

# “My life isn't my life, it's the systems”: A qualitative exploration of women's experiences of day-to-day restrictive practices as inpatients

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## Accessible summary

### What is known on the subject?

- Sometimes someone needs to be in hospital because they are struggling with their mental health and need some extra support but being in hospital can also be a difficult experience.
- There are a lot of restrictions in place in hospital, like locked doors, rules to follow and not much choice about what happens to you.
- Other research has found that these restrictions can feel difficult and stressful for people and so more research is needed about this.
- We wanted to know what being in hospital felt like for women in particular.

### What the paper adds to existing knowledge?

- We interviewed women who were in hospital because of their mental health about what it was like for them in hospital.
- The women told us that they felt powerless while they were in hospital. They sometimes felt like they were being punished and this could affect their mood and could lead to them hurting themselves.
- They also said that they were not always listened to by staff, and they found it difficult being away from their family and friends while they were in hospital.
- The women also told us that being in hospital could sometimes help them to feel safe.

### What are the implications for practice?

- Women should be looked after in hospital in a way that helps them to feel in control of what happens to them.
- They should be supported to be able to go outside the hospital on leave, to keep in touch with their family and friends, and they should be listened to by staff.
- A project called “safewards” has suggested some ways for helping to make hospital wards safer. They have suggested that everyone should be clear about what the rules are when they go into hospital and ways that staff could communicate more clearly with the people they are working with. Our research supports using these techniques.

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## Abstract

**Introduction:** Inpatient care often involves restrictive interventions such as seclusion and restraint and restrictive practices that limit the person's freedom, rights and daily activities. Restrictive practice has not been the explicit focus in previous research; however, it often appears as an important theme, with participants identifying it can have a detrimental effect on their well-being. More research specifically on this topic in an inpatient setting is, therefore, needed. Women might be particularly vulnerable to adverse effects of restrictive practices compared to men as women generally occupy less powerful positions in society and more often experience abuse.

**Aims:** The study aimed to explore women's experiences of routine restrictive practices in mental health inpatient settings.

**Methods:** Twenty-two women who were currently inpatients on mental health wards were interviewed about their experiences of restrictive practices in hospital. Interviews were analysed using thematic analysis.

**Results:** An overarching theme emerged of powerlessness. Four key sub-themes were also identified: restrictions perceived as punitive, having no voice, impact of restrictions on relationships and restrictions providing safety and support.

**Discussion:** Although restrictive practices were found to provide the women with a sense of safety, they were also found to impact upon the women's well-being, leading to increases in self-harm and over-reliance on restrictions.

**Implications for practice:** This research highlights the importance of gender-informed inpatient services for women that foster independence, empowerment and allow women to have their voices heard. Safewards interventions such as clear mutual expectations and soft words could contribute to mitigating the impact of restrictive practices.

## KEYWORDS

inpatients, qualitative, restrictive practice, thematic analysis, women

## 1 | INTRODUCTION

The Mental Health Act (The Stationery Office, 1983) in the United Kingdom, like other legislation across the world, allows a person to be detained in hospital in order to protect their safety or the safety of others. A key principle of the Mental Health Act, as well as mental health law internationally, (WHO, 1996) is that care should be provided in the least restrictive environment (DoH, 2015). Restrictive care ranges from restrictive interventions, actions taken to immediately take control of a dangerous situation, including restraint, seclusion and rapid tranquilisation (NICE, 2015), to more subtle forms of restrictive practices that are used as a routine part of care, such as locked doors, routines on the ward forcing everyone to get out of bed at the same time or "blanket rules," for example restricted mobile phone access (DoH, 2014). Although restrictive practices are in place to promote safety (DoH, 2015), they can limit a person's freedom, rights and daily activities (RCN, 2017).

A recent review of 35 studies examining seclusion and restraint found that such interventions have a negative and often traumatic impact on the recipient (Chieze et al., 2019). Although routine restrictive practices have not been the focus of previous research, they might also have a damaging impact, for example, realizing doors are locked, being denied choices and being forced to conform to the system can impact upon self-esteem or result in conflict (Bowers et al., 2014). Previous research has explored experiences of being detained under the Mental Health Act (e.g., Seed et al., 2016) and of experiences of inpatient care more broadly (e.g., Wood & Alsawy, 2016). Such previous research often finds that service users express a level of dissatisfaction with inpatient care and that this dissatisfaction might be in response to restrictive practices, such as being unable to go outside (Rose et al., 2015). A meta-synthesis of studies including data from 394 participants with experience of hospitalization on locked wards or seclusion found that individuals admitted to hospital felt like prisoners, limited by rules and controlled (Lindgren et al., 2019). This was found to contribute to stress and frustration and was overall viewed as making recovery more



difficult (Lindgren et al., 2019). In contrast, participants also expressed feeling that consistent and fair rules could lead to feeling safe and protected whilst on a locked ward (Lindgren et al., 2019). Similarly, a meta-synthesis looking at experiences of care following self-harm found that restrictions on certain items and increased observations on hospital wards could contribute to the individual feeling reassured that they were safe (Lindgren et al., 2018). The need to regularly re-assess such restrictions is noted (Lindgren et al., 2018). The importance of good relationships with staff enforcing boundaries and being involved in decisions about their care is emphasized by these participants (Lindgren et al., 2018). However, this study did not focus specifically on care within an inpatient setting and includes male and female participants (Lindgren et al., 2018). Restrictive practices were not the explicit focus in any of the above studies; however, it often appears as an important theme for the participants interviewed. More research specifically on this topic in an inpatient setting is, therefore, needed.

Although the potentially damaging effect of restrictive practices is likely to be experienced by both men and women, it is possible that restrictive practices impact women more adversely. For example, restrictions in inpatient settings could mirror the lack of power and control that women hold in society (UNICEF, 2018) as well as abusive life experiences they might have experienced. Women are more likely to be the victims of interpersonal abuse across their lifetime than men (Scott & McManus, 2016). Indeed, women accessing mental health services are more likely than men to have suffered abuse both in childhood (Shah et al., 2014) and as adults (Morgan et al., 2016). Female inpatients are significantly more likely to have a history of sexual abuse than male inpatients (Sahota et al., 2010). The abuse that women suffer is more likely to be within a close personal relationship and to involve the abuser having power over the woman, making it difficult for her to escape the abuse (Wilton & Williams, 2019).

Women's mental health has received a greater focus of attention internationally over the past 20 years (Stewart, 2006). In 2002, the UK Government for the first time acknowledged the different needs of women and made suggestions for the development of more gender-sensitive services and the provision of single-sex accommodation (DoH, 2002). However, almost two decades later, services still need to be better equipped to support women (DoH, 2018). As restrictive practices are such a fundamental aspect of inpatient care, further research is needed, specifically examining restrictive practices and how these are experienced by women.

The aim of this study is to explore women's experiences of restrictive practices as inpatients. In doing so, we aim to make recommendations as to how inpatient services could be improved specifically in relation to supporting women.

## 2 | MATERIALS AND METHODS

### 2.1 | Methodology

A qualitative research design utilizing one to one semi-structured interviews was employed.

The epistemological perspective used was critical realism, which emphasizes the importance of both the social reality as experienced by the researcher and participant but also the power of existing theories to explain this reality (Fletcher, 2017). Critical realism is considered a useful research approach as it allows for critique of such existing theories and of the researchers own assumptions (Pilgrim, 2020). Critical realism posits that individuals do not exist in isolation but rather identity is shaped by relationships with others, the wider community and the social structures we live within (Bhaskar, 2020; Pilgrim, 2020). Therefore, in social sciences, there is a need to not only consider individuals but also the relationships between individuals and how this might shape their opinions and behaviour (Bhaskar, 2020). Therefore, during analysis, individual interviews were considered in the context of the wider mental health system and cultural context (Bhaskar, 2020). Further to this, the researcher also exists within the same social structure and, therefore, detachment is not possible, and the researcher's own position must be actively reflected upon (Pilgrim, 2020). The researcher kept a reflective journal throughout the research process and reflective discussion took place within the research team.

### 2.2 | Participants

Individuals were eligible if they identified as female, were aged >18 years, were currently an inpatient on a mental health ward and provided informed consent. The only exclusion criterion was non-English speaking (due to lack of resources for translation). Participants were recruited via referral from a member of the ward staff or through self-referral by use of a poster displayed on the ward and presentations made at weekly ward meetings attended by staff and service users. The researcher had no prior relationship with any of the participants. Twenty-two participants were recruited from hospitals across the North-West of England. See Table 1 for sample characteristics.

The ethnic backgrounds of the participants were as follows: White British (17), Black British (1), Black African (1), Black Caribbean (1), Mixed White and Black Caribbean (1) and Asian (1). One of the women was married, one was engaged, two were divorced and 18 were single. The settings where women were recruited from was as follows: acute wards (7), low secure units (7), psychiatric intensive care units (4), community rehabilitation wards (3) and a medium secure unit (1). Three women were recruited from mixed-sex wards with the rest being from single-sex wards. Details are not provided individually for each participant in order to protect confidentiality.

### 2.3 | Ethical considerations

Ethical approval was granted from the relevant local ethics committee (19/NW/0244). Participants were given a minimum of 24 h to consider the study and read the participant information sheet (PIS) before providing written consent. The first author took consent

TABLE 1 Sample characteristics

Number	Pseudonym	Age	Length of stay (months)	Diagnosis
1	Emmeline	20	7	Antisocial personality disorder
2	Li	39	24	Psychosis, depression
3	Michelle	19	3	Depression, anxiety
4	Matilde	33	60	Paranoid schizophrenia
5	Maya	37	6	Bipolar
6	Amelia	45	24	Schizoaffective disorder
7	Marie	29	5	Borderline personality disorder
8	Edith	28	108	Personality disorder, PTSD, anorexia
9	Rosa	25	60	Personality disorder, ADHD
10	Jane	36	4	Personality disorder, psychosis / schizophrenia
11	Millicent	20	9	Borderline personality disorder
12	Elizabeth	41	0.5	Not known
13	Flora	24	12	Borderline personality disorder
14	Harriet	39	16	Schizophrenia
15	Noor	48	48	Bipolar
16	Valentina	56	4.5	Schizoaffective disorder, personality disorder, depression
17	Ada	36	60	Paranoid schizophrenia
18	Josephine	24	9	Personality disorder
19	Mary	22	24	Borderline personality disorder, psychosis, ADHD
20	Chimamanda	49	0.5	Bipolar
21	Viola	46	12	Schizophrenia, emotionally unstable personality disorder
22	Christabel	22	3	Borderline personality disorder

after reading through the PIS with the participant, ensuring they understood the information and answering any questions.

Protocols for risk management and for managing distress were created to mitigate key ethical considerations and these were approved by the ethics committee. Participants were explicitly told prior to the interview that they did not have to answer any questions that they did not feel comfortable with. Participants were also informed that they may stop or take a break at any point during the interview. Participants were aware that they could withdraw from the study at any time and that they could request that their data was removed from the study for up to 1 month following the interview. Additionally, participants were provided with phone numbers on the PIS for services where support could be accessed. The researcher also offered to contact participants by phone the day after the interview as a follow up. Five women accepted the offer of a phone call and were contacted the following day. No ongoing distress was reported by the women at the time of the phone call. Data were managed in accordance with the policies of the research sponsor to ensure confidentiality and compliance with data protection regulations. All of the above was outlined in detail in the PIS, of which the participant retained a copy.

## 2.4 | Data collection

Interviews had an average duration of 45 min (range 10–67 min). Interviews were conducted by the first author and were semi-structured using a topic guide. The topic guide comprised open-ended questions relating to choices the women had been given on the ward, rules they must follow, and the ways in which restrictive practices impacted upon relationships and use of coping strategies. The women were also asked if anything had helped them to feel empowered and if anything would be helpful to improve the experience of restrictive practices for women. These open-ended questions were followed up with prompts as appropriate. The topic guide was initially developed by the researcher with reference to key areas of restrictive practices (e.g., DoH, 2014) and with additional prompt questions about how these might particularly affect the participants as women. The topic guide was then discussed with an expert by experience. Consulting existing literature and with experts by experience is recommended as part of the process for developing a topic guide (Kallio et al., 2016).

Participants were compensated £10 for their time. Interviews were audio-recorded and transcribed verbatim.

## 2.5 | Analysis

The data were analysed using thematic analysis following the six phases outlined by Clarke and Braun (2013). The process of seeking out patterns in the data began during data collection and transcription with reflective notes being made throughout. Both stages were completed by the first author, allowing for a high degree of familiarity with the data. Initial codes were generated through line-by-line coding. Codes were then grouped together to form themes and a thematic map was utilized to examine relationships between themes. An inductive, data-driven approach was initially used; however, the research questions relating to restrictive practices and the specific impact of these on women were held in mind during the later stages of analysis when reviewing and refining themes. Two early interviews were additionally coded by the second and last authors to contribute alternative perspectives to the analysis (Braun & Clarke, 2019). The research team discussed the themes and relationships between these in relation to the research question and theoretical knowledge of the topic. It is acknowledged that themes are created by the researcher using the evidence from the data but also their own knowledge and beliefs, under the influence of existing theoretical frameworks (Braun & Clarke, 2019). The lens the researcher is viewing the data through is not seen as a weakness but rather as a resource to be capitalized upon (Clarke & Braun, 2018).

## 2.6 | Reflexivity

All members of the research team advocate psychosocial approaches to treatment of mental distress, including the importance of access to psychological therapies in inpatient settings, oppose a purely medical approach and seek to promote gender equality.

## 3 | RESULTS

### 3.1 | Overview

One overarching theme of powerlessness was developed from the data. Four key themes were found that related to the overarching theme: restrictions perceived as punitive; not being heard; impact of restrictions on relationships; and restrictions providing safety and support and are presented in diagrammatic form in Figure 1.

### 3.2 | Overarching theme: Powerlessness

Women described how restrictive practices on the ward removed their ability to choose and control what happened to them. They described how important decisions in relation to restrictions (e.g.,

their treatment or use of leave) were decided by other people without consideration given to their own view. Women described feeling unhappy or angry because of these decisions and felt they were not able to be themselves or live a normal life.

I feel like my life is not my life, it's the system's. I feel like a puppet because I'm on a section like they can do whatever they want with you d'y'know what I mean and like...you just feel like it's not your life ...it's not just your say in a lot of situations

(Flora).

The women frequently compared this lack of power with feeling like a child again. They talked about being “bossed about” (Maya) and having to ask staff for help with everything, even something as simple as access to a spoon to eat a yoghurt with. They said that “what staff says goes” (Marie) and for some this contributed to the frustration and distress they experienced on the ward.

**P:** ...They tell me to clean my room like I'm a child (crying).

**I:** How does that make you feel?

**P:** Awful (Michelle).

The women explained that when arriving on a ward, they often did not know what the rules were, contributing to feelings of powerlessness as they often did not learn a rule until they were sanctioned for breaking it. One woman said that not knowing the rules could lead to being “in the system a lot longer” (Amelia). The women felt that clearer explanations about the rules might reduce feelings of powerlessness.

I feel powerful now yeah 'cause I know my rights, that's the only reason I feel powerful

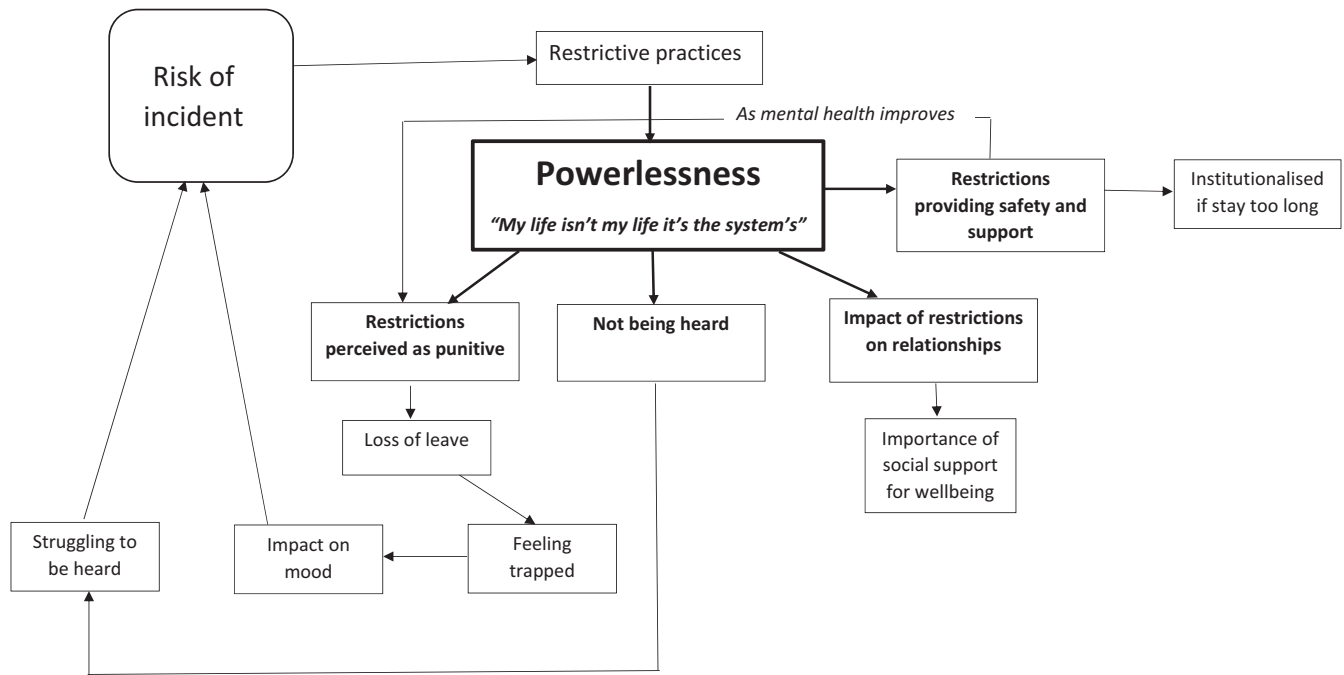
(Viola).

### 3.3 | Restrictions perceived as punitive

The women felt that restrictive practices were used for punishment. They also felt that threats of restrictive practices were used to ensure they followed the rules. For example, threats of changes to medication or loss of privileges such as access to bank cards, craft materials or activities were described as impacting upon coping and seen as ways for staff to keep control. Most commonly the women felt they were punished with loss of day leave from the ward, meaning they were unable to go out.

I do not know I kept on telling them and they just were not listening to me then they'll go on, they'll say to me right you have lost your leave 'cause you are staying in bed longer to what you should of

(Rosa).



**FIGURE 1** Diagrammatic representation of the study themes. The figure highlights how key themes are linked. The text in bold indicates the overarching theme and the four sub-themes. The non-bold text and arrows illustrate some of the key details about each theme and hypothesised links between them

The women felt that being punished through having leave stopped or losing access to other meaningful activities could lead to a vicious cycle. They described feeling trapped on the ward with the other women and with few distractions as having an impact on their mood resulting in the increased likelihood of incidents such as self-harm, which would in turn lead to further restrictions and so continue the cycle:

It's quite difficult 'cause you get in a cycle of self-harming and stuff...'cause I cannot go out so I'm like stuck on the ward so I start struggling more 'cause I do not have any distractions

(Mary).

The women talked about how being permitted leave could contribute to their recovery as they would often use it as a coping strategy to clear their minds and to *"relax and get used to being back in the community"* (Josephine). They described how leave enabled them to feel as though they had some normality in their life, facilitated independence, provided distraction and took them away from the often-difficult ward environment.

Oh it's amazing, absolutely amazing. Just to go out like just to go even just to (shop) I went before on my own to (shop) with no staff it was amazing...It's independence at the end of the day y'know and it's so good

(Marie).

### 3.4 | Not being heard

The women described how the powerlessness they felt as a result of the restrictive practices removed or minimized their voices. This appeared to be especially true in the ward round where the women felt unable to contribute to decisions that were made about restrictions. Not being heard appeared to further emphasize the women's lack of control over their own lives.

When I had my ward round on Tuesday, I asked my consultant for more leave but he's not even given me more leave he's just kept it as it is and it's just felt like I've not been heard so I felt like I've gone in to ward round for nothing

(Christabel).

Some of the women described how, when they were not listened to, they would use self-harm in an attempt to express themselves or as a way of asking for help. Less often, the women also described having to speak aggressively, protest or *"throw a temper tantrum"* (Elizabeth) in an attempt to be heard. Responses such as self-harm or aggression could then lead to further restrictions. This cycle overlaps with the women's description of feeling punished leading to increased self-harm and further restrictions.

By self-harming because it's like that's the way I can physically show them that this is what you are doing



to me...Yeah 'cause I think with me like if I cannot explain it, I end up showing it by self-harming

(Edith).

Some women described eventually giving up their fight to be heard. They described it being pointless to keep arguing or challenging decisions that are made because ultimately the decision would be taken out of their hands. Some women said that the fight inside them eventually “died out” (Edith) and they became passive to restrictive practices, saying that they are “worn out” (Chimamanda).

**I:** So what's changed now, what's kind of stopped you fighting it now?

**P:** 'Cause there's no point...I just go along with it. Just go along, take me meds... (Valentina).

The women felt that it was easier for men to get their voices heard and to challenge restrictions because they were more physically powerful than women. Male aggression or protests were perceived to be taken more seriously by staff, in contrast to the women's attempts, which were often ignored.

It makes you feel a bit rubbish inside because it's like you wish you could get your point across like a man can, but you cannot because you are not built like a man

(Edith).

No nobody will give them (the men) nothing...but the good thing is they say no to them they could really break anything or shout...at least they have that power

(Chimamanda).

The importance of having someone to talk to and being listened to was emphasized by the women as an important way of increasing feelings of empowerment within the restrictive system where they felt powerless and as though they were not heard. In addition, an advocate who could speak on their behalf was invaluable. This provided a sense of being heard and resulted in changes to unhelpful restrictive ward practices.

So I knew it was against article three which is humiliation and degrading and stuff so erm I rang human rights and they told me the CQC so I rang them, they emailed the head

(name of head of inpatient services, Viola).

The above quote suggests that this participant found it easier to be heard by individuals outside of the ward team who themselves were able to influence the participants care and support her to be heard.

Finally, it was suggested that the opportunity to talk may be considered more valuable by women than by men. This viewpoint also resonated with the relationships theme outlined below. As restrictive

practices impacted upon women's ability to access their usual social support, they may have placed additional value on the opportunity to speak with a professional. Harriet below described her experience of working with a psychologist.

Well I think men bottle a lot of things up y'know, they just get on with it and do what they have gotta do but I'd rather get it out than bottle it up for years and it become like a festered wound inside your soul eating away at you and making you angry

(Harriet).

### 3.5 | Impact of restrictions on relationships

The women described how restrictions such as visitors or mobile phone access impacted on their ability to form and maintain relationships with others. Some women said they felt “awkward and ashamed” (Li) in front of their friends and families because of the restrictions placed upon them.

It's very difficult having fixed yourself and made yourself better that you do not get enough time with family to amend that relationship after all the suffering that's been caused and time's a healer and it's that time what you put in that heals that, it just does not heal overnight

(Ada).

Some women said that restrictive practices in hospital were a “barrier” (Millicent) to their relationships. Loss of such relationships was described as detrimental, as social support was an important source of coping for participants. The following interaction between the interviewer (I) and the participant (P) clarifies the importance of connection to the social world:

**I:** How important is that kind of social network to you for your kind of coping and your wellbeing?

**P:** It's really important like those two and a half years I was out it was so helpful like my friends especially y'know it got me through so much it really did.

**I:** Gosh so what's it like being here then without that network of support?

**P:** It's horrible, it's not easy (Marie).

Some women also talked about the impact of restrictive practices on them as mothers and how this could disrupt their bond with their children:

Yeah from my daughter d'y'know what I mean from bonding with her and I just feel like it's tight like I feel like she needs her Mum right now...I'm her birth





Mum d'y'know what I mean so she needs to bond with me

(Christabel).

Women talked about the importance of being able to turn to other women on the ward for support if they were struggling to cope with restrictive practices. One participant explained that during each of her admissions, another female inpatient had been like a “knight” (*Jane*) who came to her rescue and explained the rules and restrictions in place on the ward.

We just look out for each other. If someone's gonna do something, if we know someone's down and they are having a bad day, we'd be there for them and we'd sit and talk to them. We do more than what the staff do

(Millicent).

However, not all the women shared the view that the other women could be an important source of support. Some described the ward as being like “cat and mouse” (*Emmeline*), said they “hate each other's guts” (*Edith*) or said that seeing the other women struggling could be triggering for them.

### 3.6 | Restrictions providing safety and support

The restrictive environment of hospital was also viewed as a safe and supportive place at times. Women often seemed to hold conflicting views and talk about being “strangled” (*Maya*) by restrictions and feeling as though they are “in chains” (*Amelia*), but at the same time being supported and given “peace of mind” (*Matilde*).

**P:** Yeah last year was the first year that I'd actually been out of the hospital environment and dealing with the bereavement without any support network round me and my head fell off and that's why I got ill.

**I:** Yeah ok, so there's something about the hospital environment that does support you and...

**P:** It does, it's like a safety net (*Maya*).

The women generally seemed to feel that some rules needed to be in place to keep the ward calm and settled. Participants overall also felt that rules that provided structure and routine were good for their mental health. However, as their mental health improved, they perceived restrictions as more punitive.

I feel quite well now, so I feel quite frustrated sometimes with some of the restrictive practices that are in place

(Noor).

There was also a suggestion that staying in hospital for too long could lead to a reliance on the safety and support offered by restrictive practices or becoming institutionalized:

You feel institutionalized because you have been in hospital for so long, you have got staff around you 24/7...it's like even though I hate being in half the time, you feel safer because...it's not like you can just go out whenever you want and just think if you are very suicidal all of a sudden, d'y'know what I mean?

(Flora).

This was in contrast to the view that men might progress through the system quicker and be given more freedom than women, suggesting that men might not get as caught in the “safety net” (*Maya*) as women:

The men seem to get a lot more...I mean we only get three leaves a day, the men are out I do not know how many times...the men always seem to get more...The men seem to move on quicker than women as well

(Valentina).

## 4 | DISCUSSION

Powerlessness was the overarching theme identified as it appeared to be central to the analysis and to relate directly to each of the other themes. Powerlessness led women to see the restrictions as punitive, to feel they were not heard and negatively impacted close relationships. Although there was an aspect of the restrictions that provided feelings of safety and support, there was also a detrimental impact leading to increases in self-harm and to an over-reliance on the safety that restrictions provide. Additionally, women provided examples of care that increased their feelings of power whilst in the restrictive environment, such as being allowed some independence and having someone to speak to or to advocate on their behalf.

Feelings of powerlessness have been identified previously in relation to restrictive interventions (e.g., Fugger et al., 2016), and so our findings demonstrate that more subtle forms of restrictive practices can produce similar feelings. The finding that restrictive practices were seen as punitive is at odds with the UK Department of Health recommendation that restrictive practices should not be used as a punishment, but should be in place to promote safety (DoH, 2015). Previous research has indicated that participants see seclusion (Keski-Valkama et al., 2010) and forced medication (Seed et al., 2016) as being used for punishment. Our findings extend this to include some of the day-to-day restrictive practices. The vicious cycle described of having leave stopped or restricted access to other coping strategies, leading to greater likelihood of incidents such as self-harm and in turn leading to greater restrictions being put in





place, was a theme that recurred in this sample. Women are more likely to self-harm than men (Mental Health Foundation, 2020), and women who self-harm often remain in services, in particular secure services, for longer than they need to as a result (Bartlett & Somers, 2017). Our findings suggest that restrictive practices could be contributing to these extended hospital stays for some women.

Participants described feeling that restrictive practices resulted in them not being heard. The women interviewed here felt that men found it easier to be heard and this might reflect differences in social expectations for men and women. For example, men are more often viewed as dominant and assertive, whereas women might be viewed as passive and submissive (Logan & Taylor, 2017). Young girls are taught not to show anger or to get in to fights and so may feel less equipped to assert themselves and get their needs met independently than men in general (Wienclaw, 2011). Women are less likely to hold positions of power; for example, in Government (UNICEF, 2018), the police (Silvestri et al., 2013) and other senior management positions (Johns, 2013), and so have less of a voice in decision making across sectors (UNICEF, 2018). Men may also find it physically easier to be heard as they tend to have louder and deeper voices than women (Watson, 2019).

A further theme identified was the impact of restrictive practices on relationships. Relationships are known to be of particular importance to women (DoH, 2018). The impact, therefore, of restrictive practices reducing access to close relationships could be particularly detrimental to women. On a positive note, some women attempted to seek social support from professionals or by speaking to each other. Peer support is crucial in an inpatient setting where professionals are not always perceived to be available (Phillips et al., 2021).

A further theme highlighted positive aspects of restrictive practices that provided women with a safe and containing environment. Women have previously reported that secure services can feel reassuring and safe (Pashley et al., 2018). If they have experienced abuse and chaotic environments throughout their lives, as some of the women interviewed here described, hospital could be the most stable environment that they have experienced. Women described how, as they began to feel well, the restrictions began to feel more punitive and “strangling”. Staff in secure settings have reported that, in some cases, services might be particularly risk averse with regards to women and keep restrictions in place for longer than might be required (Bartlett & Somers, 2017). This cautious approach to working with women also reflects gender role socialization more broadly, as from a young age, girls are treated more carefully than boys and have greater restrictions placed on their freedom (Wienclaw, 2011). This could contribute to women staying longer in hospital than men (Fowler et al., 2017). Participants in this study described becoming reliant on the safety of hospital surroundings because of being in hospital for too long. There is a risk of institutionalization, and service users being less equipped to cope upon discharge to the community.

As men were not included in this sample, we cannot be certain that our results are unique to women. The women included in this study often felt unable to reflect on whether their experiences of restrictive practices were different to those of men. However, this

could be because the oppression of women is so ingrained in our culture that it is not always recognized (Herman, 2015). Indeed, female victims of sexual assault do not always report the crime and women continue to be blamed for crimes committed against them (Herman, 2015). More recently, powerful perpetrators have been held accountable for their crimes and it is hoped that such social movements will help to empower women (Herman, 2015).

#### 4.1 | Strengths and limitations

We recruited a sample size large enough to reach data sufficiency and large enough to capture a variety of views and experiences. Although attempts were made to sample a range of services and settings, only three of the women interviewed were currently on a mixed-sex ward. Sampling more women with experience of mixed-sex wards would have provided a valuable perspective on how women feel sharing the restricted environment with men. All women in the present analysis were cisgender. With increasing need to provide appropriate services for transgender women, hearing their perspective would have been valuable. This study focussed on the experiences of women. However, we acknowledge that women are not the only disempowered group in society and other groups are also likely to be differentially affected by restrictive practices. People from minority ethnic backgrounds are more likely to have repeated hospital admissions (Barnett et al., 2019), poorer outcomes from hospitalization (Eack & Newhill, 2012) and are more likely to experience coercion during an inpatient stay (CQC, 2011). Although our themes were apparent across all subgroups included in the sample, it is notable that women from minority ethnic backgrounds did particularly appear to feel powerless. One participant in particular expressed feeling that she was listened to less than other women on the ward as a result of the colour of her skin. This disparity requires further investigation.

#### 4.2 | Practice implications

Our findings indicate that restrictive practices can have a detrimental impact on women by leading to increases in self-harm, negatively impacting relationships or to an over-reliance on the safety that such restrictions provide. Therefore, in line with both international mental health care law (WHO, 1996) and DoH (2014) guidance in the United Kingdom, these results indicate that restrictive practices must only be used when it is unavoidable to prevent harm. We must use the least restrictive option available and it must be used only for the shortest possible time (DoH, 2014; WHO, 1996).

Promoting independence through allowing leave and access to individually meaningful activities during their hospitalization could be beneficial for women's mental health and help to reduce risk of incidents. A comparison of open and locked wards found less suicide on open wards (Huber et al., 2016), supporting the view that less restrictive approaches might contribute to self-harm reduction.



TABLE 2 Summary of clinical recommendations

Theme	Clinical recommendation	Suggestions for implementation	Relevant policy or research
Powerlessness	Promote equality	<ul style="list-style-type: none"> <li>• A public health approach to reducing gender inequality and violence towards women</li> </ul>	Magar et al. (2019)
	Trauma-informed care	<ul style="list-style-type: none"> <li>• Promote empowerment</li> <li>• Allow women to retain control over their care</li> <li>• A collaborative approach</li> <li>• Highlight strengths and resilience</li> <li>• Reduction of power imbalances</li> </ul>	DoH (2018), Elliott et al. (2005); Johnstone and Boyle (2018)
	Provision of information	<ul style="list-style-type: none"> <li>• Explain the rules on admission to hospital</li> <li>• Safewards: clear mutual expectations</li> <li>• Provide information about an individual's rights in hospital</li> <li>• Use of peer support workers</li> </ul>	Bowers et al. (2015); DoH (2010); DoH (2014); Pashley et al. (2018)
Restrictions perceived as punitive	Promote independence	<ul style="list-style-type: none"> <li>• Allow access to leave</li> <li>• Use of escorted leave could represent a less restrictive option than stopping leave</li> </ul>	DoH (2014)
	Enhance trust	<ul style="list-style-type: none"> <li>• Removal of restrictions as soon as possible</li> <li>• Enhance motivation through acknowledging hard work</li> </ul>	DoH (2014); Pashley et al. (2018)
Not being heard	Access to therapy	<ul style="list-style-type: none"> <li>• Access to psychological therapy</li> <li>• Discussion of past trauma if the woman wants to do this and it is safe</li> </ul>	DoH (2010); Pashley et al. (2018)
	Listening to women's voices	<ul style="list-style-type: none"> <li>• Ensuring women have a space to speak and to be listened to in ward round</li> <li>• Creating other forums to allow women to be heard</li> <li>• Safewards: soft words</li> <li>• Support from an independent advocate who can help the women to be heard</li> </ul>	Bowers et al. (2015); DoH (2014)
Impact of restrictions on relationships	Support to maintain relationships	<ul style="list-style-type: none"> <li>• Encourage women to access social support</li> <li>• Use of leave for this purpose</li> <li>• Possibility of encouraging supportive relationships with other service users</li> </ul>	DoH (2010); Elliott et al. (2005); Pashley et al. (2018)
Restrictions providing safety and support	Shorter admissions	<ul style="list-style-type: none"> <li>• Admission only when acutely unwell and discharge as soon as possible, representing least restrictive option</li> </ul>	DoH (2014)

Hospital advocates who can support women to be heard and offer advice could be particularly helpful for female inpatients. This could be a valuable role for peer mentors who have been through the system themselves and have been found to help women in secure services to feel more hopeful about the possibility of recovery (Pashley et al., 2018).

Our findings suggest that women should be supported to move on more quickly from an inpatient stay. Hospitalization is likely to be most beneficial for a very brief period when a woman is struggling with acute mental distress. As soon as she feels well enough, she should be able to move on, so she is not kept in hospital for too long with the associated impact that restrictive practices have on her mental health and well-being.

It has been recognized that restrictive practices can contribute to conflict on mental health wards (Bowers et al., 2014). The Safewards model provides mental health nurses with evidence-based interventions to therapeutically prevent or contain such conflict (Bowers

et al., 2015). The clear mutual expectations intervention recommends staff and service users collaboratively identify and agree to a list of standards for the ward. These standards should then be displayed on the ward and included in the admission process. It is hoped that by ensuring all service users are aware of the expectations placed upon them, this could reduce feelings of powerlessness. The soft words intervention suggests ways of communicating with service users in difficult situations, for example, having to turn down a request. It emphasizes respectful listening, saying yes to requests wherever possible, apologizing, explaining clearly why the request cannot be granted and negotiating alternatives. This intervention could contribute to service users feeling that they have been heard and understood.

It is now recognized that people must be supported with their mental health in the context of their life experiences (Stewart, 2006). Relational security and trauma-informed care have been particularly recommended for women in secure care (NHS, 2017) and our



findings extend this recommendation to other settings. Relational security includes being clear about rules and boundaries, provision of therapy and supporting service users with their connections to the outside world (DoH, 2010). Trauma-informed care that promotes empowerment should be seen as essential, otherwise there is a risk that the powerlessness that an individual faced at the hands of their abuser is recreated through services (Elliott et al., 2005). A summary of clinical recommendations can be seen in Table 2. As previously stated, these recommendations are not necessarily specific to women. However, it will be important for staff to reflect on how gender might inadvertently influence treatment and to be more aware of the highlighted issues when working with women, due to women's differential experiences of and response to trauma, as well as wider social and political issues resulting in the oppression of women.

### 4.3 | Future research

Future research investigating less restrictive alternatives to inpatient care specifically for women would be beneficial. In particular, research might examine whether self-harm can be managed without increasing restrictions, to determine if this has a positive effect on rates of self-harm and recovery. Seeking the perspectives of men on restrictive practices would add to this analysis and determine which aspects are most specific for women, as well as incorporating the views of transgender women. Finally, similar research needs to be conducted with people from other minority groups who also face disempowerment in society and appear to have poorer outcomes from hospitalization. This should be a research priority to understand the factors contributing to this disparity to be able to promote equity of service provision for all.

## 5 | CONCLUSIONS

Participants described feeling powerless because of the restrictive practices used in the inpatient setting. Although the restrictions could offer a sense of safety, they were also found to have a detrimental effect. Inpatient settings should follow the principles of trauma-informed care to allow women to retain as much control as possible while they are in hospital. Steps should be taken to reduce the power imbalance that exists for women in an inpatient setting and also on a wider level through a public health approach that works to reduce gender inequality and ensures that women occupy the same social position as men (Magar et al., 2019).

## 6 | RELEVANCE STATEMENT

Mental health nurses in inpatient settings work within a highly restrictive setting. They are also involved in making decisions about

additional restrictions, such as loss of leave or removal of belongings. Restrictive practices can often result in conflict between patients and nursing staff, which can be difficult for everyone involved. Therefore, this research is relevant to nursing staff to help them to consider the impact of restrictive practices and possible alternative ways of working. For example, use of safeguards interventions to reduce the impact of restrictive practices. All staff are required to work with the least restrictive approaches possible, and this paper will support that work.

### ACKNOWLEDGEMENT

With thanks to all the women who contributed to this research.

### DATA AVAILABILITY STATEMENT

Author elects to not share data.

### ETHICAL APPROVAL

This research received ethical approval from North-West Preston Research Ethics Committee (19/NW/0244).

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**How to cite this article:** Tully, S. M., Bucci, S., & Berry, K. (2023). "My life isn't my life, it's the systems": A qualitative exploration of women's experiences of day-to-day restrictive practices as inpatients. *Journal of Psychiatric and Mental Health Nursing*, 30, 110–122. <https://doi.org/10.1111/jpm.12855>