Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings
And
Regional Operational Procedure for the Use of Seclusion

Equality Impact Assessment
Consultation version
June 2021

Contents

INTRODUCTION

1. Section 75(1) of the Northern Ireland Act 1998 requires public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity between specific identified individuals and groups, namely:
    - between persons of different religious belief;
    - between persons of different political opinion;
    - between persons of different racial groups;
    - between persons of different age;
    - between persons of different marital status;
    - between persons of different sexual orientation;
    - between men and women generally;
    - between persons with a disability and persons without; and
    - between persons with dependants and persons without.

2. The legislation requires public authorities to conduct an equality impact assessment (EQIA) where proposed legislation or policy is likely to have a significant impact on equality of opportunity. An EQIA is a thorough and systematic analysis of a policy to determine the extent of differential impact upon the relevant groups and in turn whether that impact is adverse.

Purpose

3. The purpose of this EQIA is to measure the impact that the Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion may have on section 75 groups and to detail the mitigating steps proposed where appropriate.

4. The Department has developed this Equality Impact Assessment to provide an opportunity to comment on the impact of the policy.

SUMMARY OF THE POLICY CONTENTS

5. In August 2005, the Human Rights Working Group on Restraint and Seclusion issued Guidance on Restraint and Seclusion in Health and Personal Social Services. The working group was commissioned by the then Department of Health, Social Services and Public Safety (DHSSPS) and the guidance was issued by the DHSSPS.

6. In the period since this guidance was issued, the issue of restrictive practices, including restraint and seclusion in health and social care services, has continued to be under discussion. In that context and as part of the Mental Health Action Plan published on 19 May 2020, the Department committed to review restraint and seclusion and to develop a regional policy on restrictive practices and seclusion and a regional operating procedure for seclusion (Mental Health Action Plan, Action 6.5). The draft regional policy is the conclusion of this work.

7. The draft policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on elimination of the use of restrictive practices and on minimising the use.

8. The draft policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions in the UK and across the world. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This will assist in protecting people, reducing the risk of misuse and potential over-reliance on restrictive practices.

9. The use of restrictive interventions, restraint or seclusion may be necessary on occasions, for example, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as a last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others. Nevertheless, some of those who have been involved with or subject to seclusion, restraint and/or restrictive interventions, recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.

10. The draft policy document sets out the standards required for: minimising the use of restrictive interventions, restraint and seclusion; and decision making, reporting and governance arrangements for the use of any restrictive practice.

EQUALITY IMPACT ASSESSMENT

Introduction

11. The draft policy provides guidance on the use of restrictive practices in health and social care settings and regional operational procedures for the use of seclusion. The policy is intended to positively impact on persons who would be subject to restrictive practices and seclusion.

12. It is expected that most people subject to restrictive practices are people who are older with dementia, people with mental ill health and people with a learning disability. All these people fall within protected Section 75 groups, in particular with consideration of age and disability.

13. The impact assessment has determined that there is a differential impact on these Section 75 groups. The impact is significantly positive and no negative impact has been identified. No mitigating actions have therefore been taken.

Religious Belief

Available Data

14. No recent research has been identified that would suggest an inequality in need or provision of service exists on the grounds of religion. It has not previously been identified as an area of concern for stakeholders.

15. Information on religious belief can be found in the 2011 Census. One sixth (17%) of the usually resident population on Census Day either had No Religion or Religion Not Stated. The figures for the main religions were: Catholic (41%); Presbyterian (19%); Church of Ireland (14%); Methodist (3%); Other Christian or Christian-related denominations (5.8%); and Other Religions and Philosophies (0.8%).

16. Bringing together the information on Religion and Religion Brought Up In, 45% of the population were either Catholic or brought up as Catholic, while 48% belonged to or were brought up in Protestant, Other Christian or Christian-related denominations. A further 0.9% belonged to or had been brought up in Other Religions and Philosophies, while 5.6% neither belonged to, nor had been brought up in, a religion.

Assessment of Impact

17. Health and social care services are available to everyone equally on the basis of clinical need. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on religious belief.

Political Opinion

Available Data

18. There is limited data available on political opinion. However, data on the first preference votes per party in the 2017 NI Assembly Elections can be used as proxy information:
    - DUP – 225,413;
    - Sinn Fein – 224,245;
    - UUP – 103,314;
    - SDLP – 95,958;
    - Alliance – 72,717; and
    - Other – 81,668.

Assessment of Impact

19. Health and social care services are available to everyone equally on the basis of clinical need. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on political opinion.

Racial Group

Available Data

20. Based on main ethnic groups, 98% of people usually resident in Northern Ireland on Census Day 2011 were White, 1.1% (19,100) were Asian, 0.3% (6,000) were Mixed, 0.2% (3,600) were Black and 0.1% (2,400) belonged to Other ethnic groups. 3.14% of the population aged 3 and over considered a language other than English as their main language.

21. Of the 98% of people who identified their ethnicity as White, almost 10% (179,000) were born outside Northern Ireland. This includes 19,300 individuals from Poland, 7,250 from Lithuania, 4,000 from the USA, 3,800 from Germany and 1,650 from South Africa.

22. The largest minority ethnic groups in 2011 were Chinese (6,300 people; up from 4,100 in 2001), Indian (6,200; up from 1,600), and Other Asian (5,000; up from 200), each accounting for around 0.3% of the usually resident population (Table DC2248NI). Including the 1,300 Irish Travellers, this means that 1.8% (32,400) of usual residents belonged to Black and Minority Ethnic (BME) groups in 2011, more than double the proportion in 2001 (0.8%).

23. This represents a significant increase over the ten years from 2001 to 2011, and it is expected that the proportion of BME residents will have increased further since 2011.

24. There is limited data on how different ethnic groups have different rates and experiences of mental health problems in Northern Ireland, as mental health services do not collect information on ethnic background. There is no data to suggest that BME groups are more likely to be subject to restrictive practices in Northern Ireland, either in mental health services or in the wider health and social care services.

25. However, figures from England and Wales show that people from BME groups are more likely to be diagnosed with mental health problems and are more likely to be subject to restrictive practices in their mental health care.

26. It is important to note that the data does not indicate a direct correlation between race and restraint/seclusion and that there may be other underlying reasons (such as poverty and social deprivation) as to why

BME groups are more likely to suffer from restrictive practices. It is also important to note that the racial profile of Northern Ireland is significantly different than in England and Wales, meaning that the facts there may not be directly applicable here.

27. In England and Wales, a considerable body of evidence has identified discernible differences in both the admission process and the mental health treatment provided to African/Caribbean people. The "Count Me In" census of patients in psychiatric hospitals (Healthcare Commission 2009) showed that a disproportionate number of people from African/Caribbean communities were detained, forcibly restrained, placed in seclusion and referred through the courts by police to mental health units. In England, there has also been concern that compulsory intervention to treat mental disorder within the community may have a disproportionate effect on individuals from BME groups (Mental Health Alliance 2009, The Mental Health Act Commission 2009). There is no evidence to suggest that this pattern is repeated in Northern Ireland for the proportion of the population (0.2%) which identified as African/Caribbean.

28. It is estimated that there are at least 11,000 people from BME groups with dementia in the UK. It is noteworthy that 6.1% of all people with dementia among BME groups are young onset, compared with only 2.2% for the UK population as a whole.

Assessment of Impact

29. The NICHI Health Alliance notes that many BME communities have close social networks which can promote health and social wellbeing, and support good mental and emotional wellbeing. However, some health issues and risk factors for ill health are more prevalent in BME communities. In addition, people from BME groups often experience difficulties accessing help and support, due to issues such as:
    - Language differences;
    - Lack of awareness and lack of appropriate information on the services available;
    - The failure of some services to meet migrants' cultural or religious needs;
    - Racism and negative attitudes; and
    - Immigration restrictions.

30. Evidence suggests individuals from BME communities may be less likely to be in contact with health services, for some of the reasons set out above. In particular, stakeholders have previously stressed the importance of taking a culturally sensitive approach to mental health. This can lead to an increase in restrictive practices when they engage with services.

31. However, health and social care services are available to everyone equally on the basis of clinical need. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on racial group.

32. Cultural sensitivity will be supported by ensuring a person-centred approach. This has been a foundation of the policy development to date, where a person's needs are considered first rather than their identity. Work to implement the policy will continue to be culturally sensitive.

Age

33. The proposed policy has a significant relevance to all age groups but is expected to have a significant positive impact on older people.

Available Data

34. Northern Ireland's average age increased from 34 years to 37 years between the 2001 and 2011 Censuses. Over the same period, the share of the population represented by children aged under 16 years fell from 24% to 21%, while the proportion of people aged 65 years and over rose from 13% to 15%.

Children and Young People

35. Figures from the 2011 census show that 64.5% of the population are between 16 and 64. Young people under the age of 16 represent 20.9% those aged 65 and over represent 14.6%.

36. Restrictive practices in health and social care services have some impact on children and young people. Where restrictive practices do take place, the new policy is expected to have a positive impact on children and young people.

Older People

37. Compared with the 2001 Census, the number of people aged 65 years and over living in NI increased by 18% (40,400) to 263,700 on Census Day 2011. Between 2002 and 2012, the number of people aged 60-84 rose by 20%, while those aged 85+ rose by 38%.

38. The number of people aged 65 and over is projected to increase to 356,000 by 2023, an increase of 35% (Northern Ireland Statistics and Research Agency 2008).

39. The Bamford Centre at Ulster University estimates that there are almost 20,000 people living with dementia in Northern Ireland. This number is estimated to treble by 2051, which is the fastest expected rate of increase in the UK.

40. Restrictive practices in health and social care services have an impact on older people, in particular those with dementia. Where restrictive practices do take place, the new policy is expected to have a positive impact on older people.

Assessment of Impact

41. It is expected that the new policy will have a differential impact based on age. Most people who are subject to restrictive practices in the health and social care services are older and have dementia. The impact of the new policy is therefore expected to have a greater impact on older people than other people groups.

42. However, the intention of the policy is to develop a new regional policy to protect people who are subject to restrictive practices. The impact is therefore significantly positive and no mitigating actions are therefore needed.

Marital Status

Available Data

43. Recent research has indicated a correlation between marital status and suicide rates in Northern Ireland (O'Reilly et al 2008, Corcoran Nagar 2009). Unmarried men over 55 and younger divorced men were shown to be at a higher risk than the population as a whole.

44. The 2011 Census data provides information on marital status. It showed that almost half (48%) of people aged 16 years and over were married, and over a third (36%) were single. Just over 1,200 people (0.1%) were in registered same-sex civil partnerships in March 2011. A further 9.4% of usual residents were either separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8% were either widowed or a surviving partner.

45. Of the population aged 16+ (1,287,211), 33.11% had never married. Almost 660,000 persons were either married or re-married (51%), while just over 100,000 were separated or divorced (8%); a similar figure were widowed.

Assessment of Impact

46. Health and social care services are available to everyone equally on the basis of clinical need. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on marital status.

Sexual Orientation

Available Data

47. There are no official statistics in relation to the size of the LGBT+ community in Northern Ireland, and little research available in terms of mental health of NI's LGBT+ population.

48. The 2012 Life and Times Survey interviewed 1,204 adults to establish their sexual orientation. 98% of respondents identified themselves as Heterosexual/Straight, 1% as Gay/Lesbian, and 1% provided No answer/Refusal. Figures published by the Office of National Statistics in 2010 recorded that 0.9% of the UK population identified themselves as gay or lesbian, while a further 0.5% identified themselves as bisexual (Measuring Sexual Identity: An Evaluation Report).

49. There is no indication that people are experiencing restrictive practices based on sexual orientation. However, it is known that LGBT+ people are over-represented in mental health services, where restrictive practices are common. Of the 75% of respondents who accessed general mental health services, 63% experienced one or more negative interactions. In terms of future use, only half of respondents stated they did not have any concerns about accessing mental health services in the future, for reasons such as:
    - Previous negative or prejudicial treatment;
    - Concern about healthcare reforms;
    - Inflexible computer systems which do not reflect trans identities and experiences;
    - A lack of trans awareness among managers and staff; and
    - A fear of being denied gender related treatment.

50. Between February and April 2017, 5,375 LGBT+ people across England, Scotland and Wales completed an online questionnaire about their life in Britain, administered by YouGov on behalf of Stonewall. Key findings from this survey in relation to mental health are as follows:
    - 52% of respondents indicated they had experienced depression in the last year;
    - 1 in 8 LGBT+ people aged 18-24 said they had attempted to take their own life in the last year;
    - Almost half of trans people who responded said they had thought about taking their own life;
    - Almost 1 in 4 LGBT+ people had witnessed discriminatory or negative remarks against LGBT+ people by healthcare staff.

51. A 2011 paper on healthcare issues for transgender people in Northern Ireland found that many respondents experienced mental health concerns at some point, with depression being the most frequent. The poor mental wellbeing was linked to adverse social experiences such as stigma, prejudice and discrimination.

52. Research in 2013 by the Rainbow Project into emotional health and wellbeing of lesbian, gay, bisexual and transgender people found that 13.5% of those asked identified as having a mental health disability. The research considered the respondents' wellbeing on the Warwick-Edinburgh Mental Wellbeing Scale, with respondents overall providing a lower score (Northern Ireland mean of 45.8) than those who are heterosexual (a score of 50). However, the scale categorises a score of 40-59 as normal. The highest scores were provided by those identifying as female (47), with male (45.4) and transgender (45.6) both scoring lower. It is worth noting that 14.2% of respondents scored a very low score (below 32), with 16% of those reporting as transgender scoring very low.

53. The research also identified those who had been diagnosed by a mental disorder:
    - Anxiety – 21%
    - Mood disorders – 25%
    - Psychotic issues – 3%
    - Personality issues – 5%
    - Eating disorders – 5%
    - Sleep issues – 14%
    - Sexual and gender issues – 2%
    - Developmental issues (including autism and ADHD) – 2%

Assessment of Impact

54. LGBT+ people, especially trans people, can experience more social isolation than the general population. This could make it harder for LGBT+ people who have mental health problems to get support and treatment. Later engagement with services could lead to more severe interventions when they do engage. This could lead to an over-representation in mental health services where restrictive practices are common. This, however, is an indirect impact and where it is occurring, the impact of the policy will be significantly positive.

55. As health and social care services are available to everyone equally on the basis of clinical need, there are no direct differential impacts on LGBT+ people. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on sexual orientation.

Gender

Available Data

56. The 2011 Census data showed that 49% of all usual residents in Northern Ireland are male, with 51% of the population female. In addition, a small number identify as neither male or female or both.

57. Restrictive practices are common across dementia services, mental health services and learning disability services. There are no indications that gender is a factor in the use of restrictive practices across these services.

58. However, it is accepted that to some degree, males are more likely to be subject to more severe restrictive practices than females. This is often due to the physical size and strength of the individual patients rather than the gender. In any case, as the draft policy provides new guidance on when restrictive practices are to be used, the policy is not expected to have significant differential impact based on gender.

Assessment of Impact

59. Health and social care services are available to everyone equally on the basis of clinical need. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on gender.

Persons with a Disability

60. The term disability is not always clearly defined and it incorporates a broad range of physical and cognitive limitations. The Northern Ireland Survey of Activity Limitation and Disability (2006/07) used categories based on limitations in seeing, hearing, speaking and communicating, mobility, dexterity and co-ordination, pain, chronic illness, breathing, learning, intellectual / developmental, social / behavioural, memory, emotional / psychological or mental ill health or head injury. They also allowed respondents to include other conditions that were not adequately covered by these.

61. Dementia, mental illness and learning disability can be classed as a disability.

Available Data

62. The Northern Ireland Survey of Activity Limitation and Disability (2006/07) found that 18% of the population in Northern Ireland were limited in their daily activities because of a disability or long-term condition. Prevalence rates were higher for adults (21%) than for children (6%) and the majority of respondents described more than one category of disability.

63. It has been estimated that 250,000 adults and 45,000 children and young people in Northern Ireland have a mental health problem, and about 26,500 people have a learning disability, of whom about half are aged 0-10 (DHSSPS 2008).

64. In 2011, Census data showed that just over one in five of the usually resident population (21%) had a long-term health problem or disability which limited their day-to-day activities.

65. The most common long-term conditions among the usually resident population were: a mobility or dexterity problem (11%); long-term pain or discomfort (10%); shortness of breath or difficulty breathing (8.7%); chronic illness (6.5%); and an emotional, psychological or mental health condition (5.8%).

66. The Youth Wellbeing Survey, commissioned by the Health and Social Care Board and published in October 2020, found that:

- One in eight children and young people in Northern Ireland experienced emotional difficulties, one in ten had conduct problems and one in seven problems with hyperactivity.
- One in eight young people (12.6%) met criteria for any mood or anxiety disorder.
- One in six young people (16.2%) engaged in a pattern of disordered eating and associated behaviours that might indicate the need for further clinical assessment.
- Almost one in ten (9.4%) 11-19 year olds reported self-injurious behaviour and close to one in eight (12.1%) reporting thinking about or attempting suicide.

67. Statistics for August 2020 show that 78,360 people were claiming Disability Living Allowance. 33% of claimants were under the age of 16, 2% were aged between 16 and 64, and 66% were aged 65 or over. 81% of claimants were receiving the care and mobility components, and 19% of claimants were claiming the highest rate of award.

68. Personal Independence Payment replaced Disability Living Allowance for claimants of working age on 20 June 2016. At August 2020, there were 149,360 Personal Independence Payment claims in payment. The overall award rate for Personal Independence Payment claims was 65%. 42% (62,360) of claims in payment had psychiatric disorders as the main disabling condition. 21% of claims in payment were receiving the daily living component only, 3% were receiving the mobility component only and 76% were receiving both the daily living and mobility components.

Assessment of Impact

69. People subject to restrictive practices are almost exclusively disabled. The policy is therefore expected to have a significant impact on people with a disability.

70. The policy provides new standards for the use of restrictive practices in health and social care settings and provides a new regional operational procedure for the use of seclusion. This will ensure that the use of restrictive practices is minimised and only used when absolutely necessary. It will also ensure that clear definitions are in place, and that staff are provided with clear operating guidance.

71. The policy is expected to protect people with a disability and strengthen their human rights (in particular relating to ECHR Article 2, 3, 5, 8 and 14). As such, significant positive differential impact has been identified.

72. No negative impacts have been identified and therefore no mitigating actions have been taken.

Persons with Dependents

Available Data

73. In the 2011 census, 214,000 people in Northern Ireland identified as carers. Census data from 2011 reveals that the majority of carers are within the 35–64 age band, with one third (33%) aged 35–49, and a further 31% aged 50–64. There are also a significant number of young carers (those aged under 18). For example, 6,700 young people (aged 0–17) in Northern Ireland provide between 1 and 19 hours of unpaid care per week, while a further 960 provide 20–49 hours, and 820 care for 50 hours or more. There are also 11,300 older carers (those aged 75+), more than half (52%) of whom are engaged in caring for 50 hours or more each week. Given the steady rise in population since 2011, these figures are likely to under-estimate the current position.

74. Research evidence has identified a link between caring responsibilities and mental ill health, including depression and anxiety. However, there have been no links between persons with dependents and restrictive practices.

Assessment of Impact

75. Health and social care services are available to everyone equally on the basis of clinical need. In some circumstances, restrictive practices are needed, however, there is no indication that restrictive practices are disproportionally used to this Section 75 group. The policy is therefore not expected to have any differential impact based on having dependents.

CONCLUSION

76. The central focus of the draft policy is to ensure the human rights of people who are subject to restrictive practices. As set out above and in the preceding chapters, significant positive impact has been identified in particular for the Section 75 groups of age and persons with disabilities, as well as minor positive impacts. No negative impacts were identified, and no opportunities for further improvement were identified.

77. The policy remains out for public consultation, and a suite of consultation documentation can be accessed on the Department of Health website. Comments are encouraged and welcomed in relation to the policy content and the content of this Equality Impact Assessment.

78. On receipt of all consultation responses, the Department will complete a comprehensive analysis and consider whether changes to the draft policy are required.

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