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BRIEFING PAPER

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Mental Health Units (Use of Force) Bill 2017-19

By Elizabeth Parkin
Pat Strickland

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Summary

This House of Commons Library briefing provides information on key provisions in the *Mental Health Units (Use of Force) Bill 2017-19.*

Steve Reed MP presented the Bill on 19 July 2017, having come second in the Private Members' Bill ballot. This briefing has been prepared in advance of the Bill's second reading on 3 November 2017.

The Bill is seeking to make provision about the oversight and management of use of force in relation to patients in mental health units and similar settings.

The Bill would introduce statutory requirements in relation to the use of force in mental health units. It would require service providers to keep a record of any use of force, have a written policy for the use of force, commit to a reduction in the use of force, and provide patients with information about their rights.

The Bill would require a provider to notify the Secretary of State for Health, within seven days, of a death that occurred during, or as a result of, a patient being subject to the use of force whilst in a mental health unit. On being notified of such a death, the Secretary of State would be required to appoint an independent person to investigate the death and produce a report.

It would also place a new duty on the Secretary of State to produce an annual report on the use of force at mental health units during each calendar year. At present, data is not routinely published on this.

The Bill also makes provision about the use of body cameras worn by police officers who attend mental health units for any reason.

Steve Reed MP introduced the Bill after a constituent, Olaseni Lewis, died in a mental health unit. The patient had been physically restrained by police officers. Mr Reed said:

> Seni Lewis was a young man from Thornton Heath with his whole life ahead of him. But he died after his parents took him to hospital for help when he showed signs of mental ill health. Instead of receiving the care and understanding he needed, he was subject to severe physical restraint by 11 police officers until he stopped breathing. I want Parliament to pass Seni's Law to make sure the serious mistakes that led to Seni's death can never happen to anyone else.[1]

The Bill will apply to England only.

[1] Steve Reed MP, Steve launches Seni's law to protect mental health patients, 21 July 2017

1. Background on the use of force

1.1 Use of force in mental health units

Mental Health Act 1983: Code of Practice

The *Mental Health Act 1983: Code of Practice* (the Code) provides statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder.

It provides guidance on restrictive interventions for people receiving treatment for a mental disorder in a hospital. This applies to all people receiving treatment for a mental disorder, whether or not they are detained under the *Mental Health Act*.

The Code states that when restrictive interventions are required, they should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.[2]

It also states that service providers should have programmes in place to reduce the use of restrictive interventions.

The Code requires that all hospitals should have a policy on training for staff who may be exposed to violence or aggression in their work or who may need to be involved in the application of a restrictive intervention.[3]

The Code's section on physical restraint says that if physical restraint is necessary, patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. Full account should also be taken of their physical health, and staff should constantly monitor their airway and physical health throughout the intervention.[4]

The Code also states that where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response.[5]

Positive and Safe programme

In April 2014 the Department of Health launched the Positive and Safe programme, which aims to reduce use of restrictive interventions across all health and adult social care.

As part of this, the Department of Health published new guidelines on ending the deliberate use of face-down-restraint for people receiving care. Positive and Proactive care: Reducing the need for restrictive interventions, provides non-statutory guidance for adult health and social care staff to develop a culture where restrictive interventions are

2 *Mental Health Act 1983* Code of Practice, January 2015, para 26.37
3 *Mental Health Act 1983* Code of Practice, January 2015, para 26.175
4 *Mental Health Act 1983* Code of Practice, January 2015, para 26.71
5 *Mental Health Act 1983* Code of Practice, January 2015, para 26.72

only ever used as a last resort, and only then for the shortest possible time.

The Department of Health has said that guidance will inform the CQC's programme of regular monitoring and inspection against CQC standards.

It identifies key actions that aim to better meet people's needs and enhance their quality of life, reducing the need for restrictive interventions.

The key actions for improving care:

a. Staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface, not just on the floor.

b. If restrictive intervention is used it must not include the deliberate application of pain.

c. If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.

d. Staff must not use seclusion other than for people detained under the Mental Health Act 1983.

e. People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.

f. Individualised support plans, incorporating behaviour support plans, must be implemented for all people who use services who are known to be at risk of being exposed to restrictive interventions.

The guidance specifically says that face down restraint should not be used:

> People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.[6]

The guidance also introduced new monitoring and governance mechanisms to hold services to account for making these improvements.

The guidance was accompanied by an investment of £1.2 million in staff training so they can avoid using restrictive interventions.[7]

The Department said that increasing concerns about restrictive interventions in health and care settings had led to the guidance, including *Transforming Care: a national response to Winterbourne View*

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6 Department of Health, Positive and Proactive Care: reducing the need for restrictive interventions, April 2014, para 70

7 Department of Health, New drive to end deliberate face down restraint, 3 April 2014

Hospital (December 2012) and *Mental Health Crisis Care: physical restraint in crisis* (June 2013) by Mind.

In February 2017, the Department of Health Minister gave an update on the implementation of Positive and Safe:

> **Norman Lamb:** To ask the Secretary of State for Health, what progress has been made on implementing the recommendations and guidance of the Positive and Safe initiative.
>
> **Nicola Blackwood:** Since the Coalition Government published Positive and Proactive Care: reducing the need for restrictive interventions in April 2014, the Department, with its partners, has taken a number of steps to implement its recommendations.
>
> These include the development of the Positive and Safe Champions Network to promote good practice in the reduction of restrictive interventions; the inclusion of information about the number and type of restraints in the Mental Health Services Dataset and the development of core standards for the training of staff in techniques of prevention and management of violence and aggression.
>
> The Department of Health and the Department for Education are working to produce, for consultation, new guidance on minimising the use of restraint on children and young people who have autism, learning disabilities or mental health issues, and whose behaviour challenges, in health and care settings and in special schools.
>
> Positive and Proactive Care introduced a requirement that services develop Restrictive Intervention Reduction Plans. These plans along with organisations' relative use of restraint in comparison with other organisations, form a key focus of the Care Quality Commission's (CQC) inspections. We expect the CQC to use its regulatory powers to ensure that services minimise the use of restraint and other restrictive interventions, including face down restraint.[8]

NICE guidance

The National Institute of Health and Care Excellence (NICE) produces national guidance and quality standards to improve health and care services. NICE guidelines are not mandatory, but provide evidence-based recommendations.

The NICE guideline on *Violence and aggression: short-term management in mental health, health and community settings* (May 2015) recommends ways to reduce the use of restrictive interventions, such as through staff training and de-escalation techniques. The guideline states that a restrictive intervention should only be used if de-escalation techniques and other preventative strategies have failed and there is a risk of harm to the service user or other people if no action is taken. The guideline states that sufficient numbers of trained staff, including a doctor trained in resuscitation, should be immediately available.[9]

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8 PQ 63005 [on mental health services: restraint techniques], 10 February 2017

9 NICE guideline, Violence and aggression: short-term management in mental health, health and community settings, p30-31, 28 May 2015

The NICE guideline advises against face down restraint, but does say it can be used if necessary, unlike the Department of Health's *Positive and Proactive Care* guidance.

The NICE quality standard on *Violent and aggressive behaviours in people with mental health problems* (June 2017) states that restrictive interventions should only be used if other preventive strategies have failed. They should be used for no longer than necessary and de-escalation should continuously be attempted.

The quality standard also recommends that people who use mental health services who have been violent or aggressive should be supported to identify successful de-escalation techniques and make advance statements about the use of restrictive interventions. If a restrictive intervention is used, the patient's physical health should be monitored during and after physical restraint.

1.2 Patients' ethnicity

There are references in the Bill to recording patients' ethnicity and ensuring that staff have training in the provisions of the *Equality Act 2010*.

Concerns have been raised in Parliament and among stakeholder groups about the disproportionate use of physical restraint on people from certain minority ethnic groups, particularly from African Caribbean communities.

Steve Reed MP has called for an enquiry into what he called the "institutional racism" in the mental health system:

> **Steve Reed MP:**
>
> […] Young black men who use mental health services are more likely than other people to be subject to detention, extreme forms of medication and severe physical restraint, and, in extreme cases, this has led to death, including that of my constituent Seni Lewis. Too many black people with mental ill health are afraid to seek treatment from a service they fear will not treat them fairly. Will the Prime Minister meet me and some of the affected families to discuss the need for an inquiry into institutional racism in the mental health service?
>
> **The Prime Minister:**
>
> [..]
>
> It is precisely because of concern about how various people were being treated within our public services that last year I introduced a racial audit of the disparity of treatment within public services. As Home Secretary, I saw this when I looked at the way that people, particularly black people with mental health issues, were being dealt with by the police and in various forms of detention. That is exactly the sort of issue that we are looking at. I am very happy for the hon. Member for Croydon North (Mr Reed) to write to me with the details of the particular issue that he set out.[10]

The Cabinet Office published the Race Disparity Audit in October 2017. The Audit found that Black Caribbean adults were the most likely to

[10] HC Deb 1 March 2017 c291

have been detained under the *Mental Health Act*[11], but did not make specific reference to the use of force in mental health settings.

A Home Affairs Select Committee report on *Policing and mental health* was published on 6 February 2015. The report highlighted concerns that black people more commonly reported the use of force:

> There are real concerns that black and ethnic minority people are disproportionately detained under s. 136. Matilda MacAttram of Black Mental Health UK said there was still a feeling in the black community that the young black men are presumed to be dangerous based on their physical appearance, and this perception determines how they are labelled and the treatment they receive. At events organised by the Centre for Mental Health to hear views on experiences of detention under s. 136, black people more commonly reported the use of force and that force was used at an earlier stage during contact with the police. Deborah Coles of INQUEST, agreed that there was a prevailing assumption that people with mental health illness would be dangerous, and that is doubled if the person is from the African Caribbean community. She said the answer was largely to do with training.[12]

A report published in 2015 by the charity INQUEST stated:

> The lack of publicly-available data is particularly concerning in relation to ethnicity where…there have been significant questions raised about an over-representation of black people in mental health settings and the coercive use of force that features in some of their deaths.[13]

Mind's report on *Mental health crisis care: physical restraint in crisis* (June 2013) and its guidance on Restraint in mental health services also raise concerns about inequalities in mental health care for people from some black and minority ethnic groups.

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11 Cabinet Office, Race Disparity Audit, October 2017, page 49
12 Home Affairs Select Committee, *Policing and Mental Health*, 6 February 2015, HC 202 2013-14, para 71
13 Inquest, Deaths in mental health detention, February 2015

2. Use of force in mental health units: Clauses 1-12

2.1 Definitions

Clause 1 of the Bill sets out key definitions in relation to the Bill's provisions. For example, a 'mental health disorder' has the same meaning as under the *Mental Health Act 1983.* A mental health unit is defined as "a hospital, independent hospital, care home or registered establishment, in England, that provides treatment for mental health disorders."

2.2 Accountability

Mental health units to have a registered manager

Clause 2 of the *Mental Health Units (Use of Force) Bill* (the Bill) would require a person operating a mental health unit to be a registered manager. Currently, in order to be registered as a provider of health or social care under the *Health and Social Care Act 2008,* the provider must appoint a registered manager – this is referred to as 'the registered manager condition.' This clause would bring mental health units within the ambit of section 13 of the 2008 Act.

Policy on the use of force

Clause 3 of the Bill would require registered managers of mental health units to have a written, published, policy on the use of force on patients, to take all reasonable steps to ensure that force is only used in compliance with that policy, and to commit to an overall reduction in the use of force. The policy would be subject to regular review and republication if amended. In preparing the policy the registered manager would be required to consult with the police in the local area and 'other persons' as considered appropriate.

At present, the *Mental Health Act 1983* Code of Practice states that health and social care providers should have policies on restrictive interventions, including how restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed, and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention. The policy should also set out local recording and reporting mechanisms around the use of restrictive interventions.[14]

The Code of Practice is statutory for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder. The Bill would place similar requirements on a legislative basis.

Information about the use of force

Clause 4 would also require registered managers to provide patients in mental health units with information about their rights in relation to the

[14] Mental Health Act 1983 Code of Practice, January 2015, para 26.7

use of force. The Secretary of State would be required to make regulations prescribing the information which must be provided. This information would include:

- The registered manager's policy for the use of force;
- The person to whom any complaint about the use of force may be made; and
- Details of organisations from which the patient can get free independent advice on the use of force.

Staff training on the appropriate use of force

Clause 5 of the Bill would require that registered managers must have a training programme for all front-line staff. This would include training in the provisions of the *Equality Act 2010* and techniques for avoiding and reducing the use of force.

Front-line staff would include all people that a registered manager 'might reasonably expect to use force, or authorise the use of force' on a patient.

The *Mental Health Act 1983* Code of Practice currently requires that all hospitals should have a policy on training for staff who may be exposed to violence or aggression in their work or who may need to be involved in the application of a restrictive intervention.[15] It also states that staff should only use restrictive interventions for which they have received training.[16]

Care Quality Commission guidance

Clause 6 would require the Care Quality Commission (CQC) to publish guidance for registered managers about the exercise of functions introduced by the Bill. The guidance may make different provisions for different cases and circumstances.

2.3 Reporting

Recording the use of force

Clause 7 of the Bill would require that registered managers must keep a record of any use of force on a patient in a mental health unit for at least 10 years. The Secretary of State would prescribe, in regulations, the information that must be contained in the record, including: the type of force used; death of, or any serious injury sustained by the patient where use of force was a contributing factor; and all efforts made to avoid the need to use restraint on the patient.

The record must also include the gender, age and ethnicity of the patient, and any other known protected characteristic, as defined by the *Equality Act 2010*.

Data is currently not routinely published on the use of force and on patients' ethnicity. See section 3.2 below for further comment on patient ethnicity and the use of force.

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15 *Mental Health Act 1983* Code of Practice, January 2015, para 26.175
16 *Mental Health Act 1983* Code of Practice, January 2015, para 26.65

Statistics prepared by mental health units

Clause 8 requires registered managers of mental health units to prepare statistics on a number of points including: the number of times force was used at the mental health unit during the previous year, and the effect of each use of force on the patient (for example, whether the patient died or sustained a serious injury).

These statistics are to be used by the Secretary of State in an annual report to Parliament (see below).

Annual report by the Secretary of State

Clause 9 would place a duty on the Secretary of State to prepare an annual report which would be laid before Parliament. The report must also include the Secretary of State's response to any findings made by a court, the CQC, or a coroner in relation to the death of a patient during, or as a result of, the use of force.

Requiring information on the use of force

Clause 10 would allow the Secretary of State to require a registered manager to provide information (of a type to be set out in regulations), that is necessary to prepare the report to Parliament.

2.4 Investigation of deaths

Clause 11 would introduce a duty to notify the Secretary of State, within seven days, of a death that occurred during, or as a result of, the deceased being subject to the use of force while a patient, and that it occurred in a mental health unit.

Clause 12 would place a duty on the Secretary of State to appoint an independent person to investigate the circumstances of a death, as notified under clause 11, who must report within three months.

Having received a report, the Secretary of State would be required to publish report within 14 days, or publish a statement that a report had been received.

Currently, section 1 of the C*oroners and Justice Act 2009* states that coroners must conduct an investigation into all deaths in state detention, including people subject to the *Mental Health Act* in hospital. However, many patients on mental health units are voluntary patients and not subject to detention under the *Mental Health Act*, so would not be automatically covered by the current requirement. However, the 2009 Act also provides that a coroner must investigate where there is reason to suspect that the deceased died a violent or unnatural death.

3. Body worn video: Clauses 13-16

3.1 The Bill

Clause 13 provides that on-duty police officers called to a mental health unit for any reason must wear a body camera, that is recording from "as soon as reasonably practicable" after the time they receive the request to attend the unit until they leave the unit.

Clause 14 sets out the rules on retention and destruction of video recordings. If there is no evidence of the use of force, the police must destroy the video "as soon as practicable after 31 days from the date the recording was made." If there is evidence of the use of force, the video must be destroyed as soon as practicable after:

- 12 months after the video was made
- The conclusion of relevant court proceedings

(whichever is later).

Clause 15 circumstances in which people have a right of access to statutory recordings. Where someone has been the subject of use of force while a patient, the recording maker must give them a copy of the recording of the use of force within 10 days of a request, for free and in a generally accessible format. This applies to their nearest relative if the patient is dead or lacks capacity, as defined by the *Mental Capacity Act 2005*.

An exception to this 10 day time limit applies if the police apply to the High Court for an order permitting the redaction of the video recording. The Court can make such an order if it is satisfied that this is necessary to protect a person's human rights. In this case, the police must provide the recording as soon as practicable after the conclusion of those proceedings.

3.2 Background

Background on the introduction of Body Worn Video (BWV) is in the Parliamentary Office of Science and Technology's POST Brief No 14, Body-Worn Video in UK Policing (September 2015).

No specific legislation was required to allow police officers to wear body cameras. The Government's general view is that "the decision to procure and deploy BWV cameras is a matter for Police and Crime Commissioners and chief officers."[17] However, the operation of body worn cameras takes place within a broader legal framework including the *Data Protection Act 1998*, the *European Convention on Human Rights*, and the *Protection of Freedoms Act 2012*. This framework is described in detail in the College of Policing guidance, *Body Worn Video*, but a broad outline is given below.

[17] See for example Written Question 8878 [on Police: Cameras] 12 September 2017

The Data Protection Act

The *Data Protection Act 1998* (DPA) regulates the processing of personal data, and this includes any recorded image that captures an identifiable individual. The person or organisation holding the data (known as the "data controller") have to comply with the eight data protection principles which the Act sets out. These include the principle that personal data should be processed "fairly and lawfully" and that it must be obtained only for "one or more specified and lawful purpose" and that it should not be further processed in a manner which is incompatible with that purpose. Further detail is in Library Briefing Paper 0830, *Data protection: access to personal information*

The College of Policing gives guidance on how the DPA applies to BWV, including that forces wishing to use body-worn video should:

- publicise this before they start doing so
- clearly label devices
- announce "where possible/practicable" to the subjects of an encounter that video and audio recording is taking place
- "Begin recordings at the start of any deployment to an incident and continue uninterrupted until the incident is concluded" [18]

The European Convention on Human Rights

The College of Policing guidance on BWV discusses the relevance of article 6 (the right to a fair trial) and article 8 (the right to respect for family and private life) of the European Convention on Human Rights. The guidance stresses that the use of BWV "must be in accordance with the law and proportionate." Case law has established that, for the purposes of the ECHR, police users have sufficient powers in common law to justify the use of BWV. However, its use "must always be justifiable, on a case-by-case basis." The guidance continues:

> In principle, the use of BWV is justifiable for preventing and detecting crime. BWV can collect valuable evidence for use in criminal prosecutions and provides a record to promote integrity and confidence in policing, and objective evidence of controversial events and interactions. It offers protection for the police and for citizens. However, a court may closely scrutinise this justification and it is essential that forces do not retain BWV recordings where there is no clear evidence of an offence, unless some other good reason exists for their retention.[19]

Protection of Freedoms Act 2012 and the Surveillance Camera Code of Practice

Part 2 of the *Protection of Freedoms Act 2012* deals with the regulation of CCTV and other surveillance camera technology and introduces the

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18 College of Policing, *Body Worn Video*, 2014 pp7-8
19 Ibid, p9

Surveillance Camera Code of Practice. A police force must consider the code and its twelve guiding principles. These include the following:

- the use of surveillance cameras must always be for a "specified purpose which is in pursuit of a legitimate aim"
- their use must "take into account its effect on individuals and their privacy, with regular reviews to ensure its use remains justified"
- there must be as much transparency in the use of a surveillance camera system as possible, including a published contact point for access to information and complaints.

Police and Criminal Evidence Act 1984 (PACE)

Whilst PACE would not cover general operational use of BWV, there are circumstances where it would apply. Section 64A of PACE allows a person to be photographed with or without their consent elsewhere than in a police station in various circumstances, for example if they have been arrested by a constable for an offence, or if they have been issued with a fixed penalty notice. PACE Code D, *(Code of Practice for the Identification of Persons by Police Officers*) would have to be followed if an material from BWV is to be used to assist with PACE Code D.

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