Experiences of restrictive practices in inpatient psychiatric services: Staff and patient perspectives

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This thesis has been submitted as part of the fulfilment of requirements for the degree of

Doctorate in Clinical Psychology

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List of Abbreviations

NICE	National Institute for Clinical and Health Excellence
DoH	Department of Health
RCN	Royal College of Nursing
UK	United Kingdom
PCO	Population, Context, Outcome
PRISMA	Preferred reporting items for systematic reviews & meta-analyses
IPA	Interpretative phenomenological analysis
MDT	Multi-disciplinary team
PSRR	Post restraint and/or seclusion review
BPS	British Psychological Society
PBS	Positive Behaviour Support

List of Appendices

Acknowledgments

I would like to start by thanking the individuals who took part in this study. I was touched by the brave honesty with which you presented during the interviews. I hope that the published outcomes of this research offer you the voice that you feel isn't always heard.

I would also like to thank my research supervision team. Dr. Louise Pearson, your enthusiasm for the project and persistence with recruitment has been the driving force towards these meaningful results. To Dr. Tony Colombo, your tireless efforts and commitment to support me with all aspects of the research process are greatly appreciated. Also, to both my initial cohort, and my current cohort who welcomed me back to training after maternity leave - thank you for your support.

I am very lucky to be surrounded by such a supportive group of friends and family. Thank you for all the continued fun times. To my parents, thank you for your dedicated support throughout my education and your motivation to see me pursue my career aspirations. I also want to acknowledge the grandparents that I've recently lost. Your gentle belief in me and the love you have always shown me is still felt, even though you're no longer here.

To my wonderful husband, Sam, your love and commitment to supporting me to succeed in whatever route I choose is my strength. You are my best friend. Finally, to my beautiful little boy, Teddy. Watching you develop amazes me and I feel lucky every day. Your smiles ground me, even during the most stressful times. You really are my inspiration. I love you.

Declaration

I hereby confirm that this thesis, submitted as part of my Doctorate in Clinical Psychology at the Universities of Coventry and Warwick, has not been submitted for a degree at another university. This project was conducted with the support of my supervision team, Dr. Tony Colombo and Dr. Louise Pearson. The content of this thesis is my own work and was contributed to by the feedback and comments of my supervision team as I submitted draft reports.

The literature review presented in chapter one has been prepared for publication in the International Journal of Mental Health Nursing. The empirical research study presented in chapter two has been prepared for publication in the British Journal of Psychology. I also intend to present a poster of the empirical research at the postgraduate conferences held at Coventry University and University of Warwick during the summer of 2019.

The findings of the literature review and the empirical paper have been presented to an expert panel within the NHS Trust from which I recruited, to inform their work on 'positive and proactive care'.

Summary

Despite the increasing regulation of their use, restrictive interventions continue to be used in psychiatric inpatient services, including secure services. The literature asserts such practices cause distress to all involved. This thesis informs an in-depth understanding of the experiences of both the nursing staff and patients involved in incidents of restrictive practice, concluding with the author's reflections on the research process.

Chapter I: Chapter one offers a meta-ethnographical review of the qualitative literature exploring nurses' experiences of restrictive interventions in inpatient psychiatric services. Following a systematic search of the literature, 11 studies were included for review and the quality of each was assessed. The review generated three meta-themes, including *'The Conflicted Nurse', 'The Distressed Nurse'* and *'The Surviving Nurse'*, reflecting nurses' journeys before, during and after incidents of restrictive practice. The clinical implications of the findings, along with future directions for research are discussed.

Chapter II: Chapter two reflects an empirical piece of qualitative research. Using interpretative phenomenological analysis, patients' lived experiences of restrictive interventions in a forensic, inpatient service were explored. Three superordinate themes emerged, including '*Powerlessness', 'A Sense of Injustice'* and *'A Sense of Resignation'*. The clinical implications of the findings, along with future directions for research are discussed.

Chapter III: Chapter three offers a reflective account of the author's experiences of the research process. Specifically, it explores the reason that the author chose to study restrictive practices, followed by reflections on the recruitment and interview stages of the research, and the conflicts experienced between the researcher and clinician roles.

Overall word count: 18, 673

Chapter I: Literature Review Paper

Nurses' Experiences of Restrictive Interventions in Inpatient Psychiatric Services: A Meta-Synthesis of the Literature

This paper was prepared for submission to the International Journal of Mental Health Nursing. Refer to Appendix A for author guidelines.

Word count for chapter when submitted (excluding abstract, tables, figures and references): 7,557.

1.0. Abstract

Purpose: Despite the increasing regulation of their use, restrictive interventions continue to be used in psychiatric services. The aim of this meta-synthesis was to review the qualitative research exploring nurses' experiences associated with their involvement in incidents of restrictive practice in inpatient, psychiatric services.

Methods: A meta-ethnographic synthesis was conducted. Using five databases, eleven empirical studies were identified that met the inclusion criteria. Each was assessed using a recognised quality assessment framework.

Main Findings: Three meta-themes emerged, including: '*The Conflicted Nurse', 'The Distressed Nurse'* and *'The Surviving Nurse'*. These themes reflect the nurses' journeys through the restrictive practice process as they consider, implement and cope with restrictive interventions.

Conclusions: The findings reflected the benefits of debriefing sessions, but also spoke to the inconsistent nature of these which is reflected in the literature by the lack of an agreed definition. It is recommended that services encourage a meaningful debrief protocol to support staff involved with restrictive interventions. Additionally, the findings revealed the importance of incorporating some consideration of the ethical and emotional contradictions nurses may experience during restrictive practices into their initial training. Future research directions are also discussed.

Key Words: *psychiatric, nurses, experiences, restrictive practice, review*

Abstract word count: 188

1.1. Introduction

1.1.1. Review Subject and its Significance

This review attempts to gain a clearer understanding of how nurses experience their involvement in restrictive practices within inpatient psychiatric settings. Restrictive practices or restrictive interventions, also known as coercive treatments, can take the form of physical or mechanical restraint, forced chemical injection or seclusion. Such practices are regulated by guidance set out across various legislative documents written for psychiatric care (e.g., National Institute for Health and Clinical Excellence [NICE], 2015), with a focus on adopting least restrictive and more proactive approaches for managing self-injurious and challenging behaviours in psychiatric services (Department of Health [DoH], 2014). Nurses represent the practitioner group most commonly involved in implementing restrictive practices and as such, their professional body has published specific educational documents regarding restraint (Royal College of Nursing [RCN], 2016).

Despite the aforementioned regulations, the use of restrictive interventions is prevalent within inpatient psychiatric care. An international study reported that of patients admitted involuntarily to a psychiatric ward in the United Kingdom (UK), namely under section of the Mental Health Act, 30% experienced seclusion, 26% experienced physical restraint and 58% were subject to forced medication (Raboch et al., 2010). Research has revealed the emotional distress experienced by the nursing staff involved in the implementation of restrictive interventions (Gelkopf et al., 2009) and the links between stress at work, professional burnout and job turnover is well documented. For example, a recent review revealed that emotional exhaustion, a core element of burnout, is prevalent in 40% of health care professionals working

in psychiatric care (O'Connor, Neff, & Pitman, 2018). Evidence also suggests that 25% of absenteeism amongst psychiatric nurses is a result of stress and that burnout is associated with high rates of job turnover in the profession (Johnson et al., 2018), especially amongst nurses working in forensic psychiatric care (DeLooff, Didden, Embregts, & Mijman, 2018). In addition to the personal distress experienced by nurses, professional burnout has wider reaching consequences, including its significant impact on patient safety and care (Johnson et al., 2018), as well as the economic costs associated with the aforementioned job turnover and absenteeism.

It is anticipated that one of the main outcomes of this meta-synthesis will be a clearer understanding of the psychological impact that exercising restrictive interventions has for nurses, and the methods they employ in an effort to mitigate their distress. Gaining a better understanding of how nurses experience their engagement in restrictive practices within inpatient psychiatric care will inform best practice and help in the development of more meaningful and relevant forms of supervisory environments. Research has shown that environments organised around the formulation of supportive interventions directed towards helping protect the emotional wellbeing of nurses have a protective role against the high levels of distress and burnout typically identified within the psychiatric nursing profession (e.g., O'Connor et al., 2018).

1.1.2. Evaluation of Previous Reviews

A number of reviews have been carried out drawing together the evidence on the patients' experiences of restrictive practice within psychiatric services. For example, Strout (2010) concluded that the experience is distinctly negative and re-traumatising in nature. A more recent review, exploring the perspectives of those cared for in

inpatient psychiatric settings specifically, echoed this distress and reported that patients feel ignored and disempowered; they concluded that physical and psychological harm was an "inherent" consequence of restrictive practice (p. 1162; Cusack, Cusack, McAndrew, McKeown, & Duxbury, 2018).

To the authors' knowledge, whilst no review has been published to consider the experience of the nursing staff involved, existing reviews have focussed on nurses' attitudes towards such practices and their decision-making processes. For example, a systematic review of 28 qualitative and quantitative studies, between 1995 and 2009, evidenced nurses' attitudes towards the use of seclusion (Happell & Harrow, 2010). The review concluded that nursing staff were confronted with an ethical conflict that arose between their role and beliefs as care givers, and the power they exercised during the seclusion process, which they believed to be a necessary intervention.

In a more recent review, Riahi, Thomson and Duxbury (2016) aimed to understand the decision-making factors influencing mental health nurses in their use of restraint. Their review included 16 studies conducted between 1999 and 2012, with quantitative and qualitative methodologies. The emerging themes echoed the role of conflict found in the aforementioned review and also considered how decision-making is influenced by a responsibility to maintain safety on the ward, as well as interpersonal and staff-related factors.

1.1.3. Rationale for Current Review

The previous reviews differ from the present review in three fundamental ways. Firstly, whilst reviews that explore patients' experiences of restrictive interventions have been published (e.g, Strout, 2010; Cusack et al., 2018), no effort has been made to draw together nurses' qualitative experiences of being involved in restrictive

interventions. Secondly, the reviews of research conducted with nurses have focused on their attitudes towards restrictive practices and the factors associated with the decision making, rather than their experiences of such interventions. Finally, the previous reviews have examined studies employing both quantitative and qualitative research designs, rather than attempting to conduct a meta-synthesis of qualitative studies; the present review will help to provide a richer, more immersive overview of the experiential evidence.

1.1.4. Aim of Current Review

The aim of this meta-synthesis was to systemically review qualitative research exploring nurses' cognitive and emotional experiences associated with their involvement in incidents of restrictive practice that have taken place in mental health settings. More specifically, the principal question governing this review is: what are nurses' experiences of being involved in restrictive interventions within inpatient, psychiatric services?

1.2 Method

1.2.1. Literature Search

Prior to commencing this systematic literature review, ethical approval was granted by Coventry University (see Appendix B). A systematic search of research exploring nurses' experiences of restrictive practices in inpatient, mental-health settings was conducted in August 2018. The search employed five electronic databases relevant within this field: Psychological Information (PsychINFO), Cumulative Index to Nursing and Allied Health Literature (CINAHL), SCOPUS, EMBASE and Medical

Literature Analysis and Retrieval System Online (MEDLINE). To establish whether additional research may have been missed by the database search, additional searches of published literature was carried out using Google Scholar and also manually, by reviewing the reference lists of included articles. The search terms used to retrieve relevant articles from the databases were identified within the title, abstract or key words, to increase the likelihood of identifying relevant articles. They are presented in Table 1.1, as guided by the 'Population, Context, Outcome' (PCO) framework (Butler, Hall, & Copnell, 2016).

Table 1.1

Search Terms: An Overview of the Concepts and Synonyms Included in the Search

Main Concept	Synonyms
Nurse	Nurse, nursing staff, staff
Restrictive Practice	Restraint, seclusion, coercion, restrictive practice, restrictive intervention
Psychiatric Setting	Psychiatric, acute, inpatient, mental health
Experience	Experience, perception, attitude, view, feeling

The proposed literature review adopted a Boolean search strategy and made use of the truncation symbol (*), which can be placed at a given point in a word to account for variations in the spelling of the word from that point forward. For example, when searching for 'nurs*', the truncation symbols instructed the database to retrieve results for 'nurse', 'nurses' and 'nursing'. In addition, the use of AND, OR, NOT in the search formations provided instruction to the database to combine the keywords, search for at least one keyword or exclude keywords respectively. This ensured the resulting search retrieved studies linked to each of the main concepts explained in

Table 1.1. The search formation for the proposed study was as follows: (nurs* OR staff OR 'nursing staff') AND (experience OR perceptions OR attitudes OR views OR feelings) AND (restrain* OR seclusion OR coercion OR 'restrictive practice' OR 'restrictive interventions') AND (psychiatric OR acute OR inpatient OR 'mental health').

The review was only concerned with qualitative data. Evans (2002) has detailed the complexity of identifying qualitative papers when searching using an electronic database; as a result, instead of including 'qualitative' within the search terms or advanced search options, the design of the study was noted when screening the title and abstracts of the retrieved papers.

1.2.2. Inclusion and Exclusion Criteria

In order to manage the range of literature arising from use of the search terms, a set of selection criteria were established (Table 1.2). During the initial screening of the resulting articles, title and abstracts were considered in relation to these criteria and, where relevant, the full text was accessed. This process was used to establish whether the research was eligible for inclusion in the review. Each criterion is discussed in more detail below.

Table 1.2

Selection Criteria for the Studies Included in the Review

Criteria	Inclusion	Exclusion
Geographical region	Research conducted anywhere that exercises restrictive interventions	
Language of publication	Studies published in, or translated to English	
Peer review status and accessibility	Peer reviewed articles published in an academic journal where the full text is available	
Time period	2000-2018	
Epistemology	Social constructivism	Other paradigms e.g., positivist
Methodology	Empirical, qualitative (e.g., IPA, grounded theory, and thematic, discourse, narrative and content analysis) or the qualitative aspects of mixed methods studies	Quantitative study design or non-empirical research (e.g., reviews, commentaries)
Methods	Interviews or focus groups	Qualitative data collected via surveys, questionnaires, scales
Sample	Includes nurses or nursing assistants, male or female	
Subject	Nurses experiences of using restrictive practice	Research that focusses on the decision-making process behind initiating the practice or attitudes towards it
Setting	Psychiatric hospital, adult inpatient mental health wards	

Restrictive interventions are practiced worldwide, although the type differs between countries (Bowers et al., 2007) as does the prevalence of its use in inpatient psychiatric services (Raboch et al., 2010). Therefore, the literature review included research conducted anywhere in the world, providing it was peer-reviewed and published in the English language. This helped to ensure that different cultural perspectives of restrictive practices were included where possible. Articles published after 2000 up to the present year were included in the review. This year marked a fundamental shift in attitude and practice, as the first national guidelines were published to address adult abuse in health and social care (DoH, 2000).

Whilst a wealth of data exists identifying nurses' feelings during restrictive interventions, much of this information is derived from studies employing a questionnaire-based methodological design (e.g., Gelkopf et al., 2009). The current literature review wished to provide a deeper understanding of nurses' experiences and therefore, only empirical qualitative research, or mixed methods research with in-depth qualitative accounts of nurses' experiences of restrictive practices were included. The studies included collected their data via interviews or focus groups and employed in-depth data analysis methods. Quantitative or non-empirical articles were excluded, as were those who had gathered qualitative data from surveys and questionnaires.

Nursing staff play a considerable role in incidents of restrictive practice (Goulet & Larue, 2016) and as such, much of the existing research focuses on this group of mental health professionals. For the purpose of this review, any papers exploring the impact on other professionals, or patients, were excluded. The literature review aims to explore nurses' *experience* of employing restrictive practice, that is the cognitive and affective processes that occurred during and after the intervention. Research

exploring nurses' attitudes towards and understanding of restrictive practice, or studies examining the decision-making process which occurred prior to employing the restrictive intervention were excluded. However, to ensure that no relevant literature was missed and to account for 'experience' being lost in translation of articles, multiple synonyms of 'experiences' were used in the database search, including attitudes. During the screening process, the author looked at the methodological design and the research question to ascertain whether in-depth exploration of 'experiences' was present. Further, the literature review only included research conducted with psychiatric nurses working on adult, inpatient wards; data collected from community-based nurses or acute medical wards were excluded.

1.2.3. Study Identification

The process of searching for, and selecting articles has been captured in the 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' flow diagram (PRISMA; Moher, Liberati, Tetzlaff, & Altman, 2009), which is depicted in Figure 1.1. The PRISMA statement suggests that when conducting a systematic review of literature, information pertaining to the number of identified, screened, eligible and included studies should be presented.

When combining the output of the electronic database searches on PsycINFO, CINAHL, SCOPUS, EMBASE and MEDLINE, which retrieved 276, 249, 434, 297 and 259 studies respectively, a total of 1515 articles were identified. Initial screening revealed 566 duplicates. The abstracts of the remaining 949 studies were screened and 922 were excluded on the basis they did not meet the eligibility criteria of the review. This left 27 studies, the full texts of which were accessed by the author and further assessed for eligibility based on the inclusion and exclusion criteria outlined

above. Of these, 16 were excluded on the basis that they generated data using a questionnaire, were not empirical studies, were not on topic or recruited nurses that did not work in an inpatient psychiatric setting. A total of 11 studies met the selection criteria and were retained for the purpose of the systematic review.

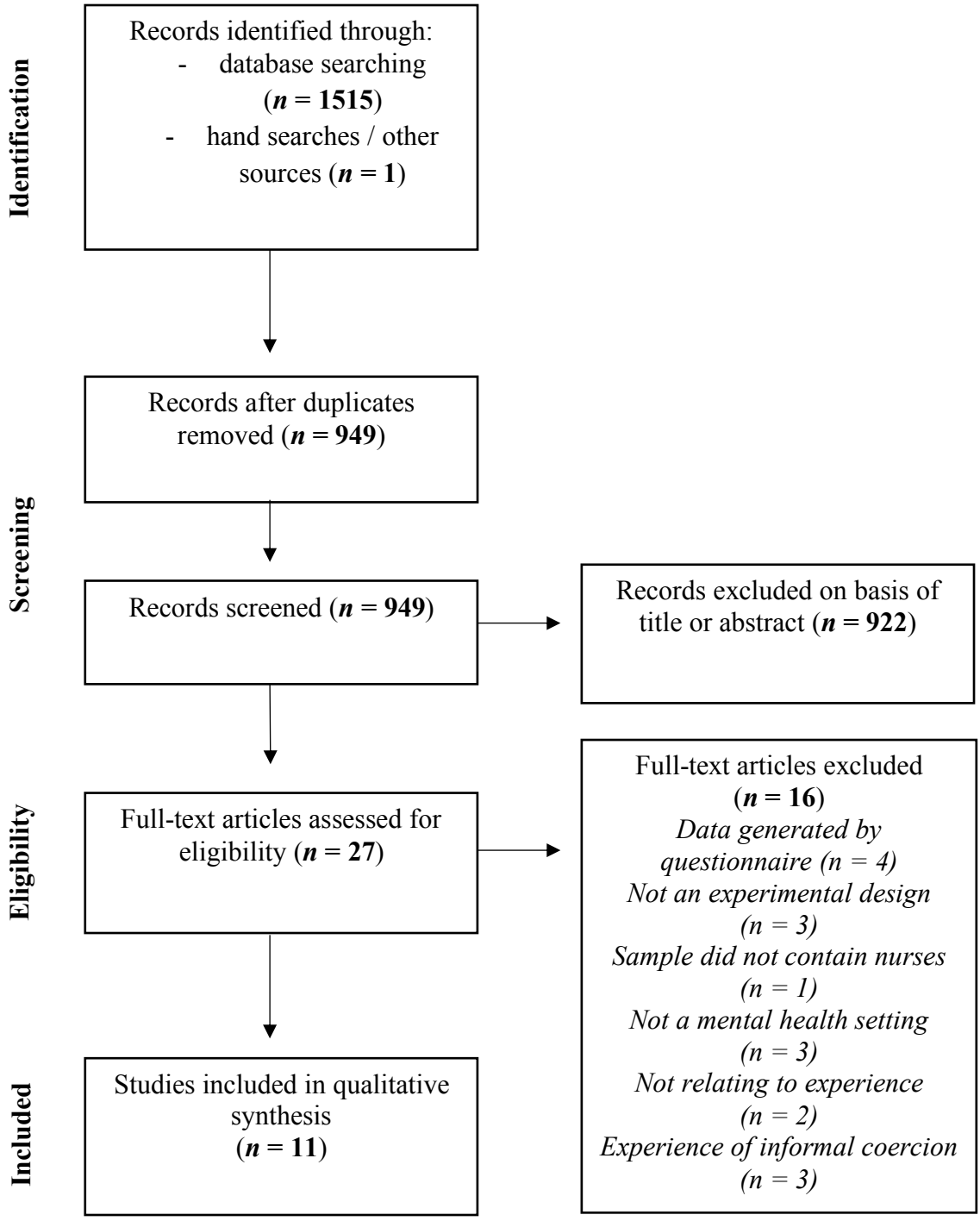

Figure 1.1: PRISMA Flow Diagram

1.2.4. Quality Appraisal Tool

Once the systematic search process was completed, the quality of articles that had been selected for inclusion in the review were assessed. All included articles were published in a peer-reviewed journal, which accounted for a certain level of rigour. However, the quality of published research does still vary. The quality of the 11 studies which satisfied the inclusion criteria and were assessed using a framework put forward by Kmet, Lee and Cook (2004; see Appendix C). This recognised framework has been used in various reviews of healthcare-related topics (e.g., Labrague, McEnroe-Petitte, Leocadio, Van Bogaert, & Cummings, 2018). It poses a 10-item checklist against which an empirical study with a qualitative design can be scored on the basis of how well it meets the requirements of the given criteria. For each criterion, the scoring guidelines are as follows: does not meet (score 0); partially meets (score 1); or fully meets (score 2). Studies can receive a score between 0 and 20, with higher scores indicating higher quality research.

1.2.5. Outcomes of the Quality Assessment

As reported in the PRISMA, eleven articles met the aforementioned inclusion criteria. The quality assessment framework was applied to each of these. Kmet et al. (2004) advise a cut-off of 75%, and suggest a 'liberal' cut-off score of 55%. Quality assessment scores ranged from 16 to 20, with a mean of 17.18. To increase the reliability of this quality assessment, each article was scored independently by two assessors. Cohen's Kappa (κ) coefficient was performed to determine inter-rater reliability. These ranged from .51-1.00 (M = .79), indicating good inter-rater reliability. Where there were discrepancies between the scores of the two assessors, these were discussed and a consensus score was achieved (Table 1.3).

The majority of included studies justified their design and methodology, including sampling strategy, data collection and data analysis. Most also utilised verification measures to ensure the credibility of their results as they recounted that researchers had co-developed codes and themes. However, half of the studies made no reference to the reflexivity of their account, that is to consider how their own characteristics and experiences may have influenced their analysis of the data. In fact, only two studies made explicit references to methods taken to minimise potential influence over the interpretation of the data. Acknowledging reflexivity is important in qualitative research due to the influence of hermeneutics in the process of analysis but its absence is common in empirical research (Walsh & Downe, 2005).

Table 1.3
Quality Assessment Framework as Applied to Each of the Studies

	Study objective sufficiently described?	Study design evident and appropriate?	Context for the study is clear?	Connection to theoretical framework / literature?	Sampling strategy described/ justified?	Data collection clearly described?	Data analysis is clearly described/ systematic?	Verification procedure(s) to establish credibility?	Conclusion supported by the results?	Reflexive account?
Vedana et al., 2018	**	**	**	**	**	**	**	**	**	
Wilson et al., 2017	**	**	**	**	**	**	**	**	**	
Muir-Cochrane et al., 2015	**	**	**	**	**	**	**		**	*
Holmes et al., 2012	*	**	**	**	*	**	**	**	**	
Moghadam et al., 2014	**	**	**	**	**	**	*	**	**	
Moran et al., 2009	**	**	**	**	*	*	**	**	**	*
VanDerNagel et al., 2009	**	**	**	**	*	**	*	**	**	**
Bigwood & Crowe., 2008	**	**	**	**	**	**	**	**	**	**
Sequeira et al., 2004	**	**	**	**	**	**	**	**	*	*
Bonner et al., 2002	**	**	*	**	**	**	*	**	**	
Marangos-Frost & Wells, 2000	**	**	**	**	*	*	**	**	**	

Note. ** = criterion was met in full; * = criterion was met partially; absence of asterisk = criterion was not met

1.2.6. Characteristics of Studies

A summary of the 11 included studies, along with their quality assessment score, has been presented in Table 1.4. The specific aims of the studies varied but all related to nurses' experiences of employing restrictive interventions.

In line with the selection criteria, all included studies were conducted between 2000 and 2018. Five were conducted in Europe (Bonner et al., 2002; Moran et al., 2009; Sequeira & Halstead, 2004; VanDerNagel et al., 2009; & Wilson et al., 2017), two in Canada (Holmes et al., 2015; & Maragos-Frost & Wells, 2002), two in Australasia (Bigwood & Crowe, 2008; & Muir-Cochrane et al., 2018), one in South America (Vedana et al., 2018) and one in Iran (Moghadam et al., 2014). Given the nature of the inclusion criteria, there was little difference in the demographics of the participants, although sample sizes ranged from six to thirty-nine nursing staff.

All employed a qualitative design; all but one study employed semi-structured interviews which were conducted on an individual basis and one used focus-groups to extract data from their sample (Moran et al., 2009). A range of data analysis methods were used; four studies employed interpretative phenomenological analysis (IPA; Bigwood & Crowe, 2008; Holmes et al., 2015; Moran et al., 2009; & Muir-Cochrane et al., 2018), four used thematic analysis (Moghadam et al., 2014; Sequeira & Halstead, 2004; Vedana et al., 2018; & Wilson et al., 2017), one used grounded theory (VanDerNagel et al., 2009), and two used unspecified methods (Bonner et al., 2002; & Maragos-Frost & Wells, 2000), although the articles outlined qualitative methods that resulted in themes.

Table 1.4

Characteristics of Studies

Study Authors	Aim	Sample & Setting	Methodology & Analysis	Findings / Themes & Subthemes	Quality Assessment Score & KAPPA
Vedana et al., 2018	To understand the experiences and perceptions of nurses regarding physical restraint in psychiatric units.	29 nurses working in psychiatric units, Brazil	Interviews Thematic Analysis	Aggressiveness and restraint: Unpleasant, challenging and harmful The need and purpose of the physical restraint Strategies to reduce physical restraint related damage	18/20 κ=1.0 (p<.01)
Wilson, Rouse, Rae, & Ray, 2017	To improve understanding of the experience for all involved, patients and staff.	(13 patients) and 22 staff working in adult mental health wards, UK	Interviews Thematic Analysis	A necessary evil It's never very nice Emotional outcomes Relational outcomes	18/20 κ=1.0 (p<.01)
Muir-Cochrane, Baird, & McCann, 2015	To explore nurses' experiences of restraint and seclusion.	39 nurses working in old age psychiatry units, Australia	Interviews IPA	Lack of accessible alternatives Adverse interpersonal environment contributes to use Unfavourable physical environment contributes to use Practice environment contributes to use	17/20 κ=.71 (p < .01)
Holmes, Murray, & Knack, 2015	To understand patients' and nurses' experiences of seclusion in a secure psychiatric unit.	(13 patients) and 13 nurses working in a forensic inpatient unit, Canada	Interviews IPA	Resorting to seclusion Observing and assessing patients Experiencing seclusion	16/20 κ=.76 (p<.01)

Table 1.4 Continued

Characteristics of Studies

Study Authors	Aim	Sample & Setting	Methodology & Analysis	Findings / Themes & Subthemes	Quality Assessment Score & KAPPA
Moghadam, Khoshknab, & Pazargadi, 2014	To investigate the experiences of nurses working in psychiatric wards regarding physical restraint.	14 nurses working in a psychiatric hospital, Iran	Interviews Content analysis	Restraint as a multi-purpose procedure Processing of physical restraint Restraint as a challenging subject Effect of restraint on a spectrum	17/20 κ=1.0 (p<.001)
Moran et al., 2009	To explore the emotions and feelings experienced by nurses in relation to restraint and seclusion.	23 nurses working in a psychiatric hospital, Ireland	Focus groups IPA	Last resort Emotion distress Suppressing unpleasant emotions	17/20 κ=.74 (p<.05)
VanDerNagel, Tuts, Hoekstra, & Noorthoorn, 2009	To understand nurses' feelings before, during and after seclusion.	8 nurses working in a psychiatric ward, Holland	Interviews Grounded Theory	Tension-related feelings Trust-related feelings Power-related feelings	18/20 κ=.74 (p<.05)
Bigwood & Crowe, 2008	How do mental health nurses experience physical restraint in an acute, inpatient psychiatric setting?	7 nurses working in acute and ICU psychiatric wards, New Zealand	Interviews IPA	It's part of the job Control *Scared nurse* *Conflicted nurse*	20/20 κ=.71 (p<.01)

Table 1.4 Continued

Characteristics of Studies

Study Authors	Aim	Sample & Setting	Methodology & Analysis	Findings / Themes & Subthemes	Quality Assessment Score & KAPPA
Sequeira & Halstead, 2004	To examine the experiences of physical restraint as reported by nursing staff in a secure setting.	17 nurses / nursing assistants working in a forensic mental health unit, UK	Interviews Thematic Analysis	Emotional responses Inhibition of emotional distress Laughing and joking to release feeling	18/20 κ=.71 (p<.01)
Bonner, Lowe, Rawcliffe, & Wellman, 2002	To explored the lived subjective experience of restraint.	12 nursing staff working in a psychiatric inpatient unit, UK	Interviews Analysis unclear	Themes organised in sequential order Antecedents In the midst of conflict The aftermath	16/20 κ=.80 (p<.01)
Marangos-Frost & Wells, 2000	To understand the thoughts and feelings nurses' experiences during the decision to restrain.	6 nurses working on a psychiatric ward, Canada	Interviews Analysis unclear	Framing the situation as the potential for imminent harm Unsuccessful search for alternatives The conflicted nurse Contextual conditions of restraint	16/20 κ=.51 (p<.05)

1.2.7. Synthesis of the Findings

A meta-ethnography approach, originally developed by Noblit and Hare (1988) was used to synthesise the findings from the studies included in this review. Some have argued that synthesising qualitative data dilutes its richness (e.g., Sandelowski, Docherty, & Emden, 1997) but others argue that it can be seen as a "multivocal interpretation of phenomenon, just as the voices of different participants might be in a single study" (Zimmer, 2006, p. 315). Noblit and Hare's seven stage model is a widely accepted and credible approach to synthesising empirical qualitative studies with a high standard of rigor and has been influential in health and social care research (Britten & Pope, 2012).

In accordance with the model, and as described by Atkins et al. (2008), the lead author read and re-read the papers to familiarise herself with the content and to consider the emerging themes or concepts. The translation and synthesis of concepts was carried out systematically by comparing each theme from each article with all of the other articles in turn. For example, themes found in paper 1 were compared with themes found in paper 2 and the synthesised findings from these two papers were compared with paper 3. This repeated analysis and revision of themes was completed until all eleven papers had been translated into one another; this process is defined as a constant comparison.

This systematic process of the meta-ethnography allows for the synthesis of congruent findings as well as the identification of those that refute each other. Indeed, a meta-ethnography has been defined as a method that "translated the findings of different primary research studies into each other to generate overarching themes… (reciprocal translational analysis) [and] identifies and explains

contradictions and differences that exist between the various studies (refutational synthesis)" (Paterson, 2012, p. 15). The lead author generated the final meta-themes; Noblit and Hare (1988) describe that the name used to describe each of the concepts or themes can be taken directly from one of the papers, or can be chosen by the researcher.

1.2.8. Reflexivity

The lead author has previously worked in a medium secure unit. Whilst she did not actively participate in any physical restraints or transfers to seclusion, she did witness these and was able to see the impact they had on the staff and patients alike. The author recognises that these experiences may have influenced her interpretation of the articles included for this review. Aforementioned steps have been taken to reduce any potential bias, included dual rating of the included articles on the basis of their quality assessment and discussions with the research supervision team regarding the emerging themes throughout the process of analysis. No considerable differences were observed and as such, the author is happy that the findings of this synthesis are valid and credible.

1.3 Results

A meta-ethnographic analysis of the qualitative findings drawn from 11 studies exploring nurses' experiences of restrictive interventions within inpatient settings revealed three meta-themes. These themes reflect nurses' journeys through incidents of restrictive practices and include: 1) the intrapersonal conflict they experience as they decide whether to employ restrictive interventions; 2) the distress they

experience during and after the intervention has been used; and 3) the ways in which they attempt to cope with, and adapt to, their experiences of incidents of restrictive interventions. Table 1.5 displays which meta-themes and subthemes were considered within each of the articles.

Table 1.5

Meta-themes and Sub-themes

Meta-Themes	The Conflicted Nurse		The Distressed Nurse				The Surviving Nurse		
Subthemes	A necessary evil	The last resort	The emotional experience	Low morale	Damage to therapeutic relationship	Damage to working alliance with colleagues	Emotional suppression	Emotional acclimatisation	Emotional wellbeing through debriefing
Vedana et al., 2018	✓	✓	✓			✓			✓
Wilson et al., 2017	✓	✓	✓	✓	✓			✓	
Holmes et al., 2015	✓	✓	✓		✓			✓	✓
Muir-Cochrane et al., 2015	✓	✓	✓		✓				
Moghadam et al., 2014			✓		✓				
Moran et al., 2009	✓	✓	✓				✓	✓	
VanDerNagal et al., 2009			✓			✓	✓		✓
Bigwood & Crowe, 2008	✓		✓		✓	✓			✓
Sequeira & Halstead, 2004	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bonner et al., 2002	✓	✓	✓	✓			✓		✓
Marangos-Frost & Wells, 2000	✓	✓	✓	✓		✓			

1.3.1. The Conflicted Nurse

This meta-theme of conflict reflects the fundamental juxtaposition between the care nurses provide within a therapeutic environment and their acknowledgement that exercising restrictive interventions is, at times, a necessary, integral and unavoidable part of their job. This theme highlights that the shape of these intrapersonal conflicts is often defined by the absence of alternative and less invasive strategies for managing challenging behaviour. There were two meta-subthemes: 'a necessary evil' and 'the last resort'.

1.3.1.1. A necessary evil.

The data revealed nurses' beliefs that restrictive interventions are necessary, but that employing them creates a conflictual experience and ethical dilemma as it sits in direct contrast with their caring vocation. This subtheme is neatly summed up by nurses' reflections that *"it's a part of the job … but it spoils the job"* (Bigwood & Crowe, 2008, p. 219).

Nurses described that maintaining a safe ward environment was integral to their job and therefore, the decision to employ a restrictive intervention was determined by their perception that a situation had the potential for imminent harm, specifically that *"the patient … will either hurt themselves and hurt others or damage equipment"* (Wilson et al., 2017, p. 506). In this context, restrictive interventions were considered *"a necessary therapeutic tool. Yes, it is unavoidable in certain circumstances… to keep everyone safe basically and to just re-establish control."* (Bigwood & Crowe, 2008, p. 219).

The data highlighted that nurses considered there was a lack of alternative measures to effectively maintain safety on the wards. They shared the belief that *"without restraint and seclusion, there would be chaos"* (Muir-Cochrane et al., 2015, p. 111). As such, nurses expressed their belief that it could not be eliminated from nursing practice, otherwise *"nurses would leave the profession"* (Muir-Cochrane et al., 2015, p. 111).

> *"I guess the thing is, if they ever got rid of the seclusion rooms here, I wouldn't work here. I feel strongly that they are a useful tool, both for us and the client."*
>
> (Holmes et al., 2015, p. 210)

However, whilst nurses acknowledged that restrictive practices undermined the therapeutic environment within inpatient settings, safety was considered the ultimate priority. Nurses expressed the intrapersonal conflict that they had to battle when they implemented restrictive interventions, describing that *"to go from caregiver approach to prison guard approach within a couple of minutes"* (Moran et al., 2009, p. 602) sat in direct contrast with their professional principles of care and on a personal level, went *"against my conscience"* (Sequeira & Halstead, 2004, p. 8)

> *"I felt instantly like a bully, I am awful, you know, look what I did to this man … I had been controlling … all the things that I hate."*
>
> (Bigwood & Crowe, 2008, p. 220)

1.3.1.2. The last resort.

In line with government guidance to use least restrictive practices, the majority of the nurses interviewed in the studies reported that self-injurious and challenging

behaviour was managed via proactive and cooperative means in the first instance and that restrictive practices were largely implemented as a last resort. They described drawing upon de-escalatory techniques such as therapeutic communication with patients, efforts to understand the causes of behaviour and reducing stimulation in the environment (e.g., Holmes et al., 2015; Moran et al., 2009; Vedana et al., 2018).

> *"The initial approach [to manage challenging behaviour] would be the least restrictive form of treatment…. the worst possible scenario would be someone ending up in seclusion… that would be end game really."*
>
> (Moran et al., 2009, p. 601)

Nursing staff shared the sentiment that restrictive interventions were employed only when other avenues had been exhausted and described them as *"the last thing you want to do"* (Bigwood & Crowe, 2008, p. 206).

> *"It was always absolutely the last resort… with all the will in the world, you've tried every angle possible, but it comes down to that in the end."*
>
> (Wilson et al., 2017, p. 507)

1.3.2. The Distressed Nurse

Four meta-subthemes emerged to reflect the complex layers of nurses' distress: 'the emotional experience', 'a sense of low morale', 'damage to therapeutic relationships with patients' and 'damage to working alliance with colleagues'.

1.3.2.1. The emotional experience.

All 11 papers captured, to varying degrees, nurses' emotional experiences relating to their involvement in restrictive interventions. The meta-ethnographic process

revealed three pertinent issues within this meta-subtheme, including anxiety, shame and relief.

The data reflected nurses' anxiety associated with *"knowing we'll have to act"* (VanDerNagel et al., 2009, p.409) and initiate a physical encounter with a patient.

> *"Everything was telling me run away, run away, you know I was really scared … but there were people behind me. The team were behind me, they were expecting me to perform here, you know, so I couldn't run away."*
>
> (Bigwood & Crowe, 2008, p. 220)

Nurses' reflected anxiety around feeling *"unsafe"* (VanDerNagel et al., 2009, p. 410) and *"at risk … you could easily get assaulted"* (Moran et al., 2009, p. 601). The fear of physical injury is a valid one. Nurses described that staff had been injured, as a direct result of physical restraint; for example, *"I've seen a broken tooth … bruises, injuries, scratches … There is a risk for the employee always"* (Vedana et al., 2018, p. 369).

The second issue that arose within this meta-subtheme was nurses' sense of shame when exercising the *"degrading"* (Holmes et al., 2015, p. 209) and *"dehuman"* (Wilson et al., 2017, p. 504) practices during which they exerted power over another human being.

> *"You can't help but feel guilty at times, even though you know you're doing it for the patient's safety and for everybody else's safety."*
>
> (Moran et al., 2009, p. 601)

Nurses also reflected on their distress when connecting with the patients' experiences of restrictive practice, expressing "*helplessness and despair and anger, so I know why I'm crying and what I'm feeling is theirs … it's not mine … but I've been left with it"* (Sequeira & Halstead, 2004, p. 8).

The third issue relating to the nurses' emotional experience was their sense of relief after the implementation of a restrictive intervention, which centred around the restoration of a safe ward environment for staff and patients.

> *"Everyone just immediately relaxes … everyone's safe now. No one's going to get hurt. We got it under control."*
>
> (Holmes et al., 2015, p. 210)

1.3.2.2. Low morale.

The data also revealed a sense of low morale and decreased job satisfaction that arose as a consequence to being part of a restrictive intervention. For example, nurses described that being *"expected to restrain patients… can make you feel differently about the job"* (Wilson et al., 2017, p. 505). Feelings of reduced job satisfaction were further exacerbated by the policies surrounding restrictive interventions, such as the requirement to document incidents, as nurses described that this was time-consuming and reduced time that could be spent caring for their other patients (e.g., Bonner et al., 2002; Marangos-Frost & Wells, 2000; Sequeira & Halstead, 2004).

1.3.2.3. Damage to therapeutic relationships with patients.

Nurses spoke about the relational outcomes that occur as a result of being involved with an incident where restrictive practice was used. The findings reflected that

damage to the therapeutic relationship was often due to nurses being *"blamed"* by patients (Moghadam et al., 2014, p. 26), which in turn undermined the therapeutic alliance and led to the *"break down [of] some of the trust"* (Wilson et al., 2017, p. 505).

Nursing staff described the reparative efforts they take to rebuild the relationship with the patient by talking things through after. In some instances, the damage can be temporary, (e.g., *"we work through it"*, Wilson et al., 2017, p. 506). However, nurses reflected that sometimes the breakdown can be permanent and continue for the *"remainder of their admission … you gained a little bit of trust, and then that's it after that"* (Wilson et al., 2017, p. 506).

In addition, the data revealed that some nurses' experienced anger when patients did not respond to less restrictive interventions, as well as towards oneself for feeling like they have tried but failed to meet the needs of the patient. Nurses' feelings of frustration also contributed towards the damage to the therapeutic relationship.

> *"We are here to reassure them, to calm them down in a soft, caring and professional way but if they don't respond to that then you tend to get angry – I mean I'm only human."*
>
> (Sequeira & Halstead, 2004, p. 7)

1.3.2.4. Damage to working alliance with colleagues.

This meta-subtheme comprises two issues; the first is the sense of division that arose among the multi-disciplinary team (MDT) and the second is a sense of mistrust within oneself and amongst colleagues derived from the potential to abuse power.

Studies included in this review captured the divide that restrictive interventions generated amongst the MDT. Nurses expressed their belief that the weight of responsibility to get involved in restrictive interventions "*falls on our shoulders"* (Bigwood & Crowe, 2008, p. 218). This serves to produce an *"undercurrent of resentment"* towards the doctors, who dismissed the impact that restrictive interventions have on nurses as being part of their job, but "*raise a tremendous ruckus about it"* if they themselves were involved (Marangos-Frost & Wells, 2000, p. 367). Such sentiments were echoed by nurses who expressed *"the doctor has made the decision … but the nurses have to live with it … I feel I am not heard"* (VanDerNagel et al., 2009, p. 410).

Separate to the conflict that restrictive interventions created amongst the MDT, the data also revealed a sense of mistrust amongst nurses who expressed their belief that some staff misuse restrictive interventions as *"punishment"* (Vedana et al., 2018, p. 370). They also shared that *"any member of staff could lose control, that frightens me a bit"* (Sequeira & Halstead, 2004, p. 7). This fear was validated as some nurses acknowledged they felt justified in exercising this power in a *"not pleasant way"* (VanDerNagel et al., 2009, p. 410) when believing patients had made a choice to behave in a particular way. In addition, whilst nurses did not report the misuse of their power, some reflected on their thought to do and the sense of mistrust this created in oneself (e.g., Sequeira & Halstead, 2004).

1.3.3. The Surviving Nurse

The final meta-theme focusses on the strategies employed by nurses to manage the emotional and relational consequences they experienced as a result of being involved with a restrictive intervention. Across the studies, nurses described a broad range of

techniques and these are reflected in three meta-subthemes, including 'emotional suppression', 'emotional acclimatisation' and 'emotional wellbeing through debriefing'.

1.3.3.1. Emotional suppression.

Findings showed that nurses suppressed their emotional responses as a way of coping. Some studies noted that nurses made a conscious choice to switch off (e.g., Bonner et al., 2002; and Moran et al., 2009), whilst others reflected a sense of working on autopilot, a numbness as they did not connect with the salience of the experiences. Nurses cited that emotional suppression was motivated to facilitate getting on with the job, *"you must act and you simply do … you have no opportunity to feel emotions"* (VanDerNagel et al., 2009, p. 410) and protected their *"sanity"* (Sequeira & Halstead, 2004, p. 10). Other motivations included a perceived responsibility to model emotional control to the patients for whom they care.

> *"I am in charge of this ward and you know, I can't let myself look … you know – unprofessional … If they [patients] don't see us in control emotionally, that's when they get stressed out as well. You know, "We look at you to control your emotions, be emotionally strong"."*
>
> (Sequeira & Halstead, 2004, p. 8)

1.3.3.2. Emotional acclimatisation.

A further method employed by nursing staff to 'survive' the emotional impact of being involved with restrictive interventions was to remind themselves that it was a justified action that had restored safety on the ward and was in the best interest of the patient.

> *"I'd say it's a higher level of care … [the patients are] discussed regularly … their needs are met, you know, a lot quicker than they are if they are [just] milling around the ward."*
>
> (Holmes et al., 2015, p. 208)

Further, studies addressed how nurses described feeling 'hardened' as familiarity with such procedures developed. For example, *"I've sort of hardened myself to it … it used to affect me but it doesn't now"* (Sequeira & Halstead, 2004, p. 9) and *"the first real incident … it scared me … a year into working here I lost that feeling"* (Sequeira & Halstead, 2004, p. 6). The data revealed some staffs' concerns around this concept. For example, "*if you hardened up, then the caring would go out of it"* (Moran et al., 2009, p.602). The data also captured the nurses' journeys from idealistic views (e.g., *"why can't you just talk to them"*, Wilson et al., 2017, p. 504) to more pragmatic views regarding its necessity (e.g., "*people can suddenly turn into this total whirlwind … I understand it [the need for restrictive practice] now",* Wilson et al., 2017, p. 504)

1.3.3.3. Emotional wellbeing through debriefing.

Nurses reported the benefits of 'debriefing', following an incident of restrictive practice. The studies conveyed a sense that either formal *"meetings"* (Vedana et al., 2018, p. 370) or informal opportunities to debrief "*in the form of a cup of tea, nothing major"* (Bonner et al., 2002, p. 470) were both experienced as effective.

Interestingly, the studies revealed the multifaceted purpose of the debrief session. Nurses spoke to the role of debriefing to provide a supportive space in which to learn and "*provide a more overall picture to help understand the situation"* (Bonner et al.,

2002, p. 470). Across the studies, topics for debriefing discussions included reviewing the incident in terms of whether there were missed opportunities for de-escalation, the appropriateness of the practice and decision-making according to policy, familiarising oneself with guidelines or identifying training needs where necessary. Nurses described a further function of the debrief was to check in with each other, although some described a culture where it felt unacceptable to express feelings.

> *"We're helping them [patients], soaking up their pain and anxiety… there's no next step for staff to go on and say what happened to this person and explode about it or cry about it. I think we're still in this culture here that if you cry you're not coping, but it's not, [it's] just an expression of how helpless you feel".*
>
> (Sequeira & Halstead, 2004, p. 10)

Nurses also commented on the importance of laughing and joking to *"get rid of a lot of stress"* (Sequeira & Halstead, 2004, p. 9) as an important element of their support from colleagues.

> *"We joked around about it [the restrictive intervention] … I think we used humour to make ourselves feel better about the whole thing."*
>
> (Bigwood & Crowe, 2008, p. 221).

1.4 Discussion

1.4.1. Summary of Findings

Three meta-themes emerged from this meta-synthesis of the research literature on nurses' experience of restrictive interventions in inpatient psychiatric services. These included: 'The Conflicted Nurse', 'The Distressed Nurse' and 'The Surviving Nurse'.

Firstly*, The Conflicted Nurse,* highlights the psychological struggle that nurses experience between wishing to exercise their caring responsibilities towards patients and recognising that such a role may inevitably give way to the adoption of more controlling practices via the use of restrictive interventions. It was revealed that nurses attempted to reconcile this intrapersonal conflict as they considered the use of such interventions as necessary in order to safeguard the interests of everyone concerned, including the patient involved, as well as staff members and the broader ward environment.

Secondly, *The Distressed Nurse*, reveals the psychological difficulties that nurses experience in their conflicting responsibilities between patient care and control. Here, nurses reported a range of negative emotions associated with this practice, more concerned with control than in line with their values of compassion. These emotions included anxiety, shame and distress. The findings also show that nurses often felt uncomfortable allocating so much of their time documenting incidents of restrictive practice, further reducing their capacity to hold true to the compassionate values and 'care' for patients. Nurses also reported on the general lack of meaningful support they received from colleagues of other professions, which played a significant contributory role to the relational distress they experienced.

The final meta-theme identified in this review, *The Surviving Nurse*, reveals a series of strategies employed by nurses in order to cope with, and adapt to, the conflictual and emotional difficulties they experience. These included suppressing ones' feelings in service of 'getting on with the job' and the perceived need to model emotional control to the patients. Further, the findings revealed that nurses 'hardened' to the process, feeling more confident that they could justify the necessity of restrictive interventions as their familiarity with the process developed. Finally, nurses talked about the use of debriefing to manage their emotional wellbeing. The analysis of the literature included in this meta-synthesis revealed a lack of clarity amongst nurses' about how best to cope with, and survive, their experiences of restrictive practice. These strategies were influenced by the culture of their colleagues and the broader organisation.

1.4.2. Relations with Wider Research

The findings from this current meta-synthesis supported the outcomes of previous reviews. This was especially the case with regards to highlighting nurses' perceptions that restrictive practices are a necessary tool to maintain safety on psychiatric wards, but that they struggle with an ethical dilemma because these interventions go against their perceived duty of care (e.g., Happell & Harrow, 2010; Riahi et al., 2016). However, the current review goes beyond the findings of the conflictual experiences and offers a broader, more in-depth exploration of the nurses' journey; the current review draws out the layers of distress that nurses experience, as well as reviewing the coping strategies nurses employ in an attempt to reconcile these experiences.

The meta-synthesis revealed nurses' intrapersonal conflict as a result of the dissonance between their attitudes and practice, as they are compelled to carry out the 'necessary' restrictive practices despite this going against their values of care and compassion. Previous research has reflected that restrictive practice is a necessary evil that is justified in the context of the unpredictable milieu on psychiatric wards (Perkins, Prosser, Riley, & Whittington, 2012). It is important to acknowledge the potential impact of such cognitive dissonance, as recent literature has highlighted the links between role conflict and value incongruence as significant factors associated with stress and burnout among nursing staff working in psychiatric care (O'Connor et al., 2018 and Hylen, Kjellin, Pelto-Piri, & Warg, 2018 respectively), which is in turn associated with the high level of turnover in the profession (Johnson et al., 2018). The intrapersonal conflict and associated emotional distress highlighted in this current review may explain the high levels of work-related stress and burnout found in the psychiatric nursing profession.

Interestingly however, the current meta-synthesis showed that despite the conflict and distress experienced by nurses involved with restrictive practices, and its contribution towards work-place stress, nurses' also spoke to their reliance on restrictive interventions to facilitate feelings of safety at work. This concept echoes the findings of a recent study in which nurses expressed concerns about eliminating these interventions in the context of a perceived lack of alternatives to manage the challenging behaviours they are exposed to in psychiatric wards (Muir-Cochrane, O'Kane, & Oster, 2018).

The meta-synthesis also highlighted the considerable and multifaceted emotional and relational distress experienced by nurses involved in restrictive interventions. Whilst this review focussed on the experiences of nurses working in adult, inpatient

psychiatric settings, related research suggests that the patterns of psychological struggle and emotional distress associated with such interventions is ubiquitous for nursing practitioners across a range of services. For example, research with nurses working with adults in secure learning disabilities services, on medical wards and within psychiatric facilities for adolescents have all reported their distress when involved with restrictive interventions (e.g., Fish & Culshaw, 2005; Chuang & Huang, 2007; Petti, Mohr, Somers, & Sims., 2001 respectively).

The current meta-synthesis highlighted that nurses perceive opportunities to debrief and talk with colleagues as an important element to 'surviving' an incident where restrictive practice. This finding is echoed by a recent review that highlighted the importance of clinical supervision as a protective factor against burnout in mental health professionals (O'Connor et al., 2018). However, data from the current meta-synthesis also revealed the lack of consistency in the method through which debriefing is achieved or what these sessions comprised. This is reflected in the findings of a previous scoping review looking at post-seclusion and/or restraint review (PSRR) in psychiatry (Goulet & Larue, 2016); the authors argued that whilst most services have policies around the use of debrief, a lack of definition in the literature meant that services drew on and exercised elements of multiple models of debriefing and reflective practice. A lack of a consistent and meaningful approach to debriefing means that this strategy cannot be used to its full benefit.

1.4.3. Clinical Implications for Policy and Practice

Three distinct clinical implications and policy initiatives are proposed based on the findings from this meta-synthesis.

Firstly, professionals working in psychiatric hospitals are provided with training to develop their knowledge around de-escalation techniques and the physical manoeuvres associated with restrictive practices, to support them to feel confident that they can execute such interventions effectively and safely (Livingston, Verdun-Jones, Brink, Lussier, & Nicholls, 2010). It is important to all involved that services offer training with a greater focus on primary prevention in order to ensure that restrictive interventions are only employed as an absolute last resort. This is line with the initiative laid out by the DoH, recognising the importance of proactive care (DoH, 2014). If fewer incidents of restrictive practice can be observed through enhanced de-escalation then, in turn, the degree of conflict and distress experienced by nurses will be reduced. Furthermore, if satisfactory de-escalation protocols are in place, then the conflict and distress experienced by nursing staff in incidents requiring restrictive practice will be easier to reconcile within oneself. They will feel confident that such interventions were exercised as the last resort, employed only when there were no viable alternatives that could otherwise have served to ensure safety.

Secondly, the findings of the current meta-synthesis highlight that nurses experience less distress as familiarity with the practice increased. This suggests that in addition to the training typically provided by services, that is how to safely exercise a physical restraint, it would be beneficial to use training as an opportunity to support nursing practitioners, particularly new starters, to consider the ethical and emotional contradictions they may experience when involved in restrictive practice.

Finally, the present review highlights nurses' distress associated with implementing restrictive practice and the perceived importance of debriefing sessions, which serve as learning opportunities and a space where they can manage their emotions. Despite

this, the author noticed a distinct lack of congruency across the studies, which has also been highlighted in a recent scoping review around debriefing (Goulet & Larue, 2016). They concluded that effective PSRRs are concerned for the safety of the patient and staff members and therefore, that all should be involved in this reflexive process. It is therefore recommended that services encourage a more transparent and meaningful debrief protocol and that all staff involved, or witnessing, restrictive interventions are offered a suitable debrief sessions.

Taken in sum, in order to reduce the range of practical and emotional conflicts experienced by nurses as a result of restrictive practice, creating better clinical interventions in terms of de-escalation training and debriefs could help to resolve, or mitigate, many of the difficulties highlighted in this review. This may, in turn, protect against staff burnout and associated turnover.

1.4.4. Limitations

The author of the present review has acknowledged their professional experiences with restrictive interventions. This explicit reflexivity is an important quality control measure in qualitative research (Walsh & Downe, 2005). However, it is often considered "impossible to remain outside of one's study topic" (Palaganas et al., 2017) during the undertaking of qualitative research and as such, the steps outlined in the methods were taken to reduce any potential bias and to enhance the credibility and validity of the findings of this meta-ethnographical review.

This meta-synthesis did not exclude studies on the basis on geographical location, providing they were published in the English language. The use of restrictive interventions is regulated in the Western World (e.g., Australian Council on Healthcare Standards, 2008; DoH, 2014; RCN, 2008 etc.), with principles of 'human

treatment' and 'least restrictive practice' at the heart of psychiatric care. However, it is unclear how restrictive practices are considered and regulated in different cultures and the impact that this cultural understanding will have on the experiences of nursing staff. Whilst the concept of emotional distress and damage to the therapeutic relationship was common across studies, the study conducted in Iran used language that was considerably different as they talked about 'fixing' a patient and using other patients to support with restraint when staffing was low (Moghadam et al., 2014). Therefore, this study bared less weight in its contribution towards the meta-themes within the present review. It is suggested that the findings of this meta-synthesis relate predominantly to nurses living with Westernised cultures and values.

1.4.5. Future Research Directions

The current meta-ethnography highlights that nursing staff consider the debriefing process to be a positive forum to support and manage their distress following involvement with restrictive practices. Indeed, Goulet and Laure (2016) reflected that PSRR serves to improve patient and nurse experience, as well as "continually enhance the quality and safety of patient care" (p. 127). However, their paper highlighted that its evaluation is scarce in the literature. Future research should be conducted with nursing staff to understand exactly what elements of debriefing are considered most helpful and which serve little benefit so nursing staff can be supported in this integral, but difficult element of their practice.

1.5. Summary and Conclusions

This was the first review of the qualitative literature exploring nurses' experiences of being involved with incidents of restrictive practice in inpatient psychiatric services.

The findings highlight the complex nature of this experience for nursing staff and documents their journey through intrapersonal conflict in the face of the restrictive practices, their subsequent distress when exercising such interventions and the techniques they employ to survive. This data used to develop the meta-themes presented in this review suggests this journey is cyclical in nature and experienced by nursing staff as part of each restrictive practice. It is therefore important to incorporate a focus on the ethical and emotional challenges experienced by nurses during their training of the physical techniques of restraint practices, as well as to improve their access to, and experience of debriefing.

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Chapter II: Empirical Paper

Patients' Experiences of Restrictive Interventions at a Medium Secure Psychiatric Unit: An Interpretative Phenomenological Analysis

This paper was prepared for submission to The British Journal of Psychology. Refer to Appendix D for author guidelines.

Word count for chapter when submitted (excluding abstract, tables, figures and references): 7,999

2.0. Abstract

Purpose: Literature asserts that restrictive practices are inherently harmful to the psychological wellbeing of psychiatric inpatients. However, research exploring patients' experiences in forensic mental health services are limited. The current study aims to explore forensic psychiatric patients' experiences of restrictive interventions in a medium secure service.

Methods: Six adult, male participants were recruited to the study. Audio-recorded, semi-structured interviews were conducted to gather their experiences of restrictive practice in a medium secure psychiatric service. The data was analysed using an Interpretative Phenomenological Analysis framework.

Main Findings: The findings revealed three superordinate themes: '*Powerlessness'* (participants reported their experiences of their voices not being heard and feeling physically powerless), '*A Sense of Injustice'* (participants reflected their emotional distress, as well as their experiences that staff made little attempt to understand the meaning that the restrictive practice held for them) and *'A Sense of Resignation'* (participants described the techniques they employed to manage these restrictive interventions, for which they had come to hold an attitude of uneasy acceptance).

Conclusions: Participants' experiences were considered in the context of existing literature. Clinical and service implications, as well as recommendations for future research are discussed.

Key Words: *patients, psychiatric, secure, forensic, restrictive practice, restraint, seclusion, phenomenological, IPA*

Abstract word count: 189

2.1. Introduction

2.1.1. Research Aim and Significance

This study explores patients' experiences of restrictive practice in secure forensic psychiatric services. Such services hold both custodian and therapeutic responsibilities, and patients detained there typically present with challenging and often criminal behaviour due to their severe and enduring mental health difficulties (Mason, King, & Dulson, 2009). Restrictive interventions, practiced in such settings, constitute any form of coercive treatment or intervention that "may infringe a person's human rights and freedom of movement" (National Institute for Health and Clinical Excellence [NICE], 2015, p.15). These can include observation, physical restraint, mechanical restraint, rapid tranquillisation and seclusion.

Of patients detained involuntarily, 30% experience seclusion and 26% experience physical restraint (Raboch et al., 2010). Within forensic psychiatric settings, these rates are considerably higher (Keski-Valkama, Koivisto, Eronen, & Kaltiala-Heino, 2010). Such restrictive practices can be psychologically distressing, and sometimes re-traumatising for patients, especially for the estimated 40% of forensic patients who have a history of childhood abuse (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Shack, Averill, Kopecky, Krajewski, & Gummattira, 2004; Steinert, Bergbauer, Schmid, & Gebhardt, 2007). Research has shown the effect of gender on the frequency of restrictive interventions, with men more likely to be subject to such practices (e.g., Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009).

Legislation recognises the need for psychiatric services, including secure services, to employ restrictive interventions to manage "behavioural disturbance" within a safe and therapeutic culture (Department of Health [DoH], 2015, p. 281). However, the

use of such restrictive interventions remains vulnerable to abuse and at times raises ethical concerns around the violation of human rights and deprivations of liberty (Mohr, 2010).

2.1.2. Evaluation of Previous Literature

Research has also started to take an interest in exploring the impact that restrictive interventions may have on patient wellbeing. Strout (2010) conducted a systematic review of 12 qualitative studies, four of which recruited from secure psychiatric services, to explore patients experiences' of restrictive practices. The findings identified four themes: 1) the negative psychological impact on patients' emotional experiences (including anger, fear, humiliation, powerlessness, distress, dehumanisation and violation); 2) re-traumatisation (patients reported that being restrained bought back memories of abuse experienced as a child); 3) perceptions of unethical practices (patients felt incidents had been punitive and abusive); and 4) the broken spirit (patients reflected on the hopelessness and helplessness they experienced during the restrictive practice). These findings have been replicated by a more recent review of 10 studies exploring patients experiences of physical restraint within psychiatric inpatient facilities. These studies, which employed both qualitative and quantitative methodologies, led the authors to conclude that restrictive practice continues to be inherently linked to physical and psychological distress (Cusack, Cusack, McAndrew, McKeown, & Duxbury, 2018).

Research has also looked specifically at patients in forensic psychiatric services. For example, Haw, Stubbs, Bickle and Stewart (2011) interviewed 57 patients and found they often acknowledged restrictive practice served to prevent harm to oneself or others and some reflected on this positively as a demonstration of nurses' care.

However, patients also reflected on more negative impact of the interventions, including the physical pain and emotions including fear, anger, humiliation and re-traumatisation, as well as a sense of powerlessness. This in turn led to some patients holding negative attitudes towards the staff involved.

Holmes, Murray and Knack (2015) explored 13 patients' experiences of seclusion in forensic psychiatric services. The findings revealed that patients experienced a broad range of negative emotions, as well as a perceived reduction in the quality of their care, driven by their sense of feeling ignored. Despite holding it as a negative experience, patients shared their understanding of the necessity of restrictive practices, supporting the findings of Haw et al. (2011).

In a further study conducted with a psychiatric forensic sample, eight patients were interviewed about their experiences of physical restraint. Thematic analysis revealed that patients reflected on it as degrading and traumatic and they also spoke to its impact on the therapeutic relationship as it highlights the power imbalance between staff and patients (Knowles, Hearne, & Smith, 2015).

2.1.3. Rationale

The current study adds to the literature in three fundamental ways. Firstly, a recent review highlighted that the volume of research concerned with patients' experiences of restrictive interventions in psychiatric care is limited, and even more so in forensic psychiatry (Cusack et al., 2018). Secondly, there has been a lack of homogeneity across the samples of the existing studies. To the author's knowledge, there have been just three qualitative studies exploring patients' experiences of restrictive practices within a forensic psychiatric sample in the UK (Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002), with other studies drawing their

sample solely from forensic patients with a learning disability (e.g., Fish & Culshaw, 2005; Jones & Kroese, 2006; Sequeira & Halstead, 2001). Thirdly, despite a number of studies in this area adopting a qualitative methodology, few have attempted in-depth explorations of patients' lived experiences and the meanings associated with those experiences through employing a phenomenological research framework.

2.1.4. Aim

This study aims to address these gaps in the current literature by exploring forensic psychiatric patients' experiences of restrictive interventions. This qualitative study will be organised around an Interpretative Phenomenological Analysis (IPA) research design, which will enable a deep and meaningful interpretation of the findings obtained in response to the research question: What are male patients' experiences of restrictive interventions in a medium-secure hospital setting?

2.2. Method

2.2.1. Research Design

There are various research designs within the interpretivist stance, which are often qualitative in nature. One such qualitative approach is IPA, which is "how people make sense of" their lived experiences (Smith, Flowers, & Larkin, 2009, p. 1). As this is consistent with the research aim, the current study adopted this design.

Smith and colleagues (2009) assert that one of the theoretical underpinnings of IPA is the hermeneutics principle. This accounts for the researcher's role in interpreting the data, specifically, acknowledging the process whereby the researcher makes sense of the experiences that participants have already made sense of. They further

describe how the process of IPA supports insight into an ideographic narrative, which involves understanding experiences as they are interpreted at the level of the individual and the contextual meaning that each individual attributes to their lived world.

2.2.2. Participants

2.2.2.1 Sampling design and eligibility criteria.

A purposive sampling design was employed. This type of non-probability sampling design allows the researcher to select "information-rich cases whose study will illuminate the questions under study" (Patton, 2002, p. 230). Selecting a sample purposively facilitated the recruitment of a homogenous group of individuals, that closely reflected the study's inclusion criteria. Selection criteria are in Table 2.1.

Table 2.1

Participant Inclusion and Exclusion Criteria

Criteria	Inclusion criteria	Exclusion criteria
Gender	Men	
Ethnicity	All ethnicities	
Age	Adults, to include older adults and those of working age	
Diagnosis	Currently residing in a medium-secure unit, that is with forensic history and diagnosis of a mental health difficulty	Co-morbid diagnosis of a learning disability
Language fluency	Can communicate fluently in English	Non-English speakers who require the presence of a translator
Experience of restrictive practice	Experienced at least one form of restrictive practice (physical and chemical restraint, seclusion) within the last two years	
Risk status	Individuals who can meet with the interviewer without a chaperone	

The literature reports differing rates of restrictive interventions across gender (Stewart et al., 2009), ethnicities (e.g., Gudjonsson, Rabe-Hesketh, & Szmukler, 2004; Price, David, & Otis, 2004) and age groups (Knutzen, Sandvik, Hauff, & Opjordsmoen, 2009). However, the current study is interested in exploring the

experience of restraint only, not in factors surrounding frequency, so adult males of all ethnicities who satisfied the other inclusion criteria were invited to participate.

Participants were recruited from a medium-secure hospital in the NHS. The hospital cares for adult males with a forensic history who have a psychiatric diagnosis. The study excluded individuals with a comorbid diagnosis of a learning disability, who may have found it difficult to articulate their experiences due to their cognitive capacity. Similarly, individuals whose clinical teams assessed that they did not have the capacity to consent, as guided by the principles on the Mental Capacity Act (DoH, 2005), were also excluded.

The study also excluded those who required the presence of a third party in the interview. For example, for those who are unable to understand or speak English fluently and would have needed an interpreter, and also those whose current level of risk meant they would have required a chaperone. This decision was made to facilitate an in-depth exploration of participants' lived experiences, which may otherwise have been hindered by the presence of a third party. One-to-one interviews facilitate authentic disclosures and maximise the exploration of experience; it was likely that participants would have felt pressured to offer a more sociably desirable and positive account of their experiences if witnessed by a third party.

Finally, this study explored patients' experiences of seclusion, physical restraint and rapid tranquillisation. Patients were not asked about their experiences of mechanical restraint as it is not permitted in the UK (Steinert et al., 2010). To embed the study in recent legislative changes, it was specified that participants must have experienced restrictive interventions in the last two years, that is after April 2016, as this marked

the end of the two-year initiative, which emphasised the need to reduce restrictive practice and encourage positive and proactive care (DoH, 2014).

2.2.2.2. Participant characteristics.

The literature surrounding the topic of an appropriate sample size within IPA suggests that the answer lies within the richness of data, as well as organisational constraints (Smith et al., 2009). It is argued that for professional doctorates, a sample size of four or greater is adequate (Hefferon & Gil-Rodriguez, 2011). Indeed, literature argues that successful analysis is dependent on rich data and that more participants could inhibit the successful exploration of the dialogue and sound data analysis (Smith et al., 2009).

The study recruited six participants, all of whom met the criteria outlined above. With the participants' consent, some demographic information was collected at the time of interview to formulate 'pen portraits'. This included: age, ethnicity, length of stay, number and type of restraints, their current section and legal status, as well as their diagnoses. Pen portraits (Table 2.2) allow for "biographical information" to be shared with the reader in a way that brings participants to life (King & Horrocks, 2010, p. 139).

Table 2.2

Participant Characteristics

Participant pseudonym	Ethnicity	Years since admission	Primary diagnoses	Incidents of restrictive practice
Steve	Asian	2 years	Psychosis	2 physical restraint
Lincoln	White Other	1 year	Paranoid Schizophrenia	1 seclusion
Paul	White British	2 years	Paranoid Schizophrenia, Borderline Personality Disorder	2 seclusion
Charlie	White British	4 years	Paranoid Schizophrenia, Autism Spectrum Disorder	1 physical restraint and 2 seclusion
Bob	White British	< 1 year	Paranoid Schizophrenia	1 physical restraint and 1 seclusion
Phil	Asian	< 1 year	Paranoid Schizophrenia	2 seclusion

2.2.3. Procedure

2.2.3.1. Ethical considerations.

The research was conducted in line with ethical considerations put forward by the British Psychological Society (BPS, 2010). Ethical approval was sought from Coventry University and also from the NHS's Research Ethics Committee (see Appendices E & F respectively). In accordance with ethical guidance, the following issues were addressed.

Participants were provided with an information sheet (Appendix G), which was developed in accordance with the Code of Human Research Ethics guidelines (BPS, 2010). It included information about the aim of the study, what participation would involve and participants' right to withdraw. Participants were asked to sign a form, confirming their informed consent (Appendix H). Participants were fully informed of the purpose of the research and no information about the nature of the study was withheld; no deception was involved.

Whilst it was not anticipated that the study would cause harm, the nature of the interview material was likely to be sensitive, with previous literature describing the traumatising nature of restraint (e.g., Strout, 2010). Therefore, after completing the interview, all participants were provided with a debrief form (Appendix I) and given information regarding who to contact should they require additional support to manage any emotions that arose. Also of note, whilst research in this setting does strike a power imbalance, inviting participants to tell their story is an enabling and empowering process, allowing their voices to be heard.

The collected data, including the consent forms and audio-recorded interview, was kept in accordance with the Data Protection Act. Participants were informed that the interview transcript was only available to members of the research team and would be anonymised prior to dissemination. Audio-recordings were deleted as soon as they had been transcribed. Further, prior to participation, all participants were informed that whilst the content of the interviews would remain confidential and held in accordance with data protection legislation, the researcher was obliged by a duty of care to inform the clinical supervisor of the project should they identify with a risk to themselves or others.

2.2.3.2. Materials.

Given their many benefits, semi-structured interviews are the preferred method for researchers to collect data when employing an IPA research design (Reid, Flowers, & Larkin, 2005). The interview guide (Appendix J) was constructed in collaboration with the other researchers and clinicians involved in this study.

Previous literature reviews have described the negative emotional impact of restrictive practice for patients in acute mental health settings and also, report patients' perceptions of unethical practice amongst staff; as such, these interventions are linked to physical and psychological harm (e.g., Cusack et al., 2018; Strout, 2010). Questions were organised around these key themes from the existing literature. Although this a-priori and deductive element to the interview guide can serve as a limitation by guiding the participants towards a particular, pre-determined focus, the questions were prepared as a flexible guide and the participant was provided with every opportunity to explore their own experiences and reflect on the meanings associated with those experiences. As such, the structure of the interview guide was designed in order to facilitate and maximise the voice and concerns of the participants (Smith, Flowers, & Larkin, 2009).

As guided by literature outlining IPA methodology (Smith, Flowers, & Larkin, 2009), the interview guide contained various types of questions, alongside suitable prompts to facilitate the gathering of rich data. The interview guide was also sensitive to the 'rhythm' of the interaction, that is, it started with more descriptive questions about a poignant experience of restrictive practice and progressed onto the associated affective and cognitive experiences.

2.2.3.3. Recruitment.

With support from the lead researcher's clinical supervisor for the study, the research idea was initially shared with the research panel at the hospital from which participants were recruited. Upon commencement, it was subsequently introduced to the team of psychologists, each of whom was attached to a clinical team within the hospital. The clinical teams were then asked to identify potential participants, as guided by a letter from the researcher to outline the selection criteria (Appendix K). Patients who met the criteria were informed of the study. Those who expressed an interest were given an initial invitation letter (Appendix L), following which a meeting with the lead researcher was arranged to share more information and where appropriate, to gain consent. A figure to show the recruitment process can be found Appendix M.

2.2.3.4. Interview procedure.

Interviews took place between April and October 2018 and lasted between 15 and 48 minutes (*m* = 29 minutes). All were audio-recorded; this reduced bias and meant the researcher did not need to take detailed notes during the interview, which facilitated the development of rapport (Howitt, 2010).

To establish rapport, review the information sheet and obtain informed consent, the participants and researcher met on the ward. Whilst IPA principles typically enable the participant to choose where the interview is conducted (Smith et al., 2009), issues relating to the secure environment where patients were residing were considered. For example, to adhere to hospital policy which prohibited the use of recording devices on the wards, interviews were completed off the ward, in the hospital's family room. Being away from ward staff and other patients facilitated a

‘safe’ feeling to disclose true experiences. However, the risk that leaving the ward environment posed to both the patient and researcher had to be considered and as such, patients who had not been granted ‘leave’ from the ward by their clinical team were unable to participate.

There was potential for participants to find the topic distressing, and some had impaired concentration as a result of their psychiatric diagnoses and medication, therefore, all were given the opportunity to take breaks and terminate the interview. Participants were also advised that they could withdraw their data in the 7 days after interview, prior to the commencement of transcription and analysis.

During the interview, the researcher monitored the impact that the interview was having on the participant and responded empathically. However, the researcher was not to fall into a therapeutic role, or collude with the individuals if asked to disclose their opinion regarding the actions of staff in the event described, that is, the research maintained a neutral position (Patton, 2002). Debriefing was used as an opportunity to signpost participants to supportive interventions.

2.2.4. Data Analysis

All interviews were recorded on a Trust-issued audio device and transcribed, prior to analysis. Identifying information was omitted or changed as necessary so that written transcripts reflected anonymised accounts. Data was analysed using the six key steps of IPA (Smith et al., 2009) including: 1) reading and re-reading the transcript, immersing oneself in the data; 2) initial noting, that is attending to the descriptive comments, as well the language used and concepts considered; 3) developing emergent themes; 4) drawing links between emerging themes; 5) repeating the aforementioned processes with subsequent interviews; and finally, 6) looking for

patterns across the interviews. An example of a coded extract can be found in Appendix N. Themes were considered to address the initial aim of the research study, that is, to capture and understand patients' experiences of restrictive practice in a medium-secure hospital.

2.2.4.1. Credibility of the study.

The lead researcher was responsible for the initial coding and development of emerging themes. These were then discussed within the supervision team and reflections were shared. Further, a section of a transcript was coded by a second researcher (Appendix O); these codes were compared and discussed. The literature asserts that this triangulation of the interpretation across researchers serves to enhance the validity of the findings (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Reid et al., 2005).

Further to this, as part of the consent form, participants were asked whether they would like to be informed about initial themes as they emerged during the analysis. Five of the six participants gave their consent to be part of this respondent validation. All five were sent a letter comprising a brief summary of the initial themes (Appendix P) and this was followed up with a telephone call from the lead researcher to discuss further. This procedure ensures the final themes accurately represent participants' accounts (Mays & Pope, 2000). The researcher was able to speak with three participants, as one was on leave during each attempted contact and one had already been discharged from the hospital. All participants reflected that the themes resonated with their experiences.

2.2.4.2. Reflexivity.

As asserted in the literature, the researcher's own experiences are brought into the research and may influence the analysis (e.g., Smith et al., 2009). Therefore, acknowledging one's position and taking steps to enhance the objectivity of the analysis is fundamental in ensuring the validity of the research findings.

A bracketing approach was adopted (Tufford & Newman, 2012), comprising an interview as well as continued reflective practice within the supervision team. During this process, the lead researcher explored their experiences of when previously employed as an assistant psychologist within the secure hospital involved in the recruitment and how this may influence the analysis. This reflexivity is considered good practice within qualitative research (Reid et al., 2005).

2.3. Results

Analysis of the interview transcripts revealed three superordinate themes: 'Powerlessness', 'A Sense of Injustice', and 'A Sense of Resignation'. Each of these superordinate themes held several subordinate themes (Table 2.3).

Table 2.3

Superordinate and Subordinate themes

Superordinate theme	Subordinate theme
Powerlessness	1) Powerlessness of voice
	2) Powerlessness of body
A Sense of Injustice	1) A breach of human rights
	2) The true issue had been missed
A Sense of Resignation	1) Learn how to play the game
	2) A necessary evil

2.3.1. Powerlessness

All participants spoke about their experiences of feeling that they had no power or control over being restrained or secluded and described how, in the context of restrictive practices, *"staff take power from us"* (Charlie, follow-up interview, 442). This sense of powerlessness was described by participants as taking two important forms. Firstly, that they had no voice and that they did not feel listened to by staff. Secondly, participants experienced a lack of physical power and control over their own bodies as a result of the force used by staff during the restrictive intervention.

2.3.1.1. Powerlessness of voice.

This subtheme centred around the idea that throughout the whole restrictive process, participants felt their voices were not heard. For example, Steve described how, prior to the intervention, he had tried to alert staff about the escalating nature of the difficult relationship he was having with another patient but reflected that staff had ignored his concerns until after the situation reached a point at which restrictive interventions were employed.

> "*It's not like it [the fight] happened with no warning, I was talking to staff … and I told them I don't get on with him, he's going to cause me trouble … then when it happened everyone was shocked, but like I'd been telling the truth all along … I told them everything about the problem that I had … but they didn't listen. Then when it came to it, to the crunch, erm, when I punched the person I had a problem with … that's when they listened.*"
>
> (Steve, 101-133)

In part, Steve attributed the incident to the powerlessness of his voice. He shared his belief that this incident could have been avoided if the concerns he voiced to staff had been taken more seriously and that in this context, staff were "*partly to blame*" (line 123). This experience was shared amongst participants.

> *"[Staff need to] do their best to stop it like … pay more attention to what patients are doing… I'm just saying if it kicks off, they [staff] need to know an explanation, don't they?"*
>
> (Paul, 102-107)

Further to this, other participants asserted that communicating their distress with staff verbally did not lead to action, and as a result, felt that their voice was rendered powerless to change the circumstances they were in.

> *"I kept bringing that up [my distress] … but yeah, there's nothing they'd do differently. That's how they do it, how they've always done it, how they will continue to do it … I felt ignored."*
>
> (Bob, 278-283)

Participants attributed staffs' dismissal to the culture of power within the system and reflected on how their psychiatric status further rendered their voice powerless.

> *"We have a voice on paper and staff claim we have a voice but the reality is that the words of a psychiatric patient, the voice we have, is very small, very weak, ineffective ... the reality is that the voice of the patient is well, well it's not even worth being called a voice really. We will be heard perhaps, but nothing will ever be done."*

(Charlie, 322-405)

As a result of not feeling listened to, participants reflected on their experiences in terms of having a voice which was always subordinate to others and recalled their experiences that staff accept each other's versions of accounts more readily than the narratives of patients.

> *"Nobody takes the word of a psychiatric patient very seriously. Their judgment is always held in question. The patient's account of a situation … in this hospital is always going to be held with a degree of doubt … Everyone will always take the words of a psychiatric patient with a pinch of salt … [but] staff members are more than happy enough to see things from their colleagues' perspectives."*

(Charlie 187-246)

2.3.1.2 Powerlessness of body.

This subtheme centred around participants' experiences of physical restraint and was not experienced by participants in relation to seclusion, other than in the restraint used to guide patients towards the seclusion room. Participants described their

experiences that physical restraint was often exercised with *"disproportionate force"* (Charlie, 53).

> *"When you're being pinned down by seven people … you can't really fight back against seven people, can you? … [My distress] was more about the amount of people than what they did. Cos it was all staff members from other wards as well … press the alarm and they all come running … all crowded into my room and they crammed in and pinned me down."*
>
> (Bob, 355-373)

Participants described that this use of force resulted in their sense of feeling physically powerless and that they had experienced a complete loss of control of their own bodies.

> *"They were pinning me down, hands on my head, some had hands on my arms, hands on my legs, hand everywhere basically … I was never going to escape it."*
>
> (Bob, 128-377)

> *"Feeling powerless [was the worst part of the restrictive intervention] to be honest with you … You know, when they hold your hands you're not able to do anything you know."*
>
> (Steve, 136-139)

2.3.2. A Sense of Injustice

This superordinate theme centred around participants' sense of injustice as they reflected on the emotional distress they experienced as a result of the intervention, as

well as how staff made little attempt to understand the triggers to the incident that led to the restrictive practice. This is represented by two sub-themes, including *"A breach of human rights"* and *"The true issue had been missed"*, both of which are quotes lifted directly from the interview transcripts.

2.3.2.1. "A breach of human rights".

Participants reported that their human rights had been breached when discussing both physical restraint and seclusion. However, this was experienced differently across the two forms of restrictive practice.

With regard to physical restraint, participants described their experiences of feeling *"violated in some way, mistreated and abused"* (Charlie, 264).

> *"I don't like being pushed and poked … but all they were saying was grab his glasses, drag him out and all that … They said we all need to grab him out, grab him out … It was just the staff like manhandling me basically … I felt violated in a way … It wasn't justified, it wasn't reasonable means".*
>
> (Bob, 204-239)

Participants reflected on the lasting emotional distress associated with the restraint. For example, Bob described how the restraint had an impact of his self-esteem.

> *"It doesn't help your self-esteem or your confidence, cos you're lacking in confidence when you go in [to hospital] and then you're lacking in confidence all the time [after the restraint]."*
>
> (Bob, 355-357)

With regard to seclusion, participants recalled their experiences around the isolative nature of this process where *"you don't get no freedoms"* (Phil, 136). All participants who had experienced seclusion reflected on the lack of stimulation and interaction as being the worst aspects of the intervention. For example, Paul described how *"[the worst part of seclusion was] the boredom … just cut off from everyone"* (111-116).

Participants reflected that at the time of the incident, the restrictive intervention felt unfair and an injustice. Indeed, participants shared their feelings of anger and disappointment as they questioned the motives of the staff involved, asking "*why are they [staff] doing this to me"* (Bob, 379). Participants also alluded towards their experiences of restrictive practice being *"used for punishment, rather than its correct purpose"* (Charlie, follow up interview, 442) and that this contributed to their sense of injustice.

2.3.2.2. "The true issue had been missed".

One of the experiences raised during the interviews was that following an incident of restrictive practice, participants felt staff seemed primarily focussed on managing the situation with medication and on assessing the level of risk they posed to both themselves and others, rather than on understanding the build-up to the interventions. In this context, participants shared their experiences that *"the interactions you have [with staff] are pointless"* (Lincoln, 65-66).

> *"The doctor comes round a few times … but I think all they think about is medication. Staff are all in it for medication."*
>
> (Phil, 93-96)

"They [nurses] were only interested in what pills they could give me. The HCAs [health care assistants] weren't interested [about why this had happened], just wondered 'how can we stop this guy from killing himself' and 'how many obs [observations] have we got to do' … I mean, it would have been better to talk to someone about the whole experience, but it didn't happen … I would have preferred someone to talk to".

(Bob, 324-338)

"The debrief process tends to come from the doctor who erm has jurisdiction over the ward, coming down and speaking to you, and checking you're in the right mind [to end the intervention] … deemed safe …You speak to the doctor, he asks you a few questions and it's not very in depth, no digging about why this occurred."

(Charlie, 302-309)

As a result of the focus of discussions being elsewhere, participants recalled that *"the true issue had been missed"* (Charlie, 82). That is, participants shared their experiences that staff didn't try to understand their feelings, or the function of the behaviour that led to the restrictive practice and the meaning that the restrictive practice had on them.

"[The patient's behaviour] cast a shadow over everything … when their response is not proportionate, staff forget to ask why they did it … there is no in-depth discussion. [Staff] listen to your point of view as a matter of courtesy … but they don't really take any of it on board most of the time …

you're placed in there while you're a problem, but no one asks why you're a problem, how it [the incident] occurred."

(Charlie, 329-342)

2.3.3. A Sense of Resignation

This superordinate theme reflected how participants form an uneasy acceptance in their attitudes towards restrictive interventions and their recognition, typically developed with hindsight, that such practices can sometimes be necessary to support them. It is represented by two subthemes, to include, *"Learn how to play the game"* and *"A necessary evil",* both of which are quotes lifted directly from the transcripts.

2.3.3.1. "Learn how to play the game".

This subtheme focussed on how participants described that they have had to *"learn to play the game*" (Charlie, 363) in order to minimise the time in such interventions.

"Playing the game is a disingenuous way of ending the restrictive practice but it's just about jumping through the hoops and that's the reality."

(Charlie, follow up interview, 442)

Participants described that sometimes this meant they adopted a compliant approach, cooperating with staff as a means to end their restrictive practice. Indeed, during discussion in the follow up interview, Bob said that he had *"learnt to accept that they give you more freedom if you comply with their rules"* (422).

"To get out of seclusion you have to cooperate with doctors … I have no choice but to take it [the medication] or I'd be there for a longer time."

(Phil, 44-101)

Participants reported that putting forward their own version of events would only serve to extend the restrictive intervention. As a result, they described that sometimes 'playing the game' took the form of deliberately using silence to manage the time spent in the restrictive intervention.

> *"It involves staying quiet and not retaliating or challenging staff … they are the ones who call the shots … it doesn't matter about right of wrong … you either have the power or you don't and the people who have the power impose their version of events, which will be always be held above the people who don't have power."*
>
> (Charlie 368-378)

2.3.3.2. "A necessary evil".

Participants reflected their understanding that restrictive interventions were exercised to ensure "*people are safe*" (Paul, 56) in an environment where they, or others, present with a risk to harm.

> *"It was about keeping me away from other patients, so you don't hurt yourself or others."*
>
> (Bob 81-82)

> *"The way I see it yeah is that seclusion is there for a reason yeah … [at the time of the incident] I was just off my head, I was really confused … I was screw balled yeah … I thought I was superhuman or something … at the time I needed seclusion."*
>
> (Lincoln, 153-177)

They recognised that staff were fulfilling their job to protect them and others from physical harm. In this context, participants described how they accepted their restrictive intervention was a direct consequence of their behaviour and *"my own fault"* (Paul, 30).

> "*They [staff] got a job to do … I got into an altercation with somebody so it's only fair they do whatever to diffuse the situation … I did something wrong so it's expected of them to restrain you … basically I was in the wrong, so I took it on the chin."*
>
> (Steve, 55-66)

As a result of understanding the necessity of the practice, participants reflected on the more positive aspects of staffs' intervention with restrictive practices. With regard to physical restraint, of the three participants who had experienced it, only one shared a positive response as he recalled how it had served to prevent the situation from escalating.

> *"I was kind of relieved at the end because I don't want to fight anyway. And so when they got me, straight up, I was kind of relieved as much as anything … It would have gone on for longer, it would have been more serious than it actually was, cos it was just like a scuffle. But if no-one had jumped in, it would have been worser [sic]."*
>
> (Steve, 72-82)

Of the five participants who had experienced seclusion, four of them felt that it had been of some benefit to them, with all citing the calmness of the seclusion

environment, which gave their own space where they could "*calm it down*" (Paul, 113).

> *"I just found it peaceful … no-one in there trying to wind me up. [Seclusion was] a change in circumstance from what I was in before … it was very quiet, even though it was very busy on the ward it was very quiet in the seclusion room".*
>
> (Bob, 51-68)

In the context of being used to keep people safe, restrictive interventions were understood by participants as a necessary part of the hospital system. However, despite this, they still reflected on the undesirable aspects of the practice.

> *"I think it [restrictive practice] is justified, some patients genuinely are a threat to other people around them … and those people need to be restrained. It's a necessary evil … The undesirable thing is that erm that essentially, you're overriding a human being's will and you're forcing them to be in a place that they don't want to be, and you're doing it with force. It's never desirable to do that. Ever. But it is necessary."*
>
> (Charlie 271-285)

Interestingly, participants reflected their experiences that their perception had changed with hindsight, moving away from positions of anger and feeling attacked, towards a sense of understanding why staff had exercised the restrictive practice.

> *"I felt angry but I don't now … they're doctors and nurses at the end of the day and they're here to help, not to harm …. I have a different outlook [now] … At the time, part of me thinks something but I don't know, that feeling, it*

hasn't stuck with me … My mind were racing, probably thought they [staff] were against me at the time".

(Steve, 192-207)

Bob also shared *"I was quite unwell at the time and I was pissed off [being placed in a restrictive intervention]. But [now] I can see why it happened".*

(Bob, 160-161)

2.4 Discussion

The aim of the current study was to explore patients' experiences of restrictive practice in a secure forensic psychiatric service. Three superordinate themes emerged from participants' narratives of their experiences; these are discussed below in the context of the existing literature. Clinical implications arising from the study findings, limitations and recommendations for further research are also discussed.

2.4.1. Discussion of Findings

2.4.1.1. Theme 1: Powerlessness.

In the current study, participants spoke about how the restrictive process had served to highlight the power imbalance in the therapeutic relationship between staff and patients. This finding is in line with previous literature, which has consistently demonstrated patients' perceptions that staff hold all the power with regard to restrictive practices in forensic psychiatric settings (e.g., Haw et al., 2011; & Knowles et al., 2015). Participants in the current study also reflected how they experienced their voice as powerless, describing how they had attempted to

communicate their distress with staff prior to the incident escalating. In a study by Knowles and colleagues (2015) patients also noted that staff missed opportunities to act before the situation escalated to the point at which restrictive practice is exercised. However, the findings of the current study extend beyond this, as participants attributed the dismissal of their voices to the culture of the system, stating that in their experience, having a psychiatric diagnosis rendered their voice powerless in the process of restrictive practice.

2.4.1.2. Theme 2: A Sense of Injustice.

In the current study, participants' accounts suggested that the sense of injustice around the restrictive intervention was influenced by whether they perceived that staff used reasonable force, and whether they felt it had been used for the correct purposes, that is to ensure safety and not a means of punishment. These two ideas have also been expressed by Sequeira and Halstead (2002) and Holmes and colleagues (2015), respectively. The current study extends beyond the existing literature and appears unique in participants' reflections that the true issue behind the restrictive intervention is often missed by staff and they described how this contributed towards their sense of injustice. Participants reported their lack of meaningful interactions with staff in the aftermath of the intervention, and described how this had meant they were not afforded the opportunity to share their understanding of the triggers or to process the difficult cognitions and feelings associated with the incident. This finding adds weight to the importance of using a meaningful debrief as part of the post-incident review, to further inform patients' treatment plans, including the Positive Behaviour Support (PBS) framework, which is now a good-practice standard for all patients cared for in inpatient psychiatric settings, including secure services (DoH, 2014). The existing literature, along with

the findings of the current study, asserts that patients feel staff justify their decision to use a restrictive intervention in the way they construct their narrative of the events in the post-incident paperwork (Knowles et al., 2015), whilst the patients' account is often missing. Participants in the current study described how this contributed to the experience that the true issue was missed and further rendered their voices powerless.

2.4.1.3. Theme 3: A Sense of Resignation.

One of the experiences raised by participants in the current study was how they had learnt to use compliance and silence as a means to end the restrictive intervention. Participants in the current study described how compliance took various forms, including accepting staffs' focus of discussion around medication and risk, as well as accepting staffs' understanding and portrayal of the events surrounding the restrictive practice. This finding is consistent with a recent study by Knowles and colleagues (2015) who reported that patients often accept the blame, even when they do not believe it to be true, just to end their intervention. Together, these findings demonstrate how patients learn to play the game, using compliance and silence in an attempt to regain control in a situation they typically feel powerless in. Interestingly however, participants' acceptance of the intervention as a 'deserved' consequence of their behaviour and their use of language (e.g., feeling it's their 'fault' and 'taking it on the chin' because they recognised that they had behaved badly) raises the issue that they see restrictive practice as a punishment, not just a means to achieve safety.

In line with the current findings, other research has demonstrated patients' understanding of the need for restrictive practices to ensure their safety, and those around them. However, the current study extends beyond the existing literature as it

explores participants' shift in perception over time. Participants' shared their experiences of feeling able to make more sense of why staff had exercised a restrictive practice with hindsight. They referenced how, at the time of the restrictive intervention, they had been more unwell and that the acute nature of the emotional distress and behaviour had contributed to their anger and sense of being under attack at the time of restrictive practice. During the interviews, they reflected how, with hindsight, they were able to see the protection that the restrictive practice had offered them, preventing the situation from escalating to a point when injury to self or others could have been more severe. However, even with hindsight, restrictive practice was still viewed as undesirable and distress remains a longer-term consequence of others overriding their will.

The current study recruited participants with experiences of both physical restraint and seclusion. Not surprisingly, participants looked back less favourably on their experiences of restraint, whilst all participants who had been secluded reflected their experiences of finding the space to be calm; this is consistent with other research (e.g., Haw et al., 2011). However, the current study extends our understanding of the complexity of seclusion, as participants reflected that being away from other patients and having the space to calm down was both a benefit of seclusion, but also the worst part of the process in the sense they felt socially disconnected and lonely.

2.4.2. Clinical Implications for Policy and Practice

The findings from the current study give rise to three important clinical implications. Firstly, research shows that the patients feel their voices are not heard in the lead up to a situation that ends with a restrictive intervention. Participants shared their experiences of attempting to communicate their distress with staff but reflected that

their concerns had been dismissed; participants shared how they had either felt ignored, or dismissed with comments such as 'you'll be fine'. Consequently, participants asserted that some incidents of restrictive practice could have been diffused or avoided. This finding highlights the importance of personalised PBS plans, which identify potential triggers and techniques to keep a patient calm. Indeed, PBS plans are now a recognised good standard for psychiatric inpatients (DoH, 2014). Whilst placing more emphasis on the primary strategies to diffuse a situation, and hearing patients' concerns, could mean fewer incidents of restrictive practice, it is important to bear in mind that this research did not gather staff's perspective on the workability of preventative strategies in these specific given incidents of restrictive practice.

Secondly, the study reveals that patients' felt interactions with staff after an incident of restrictive practice lack depth, and that they have limited opportunity to share the meaning that the restrictive practice for them. Indeed, a recent review of patients' experiences of restraint in inpatient psychiatric services argued that best clinical practice requires staff to understand the meaning that care and practices have for patients and they highlighted that a deeper understanding is integral to improving the quality of inpatient mental health (Cusack et al., 2018). In part, this can be achieved through ensuring patients are offered an opportunity for a meaningful debrief. The findings of the current study revealed that participants feel their voices are not heard by staff in the lead up to a restrictive practice and that they perceive staffs' primary concerns to be assessing risk and medication-related issues in the aftermath. Indeed, Goulet and Larue (2016) have argued that the debrief protocol should offer a reflexive process for all staff and patients involved, allowing all involved to reflect their version of events and maximising the potential for the reciprocity of learning

between staff and patients. When the lead author fed the findings of the current study back the host Trust's 'Positive and Proactive Care Expert Panel', she was informed that this clinical recommendation was in line with some feedback they had received from experts by experience (patients) who had recently presented to them and they reported they would use the evidence from the current study to assert the importance of the debrief process to the hospitals whom they represented.

Finally, the broad-reaching and complex impact of restrictive practice on patients' psychological wellbeing, as well as on their perceptions of staff, highlights the importance of attuned and transparent therapeutic relationships between staff and patients in forensic psychiatric care. However, the current study highlights the power dynamics held between staff and patients in a secure psychiatric hospital, which are particularly prominent throughout the restrictive process. It is important to consider the impact that such a dynamic will play on patients' ability to share an honest account of their version of events during the debrief process. This dilemma calls for a cultural shift in psychiatric services and asserts the importance of using formulation-based conversations to understand patients' experiences of restrictive practice during the debrief process. The recent Power Threat Meaning (PTM) framework (Johnstone et al., 2018) may offer a helpful way to consider these conversations. Research exploring trauma-informed care in psychiatric services highlights that regardless of the perceived intention behind restrictive practices, they are experienced as a coercive and traumatic (Watson, Thorburn, Everett & Fisher, 2014). Further, it is important to consider that the suffering of those who have a trauma history may be exacerbated when power is exercised in a caring environment. In particular, using the PTM framework to make sense of how threat is experienced on the ward in the context of people's histories may support patients to feel

understood and to be open during these debrief discussions, without fear of further consequence.

2.4.3. Limitations

It is important to reflect on four methodological issues and limitations when interpreting the findings of this study. Firstly, the policies of the hospital site, such as not being able to take a dictaphone onto the wards, meant that participants recruited to this study reflect a sub-sample of the population that the study aimed to explore and therefore the findings may reflect a bias towards the narratives of patients who are less acutely unwell with lower risk profiles, that is, are granted more leave around the hospital grounds.

Secondly, the study findings highlighted the power dynamics between staff and patients. As the research recruited patients who were currently residing in a secure hospital, these power relationships were currently present in this cultural system at the time of the interviews and as such, this may have had an impact on participants' narratives and experiences. Indeed, the researcher noticed that many of the participants called her 'miss', a term commonly used by prisoners when addressing female staff; therefore, it is possible that the researcher may have been seen by some participants as a member of staff and this may have played into the dynamic. It may be that the participants and the researcher would have a different interpretation of their experiences if the interviews had been conducted post-discharge, when participants were more detached from the process and could reflect retrospectively. Indeed, the study findings do provide emerging evidence that perceptions of restrictive practice change with hindsight.

Thirdly, the researcher's understanding of previous research in the field was used to support the development of the interview questions. This a-priori nature of the interview schedule could have posed as possible limitation in the context that it was used to guide participants to a particular focus which may have had an influence on the data and themes generated in this study. However, with this in mind, participants were encouraged to offer their own experiences, and the questions were mainly used to prompt further exploration when needed.

Finally, whilst the researcher did make some attempts to validate the study findings using response validation, time and resources meant that the validation interviews were conducted over the phone. Additionally, the researcher was only able to speak with three of the five participants who consented to being part of this element of the research. In the context of an IPA framework, it would have been helpful to have more a more in-depth and thorough approach to the validating process of the study findings.

2.4.4. Future Research Directions

The findings from the current study give rise to three recommendations for future research in this field. Firstly, the researcher noticed that during the interviews, some participants made references to having observed other patients' experiences of restrictive practices and briefly spoke to their cognitive and affective responses to this. Passive observation is the process whereby an individual generates knowledge without actively experiencing something themselves. It would be of interest to conduct a qualitative study with patients who have observed restrictive practices on a secure psychiatric ward, to understand the impact that such interventions have on the broader population, rather than just focussing on those directly involved. A study of

this kind would benefit from a grounded theory approach as little is known in the existing literature about this phenomenon.

Secondly, it would be useful to understand whether the research findings from this study are relevant beyond this homogenous group of adult males in a secure psychiatric hospital. The current study could be replicated to recruit from other populations residing in forensic psychiatric hospitals, for example, females or young people; to the researcher's knowledge, no study has been carried out directly exploring the later.

Finally, in light of the clinical implication to promote a cultural shift and further embed a formulation-based approach to early intervention and debriefing with patients into the post-incident review, it would be interesting to conduct a longitudinal study to ascertain whether this resolved some of the prominent experiences raised by participants in the study. Such a study would provide evidence of the psychological benefits of debriefing for patients who experience a restrictive intervention in a secure psychiatric hospital.

2.5. Summary and Conclusions

The current study offers an in-depth, qualitative exploration of patients' experiences of restrictive practice in secure services and contributes to the limited literature base. The findings, although supportive of other studies, extend beyond what is currently known and further asserts the importance of primary preventative strategies, as well as a formulation-based debrief process after an incident of restrictive practice. This would encourage a cultural shift to address the power imbalance in the therapeutic relationship, a prominent feature of patients' experiences.

2.6. References

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Chapter III: Reflective Paper

Personal Reflections of the Research Process when Exploring Experiences of Restrictive Practice

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3.1. An Introduction to Reflection

This chapter offers a reflective account of my experiences during the research process. As part of clinical psychology training, I have been encouraged to reflect on my clinical work in various forms including supervision, reflective discussions in groups, as well as presenting more formal reflective essays. I have found using these dedicated spaces to reflect really valuable and I often come away having learnt a lot about myself and the situation. Indeed, the literature asserts that professionalism can be enhanced through self-reflection (Knapp, Gottlieb, & Handelsman, 2017) and such professionalism is often recognised as a core competency for clinicians working in health care (e.g., Kaslow et al., 2018). It is argued that "the best psychologists have the ability to self-reflect and modify their behaviour as needed" (Knapp et al., 2017, p. 167).

However, the reflective process extends beyond clinical work and also hold benefits with relation to research. Whilst there is no single definition, it is largely agreed that reflexivity in research is concerned with paying attention to the researchers' influence of, and how they are influenced by, the study topic (Palangas, Sanchez, Molintas, & Caricatavio, 2017). That is, the researcher must continually monitor their personal values and how these may impact upon the interpretation of the research findings and as such, it is considered one of the fundamental pillars of credible qualitative research (Jootun, McGhee, & Marland, 2009). Indeed, it is argued that engaging openly with the reflexive process enhances the validity of the research findings in qualitative methods (Berger, 2015).

Given the integral feature of hermeneutic principles within the framework of interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009), I

have been mindful to pay close attention to reflexivity during the research process. Due to the idiosyncratic nature of the reflective process, there are various reflective models. One such model was put forward by Gibbs (1988), who offered a six-stage guide to aid the reflective process about a given situation. Of note, this model is not presented in a linear context, but as a cycle, consistent with the continuous and evolving nature of the reflective process. This cycle suggests that a person may wish to consider the following as part of their reflections: 1) a description of what happened, 2) their thoughts and feelings in relation to this event, 3) an appraisal of the situation in terms of its positive and negative aspects, 4) making sense of the meaning that this situation for them, 5) what they could have done differently, and 6) what they may do if this happened again. Whilst I will not explicitly refer to this model during this chapter, I have organised my thoughts and narrative around this process whilst reflecting on particular issues that I considered during my research.

This reflective chapter provides a space for sharing candid insights into the research process and its challenges. These reflections aren't a typical feature in academic journal articles, perhaps due to word limitations. Researchers are now being encouraged to provide a more reflexive account, to support their own research and also to offer other researchers the opportunity to consider hidden issues; such accounts are often referred to as confessional tales (Van Maanen, 1988). In line with this, my specific reflections in this chapter include why I chose the topic of restrictive practice, the ethical issues that arose during recruitment, my experiences of the interview process, and the overlap and conflict between being a researcher and being a clinician.

3.2. Why I Chose to Research Restrictive Practice

Whilst I have never been directly involved in an incident of restrictive practice, I have observed multiple physical restraints and incidents of seclusion whilst working in both secure and inpatient mental health services. The first time I witnessed a restraint was when I worked as an assistant psychologist in a secure hospital which cared for forensic patients with psychiatric diagnoses. I remember feeling shocked and anxious at the intensity of the intervention, including the accompanying noise and rush of chaos that surrounded the event. This is an experience I took to my supervision at the time, and has remained with me to the present day. I have often reflected on the impact that this has had on me, despite holding what I perceive to represent two protective factors: 1) I was not directly involved in the incidents, and 2) I do not have a trauma history upon which to hang the event or that may impact upon the meaning that I attribute to it. Indeed, these factors contrast with the frequency with which restrictive interventions are directly experienced by psychiatric patients, a significant proportion of which have experienced childhood abuse (e.g., Raboch et al., 2010; Shack, Averill, Kopecky, Krajewski, & Gummattira, 2004). The long-standing influence that restrictive practices have had on me as a passive observer has always led me to wonder how patients experience such interventions. As I started to look at the literature base, I noticed its limited references and so I decided to use the research requirements of the Doctorate in Clinical Psychology as an opportunity to further understand the meaning that restrictive interventions have for the forensic psychiatric patients who experience them.

Holding in mind my own experiences, I recognised the potential for a biased interpretation as I embarked upon the research. As such, a bracketing approach was

adopted (Tufford & Newman, 2012) and I had frequent conversations with members of my clinical team, as well as keeping reflective notes during the research process. This reflexive approach supported me to hold a more balanced appraisal, whilst still being sensitive to the hermeneutics and subjectivity of the interpretative process.

At the outset of the research process, whilst I understood the function of and requirement for restrictive practices, my empathy was solely attuned with the patients who experience such practices, particularly as research has shown it to be re-traumatising for those with abuse histories (Bonner, Lowe, Rawcliffe, & Wellman, 2002). I had not spent much time considering the impact that it has on the staff who employ them, probably because it wasn't something I heard talked about much by the nurses with whom I've worked. However, during the process of reading the literature included in my meta-ethnographical review, I noticed how I started to consider the distress, not just of the patients, but for all involved in incidents of restrictive practice, including the nurses who so openly spoke to their cognitive and emotional turmoil during the interviews presented in the studies.

My empathy for the staff who have to exercise these restrictive interventions as part of their job was further enforced when I fed the results of the review back to an expert panel in the recruiting Trust. The nurses on the panel nodded in agreement as the meta-themes I presented resonated with them and they shared some of their own experiences, which further brought the meta-themes to life. Indeed, the panel reflected their gratitude for me providing 'evidence' in a way that could action change and they fed-back that "without data, we are just a bunch of people with opinions".

In summary, my emotional journey over the course of this research process has ended with a more balanced view, as I am aware of and compassionate towards the distress and trauma for both staff and patient in relation to restrictive practice.

3.3. Ethical Dilemmas in the Recruitment

The project required ethical consent from Coventry University, as well as a local Research and Ethics Committee and Health Research Authority, and from the Research and Development department in the recruiting NHS Trust. Given the vulnerable nature of the sample from which I wished to recruit, along with the sensitivity of the topic area, I understood the importance of following the ethical procedures and generated the relevant documentation as guided by the British Psychological Society (2010) Code of Ethics to support my application for ethical approval.

During the process of ethical consent being granted, I attended various meetings with my supervision team, as well as larger panel meetings with the 'Research and Innovation' group at the recruiting site. These meetings supported my understanding of the research process within this particular setting and helped me to develop an interview guide in a manner that gave opportunities for meaningful data, whilst also being sensitive to potential impact of the topic and the vulnerable nature of the participants.

After over a year of preparing the research proposal and applying for ethics, I was in a position to send out the project information to staff teams and I was excited to start gathering the data. However, what followed was a very slow response rate and I

found I had to send follow up requests to prompt recruitment. I recall feeling frustrated that my passion and enthusiasm for the project was not being matched. As I tried to make sense of the slow nature of the recruitment, it was fed-back to me that whilst some patients did satisfy the *majority* of the inclusion criteria, they were either too acutely unwell to be able demonstrate their capacity to consent, or their current presentation meant they were too 'risky' for me to see them off the ward. In accordance with the ethical consent and hospital regulations, all interviews had to be conducted off the ward so the prospective participants' clinical teams had to assess whether their risk was low enough that they were permitted leave from the ward, without a chaperone.

In my enthusiasm to use this research to represent the under-represented voices of this population, I had not considered the extent to which the patients' psychological and physical safety, and my own physical safety, would play a role in the selection of an appropriate sample. Whilst I do understand the importance of adhering to the selection criteria, including the patients' capacity to consent, I found myself battling thoughts of how this may bias the selection of participants and that the subsequent research findings may be more reflective of those further along the treatment pathway. As I started to analyse the data and reflect on the emerging theme of '*a powerless voice'*, I noticed how this issue with the recruitment gave further rise to the voices of those who are most acutely unwell being silent in the literature.

Whilst discussions with my supervision team have supported me to hold the positive elements of how upholding ethical constraints, even when frustrating, serves to minimise potential harm to patients, it remains an issue I have not fully resolved. After all, as aforementioned, personal experience has shown me the impact that simply observing a restraint can have and I chose this research topic as I am

passionate about understanding the experiences of those more directly involved, particularly those who are most vulnerable and, in that context, most likely to encounter a restrictive practice.

3.4. Reflecting on the Interview Process

One of the first things I noticed when sitting in a room with the participants who were recruited to the study was how much more vulnerable I felt being in a secure environment as a researcher, rather than in the context of a clinical member of staff. Upon reflection, I wondered whether this was because I did not know anything about the person in front of me, including whether memories or ideas associated with the interview may trigger a heightened emotional response. Further, whilst I did develop a rapport with the participants in the lead up to, and during the interview, I was less confident that my rapport would be strong enough to support me to diffuse any potential escalation of a situation.

My anxiety was more heightened with some of the patients who presented more acutely unwell. For example, some of the participants' appeared to be responding to unseen stimuli whilst in the interview and my lack of knowledge about the people with whom I was sitting made it more difficult for me to assess whether this was typical for them, or whether it reflected a more agitated presentation that meant I needed to proceed with caution.

Additionally, one gentleman presented with considerably slurred speech which made understanding some sections of the interview more challenging. In order to be able to share the participants' stories with focus they deserved, I was keen to get as much

depth to the interviews as possible and so I asked this particular gentleman to repeat himself. I was conscious that this was frustrating for him and it further drew my attention to the fact that I was in a potentially vulnerable situation, at a distance away from the wards and staff should I require any support. Interestingly, in relation to this particular challenge, I found that when listening to the audio-recording back on double speed, his speech sounded considerably clearer, which facilitated my sense making.

In relation to managing my own risk, as per the policy of the hospital, I was provided with a personal safety device that, if triggered, would activate an alarm and alert staff to my location and the fact I required assistance. I did not require this alarm at any point during the research process, although did reflect on the irony of the situation that if I had a pressed my alarm, the likelihood is that the participant I was interviewing would have been subject to a restrictive intervention, the main topic of the research.

When reflecting upon the thoughts I had regarding my physical safety with my supervisory team, and also when writing this reflective chapter, I noticed some parallels with the meta-themes presented in literature review in chapter one. For example, one the ideas that emerged from the findings of the review was the concept of *'the conflicted nurse'*. This captured how nurses felt the use of restrictive practices went against their moral code and professional duty of care, yet they still employed such interventions, as a last resort, in order to ensure their safety and the safety of patients. I too sat with the same dilemma in the back of my mind, knowing that if the situation became unpredictable I would need assistance, but that this support would likely come in a form that went again my moral and professional code.

Further, as the themes started to emerge from the data, I reflected on how counterintuitive it was that the adult males I was interviewing, some of whom were tall and well-built, could ever feel physically powerless. Whilst I had anticipated the emotional impact of restrictive practices, this was not concept I had not really considered prior to interview.

In sum, it is likely that these factors influenced the extent to which I attempted to gain a deep understanding of their experiences, their communication of which, at times, was reflected with fragmented ideas or slurred speech. Despite this, I did develop rapport with participants and felt able to probe, to some extent, to gain a rich understanding of the meaning that their experiences of restrictive practices had for them.

3.5. Researcher versus Clinician: Overlaps and Conflicts

During the interview process, participants shared with me their distress in relation to their experiences of restrictive practices. Whilst I was empathic and compassionate in my responses, I was aware that my role was not to offer therapy but that I was sitting with them in my capacity as a researcher, to hear how they made sense of their experiences. I did however notice a pull to want to do more than just listen, I wanted to try and 'fix' their distress and the wider systemic issues they spoke to during their interview. However, perhaps as a process of identifying countertransference, at times during the research process I noticed my own sense of hopelessness and feelings of powerless in the context of the complex systemic challenges at play.

Further to this, I reflected upon how typically, when working clinically in an acute psychiatric service, I would come away from a therapy session and share specific details that pertained to the individual's emotional wellbeing, even if there were no prominent risk issues. In my experience, this sharing of information affords nursing staff a psychological insight into the patients' current wellbeing and gives rise to additional care and support for patients when required.

In the current study however, despite participants sharing the distress they experienced in relation to the restrictive practice, the confidentiality clauses of the ethical approval for the empirical research meant that, with the exception of risk-related information, I was not permitted to share details of the interview with anyone outside of my supervision team. This meant that I could not share the insight participants had been offered with the ward staff, at least not until it was prepared in an anonymised format. This led to a part of me feeling I had failed the participants, failed to share their voice with the people who care for them.

Additionally, when escorting participants back to the wards after the interview, I noticed that their demeanour changed slightly. Participants had shown me their more vulnerable side during the interview and had shared their experiences of distress that restrictive practice elicited in them. However, when they walked back on to the wards, their posture extended and some became more jovial in character, sharing 'banter' with other patients and staff. Others appeared to retreat into themselves. It was in these moments that I felt the pull to communicate the smaller, more vulnerable voice they had so bravely shared with me. However, in line with my role as a researcher and the stipulations of the ethics and consent procedures, I simply handed over that there were no risk issues to share.

3.6. Conclusions

Whilst writing this thesis, I have experienced a range of emotions and I feel proud of the output, not just as a piece of academic work, but at how it has given a voice to those who typically feel powerless. When I look back, I can see that ultimately, despite the undeniable power imbalance in the therapeutic relationship between staff and patients in a secure psychiatric service, both feel distressed by the use of restrictive practice and it is hoped that the review and empirical paper will give rise to important clinical changes for those working, and residing, in these services.

This chapter has provided me with time in which to reflect, an opportunity I have really valued. Processing some of the reflections I have had over the course of the research process has served to draw this research element of my training to a conclusion. However, writing this essay has shown that my learning and development during the research process has stretched beyond a deeper insight into the complexities of conducting research and has also served as an opportunity for personal growth, all of which I will take forward with me.

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Appendix A

Author Guidelines for Submission: International Journal of Mental Health Nursing

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once you have prepared your submission in accordance with the Guidelines, manuscripts should be submitted online at **http://mc.manuscriptcentral.com/ijmhn**

We look forward to your submission.

2. AIMS AND SCOPE

The *International Journal of Mental Health Nursing* (IJMHN) is the official English journal of the Australian College of Mental Health Nurses Inc. The Editors welcome original articles dealing with current trends and developments in mental health nursing. The Editors are also looking for papers that will be widely read and cited, thereby having an international impact on mental health nursing education, practice and research. Papers submitted should be relevant to the Aims and Scope of the IJMHN and written in a manner that makes the relevance of content clear for IJMHN's international readership.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Review Articles: Qualitative and quantitative literature reviews on any area of research relevant to clinical nursing are welcomed. Submissions should not exceed 8,000 words. Quotes are included in the overall word count of the main text. Authors are advised to explain their methodology clearly (e.g., overall approach, literature search strategies, data analysis). The **PRISMA** checklist and flow diagram should be used to guide manuscript development. Systematic review methods are evolving and authors are urged to cite supporting references. The main text should be structured as follows: Introduction; Aims; Methods; Results; Discussion; Conclusion; Relevance for clinical practice. We also ask that authors limit their references to 50 in total and all references must be available in English.

4. PREPARATION OF THE MANUSCRIPT

Format

The main text file should be prepared using Microsoft Word, doubled-spaced. The top, bottom and side margins should be 30 mm.

Style

The journal uses UK spelling and authors should therefore follow the latest edition of the *Concise Oxford Dictionary*.

Abbreviations should be used sparingly and only where they ease the reader's task by reducing repetition of long, technical terms. Initially use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

Title page

The title page should contain:
(i) manuscript category;
(ii) a short informative title that contains the major key words. The title should not contain abbreviations;
(iii) the full names of the authors;
(iv) the author's institutional affiliations at which the work was carried out;
(v) an authorship statement: in keeping with the latest guidelines of the International Committee of Medical Journal Editors, each author's contribution to the paper is to be quantified;
(vi) the full postal and email address, plus telephone number, of the author to whom correspondence about the manuscript should be sent;
(vii) acknowledgements;
(viii) disclosure statement;
(ix) word count, including abstract and acknowledgements, but not table or figure legends and references.

The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Authorship statement

This must acknowledge i) that all authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and ii) that all authors are in agreement with the manuscript.

Acknowledgements

The source of financial grants and other funding should be acknowledged, including a frank declaration of the author's industrial links and affiliations. The contribution of colleagues or institutions should also be acknowledged. Thanks to anonymous reviewers are not allowed

Disclosure
Authors must declare any financial support or relationships that may pose conflict of interest. This includes any financial arrangements authors have with a company whose product figures prominently in the submitted manuscript or with a company making a competing product. For more detail on disclosure refer to Section 5 'Editorial Policies and Ethical Considerations'.

Main text

As papers are double-blind peer reviewed the main text file should not include any information that might identify the authors.

The main text of the manuscript should be presented in the following order: (i) abstract and key words, (ii) text, (iii) references, (iv) tables (each table complete with title and footnotes), (v) appendices, (vii) figure legends. Figures and supporting information should be submitted as separate files.

Abstract and key words
Articles must have an unstructured abstract that states in 250 words or less the purpose, basic procedures, main findings and principal conclusions of the study. The abstract should not contain abbreviations or references. Five key words, for the purposes of indexing, should be supplied below the abstract, in alphabetical order, and should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list (**http://www.nlm.nih.gov/mesh/meshhome.html**).

Text
Authors should use subheadings to divide the sections of their manuscript as outlined for each article type.

References
• The Harvard (author, date) system of referencing is used (examples are given below).
• In the reference list, references should be listed in alphabetical order.
• In the reference list, cite the names of all authors when there are six or fewer; when seven or more, list the first three followed by et al.
• All citations mentioned in the text, tables or figures must be listed in the reference list.
• Authors are responsible for the accuracy of the references.

References should be listed in the following form.

Journals
Meehan, T. (1994). Questionnaire construction and design for surveys in mental

health. *Australian and New Zealand Journal of Mental Health Nursing*, 3, 59–62.

Books
Taylor, J. & Muller, D. (1994). *Nursing adolescents: Research and psychological perspectives*. Oxford: Blackwell Science.

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Bergen, A. & Labute, L. (1993). Promoting mental health. In: A. Dines & A. Cribb (Eds), *Health promotion: Concepts and practice* (pp. 93–109). Oxford: Blackwell Science.

Electronic material
World Health Organisation (3 July 2003). Update 94: Preparing for the Next Influenza Season in a World Altered by SARS.
http://www.international/csr/disease/influenza/sars. Accessed: 15 September 2003.

Tables
Tables should be self-contained and complement, but not duplicate, information contained in the text. Tables should be numbered consecutively in Arabic numerals. Each table should be presented on a separate sheet of A4 paper with a comprehensive but concise legend above the table. Tables should be double-spaced and vertical lines should not be used to separate columns. Column headings should be brief, with units of measurement in parentheses; all abbreviations should be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. The table and its legend/ footnotes should be understandable without reference to the text.

Figure legends
Legends should be self-explanatory and typed on a separate sheet. The legend should incorporate definitions of any symbols used and all abbreviations and units of measurement should be explained so that the figure and its legend is understandable without reference to the text.

Figures

All illustrations (line drawings and photographs) are classified as figures. Figures should be cited in consecutive order in the text using Arabic numerals.

Appendix B

Coventry University: Certificate of Ethical Approval for Literature Review

Certificate of Ethical Approval

Applicant:

Robyn Cooley

Project Title:

Nurses Experiences of Restrictive Interventions in Psychiatric Inpatient Care: A Meta-Synthesis

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

31 July 2018

Project Reference Number:

P73063

Appendix C

Quality Assessment Framework

Definitions and Instructions for Quality Assessment Scoring

How to calculate the summary score

- **Total sum** = (number of "yes" * 2) + (number of "partials" * 1)
- **Total possible sum** = 20
- **Summary score:** total sum / total possible sum

Quality assessment

1. *Question / objective clearly described?*

   Yes: Research question or objective is clear by the end of the research process (if not at the outset).

   Partial: Research question or objective is vaguely/incompletely reported.

   No: Question or objective is not reported, or is incomprehensible.

2. *Design evident and appropriate to answer study question?*

   (If the study question is not clearly identified, infer appropriateness from results/conclusions.)

   Yes: Design is easily identified and is appropriate to address the study question.

   Partial: Design is not clearly identified, but gross inappropriateness is not evident; *or* design is easily identified but a different method would have been more appropriate.

   No: Design used is not appropriate to the study question (e.g. a causal hypothesis is tested using qualitative methods); *or* design cannot be identified.

3. *Context for the study is clear?*

   Yes: The context/setting is adequately described, permitting the reader to relate the findings to other settings.

   Partial: The context/setting is partially described.

   No: The context/setting is not described.

4. *Connection to a theoretical framework / wider body of knowledge?*

Yes: The theoretical framework/wider body of knowledge informing the study and the methods used is sufficiently described and justified.

Partial: The theoretical framework/wider body of knowledge is not well described or justified; link to the study methods is not clear.

No: Theoretical framework/wider body of knowledge is not discussed.

5. *Sampling strategy described, relevant and justified?*

Yes: The sampling strategy is clearly described and justified. The sample includes the full range of relevant, possible cases/settings (i.e., more than simple convenience sampling), permitting conceptual (rather than statistical) generalizations.

Partial: The sampling strategy is not completely described, or is not fully justified. Or the sample does not include the full range of relevant, possible cases/settings (i.e., includes a convenience sample only).

No: Sampling strategy is not described.

6. *Data collection methods clearly described and systematic?*

Yes: The data collection procedures are systematic, and clearly described, permitting an "audit trail" such that the procedures could be replicated.

Partial: Data collection procedures are not clearly described; difficult to determine if systematic or replicable.

No: Data collection procedures are not described.

7. *Data analysis clearly described, complete and systematic?*

Yes: Systematic analytic methods are clearly described, permitting an "audit trail" such that the procedures could be replicated. The iteration between the data and the explanations for the data (i.e., the theory) is clear – it is apparent how early, simple classifications evolved into more sophisticated coding structures which then evolved into clearly defined concepts/explanations for the data). Sufficient data is provided to allow the reader to judge whether the interpretation offered is adequately supported by the data.

Partial: Analytic methods are not fully described. *Or* the iterative link between data and theory is not clear.

No: The analytic methods are not described. *Or* it is not apparent that a link to theory informs the analysis.

8. *Use of verification procedure(s) to establish credibility of the study?*

Yes: One or more verification procedures were used to help establish credibility/ trustworthiness of the study (e.g., prolonged engagement in the field, triangulation, peer review or debriefing, negative case analysis, member checks, external audits/inter-rater reliability, "batch" analysis).

No: Verification procedure(s) not evident.

9. *Conclusions supported by the results?*

Yes: Sufficient original evidence supports the conclusions. A link to theory informs any claims of generalizability.

Partial: The conclusions are only partly supported by the data. *Or* claims of generalizability are not supported.

No: The conclusions are not supported by the data. *Or* conclusions are absent.

10. *Reflexivity of the account?*

Yes: The researcher explicitly assessed the likely impact of their own personal characteristics (such as age, sex and professional status) and the methods used on the data obtained.

Partial: Possible sources of influence on the data obtained were mentioned, but the likely impact of the influence or influences was not discussed.

No: There is no evidence of reflexivity in the study report.

Table 2. Checklist for assessing the quality of qualitative studies

Criteria		YES (2)	PARTIAL (1)	NO (0)
1	Question / objective sufficiently described?			
2	Study design evident and appropriate?			
3	Context for the study clear?			
4	Connection to a theoretical framework / wider body of knowledge?			
5	Sampling strategy described, relevant and justified?			
6	Data collection methods clearly described and systematic?			
7	Data analysis clearly described and systematic?			
8	Use of verification procedure(s) to establish credibility?			
9	Conclusions supported by the results?			
10	Reflexivity of the account?			

Appendix D

Author Guidelines for Submission: British Journal of Psychology

1. SUBMISSION
Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.
Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/bjp

2. AIMS AND SCOPE
The *British Journal of Psychology* publishes original research on all aspects of general psychology including cognition; health and clinical psychology; developmental, social and occupational psychology. For information on specific requirements, please view **Author Guidelines**.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- All papers should be no more than 8000 words (excluding the abstract, reference list, tables and figures). In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

4. PREPARING THE SUBMISSION
Contributions must be typed in double spacing. All sheets must be numbered.

Cover Letters
Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript
The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page
You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;

- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Acknowledgments.

Authorship
Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract
Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

Keywords
Please provide appropriate keywords.

Acknowledgments
Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Main Text File
As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.
The main text file should be presented in the following order:
- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.
- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.

- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, *159*, 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

General Style Points

For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Appendix E

Coventry University: Certificate of Ethical Approval for Empirical Study

Certificate of Ethical Approval

Applicant:

Robyn Cooley

Project Title:

Patients' Experiences of Restrictive Practice in a Medium Secure NHS Service

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as High Risk

Date of approval:

17 May 2017

Project Reference Number:

P50737

Appendix F

NHS Research Ethics Committee: Approval Letter from Health Research Authority

NHS
Health Research Authority

Mrs Robyn Cooley
Clinical Psychology Doctorate
School of Psychological, Social and Behavioural Sciences
Coventry University
James Starley Building
Priory Street
Coventry CV1 5FB

Email: hra.approval@nhs.net

07 August 2017

Dear Mrs Cooley,

Letter of HRA Approval

Study title:	**Patients' Experiences of Restrictive Practice in a Medium Secure NHS Service**
IRAS project ID:	**224018**
REC reference:	**17/WM/0237**
Sponsor	**Coventry University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Page 1 of 7

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **224018**. Please quote this on all correspondence.

Yours sincerely,

Emma Stoica
Senior Assessor

Email: hra.approval@nhs.net

Copy to:

Prof Ian Marshall [sponsor contact]
Ms Katie Williams [lead NHS R&D contact]

IRAS project ID	224018

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Liability Insurance]		23 May 2017
GP/consultant information sheets or letters [Information Sheet for Clinical Teams]	1	31 May 2017
HRA Schedule of Events	2	07 August 2017
HRA Statement of Activities	2	07 August 2017
Interview schedules or topic guides for participants [Interview Guide]	1	31 May 2017
IRAS Application Form [IRAS_Form_31052017]		31 May 2017
Letter from sponsor [Sponsor Confirmation (No Finance Needed)]		23 May 2017
Letters of invitation to participant [Letter of Invitation (Prior to PIS)]	1	31 May 2017
Other [Sponsor Indemnity Insurance]		23 May 2017
Other [Debrief Form]	1	31 May 2017
Participant consent form [Consent Form]	3	21 July 2017
Participant information sheet (PIS) [Participant Information Sheet]	2	06 July 2017
Research protocol or project proposal [Research Protocol]	1	31 May 2017
Summary CV for Chief Investigator (CI) [CV for CI]		31 May 2017
Summary CV for supervisor (student research) [CV Academic Supervisor]		23 May 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Flowchart of Participant Recruitment]	1	31 May 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Dr Anthony Colombo
E-mail a.colombo@coventry.ac.uk; Telephone 02476887806

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A Statement of Activities and a Schedule of Events have been provided to aid the set-up of the study at the participating NHS site. The Statement is intended to form the agreement of the NHS site to participate.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study.
4.3	Financial arrangements	Yes	No application for external funding has

Section	HRA Assessment Criteria	Compliant with Standards	Comments
	assessed		been made. The sponsor is not providing any funding to the participating NHS organisation.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is only one NHS organisation participating in the study, where all research activities will be undertaken, as described in the Statement of Activities and Schedule of Events.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at

hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator should be in place at the participating NHS organisation to facilitate identification of potential participants and arrange access of researcher on site to conduct the research activities. Part C of the IRAS form lists the CI/student researcher as the investigator at the participating NHS site; however a local collaborator has been identified, which is also one of the researcher's clinical supervisors.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

The student researcher undertaking research activities at the host NHS trust would be expected to obtain a Letter of Access on the basis of an NHS to NHS confirmation of pre-engagement checks pro forma as she is NHS employed. Standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix G

Participant Information Sheet

IRAS: 224018 – 06/07/2017 - version 2

Participant Information Sheet

Research Title: Experiences of Restrictive Practices in a Medium-Secure NHS Service

Principal Researcher: Robyn Cooley

Research Team: Robyn Cooley and Dr. Anthony Colombo (Academic Supervisor and Senior Lecturer in Clinical Psychology at Coventry University)

Dr. Louise Pearson & Dr. Francesca Mantia-Conaty, Clinical Psychologists at [redacted], will support the researcher to meet with potential participants.

Email: [redacted] - Tel: [redacted]
Email: [redacted] - Tel: [redacted]

An invitation

I am carrying out a research project looking at experiences of restrictive practices in a medium-secure unit. Restrictive practices include being held or restrained by members of staff or being kept in a room on your own. Another type of restrictive practice is being given an injection containing medication without your consent. Sometimes these are known as physical restraint, seclusion and rapid tranquilisation. If you are interested in taking part in this research, please read the information below.

Why have you been invited to take part?

You have been invited to take part because you have experienced a restrictive practice within the last two years and the researcher wants to gain a better understanding of what this is like for you.

Do you have to take part?

No, you do not have to take part in this study. Your participation is completely voluntary. It is your choice whether or not to take part in this study. If you decide that you don't want to take part, you do not have to give a reason and it will not affect the care that you receive.

What will you have to do if you want to part?

If you decide to take part in the study, then you will be asked to sign a consent form. Members of your clinical team will be informed that you are going to participate in the research, but they will not be told any details about what you talk about in the interview.

If you would like to participate in the study, then you will be asked to take part in an interview with the researcher, who will ask you a series of questions about

any thoughts and feelings you have about your experiences of restrictive practice. If you would like to see a copy of the interview questions before the interview then this can be arranged.

It is expected that the interview will take no longer than 90 minutes and will take place in the interview room on the ward. The door will be closed to ensure that you can speak privately with the researcher.

Following the interview, you will be offered information about who to speak to if you feel you need to talk to someone about any issues your participation has raised. You will have 7 days to withdraw your interview from the study. To do this, please inform Dr Louise Pearson or Dr Francesca Mantia-Conaty (based in the psychology department), or ask a member of staff to do this for you. You do not need to give a reason for your withdrawal. The researcher will be informed so that your interview can be destroyed and it will not be included in the study. After 7 days, you will not be able to withdraw because the researcher will start to type up (transcribe) the interview and make sure that all comments are made anonymous.

Once the researcher has analysed the interviews, you will be offered the opportunity to take part in a follow up interview, to discuss the general issues raised in the findings. You will be given the opportunity to consider whether these themes represent your experiences. This follow up interview is not compulsory. You can choose not to participate and your original interview will still be used in the study.

What are the risks or possible disadvantages of taking part?

During the interview, you will be asked about a time when you have been involved in a restrictive practice whilst at this hospital. This is often a sensitive topic and it is possible that you may feel distressed after talking about this incident. If this occurs, the researcher will offer to pause or end the interview and will encourage you to speak to your psychologist or named nurse who will support you to manage your emotions.

What are the benefits of taking part?

While there are no direct benefits to taking part in this research project, some people find it helpful to talk about things and the interview will give you an opportunity to share your experiences of restrictive practice. Your experiences will be anonymised and will contribute towards the generation of themes developed to capture your experiences.

Confidentiality

With your consent, the interviews will be audio-recorded. These recordings will be kept in a locked safe until they have been typed up and stored on a computer. Then, the audio-recording will be destroyed.

The typed up interview will be anonymised. That means all information that identifies you as a person, such as your name, will be removed or changed. The written transcript will be kept in a password-protected computer. Please note that only the researcher and her academic supervisor will see the transcript, members of staff at the hospital will not be able to see your interview.

The consent form you will need to sign before taking part will be stored in a locked cabinet on Trust premises and will be kept for five years after the study is complete, in line with university policy. This identifying information will be kept separately from your anonymised transcript, to maintain anonymity.

Whilst members of staff at the hospital, including nursing staff and members of your clinical team will be aware if you choose to participate in the study, they will not be informed about any details from the interview. However, in line with a duty of care, the researcher is obliged to inform Dr Louise Pearson, Clinical Psychologist, if they are concerned about your wellbeing or the wellbeing of someone else as a result of anything you disclose. For example, if during the interview you said you were planning to harm yourself, then this would not be kept confidential and would be handed over.

What will happen to the results of the study?

This study forms part of the thesis that the researcher will submit as part of her Doctorate in Clinical Psychology; the final report will be written up as part of a research thesis, it may also be published and accessed by healthcare professionals. However, please be reassured that no identifiable information will be used and any quotes offered to illustrate the findings will be done so anonymously.

What if you want to complain?

If you have any concerns about this research project, please speak to the researcher who will do their best to answer any questions you have. You can also speak to Dr Louise Pearson or Dr Francesca Mantia-Conaty, based in the psychology department, who are supervising the study. Alternatively, you can speak to any member of staff and share your concerns. They can also put you in touch with Patient Advocacy and Liaison Service (PALS) who can support you to make a complaint.

The PALS service is open Monday to Friday, 8am to 8pm. It has an answer message service outside of these hours and messages will be responded to as quickly as possible. Telephone: [redacted]
Alternatively, you can write to them at the following address:

Customer Relations, PALS service
[redacted]

Who has reviewed the study?

The research project has been granted ethical approval from Coventry University and by the local Research Ethics Committee within the NHS. It has also been registered with the local research and development team within the Trust.

For more information…

Thank you for taking the time to read this information leaflet. If you would like any more information about this study, please ask the researcher. You are welcome to keep this information sheet to refer back to. You can also speak to Dr. Louise Pearson or Dr. Francesca Mantia-Conaty.

Appendix H

Consent Form

24018 – 21/07/2017 - version 3

Consent Form

Research Title: Experiences of Restrictive Practices in a Medium-Secure NHS Service

Principal Researcher: Robyn Cooley

Instructions: Please read each of the statements below and if you agree, please put your initials in each box on the right-hand side of the page.

have read and understood the participant information sheet ☐

have had the opportunity to ask any questions about my participation in this udy and I am satisfied with the answers ☐

understand that my participation is voluntary ☐

understand that the interview will be audio-recorded ☐

understand that the interview transcript will only be seen by members of the esearch team ☐

understand that the researcher can inform a member of staff about anything I ay that makes the researcher concerned for my well-being or the well-being of omeone else ☐

understand that if I wish to withdraw from the study I can do so at any time uring the interview or up to 7 days following the interview ☐

agree that the researcher may obtain basic information about me from myself and/or aff. The only information they can obtain relates to: age; ethnicity; length of stay; umber of restraints; current section; and current diagnoses. The researcher will not ave access to my health care records. ☐

understand that my name will not be used alongside any quotes from my terview that are presented in the results ☐

understand that relevant sections of my medical notes and data collected during e study, may be looked at by individuals from regulatory authorities or from the HS Trust, where it is relevant to my taking part in this research. I give ermission for these individuals to have access to my records. ☐

agree to take part in the study. ☐

Please answer yes or no:

11. Once the results have been collected, would you like to take part in a follow-up interview to help discuss the themes that have been found? ☐

Participant's name (printed): ……

Participant's signature: ……

Date: ……

Name and signature of person obtaining consent: ……

Appendix I

Debrief Form

IRAS: 224018 - 31/05/2017 - version 1

Debrief Form

More Information

Thank you for taking part in this research study, which has been designed to understand patients' experiences of restrictive practices in a secure hospital. The questions you answered have provided lots of information about your thoughts and feelings about this and may have offered staff an insight into ways to make the experience feel safer in the future.

You now have one week to inform the researcher if you would like to withdraw your interview from the study. To do this, please inform Dr Louise Pearson or Dr Francesca Mantia-Conaty (based in the psychology department), or ask a member of staff to do this for you. You do not need to give a reason for your withdrawal. The researcher will be informed so your interview can be destroyed and it will not be included in the study. After 7 days, you will not be able to withdraw because the researcher will start to type up (transcribe) the interview and make sure that all comments are made anonymous.

Once all of the interviews have been typed up, the researcher will start to explore them in more detail. As part of this, themes will be developed to capture the range of experiences offered.

The findings will be presented to staff and a written report summarising the findings will be produced and may be submitted for publication. Please be reassured that no personal or identifiable information will be offered and any quotes used to illustrate the themes will be anonymised.

If you still have questions or need to talk to someone...

If you still have questions following the interview, or if it has raised any difficult emotions for you, there are a number of people you can talk to. You can talk to any member of staff who you feel comfortable with, including your named nurse or psychologist. They will do their best to answer any questions you have about the study or to support you with your feelings. If you are unhappy with any aspect of this research study, you can speak to any member of staff or an independent advocate who will support you to make a complaint to the Trust.

Thank you again for taking the time to complete the interview. Your contributions offer an invaluable insight into patients' experiences of restrictive practice and will help clinicians to better understand the impact of such experiences.

Appendix J

Interview Guide

IRAS: 224018 - 31/05/2017 - version 1

Interview Guide

Thank the participant for agreeing to take part and ask them how they feel about taking part / any outstanding questions

1. So just to recap, the purpose of this research is explore your experiences of 'restrictive practices'. Had you heard of the term 'restrictive practices' before enrolling on this study? What does this phrase mean to you?

2. Do you feel able to share your experiences of being involved in a restrictive practice? So it could be a seclusion, rapid tranquillisation or a physical restraint.

3. What were your thoughts and feelings during this event?

- Prompts: either draw on aforementioned restrictive practice from Q2, or prompt for recent/poignant experience if one has not come to mind

4. What are your thoughts and feeling about it now?

- Prompts: If their response suggests a changed feeling, enquire what led to this change e.g., processing with staff, time to reflect on it, debriefing etc.

5. Do you think staff could have done anything to avoid it or to de-escalate the situation or do you think it was fair?

- Prompts: Was it justified? Perceptions of staff involved?

6. In the past, have restrictive interventions been a positive or negative experience?

- Prompts: Beneficial, harmful, worst element, anything handled well?

7. If you become distressed in the future, how would you like staff to facilitate you feeling safe?

- Prompts: Preferred intervention, what makes this preferential? Have you made an advance statement? Has this been adhered to in subsequent interventions? Require talking therapy to process the experience?

8. Is there anything else you want to tell me before we finish the interview?

Appendix K

Information for Clinical Teams

IRAS: 224018 - 31/05/2017 - version 1

Research Title: Experiences of Restrictive Practices in a Medium-Secure NHS Service

Principal Researcher: Robyn Cooley

Research Team: Robyn Cooley and Dr. Anthony Colombo (Academic Supervisor and Senior Lecturer in Clinical Psychology at Coventry University)

Dr. Louise Pearson & Dr. Francesca Mantia-Conaty, Clinical Psychologists [redacted] support recruitment.

Information Sheet for Clinical Team

As part of my Doctorate in Clinical Psychology, run jointly by the Universities of Coventry and Warwickshire, I am conducting a piece of qualitative research to explore patients' experiences of restrictive practices in a medium-secure NHS setting. This is being supporting by [redacted], with Dr Louise Pearson supervising the clinical element of the project.

As I do not have access to patient records, I would be most grateful if you could help me with the initial screening for potential participants, using the brief inclusion and exclusion criteria set out in the table overleaf.

For patients who meet all criteria for inclusion, please introduce the study to them during a routine clinical review and ask if they are interested to find out more information, reassuring them that this is entirely optional and that their decision whether or not to take part will not affect their care.

For those who express an interest, please give them an 'Invitation Letter' and then pass their name onto Louise, so that I can arrange an initial meeting. During this meeting, the patient will learn more about the study and what their potential involvement would entail. This initial meeting poses NO obligation to participate in the study.

Please note that whilst you may know who has / has not participated, the data gathered at interview will remain confidential within the research team. However, emerging themes, alongside illustrative, anonymised quotes will be shared during dissemination at an academic meeting once the study is complete.

Thank you for your support!

Inclusion Criteria	Exclusion Criteria
Men	Women
All ethnicities	No ethnicities excluded
Adults, to include older adults and those of working age	Exclude those under the age of 18
Currently residing in a medium-secure unit, that is with forensic history and diagnosis of a mental health difficulty	Co-morbid diagnosis of an learning disability
People who can communicate fluently in English	Non-English speakers who require the presence of a translator
Experienced at least one form of restrictive practice (to include physical and chemical restraint, seclusion) within the last two years	Experienced no form of restrictive practice in the last two years
Individuals who can meet with the interviewer without a chaperone	Individuals currently under special observations who would require a chaperone during the interview (e.g., due to risk)

Appendix L

Invitation to Participate

IRAS: 224018 - 31/05/2017 - version 1

Invitation Letter

Hello,

As part of my Doctorate in Clinical Psychology, I am doing some research into patients' experiences of being secluded, tranquilised or physically restrained in a medium secure NHS setting.

You have been given this invitation letter because when your clinical team told you about this project, you said that you were interested in getting more information.

If you agree, I will arrange to come and meet with you soon to discuss the study in more detail. You will then have all the information you need to decide if you want to take part. Your decision to take part in this study is entirely voluntary and will not affect your care here at the hospital.

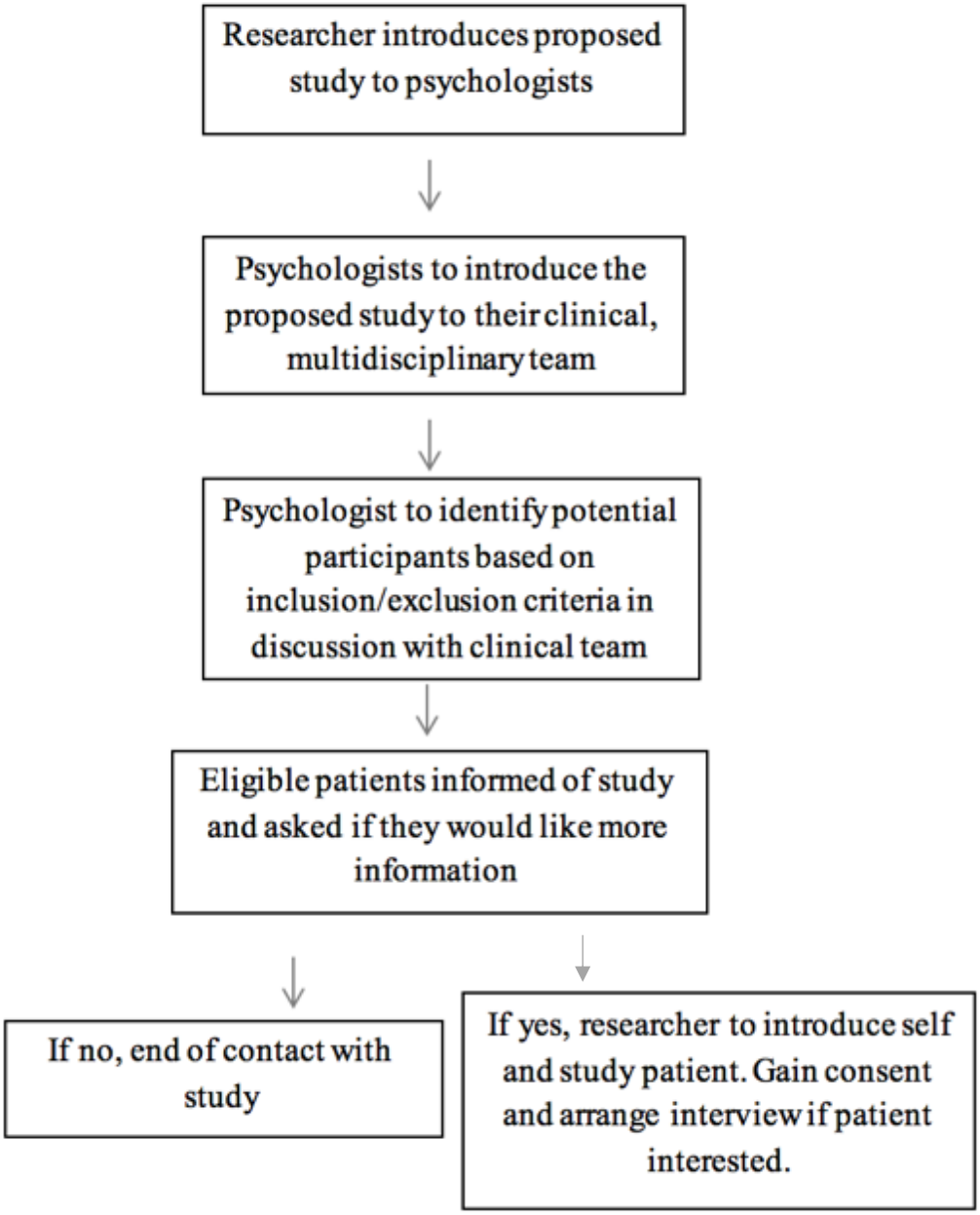
If you have any queries before we meet, please ask any member of your clinical team.

I look forward to speaking with you soon,

Robyn Cooley

Appendix M

Figure Outlining Recruitment Process



Appendix N

Extract of Coded Transcript

I: **How was it having someone holding you, holding each hand and someone behind you. What did that feel like?**

C: It didn't feel like anything really, it was, it was erm something that I didn't really any strong emotion, I felt it was justified to resist to a certain degree and anger was the only real emotion I can remember feeling at that point.

I: **So you felt that their reaction was unjustified so therefore… [interrupted]**

C: I wasn't angry at being restrained, I was angry at the decision at being put in isolation. Because some member had staff had spoken to me in such a poor manner that I felt obliged to dash orange juice in her face. Now I'm not suggesting that it's good behaviour and obviously if I could, [pause] obviously I did overact, I could have handled the matter with words or ignored the member of staff, but I didn't. At that particular moment I was irritated, I'd not long got up and that member of staff had pressed a button so to speak and I was irritated so I decided to do that. And then when they came to restrain me and take me off to the isolation room I felt it was an injustice and that the true issue had been missed. The true issue that the member

Appendix O

Extract of Transcript Coded by Second Researcher

IPA – Coding

	1	I:	**How was it having someone holding you, holding each**
	2		**hand and someone behind you. What did that feel**
	3		**like?**
	4	C:	It didn't feel like anything really, it was, it was erm
Anger as dominant emotion	5		something that I didn't really any strong emotion, I felt
	6		it was justified to resist to a certain degree and anger
Justified to resist	7		was the only real emotion I can remember feeling at
	8		that point.
	9	I:	**So you felt that their reaction was unjustified so**
	10		**therefore... [interrupted]**
Not angry at restraint	11	C:	I wasn't angry at being restrained, I was angry at the
	12		decision at being put in isolation. Because some
Poor treatment by staff caused anger	13		member had staff had spoken to me in such a poor
	14		manner that I felt obliged to dash orange juice in her
	15		face. Now I'm not suggesting that it's good behaviour
	16		and obviously if I could, [pause] obviously I did overact,
	17		I could have handled the matter with words or ignored
	18		the member of staff, but I didn't. At that particular
	19		moment I was irritated, I'd not long got up and that
	20		member of staff had pressed a button so to speak and I
Unfair how treated/spoken to by staff	21		was irritated so I decided to do that. And then when
	22		they came to restrain me and take me off to the
Patient felt unheard, not listened to.	23		isolation room I felt it was an injustice and that the true
	24		issue had been missed. The true issue that the member

Function of/Reason for behaviour missed.

is this dissociative? traumatic memory?

couldn't identify any strong emotion

felt angry at time ok/awared to resist a little

within rights to resist

other emotions felt that he couldn't identify or articulate?

anger - only emotion that matter

not angry at restraint, angry at isolation

anger at not being listened

didn't feel he was treated well by staff

insight into how behaviour lead to consequence

hindsight = other ways to respond

why were these behaviours not used?

fight/flight/freeze, limited to previous responses?

felt that staff deliberately upset him

it was injust, unfair

felt the true issue had been missed.

Not listened to or asked for explanation

staff pressure behaviour doesn't have reason.

assumption that patients are

Appendix P

Letter to Participants Outlining Initial Themes

Hello,

A few months ago, you and I met to discuss your experiences of restraint and seclusion. This was part of a research project I am doing at Coventry University.

I have now started to look back over what you and other patients at [redacted] talked about. What I have noticed is that whilst each of you had a personal story to tell about your own experiences, some of you expressed similar ideas. I have grouped some of these ideas together into 'themes', which are summarised below.

Theme 1: Powerlessness

This theme was about how patients felt upset that they had no power or control over being restrained and secluded. One issue that was discussed was about the lack of physical power and control patients felt they had over their own body when physical force was being used. Another issue was about patients feeling that they weren't being listened to by staff. Here patients talked about feeling angry and frustrated that staff just didn't seem to listen to what patients had to say.

Theme 2: A Sense of Injustice

This theme centres on how patients restraint and seclusion was unfair. One issue focussed on the emotional distress that patients reported, including feeling angry, bullied, ignored and lonely. Another issue was that patients felt the staff don't try to understand how you were feeling in the lead up to the restraint or seclusion.

Theme 3: A Sense of Resignation

This themes looks at the way patients come to an uneasy acceptance that restrictive interventions is part of their hospital experience. The first issue was how patients learn to use silence, or to agree with a staff as a way to end the restraint or seclusion. The second issue looked at how patients hold in mind that sometimes these interventions are used to maintain safety, but nevertheless they are undesirable. Finally, patients reported that alongside their distress, they felt a sense of calm or relief, that seclusion and restraint had taken them out of a stressful situation.

Your thoughts about whether these results fit with your experience are most welcome. I will contact you by telephone so that we can discuss your ideas. If you no longer wish to take part in this part of the research process that's okay, please tell a member of the psychology department or tell me when I call you.

Finally, I just wanted to say thank you again, for your time and honesty in sharing your experiences with me. I will be presenting this information to the Trust and also intend to publish the research in a journal. As discussed, please be assured that whilst these themes and supporting quotes will be shared, your individualised contributions will remain anonymous.

With best wishes, Robyn