In children and young people’s (CYP) psychiatric inpatient services, restrictive practices are one of the methods used to address behaviours that challenge, despite the fact that they are widely recognised as harmful. In November 2015, a qualitative study sought the views of former service users, relatives, health professionals and non-clinical staff on this contentious issue.

Study background

The use of restrictive practices – such as prolonged manual holding, tranquillisation, mechanical restraint (with handcuffs or/and emergency response belts) and seclusion – has been shown to have potential negative consequences for the well-being of patients (Lu et al, 2011) and frontline nursing staff (Bonner et al, 2002). Research has also indicated that there are cases when nursing staff see restrictive practices as the only viable method of reducing risk in inpatient settings (Bigwood and Crowe, 2008).

In its guideline, Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings, the National Institute for Health and Care Excellence (NICE, 2015) recommends that frontline nursing staff use preventive methods or non-invasive techniques, working collaboratively with patients to identify and avoid triggers for behaviours that challenge, before considering the use of restrictive practices.

However, in 2016, there was a rise in the reported use of restrictive practices in NHS CYP inpatient settings, with 536 restraints per 10,000 occupied bed days compared with 500 per 10,000 occupied bed days in 2015 (NHS Benchmarking Network, 2016). We need to understand the factors that may be causing this increase to support the use of preventive and non-invasive methods.

Patient age

Pogge et al (2013) indicated that patients’ age could be a factor in the manifestation of behavioural symptoms felt to require...
They observed that service users aged 13–17 years.

so it could be that younger patients need access to CYP inpatient services

● Three former service users of CYP inpatient services were interviewed individually by a nurse consultant and a clinical psychologist working in CYP inpatient settings

● One person who had experience of accessing CYP inpatient services and two people who had experience of accessing adult psychiatric inpatient services took part in a focus group facilitated by a consultant psychiatrist.

Interviews

● Four relatives of people who had previously accessed CYP inpatient services were interviewed individually by a nurse consultant and a clinical psychologist working in CYP inpatient settings

● Two former service users of CYP inpatient services were interviewed individually by a nurse consultant and a clinical psychologist working in CYP inpatient services

The ward environment itself may contribute to the causes of behaviours that challenge. It has been suggested that the loss of autonomy occurring when a person is admitted to a psychiatric ward can trigger negative emotional reactions that translate into these behaviours (Ling et al., 2015). Adults who had experienced psychotic episodes have reported that being manually restrained or secluded during their psychiatric inpatient treatment could cause re-traumatisation and distress (Lu et al., 2011). Models of inpatient care such as Safewards – which ensure the ward community and/or environment, patient characteristics, dynamics of staff team and external family factors inform patients’ care plans – have been shown to reduce the use of restrictive interventions by 23.2% (Bowers et al., 2015).

There is a need to better understand the impact of the ward environment in CYP inpatient services on the behaviours of patients and on the practices used by nursing staff to manage those behaviours.

Wellbeing of staff

The application of restrictive practices to manage behaviours that challenge also has the potential to cause re-traumatisation among nursing staff through the activation of memories associated with past events involving violence and aggression (Bonner et al., 2002). Bigwood and Crowe (2008) observed the dilemmas that frontline nursing staff can experience when using restrictive interventions to reduce risk in ward settings, to the potential detriment of the therapeutic relationship with patients.

There is a need to explore how organisations providing inpatient assessment and treatment for children with behavioural symptoms can ensure the wellbeing of their nursing staff.

Relationships with families

Good relationships between mental health professionals and families and carers is integral to good-quality patient care in inpatient services (Schroder et al., 2007). Poor relationships between paediatric nurses and families of young people accessing services have been shown to have potential negative effects on the level of trust that patients have towards health professionals (Briker, 1999). Families who have experienced a lack of communication from mental health professionals have reported feeling isolated from their relative during their treatment in inpatient settings (Ewertzon et al., 2011).

There is a need to gain an insight into relatives’ experiences of collaborating with mental health nursing staff and their views on the practices used to manage behaviours that challenge.

Study methods

Aim and approach

Our study aimed to gain an understanding of the attitudes of frontline health professionals, non-qualified staff, patients and relatives regarding the use of restrictive practices to manage behaviours that challenge in CYP psychiatric inpatient services. A qualitative research design and thematic analysis of the data were used. The study was registered with, and approved by, the research and development department at Northumberland, Tyne and Wear Foundation Trust.

Participants and facilitators

In total, 26 participants – six non-clinical staff, 11 mental health professionals and nine patients and relatives – took part in a focus group or were interviewed (Box 1). Each focus group was led by a lead facilitator and an assistant facilitator.

Materials

Four vignettes describing fictional scenarios likely to occur in CYP inpatient services, as well as a semi-structured interview schedule, were used to guide discussions and elicit qualitative data.
A digital dictaphone was used to record both the focus group discussions and one-to-one semi-structured interviews.

**Procedure**
Participants attended a service evaluation day and were asked to sign an informed consent sheet. They then attended a verbal presentation about restrictive practices in inpatient settings. After the presentation, the four focus groups were conducted concurrently; the interviews were completed after the focus groups to gather feedback from service users and carers who were unable to participate in the group sessions.

The vignettes were used to generate discussion among participants. The facilitators asked them to consider each vignette in a context where non-invasive or preventive strategies had been tried and deemed unsuccessful. After the group discussions, participants were asked to reconvene and received a debriefing. They were also offered the opportunity to speak with a health professional individually if they wished as part of the debrief process.

The transcripts of the focus group discussions and interviews were analysed using the six-stage thematic analysis protocol proposed by Braun and Clarke (2006). Two themes emerged: ‘dissonance’ and ‘uncertainties’. Fig 1 summarises the findings in a visual form.

**Dissonance**
The ‘dissonance’ theme reflected how the use of restrictive practices to manage behaviours that challenge potentially conflict with the values and expectations of participants.

**Reducing risk of harm to patients**
Some participants thought the use of restrictive practices could sometimes be a necessity to protect patients from harm to their physical wellbeing.

“I would be doing everything in my power to stop him leaving the ward if my view was that he wanted to be somewhere else to kill himself.”

(Non-clinical member of staff)

“[..] It just isn’t going to stand up, is it? If you have to do it, you have got to do it.”

(Service-user relative)

This is consistent with previous research showing that there can be situations in which restrictive practices are the only method available to address behavioural symptoms and reduce risk of harm to patients (Bigwood and Crowe, 2008).

**Potential to cause harm to patients**
Negative views of restrictive practices arose when their use was perceived as having a more negative impact on patient wellbeing. Some participants thought the use of restrictive practices could potentially be detrimental to the physical and emotional wellbeing of younger patients.

“In my opinion, the use of restraints would do more harm than anything else at such a young age. The use of restraints will eventually just heighten her distress and probably do damage to her in the future.”

(Former user of CYP inpatient services)

“I found it distressing and traumatic to be having to hold a young person against their will”

“You can hear it now, can’t you? ‘Oh, we didn’t use a restraint for whatever reason and he went off and killed himself.’ [...] It just isn’t going to stand up, is it? If you have to do it, you have got to do it.”

(Service-user relative)
Clinical Practice

Research

“With the handcuffs, you could actually do more physical harm as well as cause the individual more distress.” (Service-user relative)

In 2012, it was reported that there had been over 1,000 incidents where people accessing mental health services had been physically injured as a result of manual restraint (Mind, 2015). Patients accessing adult psychiatric inpatient services have reported that being manually restrained or secluded can be a traumatic experience (Lu et al, 2011).

Provision of debrief
Participants who had lived experience of accessing CYP inpatient services stressed the importance of post-incident debriefing for therapeutic purposes.

“Talk it through with the patient and hopefully you will learn from it. The staff would learn and the patients would learn as well. That’s part of starting to get patients to learn coping strategies.” (Former user of CYP inpatient services)

“I think it’s really important, after they have been held down, to get in touch with and talk to the person and tell them why it had happened. [...] Give them an explanation of what causes this [use of manual holding] in the first place.” (Former user of CYP inpatient services)

Previous research has indicated that the lack of post-incident debriefing following seclusion in psychiatric inpatient settings can prevent patients from developing coping strategies to regulate emotional reactions, and stop frontline staff from learning how to avoid further occurrence of behaviours that challenge (Fasching-bauer et al, 2013). Service providers need to ensure effective debriefing is provided.

Staff distress
Participants discussed the difficulties that nursing staff may experience when required to consider the use of, or apply, restrictive practices in CYP.

“Having worked in a residential setting [...] with 9-16-year-olds with emotional and behavioural difficulties, I had to, on occasions, use restraint to keep kids from hurting themselves or other people seriously. I know what a difficult area this is, and I would love to see the day where we could work with young people safely without ever needing to use restraints, because it’s not only traumatic for the young people, but I hated doing it as a member of staff. I found it distressing and traumatic to be having to hold a young person against their will until they calmed down.” (Health professional with experience of working with children and younger people)

“...I am finding it really difficult to kind of put myself in these scenarios as to how I manage children, which is not a clinical area that I am used to, and certainly not used to using these types of devices [handcuffs and emergency response belts]. I think each and every scenario we’ve talked about, there could be a need for them, but I am finding it absolutely abhorrent to think about.” (Health professional with experience of working with clients other than young people)

The views expressed by some participants are consistent with the notion that, although restrictive interventions may be effective in de-escalating behaviours that challenge, their use can potentially conflict with nurses’ values (Bigwood and Crowe, 2008). Their use could also reawaken memories of violent incidents that staff have experienced (Bonner et al, 2002). Providing staff with structured debriefing sessions offering both emotional and educational support immediately after incidents can contribute to reducing the use of restrictive practices in paediatric psychiatric inpatient settings (Azeeem et al, 2011).

Box 2. Initiatives for reducing restrictive practices

- 4PI National Involvement Standards: Bit.ly/NSUN4pi
- Centre for the Advancement of Positive Behaviour: bild.org.uk/capbs/capbs
- PROMISE: promise.global
- RESPECT Training Solutions: respecttrainingsolutions.co.uk
- Restraint Reduction Network: restraintreductionnetwork.org
- REsTRAIN YOURSELF toolkit: Bit.ly/AQUARestrain
- Safewards: safewards.net

Source: Mind (2015)

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Triggers in inpatient settings
Some participants discussed how the ward environment could trigger behaviours that challenge, leading to the use of restrictive practices to the potential detriment of patient wellbeing.

“I think we saw a very big rise in my son’s behaviours when he came into hospital compared to when he was in the classroom [at school]. He had some cokers in the community, but when he was put into seclusion, he just went off the scale […] I just think it was the environment that he went into and he wasn’t with his family. For any 12-year-old, being separated from their family is massive. I just think that in itself is awful. The kind of level of assessment is great and it is necessary. But it is like separating them from what they are used to. Anybody that didn’t have behaviour problems would probably end up having a behaviour problem after being put in this setting. Part of the reason for them [restrictive practices] needing to be used is because of where he is and all of the things that go with that.” (Service-user relative)

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informed of what restrictive practices entailed after these had been used. “When our son was put into seclusion, we would get a phone call to say he was in seclusion, and it was just horrible getting the phone calls because you weren’t with him. I think it was being described as ‘open seclusion’ and ‘closed seclusion’, and I think it would have been nice to have the option to look at what seclusion was. I don’t remember [having] the option to be able to look at it [a seclusion room] because it is a clinical area, that’s what was quoted to us when we asked about that.” (Service-user relative)

“When we were first told about the ERB [emergency response belt], we were horrified at the thought of it. I went onto Google and typed in ERB, and it just brought up a load of information about imprisonment and it is just horrible. I mean, lots of people would do that as a first thing, just type in ERB. We were never happy with it because it had the association with prisoners.” (Service-user relative)

Family members potentially encounter situations where they are not briefed on the methods used to manage behaviours that challenge. The views they expressed were consistent with previous research, which had observed that poor communication on the part of mental health professionals can lead to relatives feeling isolated from their loved ones (Ewertzon et al, 2011). A potential outcome of poor communication between frontline nursing staff and relatives is patients’ loss of trust towards health professionals (Bricher, 1999).

Relatives can help to identify triggers and inform a prevention strategy (Schröder et al, 2007). Service providers should therefore support frontline nursing staff to develop collaborative relationships with families and engage in potentially difficult conversations on how behaviours that challenge are managed.

**Difficulties in predicting outcomes**

Professionals working in CYP inpatient settings can experience uncertainty in predicting the outcomes of the use of restrictive practices.

“There are times when you learn from your mistakes. I mean, what you are trying to do is predict the unpredictable. Sometimes, you don’t really know what the outcomes are going to be, there’s a bit of trial and error in the safest possible way.” (Clinical member of staff working in a CYP inpatient setting)

These difficulties in predicting outcomes are problematic, particularly given how the incorrect application of restrictive practices such as manual holding potentially leads to serious injury to patients (Paterson et al, 2003). There may be a need to develop training programmes and/or working practices aimed at reducing this unpredictability.

**Study limitation**

A limitation of this study was that the focus groups and interviews were conducted by different facilitators. This means the quality of discussion may have varied depending on facilitators’ level of engagement and experience of moderating group discussions or interviewing study participants. However, the study did ascertain the opinions of people who have an interest in the standards of care delivered by CYP inpatient services, which could inform the development of safer working practices for nursing staff.

**Summary**

The use of restrictive practices potentially creates harm, conflict and uncertainties. Various initiatives aimed at reducing their use have been launched in recent years, some of which are listed in Box 2. In this study, although restrictive practices were seen by some as necessary in certain circumstances, they were also considered as having the potential to negatively affect the wellbeing of both patients and nursing staff. The findings suggest that, to facilitate the safe management of behavioural symptoms in CYP inpatient settings, service providers need to ensure that working practices include post-incident debriefs, preventive strategies and collaborative working with families.

**References**


