

Middlesex University Research Repository

An open access repository of
Middlesex University research

<http://eprints.mdx.ac.uk>

Obi-Udejaja, Jane (2009) An exploration of mental health service users' experience of being manually restrained in local NHS in-patient wards. Masters thesis, Middlesex University.

Final accepted version (with author's formatting)

Available from Middlesex University's Research Repository at
<http://eprints.mdx.ac.uk/17213/>

Copyright:

Middlesex University Research Repository makes the University's research available electronically.

Copyright and moral rights to this thesis/research project are retained by the author and/or other copyright owners. The work is supplied on the understanding that any use for commercial gain is strictly forbidden. A copy may be downloaded for personal, non-commercial, research or study without prior permission and without charge. Any use of the thesis/research project for private study or research must be properly acknowledged with reference to the work's full bibliographic details.

This thesis/research project may not be reproduced in any format or medium, or extensive quotations taken from it, or its content changed in any way, without first obtaining permission in writing from the copyright holder(s).

If you believe that any material held in the repository infringes copyright law, please contact the Repository Team at Middlesex University via the following email address:

eprints@mdx.ac.uk

The item will be removed from the repository while any claim is being investigated.

**An Exploration of Mental Health
Service Users' & Carers' experience of being
manually restrained in local NHS in-patient wards
for the purpose of informing training on
Physical Intervention Techniques**

Dissertation for the MSc in Risk Management
(PRS 4599)
School of Health & Social Sciences
Middlesex University

By
Jane Obi-Udejaja
Student number 2347017

Supervised by John Watt & Janet Holmshaw

May 2009

Acknowledgement

I want to thank my supervisors Janet Holmshaw and John Watt for their support and guidance.

My thanks and gratitude go to all work colleagues, friends and neighbours including: David Price, Lawrence Dadzie, Aase Villasden, Sarah Cox, Elizabeth Sylvanus Ley who patiently put up with my interruptions and questions and supported me often at very short notice.

Immense love and gratitude go to my family for their support and sacrifices that enabled this work.

Finally, I want to express special thanks and indebtedness to the service users whose contribution made this study possible.

I certify that the work presented in the dissertation is my own unless referenced.

Signature

Date

Total number of words: approx. 15,374

Abstract

Physical intervention is often used to manage incidents involving service users in mental health in-patient wards. Yet, little effort has been channelled into finding out the views of such individuals regarding the experience.

This study aimed to document the experiences and perceptions (good and bad) of local mental health service users who had the experience of being restrained whilst in admission.

A qualitative research approach adopting the phenomenological strategy was employed. Semi-structured interviews were used to collect data from five service users with seven experiences of manual restraint and who either volunteered, were contacted purposively or recruited through snowball sampling.

Service users identified two contrasting moods (anger and concern) of the staff restraint team. These moods they said, determined how the procedure was carried out. Twenty nine categories of restraint team practices were identified including: non-pain compliant holds, early intervention, post incident review including debriefing, pain compliant holds, angry orders/no communication, abandoned after being restrained.

The categories clustered under the six core themes that emerged from the data including: build-up to physical restraint, power imbalance, communication, staff training. The themes were discussed. One of the areas suggested for further research was how staff mood and feelings towards the person being restrained affect their practice during the process. The implications for future physical intervention training were considered.

Key words: in-patient ward, mental health, manual restraint (control and restraint), NHS, service users, violence and aggression.

Table of Contents

| | Page |
|--|-------------|
| Acknowledgement | i |
| Abstract | ii |
| Chapter One – An Overview | |
| 1.1 Introduction | 1 |
| 1.2 Rational for the Study | 3 |
| 1.3 Aims and Objectives | 4 |
| 1.4 Operational Definitions | 5 |
| 1.5 Scope of the Study | 6 |
| 1.6 Outline of the Study | 6 |
| Chapter Two - Literature Review | |
| 2.1 Control and restraint is used as Punishment | 10 |
| 2.2 Emotional and Psychological Effect | 12 |
| 2.3 Post Incident Support and Therapeutic Relationship | 13 |
| 2.4 User Centred Approach | 15 |
| 2.5 Staff Training | 16 |
| Chapter Three - Research Methodology | |
| 3.1 Research Approach and Design | 19 |
| 3.2 Research Method | 20 |
| 3.3 Access to Study Sample | 21 |
| 3.4 Ethical Considerations | 25 |
| 3.5 Preparation and Collection of Data | 27 |
| 3.5.1 Data Collected | 30 |
| 3.5.2 Limitations of the Data Collection Method | 31 |
| 3.6 Data Analysis | 32 |
| 3.6.1 Transcribing Data | 33 |
| 3.6.2 Data Components | 34 |
| 3.6.3 Reducing Data to Invariant Horizons | 36 |
| Chapter Four - Results and Discussion | |
| 4.1 Results | 37 |
| 4.1.1 Identifying Concepts and Categories | 37 |
| 4.1.2 Summary of the Results | 44 |
| 4.1.3 Taking the Results to Team Colleagues | 44 |
| 4.2 Discussion | 45 |
| 4.2.1 Approach to the discussion | 45 |
| 4.2.2 The Themes | 46 |

Chapter Five - Conclusion

| | | |
|-----|---------------------------------|----|
| 5.1 | Summary | 55 |
| 5.2 | Findings | 55 |
| 5.3 | Strengths and Limitations | 55 |
| 5.4 | Suggestions for further studies | 57 |

| | |
|-------------------|----|
| References | 58 |
|-------------------|----|

| | |
|-------------------|----|
| Appendices | 66 |
|-------------------|----|

Chapter One

AN OVERVIEW

1.1 Introduction

The fundamental reason for admitting mentally ill people into the wards is to support them to get well enough for life back in the community. Physical intervention is often used to manage incidents of aggression and violence involving these individuals (service users) during their stay in the hospital, yet little effort has been channelled into finding out their experiences and feelings regarding the staff use of such management tool.

People with severe mental illness represent some of the most vulnerable people in our society (Borckardt et al 2007, p355; Kumar, Guite and Thornicroft 2001, p597). As a group, they have high rates of life time trauma exposure compounded by the fact that certain psychiatric experiences may recapitulate previous trauma, exacerbating psychiatric symptoms (Borckardt et al 2007, p355).

Contrary to media representation and popularly held views, this group of people experience violence from a variety of sources that may include fellow service users, the general public, and even the professionals in whom they may invest trust to care for them (Kumar et al. 2001, p597). Evidence shows that despite their vulnerability, clinicians are quick to employ physical intervention in managing issues involving patients in psychiatric wards (Shepherd and Lavender 1999, p165; National Audit of Violence 2006-2007, p3; Johnson 1998, cited in Ryan and Bowers 2006, p528). Fisher (2003 cited in Paterson 2005, p20) stated that restraint unless its use is contextualised and subject to rigorous safeguards may represent in and of itself a form of violence which ‘precludes therapy’.

Physical intervention is the most commonly taught response for the management of violent behaviour in the UK, yet there is little research on its safety and effectiveness Southcott and Howard (2007, p35), in particular its effect on the recipient. Evidence abounds to show that a poorly executed restraint procedure can result in injuries (physical and/or emotional) or even death such as the deaths in restraint of David Rocky Bennett 1998 and Gareth Myatt 2004.

Middlesex University mental health and social works department supports and promotes government initiatives on service user involvement in their care. The researcher works within a team whose subject area – the therapeutic management of violence and aggression involves training clinicians in the skills of prediction, prevention, de-escalation and management of aggressive and violent behaviours in the NHS. The team works within ‘best practice’ guidelines from various bodies including the National Institute for Clinical Excellence (NICE), and the National Mental Health Development Unit (NMHDU) formally NIMHE. Notwithstanding the guidelines from these bodies, members of the team believed that greater insight could be gained by re-looking at what they taught from the service users’ and their carers’ view point i.e. users who experienced manual restraint while in a psychiatric in patient setting and the insight used in the improvement and delivery of the team’s training service. As Tew, Gell and Foster (2004, p4) aptly put it “By virtue of their direct experience of mental distress and of professional responses (helpful and unhelpful), service users and carers have valuable knowledge and expertise to offer.”

The model of physical intervention taught at Middlesex University is approved by General Services Association (GSA). The entire package is continually undergoing modification to ensure it continues to meet various requirements including legal, ethical, medical, and biomechanical expectations. From a pain compliant background, it has evolved to “non pain compliance”. Participants in the course undergo five full days of rigorous training. Apart from a continuous assessment of competence on practical skills, they must show among other things, professionalism in their approach,

observation skills, good attitude and effective communication skills during a restraint procedure with the objective of de-escalating the incident and bringing the restraint to an end.

In a non operational training environment, it is easy to achieve a perfect restraint procedure. In a real ward scenario, when many factors enter the equation, the process may become anything but perfect. Paterson (2007, p30-31) had observed that during a contested struggle for control, frightened, angry staff, whether trained or otherwise, can find themselves unwittingly drawn into a modification of the technique, in particular, into the use of forceful prone (a restraint approach where pressure is applied to the back, abdomen or hips rather than, or in addition to, the holding of the limbs).

This study aims to identify both good and bad practices of staff as they use the model of restraint procedure they are taught. The researcher believes that the individuals who have experienced the procedure are the right people to ask.

The study presents the perspectives of service users and carers living in the community who had been restrained while in a local in-patient mental health ward. The main focus is on their experiences and perceptions of the incidents.

It is important to state that in exploring the users'/carers' perspectives, the aim is not to step outside the existing guidelines but to look beyond them to see what else might be used to support them.

1.2 Rationale for the study

Much has been written on the topic of violence and aggression (Mason and Chandley 1999, p16; Wand and Coulson 2006, p163), but there is a paucity of work on physical intervention as a management option for a violent incident and more so on the subjective experiences of individuals who have been manually restrained in a mental health in-patient ward (Sequeira and Halstead 2002, p10; Kumar et al. 2001, p598). As Wright (1999, p466) puts it, research in 'Control and Restraint' is

quite patchy. There is a dearth of study that has viewed the issue through the restrained person's lenses. This is hardly surprising considering that until the relatively recent initiatives to involve patients/service users in their care, the approach in the health service had been that of 'clinicians have all the answers'. Faced with an aggressive situation, staff would employ manual restraint even when interventions other than physical could do – 'power imbalance'? (Gilburt, Rose and Slade 2008; Kumar et al. 2001; Paterson, Leadbetter and McComish 1997).

Anecdotal evidence suggests that there is a disparity between the perceptions of those carrying out manual restraint techniques and those receiving them Brennan (1999, p258). Brennan (1995, cited in Brennan 1999, p260) further states that the ultimate measure and mode of evaluation needs to be the perceptions expressed by the latter group. Reiterating, Gilburt et al. (2008, p81) state that the patients' experience is increasingly recognised as an important factor in developing and providing excellence in health care.

The writer believes that research into patients'/carers' experience of physical intervention is necessary in order to establish a bench mark for good training and practice in the use of this life saving but rather sensitive tool. It is hoped that the outcome of this particular one will help to enrich the team's training service – a benefit to commissioners of the training service, to the team, Middlesex University and ultimately to the society.

1.3 Aims and Objectives of the study

The study aimed to answer the following research questions:

- Why would service users/carers in mental health wards behave in ways that may require physical intervention to manage?

- What were the experiences and feelings of these service users/carers during their respective restraint process?

The objectives were:

- to gain an insight into the perceptions and feelings of these individuals regarding the incidents, and
- to identify and document staff practices (good and bad) during each restraint process that could be used to improve the physical intervention training for Trust staff.

1.4 Operational Definitions

Service User: For the purpose of this study, a service user is an adult male or female who have previous experience of being physically restrained whilst in a local in-patient mental health ward, and who is now living in the local community.

A *carer* is a person caring for/working in the interest of a service user. It could be a relation, a friend, an advocate, a paid professional/staff etc.

Mental health: The World Health Organization (cited in Golightley 2004, p2) described mental health as a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Physical Intervention (hands-on restraint): Skilled, hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned (NICE 2005, cited in the National Audit of Violence 2007, p21).

Manual restraint is used interchangeably with physical intervention in the study.

1.5 Scope of the study

This research is concerned with the management of violence and aggression in the short term, that is, as it comes closer to us and ultimately embroils us in the physical effort of practical management (Mason and Chandley 1999, p33). It is limited to the encroachment of an incident that results in a hands-on restraint by the staff and what happened after. The focus thus is on the build-up to a crisis, the intervention by the staff at the build-up stage, the use of physical intervention at the crisis stage and what happened when it was over (post incident follow up) as depicted in figure 1.

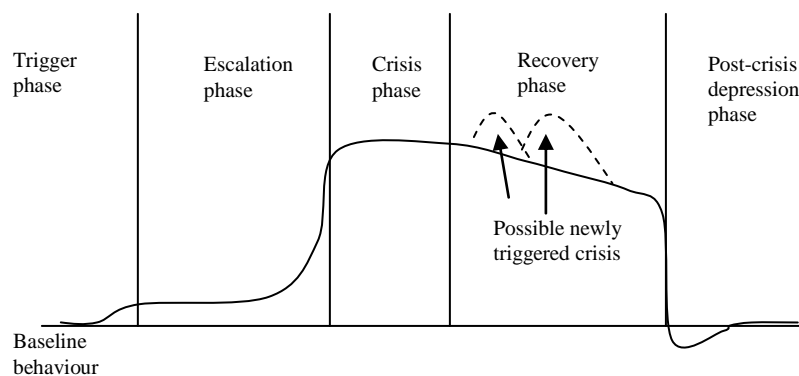


Fig. 1: *Phases of a typical assault cycle adapted from Kid and Stark (1995, p8)*

While acknowledging the importance of long-term therapeutic management approaches to reduce incidents of violent and aggressive behaviours in the first instance, such approaches are beyond the scope of this study.

1.6 Outline of the study

Chapter one provides an overview of the research topic, the rationale for the project as well as its aims and objectives.

Chapter two presents a review of the literature related to the use of manual restraint in the management of incidents in the health sector with particular focus on the NHS mental health in-

patient wards.

Chapter three attempts to explain the approach adopted for this study. Among the issues discussed are: the conceptual approach, the methods used and why, the data sources and the ethical considerations.

In chapter four, the results from data analysis are presented and also the summary of the findings. Discussion on the results and justification for the interpretation is also presented in this chapter.

Chapter five concludes with a short summary of the study and its findings, the strengths and limitations of the study and recommendations for further work.

Chapter Two

LITERATURE REVIEW

The risk of aggression and violence in the health sector in particular the NHS mental health in-patient wards is a social reality (National Audit of Violence 2006-2007, NHS Security Management Services 2007) and so also the use of physical intervention to manage violent incidents. We are all challenged to contribute to finding out all that is possible to know about this work place risk in order that the right solution to the problem may be devised. Parahoo (2006) had said that the purpose of research is to make a contribution, however small towards understanding the phenomenon being studied and ultimately towards the total body of knowledge.

The few studies so far on the use of manual restraint in mental health in-patient wards tend to focus the investigation on descriptions of assailants and the violence perpetrated (Shepherd and Lavender 1999, p159). The notion is that the assailants, assumed to be the patients, are reacting to their mental health symptoms. The blame for the incident is thus automatically attributed to these individuals. Contrary to this view, in their investigation of incidents resulting in restraints, Sheridan et al. (1990, cited in Shepherd and Lavender 1999, p160) reported that aggressive behaviours leading to restraint were more likely to relate to external situations such as authoritarian regimes than to patients' internal psychiatric symptoms. Although some studies contradicted Sheridan's findings example Powell et al. (1994, cited in Shepherd and Lavender 1999, p160) nevertheless, common to all of them is the acknowledgement that violence and aggression by mentally ill patients are caused by a multiplicity of factors including factors external to them and those internal to them. In other words, patients in mental health wards are restrained not only because of their reactions to mental health symptoms but also, indeed more often, because of their reactions to external provocations and triggers.

This study seeks to find out how mental health patients who found themselves being restrained for

whatever reasons perceived the restraint process – their subjective experiences and perceptions before, during and after the restraint process, their side of the story. The study starts by critically evaluating relevant literature and justifying the need for the study.

The Cumulative Index to Nursing and Allied Health (CINNAL 22nd September 2008) and Medical Literature On-Line (MEDLINE 22nd September 2008) were searched to find studies that specifically explored the experiences and perceptions of mentally ill people who had been manually restrained in mental health wards. Key search terms included: violence and aggression, NHS settings, mental health wards, physical intervention, ‘control and restraint’, service users’ perspective. Based on these searches and other efforts to locate prior studies on the topic, it was evident that little research work had been carried out that looked at manual restraint from the recipients’ view point.

Further searches were carried out to locate related studies on the topic. This yielded a more satisfactory result. Fifteen examples of literature that included studies on the topic under investigation as well as related topics were logged and classified. Published books were consulted for further information, so also dissertation abstracts and conference presentations that related to the field of study.

The review process was guided by methods used in the research texts (Grix 2004; and Bell 2005). Thus, a critical analysis of each item of literature involving a visual search for, and pulling together of themes and issues that were associated was carried out. These were categorised and a total of five key themes was identified. The discussion on the contents of the published papers was carried out using the identified themes as the structure.

2.1 ‘Control and Restraint’ is used as Punishment

The studies reviewed found mixed perceptions of restraint process. The majority, particularly those that used in-depth interview method to explore the perceptions of service users on the issue, reported that in most of the interventions, the service users perceived manual restraint as a punishment.

Service users in Kumar et al. (2001, p602 and p605) described it as ‘being jumped’ that it appeared punitive, revengeful, physically painful and used too frequently. They believed it was done at the convenience of the staff and not in the interest of the patient. According to them, if you were told to do something and you began to argue, you were seen as stubborn and you were “jumped”.

Agreeing with the view of frequent use, Shepherd and Lavender (1999, p167) found that physical interventions were significantly more likely to be used than verbal interventions in managing aggressive incidents (approximately 65% :31% respectively).

Gilburt et al. (2008, p4 and p10), using a participatory research approach and in-depth interview to study 19 service users’ experience of psychiatric hospital admission had described restraint, seclusion and forced medication as objective coercion. According to them, inherent in the staff role of maintaining control is a level of power over patients – a power imbalance that leads to abuses and unethical use of coercion as depicted in the description of a restraint experience by a participant in their study “I wasn’t restrained, I was attacked. They wanted to tear me to pieces and I have arthritis of the shoulder to prove it”.

In his response to Millfields Charter’s proposal to ban ‘prone’ restraint, Paterson (2007, p31) talked about ‘field modifications’ of restraint techniques by staff seeking to contain (or punish) the service user more effectively – a situation which increases the risks involved as well as gives rise to the perception of the procedure as punishment by both recipients and witnesses.

Using content analysis of post-incident reports, Ryan and Bowers (2006, p527) found that the use of manual restraint was more related to patients' ill-directed frustration, resistance to containment and their desire to leave the ward.

In his research on aggression management training in health care, Brennan (1999, p259) raised the concern about practices in settings where the culture promotes restraint as a response from staff not only to aggression and violence but to non-co-operation such as refusal to get out of bed - a misuse of restraint as a management tool that can lead to negative outcomes and perceptions of physical intervention. Buttressing this point, Soloff (1979, cited in Shepherd and Lavender 1999, p167) noted that only 45 out of 111 episodes of restraint followed violent behaviour suggesting that some care environments may have a culture of over reliance on physical intervention even where less restrictive methods could be employed.

The risk that an abuse of 'control and restraint' may increase the likelihood of aggression through modelling and reinforcement was observed by a number of the studies reviewed (Jones and Stenfert Kroese 2006, p52; Sequiera and Halstead 2002; Kumar et al. 2001, p606; Brennan 1999, p259). In an abuse context, the restrained individual could either become very resistive or resign himself/herself to the situation. Where resistance is the case, staff may resort to 'field modifications' (Paterson 2007, p31). The outcome either way could be physical and/or emotional injuries or even death, thus, fuelling the negative perception of this sometimes life saving management tool.

In contrast to this negative view, some researchers found that some recipients of the process actually crave it because according to them it helps them to release feelings especially that of anger (Sequiera and Halstead 2002; Steckley 2008). In a study of young people and their residential staff regarding their physical restraint experiences, Steckley (2008) found among other things that some of the residents crave physical restraint because according to them, it un-bottles their anger and helps them

to get it out. A user in this group said that she would feel so angry with so many people around her that her eyes would fill up and she would cry and then feel alright. This presents a situation where staff would have to be careful or they would be reinforcing the challenging behaviour.

While proposing alternative strategies to physical intervention, Paterson (2007, p33) admits that there are situations where physical intervention is the only adequate tool for safe management of an incident.

2.2 Emotional and Psychological effect

All the papers that explored the patients' views had much to say about the emotional effects of manual restraint especially on the recipient. Unfortunately, when staff judge the restrained person as violent and nothing but "trouble", little attention is paid to this very worrying possible by-product of physical intervention.

From the feedback given by the women such as negative experiences of flashbacks of sexual trauma, feelings of domination, loss of dignity and vulnerability, Sequeira and Halstead (2002, p10) concluded that restraint can be experienced as rape re-traumatisation. In Kumar et al. (2001, p602) a service user had said that abuse has devastating effects particularly when it is from the people in the trusted position of helpers.

By examining the incident report forms in a medium secure unit over a seven year period, Green and Robinson (2005 p41-42) were able to identify and categorise violence and aggression by focusing on the degree of physical connection with and damage on the intended object. The short-coming of this approach however is its inability to recognise the effects other than physical on those involved such as the emotional/psychological effect of violence.

Steckley (2008) using in-depth interviews found that some residents felt very negative emotions about restraint. The same study, however, found that some residents did not enjoy being out of control and so felt safer and reassured when staff had got them physically. Another group in the same study craved physical intervention because it un-bottles their feelings of anger.

It is significant that only the few studies that used semi-structured/in-depth interview method that actually covered the psychological effects on the recipients of physical restraint. Studies that use other methods tend to focus on anything but the emotional trauma. Yet, given the opportunity, many patients state that they find the emotional trauma more painful and devastating. This emphasises the need for more studies using in-depth interview method to confirm or discredit the few existing findings on the emotional effect of 'control and restraint', and to add to them.

2.3 Post Incident Support and Therapeutic Relationship

Much mental health care is dependent on a strong therapeutic alliance between patients and nursing staff (Outlaw and Lowery 1994, cited in Sequeira and Halstead 2002, p10).

Brennan (1999, p259) had stated that the efficacy and therapeutic value of manual restraint should be measured and monitored not by how proficiently staff are able to recall and apply the physical skills but by how reassured, pain-free and dignified the service user reports to be when interviewed after an incident.

Borckardt et al. (2007) using a review of literature method noted the growing national consensus that institutional control measures (such as physical intervention) within psychiatric hospitals are both frequent and potentially counter-therapeutic for people with mental illness.

In a study of 10 restraint incidents Jones and Stenfert Kroese (2006) found that only two of the participants had a positive interaction with staff after the incident. Three were ignored and not spoken to for days while five said they were spoken to but in a threatening manner such as, 'you either behave yourself or you'll be sent to your room' and 'if you calm down, we'll let you out of the seclusion room'.

Steckley (2008), on the other hand, found in her study that when control and restraint is professionally and sensitively conducted for good reason, the therapeutic relationship and trust between staff and patient can be enhanced. In her study, one resident had said that he actually felt that the staff were protecting him and that increased his confidence in the staff. Another said that he had only ever been restrained by his key worker and that made him feel better in his relationship with the key worker. The latter example gives credence to the observation by Ryan and Bowers (2006, p532) that restraint techniques appear to be necessary skills in the health sector. If such is the case they argued, then all nurses and staff from allied services should acquire the skills in order that care units may become self sufficient and less reliant on formal team responses or, indeed, police involvement.

As a whole, the majority of the literature reviewed failed to treat the issue of debriefing and support for those involved in restraint (staff, patient and witnesses) and post incident review. This is a worrying situation because debriefing and post incident review are very important parts of physical intervention. Among other things, a post incident review would look at ways of avoiding the recurrence of the situation. More importantly, debriefing ensures emotional and practical support for all involved. The fact that existing studies have not adequately treated this aspect of physical intervention as a management tool does leave a gap which needs to be filled.

2.4 User centred Approach

In spite of the current and ongoing government initiatives and efforts directed at service user orientation in care delivery, especially in psychiatric settings, and the best practice guidelines on physical intervention from bodies such as National Institute for Clinical Excellence and the National Mental Health Development Unit in England, the literature reviewed did not fully address the specific question of how service user/carer oriented hands-on physical interventions in in-patient wards were.

The few authors who touched on the issue did so briefly. In their seven year study of reducing violence in a forensic mental health unit, Green and Robinson (2005, p44) talked about the development of user partnerships (groups, committees) and the involvement of service users in their care which strategy, in their findings, contributed along with others to the achievement of a reduction in violence over the period of their study.

As stated earlier, Brennan (1999, p259) had said that service users' feedback after an incident should be used to assess the efficacy and the therapeutic values of the tool. This view re-emphasises the importance of debriefing and post incident review, those aspects of a physical intervention process which allow for the service user's feelings and views on the incident and which input may help to improve practice.

Paterson (2005, p18) in his study found that among the initiatives that helped in the reduction of the use of restraint was the practice by the organisation in establishing and maintaining a dialogue with the service user and in involving service users in crisis management planning.

Borckardt et al. (2007, p358) explained the engagement model of care as a framework for improving the therapeutic milieu of inpatient settings in order to reduce potential antecedents to adverse psychiatric events and the subsequent need for seclusion and restraint. The model advocates an intensive involvement of the service users in the care environment system.

2.5 Staff Training

All the papers reviewed talked about training, some more elaborately than others, depending on their focus point.

Using semi-structured interview, Jones and Stenfert Kroese (2006, p50) found among other things that there is a definite need for staff training for those involved in performing restraint. According to the study, all the participants acknowledged this need when concern for injuries due to poor proficiency and training was discussed. A patient in the study had retorted that if staff could not handle restraint, then they should not be working in the establishment. Another patient was concerned that staff performed the techniques in different ways – field modification?

Many of the studies emphasised the importance of non physical skills that would enable staff to risk assess in order to predict and prevent as well as skills to de-escalate incidents so that physical intervention remains a ‘last resort’ option. Brennan (1999, p260) refers to such skills as ‘non-touch intervention’ saying that by having an extended number of responses, carers can indulge in systematic risk taking – talking or negotiating with clients in situations they may previously have been resolved using physical intervention. Putting it more succinctly, Paterson (2005, p20) said that training must emphasise the proactive prevention rather than just the reactive management of incidents.

Brennan (1999, p260) acknowledged that physical restraint have started to respond to the needs of the patients, nevertheless, he emphasised the need for the techniques to be taught within a framework of antecedent analysis, trigger awareness, theories, post traumatic stress disorder and others. This he hoped would challenge the myth that only those of a machismo disposition are considered most suitable for coping with aggressive patients.

In their work, Green and Robinson (2005, p44) found that when training in the management of aggression was comprehensive enough, encompassing awareness and recognition of aggression, risk assessment and prevention strategies, through to observation, interaction and de-escalation strategies, up to breakaway techniques, and team work physical intervention, staff reported increased confidence in their ability to deal with violence and aggression, with a resulting reduction in fear and expressed emotion.

Paterson et al. (1997) meanwhile, refuted the nurses' historical view of de-escalation as an intuitive process and argued instead that de-escalation could be developed as a set of practice skills. They believed that de-escalation could supplement physical restraint and might contribute to a quick cessation of the restraint process and the re-establishment of therapeutic relationship.

Having found that ward violence was influenced by factors internal and external to the assailant, Shepherd and Lavender (1999, p169) noted that the external factors appeared to be particularly important and most amenable to intervention using knowledge and skills acquired and developed through training and practice.

Service users laid emphasis on the role of staff in maintaining a sense of safety for the patients in an in-patient setting (Gilburt et al. 2008, p9). According to this finding, an experience of safety was

maintained despite fearful situations arising, when staff demonstrated professionalism in their job and were able to control and contain situations, preventing them escalating and affecting other patients. This again emphasises the importance of knowledge and skills – capabilities usually gained through training and improved through practice.

Chapter Three

RESEARCH METHODOLOGY

In this section, an attempt is made to explain how the study was undertaken, the choice of research strategy driven by the researcher's ontological and epistemological assumptions (Grix 2004, p32-33). Among the issues discussed were: the conceptual approach, the methods used and their justifications, the data sources and ethical considerations.

3.1 Research approach and design

The issue being researched was a social phenomenon – the use of physical restraint to manage incidents involving mentally ill patients.

The question was 'What approach was best suited for this study?' - A 'detached' or an 'interactive' stance? In deciding which strategy to use, the researcher reasoned that if one wanted to get a true picture of what happened in each scenario, including the feelings of the participants regarding the experience, then there was a need to get close to the data source in line with interpretivism (Gray 2004, p22).

In order to gain the required close interaction with data source, the researcher chose a qualitative research approach whose essential characteristic is exploration in order to understand perception and actions (Parahoo 2006, p63).

The researcher wanted to get close to those individuals who had experienced physical restraint techniques either as service users or as carers of service users. The idea was to set aside/bracket one's own prevailing understanding of the subject matter and work collaboratively with these individuals in the belief that new meanings might emerge (Gray 2004, p21; Parahoo 2006, p68, Crotty 1996, p19). This strategy identifies with Husserlian phenomenological philosophy which

stresses the notion that only those who experience phenomena are capable of communicating them to the outside world (Parahoo 2006).

The researcher wanted to hear what the participants had to say about their experiences. Using phenomenological research strategy made it possible to pick up ‘thick descriptions’ (Gray 2004, p28) of these experiences which were analysed qualitatively to identify practices of interest in restraint procedure as used by staff. Findings would be used to improve training for staff that carry out restraint procedures. In effect, service users were given the opportunity to contribute to the way they would be managed during a restraint process in line with government initiatives on service user involvement in their care (DoH 1996).

3.2 Method

The choice was made to carry out the project using:

Semi-structured interview

This chapter describes how semi-structured interviews were used to capture the experiences during restraint procedures of service users - the data source. Each incident was critically analysed to see what could be learnt and used to improve training.

Semi-structured interview was considered appropriate because of its qualities and features, in particular its flexibility, allowing opportunities to pursue unexpected lines of inquiry during the interview (Robson 2002, p272-273; Bell 2005, p157). This quality of the method made it possible to capture details of each service user’s experiences and perceptions regarding their respective incidents, an opportunity that other methods such as a self-administered questionnaire would not give. Equally the face-to-face interview provided the opportunity to observe non-verbal cues which held messages that helped in understanding the verbal responses.

It was considered that a completely unstructured interview could result in the loss of essential points as participants could easily deviate from the issue under discussion. Equally, a fully structured interview method might have been too rigid and prescriptive, and not given opportunity for the participants to honestly express their experiences and feelings or for the researcher to probe.

3.3 Access to study sample group and how the challenges were managed

A study sample is the proportion or subset of the total number of units (the population) from which data can potentially be collected (Parahoo 2006, p256). Five to fifteen participants for an in-depth interview had been suggested by Gray (2004, p22). The researcher had aimed to recruit eight to ten participants.

The target population was former NHS mental health inpatients who were living independently in the community. This group was classified as vulnerable (Parahoo 2006). To reduce the chances of recruiting persons who might be undergoing a relapse and unable to make informed decisions, the population was narrowed down to local service user groups who had established links with Middlesex University through the Centre for Excellence in Teaching and Learning and whose members worked collaboratively with Middlesex University mental health and social work staff to develop and facilitate teaching and learning activities.

Subsequently, in terms of inclusion criteria, the target population was described in the ethical approval application form as former NHS mental health inpatients that had experience of restraint while in a local mental health ward, were able to make informed decisions, were living in the community and were members of the local service user group - Camden Borough User Group.

Initial contact with a service user in this group was facilitated by a colleague and co-ordinator of the Middlesex University Centre for Excellence in Teaching and Learning (CETL) service user/carer involvement group.

In a snowball fashion, this first contact who was involved in various community activities introduced the researcher to leaders of some of the main community groups – Islington Borough User Group (IBUG) and Camden Borough User Group (CBUG).

At the same time as this was happening, the researcher met two service users in a forum who (voluntarily) expressed great interest in the project. Subsequently, the mistake made in the ethical application form was realised. Only Camden Borough user group was mentioned in the form when in fact service users from other local Borough user groups such as Haringey, Islington, Barnet and Enfield were also involved in (CETL) activities. These two keen contacts were not from Camden. An appeal to the ethical committee widened the study population to include Islington, Haringey, Barnet, and Enfield. Appendices (A and B) were the approval letters.

On the advice of CBUG user group manager, some flyers (Appendix C) were posted to her to distribute to the members. The content of the flyer was edited and put in the group's monthly magazine (Appendix D). The manager fed back that none of the members to whom she gave the flyers had experienced manual restraint.

On the invitation by IBUG manager, the researcher attended their group's monthly meeting where an opportunity was given to explain the project. Appendix (E) was the minutes of the meeting. The topic appeared to evoke strong emotions and a great deal of interest. Many members raised their hands to ask questions such as "You want us to take part in the research, what are we going to get out of it?" It was explained that there was no financial reward for taking part in the study, but that some

people might experience a feeling of relief after talking through their experiences just as others might feel happy about participating in improving practice. As this question was answered in the information pack (Appendix F) a copy of which was given to each person, reference was made to the pack and the contents were discussed. Others talked heatedly about restraint and why it should not be employed and that people had died while being restrained. It soon became clear that members were talking about restraint in general as they started referring to the police model of restraint and restraint in community settings. A member passionately suggested that the recruitment be conducted at a particular day centre. Quoting him, "A lot of the service users there will have something to say about control and restraint". This suggestion was not followed up because restraint in community settings was not within the scope of the study.

Some of the studies reviewed had stated that black minority ethnic groups were proportionately highly represented with regard to compulsory admission into mental health wards Duff et al. (1996, cited in Ryan and Bowers, 2006, p528; Spector 2001, p6), indicating that similar proportions would be reflected in the statistics of those who had experience of restraint. The researcher therefore purposively tried to ensure their representation in the study sample. To achieve this, the researcher contacted a local Day Service for Afro-Caribbean service users. Permission was obtained from the manager to attend their weekly group meeting in order to explain the project and to give out the flyers to the service users. Similar to the scenario at IBUG, the service users appeared aroused by the topic and there was a heated discussion on the issue. But again, only one was willing to participate in the study and did so.

National Institute for Clinical Excellence (2004, cited in Marshall, Lelliott and Hill 2004, p7) had concluded that men and women were equally likely to act violently, or to be a victim of violence,

when in-patients in an acute psychiatric ward. It was therefore considered essential to represent both genders in the study. This objective was achieved purposively.

Following a high number of cancelled interview appointments the researcher became anxious about meeting the target number of study sample. She was promptly reassured and reminded by her supervisor that what determines the optimum number is the data content. When no new facts are coming from further interviews, one assumes that the optimum number or the saturation point has been reached (Parahoo 2006, p325). Remembering that the study was about capturing the experiences, perceptions and feelings of people who have been restrained in order to identify staff practices that could be used to inform training and not the generalization of findings also helped to reassure the researcher.

As mentioned earlier, the team's model of physical intervention has evolved over the years and continues to do so. It was initially considered that interviewing only users with recent experience of restraint would ensure that only current practices were studied. This idea was discarded however when it became clear that due to the nature of this social problem many of the few service users who met the inclusion criteria were not keen to talk, and less so, those with fresh experience who were probably afraid of possible reprisals from clinicians should they be readmitted.

Interestingly, much could be learned from any physical intervention scenario irrespective of when it happened. In fact, one of the participants in the study comes regularly to share her experience with the trust staff during the team's physical intervention training. This participant's experiences were mostly in the 1990s yet many of the issues raised in those scenarios are still happening in the wards and are such relevant learning points that the course attendants' feedback on each occasion has been

unanimously positive. A number of them had described the service users' experiences as 'thought provoking'.

3.4. Preparation and Collection of Data

Having identified the study sample, the next stage was to use the data collection instrument to collect information from the sample.

Interview questions

The researcher prepared what she termed "Guiding Interview Questions" (Appendix G) which were vetted by her colleagues. The idea was to use these in conjunction with other prompts to maintain a flexible structure and to stir the interview back on course when a deviation occurred.

Piloting the instrument

The first contact as earlier said was a very experienced service user who participated regularly in the departmental learning and teaching activities. He very willingly accepted to join three colleagues who volunteered to pilot the instrument. A number of suggestions were made by the pilot team including the use of simpler words. A question had read "Did the staff try to de-escalate your anger?" A member of the team suggested finding a simpler word for 'de-escalate' saying that some interviewees might struggle with the meaning. The researcher was encouraged and supported by the service user member of the pilot team in the recruitment of the Black minority participants for the study. The service user had explained that from his experience in the wards, this group was highly represented there and ought to be represented in the study.

The questions were fine tuned in line with the pilot team's suggestions.

Interview venue

Since all the interview sessions took place in the researcher's place of work (choice of the participants), the available facilities were used to achieve a relaxed interview environment. The researcher would ask the participant on each occasion to accompany her to the kitchen where they chatted as they made drinks and explored the kitchen for snacks. Back in the interview room, they continued to chat about issues in general as they drank. This strategy proved very useful in making the participant feel at ease and in relaxing both individuals as indeed the researcher was equally apprehensive about the exercise, praying inwardly that everything went well.

The consent form

Each participant was requested to sign the consent form (Appendix H) before the interview, and each was reminded about the right not to answer a question if he or she did not wish to and the right to withdraw at any time without explanation.

Offer of emotional support

A colleague who had worked closely with the participants within the Centre for Excellence in Teaching and Learning was happy to give emotional support if needed. Each was informed of this but each said it was not necessary. One said she would contact her psychologist if she needed to.

Tape recording the interview

Permission to use the tape recorder was sought in each case before starting the session. It was explained that the tape would ensure that the interview was recorded accurately without too many interruptions.

Robson (2002, p167) had said that the quality of a flexible design study depends to a great extent on the quality of the investigator. According to him, such personal qualities as open and enquiring mind, being a good listener, being sensitive and responsiveness to contradictory evidence are essential. The researcher would not claim to be particularly strong in all these but special effort was made to bear them in mind during the interviews.

Taylor and Bogdan (1998, p88) said that in an effort to establish rapport with informants, in-depth interviewers ask nondirective questions early in the research, and learn what is important to informants before focusing the research interests. In line with this strategy, the pilot study participants had suggested that starting with the general questions would act as a warm up for the session. And so, each interview was started with general and demographic questions before progressing to participant's specific scenario on restraint experience.

Having warmed up to the interview, the participant was then asked if he/she could recall and narrate the experience of a restraint incident in an in-patient ward starting from the build-up to the incident to the restraint process itself and what happened after.

The researcher used the approach recommended by Robson (2002, p274) and listened intently as each participant talked about his/her experience.

As the narration progressed the flexibility of the data collection method enabled the researcher to modify the probing to suit each unique situation. Prompts and facial expressions including head nodding were used to support and encourage the participant, to verify points, and check out participant's stories as well as to follow up on leads and hunches.

In line with the flexibility of the tool, the lengths of the interviews were equally flexible, matching the need in each case – forty minutes on the average.

As the data collection progressed, the researcher began to focus interests, and ask directive questions to clarify any identified theme of interest such as whether and how the participant was debriefed after the restraint process.

Right through the interview, the researcher jotted down points of special interest some of which needed further probing in order to elicit the required information.

Because most of the participants were individuals actively involved in the Middlesex University CETL activities, they were used to sharing their experiences through discussions in classes and presentations in forums. Subsequently, they appeared very comfortable with the interview and did not appear to mind about their disclosures.

3.4.1 Data collected

See sample (Appendix I).

Perhaps it is worth mentioning here that the researcher's relationship with the participants throughout this study and in particular, during the interview sessions was that of equal partners. This reflects the characteristics of in-depth interview which is modelled after a conversation between equals rather than a formal question-and-answer exchange (Taylor and Bogdan 1998 p88).

Indeed if any party had an advantage of power during the study, it was the participants. They were aware that there were not many people who met the criteria for the study or who were willing to talk about their experience of this social reality. And so they knew how important their role was for the success of the investigation. They cancelled appointments at the last minute and were free to opt out

at any time and without notice. They chose the date, time and venue for the interview and knew that they could refuse to answer any question or to elaborate on any issue they did not feel comfortable about.

The researcher had established a level of rapport and trust with the participants that made the interview sessions flow smoothly. The participants narrated their experiences without hesitation. It was easy to sense the honesty and truthfulness in the stories. Only in one instance was there an aspect of the story which conflicted with information given earlier. Further probe however had it sorted and it was obvious that there was no deliberate intention to give false information. It was a case of mixing up the post incident aspects of two different restraint scenarios – a weakness of a study in ‘retrospect’.

3.4.2. Limitations of the data collection method

A major weakness of the data collection method used for the study was its reliance on the service user’s ability to recall incidents that had happened months and in some cases years ago. In reality, some of the facts might have faded away over time, raising doubts about the accuracy of data, as happened above when a participant got mixed-up with the outcomes of two different restraint incidents.

In addition, the topic under study was a very emotive one. Some of the participants, at some points deviated from the line of enquiry, carried away by emotion. The guide questions and other prompts including ‘silence’ were used to give support, jog memory and to steer the interview back on course.

Another disadvantage of this method of data collection was non-anonymity of the interviewee. This was overcome by observing the rules of confidentiality as suggested by Parahoo (2006, p112). The participant was reassured before each session that all necessary care would be taken to ensure

anonymity. This was achieved by for example using codes to identify transcripts. As it happened, none of them appeared bothered by this issue. One had said categorically that she did not care if her narration was sent to the ward in question.

A major challenge for the researcher in conducting the interview was the fact that the topic was on her own subject area. That placed her in an 'insider researcher' position Robson (2002, p382). Knowingly or unknowingly she could have been holding some preconceived ideas or convictions about the topic under investigation. Robson (2002, p172) explains that 'researcher bias' is what the researcher brings to the situation in terms of assumptions and preconceptions. The researcher had some strong views about aspects of the topic under study. Her adoption of General Service Association's principle of 'non-pain compliance' for example made her want to cringe as participants narrated certain poor practices by staff during their respective incidents. Prior assumptions were known to unwittingly distort the interpretation of qualitative data Parahoo (2006).

In order to achieve a valid and relatively untainted accounts of the participants' experiences, the researcher tried to acknowledge and 'bracket' off these preconceptions and checked her body language in compliance with Gray (2004, cited in Bell 2005, p166) who suggests that the way to combat bias is to constantly question one's practice and to adopt a critical attitude towards the data interpretation.

3.5 Ethical Considerations

All necessary steps were taken to ensure that the research participants did not suffer harm in any way as a result of the study.

Permission was sought and obtained from Middlesex University Natural Sciences Ethics sub-Committee (Appendix A) to carry out the project. Permission to widen the population was also sought and was granted by the body (Appendix B).

An awareness of the vulnerability of the study sample was reflected right through the study. An example is the inclusion criteria as stated under ‘Access to study sample...’ and in the way cancellations of interview appointments were handled.

The study entailed asking participants to recall what may have been a traumatic experience. This memory recall could have had a psychological/emotional effect on them hence the arrangement for emotional support as explained under ‘Preparation and Collection of Data’.

As earlier explained, this is a sensitive subject and not everybody who had experienced the phenomenon was willing to talk about it. Notwithstanding, the researcher was determined not to rush anybody into agreeing to participate even when she was worried that she might not get enough people to participate in the study. For example, during the meeting with one of the service user groups, the manager had kindly suggested that the interview be conducted on the spot during their break time. But in the spirit of non-malevolence Parahoo (2006), the researcher, determined not to rush the contacts into a decision to participate, however tempting it was in order to save time, considered it fair and ethical to give them time to think carefully about the issues. They were left with the researcher’s contact details and requested to get in touch if they wished to participate.

When the researcher went to a centre for an interview appointment with one of the service users, the individual neither turned up nor left a message. Interestingly the same service user had asked when the appointment was agreed whether there was going to be a payment. In line with the principle of veracity Parahoo (2006, p112), the researcher truthfully explained that the cost of transport if applicable and a light lunch would be paid for and that there was no payment for participation.

The researcher made conscious effort to establish good relationship and trust with contacts. Appendices (J and K) are sample copies of correspondence with two contacts.

When an interview appointment was cancelled at the last minute by any participant, the researcher reassured the individual and worked with the person to identify another suitable date (Appendix L).

3.6. Data Analysis

Data analysis is that stage of the research process in which the researcher tries to make sense of the information collected from the study sample. Robson (2002, p459) defined it as the test of the ability to think – to process information in a meaningful and useful manner.

Authors on qualitative research approach argue that data analysis is not a ‘bolt-on’ feature that can be ignored until all the data are collected (Robson 2002, p387), but one that should begin during the data collection stage (Gray 2004, p327; Parahoo 2006, p376).

Following the above suggestions, the researcher began to think through, process information and look for patterns the moment the data started coming in via the interviews. During each interview process, the researcher was constantly theorizing, trying to make sense of the data (Taylor and Bogdan 1998, p141). She tried to keep track of the emerging themes by jotting down thoughts as they emerged. She recalls getting up from bed to note down a pattern that suddenly hit her as she was drifting off to sleep.

3.6.1. Transcribing data

The recordings of the interviews were mostly clear and audible. There was an odd background noise from an Ambulance siren as well as a few rather faint bits.

The transcription was carried out after each interview. As the data was being transcribed, the researcher was once again theorizing, trying to make sense of the data and comparing the emerging themes from the transcribed data with those jotted down during the interview sessions.

Because the researcher was not able to secure a back-up recorder for the interviews, she resorted to playing the tape recording over and over in order to pick up the faint bits. In addition, the researcher and the participants had established a working relationship and had each others' contact details; it was therefore easy to get back to them to check out data.

The transcriptions were scrutinized and corrections made to the texts.

Looking at the volume of the transcribed document brought to attention yet another short coming of the data collection method used - the generation of 'rich', 'full' and 'real' data (Robson 2002, p455) very exciting but rather daunting. All perspectives were worthy of study (Taylor and Bogdan 1998, p9). The researcher went through the entire volume. None was discarded.

3.6.2. Data components

The data comprised mainly of qualitative but also some quantitative components such as the demographic contents. The quantitative contents were listed and presented in table format as shown below.

Quantitative component of data

The study sample comprised of three males and two females including a male and a female of Afro-Caribbean ethnic origin. Their ages ranged between 25 years and 44 years at the time of their

respective incidents. Two of them had two experiences of the phenomenon which they willingly shared. The researcher felt very fortunate about this as it boosted the data source as well as enabled the attainment of the saturation point.

Tables 1 and 2 are the study participants' personal and incident information.

Table 1: *Study Samples' Background Information*

| Service user/carer | Gender | Ethnicity | Present occupation |
|---------------------------|---------------|------------------|---------------------------|
| 1. service user | male | White British | Community active |
| 2. service user | female | Black Caribbean | Community active |
| 3. carer | male | White British | Community active |
| 4. service user | female | White British | Community active |
| 5. service user | male | Black Caribbean | Community active |

Table 2: *Study samples' Incidents Specific Information*

| Service user/carer | No. of incidents | Year of incident | Age range at time of incident | Admission type | Period in the admission when incident happened |
|---------------------------|-------------------------|-------------------------|--------------------------------------|-------------------------|---|
| 1. service user | 1 | 1996 | 25 - 34 | Voluntary and Sectioned | 2 nd day |
| 2. service user | 1 | 2004 | 35 - 44 | Sectioned | 1 st day |
| 3. carer | 1 | 2004 | 35 - 44 | Visiting | 1 st visit |
| 4. service user | 2 | 1990 | 25 -34 | Sectioned | Mid way |
| | | 1997 | 35 - 44 | Voluntary and Sectioned | Few days |
| 5. service user | 2 | 2002 | 25 - 34 | Voluntary | Mid way |
| | | 2003 | 25 - 34 | Voluntary and Sectioned | 3 rd day |

Qualitative component of data

Before engaging in the analysis of the qualitative content, the researcher reflected on Taylor and Bogdan's (1998, p140) description of qualitative data analysis as a process of inductive reasoning, thinking and theorizing - a dynamic and creative rather than a mechanical or technical process. Putting it simply, they advised that one should continually attempt to gain deeper understanding of the study and should continually refine the interpretation drawing on the first hand experience with the participants.

Various suggestions and approaches to qualitative data analysis were studied before eventually deciding to use the approaches advocated by Taylor and Bogdan (1998, p140) and that by Stevick (1971), Colaizzi (1973), and Keen (1975) as modified in Moustakas (1994, p121). Ideas were also borrowed from the application by Kumar et al. (2001) of Strauss and Corbin (1990) grounded theory approach.

3.6.3. Reducing data to invariant horizons

It was found at this stage that the earlier effort to keep track of emerging themes during the data collection stage proved to be a very useful strategy. It meant that the researcher already had an idea of some of the emerging issues regarding the experience of physical restraint by the participants even before engaging fully in the analysis. She just needed to follow some tried and tested approaches to confirm, modify or disregard these initial hunches.

Guided by Moustakas' (1994) modification of Stevick (1971), Colaizzi (1973), and Keen (1975), the researcher found the 'invariant horizons' or meaning units of the experiences of each of the study participant. This was achieved by first considering each statement in the transcribed data with

respect to its significance in describing the experience. All relevant statements were recorded. Finally, each non-repetitive and non-overlapping statement was listed.

Initially, the researcher had felt overwhelmed, and almost despondent about the sheer volume of the transcribed data. Reducing it to invariant horizons gave her the feeling of “Yes, this can be sorted!”

Chapter four

RESULTS AND DISCUSSION

4.1. Results

4.1.1 Identifying concepts and categories:

Strauss & Corbin (1990, cited in Kumar et al 2001 p600) proposed that in order to develop categories from raw data, it was necessary to first identify the concepts contained within the data. The transcripts now reduced to invariant horizons were read over and over, scrutinising the statements in order to identify concepts within each. Statements with similar concepts were clustered together and given a heading. The data was then examined for statements of actual texts that supported the identified categories.

Service users described experiences of restraint which showed two contrasting characteristics, one displaying angry behaviours from the restraint team, the other professionalism and care. These were categorised respectively as: restraint procedure carried out by a staff team whom the service user believed were angry with him/her, and restraint procedure carried out by a staff team whom the service user believed were concerned for him/her. The categories were described in tables 3 and 4 using where possible concrete concepts indigenously derived from the service users' vocabulary describing the experiences and perceptions (Bruyn 1966, cited in Taylor & Bogdan 1998 p145).

Service users/carers further expressed strong opinions on a number of issues including staff use of high level intervention in situations where there was no resistance as well as lack of professionalism and sensitivity in communicating with service user/carer. These were categorised and presented in table 5.

As the objectives of the study were to gain insights into participants' experiences and perceptions before, during and after a restraint process and to document the restraint team's practices that could

be used to inform training, the emphasis was on identifying the diversity in accounts, rather than on quantifying the frequency of particular types of experience.

Table 3: *Restraint procedure carried out by a team of staff members believed by service user/carer to be angry*

| Category | Description | Substantive quotes from study participants |
|--|--|---|
| Build-up to restraint | Poor staff attitude and practice lead to patients' responses that resulted in the physical restraint. | I just admit myself into the hospital and that was it. I was there for two and half days, I didn't even see a doctor and the nurses that was working there, they didn't even come to ask me ... how I feel, what happen. And then I couldn't take it no more and the ward manager was offering me medication that she hadn't explained what it was about. I refused to take the medication two nurses block my way, two male nurses and I sort of start, I was taken .. I didn't know what was going on. They wanted me to empty my pocket out. ...take my jacket off ... and describe the contents. I said no. ...he stepped on my leg, and he got my hand and tell me get up, get up. And I just lose my temper there because he wasn't listening to what I was saying. He never understand that I was like a cripple I can't move. |
| Over reliance on physical intervention | Physical intervention was used where other skills and options could have achieved therapeutic outcomes | That restraint was totally unnecessary. ... I wasn't kicking out, I wasn't screaming at them. I was quite prepared to calmly walk back to the unit. I felt I didn't need restraining. But they wanted to show me that they could ... |
| Restraint seen as punishment | The way the restraint was carried out was seen by service users as staff wanting to punish them. | I see them coming for me. I said alright, alright. I said alright because I am not gonna fight five nurses. They still break me up ... I felt they were punishing me by humiliating me in a ... public environment it was hurting me – my arms, my neck, my legs and it was ignored. |
| Power and control | Restraint was also seen as a perpetration of power and control by staff | They wanted to show me that there is power dynamic going on and that they ... had power over me |
| Staff against service users | Staff would support one another against the patient. "You vs. us" culture | I wasn't even moving. I wasn't doing nothing and then all of them bending me up ... they so angry like I thought like I touch one, I touch the whole lot of them. ... I asked to see the ward manager because I wasn't happy. ...em- she listened and e- she was determined to back her staff. She went through the motions of listening. |

| | | |
|---|--|--|
| Field modification of techniques | Staff used imported techniques. Three participants said that they were lifted up by the restraint team and carried to the room. | They put my hands behind my back and ... picked me up and carried me all of a sudden I was ceased ... and carried to the ward. No, no, I was lifted up. And aam the pain was terrible. I was prone ... lying, and they carried me like that ... as if I was on a stretcher. |
| Pain compliant holds and practices | Members of restraint team were described as deliberately causing pain. | ... they still break me up and have my hand bent up and grating my ankle on the ground. Now, the holding was very painful. I almost couldn't call out for help because they were also choking – I felt choked. ... because it was hurting me ... it was ignored. |
| Non-adherence to guidelines and best practice recommendations | Restraint procedure was largely devoid of good practice and recommended guidelines such as gender issues | ... I was ceased by black nurses – black men and carried to the ward. They laid me on the bed still restrained ... They pulled down my knickers and injected me ... |
| Unnecessary use of floor restraint | Service users were restrained and taken to the floor even though they were not resisting or causing harm to self, others or the environment. | I was sitting down. I wasn't standing. So, I didn't understand why they needed me to be on the floor. I turned round and I saw about ten members of staff chasing me. ... I just stopped and stood there ... they put me on the floor with my stomach you know, face down. |
| Angry orders or no communication | The service user was not kept informed during the restraint process. One said that the only communication she had was an angry order. | No, they were communicating with themselves. ... they were telling themselves what they were doing in turn. Now, it was just "Get down on the floor" and carried me. |
| Open environment | Manual restraint can be more traumatic for the recipient when conducted in an open area. It is also traumatic for the witnesses. | It all happened in an out door space, a big ward area. So it was quite traumatic for everyone else and for me because it was not private at all. I felt they were punishing me by humiliating me in a general environment. |
| Resignation | Service users were left with no choice other than to resign themselves to and accept the situation. | They wanted to show me ... that they very much had power over me and had control over me. And that's what I took it to be. And I thought, "well let them" ... Aam, what I did was to use my knowledge of psychology and to conform to expected behaviour ... But at that time I dared not make a complaint because ... |

| | | |
|--|---|---|
| Abandoned after being restrained | Service users were left without support after the restraint. | It was silence. And then, I felt my trousers being pulled down and I was injected and then I was left. |
| Negative follow-up | A participant said that the only debriefing and review she had was a deprivation of 'privilege'. | I think she punished me by immediately saying "right, you no longer have that privilege of having a bath on your own – a member of staff will now be in the bath room at all times with you". |
| Psychological effect | Physical intervention carried out in anger with the service user, could have severe psychological and emotional effects especially on the service user. | The feeling of helplessness was terrible. The fact that it was black men that was doing it made it extra painful. ... I also felt that historically what had happened to – to many of my ancestors had happened to me. ...there was a deep feeling of suicide, of wanting to end everything. ... that's when the shock of it hit me. And ... it reduced me to tears. |
| Negative impact on relationship and care | Unnecessary and poorly managed physical restraint could impact negatively on nurse/service user relationship and on care | For the next six weeks, I didn't want anybody to observe me because I, I felt that it wasn't really the situation. Now, the men that held me down, why should those men be still looking after me? ... it has made me never to want to go back to that unit ever again. |

Observation: Restraint carried out in anger with the service user left out some of the stages of the restraint process such as the post incident support stage, used high level intervention as well as pain compliant holds when unnecessary.

Table 4: *Restraint procedure carried out by a team of staff members believed by the service user as concerned for the service user*

| Category | Description | Substantive quotes from study participants |
|-----------------------------|---|---|
| Level of intervention | An appropriate level of intervention was used by the staff | It was only two or three of them anyhow. ... and then they put me in my bed room and give me an injection. That was it. I was cool. |
| Restraint borne out of care | 'Rugby tackled' for the service user's safety. | ... suddenly I'm being 'rugby tackled' to the floor. ... they were very worried about my safety – ya. |
| Debriefed | Someone went back to explain what and why and to check that the service user was ok. | After they rugby tackled me, not straight away but once I calmed down and the situation had become less stressful if you like, they did come back and talk to me and explain to me why, what had happened and why it happened. |
| Post incident review | Staff worked with the service user to plan how they could prevent reoccurrence. | And this particular member of staff tried to understand, tried to get me to look at how I could prevent something like that happening again. ... and through that talking through after the incident, we came up with a plan |
| Relationship | Therapeutic relationship with the service user was easily retrieved when manual restraint was carried out without anger | ... I could approach a member of staff and say it's happening, the fireworks are about to go off and then the member of staff would sit with me or walk with me and try and calm me down. |
| Early intervention | Staff were able to use low level holds to guide the service user away from the trigger when they intervened in time. | I remember one nurse actually physically sort of holding me, steering me, guiding me back. |

Observation: When members of a restraint team are concerned for the service user, the exercise runs through all the stages of a restraint process including early/appropriate level of intervention, appropriate holds, effective communication, debriefing and post incident review.

Table 5: *Other issues covered by the service users/carers*

| Category | Description | Substantive quotes from study participants |
|---|--|---|
| Hands on restraint is a useful tool | Service users said that physical intervention could be very handy in situations | <p>... if a patient is going completely crazy you have to have a system for the safety of every one, for the safety of other patients, and ultimately for that patient's safety. ...you do need a system.</p> <p>If they were very worried about me running into the road or running into a dangerous situation... I think they had a duty to stop that.</p> <p>So in that situation, as I was saying, restraint plays a big part ... It can come handy you know... for the sake of some people.</p> |
| Communication | Communication from staff or lack of it was experienced severally by the interviewees during their respective incidents | <p>No, no it was silence. And then I felt my trousers being pulled down and I was injected ...</p> <p>... this seems initially signal for another nurse to basically stand between me and the exit. ... They weren't saying anything, but they were just in the way.</p> <p>There was no need to because I was completely calm. Now, it was just "Get down on the floor" and carried me back.</p> <p>They just got me on the floor. Nobody told me what was going to happen. If they had said to me – we are going to inject you, stay here ...</p> <p>No. They were communicating with themselves. They were telling each other what they were doing.</p> <p>They go "alright Jee, things aren't good at the moment are they? Shall we go back? Shall we go and do something?" and steer me probably steer me away from, and try and distract what was going on.</p> |
| Poor timing of planned restraint | In one scenario, the service user was held restrained to the floor before the nurses sent for the doctor. | They restrained me for about twenty minutes I think until they could They needed to get a new Doctor's signature... They restrained me for ages it seemed. And then eventually the Doctor came. |
| Getting the restraint team from other units | Trained staff members would sometimes come from other units to carry out the physical intervention. | <p>... what happened was they called the formal team. And so the nurses who were actually intervening were not the nice ones. It was the others who came, who took over. It was like two sets of nurses were engaged in the process... ..it was the effect of the other nurses that was quite nasty.</p> <p>... once you call out call point all the staff come from different wards and so people are dealing with you who you don't know. And the original nurses who were in control would no longer be in control.</p> <p>... they would have to radio up the next wards that are</p> |

| | | |
|-----------------------------------|--|--|
| | | around for them to come and help them, probably by that time too much damage has been done. |
| Recognition of staff difficulties | Two of the service users acknowledged the fact that the situation can be quite challenging for the staff | ... I still won't take it out because I know sometimes, I mean nurses, they are under pressure. It is as much my fault as much as their fault. So I am not really putting the blame on one person you know what I mean. So that was all part of my pattern of being very unwell and indecisive and e-m difficult. I am sure it was very difficult to deal with. |
| Properly trained staff | The need for proper training in physical intervention skills was emphasised. | Yes definitely. You need people who is trained to restrain some people the staff will have to know how to restrain them if they are fighting some one else. So it is important but they should have a good way of going about it you know what I mean. |

Observation: Over-arching issues were brought up in the interview including communication. When restraint team members were angry, communication was either non-existent (body language and behaviour saying volumes) or the service user was spoken to in a threatening manner. When they were concerned for the service user, communication took the form such as informing, pleading and negotiating in order to defuse and calm the situation.

4.1.2 Summary of the findings

- * Practices and behaviours of the restraint team during the narrated scenarios as categorised and described in the tables.
- * The mood and feelings of members of the restraint team towards the service user influenced their practices:
- * When the team members were angry with the service user, their behaviours and practices displayed features of 'power imbalance' such as non/angry communication, unnecessary high level intervention, painful holds. In addition some stages of the restraint process such as debriefing of the service user were left out.
- * In contrast, when team members were concerned for the service user, they used appropriate levels of intervention, all the time communicating and negotiating with the service user. The holds were non-pain compliant. The restraint process including debriefing and post incident review was completed.

4.1.3. Taking the findings to team colleagues

When the concepts and categories contained in the data were identified as shown in the tables above, the researcher decided to share them with colleagues. This step was necessary because the findings were going to be used to inform the team's future training service. It was important to carry colleagues along if the implementation was going to be successful. The researcher needed to get their views and reactions to these disclosures as well as to give them the opportunity to contribute to the findings.

Some of the participants in this study were facilitators in the team's physical intervention training and had used the same scenarios for such training. Usually, during training the class would listen as the service users narrated their experiences. Questions would be asked and issues debated. The

issues raised in the scenarios such as staff practices had never been assembled together as in the tables above. When colleagues saw the tables, it was, “Wow!”

Concern was shared by them that some bad restraint practices such as being ‘carried like a log’ narrated by a service user who facilitates on the team’s training were echoed by some of the other participants in the study.

Members of the team asked for a copy of the tables in order to study them. It was agreed that the findings and the best way the team could use the findings would be discussed during team meeting.

The researcher was quite touched and energised by this show of commitment to using the findings by team colleagues.

4.2. Discussion

4.2.1 Approach to the discussion

Discussion on the findings was carried out with reference to the reviewed literature.

The study Rationale established the dearth of study on this subject matter. In addition, none of the studies reviewed had similar objectives to the one for this study. It was therefore correct to say that the study was unique. The researcher made a conscious effort to bear this in mind and to remain as original as possible in the discussion.

Most importantly, it was a study of five service users with seven experiences of physical restraint, no attempt was made to generalise the findings.

4.2.2. The themes:

Having gained a boost of energy and encouragement from the reactions of colleagues, the researcher proceeded to complete the study by finding the core themes in order to make the discussion of the findings more manageable and meaningful.

In their work, Taylor and Bogdan (1998 p144) suggested that typologies or classification schemes could be useful in identifying themes and developing concepts and theory. They mentioned two kinds of typologies – one relating to how the study participants classified others and objects, and the other to the researcher's own classification.

Deciding to adopt the latter scheme, the researcher re-read the transcripts several times and scrutinised the categories. It was possible to identify core themes by linking together a group of concepts under 'a higher order concept' (Strauss & Corbin 1990, cited in Kumar et al 2001, p601). Having achieved this stage, it was easier to see what was being described. In addition, the exercise helped in reducing the large volume of data (29 categories) into more meaningful units of analysis (Miles & Huberman, 1984 cited in Kumar et al, 2001, p602). Table 6 shows the description of the themes along with the categories which formed them.

Table 6: *Identifying themes from categories*

| Themes | Categories included |
|--|--|
| 1. <i>The build-up to physical intervention</i> | The build-up to restraint Early intervention Level of intervention |
| 2. <i>Power imbalance</i> | Power and control Restraint seen as punishment Modification of techniques Over reliance on control and restraint Pain compliant holds and practices Staff against service users Non-adherence to guidelines and recommendations Unnecessary use of floor restraint Poor timing of planned restraint Resignation Negative follow-up |
| 3. <i>Communication</i> | Angry or no communication Communication |
| 4. <i>Psychological and emotional sequel</i> | Abandoned after restraint Open environment No emotional support Psychological effect |
| 5. <i>Post incident follow-up & Therapeutic relationship</i> | Debriefed Post incident review Restraint borne out of care Relationship Negative impact on relationship Recognition of staff difficulties |
| 6. <i>Training</i> | Hands on restraint is a useful tool Properly trained staff Getting the restraint team from other units |

Theme 1. *The build-up to physical intervention*

Out of the seven scenarios described by the study participants, the triggers to only two of them could be linked directly to the service user's mental health (internal factors) – inability to swallow medication because it was thought to be an invasion of the body, and 'blind' running. The remaining five including escaping from the ward because of the oppressive environment, and being admitted

into a ward but completely ignored for more than two days could be attributed directly or indirectly to external triggers such as environmental factors and staff issues. This finding confirmed Sheridan et al. (cited in Shepherd and Lavender 1999) who had reported that external triggers were more likely to be reasons for restraint than factors internal to the patient.

When staff had their 'duty of care' in mind and were concerned for the service user, they usually intervened early and used low level holds to guide the service user away from the trigger. In one of the scenarios the service user said that the nurse physically held her, steering and guiding her back.

In contrast, when staff were angry with the service user, they tended to be the trigger or to fuel the trigger. A service user said that when he could not move because his entire body had suddenly become rigid, the nurse did not care to listen to his explanation. Instead, he stepped on the service user's leg, angrily pulling him and urging him to get up.

Theme 2. Power imbalance

Participants reported that when staff were angry, they would use physical restraint even when there was absolutely no need for it. One service user said that he was actually sitting down when the staff took him to the floor and held him there for some twenty minutes waiting for the Doctor to come and give permission for an injection. This was a clear case of over reliance on, and abuse of the tool (Brennan 1999). The NICE guidelines recommend that restraint should be used as a last resort when other less restrictive interventions are seen as ineffective.

Angry staff were also quick to use high level interventions/holds when low level ones would do and to use the opportunity to punish. A service user had the staff angrily grinding his ankle on the floor.

In three different scenarios, service users were lifted and carried humiliatingly like logs – field modifications of techniques Paterson (2007). An action clearly meant to communicate to everybody particularly the service user that the power and control belonged to the staff. It was of particular interest and concern to both the researcher and her colleagues that this lifting and carrying of the restrained person was experienced by three different participants out of five (60%), and as recently as 2004.

Because the incidents happened in local NHS establishments, one would assume that the staff members involved were trained in the General Services model of physical intervention and possibly at Middlesex University. The model recognises and operates in line with the rules of manual handling. Lifting and carrying the restrained person is not among its techniques. This evidence suggests that staff who have accessed training most probably from the team and demonstrated all the required skills, knowledge and good practice to pass the course, return to the wards where, perhaps working with colleagues either untrained or un-updated, they switch back to bad practices. This raised concern particularly for the trainers and was noted by colleagues for discussion in team meeting.

The actions of the members of the restraint team and their interactions with the service user during a restraint process should be governed by professionalism and duty of care irrespective of how angered by the service user's behaviour they are. In such a circumstance, sense of duty requires that one is honest enough to acknowledge the feeling, and to deal with it professionally in order to ensure that it does not influence the way the restraint activity is performed.

Theme 3. Communication

Communication, spoken and unspoken played a vital part in the narrated scenarios. It was experienced severally by the participants. In one scenario, staff members were not saying anything.

They were just there standing in the carer's way. No word spoken and yet volumes spoken – power and control/power imbalance/you vs. us all demonstrated without a word uttered. One can argue here that since no words were spoken, no damage could have been done. But then everybody knows how powerful silence could be especially when combined with body language.

In another scenario, the restraint team members were communicating among themselves. The service user said that if only they had told him what they wanted, he would have complied. Yet another participant said that the hold was painful and choking. She was complaining but nobody took notice or said a word to her.

Communication is a powerful tool in physical intervention. The person in charge of the process (Head person) should maintain communication with the person being restrained, with the members of the team as well as necessary others, making sure that the procedure are being carried out safely. Used effectively, it helps to de-escalate the situation quickly.

Theme 4. Psychological and emotional sequel

Each and every one of the participants had something to say about the emotional effect of manual restraint. The data collection method provided the opportunity and each seized it. One participant recalled how she experienced 'this deep feeling of wanting to commit suicide, to end it all'. Another felt so hurt that she 'never, ever' wanted to set foot again in the establishment. The most disturbing was one who almost broke down at the end of the interview. Apparently, it was her first opportunity to share her experience in such a setting. Interestingly, this individual was a carer who had gone in for a visit. It raised the question of how many such cases there might be and the need perhaps to investigate.

Physical intervention carried out in anger with the service user manifested varying features of ‘power imbalance’ which equated to ‘abuse’. It could have had severe psychological and emotional effects particularly because there was no support from the staff in those circumstances as reported by the study participants. Two participants had said that the restraint team members were so demonstrative of their power and control that they had no choice but to resign themselves to the situation and to resourcefully find ways to cope with it. One used her knowledge of psychology to conform to expected behaviour. When conducted in an open environment, witnesses could also have been affected. Abuse has devastating effects particularly when it is from the people in the trusted position of helpers (Kumar et al 2001).

Theme 5. Post incident follow-up and Therapeutic relationship

Debriefing and post incident review are the final stages of a physical restraint process. As confirmed by the participants, they automatically followed the restraint process when staff restrained without anger and with concern for the service user.

In contrast, all the participants in the study who said that the restraint team members were angry said that they were not debriefed. A participant said that the only debriefing and post incident review he got was the immediate withdrawal of the privilege of having a bath without a member of staff going into the bathroom with him.

Debriefing checked that everybody involved in the process including the service user and witnesses was alright physically and emotionally. Where necessary, support would be offered. Post incident review among other things looked at the way the process was carried out and how to avoid the same situation occurring in future. The importance of these final stages of a restraint process could not be

over emphasized especially when one reflected on disclosures of the emotional effects of insensitively conducted restraint process such as ‘a deep feeling to commit suicide, to end it all’.

The gap in the literature regarding the post incident stage of physical intervention was picked up during the literature review. Luckily it was an aspect well covered by the researcher’s team. Notwithstanding, the identification was shared with colleagues.

Therapeutic relationship with the service user was easily retrieved when physical intervention was carried out without anger and the post incident stages completed. A participant said that because he was debriefed and a line of action to take if the situation arose again was put in place, it was easy for him to approach the staff to let them know that the situation was threatening again. This confirmed Steckley (2008) who found in her study that when ‘control and restraint’ was professionally and sensitively conducted for good reason, the therapeutic relationship and trust between staff and patient could be enhanced.

On the other hand, the contrary was the case when restraint was angrily and poorly conducted. It destroyed staff/service user relationship and lead to withdrawal in one of the scenarios when a service user refused to accept care from the men she said held her down.

Two participants acknowledged that they were unwell at the time in question and that the situation must have been difficult for the staff. One said that he would not put the whole blame on the staff. These individuals’ stories indicated that staff bad practices led to behaviours that resulted in restraint. Their readiness to make allowances for the staff team demonstrated that service users like other people are individuals who could be kind, forgiving and accommodating not withstanding staff unkindness and poor practices.

Restraint team members are challenged to reciprocate by looking beyond the immediate behaviours in a challenging situation to reach the inner qualities of an individual in order to de-escalate a situation and bring an end to a restraint process and achieve the retrieval of therapeutic relationship. In a care setting the importance of a quick retrieval of therapeutic relationship with the service user can not be over emphasized. As stated by Outlaw and Lowery (1994, cited in Sequeira and Halstead 2002, p10), much mental health care is dependent on a strong therapeutic alliance between patients and nursing staff.

Theme 6. Training

The participants were unanimous in acknowledging the need for physical intervention as a management tool in violent situations in the mental health wards (Paterson 2007). They all agreed that some situations could be very frightening in the wards and would usually require urgent and competent staff intervention to re-establish a sense of safety. This confirmed Gilbert et al's (2008) finding that an experience of safety was maintained despite fearful situations arising when staff demonstrated professionalism in their job and were able to control and contain situations, preventing them escalating and affecting other patients.

Participants however emphasised the need for proper training of the staff in physical intervention skills.

Some of them expressed concern about being restrained by staff pulled from other ward areas describing them as 'staff I don't know and staff who don't know me'. One service user described his restraint process as having been manned by two sets of nurses – the staff in his ward who knew him and the staff called up from other wards who did not know him. According to him it was the effect of this latter set of nurses that was 'nasty'. He described them as very judgmental. This justified Ryan and Bowers (2006) suggestion that restraint technique is a necessary skill that should be made

available to all nurses and allied services so that care units could become self sufficient and less reliant on formal team responses.

Chapter Five

CONCLUSION

5.1 Summary

This study was about the experience of manual restraint by mental health service users and carers in local NHS mental health in-patient wards. It aimed to find out how these individuals perceived the restraint process during their respective scenarios – their interpretation of the actions of the restraint team during the procedure. The objective was to document identified practices (good and bad) of the restraint team so that such could be used to inform future training of local NHS mental health staff members involved in restraining service users.

5.2 Findings

Tables three, four and five are documentations of the identified staff practices. The study also found that the mood and feelings of the restraint team members towards the person being restrained influenced their actions and the way they conducted the procedure. For example, when the team members were angry with the service user, the approach was ‘high handed’, whereas when they felt concern for the service user, it was professional, service user oriented and sensitively carried out.

5.3 Strengths and Limitations

The approach adopted in the study and the method of data collection proved an appropriate tool for achieving what it set out to achieve. Providing a relaxed environment and allowing the service users to describe it as it felt, interrupting with a probe only when necessary, helped the accuracy of the accounts. One could sense this accuracy by the manner of the descriptions coupled with non verbal cues.

A worker researcher position comes with opportunities as well as drawbacks. The main opportunities in this case were the relatively easy identification of and access to the study population, as well as the encouraging support from colleagues.

Among the drawbacks were the unavoidable interruptions as a result of other demands on the researcher's time. This was particularly so during the data collection stage of the study. At one point the exercise was suspended for months. In addition to this, the study participants were busily engaged individuals. Finding a suitable time for the interviews in some instances needed skilful time management on both sides.

The sensitive nature of the research topic meant that data source was limited, coupled with the fact that few were willing to talk about their experiences. This became a hurdle that caused the longest delay during the work. Luckily the participants who eventually came forward had seven experiences between them which provided adequate data.

The experiences described contained more examples of poor staff practices than of good ones. Probably, users with negative experiences of the phenomenon were keen to tell their stories while those with positive experiences may have thought there was nothing to tell. The information pack had not specified any particular experience of physical restraint. In light of this, similar studies might do better by making it clear that individuals with good experiences of restraint procedure are just as welcome.

Owing to constraints such as time, the scope of the study was limited. For the same reason, the researcher had to make do with one method of data collection when she would have liked to conduct a focus group and perhaps questionnaires as a way of triangulation. Focus group is suggested

because the researcher had observed when she attended service user group meetings to explain her project that the service users spoke heatedly and without inhibitions while in their groups. When invited for one to one interview however most declined.

5.4 Suggestions for further studies

This study has thrown up other areas that need to be looked into such as:

- how staff mood and feelings towards the person being restrained affect their practice.
- the emotional and psychological effects of physical intervention on mental health service users/carers,

In view of the way the study participants grabbed the opportunity offered by the interview method and bared their hearts regarding how the experience affected them emotionally, the researcher felt that similar opportunities should be made available to a wider population of service users with such experience.

- carers' experience of physical intervention in in-patient wards
- Furthermore, to complete this work, the researcher would like to conduct a study on the implementation of the findings.

References

- Bell, J. (2006). Doing your research project: A guide for first-time researchers in education, health and social science. Berkshire: Open university press.
- Brennan, W. (1999). 'Aggression management training in health care'. Nursing & Residential Care. vo l, (No 5).
- Borckardt, J. J. Grubaugh, A. L. Pelic, C. G. Danielson, C. K. Hardesty, S. J. & Frueh, B. C. (2007). 'Enhancing patient safety in psychiatric settings'. Journal of psychiatric practice. Vol.13, (No. 6).
- Colin, R. (2002). Real world research. (2nd ed). Oxford: Blackwell publishing.
- Crotty, M. (1996). Phenomenology and nursing research. South Melbourne: Churchill Livingstone.
- Department of health. (2004). Mental health policy implementation guide: Developing positive practice to support the safe and therapeutic management of aggression and violence in mental health in-patient settings. Leeds: NIMHE central team.
- Gilbert, H. Rose, D. & Slade, M. (2008). 'The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK'. BMC health services research. 8, (92).
- Golightley, M. (2004). Social work and mental health: Transforming social work practice. (3rd ed). Exeter: Learning matters Ltd.
- Gray, D. E. (2004). Doing research in the real world. London: Sage publications Ltd.
- Green, B. & Robinson, Lynne. (2005). 'Reducing violence in a forensic mental health unit: a seven –year study'. Mental health practice. Vol 9, (no 4).
- Grix, J. (2004). The foundations of research. Hampshire: Palgrave Macmillan.
- Healthcare Commission. (2006-2007). National audit of violence: working towards a safer environment on mental health inpatient units. UK: Stationary Office.
- Hinchcliffe, G. McGeorge, M. & Shinkwin, L. (2007). National audit of violence: module 3a national report. UK: Healthcare Commission.
- Holly, M. Lelliot, P. & Hill, K. (2004). Safer wards for acute psychiatry: a review of the available evidence. UK: National Patient Safety Agency.
- Jones, P. & Stenfert Kroese, B. (2006). 'Service users' views of physical restraint procedures in secure settings for people with learning disabilities'. British journal of learning disabilities. 35, p.50-54.
- Kidd, B. & Stark, C. (1995). Management of violence and aggression in Health care. London: Gaskell.

- Koprowska, J. (2005). Communication and interpersonal skills in social work. (2nd ed). Exeter: Learning matters Ltd.
- Kumar, S. Guite, H. & Thornicroft, G. (2001). 'Service users' experience of violence within a mental health system: a study using grounded theory approach'. Journal of Mental Health 10, (6), p.597-611.
- Langan, J. (2008). 'Involving mental Health service users considered to pose a risk to other people in risk assessment'. Journal of Mental Health.
- Mason, T. & Chandley, M. (1999). Managing violence and aggression: A manual for nurses and health care workers. UK: Churchill Livingstone.
- Moustakas, C. (1994). Phenomenological research methods. London: Sage publications.
- NHS Security Management Services. (2007). Tackling violence against staff: explanatory notes for reporting procedures introduced by Secretary of State Directions in November 2003. UK: SMS.
- NHS Security Management Services. (2005). Promoting safer and therapeutic services: Implementing the national syllabus in mental health and learning disability services. UK: SMS.
- NHS. (2005). Violence: The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments: NICE guideline: quick reference guide. London: National institute for clinical excellence.
- Parahoo, K. (2006). Nursing research: principles, process and issues. (2nd ed). Hampshire: Palgrave McMillan.
- Paterson, B. (2005). 'Thinking the unthinkable: a role for pain compliance and mechanical restraint in the management of violence?'. Mental health practice. Vol 8, (no7).
- Paterson, B. (2007). 'Millfields Charter: drawing the wrong conclusions'. Learning disability practice. vol 10, (no3).
- Paterson, B. Leadbetter, D. & McComish, Alex. (1997). 'De-escalation in the management of aggression and violence: The ability to defuse an aggressive or violent situation is not simply instinct, but a set of skills that can be learnt'. Nursing times. Volume 93, (No. 36).
- Ricoeur, P. (1967). Husserl: An Analysis of His Phenomenology. Evanston: Northwestern University Press.
- Robson, C. (2002). Real world research. (2nd ed). Oxford UK: Blackwell publishing.
- Ryan, C. J. & Bowers, L. (2006). 'An analysis of nurses' post-incident manual restraint reports'. Journal of psychiatric and mental health nursing. 13, p. 527-532.

- Satori, P. & Case-Robinson, P. (2008). 'Campaign against the closure of the Haringey mental health day hospitals: The NHS is 60. London: RaHN.
- Sequeira, H. & Halstead, S. (2002). 'Control and restraint in the UK: service user perspectives'. The British journal of forensic practice. volume 4, (issue 1).
- Shepherd, M. & Lavender, T. (1999). 'Putting aggression into context: An investigation into contextual factors influencing the rate of aggressive incidents in a psychiatric hospital'. Journal of mental health. 8, (2), p.159-170.
- Southcott, J. Howard, A. (2007). 'Effectiveness and safety of restraint and breakaway techniques in a psychiatric intensive care unit'. Nursing standard. Vol 21, (no 36).
- Spector, R. (2001). 'Is there racial bias in clinicians' perceptions of the dangerousness of psychiatric patients? A review of the literature'. Journal of mental health 10, (1), p.5-15.
- Steckley, L. (2008). 'The experiences of young people and residential staff of physical restraint: Therapeutic containment as a frame work for understanding, reduction and prevention'. Glasgow: SIRCC.
- Taylor, S. J. & Bogdan, R. (1998). Introduction to qualitative research methods: A guidebook and resource. (3rd ed). New York: John Wiley & Sons, Inc.
- Taylor, S. J. & Bogdan, R. (1984). Introduction to qualitative research methods. The search for meanings. (2nd ed). New York : A Wiley interscience publication.
- Tew, J. Gell, C. & Forster, S. (2004). 'Learning from Experience: Involving service users and carers in mental health education and training'. National institute for mental health in England. West Midlands: West Midlands: NIMHE.
- Wand, C. & Coulson, K. (2006). 'Zero tolerance: A policy in conflict with current opinion on aggression and violence management in health care'. Australasian Emergency Nursing Journal. 9, p.163-170.
- Wright, S. (1999). 'Physical restraint in the management of violence and aggression in in-patient settings: A review of issues'. Journal of mental health. 8, (5), p.459-472.