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# LEAST RESTRICTIVE PRACTICES:

## An Evaluation of Patient Experiences

Dr Ada Hui

University of Nottingham | 2017



## ACKNOWLEDGEMENTS

This evaluation was funded by the Nottinghamshire Healthcare NHS Foundation Trust, and prepared in partnership with the School of Health Sciences, University of Nottingham. First and foremost, thank you to Louise Bussell, Director of Nursing, Quality and Patient Experience, and David Mason, Associate Director of Nursing, Quality and Patient Experience, for the invitation to lead this project, and to Helen Walker for organising the logistics of making this happen. Thank you also to the ward managers and teams for their time in efforts in coordinating timetables and rooms for which the interviews took place. Finally, greatest thanks to all the patients who took part in this study - whose voices form the foundations of this report - and from which work can begin towards least restrictive practices.

Dr Ada Hui  
Assistant Professor  
University of Nottingham  
May 2017



## ABSTRACT

The uses of restrictive practices have become increasingly controversial over recent decades. With an increasing emphasis in recovery orientated values and person centred care, the uses of restrictive practices have become ever more contentious. National and international policies and guidelines have called for a reduction in the uses of these practices and interventions, and emphases on 'least restrictive practices' have been outlined. The notion of 'least restrictive practices' however, is not clearly defined. Limited research has been conducted to examine the uses of restrictive practices specifically within forensic mental health services. Little is known with regards how patients perceive and experience restrictive practices within high security hospital settings. It is therefore timely to consider patient experiences of restrictive practices and interventions, specifically within the context of a forensic high security mental health hospital. This study aims to explore patients' experiences of restrictive practices and interventions within Rampton High Security Hospital.

Twenty eight interviews were conducted, with nineteen male and nine female patients. The interviews were conducted using a narrative inquiry approach in seeking the personal experiences of patients, and towards gaining a better understanding of the complexities surrounding least restrictive practices within a high security hospital context. Findings from the interviews revealed three core themes; i) patient experiences of the high security hospital environment; ii) experiences of restrictive practices and interventions, and iii) working towards overcoming trauma and adversity. Patient experiences of the high security hospital environment were narrated in terms of learning the rules of the hospital. Patient experiences of restrictive practices were spoken of both in terms of their personal involvement as well as observation of others; each of which were perceived to be traumatising and re-traumatising. Restrictive interventions were frequently perceived as punitive; either actually or inadvertently, and were described in terms of fear, anxiety and loss of dignity. In working towards overcoming trauma, patients spoke of the importance of humanity, occupation and the maintenance of relationships outside of the hospital. Findings of this report therefore highlight the importance of: i) building trust and supporting patients into this new and unfamiliar environment; ii) the maintenance of identity and relationships, and iii) being treated with dignity and humanity in overcoming past and present traumas that may be associated with experiencing restrictive practices with a high security hospital environment.



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## 1. INTRODUCTION

The uses of restrictive practices have become increasingly controversial over recent decades (Alty & Mason, 1994; The MacArthur Research Network, 2004). Training surrounding restrictive practices have differed between organisations and contexts (Ching et al., 2010; Davison, 1995; Hui et al., 2013; 2016; Parkes, 1996). Research has revealed varying rates and frequencies of restrictive practices within differing mental health environments and contexts (Heilbrun et al., 1995; Hui, 2015; Hui et al., 2013; 2016; Paavola & Tiihonen, 2010). Studies suggest differences in their indications and effects (Mason, 1993; Paavola & Tiihonen, 2010; Thomas et al., 2009). Furthermore, practitioners have questioned the safety of such methods, as well as theirs and others safety without such restrictions (Mason, 1993).

With an increasing emphasis in recovery orientated values and person centred care, the uses of restrictive practices have become ever more contentious (Duxbury & Wright, 2011; Sainsbury Centre for Mental Health, 2008; 2009). National and international policies and guidelines have called for a reduction in the uses of these practices and interventions, and an emphasis on 'least restrictive practices' have been outlined (Department of Health, 2014; Mental Health Network NHS Confederation, 2014; NICE, 2015; Sainsbury Centre for Mental Health, 2008; 2009). The notion of 'least restrictive practices' however, is not clearly defined. Limited research has been conducted to examine the uses of restrictive practices specifically within forensic mental health services (Raboch et al., 2010; Steinert & Lepping, 2009; Steinert et al., 2009). Little, if anything, is known with regards how patients experience restrictive practices within high security hospital settings, or indeed what might be perceived as least restrictive practices (Hui, 2015; Hui et al., 2013; 2016; Keski-Valkama et al., 2010). It is therefore timely to consider patient experiences and perceptions of restrictive practices and interventions, specifically within the context of a forensic high security mental health hospital.

For the purposes of this evaluation, the terms restrictive practices and restrictive interventions will be used throughout. Restrictive interventions will refer specifically to the measures that intend to control or contain patients beyond the daily norms of their hospital environment. These include the uses of physical restraint, mechanical restraint, chemical restraint (rapid tranquillisation), seclusion and segregation (Davison, 2005; Jarrett, Bowers & Simpson, 2008). Restrictive practices, by comparison, relate to the broader context of confinement, notably, the physical ward environment, ward dynamics, atmosphere and routines. These may also include and be influenced by the hospital rules, regulations and cultures, notably; the physical, procedural and relational security measures that occur within a high security hospital. As such, restrictive practices will refer to the wider context of the high security hospital environment, which may also include the uses of restrictive interventions.

## 2. STUDY AIMS AND OBJECTIVES

### 2.1 AIM

- To explore patient experiences of restrictive practices and interventions within Rampton High Security Hospital

### 2.2 OBJECTIVES

- To explore patient experiences of restrictive practices and interventions through narrative inquiry
- To improve understanding of patient experiences and perspectives of restrictive practices using thematic analysis
- To examine how patient experiences might inform the development of hospital guidelines and better practice towards least restrictive practices.

## 3. METHODS OF EVALUATION

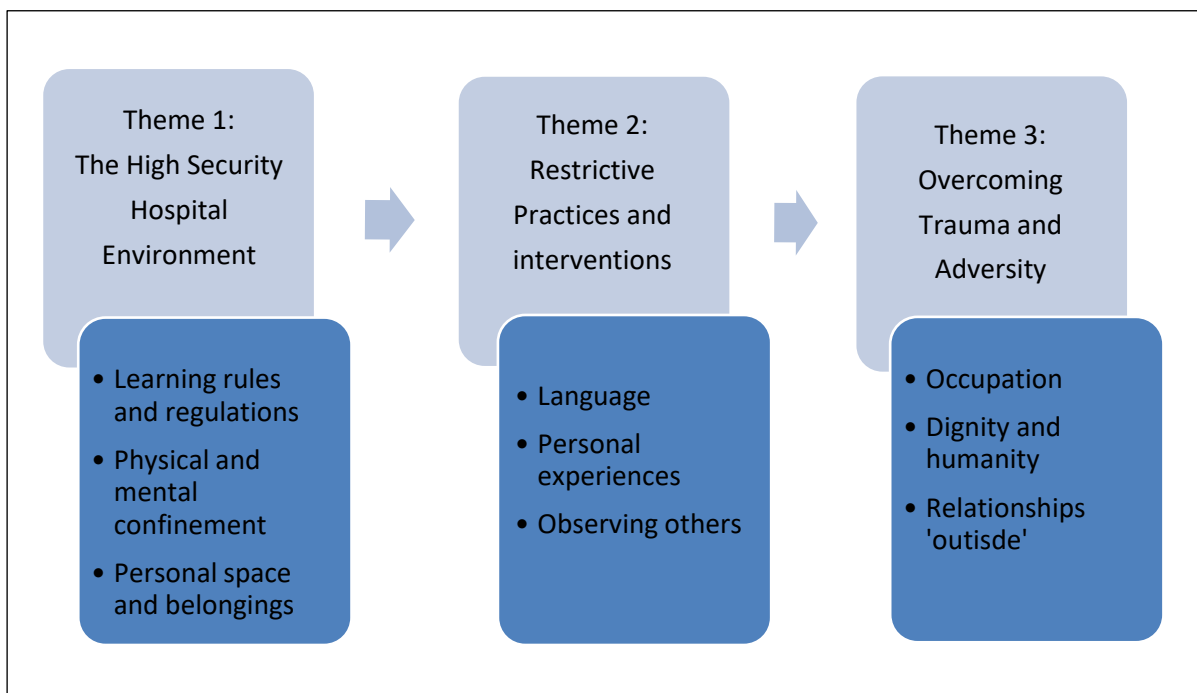
This evaluation was approved by the Research and Innovation Department, Nottinghamshire Healthcare NHS Foundation Trust. Patients across the hospital were invited to take part via their ward managers and teams. Participant information sheets were provided, opportunities for questions about the study were made available to participants and signed informed consent was gained prior to patients taking part. All patients who were resident at the hospital during the time of the study were considered eligible to take part, as long as they were able to provide informed consent. This was irrespective of their personal experiences of restrictive interventions since they were all considered to have experienced restrictive practices through being accommodated within a high security hospital environment. Twenty eight interviews were conducted between May and October 2016. Nineteen interviews were conducted with males, and nine interviews were conducted with females. These were with patients from the Mental Health, Personality Disorder, Enhanced Personality Disorder and Women's Service Directorates. Patients from the Learning Disabilities and Deaf Services Directorates did not express an interest to take part, and as such, their views and experiences are not represented in this report.

The interviews were conducted using a narrative inquiry approach. Narrative inquiry is rooted in studying lived experiences (Clandinin, 2006; Riley & Hawe, 2005; Wang & Geale, 2015). This methodological approach was used to illicit the personal and individual experiences of patients; to examine their positioning in relation to their experiences, to gain fuller understanding of their narrative accounts, and to gain greater insights into the complexities of their personal perspectives and experiences (Clandinin, 2006; Riley & Hawe, 2005; Wang & Geale, 2015). It is through this approach that the concepts of 'restrictiveness' and specifically 'least restrictive practices and interventions' might be better understood from a patient perspective. The interviews were semi-structured in nature, and topics included questions around physical restraint, mechanical restraint, rapid tranquillisation, seclusion, segregation and enhanced observations (see Appendix 1). The order of the questions were not fixed, such that there was flexibility and freedom in how patients told their stories. The topic guide, rather than interview schedule, enabled the researcher to ensure that all topics were covered and sufficient opportunities were given to prompt the participants of any topics that might otherwise have been missed.

All except one of the participants agreed to have their interview digitally recorded. For this interview, the participant agreed for notes of the interview to be logged instead. The remaining twenty seven interviews were digitally recorded, professionally transcribed, and then analysed by the researcher using a process of thematic analysis. The process of thematic analysis took place using a broadly iterative and inductive approach; moving between the digital recordings, transcripts and ideas of the participants and researcher, until core themes and ideas became apparent. These will be discussed in the following.

## 4. FINDINGS

Findings from the interviews revealed three core themes; i) patient experiences of the high security hospital environment; ii) experiences of restrictive practices and interventions, and iii) working towards overcoming trauma and adversity. Patient experiences of the high security hospital environment were narrated in terms of learning the rules of the hospital, ward dynamics, physical and mental restrictiveness, as well as the importance of personal space and belongings. Patient experiences, thoughts and feelings towards restrictive practices were presented both in terms of their personal involvement as well as observing others; each of which were perceived as traumatising and re-traumatising. Restrictive interventions were frequently perceived as punitive; either actually or inadvertently, and were described in terms of fear, anxiety and loss of dignity. Finally, patients spoke of attempting to overcome trauma through occupation, the importance of humanity and the maintenance of relationships outside of the hospital. These will be discussed in turn.



**FIGURE 1: THEMES FROM THE FINDINGS**

### 4.1 HOSPITAL ENVIRONMENT

During the interviews, patients spoke of the uncertainty of being admitted to a high security hospital, the dynamics created by those on the ward and fear of the unknown.

*“There’s certain tensions on the ward whether its created by staff or created by the staff and patients influx you know and the offences that some people have caused there’s always that kind of bridge.” (Pt1)*

*“They say an apple upsets an apple cart and if one patients got problems it send shockwaves through others and it tends to be like that especially when you are so closely confined together with each you, you know, the environment does affect individuals more than others, you know.” (Pt1)*

*“It’s complicated to start with... For me it was very confusing at that time, do you know, cos I wasn’t very well.” (Pt6)*

*“It’s a bizarre environment.” (Pt16)*

*“It was quite daunting, I was scared, I was angry and I didn’t really know what was going on” (Pt19)*

#### 4.1.1 LEARNING RULES AND REGULATIONS

Learning the rules of the hospital was spoken about in terms of the complexities of being in a new environment and learning what is and is not considered acceptable. Processes of readjustment were apparent for individuals transferred from mental health services as well as prisons, although perhaps in different ways, specifically relating to roles, identity and increased security.

*“Nobody told me what to expect, you know, your rules and regulations, and I didn’t really understand, and nobody gave me an outlay of that, you know. “ (Pt1)*

*“I didn’t really sit down and learn them; I suppose learnt when I’ve broke them.” (Pt2)*

*“There are cameras everywhere and it’s high secure which was the biggest shock when I first came because I didn’t know nothing about cameras... it’s just the shock that you’re actually camera’d while you’re living on the ward.” (Pt4)*

*“You have to readjust your way of thinking so you have to realise that you’re not in prison when you come here, you’re in a hospital and that’s the difference.” (Pt7)*

*“The routine was difficult, a lot of people had to tell me what I was allowed to do and what I wasn’t allowed to.” (Pt26)*

#### 4.1.2 PHYSICAL AND MENTAL CONFINEMENT

Patients spoke of the environment as being restrictive both physically as well as mentally, feeling confined and trapped, whilst being dependent upon others.

*“It’s just the whole layout and the confinement and close confinement... when you’re in those communal areas coping with 16 other patients sometimes it can be quite overbearing sometimes.” (Pt1)*

*“It’s very hard if you’re just trapped on the ward all the time because it is limited space in which you can move around. “ (Pt4)*

*“ I think the physical stuff I’ve got used to and the mental stuff is still very, very hard to deal with, you know, so that’s how it becomes part of your life, you just think, right I can either let this destroy me or I can just say it’s going to happen so you just get on with it.” (Pt16)*

*“Although it’s a big space it still feels very constrained especially on weekends, long weekends if you’re stuck in this environment with the same people... it just gets too much” (Pt17)*

*“We’re very dependent on other people to do things for us and it’s hard.” (Pt17)*

#### 4.1.3 PERSONAL SPACE AND BELONGINGS

As a result of the security measures and associated restrictions within the high security hospital, patients spoke of the importance of their own personal space, having their own personal belongings and having distractions as a form of escapism from the daily realities of confinement.

*“It’s good to have your own space and just reflect and calm down, and it’s about chilling out a little bit really... it does get on top of you being in there for a while” (Pt4)*

*“I’ve been up to the boiling point and the only way I cope with that is going to your room out of the way.” (Pt8)*

*“There have been times where I’m struggling with my own stuff and I don’t want to be around other patients or whatever so, you know, I can come in here and I can sit in here with my headphones on or read something and it just takes you away from other people or whatever.” (Pt15)*

## 4.2 RESTRICTIVE PRACTICES AND INTERVENTIONS

The patient narratives were revelatory of their thoughts and feelings towards restrictive practices and interventions experienced within the hospital. The language used to describe these will be presented, followed by thoughts and feelings towards different types of restrictive interventions specifically.

### 4.2.1 LANGUAGE

Nuanced language was used to describe restrictive interventions experienced by patients within the hospital. Rapid tranquillisation was frequently referred to as *‘liquid cosh’* or *‘being sticked’*, mechanical restraint was described as being *‘thrusted up like a chicken’* (Pt20) whilst physical restraint had the most varied ways of being described, including *‘twisted up’*, *‘bent up’*, *‘being folded’* and *‘eating carpet’*.

*“They call it the liquid cosh in here, that’s what they call it.” (Pt1)*

*“The problem with restraint is that they end on the floor all twisted up.” (Pt3)*

*“It’s like they’ve said relax so they’ve come into my room and four or five blokes have just basically, they say twisted, but I say folded up because I’ve let them move me out wherever they want it, do you know. So it’s twisting up where they’re using force but they didn’t have to use force.” (Pt4)*

*“That’s what we call it [seclusion], the sin bin” (Pt7)*

*“I got wrapped up to go into seclusion.” (Pt16)*

*“They came rushing over, bent us up and rubbed my head into the carpet” (Pt16)*

*“They’ve obviously got us all bent up and everything like this” (Pt16)*

*“I was for ever eating the carpet, I was for ever fighting with these guys and I was in and out of seclusion on a daily basis for years and I was using seclusion as a means of escape.” (Pt19)*

*“[I was] thrust up like a chicken.” (Pt20)*

#### 4.2.2 PERSONAL EXPERIENCES

Where patients experienced restrictive interventions, these were often felt to be traumatic, unsettling and disorientating. Patients voiced that they did not feel restrictive practices were conducive to their mental health. Patients frequently perceived these experiences as either actual or inadvertent acts of punishment that led to feelings of trauma, fear and anxiety. Experiencing restrictive interventions were also re-traumatising for many, especially for those who had previous experiences of abuse.

*“Well it is like a punishment if you’re taken away from the TV and you want music and you don’t have anything to read, and if you’re not really allowed any books in there. You’ve got your own time and that’s all you’ve got, so that’s a punishment in itself, being away from these things and that’s why people think twice about their behaviour, so it does work and that’s a punishment in itself, you know, seclusion, so and that’s what it’s there for to make people aware that if you do misbehave or do feel like you’re going to kick-off or do things you’re going to do this is what will perhaps happen to you.” (Pt1)*

*“Once you are in that’s the easy bit; getting them out is the hard part. So when they get angry inside there they’ve got no distraction, there’s no radio, no nothing, and you’ve got no clothes, how are they supposed to get themselves out, how are they supposed to prove that they are settled. If you keep somebody in that environment like that for too long you’re not doing them any favours; it makes it worse.” (Pt7)*



*"It's horrible in there, horrible. You don't have a lot of stimulus, you know, that's the main thing." (Pt9)*

*"It's confusing because you're not even allowed a watch so... you know, it's dark and you've no idea what time it is, nothing, it was very disorientating, very unsettling." (Pt16)*

*"You can either let it destroy you, which I've seen many a people do which or you can think, I'm not going to let it affect us and you just switch off, you know what I mean, you know, and I think as a person I've just had the ability to just do that. You know, the thing is, it just becomes, I don't know, it's just part of what it is." (Pt16)*

*"I don't think it's a very pleasant experience and I know it's not supposed to be but at the same time you've got to try and have some balance cos they're not supposed to make people poorly." (Pt17)*

*"I just didn't know what was happening, you know, I was frightened and I was scared and I just knew I'd been locked in a room. I wasn't used to that." (Pt25)*

*"I find night time confinement really, really difficult and that's when things happened to me when I was a child. And night time confinement can be awful and when you're sitting there and you're all alone and you're in a dark room and it's horrible; I wouldn't wish that on anyone. Because it just enables flashbacks and things like that to what happened to me in my past." (Pt25)*

*"It's distressing and it can be a bit like a bit scared. Because of how many people arrive and how people actually restraining you." (Pt26)*

#### 4.2.3 OBSERVING OTHERS

Patients spoke of similarities between their thoughts, feelings and emotions whether they were experiencing restrictive interventions personally or observing restrictive interventions being used on others.

*“As days go on and we live on the same ward and you’ve got a member of staff outside a door constantly and you’ve got people in seclusion for weeks at a time you tend to sometimes feel a little bit of pity because they’re not exercising and they don’t get the right meals and they don’t interact with people and it can be quite a lonely institution you know what I mean, when you get institutionalised like that sometimes it can be quite overbearing.” (Pt1)*

*“I think when you see somebody going into seclusion, it makes you think ‘poor fucker’ do you know what I mean, he doesn’t know where to turn after that, do you know.” (Pt4)*

*“Stress for them when you see someone kicking off, you think fucking hell he’s done it again.” (Pt5)*

*“Being fed through a little hatch in the door and everything like that, you know, and you think to yourself what you doing that’s a human being there, you know, and not just that it’s, I just .... I don’t think they should exist in this hospital it’s a hospital not a prison, you know.” (Pt16)*

*“It’s not a very pleasant experience and not one I’d want to wish on anyone. Same as, I’ve never been restrained but I find it quite hard to see other people being in pinel belt things, it’s a horrible thing to see people ... and I know it’s for their own safety but it’s still not nice to see it... it’s a horrible thing to see... it’s quite distressing to see” (Pt17)*

*“You hear the alarm bells and that’s quite distressing especially if it’s, you know, when you’ve got friends on other wards and your hearing the bell go off. I can’t pick up the phone and say to a friend are you alright so you’re just left with them thoughts thinking I hope my friends weren’t involved and any of that. Yeah, it’s very distressing just hearing that sound, very.” (Pt17)*

*“It’s disturbing. Just seeing it, it’s a bit disturbing and it’s not nice.” (Pt24)*

*“I just want to help them because the one person I have seen in the belt, and that was from a different ward, like, when I used to go out through the day room and go out to one of my sessions and I though poor thing, you know like, I really felt for them.” (Pt25)*

#### 4.2.4 PHYSICAL RESTRAINT

Experiences of restraint differed between patients. For some, being held was experienced as feeling safe and an opportunity for having time alone with a member of staff. For others, restraint was associated with fear, anger and loss of control.

*“You can tell the difference between how one member of staff is holding you to another, and one is twisting you just a little bit more and a bit more pain that creates a little bit of anger in you so you tense up to try and avoid that pain, and because you’re tense they’re telling you not to tense up, and then you say that you’re not tensing up, but you are in a sense because of the pain that person is putting through, more than the other wrist, and like it’s a vicious circle” (Pt20)*

*“It keeps me calm. I asked to be held and it makes me feel better. It makes me feel safe” (Pt21)*

*“When I get restrained you just see loads of people and I think I can just see those people running and they’re all coming towards me, so I just shut my eyes and fight. I don’t listen and it’s really hard to calm me down. Once the blicks has been sent off for me and they’re all running down I get very agitated quite easy and I just can’t say nothing about what’s going on and I just close my eyes and blank out and just fight and people have to talk me round.” (Pt25)*

*“I have been restrained a lot. Well, in a way sometimes it makes you feel safe and makes me feel scared because you’ve lost control. Errm, seclusion is my worst thing but in a way I used to like seclusion ... in a way I used to like seclusion because it gave me time with someone on your own” (Pt27)*

#### 4.2.5 MECHANICAL RESTRAINT

Thoughts and feelings towards mechanical restraint were equivocal; on the one hand mechanical restraints were seen as barbaric, inhumane and undignifying. On the other, they were seen as a mechanism that prevented severe self-injury and self-harm. These differences in perspectives point towards whether mechanical restraints are being used in incidents involving harm towards others, or harm towards oneself.

*“The thing I least liked but probably the most helpful I should say is the pinel belt... I hated it but now I’m kind of grateful for it... basically I’m still alive and I think without the pinel belt I might have been in a different place.” (Pt2)*

*“The first time they put me in it I thought this is barbaric it was like a straight-jacket like a modern day straight-jacket and I was panicking that I was going to fall over and not be able to get back up again. Wasn’t even able to stand up without someone helping me and I thought it was the worst thing in the world. But then I got used to it, you know, how to stand up and not fall over... then eventually I worked out how to get back on my feet to go to the toilet.” (Pt2)*

*“Horrendous. If you think about it you can’t go to the toilet yourself so I had to sit and, as a grown man, sorry for the language but piss and shit myself, you know, you can’t drink, you can’t do anything. It’s as degrading as you can get and it should only be used as a last, last prevention and as soon as you’ve calmed down it should be taken off... I think it’s inhumane and I think you look back at the Victorian times you think that’s like back then and we’re supposed to be, you know, a more intelligent and more, you know, consider ourselves better people but it’s not.” (Pt16)*

*“It can be very degrading.” (Pt25)*

*“I’ve seen mittens, but I haven’t seen belts. I think it’s good for that person to have them because they then can’t hurt themselves and I understand why they have to them.” (Pt26)*

#### 4.2.6 RAPID TRANQUILLISATION

Rapid tranquillisation was frequently referred to as ‘liquid cosh’ or ‘being stucked’. Of those patients who had personally experienced rapid tranquillisation, loss of dignity, side effects and involuntary nature of being medicated were recurring themes.

*“They forcefully put a needle in me... the duty doctor injected me with acuphase and something else, and the medications actually made me do like jumping jack sort of movements, involuntary, like muscle tension movements, and it was fucking horrible, and it basically learnt me a very bad and valuable lesson, you know” (Pt4)*

*"It's not very nice because you wake up and you've messed yourself or whatever and it's not nice because basically it makes every single part of your body just completely relax where you can't fight it, you know... you're trying to fight it but you know you can't" (Pt20)*

For those who had not personally experienced rapid tranquillisation, there seemed to be an awareness of this as a restrictive intervention, and anecdotes of other patients' experiences were spoken of:

*"I have heard stories of it. It does exist and they do use it sometimes... As I understand it, you cannot physically move, you're bed-ridden with it... They put him on liquid cosh and he said he'd never like to experience it again as he unable to move when he got up, you know" (Pt1)*

*"I think it's called acuphase. Sometimes it's necessary, sometimes it's not. I don't agree with it... it doesn't mean it's always right but sometimes obviously it is necessary. I've never witnessed it since I've been here" (Pt7)*

#### 4.2.7 SECLUSION

Seclusion was viewed predominantly negatively. The removal of personal clothing was viewed as particularly upsetting. Time, lack of occupation and control were all described as adding to the austerity of the environment and to the fear of being in seclusion.

*"For me personally I don't like it because of my past history and it brings back memories but probably the worst bit about like about being restrained and secluded is that when they strip you; they tend to have females in the room when they are stripping you but if you fight with them then males will strip you and that can be quite upsetting." (Pt2)*

*"About being carried to seclusion; it's horrible. Frightening. Frightening for me, yeah. Because you don't know what's happening. You're not fully aware because you're really ill." (Pt9)*

*"If you're a patient and you are upset and kicking off and going into seclusion the last thing you want is to be left in seclusion for, sometimes days on end, with nothing to do but your own thoughts, it's not productive at all." (Pt16)*

*“It’s very claustrophobic cos you’re locked in that room and there’s no windows, there’s no air and obviously you can’t access phones, you can’t even speak to your family for that kind of support, you can’t speak to any of your friends. It’s hard to interact with the staff as well cos obviously you’re feeling locked in that space and at that same time having that member of staff there, you know, when you’re being watched 24 hours it’s a horrible experience and there’s no .... I find it makes you worse, you feel ill.” (Pt17)*

*“The days are long in there and there’s a clock right outside the window so you’re constantly aware of what time it is.” (Pt17)*

*“The only control you’ve got when you’re in seclusion is the heat and cold whether it’s hot or it’s cold that’s the only thing you’ve got.” (Pt20)*

*“It’s very hard on the mind. There’s nothing to do. Nothing to keep your mind occupied. You haven’t got like your TV or books or magazines or anything like that.” (Pt26)*

#### 4.2.8 SEGREGATION

Patients spoke of segregation as being a ‘lonely’ process. In contrast with seclusion, when in segregation, patients are not required to be accompanied by a member of staff. Whilst patients found comfort in being allowed their personal belongings when segregated in their bedrooms, their experiences of coming out of segregation was spoken of as being a daunting process that was disorientating, particularly due to any changes that may have taken place during their time away from the main ward.

*“It is quite lonely. When you’re in seclusion you’ve got someone outside the seclusion room and you can talk to them but if you’re in seg you’ve got no one to talk apart from doing a session through the hatch or something.” (Pt2)*

*“At first I was terrified and I couldn’t come out. I freaked out and had to go back to my room but over the next couple of months they took me further and further so I was looking out the window in the day room and then I’d sit down on a beanbag for 5 minutes.” (Pt2)*

*"If you've got no one to talk to, I mean, at least while in seclusion you've got people to talk to outside the door but when you're in your cell all day on your own its very difficult to keep your sanity and you feel it's your personality that just drops." (Pt4)*

*"Yeah, it could have worse, you know, and it was helpful the way it was managed, you know, the way I ended up back in the group. Because when you are segregated it means that you are away from everyone for so long and it's like you come back out and maybe a new person has come on the ward and the dynamics have changed and it's like settling back into a new ward, you know, because one person can up-skittle the whole ward, you know, so the quicker you're out of seg[regation] the better really, do you know what I mean. But like, you know, it builds a stronger relationship between the other team that you're working under or, you know, your mates on the ward and your associates." (Pt6)*

#### 4.2.9 ENHANCED OBSERVATIONS

Enhanced observations were described as restricting, feeling 'under scrutiny' and having little choice or privacy within what was already perceived to be a restrictive environment.

*"It sometimes it feels like being under scrutiny, you know." (Pt9)*

*"It is quite restricting obviously, obviously patients when there is a bunch of staff around they speak differently and they don't speak as freely and that's not because they're plotting or doing anything wrong; I think it's just like in high school when you're in front of a teacher you going to speak less freely than when you're out in the playground with your friends and it is sort of like that, sort of like when I walk into the room and I've got 2 staff around me then room sort of goes quiet and everyone is like oh and it sort of a bit, huh... you can't walk away from situations you sort of have to sit there and have to tolerate it and I don't think that's helpful for anyone really." (Pt12)*

*"I have to tell them when I'm in the shower because the thing is, as a human I want to be able to take a shower without some ogling me, you know what I mean, especially when if you've got a history of being abused and things like that, you know what I mean, it bothers you, you don't let them know it bothers you, but the thing is it does bothers you. So even when you're doing nothing wrong you've got to be checked every 30 minutes." (Pt16)*

## 4.3 OVERCOMING TRAUMA AND ADVERSITY

### 4.3.1 OCCUPATION

Patients frequently voiced a lack of occupation and personal belongings as being particularly challenging aspects of restrictive practices within the hospital. Patients often felt that when they were left with nothing, they had nothing to lose and therefore no sense of purpose or motivation towards change. The opportunities for occupation and time away from the ward in contrast, were perceived as renewing their sense of self, identity and hope towards the future.

*“Last year I had nothing in my room apart from a toilet bowl and you feel that you’ve got nothing to lose because there’s nothing in there. So you know you’ve got nothing to lose so what’s the point. But now they leave all your stuff around.” (Pt2)*

*“I find that you know it’s very difficult with a low stimulus environment. To me it seems that you know when you’re in a low stimulus environment you haven’t got a lot and you can be very depressing... it’s very difficult managing from a patient’s point of view being forced in an environment that has low stimulus and that’s one of the most difficult thing for me in this environment I think.” (Pt6)*

*“I love my swimming, my gym, my English, my Maths... Yeah. They help me cope; that’s the only way I can cope, to speak to staff and go off ward.” (Pt11)*

*“If a patient is maybe feeling a bit upset or whatever and they go, basically there’s nothing for them to lose, you know... and you know you see patients on there, there’s no real motivation, there’s no small goals for them to gain, you know.” (Pt15)*

*“Getting off the ward is a big thing for me; so going to the gym, going to social events, doing things like that, you know, going to groups and courses, I’m very much an active person and I want to get off ward... I do enjoy spending my time in my room because I can listen to music freely and I can read a book, I can write stuff and I can draw and I can do all sorts of stuff in my room, more than I can do in the dayroom. I think an OT room would be good, so sort of like an occupational therapy room where you can do arts and crafts, obviously you can’t have scissors and stuff like that out freely but origami folding paper, drawing, just sort of a room where you can sort of do stuff like that; I think that would be really good, I think a lot of the lads would appreciate that.” (Pt12)*



#### 4.3.2 DIGNITY AND HUMANITY

Patients spoke of their actions and behaviours as being influenced by their frustrations at being so restricted, and that restrictive practices and interventions in themselves, can lead to embarrassment and a loss of dignity. Being treated humanely in contrast was perceived as helpful in fostering a sense of trust and regaining self-worth.

*“It’s like you’re man-pride just basically demolished and I don’t like people putting their hands on me full-stop.” (Pt4)*

*“If you treat me like an animal I will respond and behave like one.” (Pt7)*

*“It was a bit embarrassing sometimes and yeah embarrassing sometimes to be sitting there with your arms being held when everyone else was just walking freely and just sitting there and I had to just sit there and some patients were like ‘well why are you like that’ and staff did intervene and say you know ‘I don’t think this is an appropriate time to talk about that now’ sort of thing.” (Pt12)*

*“Talk to me, listen to me, acknowledge that I’m in distress and give me the time.” (Pt15)*

*“Sometimes it’s like you’re nothing, you know, and that’s not nice... Being moved to a ward that’s more suitable for you and treat you like a human and it shows how well you can do.” (Pt16)*

*“You know when you’re in a bad place, you know, and you’re target quite a lot by staff and things like this, whether you’ve helped yourself or not is irrelevant, you know, but somebody to treat like as a human that’s brilliant.” (Pt16)*

*“The only way I’m going to beat this is by keeping a bit of a shred of dignity and getting out of here and I think that’s the only way you can look at it.” (Pt19)*

*“Just someone saying calm, look we’re not going to hurt you, we’re not fighting with you, you know, we want to help. Just for somebody to say that first, you know, we’re not going to harm you, we’re not going to fight you, and we’re not going to do anything bad to you or anything and just bring me in here, just to like talk to me and say, you know, we had to move you for*

*this reason, you know, that you are okay and things will be alright, you know, just a bit of reassurance that I don't get here." (Pt25)*

#### 4.3.2 RELATIONSHIPS 'OUTSIDE'

Maintaining relationships with family and friends outside of the hospital was a crucial part of maintaining hope, a sense of self and familiarity with life beyond the hospital. This appeared to be a focal point and a motivational factor towards working with the organisation, discharge and recovery.

*"I've always had a good hope for my future, you know, I've got a good family and my family have really been quite good to me since I've been here... we still keep in contact." (Pt1)*

*"My family. The thing is when they can facilitate it my mother in the morning and my brother in the evenings. Even if I don't have 2 phone calls a day even if they don't answer I can just make those 2 phone calls a day keeps me going. My family, people in my family that haven't seen, nieces, nephews but I need to see them and I need to keep going forward. Family is a big motivation, yeah." (Pt27)*

## 5. CONCLUSIONS

This evaluation was conducted to explore patient experiences of restrictive practices and interventions, with a view to understanding and implementing least restrictive practices. Findings from this study have been revelatory of three core themes; i) patient experiences of the high security hospital environment, and their associated restrictive practices; ii) patient experiences of restrictive interventions, notably physical restraint, mechanical restraint, chemical restraint, seclusion, segregation and enhanced observations; and, finally iii) working towards overcoming trauma and adversity through occupation and maintenance of meaningful relationships.

With regards patient experiences of restrictive practices, patients frequently spoke of the fear associated with the environment. These were in relation to the physical spaces of the high security hospital, the rules and regulations there within as well as the dynamics created through a combination of patients, staff and restrictive security practices. Patients highlighted the importance of personal space and personal belongings, as means of finding solace and escapism within unfamiliar environments. These were highlighted as being particularly important when placed in an unfamiliar environment, and with unfamiliar people, where fear and mistrust often manifest.

Overall, patient experiences of restrictive interventions were viewed negatively. Restrictive interventions were often felt to be punitive, whether this was actual or inadvertent. The lack of freedom, physical and mental isolation was challenging for many. Restrictive interventions were frequently viewed as a 'consequence of rule-breaking'. This seemed to reinforce the perceptions of restrictive interventions as punitive practices. Restrictive interventions were also perceived to be inadvertently punitive through feelings of isolation, loss of dignity and lack of comfort. Despite the negative thoughts, feelings and emotions relating to restrictive practices and interventions however, patients recognised that on some occasions, these interventions were perhaps warranted. Examples of these situations included severe cases of self-harm where lives were endangered, being contained through fear of feeling 'out of control', and in doing so, preventing harm towards others. Specific types of restrictive interventions were experienced equivocally, although the importance of personal space, time and relationships were emphasised. Furthermore, preserving humanity, dignity and hope all worked towards feeling 'less restricted'.

## 6. RECOMMENDATIONS

Through the narratives and experiences of the patients taking part in this evaluation, least restrictive practices might be achieved through refocusing the organisational values and cultures of a high security hospital, from one of inadvertent fear and anxiety, towards:

- Building trust and supporting patients into new and unfamiliar environments;
- Maintaining identity and relationships, through occupation, access to personal belongings and contact with family and friends outside of the hospital, and;
- Being treated with dignity and humanity in overcoming past and present traumas that may be associated with experiencing restrictive practices and interventions within an already restrictive environment.

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## APPENDICES



## APPENDIX 1: INTERVIEW TOPIC GUIDE



### 1. De-escalation Workstream:

- Q1 Have there been times when you were getting angry or upset and staff have tried to help you to calm down?
- Q2 Have there been times when this was done well or not so well?
- Q3 Have you had the opportunity to talk to staff about a plan of what will help you to calm down and does this help?

### 2. Observations Workstream:

- Q1 Have there been times when you were getting angry or upset and staff have tried to help you to calm down?
- Q2 Have there been times when this was done well or not so well?
- Q3 Have you had the opportunity to talk to staff about a plan of what will help you to calm down and does this help?

### 3. Physical Restraint Workstream:

If you have ever been physically restrained:

- Q1 How did it make you feel?
- Q2 Did you think this was proportionate and necessary at the time?
- Q3 What type of support, if any, did you receive afterwards?

### 4. Mechanical Restraint Workstream:

- Q1 Sometimes it is necessary to consider the use of mechanical restraints, such as the 'Pinel belt', to manage risk. What do you feel about this?
- Q2 Have you ever had experience of this, either direct experience or witnessing its use with other patients?
- Q3 What impact, both positive and negative, do you feel this might have on the individual patient? And the ward in general?

### 5. Low Stimulus Workstream:

- Q1 What does a low stimulus environment mean to you?
- Q2 Are there any low stimulus type areas on your ward and what are they like?

- Q3 If you have a low stimulus area where you are how could it be improved and if not would this be helpful?

**6. Blanket Restrictions Workstream:**

- Q1 How do you get to know about the rules and restrictions in the hospital?
- Q2 Are there rules and restrictions which effect all patients on a ward that you feel are unfair?
- Q3 If so, do you feel able to challenge this and how?

**7. Seclusion and segregation Workstream:**

- Q1 Have you ever been in seclusion and / or segregation and if so are your views on it (helpful or otherwise)?
- Q2 Have you been involved in agreeing care plans about their use either before or during seclusion / segregation?
- Q3 What type of support did you receive after seclusion / segregation?

**8. Rapid Tranquilisation Workstream:**

- Q1 Do you know what this is and have you ever had rapid tranquilisation?
- Q2 If yes, was it useful?
- Q3 Has rapid tranquilisation ever been discussed with you?

**9. Debrief / Advance Statements Workstream:**

- Q1 Have you ever had a debrief (describe as required) after an incident and if so was it helpful?

If not would you think it would be useful?

- Q2 Have you had access to developing an Advance Statement?

If not, would you find one helpful?

- Q3 How important is it to be able to influence your care when you are distressed / unwell?



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Hui, A. (2017) *Least Restrictive Practices: An Evaluation of Patient Experiences*, Nottingham, Nottinghamshire Healthcare NHS Foundation Trust.

For further information please contact:

Dr Ada Hui MNursSci (Hons) PhD PGCHE RNMH FHEA

Assistant Professor, University of Nottingham

Honorary Researcher, Nottinghamshire Healthcare NHS Foundation Trust

[ada.hui@nottingham.ac.uk](mailto:ada.hui@nottingham.ac.uk)