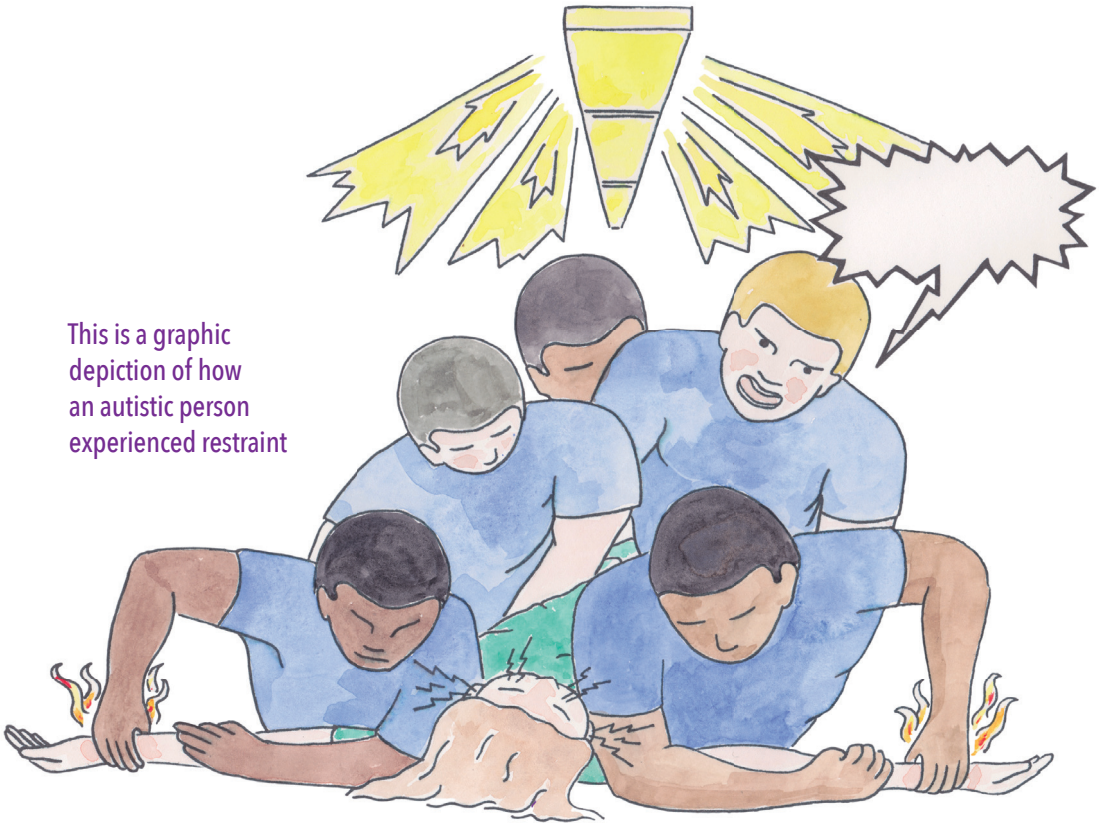
Restraint Reduction Network

Challenging restraint inequalities

Restraint inequalities are the preventable, disproportionate, and unjust use of force on certain groups of people or populations.

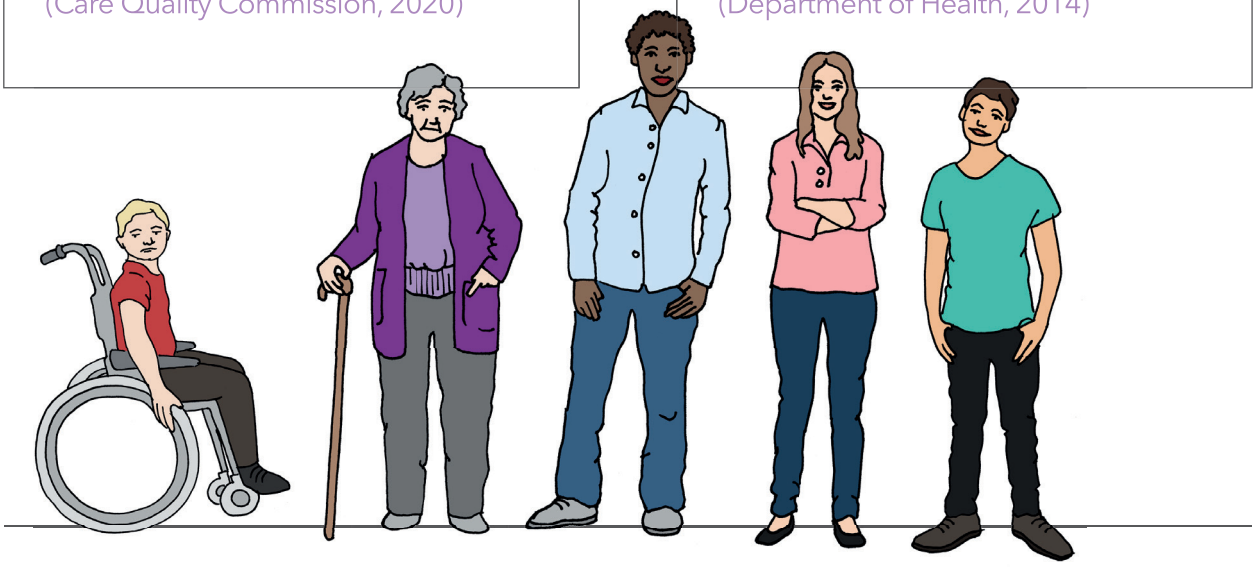


This is a graphic depiction of how an autistic person experienced restraint

Challenging restraint inequalities

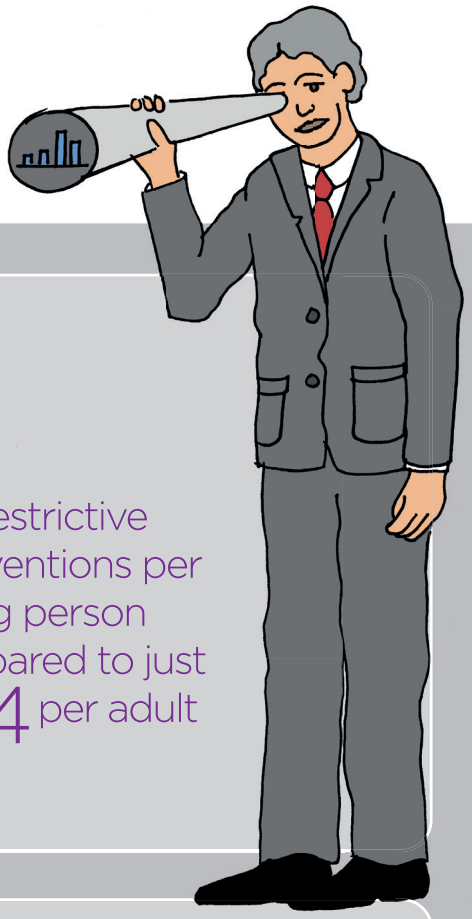
> **Restraint and restrictive practices are commonly used to manage distressed behaviour in health and social care settings**
>
> (Care Quality Commission, 2020)

> **Restrictive interventions should only be used for the shortest time possible and in the least restrictive way**
>
> (Department of Health, 2014)



However, research has shown that certain groups of people are more likely to be managed in this way than others, as shown in the table. This is called **restraint inequality**.

Data



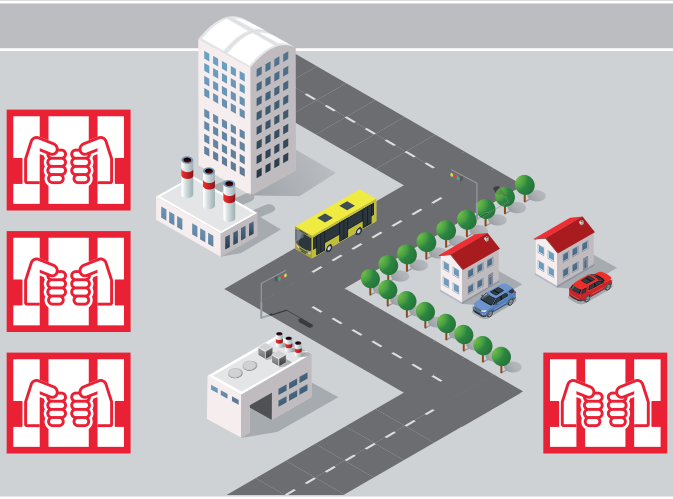
Restraint on children and young people is much higher than that used on adults averaging 16 restrictive interventions per child and young person, compared to just over four per adult *(CQC, 2022a)*.

16 restrictive interventions per young person compared to just over 4 per adult

Black people are over four times more likely than white people to be detained, have more repeated admissions and are more likely to be subject to police holding powers under the Mental Health Act *(CQC, 2022b)*.

You are 4 times more likely to be detained if you are black, compared to if you are white

People in deprived areas are three times more likely to be detained than those in the least deprived areas *(CQC, 2022b)*.



Women are more likely to be chemically restrained than men averaging three interventions per woman to one per man (MHSMS, Sept 2020-Sept 2021).

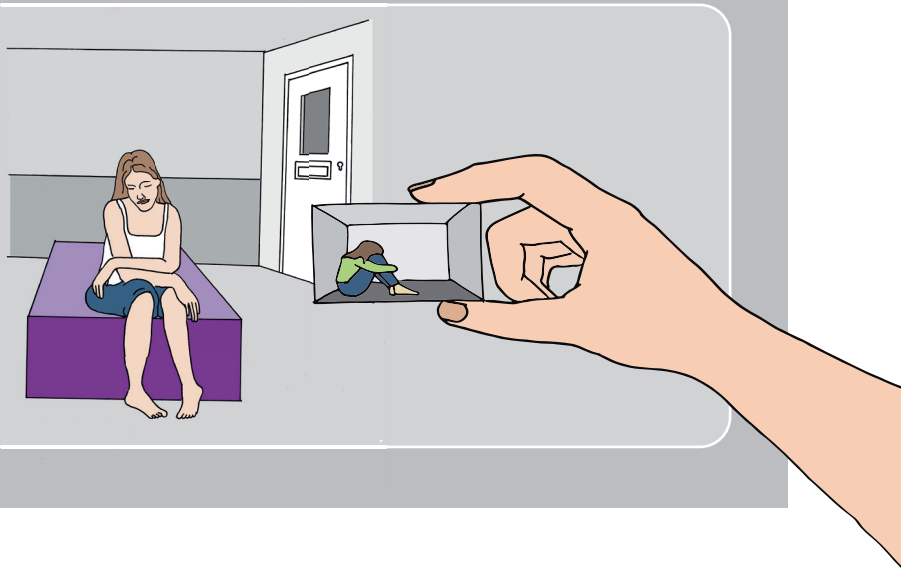
Women are 3 times more likely to be chemically restrained than men

Women are more likely to be subject to restraint in the prone position and mechanically restrained than men (MHSMS, Sept 2020-Sept 2021).

Autistic people and people with learning disabilities are likely to be detained in hospital for longer, averaging a 6-year stay (Health and Social Care Select Committee, 2021).

6 years is the average length of stay in hospital for autistic people and people with learning disabilities

Autistic people and people with learning disabilities are more likely to be subject to long term segregation than the rest of the inpatient population (CQC, 2022a).



Restraint should always be carried out in a way that protects people's fundamental human rights. Most healthcare professionals are committed to upholding the highest principles and take steps to minimise distress and deliver excellent care. So, why do some people experience more restraint and restrictive practices than others?

What causes restraint inequalities?

A significant cause of restraint inequality is unconscious bias. This can happen because of people's natural tendency for organising their social worlds into categories (eg age, gender, cultural background, body size). All humans tend to identify with certain categories, depending on the life experiences that have shaped their ideas, attitudes, beliefs, and language. These unconscious thoughts can influence how we think about certain groups of people and how we relate to them, leading to stereotyping and prejudiced views. It is therefore important for healthcare staff to be aware of the reality of unconscious bias and take steps to address it. This will ensure that everyone receives rights-respecting care and treatment.

How does unconscious bias lead to restrictive practice?

What a person thinks unconsciously can often be incompatible with their conscious values. Research has shown that even a person who is consciously committed to equality and works hard to behave without prejudice can still have biased, prejudiced, and stereotypical views (Vedantam, 2005). For example, a professional might believe consciously that people with a diagnosis of 'personality disorder' are trauma victims and are responding to horrific past events. However, they might also unconsciously view this group as attention-seeking and manipulative. Despite most healthcare professionals being committed to the wellbeing and good care of the people they support; such unconscious judgements can result in disproportionate and unnecessary restrictive practice.

Another important factor to be aware of is that stressful and emotive situations can activate people's unconscious attitudes and beliefs. This is because people think automatically, instinctively, and emotionally when they need to think fast (eg when responding to someone who is in distress). This can result in snap judgements being made and, sometimes, prejudice (Kahneman, 2011). It is important that healthcare professionals realise that this can happen so they can take steps to reduce its impact, particularly restraint inequality.

How can we address unconscious bias?

Legislation, guidance, and other literature go some way to reducing inequalities. However, on their own, they too often introduce only 'formal equality' (ie treating everyone the same, regardless of their differences), rather than 'equity' (ie recognising when those differences are becoming disadvantages).

The good news is that unconscious bias and consequent restraint inequalities can be addressed when healthcare settings and their staff take the following steps:

- Getting the culture right and creating a shared mission.
- Collecting, monitoring, and using data meaningfully.
- Being curious, open-minded, and willing to learn.
- Meeting needs in a person-centred way.
- Seeing and supporting people's identity.
- Empowering and supporting people's full participation in decision-making.

Getting the culture right and creating a shared mission

Reducing inequalities is everyone's business. It needs everyone (staff, people receiving care and their families) to work together. Services that are committed to promoting and maintaining positive and proactive cultures are key to reducing restraint inequality. It is vital that senior leaders ensure that this work goes beyond a setting's formal policies and procedures, and that they ensure what happens in day-to-day practice aligns with them.

While senior leadership is essential in setting the right tone, it is the practice leaders (ie the people 'on the floor') who can get staff thinking and feeling in a way that is consistent with policy. Good practice leaders actively seek to model good practice and encourage staff to learn. As they work alongside staff, they support their colleagues to reflect on their practice. They also work preventatively to reduce situations that rely on fast and emotive thinking. Practice leaders should encourage all team members to commit to making each other aware if they notice unconscious bias. It is important that this is done in a supportive and non-accusatory way.

The potential for unconscious bias needs to be considered when a restraint has occurred.

Practice leadership

A practice leader is a person who knows how to do something well and helps other people to do it better.

Research shows having practice leaders in services has positive outcomes in quality of life both for staff and the people they support

UK PBS Alliance

Find out more about Practice Leadership
www.bild.org.uk/uk-pbs-alliance

For more information about the role of a Practice Leader in services for people with learning disabilities
www.unitedresponse.org.uk/resource/practice-leadership/

Collecting, monitoring, and meaningfully using data

Restraint inequalities are not always obvious and are often hidden. This means it is vital for senior leaders and practice leaders to collect and analyse data regularly in a rigorous but non-punitive way. Special attention should be paid to categories such as race, gender, and disability/diagnosis. Leaders should also look at factors such as restraint usage by unit, shift day, and staff member. This will help in setting specific baselines and identify any causes for concern that need to be addressed.

Regularly gathering and analysing data in this way ensures leaders can identify any inequaities, set improvement goals, and monitor progress. It is important to look back over the data regularly to check if there are any patterns developing. It is also vital for leaders to seek the active participation of staff, the people receiving care and their families.

> Record why decisions were made and discuss these with your team in post incident debriefing.

Being curious, open-minded, and willing to learn

As previously mentioned, biased views can result in restraint inequalities. Research has shown that such bias is typically rooted in faulty information, stereotypes, and cultural ignorance (Williams, 2020).

For example, Jasmine, a young autistic child was considered,

'naughty, lazy and prone to making poor choices. The child just needs discipline.'

Yet, once staff came to understand Jasmine's unique needs and sensory processing differences, they were able to take supportive and preventative measures to avoid distress.

Training staff and supporting them in their daily practice will help them to think about marginalised groups' experiences, identity, and diversity, and to make cultural connections. Regular training on bias, protected characteristics and equality is also important, as it will help staff to understand the vulnerable details of people's lives and try to see things from their perspective. It will also help them to respond empathically, manage any feelings of discomfort that arise and develop a plan for the future that is values driven.

Meeting needs in a person-centred way

Unmet need is a major cause of predictable and preventable distress. It is therefore important for staff to avoid making assumptions and to reflect on whether a person's needs are being met in a holistic way. This means getting to know the person, finding out about their strengths, likes, dislikes and challenges, as well as ensuring they are receiving the education, health, and social care support they are entitled to.

For example, Jeffrey told us that he was 12 years old when he was admitted to hospital. He was a small boy with an active mind that needed stimulation. Without this, Jeffrey quickly became bored, which led to frustration and distress. This resulted in routine restraint and seclusion. Jeffrey was eventually long-term segregated. In this case, staff focussed on containing Jeffrey's distressed behaviour, without reflecting on the underlying predictable and preventable causes. Continued unmet need became a vicious circle of further restriction and escalating distress. Jeffrey and his family have been traumatised.

Listening to and supporting a person to participate in personally meaningful activities, which support their strengths and develop their capabilities, can significantly reduce distress. It is therefore important for staff to allow sufficient time to make decisions and work preventatively. This means getting to know the people they support, the ways they communicate and what causes them to feel dysregulated so that their needs can be met before distress occurs.

> Staff being curious about and open to new cultures, learning about differences, and exploring new ways to manage distress with groups of people, can help reduce inequalities in restraint.

Seeing and supporting people's identity

Identity is about people's views of themselves, who they are and what makes them who they are. People gain a sense of identity from feeling valued and accepted. This might include being part of a group they identify with and that understands them.

It is important for healthcare professionals to learn about, encourage, support, and accept a person's identity. Seeing the person as an individual helps to build positive relationships between professionals and the person they care for, which in turn improves outcomes.

For example, Sali a lady from the Sikh community told us that she felt unseen as an individual. It was important that her culture and beliefs were respected by staff.

"We have our own culture. If staff learnt about this and understood it then there wouldn't be so much conflict on the ward. I wouldn't have to fight all the time."

To claim her rights and make decisions, Sali instead needed to feel supported. In her case, policy was not enough. As Sali explained,

"What is experienced and felt is everything"

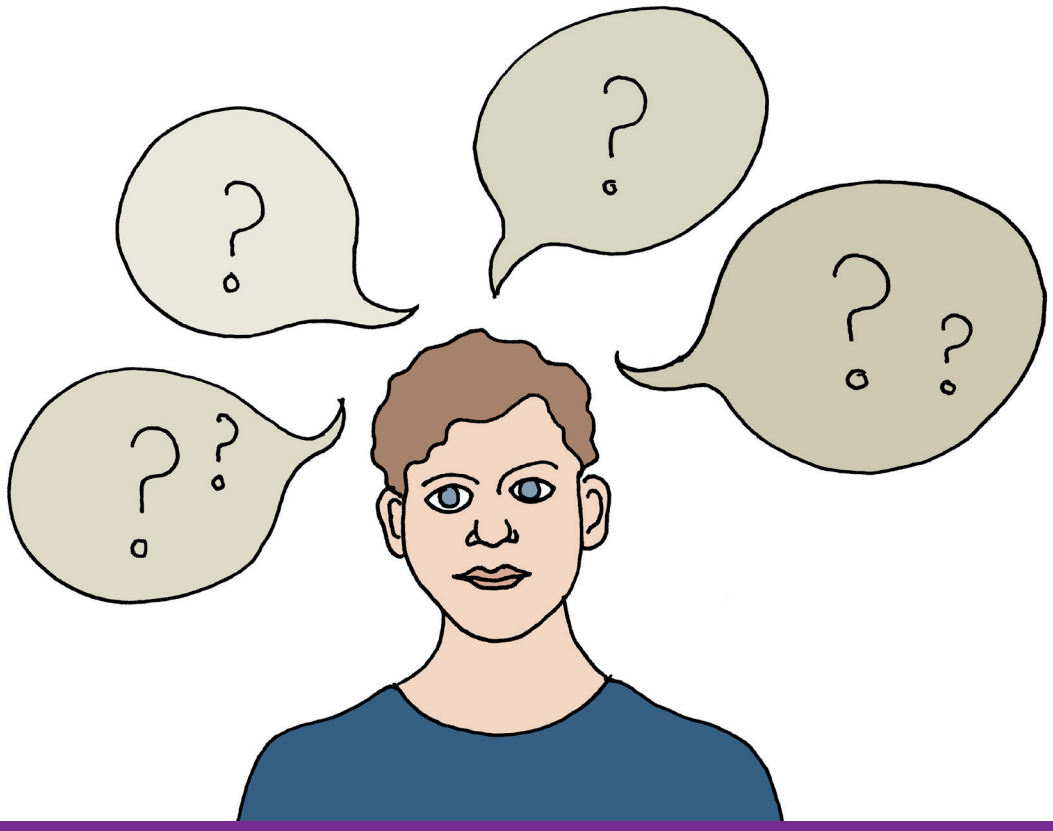
> Respecting a person's individuality is about language too. As a professional, it is crucial to reflect on how you talk to, and about people, especially if they are different to you.

Empowering and supporting people's full participation in decision-making

Everyone experiences distress if they feel unheard, isolated, and powerless. People who are cared for in inpatient settings understandably can feel this even more acutely. It is therefore important for staff at all levels to empower and support people to participate as fully as possible in their care.

Staff can do this in wide-ranging ways. For example, a healthcare worker can reflect on whether they are offering the same time and care to every person they support and take steps to address this if not. Senior leaders can improve people's rights to challenge if things are not going well. A good way to do this is to encourage people to voice their thoughts and feelings, create a space for open dialogue about inequalities and improve feedback/complaints processes. Prioritising peer-advocacy and recruiting staff that have relevant lived experience and/or are from marginalised groups can help to overcome embedded stigma and discrimination.

> A powerful way in which mental health settings can address unconscious bias is to seek and listen to the views of people receiving care (eg via peer advocacy, therapist supported 'talking mat' sessions).



Top tips to reduce restraint inequalities

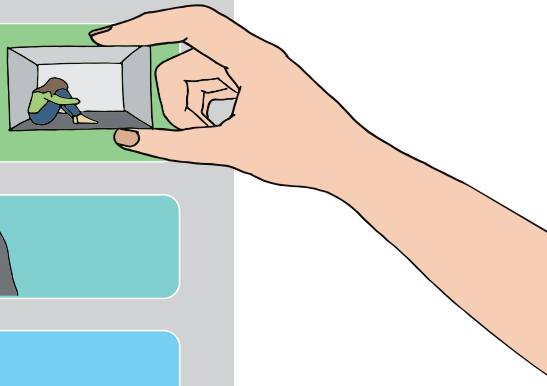
5 TOP TIPS

for challenging unconscious bias
and reducing restrictive practices

1. Accept that you are human, therefore you are biased.

2. Read about, learn from and talk to people different from you.

3. Make the invisible, visible:
   - search for your own biases.
   - reflect on your actions.



4. Act on data and evidence.

5. Validate people's experiences and feelings that might be different to yours.

References

Care Quality Commission. (2020) *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.*

Care Quality Commission. (2022a) Out of Sight – Update – final report. Available at: https://www.cqc.org.uk/publications/themed-work/restraint-segregation-seclusion-review-progress-reports

Care Quality Commission. (2022b) Annual Mental Health Act Report. Available at: https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act

Department of Health. (2014) *Positive and Proactive Care: Reducing the need for restrictive interventions.* Available at: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

Health and Social Care Select Committee. (July 2021) *The Treatment of Autistic People and People with Learning Disabilities.* Available at: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/21/2108.htm

Kahneman, D (2011) *Thinking, Fast and Slow.* New York: Farrar, Straus and Giroux.

Vedantam, S (2005) *See no bias.* Washington Post.

Williams, M (2020) *Managing Microaggressions: addressing everyday racism in therapeutic spaces.* ABCT: Oxford University Press.