Inequity in action: why minoritised ethnic patients are more often rapidly tranquilised and what needs to change

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Mental health inpatient settings are characterised by their complexity and high-pressure nature. Nursing staff are tasked with supporting patients who may be in severe distress, often exhibiting signs of confusion, hopelessness, agitation, or unpredictable behaviours. In certain instances, service-users may be perceived as violent or as posing a risk of harm to themselves or others. Ensuring the safety of both staff and patients constitutes a primary concern, alongside the provision of compassionate and fair treatment.

Achieving a balance between these two priorities can prove challenging, particularly in crises that necessitate prompt decision-making. Restrictive interventions (RIs), including physical restraint and seclusion, are frequently employed to manage behaviours such as aggression, violence, and threats (Gerace & Muir-Cochrane, 2018). The implementation of such restrictive measures has given rise to significant ethical dilemmas, which are frequently regarded as a form of abuse and a violation of human rights (An et al., 2016).

Mental health care should be equitable, just, and free from discrimination, yet widespread evidence reveals persistent systemic discrimination within mental health systems and previous studies and blogs have called for systematic change.

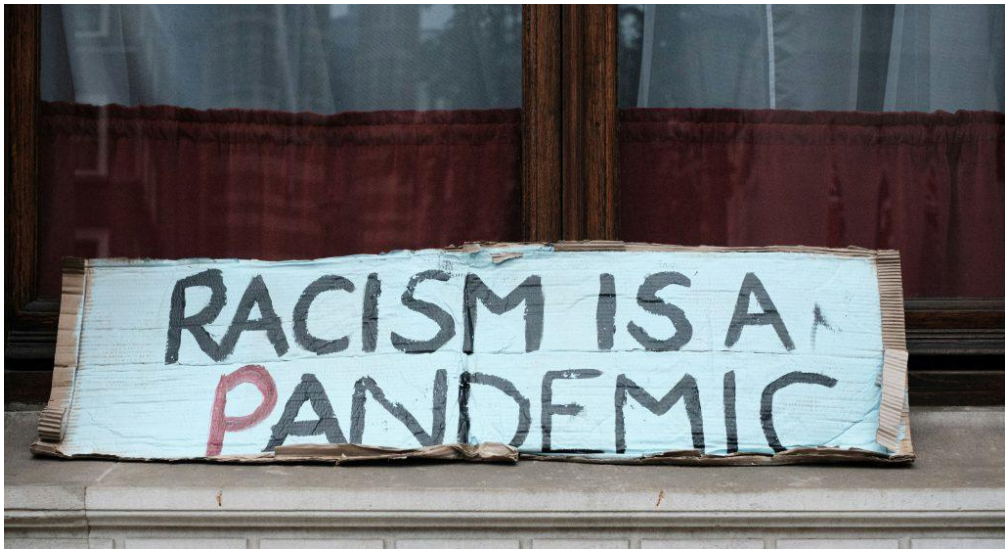
We already know:

- Black and racialised groups are also more likely to experience compulsory detention under the Mental Health Act compared to their White British counterparts. In 2020-2021, Black or Black British individuals were detained at four times the rate of white individuals, with mixed ethnicity groups detained at 1.8 times and Asian or Asian British individuals at 1.2 times the rate (UK Parliament POST, 2022).

- Community Treatment Orders are applied to the 'Black or Black British' group at a rate more than 11 times higher than that of the white population (NHS England, 2022)
- Black Caribbean, Black African, and South Asian individuals are also more likely to face coercive pathways to care, such as detention and police involvement, and are less likely to receive GP referrals compared to their white counterparts (Halvorsrud et al., 2018).

These disparities reflect systemic barriers, including rigid rules, risk-averse cultures, and task-focused care, which limit access to psychosocial support (Bansal et al., 2022). Clinicians, often pressured by these systems, may default to restrictive practices, like restraint or involuntary treatment, instead of exploring alternatives and more supportive/pro-active interventions (Cook et al., 2017).

Rapid tranquilisation (RT) is the practice of administering strong and fast acting sedatives to calm patients when other de-escalation techniques have failed and is the most common form of restrictive intervention (Belayneh et al, 2024). Research has repeatedly shown that coercive interventions, including RT, physical restraint, and seclusion, are disproportionately used on ethnic minority patients when compared to their white counterparts (Barnett et al., 2019; Singh et al., 2015). A recent systematic review and meta-analysis by Pedersen et al. (2025) further examines whether ethnic minority patients in mental health hospitals are more likely to be given rapid tranquilisation than white patients.



Widespread evidence reveals persistent systemic discrimination within mental health systems.

Methods

Pedersen et al. (2025) conducted a systematic review and meta-analysis. To find relevant studies, the researchers searched six major academic databases, focusing on research that explored the link between ethnicity and rapid tranquilisation (RT) use in adult mental health inpatient settings, bringing together data from 15 studies. This approach allows researchers to identify patterns across multiple studies, rather than relying on a single dataset. The review followed Cochrane and PRISMA guidelines, ensuring a rigorous and systematic analysis of the evidence.

The primary outcome was the association between ethnicity and receiving RT and the secondary outcome was receiving RT more than once. Sensitivity and subgroup analyses were completed to explore the risk of bias and the influence of different study characteristics including gender, age and admission status on outcomes.

Results

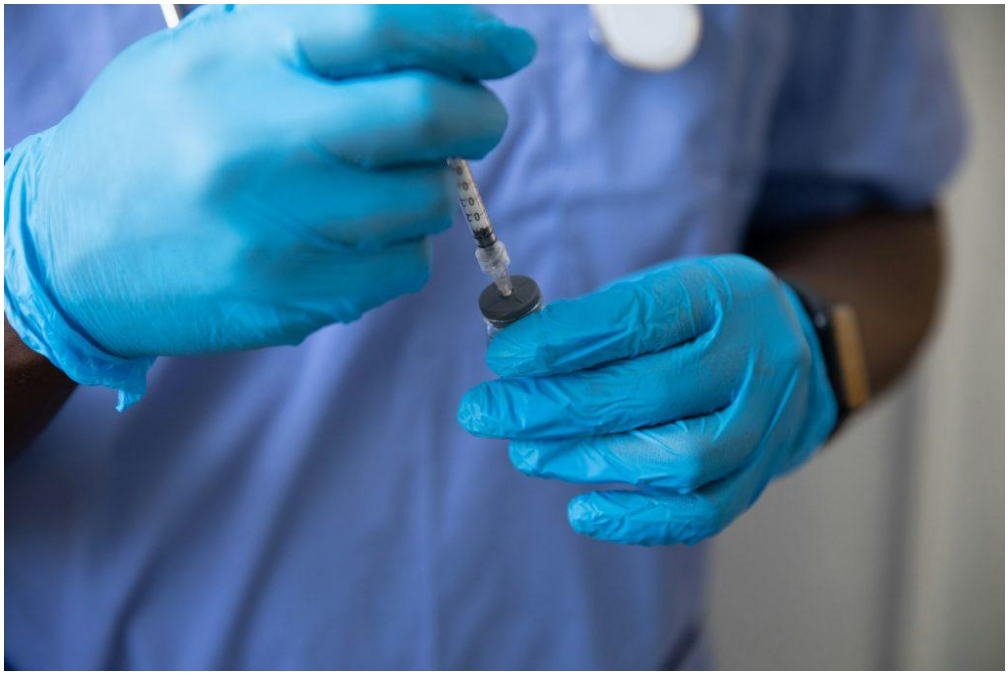
Included studies were all from European countries, with findings published between 2004 and 2019. Half of the total of 38,622 people in included studies were female and over 80% were admitted to hospital on a voluntary basis.

The meta-analysis found that people from ethnic minority backgrounds were significantly more likely to receive rapid tranquilisation than those from majority ethnic groups. The odds were 49% higher (OR = 1.49, 95% CI: 1.25 to 1.78), which corresponds to a 32% higher relative risk (RR = 1.32, 95% CI: 1.17 to 1.48).

This confirms previous research showing that coercive interventions, including forced medication, physical restraint, and seclusion, are disproportionately used on minoritised ethnic community patients (Barnett et al., 2019). These findings did not vary considerably as a result of the sensitivity or subgroup analyses undertaken.

Only two of the included studies provided possible explanations for the disparities observed. These included unequal treatment by staff, institutional racism and cultural awareness, but these suggestions were speculative and not supported by data.

Overall, the study does not fully explain why these disparities exist. While factors such as implicit bias, cultural misunderstandings, and systemic inequalities are likely to play a role. Further research, particularly qualitative studies focusing on patient and staff perspectives is needed to gain a deeper understanding of the problem.



The meta-analysis found that minoritised ethnic community patients were 32% more likely (relative risk) to receive rapid tranquilisation than white patients.

Conclusion

- Pedersen et al. (2025) provide strong evidence that minoritised ethnic community patients are more likely to receive rapid tranquilisation (RT) than white patients in mental health hospitals, but the authors also call for further research to better understand what is happening behind the data.
- **Their findings align with existing research on racial disparities in mental health care, reinforcing concerns about existing inequality.**
- The study also adds to the growing body of evidence that restrictive practices in mental health care need urgent reform.

Strengths and limitations

One of the biggest strengths of this study is that it is the first large-scale review to examine ethnicity and rapid tranquilisation (RT) use in adult mental health hospitals. The use of strict PRISMA guidelines and a meta-analysis approach also strengthens the reliability of the findings, as does the careful application of sensitivity and subgroup analyses to strengthen the validity of findings.

However, as with any research, there are limitations. Most of the studies came from Europe, meaning that we don't know if the same disparities exist in other parts of the world, which limits generalisability.

The study also relied on statistics rather than personal experiences, making it difficult to fully understand the reasons behind RT disparities, meaning that where studies did

consider possible explanations these were speculative. Another limitation is that the researchers excluded non-English and non-Scandinavian studies, which may have led to selection bias and an incomplete picture of the issue (Munn et al., 2018).

While this study clearly highlights disparities, further research is needed to explore intersecting factors that influence restrictive interventions, including gender, diagnosis, social determinants, and importantly, decision-making processes prior to an intervention (what information is used, how are decisions arrived at and why).

The study relied on statistics rather than personal experiences, making it difficult to fully understand the reasons behind rapid tranquilisation disparities.

Implications for Practice

Institutional racism has been a longstanding and deeply rooted issue in the mental health system, gaining attention after David (Rocky) Bennett's death due to excessive restraint. A 2022 NHS Race and Health Observatory review confirmed persistent racial and ethnic disparities due to structural, institutional, and interpersonal racism (Kapadia et al., 2022). **Stereotyping** and **misdiagnosis** exacerbate this, leading to punitive measures, as seen in Sean Rigg's case (INQUEST, 2012; IOPC, 2023). **Racial prejudice fosters disbelief, causing patients to be treated with suspicion**.

Studies show **rigid rule enforcement and risk-averse cultures prioritise medication and restrictive practices over person-centred care**, disproportionately impacting minoritised ethnic communities who are more often subjected to coercive practices like rapid tranquilisation (RT) (Berry et al., 2025). However, debates often oversimplify the complex realities of service provision. Research on clinicians' risk management (Challinor et al., 2025) reveals fear of scrutiny can lead to risk-averse practices

favouring coercion. International experience suggests it is possible to reduce the use of coercion while not increasing the risk of violence (Heidenheim, 2016).

Pedersen et al. (2025) suggested a few possible **explanations for these disparities**, which have implications for policy and practice. One major factor could be **unconscious bias and institutional racism**. Research suggests that healthcare **staff may unconsciously perceive minoritised ethnic patients as more aggressive or dangerous**, leading to harsher interventions (Singh et al., 2020).

Another explanation could be **cultural misunderstandings**. People from different ethnic backgrounds may express distress in ways that are unfamiliar to healthcare staff, leading to misinterpretations of their behaviour (Bhui et al., 2018).

Potential approaches available now to respond include **improving cultural competence training** to help staff recognise and challenge unconscious or cognitive bias (Barnett et al., 2019). Early intervention services should be expanded to reduce crisis admissions and prevent escalation (Singh et al., 2020). Hospitals could also focus on **alternative de-escalation techniques**, such as sensory rooms, trauma-informed care, and peer support, to reduce the need for RT (Guttridge et al., 2025). However, as well as considering immediate responses we also need to be looking more deeply for potential solutions to these widely documented inequities.

From cultural sensitivity to cultural responsiveness

If we are to reduce ethnic disparities in rapid tranquilisation (RT) and other restrictive practices, we must move beyond passive “cultural sensitivity” to **active cultural responsiveness**. This means challenging biases, ensuring equal access to appropriate de-escalation strategies, and embedding cultural knowledge into clinical practice in a way that empowers rather than excludes.

While cultural sensitivity is often framed as the solution to mental health care disparities, too often it can be **used to rationalise disparities rather than confront them**. Minoritised ethnic communities are over-represented when applying restrictive interventions, yet rather than questioning “why”, services may point to vague cultural explanations framing certain behaviour(s) as a "preference" or "response to needs" rather than a “failure of equitable care”.

Ogunwale et al. (2023) highlight the concept of **cultural syntonicity**, where mental health practices align with prevailing cultural beliefs, meaning cultural acceptance of certain treatments can reinforce both stigma and harmful practices. When applied superficially, cultural sensitivity risks reinforcing damaging stereotypes.

Services must move beyond merely acknowledging cultural differences and instead co-create interventions with communities, ensuring care is inclusive, evidence-based, and rights-driven. Mental health professionals must be trained to recognise and counteract

cognitive biases in decision-making. Minoritised ethnic service-users must have equal access to alternative interventions, including de-escalation techniques and culturally adapted therapeutic approaches.

The findings of Pedersen et al. (2025) should serve as another wake-up call. If we are serious about reducing restrictive practices, we must confront the deeper issues of racial bias, systemic inequality, and the urgent need for genuinely equitable mental health care. This will not be achieved through simplistic debates with disciplines "othering" one another. It will require 360-degree learning, integrated care approaches, and a willingness to think differently with regards to challenging both institutional racism and the structural inefficiencies of the mental health system itself.

Responses must move away from cultural sensitivity and towards cultural awareness.

Links

Primary paper

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