their carers, families, and representatives and align with the principles of the Restraint Reduction Network (RRN) Training standards, as approved by the former Health Education England (now part of NHS England).
- Ensuring that any certified training to meet identified needs incorporates the risks and impacts of different uses of force on different groups of people (i.e., those from black, racially and ethnically minoritised groups, children and young people, older adults).
- Assuring the board, the responsible person and/or any delegated persons who become responsible, embed training requirements into team and individual staff training plans, to ensure there is consistency in all practices; from a person's assessment to their discharge and any aftercare (i.e., section 117 of the Mental Health Act 1983).

Further links and resources:

- Mental Health Units (Use of Force) Act 2018 statutory guidance (sec tion 5). https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales
- Restraint Reduction Network (RRN), Training standards. https://restraintreductionnetwork.org/wp-content/uploads/2023/10/RRN_standards_v9_accessible_PDF_updated.pdf

Requirement K:

Details of how patients, their families, carers and independent advocates will be involved in care planning which sets out the preventative strategies to the use of force, through, for example, advance statements. It is important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers, for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account.

Key considerations:

- Including in prevention planning (as described above), policies, interventions and support that seeks to prevent avoidable and unnecessary admissions into crisis and mental health services and especially focuses on minimising compulsory detention and/or prolonged hospital stays for the purposes of assessment under the Mental Health Act 1983.
- Committing to focusing on support for distress, effective crisis planning and management and the promotion of dignity, respect and personal autonomy within all mental health service prevention, care and support strategies (as detailed in the principles above). As part of this, ensuring that it is informed by the experiences and insight of people who have been subject to the use of force, their parent(s), families, carers and independent advocates such as IMHAs, IMCA and children's rights advocates.
- Ensuring all implementation of statutory duties to undertake care and crisis planning (i.e., under the Mental Health Act 1983, Care Act 2014, Children and Families Act 2014) involve the meaningful coproduction and involvement of people who may be subject to the use of force and where appropriate their parent(s), carer(s), families and independent advocates. Within these care, treatment and crisis plans taking account of the specific risks associated with the use of force as related to the protected characteristics (under the Equality Act 2010) and making reasonable adjustments and including protective measures accordingly.
- Ensuring that individual care plans are regularly monitored and reviewed, including in transitions and situational changes and these reflect the wider policy committing to minimisations in the use of force and focus on support for mental distress.

Key considerations (continued):

- Including considerations of the use of force in Advance Statements (Mental Health Act 1983, Code of Practice) people can make about their care and treatment and ensuring these seek to inform the person who may be subject to the use of force about their rights and alternative forms of de-escalation and management of distress. Ensuring that these considerations take into account the person's wishes and preferences and meaningfully involve them in the decisions about their prospective care and treatment.

- Ensuring there are specific considerations (in line with safeguarding requirements) given to identify and manage concerns arising from contact with parent(s), families or carer(s), or where contact might increase risk, such as experience of domestic violence within the family or a history of coercive control.

- Committing to invest in training and support for staff focused on coproduction and the meaningful involvement of people, parent(s), carer(s), family and advocates in decision making, which includes people who have direct lived experience of the use of force and that adequately pays them for their contribution.

Further links and resources:

- Department of Health, Mental Health Act 1983: code of practice (see advocacy). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- The Mental Health Act 1983 (independent mental health advocates) (England) regulations 2008. https://www.legislation.gov.uk/uksi/2008/3166/made
- Office of the Public Guardian, Mental Capacity Act 2005: code of practice. https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf
- The Mental Capacity Act 2005 (independent mental capacity advocates) (general) regulations 2006. https://www.legislation.gov.uk/uksi/2006/1832/contents/made
- HM Government, Working together to safeguard children. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Department of Health, Care and support statutory guidance. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#using-the-care-act-guidance
- Department for Education / Department of Health, Special educational needs and disability code of practice: 0 to 25 years. https://assets.publishing.service.gov.uk/media/5a7dcb85ed915d2ac884d995/SEND_Code_of_Practice_January_2015.pdf

Requirement L:

Information about how staff will use and follow individualised patient plans, such as Positive Behavioural Support Plans (or equivalent). See Positive and proactive care: reducing the need for restrictive interventions (2014) for further detail on Positive Behavioural Support.

Key considerations:

- Ensuring that the organisation coproduces Positive Behavioural Support (PBS) with people who have been and may be subject to the use of force and where appropriate their parent(s), carer(s), families and independent advocates.
- Requiring a lead professional and the wider multidisciplinary team (MDT) to regularly discuss and review a person's psychological formulation with the person and use this to inform their PBS, care and treatment plans and wider frameworks being used (such as the Care Programme Approach (CPA).
- The formulation should be regarded as a living description of the person's experiences and forms of distress and be held under continuous review and updating, enabling moves towards reductions in levels of restriction, support for distress and PBS wherever possible. The ethos of continuous discussion and review of the formulation (and its consequences for levels of restriction and use of force) could be incorporated into regular conversations a named professional has with a person at set times, following a Making Every Contact Count approach in mental health care.
- Reviewing and analysing incident data in order to ensure that formulations and the PBS (or other similar) plans remain accurate and are continuing to promote a reduction and minimisation in the use of restriction and force and promotion of people's dignity and support for distress.

Further links and resources:

- Department of H ealth, Positive and proactive care: reducing the need for r estrictive interventions. https://assets.publishing.service.gov.uk/media/5a7ee560e5274a2e8ab48e2a/JRA_DoH_Guidance_on_RP_web_accessible.pdf
- Care Quality Commission, Brief guide: positive behaviour support for people with behaviours that challenge. https://www.cqc.org.uk/sites/default/files/20180705_900824_briefguide-positive_behaviour_support_for_people_with_behaviours_that_challenge_v4.pdf
- The Challenging Behaviour Foundation, Positive behaviour support planning: part 3. https://www.challengingbehaviour.org.uk/wp-content/uploads/2021/02/003-Positive-Behaviour-Support-Planning-Part-3.pdf
- LGA, ADASS, NHS, Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf
- Positive Behavioural Support (PBS) Coalition UK, Positive behavioural support a competence framework. http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf
- UK PBS Alliance, Positive behaviour support. https://www.bild.org.uk/wp-content/uploads/2020/12/Copy-of-What-is-PBS-English-A4-1.pdf
- Bild, Health Education England and the Department of Health, Positive Behaviour Support: Changing practice, changing culture, changing lives. https://www.youtube.com/watch?v=OMyv4-WoyOY
- NHS England, Making every contact count. https://www.e-lfh.org.uk/programmes/making-every-contact-count/

Requirement M:

Details of how patients, their families, carers and independent advocates will be involved in care planning which sets out the preventative strategies to the use of force, through, for example, advance statements. It is important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers, for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account.

Key considerations:

- Providing people who may be subject to the use of force, their parent(s), families, carer(s) and independent advocates with accessible information (as required under the Accessible Information Standard) about what the use of force is and how they can raise a concern or make a complaint about it. This information should educate people about the right to raise concerns and complaints about the use of force. It should further reflect the organisation's complaints policy and formal internal complaints mechanism and provide detail about the ways concerns or complaints can be made, role of professionals involved (including the responsible person under the Act), how the complaint will be handled and within what timescale, and the additional support that can be provided by the local Patient Advice and Liaison Service (PALS), an IMHA, IMCA, or independent complaints advocate. It should also describe the person's right to report the use of force to other agencies (including the police), escalate the complaint to the Parliamentary and Health Service Ombudsman (PHSO) for further consideration and resolution. In situations where members of the police were involved in the use of force the person should be informed additionally of their right to raise a concern or make a complaint to the police force directly, or to the Independent Office for Police Conduct (IOPC).
- Ensuring that people who have been subject to the use of force are meaningfully involved in post incident debriefs as soon as is reasonably possible after the incident. The reasonability here should focus on the person's need to be supported in their distress and have an opportunity to describe and give their perspective of the incident and understanding of what happened.
- Considering, in the post incident debriefing, the specific needs of the person and ensuring these are met so they can fully participate in the meeting (i.e., do they require an interpretor, alternative or more accessible forms of information and communication?).

Key considerations (continued):

- Committing to the inclusion of parent(s), carer(s), families and independent advocates in the post incident debriefing (and subsequent meetings) if appropriate and aligns with the person's wishes. In some cases this might include the nearest relative (under the draft Mental Health Bill 2022 a nominated person) or an independent advocate making a representation for the person.
- Including in crisis, care and treatment plans and advance statements, accessible information on the right to raise concerns and make complaints about the use of force. Within this, including agreed details about how the person, their parent(s), carer(s), families, independent advocates or representatives (as appropriate) wish to be contacted about and involved in post incident debriefing and reporting, and ways of holding these debriefings that would be accessible for all those involved.
- Understanding the need to safeguard people who have been subject to the use of coercion, control, violence, neglect and abuse in the home or community environment and whose parent(s), carer(s), family or representatives may consent and advocate for the use of force as a continuation of the normalisation of coercion and violence between people and result in further traumatisation or retraumatisation.
- Outlining how the organisation audit and review the involvement of people, their parent(s), families, carer(s) and independent advocates in the post incident review process and how they report on this with the aim of learning from the use of force, minimising and reducing its further application and ensuring the person is supported in their distress and additional distress resulting from the use of force.
- Describing how crisis, care and treatment plans will be reviewed and updated post incident to learn from the use of force, understand the escalatory features, identify where de-escalation and alternatives to the use of force could have been used and consider any distress and/or trauma (physical or psychological) arising from the use of force, and updated to reflect learning and how the arising needs will be met.

Further links and resources:

- NICE, Violent and aggressive behaviours in people with men tal health pr oblems [QS154]. https://www.nice.org.uk/guidance/qs154/chapter/Quality-statement-5-Immediate-post-incident-de brief
- Department of Health, Mental Health Act 1983: code of practice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
- The Mental Health Act 1983 (independent mental health advocates) (England) regulations 2008. https://www.legislation.gov.uk/uksi/2008/3166/made
- Office of the Public Guardian, Mental Capacity Act 2005: code of practice. https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf
- The Mental Capacity Act 2005 (independent mental capacity advocates) (general) regulations 2006. https://www.legislation.gov.uk/uksi/2006/1832/contents/made
- Health and Social Care Act 2008 (regulated activities) regulations 2014: regulation 16. https://www.cqc.org.uk/guidance-providers/regulations/regulation-16-receiving-acting-complaints
- HM Government, Working together to safeguard children. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Gillick v West Norfolk and Wisbech AHA [1986] AC 112.
- Department for Education/Department of Health Special educational needs and disability code of practice: 0 to 25 years. https://assets.publishing.service.gov.uk/media/5a7dcb85ed915d2ac884d995/SEND_Code_of_Practice_January_2015.pdf
- Independent review of the Mental Health Act 1983, Modernising the Mental Health Act Increasing choice, reducing compulsion. https://assets.publishing.service.gov.uk/media/5c6596a7ed915d045f37798c/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf
- NHS England, Accessible information standard. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

Requirement N:

Clear information on the expectations for recording and reporting of the use of force within the organisation or trust.

Key considerations:

- Ensuring the lead professional trains and supports the organisation and all staff (defined under the Act) to comply with existing recording and reporting requirements under the NHS Digital Mental Health Services Data Set relating to restrictive practice and use of force, including the responsible person assuring the quality of the submitted data.
- Designing, implementing and auditing data recording and reporting systems to ensure that all uses of force are described and accounted for. Within this, the responsible person, all delegated persons and staff are trained and have sufficient understanding of the definitions, terminology and information required for the use of force. Also, see above suggestions relating to the definitions of 'negligible use'. The required specific information to be recorded (a-p) is set out in section 6 of the statutory guidance to the Mental Health (Use of Force) Act 2018.
- Retaining records of any use of force for three years from the date they were made and ensuring compliance with the Data Protection Act 2018 and the common law duty of confidence to protect the rights of the people who have been subject to the use of force.
- Embedding recording and reporting of the use of force within internal incident reporting systems, the person's electronic record and within any relevant crisis, care and/or treatment plan to ensure the data is available for analysis, reflections and learning to minimise and reduce the possibility of the person being subject to the use of force in the future.
- Complying with the Care Quality Commission (Registration) Regulations 2009 (Regulation 18) to record, report and notify the commission of any injury, harm, damage or death of the person resulting from the use of force. In the case of death of the person who has been subject to the use of force it must be recorded and reported immediately to the Care Quality Commission and local coroner (in this situation negligible uses of force should also be recorded and reported).

Key considerations (continued):

- Undertaking a meaningful analysis enabling the responsible person, senior leadership and board to scrutinise whether the policy is resulting in prevention and reduction in the use of force in the organisation (following the requirements of the statutory guidance this should not rely on a quantitative reduction in number of recorded incidents). See section 6 of the statutory guidance for questions senior leaders and boards should consider in this regard. We further propose a more substantive assessment focused on the qualitative experience of people subject to the use of force, their parent(s), families, carer(s), independent advocates and representatives. This assessment should be used to inform reviews and updates of the policy, associated training programmes and to contribute to quality improvement. Within this, the responsible person should undertake a meaningful analysis of the use of force on different groups, sharing protected characteristics under the Equality Act 2010 and this should be considered by the senior leadership and the board. This analysis and consideration should be used to comply with the public sector equality duty (under the Equality Act 2010 and associated statutory guidance) enabling the organisation to take further actions to prevent and reduce the use of force on specific groups who are at greater risk of its application (including those from black, racially and ethnically minoritised communities, women and girls, those with autism and a learning disability, and older people).

Further links and resources:

- NHS Digital, Restrictive intervention reporting in adult acute and adult learning disabilities inpatient services. https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/restrictive-intervention-reporting-in-adult-acute-and-adult-learning-disabilities-inpatient-services
- Mental Health Units (Use of Force) Act 2018 statutory guidance (section 6). https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales
- The Care Quality Commission (registration) regulations 2009. https://www.legislation.gov.uk/uksi/2009/3112/regulation/18
- Equality and Human Rights Commission, Public sector equality duty. https://www.equalityhumanrights.com/guidance/public-sector-equality-duty-psed

Requirement O:

Detail on how analysis of local management information will be used to inform development and review of the policy.

Key considerations:

- Including detailed descriptions of what local data on the use of force is contained within local management information systems and how this data is protected and maintained under the Data Protection Act 2018, and in relation to people's rights to privacy, anonymity and confidentiality. This would involve the inclusion in post incident review records, deaths (specifically Coroner's Prevention of Future Deaths reports) or serious injuries records, serious incident reviews complaints data, and records on the use of force on people who share a protected characteristic under the Equality Act 2010.
- Undertaking a routine and meaningful analysis enabling the responsible person, senior leadership and board to scrutinise whether the policy is resulting in prevention and reduction in the use of force in the organisation. This analysis should include longitudinal data to identify emerging trends and themes in relation to the use of force, including trends and patterns in health inequalities and disparities in the application of the use of force or post incident support. This assessment should be used to inform reviews and updates of the policy, associated training programmes and to contribute to quality improvement. Within this, the responsible person should undertake a meaningful analysis of the use of force on different groups sharing protected characteristics under the Equality Act 2010 and this should be considered by the senior leadership and the board.
- Complying with the public sector equality duty (under the Equality Act 2010 and associated statutory guidance) enabling the organisation to take further actions to prevent and reduce the use of force on specific groups who are at greater risk of its application (including those from black, racially and ethnically minoritised communities, women and girls, those with autism and a learning disability and older people).
- Escalating concerning trends and data outliers (including problematic use of force in specific wards, staff groups or departments) to internal governance processes and where appropriate, external agencies including Integrated Care Boards, the Care Quality Commission and NHS England.

Key considerations (continued):

- Making the findings of the data analysis accessible and publicly available so it can be considered by people who have been subject to the use of force, their families, carer(s), independent advocates and wider health system (including local Healthwatch and Integrated Care Boards).
- Incorporating the learning from the analysis of locally managed data into the further revisions and developments of the policy. Learning from the data should also be used to aid innovation and the adoption of alternative measures and interventions that promote the support of and de-escalation of a person's distress.

Further links and resources:

- Equality and Human Rights Commission, Public sector equality duty. https://www.equalityhumanrights.com/guidance/public-sector-equality-duty-psed
- NHS England, Accessible information standard. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

Requirement P:

Details on how the organisation or trust will work to coproduce policies with their local patient populations to reflect their needs and experiences.

Key considerations:

- Committing to the responsible person's remit to include the meaningfull coproduction of the policy with people who may, and have been subject to, the use of force, their parent(s), families, carer(s), independent advocates and representatives.
- Coproducing with a 'team' comprising representatives of all those with a key interest in preventing, reducing and minimising the use of force. This must include a 'responsible person' (see statutory guidance, section 2) who is 'employed by the relevant health organisation and is 'of an appropriate level of seniority'.
- Ensuring the team is diverse and includes professionals and those with lived experience, such as those subjected to the use of force and restraint (current and former patients), their families and carers, bereaved families, any relevant local third sector organisations and local Healthwatch as a statutory body for patients and the public. According to the statutory guidance, women and girls, people from black, racially and ethnically minoritised backgrounds and disabled people should also be involved because of the disproportionate impact of the use of force on them. Staff at various organisational levels should be involved, with the perspective of those who directly support people listened to. People who are in positions of governance and strategic oversight within the service or organisation should also be involved.
- Committing to equity between team members. The team must be facilitated in a way that enables everyone to contribute to the policy development. Within this approach, information, communication and participation methods should be adjusted to support people's participation according to their needs (e.g., English as an additional language or those who have a learning disability and/or autism). This may include using communication friendly strategies that people find helpful (i.e., visually supported or easy read information, allowing extra preparation or processing time).

Key considerations (continued):

- Ensuring that people with lived experience, their parent(s), families, carer(s) and independent advocates are involved from the initial conception of the policy development, through to completion, implementation and in their review, evaluation and updating, including through representation on relevant governance and oversight panels and boards. This would include considerations and commitment to include wider populations in the consultation and review of the implementation of the policy beyond a core team (and specifically those from groups who are at higher risk of being subject to the use of force).
- See also the sections above and below where coproduction is mentioned as a focus on the development of other specific features of the policy.

Further links and resources:

- NDTi, Embedding co-production in mental health: a framework for strategic leads, commissioners and managers. https://www.ndti.org.uk/assets/files/MH_Coproduction_framework.pdf
- Skills for Care with NDTi, Co-production in mental health: not just another guide. https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Learning-disability-and-mental-health/Co-production-in-mental-health.pdf
- Restraint Reduction Network, Working alongside people with lived experience (experts by experience). Principles for ensuring respectful and fair co-working. https://restraintreductionnetwork.org/wp-content/uploads/2019/11/Co_Working_CoP_Guidelines_07_09_19_1-1.pdf

Requirement Q:

Details of how the policy will be publicised and communicated.

Key considerations:

- Publishing the details of the policy using accessible information and alternative communication in a range of formats (as required as a minimum under the Accessible Information Standard). This includes duties under the Equality Act 2010 for reasonable adjustments. The policies should also be published in a range of accessible formats (e.g., as easy read) and languages (i.e., British Sign Language), according to the needs of the local population being served.
- Also see above requirements where accessible communication of the policy to people who may be subject to the use of force, their parent(s), families, carer(s) and independent advocates is embedded in policy activity and implementation (such as post incident debriefings or information on the person's rights).
- Training all staff on how to communicate details about the policy in everyday service interactions, and at points of service transitions (admissions, change in wards or services, change in medication or treatment plans, and as part of routine therapeutic support). Additionally, making understanding the policy and clearly communicating it to people who may be subject to the use of force, their parent(s), families, carer(s) and independent advocates a requirement of the implementation of the policy. This training of staff must also cover arrangements for clearly communicating internally about expectations of staff working within the organisation, including bank and agency workers and external contractors.

Further links and resources:

- NHS England, Accessible information standard. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/

Requirement R:

Detail of the principles of staffing for safe and effective care. Having the right number of staff with the right knowledge, skills and experience in the right place at the right time and the impact this can have on reducing the use of force.

Key considerations:

- Complying with NICE guidance [NG10] on staff:patient ratios, sufficiency of staff training (see also Restraint Reduction Network (RRN) Training standards and principles) and staff safety measures when considering and implementing restrictive interventions and the use of force in mental health settings.
- Ensuring that there are sufficient and safe staff levels (including the right mix of expertise and professionals) in services. Sufficient staff and the right staff mix enables a focus on the relational elements of care, including building trusted, respectful, dignified and therapeutic relationships between staff and people who may be subject to the use of force. Meaningful, therapeutic relationships can heal and benefit support for a person's distress. Relationships can also mitigate the impacts of institutionalisation, compulsory detention, prevent retraumatisation and address the effects of interpersonal trauma. Lower levels of staffing, high staff turnover, use of agency, temporary and/or external staff, insufficient balance of clinical expertise (the right knowledge, skills and experience), and insufficient training of staff, can all mean that there is less time and capacity available for therapeutic support and more of the focus is on behavioural and condition management. This contributes to delays in de-escalation, unnecessary escalations in distress and increases the risk of the threat or use of force. Insufficient training and staffing levels can also lead to situations where a use of force is applied without adequate and routine supervision, observation and support, which can result in disproportionately and unsafe practices that increase injury or death to the person and/or the members of staff.
- Committing to effective training, support and supervision arrangements for staff to understand the therapeutic relationships they are engaging in with people who may be subject to the use of force and challenging prejudice, discrimination, assumptions and miscommunications that may arise from some people's communication of their distress. Further, the policy should include clear escalation processes that enable staff to raise concerns about staff and sufficient staffing, and the impacts on the use of force and detail on how this will be considered and addressed by the responsible person, the senior leadership and the board or governance of the organisation.

Key considerations (continued):

- Setting out the additional arrangements that will be put in place to assure safety and to minimise and reduce the use of force in situations where agency, temporary staff and external agencies are used to provide support and services. These additional arrangements should also include mechanisms whereby concerns about the safety and sufficiency of staffing, training, skills and experience can be reported, reviewed and acted upon by the responsible person, senior leadership and the governance structure. This includes assuring the safety of staff and putting arrangements in place for those staff who would be at risk of increased harm (i.e., pregnant staff, those recovering from injury or staff with disabilities) if they were required to use force as a result of insufficient levels of quality of staffing or unsuitable clinical and therapeutic environments.

Further links and resources:

- Care Quality Commission, Brief guide: staffing levels on mental health wards. https://www.cqc.org.uk/sites/default/files/20180705_9001477_briefguide-staffing_levels_mental_health_wards_v1.pdf
- NICE, Violence and aggression [NG10]. https://www.nice.org.uk/guidance/ng10/chapter/1-recommendations
- National Collaborating Centre for Mental Health, What staffing structures of mental health services are associated with improved patient outcomes? A rapid review. https://www.england.nhs.uk/wp-content/uploads/2022/03/Safer_staffing_mental_health_evidence_review.pdf
- NHS England, Mental health staffing framework. https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf
- Restraint Reduction Network (RRN), Training standards. https://restraintreductionnetwork.org/wp-content/uploads/2023/10/RRN_standards_v9_accessible_PDF_updated.pdf

Requirement S:

Recognition of the emotional impact the use of force has on staff and how they will be supported.

Key considerations:

- Providing access to NHS staff mental health and wellbeing hubs and where required, independent (of the service) support through counselling, psychotherapy and psychology services relating to the staff experience of applying the use of force. For many staff, applying (or witnessing the application of) the use of force can be emotionally distressing in and of itself, as it involves physical intervention on a person who is in distress. This can result in feelings of guilt and shame, through the retriggering memories of when they have been subject to restriction, coercion and control in their lives and relationships, or have been the victims of violence themselves.
- Providing sufficient supervision, reflection, personal and professional development (including within appraisals, professional development plans and Continuing Professional Development) to ensure that the emotional impacts on staff are attended to. This would include addressing secondary traumatic stress or vicarious trauma, where staff might experience traumatic stress impacts through exposure to a patient being subject to the use of force (and especially in situations where there is harm, injury or death). It would also include addressing workplace stress and compassion fatigue, which would increase the risk of the application of the use of force and non empathetic relating and responses to a patent's emotional distress.
- Incorporating into staff training a meaningful understanding of the ways in which the use of force may emotionally impact staff. This would include practical ways staff can manage these impacts, ways of raising concerns about the emotional impacts on themselves and others, and practical support offered by the organisation. This could also include a more specific consideration of how the staff member's own protected characteristics might intersect and impact their experience of applying or witnessing the application of the use of force. For example, the training might describe how staff from black, racially and ethnically minoritised communities might be impacted by seeing patients with the same or similar heritage being subject to the use of force given concerns over the prevalence of racism within health inequalities, the NHS and wider society.

Further links and resources:

- NICE, Post-traumatic stress disorder [NG116]. https://www.nice.org.uk/guidance/NG116
- The contribution of organisational factors to vicarious traumatisation in mental health professionals: a systematic review and narrative synthesis. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8820814/
- Vicarious traumatization: implications for the mental health of health workers? http://svri.org/sites/default/files/attachments/2016-01-13/1-s2.0-S0272735803000308-main.pdf
- Compassion fatigue among healthcare, emergency and community service workers: a systematic review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4924075/

Requirement T:

Details of how healthcare staff and the police will work together to manage incidents of use of force if (in exceptional circumstances) thepolice are called to assist in the management of a patient. This should refer to The College of Policing 'Memorandum of Understanding' – The Police Use of Restraint in Mental Health and Learning Disability Settings.

Key considerations:

- Ensuring the policy contains principles and procedures developed for police involvement in the management of incidents and making these focused on the support of distress, de-escalation and the minimisation of the use of force (and the use of the least restrictive option available). These principles and procedures should be (as required) child centric, needs focused, and culturally sensitive. This must be compliant with the Human Rights Act 1998 and incorporate the local operating protocols set out in the College of Policing Memorandum of Understanding and be informed by the National Partnership Agreement and Right Care Right Person toolkit. This would include clear descriptions of both the organisation's and police force's commitment to avoid and minimise the use of force in the service and the agreed local protocols, roles and responsibilities between the organisation and the local police force on entry to and interventions in the service. This must include an assurance of clinical oversight and observation of all use of force by the police whilst in the service.
- Publishing accessible information about police involvement for people who may be subject to the use of force, their parent(s), families, carer(s) and independent advocates. This should include information about the person's rights and protections in relation to intervention by members of the police.
- Including in individual care, treatment, crisis plans and Advance Statements, the agreed situations in which the police may be called to assist in an incident and noting any existing distress, trauma or 'critical incidents' relating to interactions with the police. For example, if the person was brought to the health based Place of Safety by the police under duress (under Section 135) and detained without their consent under the Mental Health Act 1989. Further, there should be specific preventative and mitigation strategies in place in situations where there has previously been police involvement that was distressing or traumatic for the person.
- Undertaking joint post incident reviews (also see above requirements) and meaningfully including the person who has been subject to the use of force, their parent(s), families, carer(s) and independent advocates in these.

Further links and resources:

- College of Policing, Memorandum of Understanding' – Police use of restraint in mental health and learning disability. https://rcem.ac.uk/wp-content/uploads/2021/11/Police_Use_of_Restraint_in_Mental_Health_and_LD_Settings.pdf
- Home Office, Department of Health and Social Care, National partnership agreement: right care, right person (RCRP). https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp
- College of Policing, Right care right person toolkit. https://www.college.police.uk/guidance/right-care-right-person-toolkit
- College of Policing, Mental health – detention. https://www.college.police.uk/app/mental-health/mental-health-detention
- College of Policing, Introduction and types of critical incidents. https://www.college.police.uk/app/critical-incident-management/introduction-and-types-critical-incidents

Requirement U:

Details of how often the policy will be reviewed and by whom. This should include the role for patients, their families and carers in providing ongoing feedback for the life of the policy to inform any changes.

Key considerations:

- Designing a dynamic policy that is kept under regular review and can be easily amended and updated based on its operational effectiveness. It may therefore be different from other existing organisational policy formats and development processes, rather than be required to be restricted and conform to them. As required by the statutory guidance, the policy should be reviewed, reported upon and discussed by senior management and the governance body of the organisation ensuring the full support of the responsible person.
- Involving relevant people (people who have been subject to the use of force, their parent(s), carer(s), families, independent advocates) and local Healthwatch in the iterative review process, drawing on lived experience and insight to review the effectiveness of the policy. This would include the feedback and data inputs (i.e., complaints and incidents data) mentioned previously in the requirements above. Within this, setting out clear roles and responsibilities and accessibly outlining how involvement in the review will lead to change in the policy and its implementation. This may include a full coproduction of review of the policy and a codesign of new measures to enhance its effectiveness and/or address concerns about progress on reducing and minimising the use of force.
- Publishing accessible summaries (in compliance with the Equality Act 2010 and the Accessible Information Standard) of the review of the policy, the process involved and the changes that have been made to the policy and in practice.
- Coproduction must be thoroughly embedded into the above processes and aspects of the work led by those with lived experience. A relational approach should be taken with a focus on the timely, meaningful inclusion of people in areas of work they have experienced and find interesting. This does not necessarily mean the sharing of power or the hierarchical application of the coproduction ladder (Arnstein, 1969). Rather it means honouring people's agency, autonomy and right to be self-determining in the ways they choose to express their lived experiences by developing people's power-from-within (see RRN, 2022).
- Supervision and regular feedback should be sought throughout the coproduction process in safe spaces. A coproduction evaluation tool can be found in the RRN's relational model of coproduction resource.

Further links and resources:

- Arnstein, S (1969) 'A ladder of citizen participation', *Journal of the American Institut e of Planners*, 35: 216–24.
- NHS England, How co-production is used to improve the quality of services and people's experience of care: a literature review. https://www.england.nhs.uk/long-read/how-co-production-is-used-to-improve-the-quality-of-services-and-peoples-experience-of-care- a-literature-review/
- NHS England, Co-production and quality improvement – a resource guide. https://www.england.nhs.uk/long-read/co-production-and-quality-improvement- a-resource-guide/
- Restraint Reduction Network, (2022). The RRN relational model of coproduction. https://restraintreductionnetwork.org/wp-content/uploads/2023/11/Booklet-on-Coproduction-FINAL.pdf

In addition to the above requirements, the policy should note the intentions in England to reform the Mental Health Act 1983. As such, it should be moving towards compatibility with the proposals set out in:

- the Government's Reforming the Mental Health Act (white paper) https://assets.publishing.service.gov.uk/media/5ffc7d65d3bf7f65d55056a6/mental-health-act-white-paper-web-accessible.pdf
- The Mental Health Bill 2022 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1093555/draft-mental-health-bill-web-accessible.pdf

For more information about reducing and ending the use of force in mental health hospitals please visit the Restraint Reduction Network: https://restraintreductionnetwork.org/