The psychological impact of restraint in acute mental health settings: the experiences of staff and inpatients

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ABSTRACT

Restraint has been used as a method of managing untoward incidents in mental health practice since mental health care began. Although methods of managing untoward incidents have evolved over time, restraint remains to this day the principal model for managing violent and aggressive behaviour in acute mental health settings. Despite restraint being a dominant force in acute mental health care, the psychological impact of this intervention upon staff and patients is relatively unknown with very little research devoted to this area.

Guidelines suggest that some form of Post Incident Review should take place following untoward incidents but this is patchy in many areas, and the efficacy of approaches to Post Incident Review has not been clearly documented in related literature.

Furthermore, some staff and patients have reported that the experience of restraint triggers memories of previous traumatic encounters which have caused further distress to them during, and in the aftermath of, restraint.

This study explores the psychological impact of restraint for staff and patients who are involved in these procedures. In addition, a framework for Post Incident Review is evaluated to establish whether this is a helpful tool to address some of the limitations of current approaches to Post Incident Review. The phenomena of restraint reawakening memories of previous traumatic encounters is also considered within the study to establish whether this has a bearing upon the experience of restraint for those involved in the procedure.

The results highlight that the experience of restraint is distressing for staff and patients. The psychological impact ranges from minimal effects, to distress, through to full blown Post Traumatic Stress Disorder (PTSD). The framework for reviewing incidents evaluated within this study was well received by staff and patients and is offered as a way forward in providing a more structured approach to considering untoward incidents with staff and patients. This study has found that the experience of restraint does reawaken memories of previous traumatic encounters for both staff and patients.

The study concludes with recommendations for education, further research and clinical practice.

CHAPTER ONE – INTRODUCTION

"...I felt like an intruder who had moved into a restricted area – that my attempt to widen the frontier of understanding had instead degenerated into an acrimonious skirmish with the border guards..." (Tennant, 1997)

1.1.Introduction

The management of violence and aggression is currently a high priority in mental health care agenda, with an urgent need for comprehensive, consistent and therapeutic management of untoward incidents (NICE 2005a; NMC 2002). The recent Independent Inquiry into the death of David Bennett (Sallah et al 2003) starkly highlighted the dire inconsistencies in service provision and lack of guidance within the UK NHS towards the mentally ill at their most vulnerable.

While there have been some studies and tools developed in the measurement and prediction of violence within the acute mental health setting, there is a paucity of research on both staff and mental health service users' experiences and perceptions of untoward incidents.

For the purpose of this study untoward incidents will be defined as incidents in which some form of physical restraint has been employed towards patients in acute mental health care. Although the term service user is preferable in current mental health practice, this study relates to inpatient services and after consultation with staff and patients involved in this study, the term patient will be used throughout when referring to inpatient participants involved in the study.

Some studies have examined antecedents and management strategies in relation to untoward incidents but these studies have relied upon staff accounts as opposed to patient experiences (Shepherd and Lavender 1999). Whittington and Wykes (1996) examined both staff and patients and found that interpersonal factors and diagnosis played a significant role in preceding violent incidents. There is evidence to suggest that a number of environmental factors could prevent some untoward incidents or, at least, reduce harm (Gournay and Bowers 2000).

Bonner et al's (2002) pilot study (Appendix one) examined both staff and patients' experiences of untoward incidents using a semi-structured questionnaire to elicit what each group found both helpful and unhelpful in the management of these incidents. The results highlighted that untoward incidents generated strong and disturbing emotional reactions for patients and staff. The study established a possible connection between experiences of restraint and the reawakening of disturbing memories of previous violent encounters. Post Incident Review and support was identified as being helpful although not implemented routinely or formally. In addition, Bonner et al (2002) found that patients felt that they had often given specific warnings prior to incidents but that these warnings had not been acknowledged or acted upon by staff. The study highlighted a lack of research evidence related to the above issues and recommended further investigation.

This study aims to examine further the issues raised within Bonner et al's (2002) pilot study as well as consider some wider issues which may impact upon the experience of restraint. The study has been deliberately written in the first person. The reason for this stance is that the research approach has used mixed methods which have

contained a large element of qualitative interview data gathering. The interview process has involved engaging with staff and patients to discuss personal and emotive issues which deserve to be treated with respect and care. Writing this account using a third person representation would introduce a distance which I would like to avoid. Philosophies of the stance taken to address the research questions will be discussed in depth within Chapter three, and will add further support to the stance of presenting the study as an active participant rather than a detached observer.

1.1. Research questions and central theme

The study was guided by the following research questions:

- What is the psychological impact of restraint for staff and patients in acute mental health settings?
- Does the experience of restraint reawaken disturbing memories of earlier traumatic encounters for staff or patients?
- Does a structured Post Incident Review serve a purpose in the examination of experiences of restraint for both staff and service users?

During the analysis of the data generated within the study a central theme was identified which encapsulates the work. The theme is offered as, *"Events that contribute to subsequent psychological sequelae following restraint, feelings experienced as a result of restraint, and perceptions of helpfulness during and after physical restraint"*.

1.3. Thesis Plan

The recommended upper word limit for PhD theses in most UK universities is 80,000 words and this is the case for Thames Valley University. Managing a vast word count is a difficult and challenging task. As a student embarking upon a large research study, it is tempting to dive into the research pond on receiving appropriate ethical approval, to gather data and work with the research participants. That is the motivation for the study after all. Having already completed the stringent application process for ethical approval, and having completed Masters level study, one could argue that further preparation and consideration in relation to the 'big book' is unnecessary at this stage. An 80,000 word limit allows us freedom to develop the research in great depth, without the restrictions of structured Masters dissertation work. Study guides related to doctoral work, however, advise us to use the unstructured approach at our peril (Davis and Parker 1997; Dunleavy 2003). Without some form of breakdown related to how word count is allocated, there is a risk that three years into the study the researcher will have vast quantities of data, with little idea as to how this should be presented.

Format of chapters is also a consideration to be made when planning the overall structure of the thesis. Chapters should generally be of a comparative length and the thesis should be divided accordingly. A 10,000 word limit to each chapter is a general rule of thumb and will allow for 8 chapters within a thesis (Dunleavy 2003). This thesis will follow a similar format to that recommended by Dunleavy (2003) and is divided into chapters as follows:

1.3.1Chapter two – literature review

This chapter will consider relevant literature to support the background to the study and provide a wider understanding of the research topic. The review will outline search strategies employed to examine literature and provide a related discussion. This chapter will consider historical treatments in mental health settings which include use of restraint, as well as current interventions. The chapter will move on to consider trauma and Post Traumatic Stress Disorder (PTSD) as they relate to restraint in mental health settings, and will then critique current research evidence related to Post Incident Review and support.

1.3.2. Chapter three – research design

Chapter three will outline the research design which was developed to explore the research questions within this study. A mixed method approach to research design was employed and a detailed explanation and rationale for these methods will be offered. A constructivist research paradigm was the research philosophy which underpinned the study and a grounded theory methodology was the approach identified which would best support the constructivist paradigm within this study. The mixed methods of data collection employed a concurrent procedure which involved gathering data in a number of ways. Semi structured interviews offered a qualitative method of exploring the experience of restraint for participants. These interviews served a dual purpose by providing a Post Incident Review framework which was susceptible to evaluation by the participants and was subsequently evaluated using likert scales to measure whether this was a helpful approach to implementing Post Incident Review. A focus group provided additional qualitative data to supplement the individual interviews. In addition, demographic data were

gathered to provide a detailed description of the participant groups. A scale measuring the physical consequences of restraint was used to ascertain the extent of physical injury to participants who were being interviewed about their experiences, and a Trauma Screening Questionnaire (Brewin et al 2002) provided a measurable indicator for participants who warranted further screening for PTSD following the experience of restraint.

1.3.3. Chapter four – Staff findings

Findings of the data which were gathered and analysed in relation to staff participants within the study will be offered in Chapter four. A variety of techniques for data collection provided a wealth of information related to the staff experience of restraint to include demographic data, physical consequences of restraint, screening for trauma symptoms, and in depth qualitative interviews. Evaluation of Post Incident Review was also made by individual staff participants and will be included within this chapter. A focus group was included within the staff data collection to supplement individual interviews and results of this method will be presented.

1.3.4. Chapter five – Patient findings

Similar methods employed to collect staff data were used to gather data from patient participants and related findings will be presented within this chapter. Demographic data in relation to patient participants will be described and will include diagnoses and legal status, as well as length of contact with mental health services. Findings of in depth qualitative interviews will be presented, as well as physical consequences of restraint, screening for trauma symptoms, and evaluation of Post Incident Reviews.

1.3.5. Chapter six – Moving the findings forward

Chapter six is a shorter chapter which will describe how early research findings can be developed to effect positive change in practice. Implementation of Post Incident Review within the Trust in which the study took place will be described as an initiative which evolved directly as a result of this study. This chapter will also examine a related case study to expand understanding and context to the aims of this study.

1.3.6. Chapter seven –Discussion and limitations

Chapter seven offers a comprehensive discussion of the findings presented within chapters four, five and six. The discussion will be linked to literature reviewed in chapter two and offer fresh insights into the research questions being examined. Limitations to the study will be clearly highlighted within this chapter.

1.3.7. Chapter eight - Conclusions and recommendations

Chapter eight will conclude the main body of the work with final summarising points being made. Recommendations for future education, research and practice will be offered within this chapter.

A final reflection will conclude the thesis. This reflection will offer personal points which will highlight my own development as a researcher during the process of doctoral study and conclude the journey which has been the psychological impact of restraint in acute mental health settings: the experiences of staff and inpatients.

CHAPTER TWO – LITERATURE REVIEW

"...This female patient was placed in a wet sheet for four hours for her violent excitement, the calming effect of which lasted for months..." (Gilland 1885)

2.1. Introduction

A systematic approach to accessing relevant literature can enable the researcher to ensure that all available evidence is considered in relation to his or her research question (Hart 2001). It should be made clear which sources of evidence have been used, and when, to provide clarity and transparency for the reader. The systematic review of randomised controlled trials has achieved acceptance as the 'gold standard' for evidence based practice (Sackett et al 1997), however the focus of systematic reviews and meta-analyses is towards rigorously conducted trials of a quantitative nature. This focus prevents reviewing of smaller qualitative studies and hence often does not capture the rich descriptions of the experiences of staff and patients which are described within these papers. Mental health care has many areas in which there is a paucity of high quality data and in which the application of rigorous quantitative approaches is particularly challenging. For example, Sallas and Fenton (2004) in their Cochrane review of seclusion and restraint conducted a search which yielded 2155 citations, however none of the final 35 studies examined met the Cochrane Collaboration's inclusion criteria.

More recently qualitative meta-synthesis has been advocated as method of analysis of a wide range of qualitative studies. The broad aim of qualitative meta-synthesis is to encompass a wider understanding of a particular topic through amalgamation and

synthesis of qualitative findings presented in individual studies related to the identified topic (Paterson et al 2001).

Cresswell (2003) places emphasis upon research design and the way in which literature is considered. In quantitative studies, a thorough review of the literature should be offered before framing the research question to be tested (Parahoo 2006). Consideration of literature is made explicit at the beginning of experimental research with hypothesis or null hypothesis generated at the start. In qualitative studies, the methodology highlighted within the design would dictate how consideration of literature would be undertaken. Strauss and Corbin (1998) suggest that general reading should be undertaken at the start of the study to enhance background knowledge, however extensive reading may introduce prior theoretical assumptions to the researcher. Strauss and Corbin (1998) highlight the necessity for literature reviewing to be carried out during and after data collection. This allows the researcher to compare any existing theories to his or her own emergent categories.

In this study, a literature review was undertaken prior to data collection to establish the extent of what was already known about the topic area. The review established that few published studies had examined the aftermath of restraint in great depth and that this was an area in need of further consideration in mental health care. This provided justification and support to the mixed methods study design and was therefore a worthwhile exercise before commencing the data collection. In addition, as data was subsequently generated and analysed I returned to the literature and widened my reading as themes emerged. This allowed for consideration of similarities and differences related to these themes compared to existing theories and

studies. In this literature review I attempted to evaluate all available quantitative and qualitative literature directly related to the psychological aftermath of physical restraint in mental health adult inpatient settings and to try and capture some of the important contextual issues in this area. The literature review is presented within this chapter.

There are a number of areas worthy of consideration when examining experiences of restraint. Within this study, relevant factors would be related to the management of untoward incidents (that is incidents involving restraint), and links between restraint and earlier trauma. As well as examining literature related to these areas, it is necessary to consider some of the underpinning theories and explanations of Post Traumatic Stress Disorder (PTSD). The experience of restraint can be traumatic for staff and patients alike, therefore it is important to consider the consequences of the experience of trauma. Furthermore, one of the primary research questions within this study concerns links between restraint and reawakening of distressing memories of earlier traumatic events. Research within the field of PTSD may inform this part of the study.

This chapter is divided into sections which will discuss and consider relevant related literature. Section 2.1.1. will highlight the search strategy used to generate the literature which was reviewed. Section 2.2. will address restraint in the acute mental health setting. An overview of historical treatments will provide a background understanding to the current context of restraint in acute mental health care and then focus upon current trends in managing violent, aggressive and challenging behaviour. Section 2.3 will move the discussion towards links between restraint, trauma and Post Traumatic Stress Disorder (PTSD). Section 2.4 will examine psychological

explanations of traumatic events and will consider psychoanalytic and cognitive explanations of trauma. Section 2.5 will discuss Post Incident Review and present some of the complex issues which surround this area of practice. Each section will be considered in relation to this study with explicit links made to support the choices of topics discussed. Section 2.6 will conclude the chapter with a summary discussion of the main points raised within each section and their relevance to the development of this study.

2.1.1 Search strategy

A literature search was conducted using the British Nursing Index (BNI) (1994-July 2007), Cumulative Index to Nursing and Allied Health Literature (CinAHL) (1982-July 2007), EBSCOhost (1997-July 2007), EMBASE (1974-July 2007), International Bibliography of the Social Sciences (1951-July 2007), MEDLINE (1951-July 2007), PsycINFO (Psychological Abstracts) (1887-July 2007) databases. In addition, Emerald, ISI Web of Science and Proquest were searched in order to capture any related material which may not have been identified in the search of health databases. These electronic hosting services hold compilations of journal articles. The contents of these hosting services change periodically as different journals subscribe and unsubscribe. These services were accessed every month between October 2003-July 2007 in order to capture any related material. In an attempt to identify unpublished works, the database System for Information on Grey Literature in Europe (SIGLE) and the UK National Health Service (NHS) National Research Register were searched every month between October 2003-July 2007. Internet sites such as Google Scholar were also searched in an attempt to achieve the most comprehensive possible coverage of the literature and relevant internet discussion sites such as the City 128

project discussion board were accessed to ascertain contemporary thinking in current approaches to restraint. Hand searches were made to follow up cited references within papers. Advice was sought from Thames Valley University librarians and the librarians within the Trust in which the study took place. Initial discussion was made at the start of the literature review for assistance and guidance, further clarification was sought periodically throughout the study, and a final meeting took place in July 2007 to revisit the literature search with the Head Librarian within the Trust.

The initial search strategy decided upon was intended to maximise the chances of detecting any relevant publications. A broad initial approach employed all possible combinations of the following terms: *restraint, trauma, psychiatric inpatients, mental health, seclusion, violence, aggression, untoward incidents, post traumatic stress disorder, PTSD, Post Incident Review, psychological debriefing* and *memory*. From this initial search 10,862 hits were generated, however a high number of these were quickly discarded as inappropriate because, for example, the keywords restraint and trauma generated thousands of citations related to the building industry and bed positioning using restraints for orthopaedic and paediatric patients. Citations which were not explicitly related to mental health care were discarded and after this initial sifting was completed, the abstracts of 2,178 remaining papers were appraised. Abstracts of all of these papers were read and the studies were divided into categories related to aggression and violence, restraint, and post traumatic stress disorder. Some papers overlapped into more than one of these categories but this simple approach helped to manage the overwhelming amount of reading to be done. Papers were then appraised for their relevance to this study. Echoing the experiences of Sallas and Fenton (2004) only 6 papers were found which explicitly aimed to examine the

psychological aftermath of physical restraint (restraint specifically, as opposed to violence and aggression) in mental health care. Although only six papers were directly related to the psychological impact of restraint, a number of papers were relevant to provide a wider context to the literature review. For example, papers related to management of violence and post traumatic stress disorder helped to highlight a wide understanding of issues which can influence the course of restraint processes and the subsequent psychological effects. Some papers highlighted psychological sequelae in addition to reporting of other findings and these papers are included within this review. Table 1. outlines the six papers which specifically considered the psychological impact of restraint and a brief synopsis of each paper is included following table 1.

Author and year	Setting, subjects, sample	Type of study	Results of relevance
1. Bonner et al 2002	Acute mental health, UK, 12 staff, 6 patients	Qualitative	Negative experiences Reignition of trauma when restrained Post Incident Review
2. McDougall 1996	Review of restraint literature	Literature review	Identified lack of research related to restraint, early trauma and PTSD
3. Gallop et al 1999	Canada, 10 patient participants	Qualitative	Reignition or trauma when restrained
4. Sequeira and Halstead 2002	UK secure mental health inpatient unit 14 inpatients	Qualitative	Reignition of trauma when restrained / secluded
5. Brase Smith 1995	US, 4 case studies	Qualitative	Experience of restraint reignited memories of previous encounters of rape
6. Lee et al 2003	UK, 338 nursing staff	Postal survey	Concerns regarding post incident review

Table 1. Summary of studies directly related to the psychological impact of untoward incidents involving restraint

Bonner et al (2002)

This qualitative study interviewed twelve staff and six patients in an acute mental health setting in the UK, and attempted to explore the subjective effects of restraint.

The study found that both groups experienced a variety of strong emotions in the aftermath of restraint ranging from fear and embarrassment through to feeling dehumanised. The study reported some contextual issues which appeared to exacerbate the negative feelings experienced following restraint. These included poor communications and lack of aftercare for both staff and patients. Participants in the study reported that Post Incident Review rarely took place for staff and was even rarer for patients. Experiences of Post Incident Review and support ranged from being perceived as positive and helpful, to feeling blamed and victimised as a result of poorly managed Post Incident Review. The study did not offer ways in which Post Incident Review could be facilitated in a more positive way but suggested that there was an urgent need to examine this area of mental health practice in more depth. This study also highlighted a link between the experience of restraint and the phenomenon of this experience reawakening distressing memories of earlier traumatic encounters but did not describe this link in detail, the psychological impact that this phenomenon may invoke, or offer any description of how the psychological effects of restraint could be measured. The main limitation to this study was the small sample which would not necessarily represent a true generic picture of the psychological impact of restraint.

McDougall (1996)

This paper presented a synthesis of the literature related to physical restraint at that time. McDougall (1996) reviewed 117 papers and aimed to examine the effects of physical restraint on patients, staff, and the clinical environment. The paper highlighted that research into prevention of physical aggression tended to focus on antecedents or triggers to aggression, and that these papers offered ways of preventing

aggression such as models of de-escalation, use of communication skills, and alternative distractions such as multisensory rooms and Occupational Therapy. The clinical environment was identified in this paper as an area for consideration related to physical restraint in terms of creating personal space, ward design, and addressing non clinical factors such as boredom, frustration and anger as a method of preventing violence. McDougall's (1996) review found little evidence to support use of physical restraint, other than some findings which suggested that use of control and restraint methods reduced staff anxieties by increasing their confidence in managing aggression in a physical way. The paper highlighted that the bulk of papers related to physical restraint were focused on who was restrained, clinical diagnosis and age.

McDougall's (1996) review found that support mechanisms were important and concluded that support systems should be available to all staff and patients. He suggested that this should take the form of clinical supervision for staff to develop skills to manage aggression and deal with anger expressed towards them. He did not highlight any papers which offered a way forward in Post Incident Review for patients.

The paper emphasised prevention and de-escalation of aggression however it went on to highlight some of the negative effects of restraint upon patients who had a previous history of trauma such as restraint symbolically replicating earlier traumatic experiences such as rape, citing Brase Smith (1995) as an example. McDougall's (1996) paper also suggested that work on PTSD may help to inform our understanding of the psychological impact of restraint but did not examine this issue in depth.

This paper's main findings suggested that the effects of physical restraint had been examined more in relation to prevention of violence as opposed to the subsequent consequences of using such interventions. McDougall (1996) did, however, raise concern in relation to lack of Post Incident Review and placed emphasis upon the need to examine the relationship between physical restraint and abuse retraumatisation, as well as appealing to the literature related to Post Traumatic Stress Disorder to help inform understanding of the psychological impact of restraint.

Gallop et al (1999)

This Canadian study explored the experience of ten women who were restrained in psychiatric settings and forcibly administered medication. All of the women had a previous history of childhood sexual abuse. Gallop et al (1999) used audiotaped open ended interviews and asked these women to describe their experience of restraint and the consequences. The interview asked participants to describe in their own words the events which led up to the restraint, feelings around the experience, and perceptions of helpfulness from staff. Gallop et al (1999) also asked specifically about flashbacks, nightmares and anxiety responses following the event but did not attempt to measure these symptoms in a quantitative way. Although Gallop et al (1999) had planned to interview fifteen women, they found that after ten interviews the concerns expressed by the women were similar and felt it unlikely that new information would be generated by additional interviews.

The women reported similar negative feelings following restraint to those reported by the participants in Bonner et al's (2002) study. None of the participants viewed

restraint as helpful; rather they expressed feelings of terror and powerlessness during the event. The women reported that the restraint had precipitated flashbacks to their earlier experiences of childhood sexual abuse and that for some they felt like they were re-living earlier traumatic experiences, "I actually physically felt like I was being raped that whole night long" (p.411). The women expressed a desire to talk about their experiences following the restraint but reported that this was not always facilitated. Gallop et al (1999) acknowledge that their sample was self selecting and that women who had not felt strongly following the experience of restraint may not have opted to participate.

Sequeira and Halstead (2002)

This study explored the experience of physical restraint in a private UK secure mental health facility. Fourteen participants were interviewed about their experiences and insights were offered in relation to positive and negative feelings. Sequeira and Halstead (2002) used similar methods to Gallop et al (1999) and Bonner et al (2002) by using qualitative interviews to elicit views of participants' experiences during restraint. In this study participants were not asked about specific psychological experiences whereas Gallop et al (1999) asked specifically about psychological symptoms such as flashbacks following restraint. Emerging data from Sequeira and Halstead's (2002) study highlighted that participants did experience psychological symptoms as a result of restraint. Although participants predominantly reported negative effects such as anger, anxiety and distress, some participants reported feelings of containment and safety following restraint. These feelings were reported in relation to escalating situations being perceived as becoming under control, when restraint was applied to them.

A number of participants in this study reported that the physical experience of restraint provoked simultaneous flashbacks of previous traumatic events, and that this had caused subsequent feelings of fear and panic, for example one participant described how nurses had removed her trousers to give her an injection and that this had been reminiscent of her past when she was abused, resulting in her feeling distressed and upset. Sequeira and Halstead (2002) suggest that individuals who are restrained may well feel as if they are reliving and re-experiencing the original trauma during the restraint. They support the view of McDougall (1996) by suggesting that literature related to PTSD may help to inform the way that mental health care professionals deal with restraint towards individuals with a trauma history. Sequeira and Halstead (2002) also highlight the need to offer time to review incidents of restraint and the necessity to consider trauma histories when making decisions to restrain patients.

Brase Smith (1995)

This seminal paper explored the experience of restraint in US psychiatric units for women who had previous histories of rape. Four case studies were presented and highlighted the negative feelings associated with restraint. These feelings ranged from agitation through to guilt, humiliation, loss of dignity, and torture. The women reported that the restraint experiences had triggered flashbacks related to their rape traumas and Brase Smith (1995, p. 26) concluded that these women would "prefer to face death rather than the possibility of restraints". This paper reports cases where mechanical restraints (leather straps) were used and there is a need to explore whether

use of mechanical restraints may be more traumatising than using the physical holds promoted in the UK. Each of the cases reported had traumatic rape histories and it may be that for individuals with such a trauma history, they would be more likely to experience psychological symptoms following restraint. Brase Smith (1995) did not compare her cases to others who were restrained and did not have a trauma history. Brase Smith (1995) emphasised the need for nurses to consider previous histories when restraining patients and suggested that where nurses believe that they are restraining a patient to prevent further harm and promote safety, they may well be introducing further trauma to an already vulnerable group.

Lee et al (2003)

This postal survey was undertaken in the UK with 338 nurses working in NHS regional secure units and psychiatric intensive care units. Participants were surveyed in relation to outcomes of restraint that had taken place in their clinical work. They were asked to identify a positive outcome of restraint and provide details, as well as a negative outcome of restraint. In addition participants were asked to highlight the physical impact of restraint and any other concerns that they may have.

A high number of participants (96.3%) reported positive outcomes appertaining to incidents being brought under control but reported little consideration of the after effects following the incident. 23% of participants reported negative outcomes related to patients in terms of physical restraint being viewed as punitive, and that patients who had a previous history of abuse were particularly vulnerable. Participants reported that they had found the experience of restraint as difficult and stressful and one third of participants reported that they had not been offered the

opportunity for Post Incident Review. Lee et al (2003) highlighted the need to identify systems to allow consistent Post Incident Review to take place, as well as identifying training packages to allow staff the opportunity to develop effective coping strategies to lessen the psychological impact of restraint.

Although Lee et al (2003) surveyed a much larger group than the previous studies; use of the postal survey method would have limited the amount of qualitative contextual data which participants reported. They used thematic analysis to generate their findings from the questionnaire surveys however further exploration of these themes would have facilitated wider elaboration of some of the issues raised for consideration. For example, the survey highlighted that patients who had a history of abuse were viewed as particularly vulnerable but no detail was included to offer insight into what was viewed as vulnerable by participants. Staff had reported that they had sick leave after experiences of restraint however the survey method did not allow for further exploration of the nature of the sick leave, for example whether this may have been as a result of psychological or physical consequences of restraint.

The above search demonstrated that most of the published papers related to physical restraint are of a qualitative nature. This search replicated Sallas and Fenton's (2004) failure to find any published controlled trials evaluating seclusion and restraint techniques. The absence of any controlled studies in this area is striking given the fact that a range of different physical intervention techniques for the management of aggressive behaviour are in use around the world, these techniques have high training costs and their use sometimes results in serious adverse events including serious injury and death (Paterson et al 2003).

Although the above studies have limitations, particularly in relation to the small numbers of participants, there were common concerns which were highlighted within each study which underline the need to examine the experience of restraint for staff and patients on a wider scale. Post Incident Review and support has been identified as an area which could be of benefit to individuals who have been involved in restraint incidents, but there would appear to be no clear way which has been identified in this literature to take this forward. These studies have also suggested that the experience of restraint may add further trauma to those with a previous trauma history, as well as triggering memories of earlier traumatic encounters. The studies have acknowledged that the study of PTSD may inform further understanding related to the psychological impact of restraint but that little attention has been paid to this within acute mental health care.

This thesis aims to carry forward some of these ideas by examining these issues in much more depth to provide a clearer picture of the psychological impact of restraint, and to consider ways of addressing the aftermath of restraint in a helpful way.

2.2. Restraint in acute mental health settings

2.2.1. Defining restraint

Untoward incidents, for the purpose of this study, are defined as any incidents in the acute mental health setting which have required some form of 'hands on' physical restraint. This could range from gently assisting a patient back to a place of safety by the arm, to a situation involving control and restraint by trained practitioners to immobilise a patient. This definition of restraint was generated through a concept clarification exercise which took place as part of an earlier pilot study (Bonner et al

2002). Practitioners representing the acute areas within the earlier study had difficulty in identifying which incidents were deemed relevant to the study. Some practitioners had felt that only incidents that had involved formal control and restraint (C & R) procedures were relevant while others viewed the more diverse aspects of restraint, such as gently guiding individuals to a place of safety, as appropriate. C & R involves the administration of painful holds to contain violent patients using wrist and arm locks to restrict movement. C & R as a method of restraint has also proved difficult to define with a variety of methods being taught in a variety of settings (McDonnell and Gallon 2006).

The concept clarification exercise generated agreement that any 'hands on' approaches to managing untoward incidents were relevant. The scale of the restraint incidents examined for the pilot study ranged from manually preventing a patient from hanging, to guiding patients who were in the process of absconding back to the ward, to use of C & R by trained practitioners to immobilise patients. All of the incidents had involved managing challenging behaviour by 'hands on' approaches. There is a wide range of force used within this definition in acute mental health care. Part of this study aimed to consider whether this may have any bearing upon the psychological consequences of restraint. There is a possibility of a correlation between the more force used, the more psychological trauma caused however there is limited evidence to date to support this notion and data emerging from this study may inform this aspect of the experience of restraint. Richter and Berger (2006) found that the interpretation by the individual had more bearing upon psychological impact than extent of force and injury used. If one perceives even minimal intervention as traumatic, ie., life threatening or threatening one's integrity, then the psychological

impact can be profound. A study of the literature on war veterans and victims of violence suggests that there is a dose-response relationship between amount and severity of exposure to traumatic events and subsequent risk of psychological injury, particularly risk of developing PTSD (Stretch, 1985; Goldberg et al, 1990; Basile et al, 2004), but that this relationship is non-linear. In general, this means that the greater the exposure to trauma an individual receives, the greater his or her subsequent risk of developing PTSD but the individual's interpretations of events strongly influence outcome. The non-linearity of the dose-response relationship rests on evidence that non-injury incidents in which individuals may have experienced high levels of fear and distress have been reported to be more likely to result in lasting psychological injury than incidents resulting in very minor physical injuries such as cuts and bruises, but injuries resulting in more serious physical injury are those most likely to also result in lasting psychological injury (Richter & Berger, 2006). Walsh and Clarke (2003) have reported that verbal aggression and minor incidents of violence may have very considerable psychological effects for staff, however there are no published studies which report the effects of prolonged or repeated verbal aggression on staff, or the role that verbal aggression may have in the development of PTSD. Applied to restraint in mental health settings, this literature suggests the possibility that the greater the force used the more likelihood of subsequent psychological effects. In addition the more prolonged the restraint and the more painful the holds used, the greater the likelihood that individuals will experience psychological symptoms and suffer persisting psychological injury. It also proposes that the experience of restraint is subjective and that less dramatic events can have an equally distressing impact upon individuals if they have been perceived as a serious threat to the integrity of the self. This suggests that during restraint incidents it may be important to provide

repeated explanations and assurance to all concerned in an attempt to reduce the subjective level of fear or terror experienced by participants.

Although the examination of current literature has highlighted the non-linear dose response between physical injury and developing PTSD, another consideration must be made in relation to this hypothesis regarding the impact of restraint. Reporting systems do not always capture incidents which have involved no injury. Staff are more likely to formally report minor and major injuries which are tangible and fit with incident reporting criteria. It may be that reported incidents are viewed as more serious and at least acknowledgement has been made that they have happened, and they are significant. This may not be the case for incidents that are not reported through formal systems. This would suggest a more linear description of the impact of physical injury and subsequent psychological effects; however the impact of incidents involving no injury could be missed completely as they have not been reported through formal mechanisms. To date there are no published studies which have examined how reporting systems may influence the support offered to staff and patients who have not experienced a physical injury.

2.2.2. Historical influences upon current practice

The historical review includes terminology that would not be acceptable in discussing mental health care today, however I have used terminologies of those eras to promote further thought regarding the context of mental health care during those times.

The label of mental illness was used as an overt form of social control during Victorian times and although the element of social control is denied in the present day with various legislation to protect the mentally ill, it could be argued that an element

of social control still exists (Paterson 2006). The Victorian solution for individuals who deviated from the social norms of the time was to have them committed to lunatic asylums, usually isolated miles away from their hometowns. One of the sites in this study was a purpose built mental health inpatient unit that replaced an old Victorian asylum which previously served the patient population. This institution was situated some miles from the catchment area that it served, and in keeping with the national agenda for closing such institutions, reprovision was planned over a long period of time with the new hospital opening in May 2003. In Wynn-Jones (1993) examination of archive material from the now closed Victorian site, a fascinating picture of asylum care is portrayed where women were incarcerated for giving birth out of wedlock, failing to adhere to their husband's domestic expectations or not fulfilling their role as mother. Wynn-Jones (1993) examination reflects the general trend of asylum care of that era.

Methods of restraint date back to the 1700s with shackles, chains and manacles being common forms of managing the mad (Scull 1993) and Bethlem Hospital allowed spectators to view the mayhem at the cost of one penny (Jones 1972). As well as the moral view of mental illness at this time there was also a belief that insanity had physiological causes. The theory of the brain being the organ of the mind had been established and the search for treatments and cures began in earnest. These cures included aquatic shock treatment that involved a variety of methods of pouring cold water, usually over the head, of patients who required calming (Scull 1993). Another form of treatment was the tranquilliser chair that restricted all body movement, the underlying theory being that blood flow would be reduced to the brain resulting in a sedative effect (Scull 1981). Use of restraint, however, remained the dominant model

of treatment intervention. The shackles and chains of the 1700s were replaced with restraining gloves, sleeves and waistcoats in the 1800s. Seclusion was introduced in the form of leather or padded cells. The research site for the pilot study from which this study has been developed had its own provision of padded cells. According to the 1871 Annual Report by the Medical Superintendent, these cells contributed to the tranquillity of the dormitories as there were "more than was usual for an establishment such as this" (Gilland 1871, page not numbered).

Doors within the asylums were unlocked for the first time as a result of Pinel's revolutionary moral treatment of the insane. Pinel's belief was that the mentally disordered should be treated with mental approaches that included kindness and encouragement. By using these approaches Pinel believed that the mentally disordered would show self-restraint as opposed to enforced restraint by lunatic attendants. As word of Pinel's success spread, the asylums of Britain began to adopt this approach, the pioneering site being the York retreat founded by William Tuke and carried on through his son, Henry, and grandson, Samuel (Stone 1998).

The 1900s were dominated by physical treatments such as deep insulin therapy for psychosis and modified insulin therapy for neurotic disorders. Both involved inducing coma by the administration of insulin over a period of days or weeks depending upon the severity of mental disorder. Electro convulsive therapy was used routinely and is still in use today, albeit as a carefully selected option following a number of first line treatments. Opiates, barbiturates, bromide and chloral hydrate were the main drugs of choice for challenging and aggressive behaviour and their use continued well into the 1970's. The 1950's heralded the advent of psychotropic

medication as we know it today in the form of Largactil (Chlorpromazine). Largactil effectively treated symptoms of psychosis for many psychiatric patients, the result for some being freedom from the institutions and reintegration to the community (Goodwin 1997).

The nursing role through history has evolved from lunatic attendant (key responsibilities chaining, manacling and collecting pennies) to effective practitioner, with a range of taught skills and interventions. Medical Superintendents were responsible for every aspect of care and treatment as well as day-to-day organisation of the institution managed asylums in the 1800s. A nurse's career usually began with menial tasks such as cleaning. Promotion was gained through time and experience, although qualifications for nurses have evolved since the late 1800s when the Certificate of Proficiency in Mental Nursing was first recognised. While clearly patients were treated inhumanely by today's standards, this was often as a result of well-meant intentions. Archive material from the Victorian asylum which one of the research sites replaced includes an annual report for 1885 that describes a female patient being placed in a wet sheet for four hours as a form of restraint for her violent excitement, the calming effect of which "lasted for months" (Gilland 1885, page not numbered).

Many of the asylums, including the above, were self-sufficient. Patients were involved in farming and laundry under the supervision of nursing staff. The philosophy was that lunatics must be kept calm and under control, and working was a method of supporting this philosophy. Work provided a means of channelling energies in a productive way. This philosophy supported the Victorian work ethic by

providing structure for the perceived idle and lazy. Although friendships (and subsequent therapeutic relationships) may have developed, this was not an explicit requirement of the nursing role. Views of nurses within the pilot study research site reflected the view of society at that time, that lunatics were committed because they had misdemeanoured in some form and should be treated with the contempt that they deserved (Tilbrook 1995).

The plight of the mentally ill was highlighted through the anti-psychiatry movement of the late 1950's and early 1960s (Szasz 1962). The barbaric treatment of psychiatric patients was open to public scrutiny and the cruelty administered by nurses exposed. Psychotherapy as a treatment intervention was becoming an acceptable and credible alternative pioneered by Freud in the late 1800s to early 1900s (Stone 1998). Refined methods have continued to evolve and a range of psychological interventions can now be offered as a first line option for addressing mental health problems. In America, the nurse was being redefined as a skilled practitioner with the therapeutic qualities necessary to assist the psychiatric patient regain control over their life through the nursing process (Peplau 1952). The role of the nurse changed dramatically from custodian to therapist and alternative approaches to managing challenging behaviours began to develop. This dual role, however, has remained a tension in mental health nursing to this day, with nurses struggling to manage the custodial role within the confines of the Mental Health Act (1983) to the more therapeutic role of the helper.

2.2.3. Restraint in the 21st Century

In the late 20th and early 21st centuries, more rigorous approaches to researching and understanding mental health and illness have developed and continue to evolve. Access to research evidence is easily accessible to health care staff and a clear agenda in education, research and practice has been set for health care staff to become evidence based practitioners in order to provide the best possible, cost effective interventions to the service users with whom they work.

McDougall's (1996) review of physical restraint summed up the state of literature at that time and a review of subsequent papers related to restraint indicates that little has changed. The main points are that violence and aggression are widespread and possibly on the increase (Bower and McCulloch 2000; Wright 1999; Shah 1993), emphasis upon the prevention of aggression dominates the literature and is supported by current guidelines (NMC 2002, NICE 2005a), restraint is predominantly counter-therapeutic (Lee et al 2003; Bonner et al 2002), and interpersonal communication has a key influence upon the outcomes of incidents of violence and aggression in acute mental health care (Alexander and Bowers 2004; Lowe et al 2003; Spokes et al 2002). McDougall (1996) suggested that links between restraint, earlier abuse and PTSD were worthy of further attention, however some ten years later very few studies have considered these aspects of restraint. These papers rightly emphasise the necessity of working in a therapeutic way to prevent aggression and violence, however although studies have highlighted how these approaches can reduce violence and aggression, no study to date has claimed to eliminate violence and aggression completely. A refocus towards inpatient acute services is likely to improve practice and outcomes in

these areas; however restraint will continue to be used towards a small population who have not responded to early interventions and de-escalation techniques.

Studies related to management of untoward incidents have generally focused upon three areas; what happened before the incident (antecedents), how was the incident managed, and what happened subsequently. Studies related to antecedents have identified environmental factors such as poor staff levels and use of agency staff (James et al 1990; Gournay et al 1998; Bonner et al 2002; Bowers et al 2007). Architectural structure is also a consideration in terms of observation within the environment (NMC 2002; Gournay and Bowers 2000). Some studies have considered staff behaviour and attitudes precipitating violent incidents and conclude that aversive stimulation and staff-service user conflict leads to assaultive behaviour (Sheridan et al 1990; Whittington and Wykes 1996; Wright 1999; Lee et al 2003; Secker et al 2004).

There are a number of techniques and formal training programmes in the management of challenging behaviour involving restraint in the UK, the dominant model being control and restraint (C & R), alternatively called care and responsibility (McDougall 1996). C & R was originally developed by the prison service in 1981 and expanded into health and social care in the mid 1980's following recommendations by the Ritchie Report (1985) that training in C & R should be provided for nursing staff in special hospitals. Special hospitals provided high security care for offenders with mental health problems who had challenging behaviour which often required physical containment. Techniques were subsequently modified for less secure environments and C & R (General Services) evolved in more generic health and social care settings

(McDonnell and Gallon 2006). C & R involves taught techniques that endeavour to contain violent or potentially violent situations in the safest manner possible. Nurses involved in C & R must be trained accordingly by skilled trainers using a variety of methods which include use of breakaway techniques, immobilisation of a patient, movement of a patient to a safe area, and placing a patient in seclusion (Duff et al 1996). Seclusion involves isolating a patient in a purpose built room to provide private containment with minimal risk. Use of seclusion should be a team decision and should be recorded and monitored throughout the period that the patient is contained in this manner.

More recently it has come to light that C & R can contribute to death of individuals through positional asphyxiation when they are restrained in the prone position (NICE 2005a). It is believed that the use of this technique can restrict respiration resulting in cardiac difficulties and death.

An alternative to C & R, used more frequently in learning difficulties, is the Strategies for Crisis Intervention and Prevention (SCIP) programme (British Institute of Learning Difficulties (BILD) (2001). This method has been used within learning difficulties care settings for some years but there is a paucity of published research into its efficacy within mental health care. SCIP espouses a clear and consistent documented approach by all members of the health care team, and the method addresses antecedent and aftermath support to the patient. Other methods such as breakaway skills have been developed and are mandatory in most UK mental health care trusts; however the efficacy of breakaway training is questionable. For example, Rogers et al (2006) audited 47 staff in a medium secure unit and found that none of

the sample had used breakaway in the preceding twelve months, 40% were unable to break away within a ten second period, and 60% did not correctly employ taught techniques.

Studio 3 is another alternative to C & R which is beginning to gain credence as an alternative approach to challenging behaviour. This approach places emphasis on non-aversive interactions with individuals and managing potentially aggressive situations through techniques of diffusion. This approach has been developed in learning difficulty settings and is yet to be thoroughly evaluated in acute mental health care, however in light of the limited alternative approaches available the philosophies of studio 3 would provide explicit training in addressing challenging behaviours through less aversive responses (Studio III Group 2007).

Wright (1999) pointed out some years ago that there was a lack of research into the efficiency and safety of the methods used for C & R, and more recently Paterson et al (2003) highlighted that training techniques are costly to provide and their use can result in serious injury and death. Duxbury and Paterson (2005) have further emphasised the lack of empirical evidence related to physical restraint and continued concerns over appropriate training methods. Bowers et al (2007) found that incidents of aggression were at their highest when staff absences were high, paradoxically when staff were on leave from the clinical area to attend training in C & R.

Wright (1999) considers a number of areas that contribute to the wider context of violence and aggression in mental health settings that include inappropriate placement

of patients, clinical environment, staffing, staff behaviour and attitudes, and staff training. These areas will now be explored further.

With the advent of court diversion systems; patients are now caught in the net of the psychiatric services as opposed to the prison system. There are, however, shortages of intensive care and medium secure beds resulting in already overcrowded admission wards accepting inappropriately placed offenders with potential or proven aggressive behaviour (Gournay et al 1998). This is beginning to change in light of more recent incentives to address these difficulties, the Trust in which this study took place more recently having consistent figures below 100% bed occupancy. The government have made mental health services a priority as identified through Modernising Mental Health Services (DOH 1998) and the subsequent NHS Plan (DOH 2001). Modernising Mental Health Services (DoH 1998) identified the government vision of the way forward for mental health care outlining plans for new assertive outreach teams, 24 hour access to mental health services, secure units in every region and more modern drug treatments. These services were to be implemented through National Service Frameworks for Mental Health, which were introduced in 1999 (DoH 1999a), and underpinned through the Clinical Governance framework (DoH 1999b). More recently the Chief Nursing Officer's Review of Mental Health Nursing in England (2006) has further emphasised the need to work with patients using a Recovery approach to provide a seamless and patient driven service. These changes aimed to place mental health at the forefront of the English National Health Service and offered the opportunity to address some of the difficulties of caring for people with mental health problems, which may or may not include challenging behaviour. The most appropriate settings with the best available treatments would endeavour to prevent

many of the tragedies of the past and offer a more positive future for recipients of mental health care. Additional funding was pledged to reform mental health care by providing more secure facilities and expanding and developing community care. Addressing Acute Concerns (Standing Nursing Midwifery Advisory Council 1999) paved the way for a refocus towards acute care, however subsequent criticisms of restraint in mental health care have dominated mental health press, one of the most damning being the David Bennett Inquiry (Sallah et al 2003). This report highlighted failures in one NHS Trust where a patient was restrained and subsequently died. Although this incident took place in an NH medium secure unit, the methods of restraint were similar to those applied in most acute settings.

The inpatient population within the acute setting in the UK has changed as a result of the community care movement (Ferraz and Wellman 2008). As more mental health service users are being cared for in the community setting, the populations within inpatient units are predominantly patients with complex and challenging needs, who are unable to be maintained in the community. Shorter admissions for managing acute behavioural disturbances present new challenges in the delivery of current services (Hosany et al 2007). The closure of the large psychiatric institutions into smaller localised community facilities has resulted in a reduction of acute in patient services throughout the UK and the drive for community care has resulted in shorter stays within the inpatient facilities. The residents at any one time can therefore be a population of severely unwell people who are being offered short term admission while their psychiatric symptoms are at their worst. Over the past ten years this has had a profound impact upon the inpatient and staff experience of acute care, with criticisms being made related to the lack of therapeutic interventions available in

acute services. This is beginning to change for the better however it has some way to go before catching up with now well established community services.

Wright (1999) highlights the clinical architectural environment as a contributing factor in the management of aggressive and violent behaviour, however as well as consideration of the architectural structure of the environment for comprehensive observation, the balance of individual privacy must also be considered. In developing the environmental considerations further, Gournay and Bowers (2000) reiterate the need for careful consideration of an observational environment in risk management of suicide and self-harm. Suicide and self-harm can present different challenges to the nurse but may also require similar restraining interventions used in managing aggressive and violent behaviour.

Staffing is clearly an issue in general mental health care as well as in the discrete area of managing challenging behaviour, however there is little published research into the direct impact of staffing and restraint. Oldham et al (1983) found that violent incidents were at their lowest when staff interaction with patients was at its highest. Lanza et al (1994) found that poor staffing levels resulted in higher frequency of assaultive behaviour and Bowers et al (2007) found that incidents were higher when staff absences were higher. Binder and McNiel (1994) found that high levels of assaultive behaviour towards staff took place even when staffing levels were adequate. James et al (1990) found that high levels of agency staff equated to higher untoward incidents and Bonner et al (2002) found that both permanent staff and patients had negative views of agency staff, with agency staff playing a less active role in care and treatment interventions.

There are a number of studies that have considered staff behaviour and attitudes precipitating violent incidents. In their study, Whittington and Wykes (1996) reported that 86% of assaults to staff had been preceded by aversive stimulation by staff in the form of frustration, activity demand or physical contact. These findings supported earlier studies by Sheridan et al (1990) who found that events leading to assaultive behaviour by patients towards staff often involved patient-staff conflict. Bonner et al (2002) found that failed communication usually preceded untoward incidents. Examples of failed communication were in relation to service users receiving conflicting messages from different members of staff, and that explicit warnings were given in relation to escalating tensions which passed unheeded by staff. Lowe (1992) investigated staff interventions used when faced with challenging behaviour and identified ten categories of effective interventions as; confirming messages, personal control, staff honesty, providing face saving alternatives, setting limits, use of structure, facilitating expression, monitoring, timing and calming, and non-verbal skills. Lowe (1992) highlighted positive therapeutic qualities within each intervention and offered these categories as a framework for critical analysis when examining challenging behaviour. While Lowe's (1992) study highlighted more positive approaches to nursing interventions, there have been no subsequent studies to further evaluate Lowe's (1992) strategies or offer alternatives.

In terms of staff training, C & R would appear to be the dominant model of formal physical restraint training. Training of nurses in addressing the wider context of challenging behaviour, such as recognising antecedents, and Post Incident Review, appears to happen on an ad hoc basis. Wright et al's (2000) review examined the

management of violence policies in 33 mental health units in the UK and found a lack of consistency and guidance throughout, with some policies making no mention of a commitment to training. Bell et al's (2000) review found few alternatives to C & R training approaches other than SCIP (BILD 2001) and therapeutic holding (Stirling and McHugh 1998) which are both used within the field of learning difficulties. Infantino and Musingo (1985) reported a reduction in the number of staff injured through physical assault following training in verbal de-escalation techniques and Bell et al (2000) recommend that these techniques should be developed further in management of untoward incidents. This is supported by the NMC (2002) document, 'The recognition, prevention and therapeutic management of violence in mental health care'. This document stresses the urgent need for comprehensive, consistent and therapeutic management of untoward incidents, and highlights the lack of research evidence related to this topic. Although emphasis within training programmes is given towards physical treatment being used as a last resort, formal strategies for considering antecedents and post incident support are not routinely included within all training programmes (NMC 2002). More recent guidelines have responded to some of these issues in the form of the Policy Implementation Guide on the Management of Violence and Aggression produced by the National Institute for Mental Health in England (NIMHE) (DOH 2004) and the subsequent NICE Guidelines for short term management of disturbed / violent behaviour in psychiatric in-patient settings (NICE 2005a). These guidelines emphasise the need for early recognition of antecedent behaviours and de-escalation of potentially violent situations.

Other commentators assert that a much broader view of psychiatry as a whole should be considered in relation to the role of the nurse (Morrall 2001) and the management of violence and aggression (Paterson et al 2006). Morrall (2001) considers that mental health nurses play a role in maintaining the medical model of madness which continues to formulate unusual and deviant behaviours as illness which must be diagnosed and treated. Morrall (2001) has examined the effects of social and economic influences which have maintained the mentally ill as a marginalised and socially excluded group. He acknowledges that there is political will to improve the lot of the mentally ill, and that continuing developments in medical treatments cannot be ignored, however these influences continue to maintain the tension between the roles of custodian versus the therapeutic role of the nurse. Reforms of the Mental Health Act (1983) include changes to care at government level with the introduction of powers to use the Mental Health Act as a preventative measure for individuals with a diagnosis of dangerous and severe personality disorder who are thought to be a 'potential' risk. The risk may be that this is reintroducing another form of social control similar to our Victorian predecessors which keeps social deviants out of the public domain. Paterson et al (2006) suggest that a public health model of aggression and violence should be adopted to address prevention of violence within society, and that a cultural shift is needed to change current approaches to managing violence which in turn would change the role of the nurse as custodian of the violent individual.

2.3. Links between restraint, trauma and Post Traumatic Stress Disorder (PTSD)

2.3.1. Defining trauma

While this thesis does not propose to research PTSD, it is important to consider how PTSD and the study of trauma may inform the management of restraint and its aftermath. The two main classification manuals which outline criteria for PTSD are the International Classification of Diseases Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines (ICD-10) (World Health Organisation (WHO) 1992) and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Transcript Revised (DSM IV-TR) (American Psychiatric Association (APA) 2000). The main differences are that the DSM IV-TR (APA 2000) takes into account the subjective experience of the stressor (criterion A2) and includes numbing and avoidance symptoms (criterion C) whereas the ICD-10 (WHO 1992) does not. The DSM IV-TR (APA 2000) were chosen for this study as a large element of the project would examine the subjective experiences of the participants therefore it was important to include criterion A2 in the definition of PTSD as it may apply to the participants within this study. A summary of the DSMIV-TR criteria is included in appendix two and a summary of the differences between the two classification manuals is included in appendix three (www.ncptsd.va.gov).

The DSM IV-TR (APA 2000) describes PTSD as a disorder which can occur following exposure to a traumatic event in which both of the following were present:

- The person has experienced, witnessed, or been confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

- The person's response involved intense fear, helplessness, or horror. The traumatic event is re-experienced, and there is an avoidance of stimuli associated with the trauma and a numbing of general responsiveness.

The DSM IV-TR (APA 2000) differentiates between PTSD and Acute Stress Disorder, the latter meeting the same criteria for exposure to a traumatic event, as well as experience of three of the following symptoms: sense of detachment, reduced awareness of one's surroundings, derealisation (sense of unreality, detachment from your environment), depersonalisation (disorientation related to body or self, feeling of being in two places at once), and dissociated amnesia (inability to recall one or more important aspect(s) of the event) (APA 2000). Acute Stress Disorder has a time frame of two days to four weeks whereas PTSD presents over a longer time frame. The effects of PTSD can be acute or chronic, simple or complex. These differentiations are important considerations to be made in relation to treatment interventions and will now be discussed.

The first consideration in relation to restraint, trauma and PTSD is that of how one defines trauma or exposure to a traumatic event. The Oxford English Dictionary (Soanes and Stevenson 2005) describes trauma as: emotional shock following a traumatic event; a distressing or emotionally disturbing experience; any physical injury; physical shock following this, characterized by a drop in body temperature. The definition of traumatic exposure is subjective and personal. What one individual may perceive as traumatic, another may perceive as part of everyday life. For example a near miss in a car avoiding an accident may be viewed by an individual in terms of the criterion identified in the DSM IV-TR (APA 2000), whereas an

individual who as been the recipient of years of systematic abuse may view their situation as their life and their lot. In mental health care, although zero tolerance is the preferred and espoused option in terms of violence towards professionals, a counter-argument by many mental health care professionals is that managing violence is "part of the job" and to be accepted. The range of exposures and interpretations of traumatic encounters therefore are difficult, if not impossible, to truly quantify and one can recognise why researchers have failed to reach a conclusive definition of traumatic exposure. Bonanno (2004) develops this discussion in terms of resilience and suggests that while most individuals suffer at least one form of violent or life threatening situation during their lives, not all go on to develop psychopathological responses. These issues have implications for interventions and treatment of groups and individuals who have been exposed to some form of trauma.

An understanding of the common, natural responses to traumatic events is necessary to provide context to this study. When exposed to a traumatic event the immediate effects of the event provoke a variety of responses related to biological, psychological and social mechanisms. Responses are usually presented over a limited period of time, the immediate effects being up to seven days and short term effects up to one month. The biological responses are related to the autonomic nervous system responding to the traumatic event when the body increases its physical capacity in preparation to respond by fight, flight, or freeze. These may manifest in terms of increased ability to perform outside of one's usual ability. For example, in natural disasters individuals have displayed heroic efforts in escaping potential catastrophe; individuals have moved objects almost humanly impossible to move. Symptoms would be increased arousal and hyper vigilance. The freeze response is characterised

by the individual being unable to respond, becoming immobile and unable to react to the situation being presented to him or her. Psychological responses would be shock, numbing, distress, anxiety, for example. Social responses may be outcry and disbelief, for example in relation to terrorist attack. These responses usually pass fairly quickly when the exposure to the trauma has been removed, but may last over a period of weeks where symptoms of irritability, intrusive images, anxiety, and sleeping and appetite disturbance may persist. The experience is usually gradually assimilated for the individual and symptoms start to subside. When symptoms persist for more than this period, further assessment for Acute Stress Disorder and PTSD should be considered.

Acute Stress Disorder presents in the short term and is manifest by symptoms of dissociation, derealisation, depersonalisation, and dissociative amnesia. PTSD is categorised as either acute or chronic. Acute PTSD usually manifests in the medium term with symptoms presenting for up to six months following the traumatic exposure, and chronic PTSD presents as a longer term condition, usually with symptoms presenting for 6 months or more. Delayed onset PTSD presents 6 months or more after the event and may coincide with a new trauma months or years after the initial trauma.

Herman (1992) developed a description of PTSD further by introducing the concept of complex PTSD (Appendix four), alternatively referred to as disorders of extreme stress not otherwise specified (DESNOS). Complex PTSD describes the syndrome of symptoms related to prolonged and repeated trauma (as opposed to a one off life threatening incident as described within the DSM IV-TR classification). Examples of

complex PTSD may present in victims / survivors of hostage situations, prisoners of war, childhood sexual abuse, and ongoing domestic violence. Herman's (1992) description of complex PTSD challenges the DSM IV (APA 1994) classifications of both PTSD and personality disorders. She asserts that psychiatrists classify the symptoms and behaviours which develop as a result of prolonged traumatic exposure, in terms of personality disorders. Consideration of the impact of such trauma as a complex PTSD can be much more helpful in terms of reformulating treatment interventions. Personality disorders have historically posed a challenge in psychiatry as difficult to 'treat', the individual being blamed for their difficult and challenging behaviour. Psychiatrists have often viewed the behaviours displayed by recipients of trauma as maladaptive and sought treatments to cure these ills, ignoring the cause of the symptoms that are being presented before them. Herman (1992) challenged the APA when reviewing the DSM IV (APA 1994) in the 1980's when a proposal was raised to include "masochistic personality disorder" as a diagnosis. This diagnosis had been categorised in relation to individuals who remain in persistently abusive relationships. The APA had not considered the many underlying reasons for, particularly, women who remain in such relationships. The proposal caused outrage in women's groups in America and was eventually changed to "self-defeating personality disorder" and included as an appendix as opposed to the main body of the manual. Complex PTSD is still not categorised within the current DSM IV-TR (APA 2000) however in light of more understanding in the psychiatric community regarding the effects of prolonged traumatic exposure, it is hoped that it will be included in future revisions.

2.3.2. PTSD and mental illness

Although PTSD has been widely studied there has been little attention given to the incidence of PTSD as well as other co-morbid psychiatric disorders within the inpatient population (Meuser et al 1998; McFarlane et al 2001). Symptoms of PTSD are similar to, and overlap with, other psychiatric disorders, for example depression. Misdiagnosis can easily happen when similar presentations are evident. For example, the individual who presents to his or her GP with poor sleep, intrusive thoughts, irritability and dissociation may be diagnosed as suffering from depressive disorder when, on further detailed assessment it may transpire that the diagnosis should be PTSD. Depression can be a co-morbid diagnosis with PTSD. Differentiating between the two may be difficult. A patient with an existing psychiatric diagnosis may be less likely to be identified as suffering from PTSD, for example in schizophrenia the emphasis is usually made towards the symptoms and problems associated with this psychotic disorder. The experience of psychological trauma can be considered to be a risk factor for the development of a wide-range of psychological disorders including psychosis and major depression (Coid et al 2003, Koss et al 2003, Seedat et al 2003). There are also reports that patients may be traumatised by the onset of psychosis (McGorry 2001) and may also be traumatised by events surrounding or resulting in psychiatric admissions (Jackson et al, 2004).

Holtzheimer et al (2005) compared two groups with diagnoses of depression with PTSD and depression without PTSD. Clinical outcomes for the group with depression and PTSD were poorer in terms of symptom severity, higher levels of depression, and hostility. The group with poorer outcomes also had a significantly higher number of discharges against medical advice.

In a study conducted in Australia, McFarlane et al (2001) reported that 28% of acute inpatients in a general hospital psychiatric unit met DSM IV (APA 1994) criteria for PTSD. In studies conducted in the USA, Craine et al (1988) and Cascardi et al (1996) have respectively reported detecting high levels of sexual and physical abuse in psychiatric inpatient populations and that two thirds of the victims of sexual abuse met diagnostic criteria for PTSD. In another US study, Mueser et al (1998) reported that using appropriate screening instruments, PTSD can be detected in approximately 40% of acute psychiatric inpatients. It is noteworthy that less than 2% of the patients in Mueser et al's (1998) study and none in Craine's (1988) study had a diagnosis of PTSD recorded in their medical records, probably because appropriate screening had not been carried out. At the time of writing, a British study using similar methods has recently been completed which has reportedly replicated these US finding in a UK general psychiatric inpatient population (Purves et al, in preparation).

2.3.3. Restraint and PTSD

The consequences of these findings must be considered in relation to restraint in psychiatric inpatient settings. The effects of restraint on patients with undiagnosed trauma histories and / or PTSD are essentially unknown. It is possible that restraint may compound existing PTSD in this group and it is also possible that patients may develop PTSD as a direct result of the experience of being restrained. There have been no studies to date which have examined whether the experience of restraint has precipitated PTSD; however Ray et al (1996) have reported that patients who had been secluded stated that they felt vulnerable and fearful about the experiences for up to 2 years afterwards. Within PTSD literature it is clear that a trigger which is

construed by the individual to be life threatening is the precursor to the development of PTSD. There is no reason why this should not be the case for an individual who has been restrained in an acute mental health setting. These hypotheses may not have been examined due to the complexities of the issues for consideration. For example, a patient who has been restrained is likely to have an existing mental illness therefore defining whether restraint has then gone on to be a trigger for PTSD would be difficult to prove. The patient may have existing PTSD which has not been diagnosed, alternative diagnoses taking precedence. All of these complexities have implications for treatment and management of this group who may be involved in incidents requiring restraint. According to Bisson and Kitchiner (2003), there is a high level of psychological morbidity following accident and assault. Bisson and Kitchiner (2003) suggest that general health care providers, such as Accident and Emergency Departments, should be aware of this when treating casualties. The experience of restraint in mental health settings can be construed as assault. This too has implications for mental health care providers in terms of after care and has not been recognised within related literature.

2.3.4. The psychological impact of restraint upon staff

Needham et al (2005) conducted a systematic review and meta-analysis in relation to non-somatic effects of patients' aggression on nurses and highlighted that a number of studies have identified symptoms of PTSD in nurses. The conclusions made within this review were that nurses' reactions to aggression are complex, encompassing a broad spectrum of non-somatic reactions. They reported that the predominant effects of aggression towards nurses are those of anger, fear / anxiety, PTSD symptoms, guilt, self blame and shame. McKenna et al's (2003) study which examined newly

qualified nurses' experiences of threats and violence by patients, respondents identified common psychological consequences which included fear, anxiety, over-caution, mistrust and resentment.

In his American study, Caldwell (1992) examined the incidence of job related trauma, PTSD symptoms and PTSD among 300 staff at two mental health facilities. A questionnaire generated data related to how many had experienced traumatic events in the course of their work and how many had subsequently developed PTSD or PTSD symptoms. Across both sites, 7% (n=5) of non-clinical and 10% (n=23) of clinical staff qualified for a diagnosis of PSTD using DSM III-R (APA 1987) criteria. 24% (n=18) of non-clinical and 61% (n=137) of clinical staff had developed symptoms of traumatic stress but did not meet criteria for a clinical diagnosis. Caldwell (1992) concluded that one of the most hazardous work settings for employee mental health may be the local mental health facility.

2.3.5 Restraint and reawakening of traumatic encounters

Only four published studies have highlighted any link between being restrained and the reawakening of earlier traumatic experiences. Brase-Smith (1995) examined 4 American case studies and identified a link between earlier experiences of rape and the use of mechanical restraints. Although mechanical restraints are not used within the UK, the concept of the experience of restraint reawakening memories of earlier traumatic encounters may be comparable. Sequeira and Halstead (2002) interviewed 14 inpatients on a secure psychiatric hospital site in the UK. Their findings identified positive and negative consequences related to the experience of restraint. The positive findings were related to release of feelings and containment. Some of the negative

findings were related to the restraint being reminiscent of past physical or sexual abuse and that memories of these traumas were invoked. Bonner et al (2002) interviewed 12 staff and 6 service users about their experiences of restraint within acute inpatient services within the UK. 50% of participants reported that the experience of restraint had evoked memories of previous traumatic encounters; examples given included earlier experiences of sexual and physical abuse for patients, and previous traumatic incidents involving restraint for staff. Gallop et al (1999) interviewed 10 women who had a previous history of childhood sexual abuse and had recent experiences of being restrained and forcibly administered medication. These women described the experiences as dehumanising. They also recalled the experience as reminiscent of previous physical and sexual abuse, with one woman experiencing flashbacks of being pinned down for many months following the restraint. There is a need to examine this phenomenon further to identify whether it has any bearing upon current management of restraint.

2.4. Psychological explanations of traumatic events

The psychoanalytic view of the impact of traumatic events would be that understanding on the part of the enquirer could only be made through understanding the particular meaning for the traumatised individual (Herman 1992). The psychoanalytic approach emphasises the need for understanding of childhood experiences, as the experiences of early relationships shape the individual mentally and influence their future understanding of, and interactions within, their internal and external worlds (Bell 1998). Garland (1998) suggests that a severely traumatic event will undoubtedly stir up unresolved pains and conflicts of childhood. In applying this theory to the experience of restraint, an hypothesis would be that, if the experience is

perceived in a traumatic way to any party involved, the likelihood is that unresolved conflicts will be reawakened. This hypothesis is partly supported by Bonner et al's (2002) pilot study and Sequeira and Halstead (2002). While these studies did not aim to test this hypothesis, emerging data from the studies highlighted a link between the experience of restraint and the reawakening of earlier traumatic events. These events may not necessarily have been childhood experiences, although this was the case for some participants, and for others the reawakened events were of a more recent nature. The psychoanalytic approach to resolving psychic trauma would be to enable the individual to revisit some of these earlier conflicts. By revisiting these conflicts with the assistance of a therapist, the individual would be enabled to work through the conflicts to facilitate some form of resolution.

The cognitive model of PTSD highlights the manner in which the traumatic event is processed cognitively as an important consideration. Rose (2002) has suggested that distressing symptoms related to traumatic events arise from failures to adequately process traumatic memories. Ehlers and Clark (2000) have presented a cognitive model of PTSD in relation to how traumatic events are appraised. They have suggested that most people exposed to a traumatic event recover naturally over time, but that for individuals who go on to develop PTSD, the sense of threat (and hence autonomic and psychological arousal) in relation to the traumatic event remains current. Ehlers and Clark (2000) have attributed this to negative cognitive appraisals of the trauma made by the individual concerned. The result of these appraisals are that the individual comes to see the world as an unsafe place full of external threats or that they feel that they were somehow responsible for the traumatic event and that they attract danger. Rather than viewing common symptoms such as flashbacks as

natural, time-limited responses, the occurrence of these symptoms reinforces the subject's negative appraisals of events and strengthens their beliefs that their life has changed permanently for the worse. For example; following a terrifying road traffic accident, experiencing flashbacks may result in the victim believing that he is 'going mad' (reinforcing his internal negative appraisals). He may stop driving out of the belief that driving is no longer safe (external negative appraisal) reinforcing his avoidance behaviour and perpetuating his negative cognitions and behaviours. This cognitive theoretical viewpoint has achieved widespread acceptance in clinical practice in relation to PTSD and underpins most of the current cognitive treatment approaches in this field. In applying the above explanations of negative appraisals to the restraint situation, two factors should be considered. Firstly, given Meuser et al (1998) and McFarlane et al (2001) have reported that a high proportion of the inpatient population have an undiagnosed PTSD, it seems likely that the experience of restraint will contribute to patients developing further negative cognitive appraisals. If an individual has existing beliefs that they somehow attract danger or that the world is a dangerous place, experiencing restraint in hospital may well reinforce these beliefs. Secondly, it is not known how many staff or how many patients develop PTSD as a direct result of being restrained or applying restraint techniques. If the principles of the cognitive model in relation to PTSD are applied to the restraint situation, early screening and intervention may assist in the prevention of longer term negative psychological sequelae.

2.5. Post Incident Review and support

Post incident support is also highlighted within the literature as an area in need of consideration; however there are few guidelines as to what form this should take (Wright et al 2000). Nolan et al's (1999) study of nurses' and psychiatrists' experiences of violence in mental health care found that although both groups felt a need for after care support, few received any. The literature review found no published research regarding after support to patients, although Wright et al's (2000) policy review highlighted a failure to address this issue within the policies examined. As well as the previous areas highlighted by Wright (1999), post incident support is also highlighted within the literature as an area in need of consideration, however there are few guidelines as to what form this should take (Wright et al 2000).

Until recently, critical incident stress debriefing (Mitchell, 1983) had been used for a number of years in the immediate aftermath of disasters and a wide variety of common traumatic events. Within the PTSD literature, a number of controlled studies have examined this single-session debriefing approach following traumatic incidents (see for example Rick and Briner 2000; Rose et al 1999; Bisson et al 1997; Lee et al 1996). Rose et al's (2004) most recent updated Cochrane systematic review concluded that the outcomes of systematic psychological debriefing following a traumatic event are at best neutral, and in some cases harmful and should immediately cease. These studies seem to suggest that vividly reviewing and reliving terrifying experiences soon after they have occurred may re-traumatise the individual being debriefed thus effectively increasing the 'dose' of trauma they have experienced and consequently their risk of later developing PTSD.

Some authors have argued, however, that critical-incident stress debriefing still has a place in the management of the aftermath of traumatic events. For example, Irving and Long (2001) have published a small qualitative pilot study and argued that Rose and Bisson (1998) and Rick and Briner's (2000) reviews take an overly positivist stance by not considering the humanistic approach to psychological critical-incident stress debriefing. However, there is currently no available good quality evidence to demonstrate the safety or otherwise of the approaches advocated by Irving and Long (2001).

Caldwell (1992) highlighted that only 15% of clinicians included in his study had received any form of post-incident review. Also, the format of the reviews which had occurred had often been supervisory or disciplinary in nature rather than a supportive approach aimed at facilitating recovery from the trauma.

Some form of low-emotional intensity post-incident review may offer an opportunity to usefully review and revisit events but given that the term 'debriefing' is generally poorly defined and covers a heterogeneous group of interventions which may be administered in widely different ways and with widely differing components and approaches it is probably best avoided. Terms such as critical-incident analysis, critical-incident debriefing, reflective practice, and reflective supervision seem to be used almost interchangeably in mental health care depending upon the situation which is being reflected upon or on the events from which individuals are being 'debriefed', or on who is performing the intervention. The main purpose of all of these approaches, in whatever guise, is to reflect upon an event or situation as a means of

learning from that situation and effecting positive change where necessary. Within the study of restraint, although good practice would involve some form of post incident consultation for staff and service users, this does not always happen for staff (Nolan et al 1999) and is even more rarely offered to patients (Bonner et al 2002). There is currently no agreed format within the UK mental health care system (NMC 2002) or within the international literature as to how post-incident support should be provided.

Recent UK NICE (2005a) guidelines on the short-term management of disturbed / violent behaviour have recommended that some form of post-incident review should take place following untoward incidents. At an organisational level mental health provider organisations in the shape of NHS Trusts are responding to these guidelines with clearer methods of reporting being implemented. At a more local level (ie., in clinical inpatient settings), Post Incident Review remains a challenge with no published clinical models which consider the individual impact of restraint to staff or patients. Within forensic settings, structured clinical incident reviews are widely implemented but there remains a paucity of evaluative outcome research related to the benefits of the approaches used within these settings. Considering the findings of Rose et al's (2004) Cochrane review and the lack of existing literature related to review of the aftermath of restraint, it may be that a relatively informal and flexible approach is necessary. The wide varieties of possible approaches to psychological debriefing are clearly documented within PTSD literature (see for example Orner and Schnyder 2003); however within inpatient mental health care there are many blurred boundaries and a distinct lack of any evidence base.

Nhiwatiwa (2003) used a single-session educational intervention aimed at reducing distress in nurses who had been assaulted by patients in a study carried out in a UK private secure psychiatric hospital. The findings of this study were that participants who had received the intervention had higher levels of distress at three month follow up than controls who had not received the intervention. Nhiwatiwa (2003) has cautioned that his results should be interpreted with care because of the short follow-up period used. Nhiwatiwa has suggested that individuals do not necessarily all follow the same time-course for resolution of symptoms of acute distress. This means that while some nurses may reach a degree of resolution within three months of the incident, others may still be working through events psychologically at this point and still be experiencing distress. He has suggested that his intervention may have encouraged nurses to inspect and reflect on experiences which they may have otherwise set aside psychologically, resulting in more prolonged processing of the events and thus in higher levels of distress at the three month mark. Despite these intriguing observations, Nhiwatiwa's finding of increased distress in subjects who have received a one-off intervention following a traumatic event seems highly congruent with Rose et al's (2004) finding that such interventions are at best ineffective and at worst harmful.

An earlier pilot study conducted by the author (Bonner et al 2002) suggested that the outcomes of Post Incident Review in clinical settings are often very mixed. Outcomes range from the interventions being seen as genuinely beneficial for all concerned, to the other end of the spectrum where the interventions have been experienced as aversive, counterproductive and damaging. There is therefore a need to identify some form of consistent, beneficial, non-threatening approach which can be routinely

offered to all staff and patients who become involved in untoward incidents in psychiatric settings.

A structured, non-threatening post-incident review could be a method of acknowledging that an incident has happened, recognising what can be learned from the situation, and acting as a means to reverse the current lack of aftercare. This lack of aftercare affects both staff and more poignantly patients, who have been through what are always unpleasant and sometimes terrifying and damaging incidents. Such a consultation could also provide an opportunity to screen for early indicators of PTSD within this population. If, as Meuser et al (1998) and McFarlane et al's (2001) studies suggest, the inpatient population within the mental health system already have high levels of undiagnosed PTSD, it is crucial that this is recognised and appropriate services mobilised in the aftermath of untoward incidents to prevent mental health services damaging further those whom they exist to serve and protect.

2.6.Conclusion

The literature review has highlighted a number of areas which may influence the psychological impact of restraint. Using the search strategy highlighted in Section 1.1.1 enabled a wide consideration of studies which would have been missed using Cochrane systematic review criteria; therefore it has been helpful to expand search criteria to consider smaller qualitative studies. This has provided a rich source of material which has supported the mixed method approach within this study by providing sound background reading to underpin the research design, as well as further consideration of literature during the process of data collection and analysis. An in-depth consideration of how restraint is defined in Section 1.2.1. helped to

highlight the many grey areas which surround this area of practice and assisted in explaining some of the complexities and extremes which encircle restraint procedures. This was a good starting point from which to develop the discussion of literature.

Consideration of historical issues in psychiatric care provided a useful background to this study and assisted in highlighting how acute care and physical interventions have evolved over the centuries. Moving this discussion forward to consider the ramifications of closing Victorian asylums to provide a community focus to care highlighted that this has brought its own share of challenges to mental health nursing, particularly in relation to managing acute inpatient care. Despite a much greater evidence base to underpin interventions, the literature review has highlighted that training in restraint and management of violence remains an area which is fraught with inconsistencies and further research into physical interventions is warranted. A randomised control trial to examine the efficacy of physical interventions may be a way forward in addressing some of these issues.

Consideration of restraint, trauma and PTSD helped to provide an understanding of the potential psychological impact of physical interventions, and highlighted that PTSD is an area of mental health which is vastly under recognised in acute mental health care. Understanding the impact of traumatic events and the development of PTSD has highlighted the need to research further the psychological costs of such traumatic interventions as restraint to provide the best possible framework from which to address the consequences. While PTSD is under recognised in patient populations, this review has highlighted that issues for staff are also neglected. The psychological

impact of restraint for staff also takes its toll and there is a need to consider this further, particularly in relation to Post Incident Review and support.

This review has brought to light the potential for restraint to reawaken memories of previous traumatic encounters for both patients and staff. This highlights the need for great sensitivity during the decision making process particularly in relation to mobilising physical interventions. The act of restraint could well increase the dose of trauma to an already traumatised individual, resulting in either worsening of existing PTSD symptoms of development of PTSD as a consequence of the intervention. Even less is known regarding previous trauma in staff groups and there is a distinct possibility that staff working in acute mental health care may be carrying their own trauma histories which could be exacerbated by the use of restraint procedures. This also carries a risk to this group of retraumatisation. Furthermore, if staff are experiencing symptoms of PTSD they are surely placing the patients in their care at further risk.

Post Incident Review is an area which may address many of the issues highlighted within this literature review but there is very little evidence available to provide clear guidance as to how Post Incident Review should be implemented. This study aims to address this area while considering further the psychological impact of restraint for patients and staff in acute mental health settings.

CHAPTER THREE – RESEARCH DESIGN

"...I've never met a positivist..." (Wellman 2007, personal communication)

3.1 INTRODUCTION

This chapter will examine the design of the research project giving due consideration to traditional approaches to research as well as placing the project within the context of current mental health care. In section 3.2 the philosophical underpinnings of the approaches chosen will be discussed with analysis made in relation to the study. The research paradigm that was identified to support the study was a constructivist philosophy. Justification of this choice will be offered within the discussion of philosophical underpinnings. Alternative research paradigms will be discussed to provide comparative approaches to the research design, and defend the choices made. Section 3.3 will offer a discussion related to the methodology and methods of data collection. The chosen methodology was that of grounded theory and an in depth discussion of grounded theory and its application within this context will be offered. Strengths and limitations of the grounded theory approach will be considered, and justification made for this choice within this study. Methods of data collection will be highlighted with discussion and justification offered for the mixed methods approach that was adopted. The various methods of data collection which were identified to support the mixed methods design will be identified with supporting explanation of the choices made. Section 3.4.will present a detailed discussion related to how data was analysed using a grounded theory methodology. The application of thematic content analysis will be discussed in depth with examples of the process followed within this study relating to the analysis of transcribed interviews. A study of this nature requires detailed consideration of the ethical issues which may impact upon participants. Section 3.5 will offer a discussion of the complex ethical issues which

impacted upon the study design and implementation, and ways of addressing ethical issues will be presented. Section 3.6 will conclude the chapter and summarise the research design which was applied to the study.

3.2 PHILOSOPHICAL UNDERPINNINGS OF THE STUDY

I had to consider within which research paradigm I believed most appropriate to examine my question. According to Patton (1990, p.37) a research paradigm is "..a world view, a general perspective, a way of breaking down the complexity of the real world" . There are a number of paradigms in research, each offering alternative perspectives to consider your question (Parahoo 2006; Cresswell 2003; Polit and Hungler 1997; Patton 1990). Each paradigm has a philosophical stance in relation to how the world is viewed. I had to identify my own philosophical stance in relation to the area I intended to study and which approaches or methods would support this stance. In their discussion of inquiry paradigms Guba and Lincoln (2000) highlight three philosophical considerations: the ontological question; the epistemological question; and the methodological question.

The ontological question concerns the nature of reality and what can be known about it. The inquirer seeks to question what we know about this (assumed) reality and how it functions. Norton (1999) describes ontology as the study of being. She describes the ontological view of being, in relation to whether reality is viewed as external to the individual or a product of the individual's consciousness. The external view of reality would complement quantitative approaches to research in that reality is a measurable, observable fact detached from the researcher. The ontological view of reality being a product of the individual's consciousness would support qualitative

approaches to research in that reality cannot be viewed as separate from the individual, and that the researcher would interact with the subject of examination. The epistemological question refers to the relationship between the researcher and the 'real world'. Epistemology concerns the nature of knowledge. Researchers views of the nature of knowledge influence choices of methodology and method. If knowledge is perceived as hard and tangible, quantitative approaches to methodology would be adopted. If knowledge is perceived as subjective, personal and unique, then qualitative approaches would be adopted (Norton 1999). Within a quantitative research design ontological and epistemological stances would be viewed separately. The positivist ontology views reality as driven by laws which are context free and generalisable. The investigator and that which is being investigated are independent. Conversely, in qualitative designs, ontology and epistemology would merge because the knower cannot be separated from the known within the overall construction of a particular reality (Norton 1999). Guba and Lincoln (2000, p108) suggest that if reality is assumed (the ontological question) then the researcher must present "objective detachment" in order to examine that reality. If the researcher has an assumption of reality then he or she must have some preconceived ideas, values and judgements within his or her constructions of that reality. Objective detachment cannot therefore be guaranteed. The methodological question concerns how the researcher gathers information to examine his or her question(s). Guba and Lincoln (2000) suggest that the preferred methodology would be driven by assumptions of reality (ontology) and the relationship of the researcher (epistemology). The methodology would consider methods to address issues of objectivity and objective information gathering within the design. The chosen methodology and method to support this study will be discussed later in this chapter.

In examining research paradigms there are a number of different terms used by a variety of competing professions, often for similar stances, which can further confuse the debate (Daly and McDonald 1992). Within health care research, considerable reference is made to Guba and Lincoln's (2000) description of research paradigms. Guba and Lincoln (2000) describe the different paradigms as positivism, post-positivism, constructivism and critical theory.

Positivism (or realism) is rooted in the quantitative research camp. The ontological underpinnings of positivism are that reality is driven by unchangeable laws and that reality is time and context free. The epistemological belief underpinning positivism is that the researcher is objective and detached from what is being researched. Strategies are used to prevent the researcher influencing the study and thus a 'true' exposition of reality is made. The methodological underpinnings of positivism are that hypotheses are tested by a devised framework using tried and tested data collection methods. Experimental hypotheses are identified in advance and are tested empirically to support or disprove them (Field and Hole 2003; Stangor 2004; May 2001). Manipulation is introduced to prevent confounding influences contaminating the process. An example of the positivist paradigm would be the randomised control trial where a specific drug may be researched for cause and effect. One could question the claim that the researcher is truly objective and detached. If the researcher is using manipulation to prevent confounding influences, surely these interventions have some bearing upon the 'true' exposition of reality that is being sought? Although positivism espouses the detached role of the researcher, the researcher influences the research design to prevent confounding variables and this is contrary to the stance that

the researcher is truly detached. No data is self interpreting and the numbers that are generated through positivist approaches still have to be translated. Many would view quantum mechanics as the purest form of the positivist paradigm however, as Brooks (2007, p32) has suggested, "..we now have to face the possibility that there is nothing inherently real about the properties of an object that we measure...measuring these properties is what brings them into existence". Observations underpin these processes and some acknowledgement needs to made in relation to the influence of the researcher when using the positivist approach. Post-positivism, while still adopting the principles of positivism, accepts that objective reality may not be completely governed by universal laws. While allowing for limited researcher interaction, post-positivism denies any influence or subjectivity on the part of the researcher (Guba and Lincoln 2000).

Constructivism is rooted in the qualitative camp of health care research, although according to Appleton and King (1997) this paradigm has only received limited discussion within the literature until recently. As opposed to positivism, constructivism seeks to uncover truth in a contextual sense (Guba and Lincoln 2000). Norton (1999) describes the constructivist paradigm as mental constructions that are formed by individuals and that 'social reality is reproduced by social actors' (p.34). The underpinning ontology is that truth does not happen in isolation, that realities are formed through a number of constructions formed interactively, and that views of the world can be influenced as a result. The epistemological approach underpinning constructivism is that the researcher interacts with the research subject and that this process assists in uncovering truth. The methodologies used in constructivism are in interpreting meanings to create shared understanding (hermeneutics) and in seeking

conflicting views to build up a wider contextual understanding. Theory emerges from the data (inductively) as opposed to theory or hypotheses being tested for cause and effect in the reductionist approach of positivism (Field and Hole 2003; Stangor 2004; May 2001). This description appears simple at face value and recognises that the researcher can play an important role in unravelling a contextual understanding of the research topic. A concern regarding this approach would be in relation to how this process can claim to offer a 'true' representation of reality when the philosophy acknowledges that the researcher plays a part in influencing the generation of fresh insight. The process of generating 'truth' through the constructivist approach should be made explicit to the consumer (ie., the reader) of that truth to consider whether the representations which are being made are relevant and acceptable to the arena in which they are being presented.

Critical theory challenges the assumptions of the previous paradigms discussed. Critical theory adopts a similar ontological approach to post-positivism in that it views reality as objective however the critical theory stance suggests that this reality has been influenced by a variety of social, political and cultural factors. Over time these influences have been accepted as reality however they may not necessarily represent a true reality. The epistemological approach of critical theory is that the researcher plays a fundamental role in influencing the researched in a subjective way. Critical theorists observe social contexts of society and dominating trends which influence communities (May 01). The methodology is aimed at transforming the subject area through emancipation. An example within mental health of this approach would be the anti-psychiatry movement of the sixties predominantly influenced by Thomas Szsaz (1961). At a similar time Goffman (1961) observed the

community of the psychiatric asylum and offered seminal observations around institutionalisation within these communities. More recently, Morrall (2001) has commented upon the dominance of the medical model within mental health in Western society. He has examined how this model has evolved over the centuries and continues to this day as a method of containing 'madness' within society. Patterson (2006) supports this description of psychiatry influencing social control over deviant behaviours and asserts that a cultural shift is needed to address current Western views of mental illness. Morrall (2001) and Paterson (2006) assert that such shifts must be addressed at government level through changes to social policy. The dominance of the medical model has created a tension for mental health nursing in the split between the role of therapist and incarcerator. The therapeutic role of the nurse holistically considers the complexities of the individual and the contexts in which they have found themselves needing psychiatric care. The incarcerator role of the nurse is in opposition to the holistic approach whereby the nurse plays a key part in containing and controlling deviant behaviours through providing custodial care for individuals within the positivist medical model. Bowers et al (2007) have provided examples of how this tension can be addressed through creating low conflict, high therapy environments, changing current cultures within acute mental health care.

Cresswell (2003) examined quantitative and qualitative paradigms from similar perspectives but developed the discussion further to provide a philosophical standpoint related to a mixed method approach. Cresswell (2003) discusses the elements of quantitative enquiry from a post positive viewpoint and echoes Guba and Lincoln's (2000) consideration of the reductionist, cause and effect view of reality. Cresswell (2003) discusses the social constructivist knowledge claim of the

qualitative stance, with emphasis being given to the examination of the nature of reality through open ended questioning to understand the setting and context of the community being studied. Cresswell's (2003) discussion of advocacy and participatory knowledge claims concur with Guba and Lincoln's (2000) discussion of critical theory. Emphasis within both discussions highlights the emancipatory dynamic which challenges social and cultural views of reality to effect change.

In considering my research question in light of the above research paradigms, the constructivist vantage point supported my personal beliefs regarding the philosophical approaches towards the study as well as providing a scientific stance as a starting point to develop the project further. From an ontological perspective, the nature of my study was to examine individual experiences of two groups of people (staff and service users in mental health settings). The constructivist paradigm supports the humanistic approach and recognises the social and experiential nature of the human subject. By adopting an alternative approach such as positivism or post-positivism I would be accepting that human beings are a predictable entity. I had hypotheses which I aimed to test, however the nature of events that I hoped to study were unpredictable and thus was in opposition to the positivist paradigm. While I admired the concept of critical theory and emancipatory research, my aim was not to challenge socially constructed realities of mental health care. Rather, I wanted to seek further understanding of how that reality was viewed by different groups and individuals. From the literature review and earlier pilot study (Bonner et al 2002) I had established a need to examine the aftermath of restraint in more depth. I had identified that Post Incident Review was poorly addressed and that the experience of restraint may have complex psychological consequences which may be linked to PTSD. There was a

need to examine what could be helpful in addressing these problems. While my study would be using a constructivist philosophy to examine the qualitative experience of being involved in restraint, I also had an opportunity to identify whether a structured Post Incident Review was a helpful approach to overcoming some of the issues identified within the literature review and pilot study. I could apply a quantitative approach to evaluate whether the Post Incident Review was a helpful and effective tool for clinical practice. Furthermore, I was keen to establish whether participants in my study warranted further screening for PTSD. By introducing a screening questionnaire related to this aspect of the study, I could collate quantitative data to examine this area. Using a mixed method approach would support the qualitative nature of the constructivist paradigm while allowing flexibility to include additional methods of quantitative data collection. These additions to the design would enhance the study and establish the value (or not) of Post Incident Review, as well as identifying whether the participants did warrant further screening for PTSD. A wider discussion of the methodology and methods of data collection used to support the research design will now be considered.

3.3 METHODOLOGY AND METHODS OF DATA COLLECTION

The confusion evident within the research paradigm debate continues within the methodology / method debate with both terms often being used interchangeably (Guba 1990). For the purpose of this study Guba's (1990) approach has been adopted with methodology and method being identified as two complementary approaches to research design. According to Guba (1990) methodology concerns the process of gathering knowledge to explore the research topic and method involves techniques

used in generating data to support the process, for example research tools such as questionnaires.

I had identified my research paradigm as a constructivist approach and considered some of the methodologies which support the philosophies of the constructivist paradigm (Guba and Lincoln 2000; Appleton and King 1997). There are a number of methodologies which support this paradigm, for example phenomenology, ethnography, case study and grounded theory (Strauss and Corbin 2000).

Phenomenology focuses upon the interpretation of the experience of the individual. The aim of phenomenology is to enhance understanding of the ways in which people understand their world view, and their relationships within that world (Parahoo 2006). Two main schools of phenomenology have been influential within health care research. Husserl, a German philosopher, investigated consciousness as experienced by the research participant, the aim being to gain wider understanding of how the individual experiences their world. Heidegger, a student of Husserl, developed the hermeneutical approach. This approach not only examined the experience of the participants, but considered how they came to experience phenomena in a particular way. Heidegger took into account social and historical conditions in relation to the experiences of research participants to enhance understanding further. A phenomenological methodology can be a useful approach when examining phenomena which have been poorly defined within literature and which lack conceptual frameworks (Polit and Hungler 1999).

Ethnography involves observation and examination of the behaviour of individuals within their natural environment. Ethnography considers that people are influenced by the cultures in which they live, and that shared meaning of their world view is derived from the cultural group. The ethnographer studies these cultures from within, being an active participant within the group. The ethnographer immerses themselves within these cultures and represents the shared view of these cultural groups to others. In health care ethnography is a useful approach to examining different environments to gain understanding of the social realities of these groups (Silverman 2005).

The case study approach to examining a research problem can allow in depth examination of discrete areas of practice to generate rich depth to the study (Patton 1990). A case study as a research methodology "explores a single entity or phenomena (the case) bounded by time and activity (a programme, event, process, institution or social group) and collects detailed information by using a variety of data collection procedures during a sustained period of time" (Cresswell 1994, p12). A case study provides a snapshot of a particular area of study and may involve in depth examination of one 'case' or a number of 'cases' within a particular environment. The earlier pilot study (Bonner et al 2002) had used this methodology to examine a number of cases within an acute setting during a set period of six months and provided a snapshot of staff and inpatients experiences of restraint.

Smith and Biley (1997) suggest that grounded theory is best used when little research in the subject area is available or when existing theory fails to resolve persistent problems. Grounded theory involves generating theories from the informants (participants) of the study. This emergent theory is then used as a basis of

comparison with other theories or as fresh discovery (Strauss and Corbin 2000; Cresswell 1994). Grounded theory seeks to collect and compare data which is examined and refined to identify emergent categories. Different subject groups can be used to generate the data which can then be compared and contrasted to generate new understandings of reality. While grounded theory can offer a more structured approach to qualitative research by using *a priori* theoretical frameworks, emphasis is given to the inductive approach to knowledge generation and data should not become too restricted by the design (Cresswell 1994). Glaser (1992) warns against being too specific at the outset of a grounded theory design. Too much structure can restrict the researcher by suppressing real emergent phenomena from focus. Recognition of the emerging dialogue between the researcher and the participant is given as opposed to the detached objective testing of a hypothesis discussed within the alternative paradigms earlier. Grounded theory can be criticised as subjective. If the researcher is engaging in a dialogue with the participant, he / she is entering into the relationship with his / her own view of reality based on his / her own previous experiences. Concern arises regarding how these views can taint the process either through influencing the participant or in the interpretation of results. It is therefore important to consider how these concerns can be addressed through the design of the study to ensure that the researcher maintains an objective role within the process.

Aspects of these methodologies can overlap and description by different theorists can offer conflicting views (Dzurec and Abraham 1993). The conflicting views reflect the confusion within nursing research in general and can be off putting to the novice nurse researcher resulting in avoidance of research activity (a difficulty in implementing the current drive for evidence based practice). There were aspects of all

of these approaches which would assist me in examining my research question however grounded theory appeared to offer the most comprehensive methodology to develop my study. I had used a case study approach to support the earlier pilot study which would underpin this current study. A grounded theory approach would enable me to develop the insights gained in the earlier study further to generate a much wider examination of the experience of restraint. This methodology would offer fresh material for consideration within this area of mental health care.

In developing the grounded theory approach to this study I asked myself a number of questions related to the process of gathering knowledge; who would collect data (researchers); who did I want to gather data from (participants); where would the research take place (single site or multi-site); what other considerations needed to be made to support my methodologies (supervision, ethical requirements, Trust and University regulations).

From these practical considerations I was able to develop a framework to assist me in formulating my thoughts and ideas (figure 1).

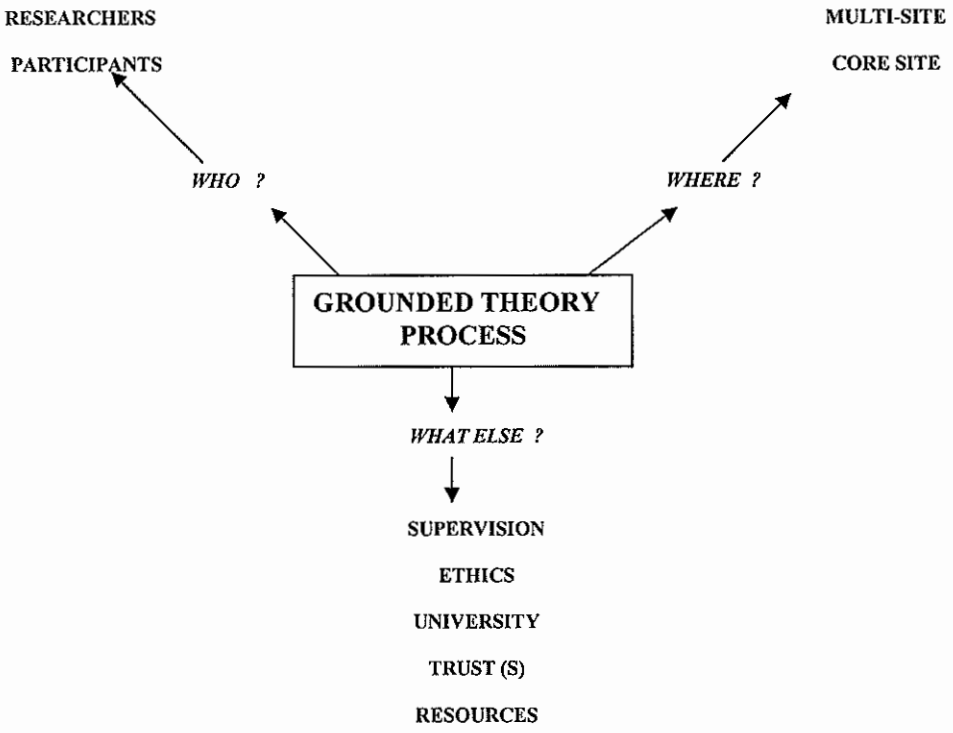

Figure 1. Grounded Theory Process

The framework assisted me in considering the practical requirements of gathering my data in depth. In considering the 'who' questions of my framework, I hoped to interview staff and patient participants to provide a wide exploration of the psychological impact for both groups. I was aware that I was likely to have more access to nurses than other disciplines and considered that nursing staff had more day to day interaction with patients. Nurses were also trained in control and restraint procedures and were therefore more likely to be involved in situations of restraint. Deciding upon how many participants should be interviewed in a study of this nature was also a challenge. Strauss and Corbin (1998) place emphasis upon the number of

participants being less important than the quality and depth of the examination to develop grounded theory. Qualitative methods consider that the sample size has been reached when the emerging data becomes saturated, in other words when no further insights can be gained from the emerging data. In small case study research this may be as little as one participant (Parahoo 2006). This approach poses a challenge to the researcher who has limited time and resources available. Cresswell (2003) suggests that researchers may set a timescale during which data is collected with a cut off point when data analysis should be completed. In terms of who should gather the data, I had no additional resources for data collection although I did have the support of two colleagues for data analysis. I calculated that my time schedule would allow me to personally interview 60 participants based on an average 45 minute interview over a period of twelve to eighteen months. This would allow for some flexibility within my schedule to accommodate unforeseen circumstances, for example sickness or difficulty in recruiting participants. The earlier pilot study had involved eighteen participants of which 50% had experienced memories of previous traumatic events during restraint. Using this larger sample would allow me to explore whether this high number of reports of reawakening of traumatic encounters would be supported in the wider follow up. The 'where' question allowed me to consider the research site. The design was for the study to take place in one NHS Trust in the South of England. I considered the wider context of this question, for example, how many clinical areas within the site, issues regarding liaison and access, and storage of data. 'What else' encouraged me to think about other aspects of the study. I would require supervision for the study by experts within the area that I was examining. Dunleavy (2003) discusses the role of the supervisor and emphasises the need to identify appropriate individuals at an early stage. I was fortunate to be offered the support of two experts

in the areas of research and PTSD at the early stages of the study design, and their support has been invaluable. Ethical issues required thorough examination and exploration. In using this framework I identified that a sub-section within this chapter ought to be devoted to ethical issues to convey the extent to which they had been considered. In terms of University regulations, I had to prepare a proposal for entry into PhD study as well as complete separate University ethical approval. These were completed and approved in Spring 2004. Consideration of the Trust encouraged me to look at more practicalities regarding the study in action. As I was not a Trust employee, an honorary contract had to be negotiated. This took some time to organise and had I not anticipated this early on in the study design, I could have been held up at a crucial stage in data collection later on. I thought carefully at this early stage about resources. I considered a clear plan in terms of time, which was being supported by my employers. At this stage I considered that my time commitments would allow me to interview 60 participants by myself and I had negotiated some administration time to assist in transcribing recorded tape interviews. This simple framework was helpful to me in considering my study in depth before going on to data collection, when some of the obstacles that I was able to anticipate at this stage may have hampered the process.

Methods (or techniques of gathering information) to support the methodology must be carefully considered. Cresswell's (2003) mixed method approach highlights the benefits of combining different methods of data collection. Multiple approaches, such as survey data (quantitative) and interview data (qualitative) can be used within one study. Cresswell (2003) acknowledges the strengths and weaknesses of both quantitative and qualitative designs and suggests that by using a combination of

approaches, these methods could complement each other by providing a contextual examination through qualitative methods, and a supplementary robust examination of measurable elements which could be analysed using quantitative techniques. These approaches have been used infrequently since the 1960s in the social sciences and have only recently gained momentum as a method of combining a variety of techniques of data collection and analysis. Also known as multi-methods, convergence, integrated, and combined methods (Cresswell 1994), there are three general strategies which can be applied with a number of variations within those strategies.

Sequential procedures involve beginning with one method such as a qualitative interview approach for exploratory purposes, followed by a quantitative method such as a survey based upon the earlier qualitative responses., or vice versa. Concurrent procedures enable the researcher to collect both qualitative and quantitative data at the same time within the study in order to build up a comprehensive picture of the problem being examined. The analysis of the methods of data collection is then integrated within the results. Transformative procedures involve the researcher using a theoretical lens approach to construct a picture of the area being studied. The lens has an overarching view of the topic area and data collection within the study may involve both sequential and concurrent approaches, depending upon changes made within the emergent analysis. All of these mixed methods procedures support the constructivist paradigm and grounded theory methodology, by allowing the researcher to interact with the participant and allow a variety of approaches and flexibility to consider emergent data both inductively and deductively. This study was examining

the qualitative experiences of individuals in the aftermath of restraint using a constructivist philosophy and grounded theory methodology.

The main approach was to use a semi structured interview to elicit in depth qualitative accounts of experiences. The interview questionnaire served as a simple format which may prove to be an effective clinical framework to review the aftermath of untoward incidents. To this end, the semi structured interview would serve a dual purpose. Firstly it would provide a format for gathering qualitative data through the interview process and secondly, participants would be asked whether this format was viewed as a helpful approach to address Post Incident Review. An evaluation form was designed to gather measurable responses using likert scales to ascertain whether this format was viewed as helpful in addressing Post Incident Review by the participants. The evaluation would be completed voluntarily at the end of the interview by the participants individually.

Early screening for PTSD was also identified as an area worthy of further investigation within the literature review and pilot study, and there was opportunity to gather related supplementary data to add depth to the study. These data could be analysed using simple descriptive statistics. Using a concurrent procedure within the mixed method approach would generate a variety of data which, if carefully considered, could provide a wealth of new understanding to this area of mental health care.

The research design of the study is summarised in table 2.

Research paradigm	**Constructivism**
Methodology	**Grounded theory**
Method	**Mixed methods**

Table 2. Summary of research design

A semi-structured interview questionnaire in the form of a Post Incident Review (appendix 5) was identified as the most appropriate method of data collection to support the qualitative elements of the study. The semi-structured interview was suitable for a number of reasons. There were specific research questions which I hoped to explore. However, the nature of the inquiry was to explain individual experiences and eventually form some common understanding. The Post Incident Review would allow for some structure within the process while providing the opportunity for relevant issues to be explored in more depth. The first part of the review was generated by an earlier pilot study (Bonner et al 2002) and examined events leading up to the incident, the incident itself, what was helpful and unhelpful in relation to the incident, and issues that may have been dealt with differently. This formed part A of the interview questionnaire and was the basis for the Post Incident Review. The Post Incident Review was based upon the earlier themes identified within the pilot study and I believed that revisiting these themes on a larger scale would allow further exploration of the original issues raised. The difficulty with using this approach was that these questions could be viewed as too leading and restrictive, which does not fit well with generating grounded theory. On balance, I decided that it was important to examine the issues raised from the earlier pilot and using this format would enable me to do this in more depth.

I shared the draft Post Incident Review format with clinical colleagues in the acute setting where the study would take place and they raised no objections to the questions. One ward manager remarked that the Post Incident Review questionnaire would be a clear guide for Post Incident Review in practice as these were the types of questions that she would expect and want to be asked during a Post Incident Review. This prompted me to consider that I had an opportunity using this format to ask the participants following the interview whether this was a helpful approach to post incident review. I therefore designed a simple evaluation questionnaire rated on a likert scale (appendix 10) which would enable me to ascertain whether this was a helpful way to review incidents for staff and patients. The dual purpose of this approach would be clearly explained to participants and it would be stressed that participation in interviews and completing the evaluation would be voluntary, and that they could withdraw from any part of the study at any time. If this format was evaluated positively it would be offered as an evidence based effective framework for clinical practice, a model which could be used to review incidents for staff and patients which would address the current lack of Post Incident Review highlighted in Chapter One.

The responses to the prompts used within the Part A Post Incident Review framework would be analysed qualitatively using thematic content analysis procedures. This would support the constructivist philosophy to build up a contextual picture of the participants' experiences and contribute to developing the grounded theory methodology employed within the study. In addition to the questions being evaluated within the Post Incident Review, a question was asked in relation to whether the

incident had been reminiscent of any other previous traumatic or upsetting encounters. If the participant responded positively to this question, a number of other questions were then asked to examine this aspect in more depth. This formed Part B of the interview questionnaire. This second part of the semi-structured interview would be analysed qualitatively to address the second research question which related to experiences of restraint reawakening memories of previous trauma.

On further discussion with my supervisors, we considered that perhaps it may still be possible that individuals who deny the reawakening of trauma may then go on to describe the experience on further review. A compromise was thus agreed that the initial Post Incident Review would form the questionnaire for all participants (Part A). A question would be asked regarding reawakening of previous traumatic experiences and if the participant reported that they had experienced this phenomenon, further structured interview questions would be asked to elaborate upon the experience (Part B). If the participant denied the phenomenon, opportunities for any further feedback would be offered and then the interview would reach a conclusion. I considered that perhaps I may still elicit responses from individuals who denied experiencing reawakening of earlier trauma but may then go on to discuss this. If this was the case, these responses would be included in the analysis of the data.

Process and exit points for participants are outlined in figure 2.

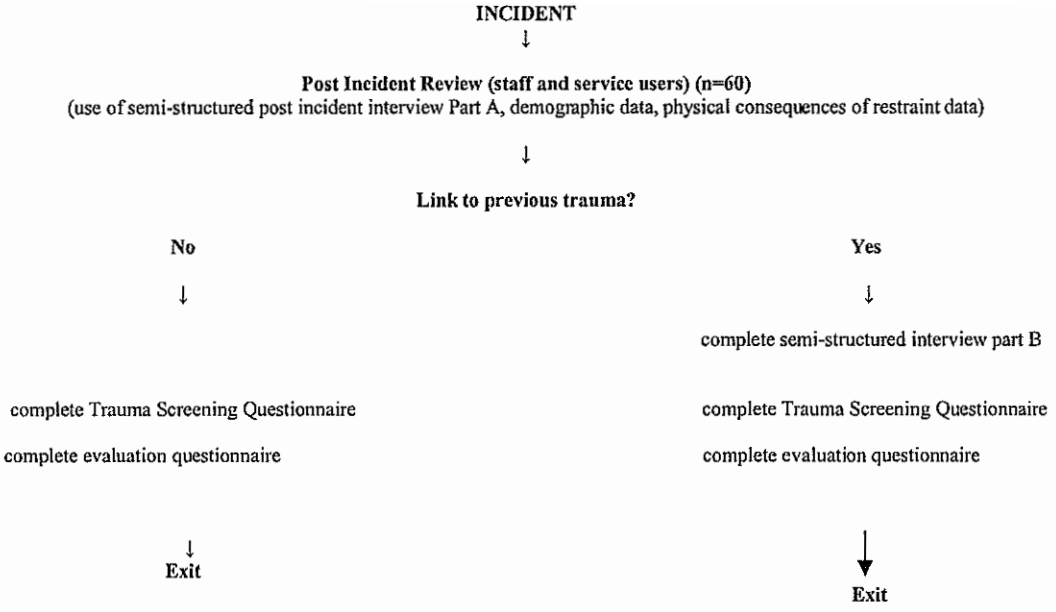

Figure 2. Process and exit points for research participants

Demographics such as length of experience, training in control and restraint methods for staff, gender and ethnicity for both groups, and Mental Health Act status for patients were gathered in order to elicit any relevance to the study from both patients (appendix 6) and staff (appendix 7).

A record of the physical consequences of restraint was adapted from the Staff Observation of Aggression Scale (SOAS) (Palmstierna and Wistedt 1987) (appendix 8). The SOAS is a tool which quantifies the nature and extent of aggressive incidents in mental health settings. This scale is a frequently used research tool in evaluating aggression in mental health settings. The scale consists of five sections which evaluate provocation, means used by patient, aim of aggression, consequences for the

victim, and measures to stop aggression. The consequences for the victim section categorises physical effects upon the person of aggressive incidents. This section was used for this study with additional sections added to address type of restraint used, length of restraint, and use of medication. These data were gathered to build a quantitative element of measuring the physical impact of the incidents for staff and patients. It has been discussed within the literature review that restraint techniques are far from perfect in current mental health care and this was an opportunity to help inform and expand this debate with tangible data related to the physical consequences. For the purpose of this study the SOAS was adapted, with the physical effects of aggression section being used to classify physical consequences in order to establish a picture of the severity of the incident itself and compare the nature of the incidents throughout the study. In addition, a record of type of restraint, length of restraint, and use of medication was introduced. These additions would help to identify whether there were any patterns related to the physical effects of restraint and would be mindful of some of the recent guidelines issued in the UK (NICE 2005a). For example NICE (2005a) guidelines for management of violence and aggression recommend that restraint should last for no longer than twenty minutes in the prone position. This element of data collection would provide evidence related to whether these guidelines were being routinely followed in practice.

A key issue in measuring psychological trauma is related to timing of assessment and intervention. In the field of PTSD, a variety of screening tools are available, however these measurements are not indicated for use within four weeks of the traumatic event. The reason for this time lapse is that results of screening within the four week period are unreliable because of natural reactions to the stressor. It was, however,

necessary to establish some measurable understanding of the impact of the event upon individuals. As no such measurement has been available for this specific quest, the Trauma Screening Questionnaire (TSQ; Brewin et al 2002, Appendix 9) was identified as a tool which would suit this purpose. Acknowledgment is made that this is not the original intended use of this tool however, with the agreement of the author of the TSQ; it was adopted for the purpose of identifying participants who may warrant further screening for PTSD. The TSQ would not be applied to participants who had been restrained less than four weeks previous to the research interview and if this was the case, subsequent arrangements would be made to complete the TSQ after the four week period. The TSQ (Brewin et al 2002) is a ten point check list used in the arena of PTSD screening and can be used to assess current symptoms of PTSD. The TSQ does not assess PTSD *per se,* rather it identifies whether an individual warrants further screening. The TSQ is a simple yes or no check list related to symptoms and if six or more positive responses are highlighted this indicates that further screening should be considered. The TSQ focuses upon symptoms of re-experiencing of the event and arousal symptoms. Lu and Shen (2002) have criticised the properties of the TSQ as it does not address avoidance and numbing symptoms, part of the DSM IV (APA 1994) criteria. In defence of this point, Brewin (2002) has highlighted that the TSQ was designed as a practical screening tool, and not a diagnostic tool for PTSD. For the purpose of this study, a simple screening measure was required and the TSQ supported this aspect of the research design adequately. The TSQ is indicated for use in acute settings such as primary care and liaison but is not in routine use in management of the aftermath of restraint in mental health settings. The clinical cut off point for this instrument is six or above positive responses. Current best evidence (NICE 2005a) advocates that assessment for PTSD

is not indicated within the first four weeks following a traumatic event, the underlying principle being that a natural healing process usually happens within this period and early intervention can potentially worsen symptoms. The TSQ would not therefore be used until a month or more following a traumatic event, and watchful waiting is the approach promoted in the early weeks following traumatic exposure. This raises some conflict in relation to the aftermath of restraint. At present, there is not enough available evidence which would suggest that being a participant in restraint is necessarily a traumatic experience. The literature review has suggested that there is some evidence that the experience of restraint can have severe psychological impact. Current evidence regarding whether the impact includes subsequent PTSD remains untested and screening is not routinely offered following restraint incidents. Best practice guidelines in prevention and management of violence and aggression in mental health settings (NICE 2005b) advocate some form of Post Incident Review, preferably within 72 hours of an untoward event taking place, whereas PTSD guidelines (NICE 2005a) indicate a much longer period as discussed. These polarities must be considered in more depth to examine the complex factors which played a part in the decision making process underpinning this study. In appealing to the guidance of NICE (2005b) regarding management of violence and aggression in mental health settings, the underlying principles are in relation to risk assessment and management. Good practice would include thorough risk assessments following untoward events to identify any failings / good practice in the process. NHS Trusts now have a reporting system whereby serious untoward incidents are recorded at the very highest levels. There is, however, a gap in relation to 'less' serious untoward incidents. The waters are muddied by the subjective appraisal of serious untoward incidents and the interpretation by practitioners regarding the seriousness (or not) of incidents. That is

not to say that good reporting systems are not in place. Certainly within the research sites considered within this study, sound systems appeared to be in place with some training offered, however clinicians still lacked agreement regarding the scale of seriousness. For example, the ethos in one ward was that any incident of aggression including verbal abuse would be formally recorded through available mechanisms. On another ward in the same site, verbal aggression tended not to be recorded on incident reporting systems for the sake of avoiding lengthy paperwork. It would appear that there is organisational drive to address the aftermath of incidents but there are gaps between organisational goals and more local practices. Post Incident Reviews which are tailored to consider the 'less' serious incidents are not used in routine practice. The psychological impact of these less serious incidents could well be missed if reviewing the aftermath of incidents such as restraint in clinical areas does not happen. The primary aim of this study was to examine the aftermath of such incidents and consider a way forward in Post Incident Review. It was necessary to try and consider what the psychological impact may be using tested tools. With the permission of one of the authors of the TSQ, this tool was used to identify whether staff participants in this study may be exhibiting symptoms of PTSD following experiences of restraint. This was used with due respect to the values and limitations of this tool in the areas indicated for its use. The tool was used to try and gather some clear form of data which may identify whether PTSD symptoms played a part in the aftermath of restraint. I was mindful of the potential for harm and re-traumatisation, and used the tool under close supervision of one of the authors of the TSQ.

At the end of the interviews participants would be asked to complete an evaluation questionnaire (appendix 10) independently and this data would highlight whether the

use of the Post Incident Review format offered as part of the study would be a helpful approach to offer as a model for clinical practice.

A focus group can be a useful way of gathering primary and supplementary data for a study for a variety of reasons. A focus group can be a starting point in developing ideas and as a method of confirming validity of qualitative material already gathered (Strauss and Corbin 1998; Cresswell 2003). For example, in generating a definition of restraint in the original pilot study (Bonner et al 2002) a focus group was organised to discuss the meaning of restraint for different practitioners. A rich discussion took place which helped to illuminate the concept of restraint and what it meant to different people. Preconceived ideas were challenged in a healthy debate, and the result was a definition agreed by consensus which underpinned both the pilot study and the current study. A focus group can also generate ideas and offer useful feedback to a researcher during the process of research design. For this study I was keen to adapt the original framework for Post Incident Review as I had found it helpful in the pilot study and participants had reported to me that they had found the process helpful, and for some therapeutic. I therefore arranged to meet with a small group of clinicians very early on in the design of this study to generate some discussion around the framework that I hoped to use. After discussion, some of the more repetitive parts of the framework were removed and the framework in appendix five became one of the methods of data collection to support the study, as well as the format proposed for a clinical model for Post Incident Review. The original study design had not included use of staff focus groups at a later stage in the study; however it became necessary as data collection progressed to consider use of a focus group both to supplement the staff data and to validate some of the early findings. The main reason for supplementing the interview

data was related to recruitment of staff participants. The Trust in which the study took place has three large inpatient facilities whose staff and patients would have fitted inclusion criteria. I spent many months before the start of data collection visiting the various practice areas to inform staff about the study that was being planned. I attended meetings to explain the aims of the study and to offer further information for staff both in terms of their own involvement, and in consideration of recruiting patient participants from their clinical areas. Staff were supportive at these meetings and appeared keen to engage with the work offering very few questions or concerns to me. This had been in contrast to the earlier pilot study when I had done similar networking but had found staff much more challenging of my intentions. In the pilot study the same staff who had challenged me had subsequently embraced the study and offered support throughout. I had expected similar responses for the current study and was initially pleased at the positive responses that I was receiving. Unfortunately the early enthusiasm for the study was short lived, particularly on two of the older sites within the Trust. This could have been for a variety of reasons. I had never been based on either of those sites therefore staff did not know me as well as staff on the other site where I had a presence. I believe that this presence did help with prompting staff at times, for example on a number of occasions I would be in a corridor or canteen and the sight of me would jog staffs' memories. This often resulted in a subsequent visit to their clinical area to interview another participant. I actively pursued other areas by arranging more visits to practice where I would again be assured of support which was subsequently not forthcoming. As data collection steadily increased on one site while trickling from the others I was becoming increasingly concerned that my participant groups were not going to be representative of the whole Trust. After discussion with my supervisors I considered the additional

strategy of arranging for a focus group of staff from the least represented area in order to supplement the data that I had already collected. This was also an opportunity for me to validate some of the early data that was emerging by presenting some of the tentative themes back to clinicians for feedback which may support or refute the emergent data. I was aware that I was already immersed in the other data and was apprehensive that I may be subjective in my facilitation within the group. I therefore asked an academic colleague to co facilitate the group with me in order to address this concern. My colleague was also agreeable to taking field notes and assist with the content analysis of the group discussion at a later date.

There was potential for a blurring of roles between researcher and practitioner. In my role as researcher I was gathering my interview data within the confines of the design and aimed to maintain an objective approach within this design. I was also using my clinical judgement as a practitioner to make decisions regarding traumatic material presented within the interviews. I distinguished traumatic material by considering whether experiences had caused subjective distress to the participants. This was elicited through gentle probing when distressing events were alluded to, and subsequently analysed through transcripts.

I was aware that the participants should be clear about my role as a researcher. I discussed this at the start of the interviews for all participants and offered opportunities for participants to pose any questions or concerns that they may have to me before and during the process. I explained to patient participants that I was a mental health nurse who usually worked with student nurses but that I was currently doing a research project to try and help nurses understand more about experiences of

restraint. Some staff participants knew me in my role as a lecturer. I explained to those staff that this was a specific research project that I was undertaking over and above my role as a lecturer.

The tension between the role of researcher and practitioner was discussed in depth with supervisors during the process of designing the study, and subsequently during the process of conducting the interviews. This experience of supervision was invaluable to maintaining the boundaries between researcher and practitioner.

Post Incident Reviews and the focus group would be analysed qualitatively to generate data to inform the study. Content analysis of qualitative data generated from these semi-structured interviews and focus group would be made, with appropriate computer package support if necessary. Other methods of data collection would be analysed using descriptive statistics, with appropriate computer packages used to assist this process. Data analysis of each of the methods used will be now be discussed.

3.4 DATA ANALYSIS

Robson (2000) suggests that there are no prescriptive formulae for analysing qualitative data. He asserts that while the collection of data, for example through participant interview, is straightforward, the main difficulty of qualitative data is the analysis. He acknowledges that some qualitative researchers resist use of a scientific framework for analysis, as their work is an art as opposed to a science. There are disadvantages to this stance, however, when presenting findings that do not appear to have any rigorous objective inspection. Grounded theory begins with identification of a research question followed by simultaneous data collection and analysis (Strauss

and Corbin 1998). Analysis involves several phases where theoretical concepts are developed according to the data. This is a repetitive process where the researcher is constantly returning to the data to check emerging themes and gather further data for comparison and analysis. Parahoo (2006) describes the characteristics of grounded theory as the interplay between induction and deduction through the use of theoretical sampling and constant comparison. Themes are generated from the data inductively and are then verified against further observation (by deduction). The research questions should provide a focus for the researcher but should be broad enough to investigate complexities of the phenomena being examined. The broad question within this study was to examine the aftermath of untoward incidents. Priest et al (2002) highlight a lack of detailed guidance regarding qualitative data analysis. They suggest that many researchers state that they have used grounded theory; however this has been limited to the procedures of analysis as opposed to the development of substantive theory. Grounded theory approaches to analysis should highlight a systematic way of analysing data which is consistent and transparent. Miles and Huberman (1994) suggest that systematic approaches to analysis will demonstrate reliability and replicability. Reliability refers to an unswerving approach using an appropriate method of research design towards a representative sample group who have been chosen objectively (Parahoo 2006). In this study the research design had identified consistent methods of data collection to be applied to every participant. Participants were staff and patients within inpatient acute units during a specified timescale who were identified as a representative sample of the wider population, in this case the wider population was the population of staff and patients in acute inpatient care within the UK. Although traditional qualitative researchers have claimed that the uniqueness of these approaches should not be applied to the wider

population there is growing acknowledgement that the use qualitative material should be applied to wider audiences (Paterson et al 2001; Cresswell 2003). Furthermore if findings related to a sensitive area of practice, such as restraint, can provide a much clearer picture of experiences of staff and patients it is vital that these findings be shared and replicated in other areas if necessary.

A common approach to analysing qualitative data is through content analysis. Robson (2000, p275) describes content analysis as "codified common sense: a refinement of ways that might be used by lay persons to describe and explain aspects of the world around them". Content analysis involves sorting data into categories or themes that best define the observations emerging from the data. While it is desirable for categories to be exhaustive and mutually exclusive, it is recognised that the volume of information generated through semi-structured interview can be difficult to manage. A category for information (or 'dump' category), which the researcher finds difficult to group, may be necessary during the process (Robson 2000). Strauss and Corbin (1998) place emphasis upon considering conflicting responses in order to gain a multidimensional view of the phenomena being studied.

Rubin and Rubin (1995) describe the coding of data that involves detailed examination of transcripts. Each time a particular subject or topic is described, a code is assigned. Data is then categorised according to assigned codes and as the examination progresses, themes emerge relating to the coded material. Categories can be changed or refined as the analysis develops. As themes emerge, a broader description or overall theory can be built. Parahoo (2006, p393) summarises the process of content analysis as 'opening up' the data into as many parts as the analyst

can identify. Similarities within these parts are then grouped together in order to describe the whole.

Miles and Huberman (1984) distinguish between first and second level coding. First level coding attaches labels to groups of words. These groups of initial codes are then organised into a smaller number of themes or patterns (second level coding). Strauss and Corbin (1998) described three coding strategies: open coding, axial coding and selective coding. Open coding is the first part of the process where data is taken apart and discrete parts are examined for differences and similarities. This stage in the analysis identifies discrete concepts which form basic units of analysis for grounded theory. Concepts are then sorted into similar groups which in turn become categories. Axial coding is the then used to highlight the way that connections are made between categories and sub categories. This stage identifies specific features of the categories, conditions and contexts, which make it unique. This promotes a systematic approach and adds precision to the analysis. Tentative hypotheses related to the data are generated at this stage and verification is made against the rest of the data or as a focus for future data collection. Discrepancies within this process should be highlighted and not ignored. For example, if a category of fear is generated related to reawakening of earlier trauma following an incident of restraint, verification would be sought in revisiting data to identify supporting statements. Where this may be identified in a number of statements, it may have been refuted in a smaller number. By highlighting such discrepancies the researcher can demonstrate consideration towards the variation and depth of the data. Selective coding is the final stage in the coding stages described by Strauss and Corbin (1998). Within this stage one or two

core categories are developed to which all sub categories relate. From these core categories the conceptual framework to develop grounded theory is built.

These approaches to managing the data appeared to be practical, although time consuming, mechanisms. They would allow me freedom to compare and contrast transcript contents, and flexibility to review and change themes as the analysis developed. I felt that a manual coding approach through thematic analysis would enable me to immerse myself within the data. Having interviewed the participants, this would provide the opportunity to revisit those interviews in depth and become truly familiar with the content. Soon after data collection had started my access to administration support with transcribing was withdrawn. This resulted in a decision being made to transcribe the tapes myself. While this would have an impact upon my time, it would also allow further opportunity to consider tone and other verbal nuances during this process. I believed that this in-depth approach would support my stance as the interviewer being a part of the process to uncover meaning.

I also considered Computerised Assisted Qualitative Data Analysis (CAQDAS) packages (Lewins and Silver 2006) as potentially helpful approaches to managing vast quantities of qualitative data. CAQDAS packages can help the researcher to develop broader, higher order categories, as well as more detailed specific codes. They also allow easy access to data, with less demand for flipcharts, stickers, coloured pencils, and similar mediums. Legeiwe (cited in Strauss and Corbin 1998) highlights that computers are incapable of comprehending the meaning of words or sentences but can assist in creating order, structure, retrieval and visualisation of tasks. Some computer packages can build theories out of text segments and formal properties

analysed within the data can be checked. Concepts can be easily connected and groundedness more readily verified. This approach to data management can also be helpful when more than one person is working on a project. Input of data can be managed on one database by a number of people; however caution should be made regarding consistency and clarity around the data that is being inputted, and the approach to analysis that is being taken. CAQDAS packages also allow for different media to be used within data programmes, for example audio recordings. Hutchinson (2005) describes how use of GoldWave v5.04 was used to assist in the qualitative analysis of focus group research. Interactions and responses in group meetings were coded, while taking into account the complex distinctions which textual transcription can miss. For example, if tension or antagonism was evident in audio replay, codes could then be categorised within the database with links to the audio recording. This system can be helpful in analysing the vast content and interaction that takes place during the group process. A drawback to this approach is the loss of the visual aspect of the written word. Individual learning styles may dictate the preferred method and this approach may not suit all (Honey and Mumford 1992). I had no experience of working with computerised approaches to qualitative data analysis but in my reading had identified that this was becoming a more acceptable and reliable way to manage large amounts of qualitative data (Williamson and Long 2005; Hutchinson 2005). I therefore attended an introduction to qualitative packages (University of Surrey 2006) to familiarise myself with the more common packages available and what they may have to offer in helping me to manage my data. From this I identified that Atlas or Nvivo packages may be helpful to me and I attended subsequent training in both (TVU 2006). Computerised packages can assist in labelling coded data in the same way as manual coding however they offer the additional attraction of managing vast

quantities of data on one database. Master codes can be created to form basic units of analysis with sub codes created as themes emerge. Free nodes can be created to store data which may not fit initially into specific categories, complementing the 'dump' category described by Robson's (2000) description of manual content analysis. A database created for qualitative data would be useful for returning to data for checking points highlighted within the analysis and would also be a practical approach which could assist triangulation methods for addressing objectivity within the design however I had some reservations.

Burton (2000) warns that over reliance upon computerised analysis of qualitative data can detract from the contextual meaning, whilst Barry (1998) suggests that researchers can become overwhelmed by the use of new computer applications and learning new approaches to managing data. As a result they can lose the closeness to data that can be formed through more traditional methods. This caution made me consider carefully the stance that I was taking in this study. I have discussed earlier in this chapter the philosophical underpinnings of my research design and did not want to compromise this in any way. Although manual coding would be time consuming it would offer less opportunity for missing finer details within the contextual analysis. I had already transcribed a number of the interviews and was making some advances in identifying early codes to the data. Lewins and Silver (2006) suggest that this early analysis of data should be made before considering CAQDAS, and that use of computerised approaches should not replace underlying philosophies and methodologies, rather they should assist identified approaches. The codes and tentative themes that were emerging appeared to be straightforward and I did not envisage at that point that further application of a computer package would enhance

the analysis any further. I was close to the data having interviewed and transcribed tape contents for all of the participants myself. I was mindful of context, tone, and emotion as well as written word, and did not believe that use of additional software would add further depth to the analysis. I had already used this traditional approach in previous studies and was familiar with strengths and weaknesses of the method. I therefore chose to apply traditional manual methods to qualitative data analysis of the interviews.

Strauss and Corbin's (1998) framework was applied to ensure a rigorous and systematic approach to the analysis. The first step of the analysis involved open coding. Open coding involves breaking data down into discrete parts to compare for similarities and differences. Strauss and Corbin (1998) describe this as the first process of concept formation. Events, descriptions and interactions found within the text which are related in meaning (or 'conceptually similar' p102) are grouped under more abstract concepts described as categories. Coloured highlighter pens were used to group categories which had similar meanings within transcripts. For example, a number of participants described feelings that they experienced during the incident of restraint. Phrases within transcripts which described feelings were highlighted in red and assigned the conceptual name of "feelings". Following the first process of concept formation, Strauss and Corbin (1998) advise returning to the data to make a more detailed microanalysis. This involves the researcher reviewing transcripts line by line and recording further thoughts through use of memos to record interpretations, questions, and directions for further data collection and analysis. For example, a category labelled "antecedents" was assigned at this early stage to group concepts that had been identified as events described by participants that had preceded incidents of

restraint. In considering this category during microanalysis I recorded a number of memos which assisted me in interpreting this phenomenon. One patient participant described boredom which I categorised as an antecedent. My memo related to this concept considered my thoughts and questions related to the concept of boredom, "What does boredom mean to this person? If I were to say I am bored what does this mean to me – I would consider having some form of stimulation and interaction to combat boredom. As I continue with my analysis I will look for descriptions which may help me to understand the term boredom and the impact that this may have upon situations of restraint". A category should be a logical description of the group of concepts therein. Once a category has been identified, properties and dimensions of the category can be differentiated. Strauss and Corbin (1998) describe properties of the category as general or specific attributes within the category and dimensions as the 'location of the property along a continuum or range' (p117). Specifying properties and dimensions can assist with the formulations and variations of patterns, thus contributing to the development of grounded theory. For example, within the content analysis a category entitled "feelings" was highlighted in the open coding phase of the process. During microanalysis, memos related to feelings were recorded within the analysis, and from the analysis properties and dimensions were identified. The data analysis highlighted negative emotions as a sub category of "feelings". Anxiety was identified as a negative emotion within the concept of negative emotions. Classification of anxiety was then identified across a range of dimensions which were summarised as anxiety being " a psychological and physical consequence of restraint which can range from feeling slightly shaken to being gripped by overwhelming physical symptoms such as hyperventilation, fear and panic".

The open coding process that was used can therefore be summarised as follows:

1. Identify concepts from the data transcripts.
2. Define a category for the concepts.
3. Micro analyse the concepts using memos.
4. Define properties and dimensions within the categories.

Axial coding is the second phase of Strauss and Corbin's (1998) model of content analysis. Axial coding involves the process of reassembling data which has been broken down during the process of open coding. Coding occurs around the axis of a category linking categories at the levels of properties and dimensions. This facilitates the expansion of well developed and related categories. Axial coding examines how categories link and should take place on a conceptual level as opposed to a descriptive level.

Strauss (1987) identified the axial coding process as follows:

1. Laying out the properties of a category and their dimensions, a task that begins during open coding.
2. Identifying the variety of conditions, actions / interactions, and consequences associated with a phenomenon.
3. Relating a category to its subcategories through statements denoting how they are related to each other.
4. Looking for cues in the data that denote how major categories might relate to each other.

Axial coding analysis involves two explanations, the use of the words of the participants, and the conceptualisation of these words by the researcher. For example, where the category "negative emotions" had been conceptualised by the researcher, the participants' words which influenced the conceptualisation were 'feeling bad', 'angry and humiliated', and so on. The process involves asking questions related to the context of the phenomenon that is being analysed such as how, when, where, why, in order to deepen understanding. Strauss and Corbin (1998) describe axial coding as the study of structure and process within the inquiry to establish why certain events occur (structure) and how persons act or interact (process). Within this phase the researcher would also consider her own field notes to assist the analysis. Diagrams can also be used as a visual aid to highlight links identified during this phase of the analysis. Strauss and Corbin (1998) advise caution against being too restricted during this phase of the analysis and that while structure can enable novice researchers to this model feel more in control of the analysis, too much adherence to structure can restrict deeper consideration of contextual factors.

In order to add further depth to this phase of the analysis I considered that application of Walker and Avant's (1995) theory of concept clarification could assist me in managing the balance between being restricted by use of too much structure or being less rigorous by not using enough structure. Walker and Avant (1995) provide a model of breaking down a concept in great depth by considering all uses of the concept, defining attributes, model case constructions and take into account additional cases related to the concept. This model has been applied in other mental health settings with good effect (Bonner 2001; Kettles 2004) and I made a decision to apply

this model to the emerging categories through the process of axial coding. This would enable me to consider the structure and process in further depth and ensure additional rigour to this stage of the analysis.

The stages of Walker and Avant's (1995) process of concept clarification are as follows:

1. Select a concept.
2. Ascertain aims of concept clarification.
3. Identify all of concept uses.
4. Ascertain defining attributes.
5. Construct model case.
6. Identify antecedents and consequences.
7. Define empirical referents.

Although this additional process was time consuming it did facilitate more depth to the complex consideration of the emerging data as well as supporting early findings within the data.

The third stage of Strauss and Corbin's (1998) approach to content analysis is selective coding. This is the process whereby data becomes theory. The procedure involves presenting the data analysis in a general sense to explain the collective voice of the participants. A central category should pull the other categories together and should completely capture the other themes. The central category should appear frequently in the data, and within (almost) all of the cases the central category should be linked. Even when conditions vary, the central category should still hold. During selective coding the researcher should step back from the data and ask herself, "what

is the main issue with which these people [participants] seem to be grappling (Strauss and Corbin 1998, p148). A memo or descriptive story encompassing main themes can then assist the researcher to name the central theme. From naming the central theme, the researcher then goes back to the existing categories to ensure they fit the central theme. Diagrams can be used again as a visual representation of how the categories link to the central theme. The central themes for this study were identified towards the end of this lengthy process of content analysis and are summarised as, "Events that contribute to subsequent psychological sequelae following restraint, feelings experienced as a result of restraint, and perceptions of helpfulness during and after physical restraint".

These central themes encompassed the core categories identified through the process of content analysis; antecedents, feelings, helpful aspects, unhelpful aspects, and reawakening of previous traumatic events (figures 3 and 4). The findings related to these themes will be presented in depth in chapters three and four.

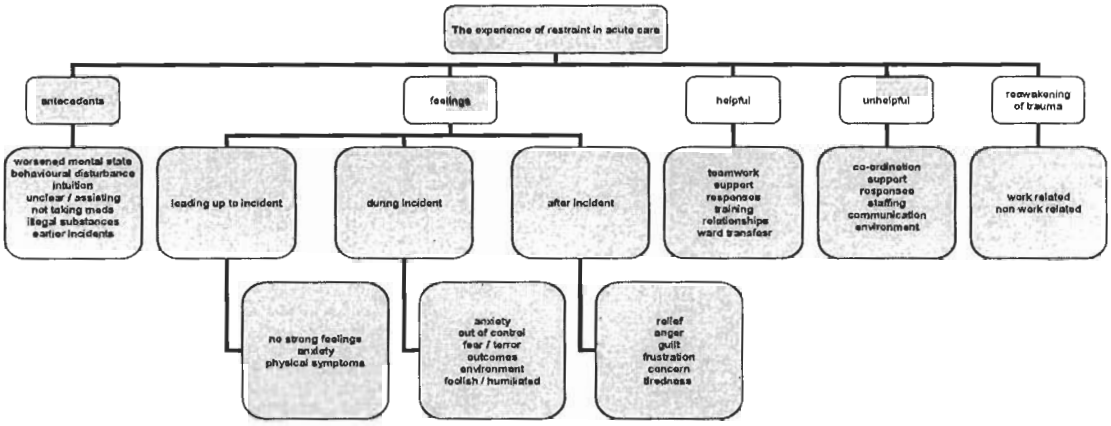

Figure 3. Conceptual framework – staff participants

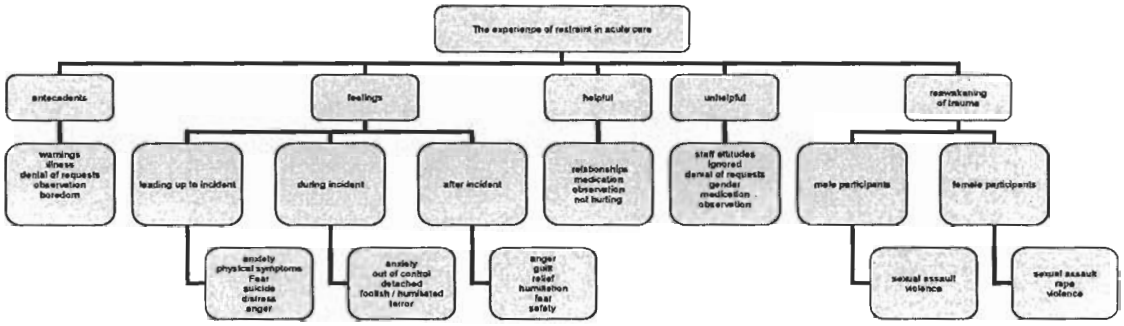

Figure 4.Conceptual framework – patient participants

Analysis of qualitative data can be subjective and mechanisms must be included in the design to address this issue. Analysis of the transcripts would be more rigorous if they were examined by a third party to provide an external overview (Cresswell 2003; May 2001). Patton (1987) describes this approach to evaluation as investigator triangulation. Different evaluators examine material and interpretations are then compared for similarities and differences. Evaluators should be familiar with the topic area that is being examined as well as being confident in applying the techniques of evaluation that the researcher has used within the analysis (Strauss and Corbin 1998). The same rigour would be applied by each evaluator using similar coding techniques. The data set would be examined separately by each individual and interpretations made independently. There are differing views in the qualitative research field regarding this method of triangulation. Mason (1998) suggests that the research design, having made the epistemological standpoint clear, allows the researcher privilege to present his or her own interpretations showing that other perspectives have been considered, and giving reason as to why they may have been discarded. Mason (1998) describes checking the validity of interpretations through respondent validation. This involves sharing interpretations with participants to seek assurance that the interpretations are a true representation of the participants' views. After considering the various arguments to support ensuring rigour and validity within the analysis, I believed that investigator triangulation best supported my epistemological stance. I was not convinced that my own interpretations would necessarily make a true representation of the content analysis. While I recognised the benefits of my subjective part within the interviews I was aware that this was only one view. I was concerned that my judgement could be influenced by my experience of

individual interviews and that I may interpret more or less of some of the content as a result. I could miss important factors that may be identified through external scrutiny. I could adopt respondent validation to address this; however I was acutely aware of the issues which arose within the ethical considerations. I felt that one examination of the incident was enough and did not want to risk unnecessary upset if there was an alternative solution. I therefore made arrangements for two colleagues to view the transcripts separately. Both colleagues were familiar with the techniques described for qualitative analysis and were experienced in applying this approach. I would then present my own analysis for comparison. Differences could then be challenged and justification of findings considered. Although this was a lengthy process for all concerned, it enabled further consideration of the concepts and categories that I had identified within my own analysis. Use of Strauss and Corbin's (1998) model allowed a similar systematic approach by the other analysts to ensure rigour within the process. Use of Walker and Avant's (1995) theory of concept clarification enabled further discussion following the process of investigator triangulation to refine the categories, concepts and support the central theme. Each investigator independently examined each transcript. They followed the thematic coding process described earlier and identified emerging themes from the data. Once they had completed the process we compared the themes identified by each investigator. There was some variance within the themes identified, for example I had identified themes related to what was helpful and unhelpful to participants, whereas my colleagues had included these aspects within other themes. We revisited the data together and reached consensus on the themes after much deliberation and discussion. The data analysis was subsequently presented to supervisors and areas

which had been challenging in the process of reaching consensus through investigator triangulation were discussed further with supervisors.

Analysis of the focus group was made by myself and my co-facilitator. We had hoped to tape record the group however one member of staff was not happy with the group being recorded. The group were agreeable to my colleague taking detailed notes during the process which were subsequently useful to assist us in generating themes which supported the analysis of the individual interviews. At the end of the meeting we made further field notes in relation to the process and other observations that we had made, for example when emphasis and agreement had been made at particular points during the process. As well as supporting some of the themes generated within the individual interviews, the focus group offered further insights into aspects of training and avoidance of aggression which will be discussed in chapter four.

In addition to the content analysis of the Post Incident Review interviews and focus group I had identified additional methods to supplement the qualitative data. These additional instruments were intended to generate further data in relation to the incidents and will now be discussed.

Demographic data was gathered using a checklist for patients and staff. Staff demographic data (appendix 7) included name, sex, ethnicity, role / grade, length of service, and previous training in management of violence and aggression. Demographic data collected for patients (appendix 6) included sex, age, ethnicity, legal status, diagnosis, number of previous admissions, length of contact with mental

health services, and previous history of aggression / violence. The demographic data was analysed using descriptive statistics to provide an overview of the participants.

A scale related to the physical consequences of restraint was also identified within the design to establish extent of physical injuries for staff and patients who were involved in restraint (appendix 8). Descriptive statistics were applied to analyse the information generated with this tool to establish the extent of physical injury, types of restraint used, length of restraint, and use of medication.

The Trauma Screening Questionnaire (TSQ) (Brewin et al 2002) was used as a tool to identify participants who may warrant further screening for PTSD. The clinical cut off point for the TSQ is 6 or above and descriptive analysis of responses was made.

Finally, an evaluation tool related to the Post Incident Review was used to establish whether participants had found the interview to be a helpful way of considering the incidents (appendix 10). This consisted of four statements related to the perceived value of Post Incident Review and two statements which asked whether the participant believed that the incident had been managed well and whether they believed that it could have been predicted. These statements were rated on a seven point likert scale where 1 equalled strongly disagree, 7 equalled strongly agree, and 4 acting as an anchor point where the participant neither agreed nor disagreed with the statement. The purpose of the evaluation tool was to establish whether this approach to Post Incident Review could be a useful model to advocate for clinical practice.

Descriptive statistics would be applied to highlight whether it was perceived as helpful.

A summary of methods of data collection and analysis are offered in table 3 below.

Methods of data collection	**Type of data**	**Methods of analysis**
Semi-structured interview	Transcribed interviews	Content analysis
Focus group	Detailed notes and field observation	Content analysis
Demographic data	Nominal data	Descriptive statistics
Physical consequences	Nominal data	Descriptive statistics
TSQ	Nominal data	Descriptive statistics
Evaluation of review	Ordinal data	Descriptive statistics

Table 3. Summary of methods of data collection, type of data, and methods of analysis

This section has offered an overview of the data analysis. Further consideration related to data analysis will be offered in chapters three and four where findings are presented.

3.5 ETHICAL CONSIDERATIONS

The nature of this enquiry presented a number of ethical issues that required careful consideration. The area of restraint in mental health remains a somewhat taboo subject. While restraint was historically a common method of managing the mentally ill, as mental health care has evolved the use of restraint has become a thorn in the side of humanistic care. If the nurse aspires to the role of carer, nurturer, therapist, then the use of restraint within this role is in conflict with the underlying humanistic

philosophy. To question what nurses find helpful during and following restraint is to acknowledge that this is an aspect of their work that is worthy of investigation. In making this explicit we are inviting the nurse to confront this aspect of their role in depth. This may create feelings of discomfort within the nurse who, according to Marangos-Frost and Wells (2000), may well view restraint with a sense of dread.

There is also a sense of intrusion into a situation of conflict where nursing decisions have been made. The culture of nursing has historically been that of blame, where any indiscretion brought to management eyes is duly met with punishment. Clinical Governance (DoH 1999b) espoused a change in culture where mistakes are remedied through supportive intervention. Clinical Governance (DoH 1999b) recognises that change does not happen overnight and I was mindful that my study might be viewed by some staff as a management investigation to expose mismanagement of untoward incidents, for which staff would be punished. Holloway and Fulbrook (2001) advise caution regarding the halo effect - participants responding in a way that they wish the researcher to view them in a favourable light. To address this I made arrangements to speak to staff groups and individuals about the project, my aim being to allay any underlying fears from staff. I was not a Trust employee and was not in a management position. I hoped that my existing positive relationship with staff as a teacher and the knowledge that I was not in a management position would allay any misconceptions regarding my role as a researcher. Holloway and Fulbrook (2001) suggest that previous association with the researcher can enable participants to feel more relaxed during interview. Many of the staff were aware of previous research that I had undertaken, and some had been participants in the pilot study. Both staff and patients had reported the experience within the pilot study as helpful, and for

some therapeutic. This was advantageous in helping to dispel fears for staff. By taking these preliminary steps to promote the study to the staff groups, I hoped that this would subsequently encourage staff to consider whether the patients that they were working with may be appropriate to be included within the study. I also wrote to Consultant Psychiatrists in the Trust requesting written agreement for patients under their care to be included in the study. I received no objections from the Psychiatrists.

I was also aware of the potential for misconduct being disclosed in the process of the study. While this could create a dilemma for me as a researcher in terms of my study being unsuccessful, I was bound by both my personal and professional codes (NMC 2004). I had a clear boundary set that should any accusations of misconduct be made I would refer this through the appropriate channels and if my research project was hampered or stopped in the process then so be it.

The main areas of risk for patients would be from the reawakening of recent untoward incidents and from the release of distressing emotions surrounding these incidents. There was a risk that by revisiting these incidents this would introduce further distress thus increasing any 'dose' of trauma. For the pilot study I had considered these issues at great length and questioned whether it was right to go over distressing events. These questions echoed Etherington's (1996) consideration of the researcher gaining from the subject's distress. On balance, my view was that if my study were to identify helpful interventions for patients this would eventually promote positive outcomes in restraint situations. Subsequently, the pilot study had not subjected participants to further distress. Although the content of the interviews had examined

sensitive and upsetting experiences, most patients had welcomed the opportunity to review events and some had reported the experience to be therapeutic. If sufficient consideration were given to protect vulnerable individuals during the investigation then there would be gains for every stakeholder. Nevertheless, arrangements were made to address ethical issues in a number of ways. No approach would be made until patient participants were deemed fit for interview by a key or associate nurse. If patients were deemed fit they were provided with an information sheet (appendix 11) and offered the opportunity to discuss the project. All participants were offered a minimum 24 hours before agreeing to consent to the study and formal consent was documented in writing (appendix 12). Arrangements were made that interviews would be terminated should patients become distressed, and appropriate psychological support for participants mobilised if necessary. If the TSQ (Brewin et al 2002) identified that patients warranted further screening for PTSD, this would be fed back to staff with a request for this to be followed up through appropriate channels.

Despite my considerations, I was aware that some staff may still be uncomfortable in engaging with this research. I recalled the earlier pilot study. Discussing my approaching a patient who had already been deemed appropriate for interview and who was expecting to meet with me on the ward, one member of staff expressed her concern,

"...well it doesn't seem right to me to be going over this stuff with patients. It's distressing enough for them without having to go back over it."

On that occasion I explained that my intention was not to cause distress and that, so far, my interviews had felt therapeutic. Although I was not intending to include the therapeutic aspect of patient interviewing for research purposes, there is evidence within the field of narrative research to support my comments made to this particular

nurse (see for example Sedney et al 1994; Jones 1998; Murray 2003). I did not go on to interview that particular patient in the pilot study but this raised further thought around the ethics of patient interviewing in mental health settings. While I had carefully considered a sensitive and protective approach to gaining access to patient's thoughts and feelings about being restrained, an individual who considered that they had superior knowledge of what was best for the patient was denying this access. If the patient was making an informed choice to be interviewed, this choice was being denied through a paternalistic stance which may not necessarily have been in the patient's best interests. Nursing ethics are about balancing fairness and justice in the dilemmas that face us daily. In protecting our patients for 'their best interest' without sound justification we are disempowering them. The drive to give patients a voice is now a fundamental aspect of mental health policy (see for example National Service Frameworks for Mental Health, DoH 1999a) however there is a danger that this may be supported through window dressing, or surface support, with little real depth in consideration of truly recognising the patients thoughts and wishes. In this example it starkly highlighted how this patient had no prospect of being heard, having been struck dumb when the opportunity arose. I had hoped that having now completed the pilot study, the more sceptical staff may be more amenable to further examination of the area, however this remained a problem in some cases. For example, on discussing in one clinical area whether any of the patients may wish to be interviewed, one senior member of staff reported that none of the patients would have anything good to say about the staff at the moment. According to this staff member it would therefore not be a good idea to interview any of the patients at that particular time. As the study developed these responses reduced, possibly as a result of my increased presence in clinical areas gradually becoming more acceptable to the more cynical staff.

I was aware that staff participants were also vulnerable to becoming distressed during the information gathering process. This had not happened during the pilot study, however should this happen during this study, I was aware of the staff counselling service within the Trust, which was available for all staff to seek confidential support as required. Should staff become upset I would suggest that they may wish to consider this avenue for further support. All participants were free to withdraw at any time and if I identified individuals who were becoming very distressed I would stop interviews and mobilise additional psychological supports if necessary. Soon after data collection began I revisited this ethical consideration. I had identified that two members of staff had scored above six on the TSQ and may warrant further screening for PTSD. I was concerned that I had a duty of care to these participants and that suggesting staff counselling may not be an adequate response. There were issues regarding how these symptoms should be managed and whether psychological treatment may be necessary. For these two staff I shared the information generated by the TSQ and suggested that they may wish to consider accessing further assessment. Both staff agreed to my suggestion; however I was concerned that not all staff may be as responsive. After discussing with my supervisors I made a decision to make this area more explicit within the patient information sheet. The wording was changed to draw attention to the results of the TSQ for staff. Wording explicitly emphasised that if TSQ scores were six or above, staff would be advised by the researcher to contact their GP or the Trust Occupational Health Service to arrange further assessment. An additional statement was added to the consent form to reflect this new emphasis. This question asked if the participant would be agreeable to consult with their GP or Occupational Health Service should TSQ results be six or over. I also discussed this

aspect of the study with the Trust Occupational Health Consultant to ensure that this would be an adequate route to appropriate interventions being mobilised and was satisfied that staff presenting to Occupational Health with high TSQ scores would be offered appropriate help.

As well as protecting staff and patients as described, I endeavoured to protect confidentiality by anonymously coding each participant, clinical area and taped transcript. Data was stored in a locked cupboard and computerised data was accessible via a password known only to myself. This had been emphasised to both staff and patients. Tape recording of interviews was stressed as optional and arrangements were made for tapes and transcripts to be stored for up to eight years and then destroyed.

Ethical approval was also sought by the Local NHS Research Ethics Committee prior to starting the project (reference 04/Q1603/17). The ethical concerns which were raised by the committee were not in relation to the possibilities of upsetting participants during the interview, or the impact of revisiting unpleasant experiences. Concerns were related to the research design, part of which was predominantly being analysed using qualitative techniques as part of the mixed methodology. My own concerns were raised in relation to this when it transpired that none of the members present on that particular committee had any background in mental health. I had myself been a representative at a Local Research Ethics Committee and my first Supervisor played a leading role within our Local Research Ethics Committee. I believed that our experience in this area informed the ethical process, however I also felt that my research participants may be at an ethical disadvantage if the proposal

was being scrutinised by a group with no clinical background experience in mental health. The committee subsequently requested that a member of another Local Research Ethics Committee with substantial psychiatric experience cast his eye over the proposal to offer an additional opinion and the proposal was passed as ethically sound. The Committee was consulted subsequently to seek further approval regarding amendments made following changes to the information sheet and consent forms discussed earlier.

3.6 CONCLUSION

This chapter has described in detail the research design of the study. Section 3.2 has outlined the underpinning philosophy of constructivism as a realistic viewpoint from which to examine the research questions and offered both strengths and weaknesses within this stance in relation to examining the aftermath of restraint. Section 3.3 offered a discussion of grounded theory as a methodology which supports the constructivist philosophy in examining the complex area of restraint, taking into account the challenges presented in gathering data using a mixed method approach. Section 3.4 examined in depth the lengthy process involved in analysing data using content analysis to generate grounded theory from the rich interview transcripts, and offered justification for the methods used. A variety of ethical considerations were summarised within section 3.5 which clearly presented the challenges of embarking upon a research study which examines a topic that can be uncomfortable and potentially distressing to the participants.

Reflecting upon the process of research design and implementing the strategies outlined within this chapter, engaging with the participants was a valuable experience.

Putting this aspect of the design into practice very much supported the constructivist philosophy and made me feel a part of the process. Hearing participants' stories first hand was humbling, thought provoking, at times funny, and a motivating force to continue the study to completion. Being so close to the research process had its drawbacks. The content of interviews was upsetting and frustrating to hear at times, and this was where supervision was invaluable. The investigator triangulation methods described in section 3.4 were to prove very useful in addressing the subjectivity which could have influenced the analysis of the data as a result of this closeness. Use of traditional methods had benefits and disadvantages. Whereas the approach that I chose helped me to completely immerse myself in the data and offered a very in depth analysis, it was very time consuming.

CHAPTER FOUR - FINDINGS – STAFF PARTICIPANTS

"...The main feeling was foolishness and humiliation. I couldn't release myself from her grip on my hair or her teeth in my cheek." (Anon 2006)

4.1. Introduction

This chapter will present findings related to staff participants. Core categories were identified in relation to antecedents; feelings; helpful and unhelpful aspects; and reawakening of earlier traumatic events. Section 4.2. will offer a discussion of how restraint was defined for the purposes of this study Examples of some of the restraint incidents which participants were reflecting upon will be included to provide some context to the situations which were being discussed. Section 4.3. will present demographic data which was gathered during the research process. This section is further divided into subsections to separate demographic data in terms of age and gender, grade of staff, length of service, previous training in prevention and management of violence, and ethnicity. Section 4.4. will offer findings related to type of restraint used, length of restraint, and use of seclusion. Section 4.5 highlights the physical consequences of restraint which were reported by staff participants within the study and section 4.6 presents findings related to use of medication during the incidents. The chapter then moves on to the findings related to the categories which were generated through analysis of the interview transcripts. Section 4.7 discusses the theme of antecedents. Section 4.8 presents findings related to feelings and is broken down further into subsections related to feelings before, during, and after the incident. Section 4.9 presents what staff participants found helpful, and section 4.10 presents unhelpful findings. The interview asked specifically about whether participants had

felt that the incident had reawakened memories of previous traumatic encounters and findings related to this question are presented in section 4.11. Following the taped interview, participants were asked to complete the Trauma Screening Questionnaire (TSQ) (Brewin et al 2002) and an evaluation form related to the efficacy of the Post Incident Review in which they had just participated. Section 4.12 will present findings related to the TSQ and section 4.13 will offer findings related to how the Post Incident Review was evaluated by staff. A focus group was arranged following data collection for staff participants which served a number of purposes. Strauss and Corbin (1998) suggest that a focus group can be a useful approach to cross-validate data generated from qualitative interviews as well as offering further insights to support the grounded theory process. Findings related to the focus group will be offered in section 4.14. Section 4.15 will conclude the chapter with a summary of the main points raised within the findings related to staff participants.

4.2. Restraint incidents

Defining restraint has proven to be a challenging task and there is no clear definition which suits all. In the earlier pilot study (Bonner et al 2002) a concept clarification exercise was arranged with staff representatives from acute and intensive care settings to try and reach some common definition for that group. Agreement was made that restraint could range from gently guiding individuals to a place of safety, to using formal taught techniques of Control and Restraint (C & R) to immobilise a patient. The earlier concept clarification exercise identified that any form of 'hands on' approach to managing untoward incidents was relevant within the umbrella of restraint. This definition was applied during this subsequent study. Incidents within this study were wide and varied, and covered the broad scope that the definition

allowed for. Examples at the less extreme end of restraint were of staff guiding a female patient out of danger when she was trying to set fire to a waste paper bin. This patient was gently taken by the arm by two members of staff to a quiet area and allowed time to voice her fears. The lighter was removed with consent and there were no further incidents with this particular lady. Another example was staff escorting a male patient back to one unit after he had absconded to local shops. Although initially resistant, this patient did finally come back with staff although they kept hands on contact with the patient throughout the journey back by foot due to concerns that he would abscond again. All parties concerned in this incident felt embarrassed and humiliated by the attention from bystanders as it was clear that *"they were taking me back to the madhouse"*. More extreme restraint incidents included a woman who was badly lacerated by a sharp knife during an act of self harm. Nursing staff intervened to prevent the woman harming herself further; however safety issues were of a paramount concern. The lacerations were deep and needed urgent medical treatment, the staff had to attempt to remove the knife while the patient continued to try and harm herself, and there was a large quantity of blood in the immediate area. Attempting to use control and restraint in this situation was particularly challenging because of the gaping wound in the woman's arm where usual techniques would have been used to hold her. Universal safety precautions related to the blood spillage and open wound were compromised raising further concerns. All of the incidents which underpin this study made an impact in some way upon the participants involved and one could not make a judgement as to which could be described as worse than another. What may appear to be a minor incident to one person can have a very damaging impact upon another. For the researcher, the most harrowing tale to be told was from a recently qualified staff nurse. She had only just returned from leave and

was not familiar with all of the newly admitted patients. A situation which had been escalating over at least twenty four hours reached a point where the staff nurse was attacked, wrestled to the ground, and beaten severely. This nurse pulled her alarm, cried for help and tried to defend herself while a multidisciplinary meeting took place in a room within a few paces distance. She was aware of a colleague nearby watching the incident but doing nothing to help. Nobody came out of the meeting room and the patient was eventually pulled off of the nurse by a visitor. The nurse received no Post Incident Review or support following the incident. She subsequently developed Post Traumatic Stress Disorder and has not worked in acute care since.

4.3. Demographic data

4.3.1. Ages of staff participants

Thirty (n=30, 100%) staff were interviewed with a split of seventeen (n=17, 57%) female staff and thirteen (n=13, 43%) male staff. The age range for the whole group was between 28 – 57 years, the mean age being 40. Female participants' ages range from 28-53, the mean age being 38. These ages were fairly evenly distributed (figure 5). Male participants' ages ranged between 28-57, the mean being 42. These age ranges reflect a mature group of people within the setting.

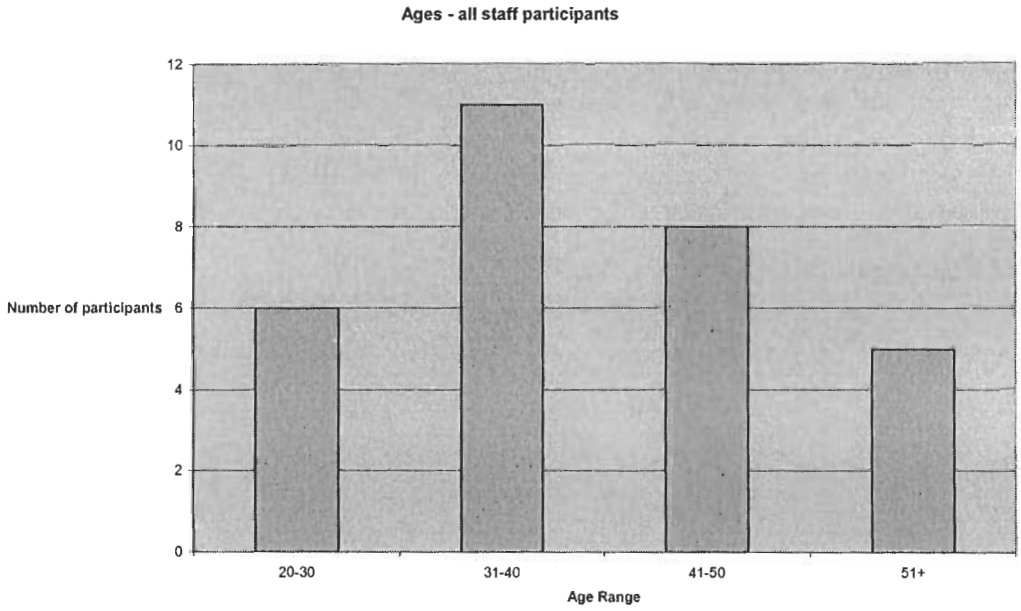

Figure 5. Ages of staff participants

4.3.2. Grades of staff participants

Grades of staff ranged between Agenda for Change bands 2-7 (figure 8). Eight (n=8, 27%) of the participants were Health Care Assistants, five (n=5, 17%) of whom were female and three (n=3, 10%) of whom were male. Half of the staff participants were Staff Nurses, the division being eight female (n=8, 27%) and seven male (n=7, 23%). Three (n=3, 10%) were Deputy Ward Managers were included in the study, two (n=2, 7%) of whom were female and one (n=1, 3%) of whom was male. Three (n=3, 10%) Ward Managers were interviewed, two (n=2, 7%) of whom were female, and one (n=1, 3%) of whom was male. The skill mix in terms of banding was typical of the general skill mix in most acute generic mental health settings within the UK. See figure 6 for breakdown of skill mix.

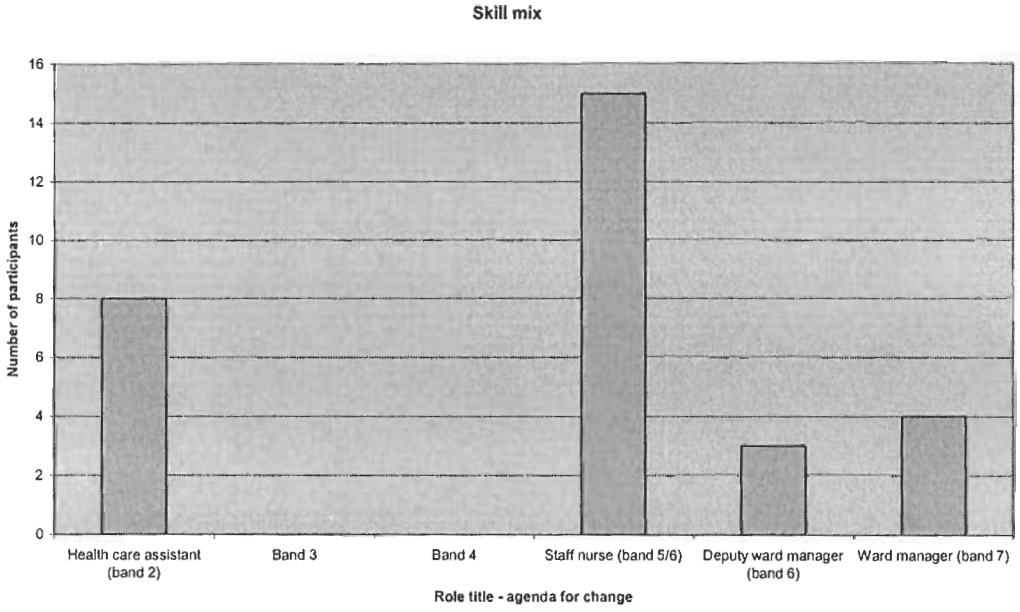

Figure 6. Skill mix

4.3.3 Length of service

Length of service ranged from six months to twenty four years, the mean length of service being nine years and six months. For female staff this ranged from one year to twenty four years, the mean length of service being eleven years. For male staff length of service ranged from six months to twenty four years, the mean length of service being eight years. The group were therefore an experienced group of staff who should be familiar with the custom and practice, guidelines and protocols for the areas in which they were working. A summary of length of service is presented in figure 7 below.

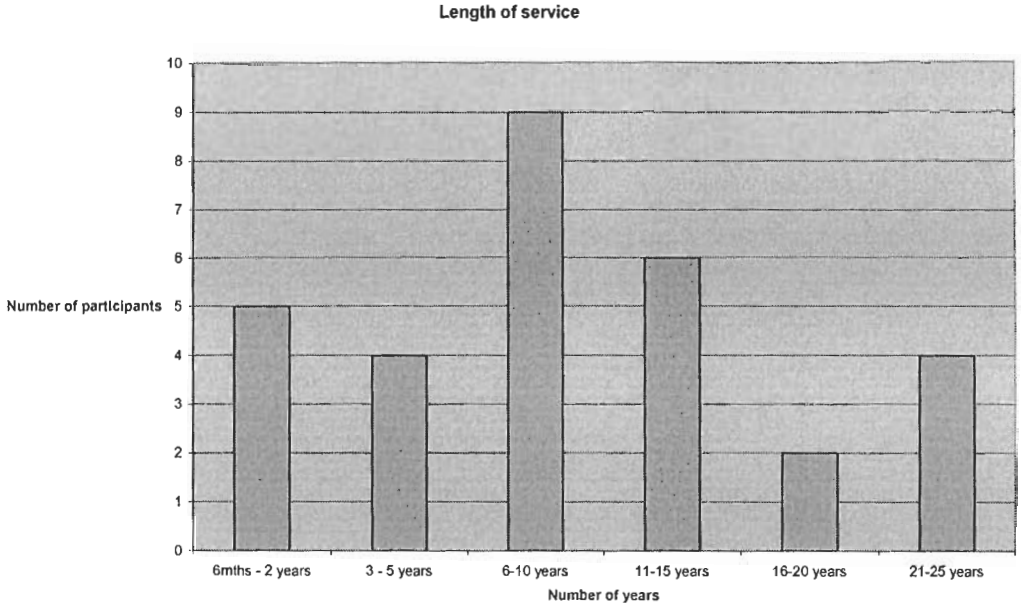

Figure 7. Length of service

4.3.4. Previous training in management of violence and aggression

All staff participants interviewed had a minimum training of breakaway skills. Within this Trust the minimum benchmark is mandatory for staff and the staff interviewed reflected that this benchmark was being reached. Eight (n=8, 27%) of the female staff and six (n=6, 20%) of the male staff had gone on to complete training in Control and Restraint, and two (n=2, 7%) staff participants, one (n=1, 3%) male and one (n=1, 3%) female, were Control and Restraint instructors. Figure 8 (p135) summarises previous training in prevention and management of violence.

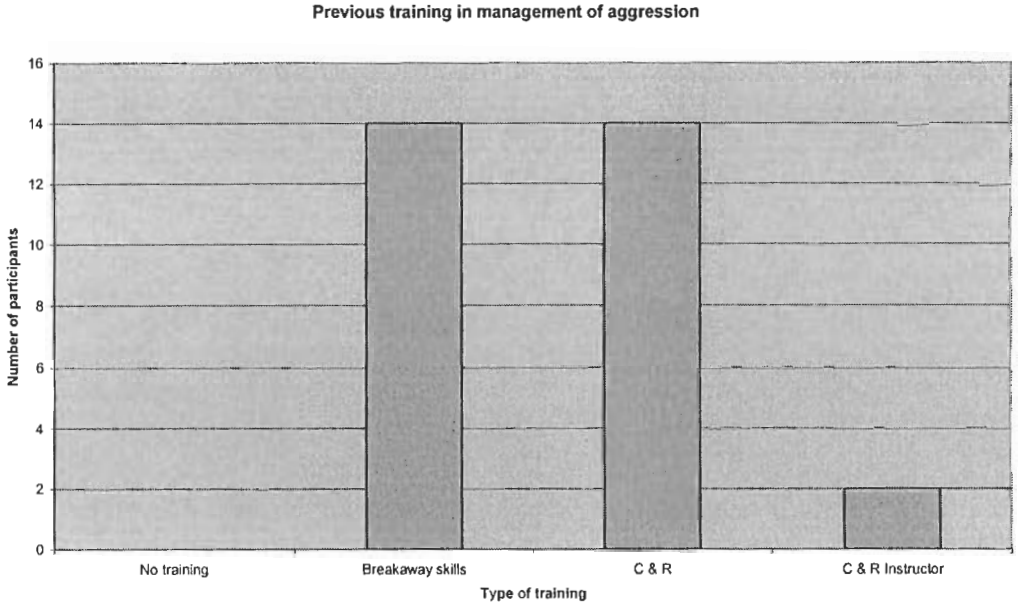

Figure 8. Previous training in management of violence and aggression

4.3.5. Ethnicity of staff participants

Ethnicity was included among demographic data for the staff group (figure 9). The majority (n=24, 80%) of staff interviewed were white British, thirteen (n=13, 43%) of whom were female and eleven (n=11, 37%) of whom were male. Two (n=2, 7%) female staff were of Philippine ethnic origin, one (n=1, 3%) female staff participant was black Caribbean, and one (n=1, 3%) was white Irish. Of the male participants, one (n=1, 3%) was black Caribbean and one (n=1, 3%) was white Irish. Ethnic distribution did not reflect the local population of the catchment area which the Trust serves. The Trust spreads over a large county in Southern England; two of the largest towns within the County have a diverse ethnic mix of British, Asian, African, Eastern European, and Caribbean cultures. Staff recruitment within this Trust reflects the UK recruitment difficulties in attracting applicants from a variety of ethnic backgrounds

to help accommodate the diverse needs of the population that the Trust catchment area serves.

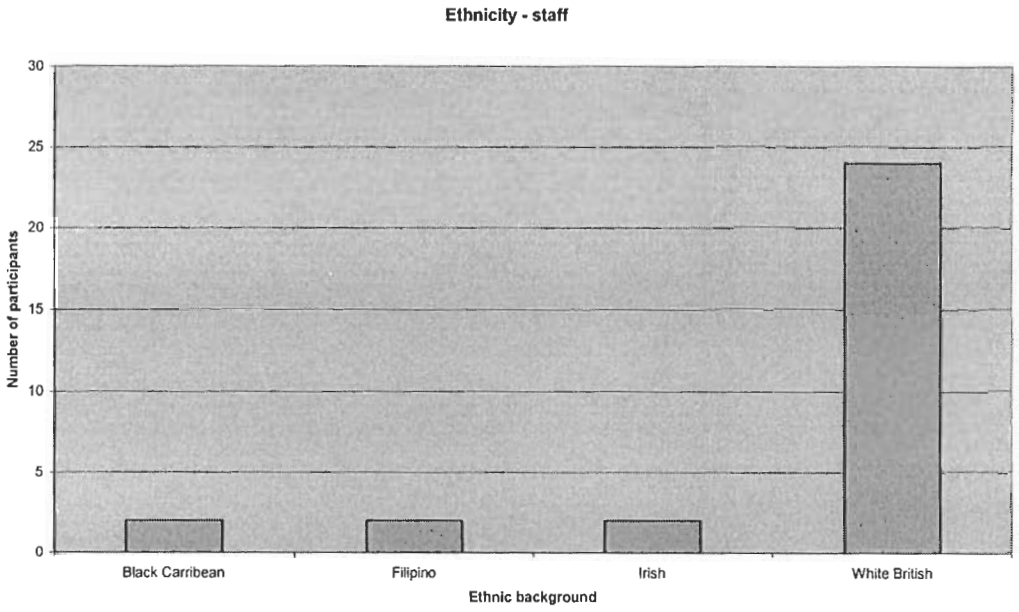

Figure 9. Ethnicity staff participants

4.4. Type of restraint, length of restraint and use of seclusion

4.4.1. Type of restraint

Type of restraint was broken down into four categories; gentle guidance to a place of safety with minimum force used, guidance to a place of safety with some force used (eg., taken by each arm to a quieter area), restraint involving two or more staff with force using C & R techniques while remaining upright, restraint involving two or more staff using C & R techniques with force in the prone position (ie., lying on the floor). Current training programmes in C & R advise that a three man team, ie., three C & R trained staff, should implement these interventions in a planned, coherent approach. It is known, both through my own experience, and through working with

staff throughout the Trust, that a three man team is not always used. For reasons such as staff shortages, or quick responses, it is known that two staff will employ C & R techniques to quickly contain escalating situations of aggression. These categories were therefore widened to include less than three people to employ C & R holds to examine the extent to which this was happening in practice. Length of restraint was noted for each incident and participants were asked if seclusion was used and, if so, for how long.

Within the first category, staff participants reported that two (n=2, 7%) incidents involved gentle guidance to a place of safety with minimum force. In the second category, guidance with some force was used in five (n=5, 17%) of the incidents. Eleven (n=11, 37%) examples of restraint involving two or more staff using force while the patient remained upright were given using C & R techniques. Seven (n=7, 24%) of the incidents within this category involved only two nurses employing these techniques. Twelve (n=12, 40%) incidents involved the patient being restrained in the prone position using force by two or more staff, on further clarification it was reported that all of these incidents involved a three man trained team. More forceful measures were therefore used in the majority of incidents, as reported by staff participants, in this study with a total of twenty three (n=23, 77%) using C & R methods to restrain patients in the standing or prone position. A summary of types of restraint is provided in figure 10 below.

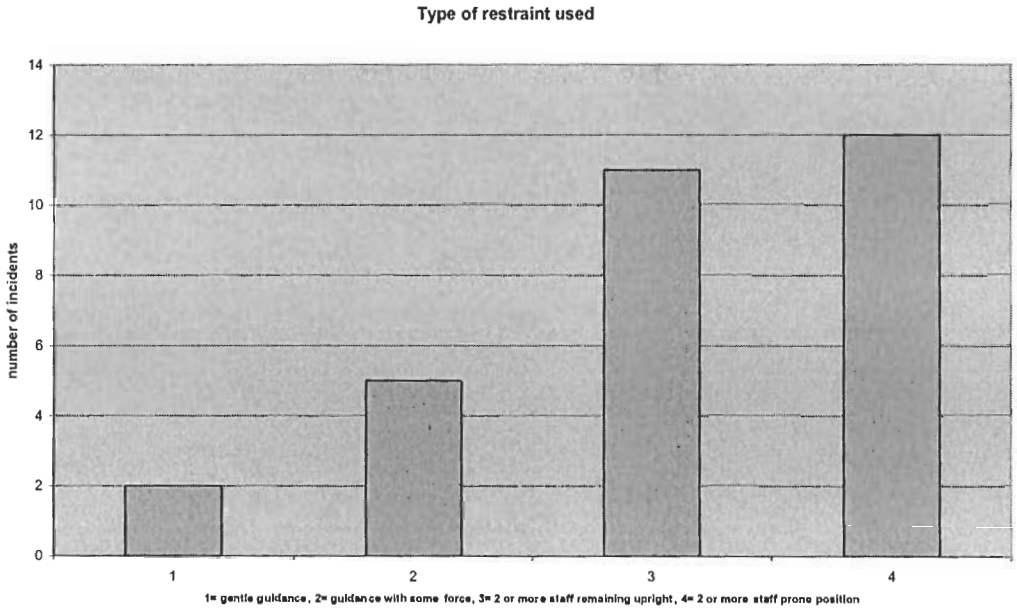

Figure 10. Type of restraint used

4.4.2. Length of restraint

Length of restraint was measured in minutes. Participants were asked to recall the length of time approximately in minutes that restraint was directly applied. Responses were broken down into five categories; less than five minutes, five to ten minutes, ten to twenty minutes, twenty to thirty minutes, and thirty to sixty minutes. Twelve (n=12, 40%) participants reported that direct application of restraint techniques lasted five minutes or less, five (n=5, 17%) participants reported that restraint lasted between five and ten minutes, eight (n=8, 27%) participants reported that restraint lasted between ten and twenty minutes, four (n=4, 13%) participants reported that restraint lasted between twenty and thirty minutes, and one (n=1, 3%) participant reported that restraint lasted between thirty and sixty minutes. Twenty five (n= 25, 83%) staff participants therefore reported that hands on restraint had lasted for twenty minutes or less, as per current UK guidelines. Five (n=5, 17%) of the incidents lasted more than twenty minutes which is outside of recommended

guideline limits (NICE 2005a). These figures should be viewed with caution. Staff do not, as a matter of course, time lengths of restraint therefore these were estimates given by staff participants. There is also the possibility, although speculative, that staff may have underestimated lengths of restraints due to their concerns about staying within set guidelines.

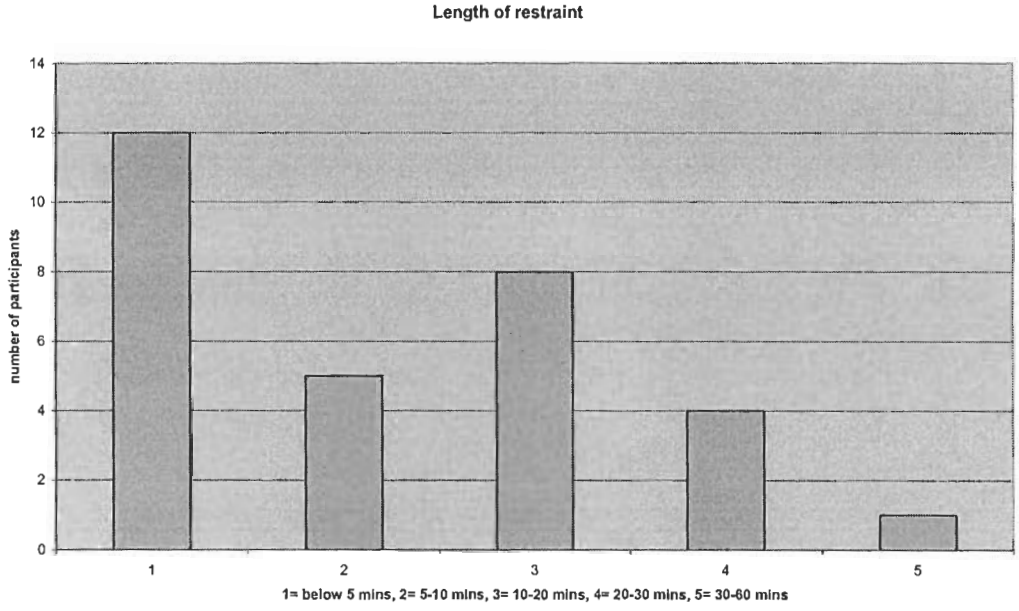

Figure 11. Length of restraint

4.4.3. Use of seclusion

Of the thirty incidents that were examined, staff participants reported that eight (n= 8, 27%) incidents had resulted in the patient being secluded. Half (n=4, 50%) of the incidents that resulted in seclusion took place on an intensive care unit where seclusion rooms were readily available and the other half (n=4, 50%) took place on admission wards where seclusion rooms were not available. These patients were transferred to intensive care and placed directly into seclusion on arrival. Twenty two

(n=22, 73%) of patients who were restrained did not go on to be managed in seclusion. Of the eight (n=8, 27%) patients who were reported by staff to have been secluded, five (n=5, 17%) were kept in seclusion for less than one hour, two (n=2, 7%) were in seclusion for between one and two hours, and one (n=1, 3%) was secluded for between two and three hours. The average length of seclusion was one and a half hours.

4.5. Physical consequences of restraint

Staff participants were asked whether injury occurred during the restraint incident. Injury was to include either to a member of staff involved or the patient to whom restraint was being applied. An adaptation of the Staff Observation and Aggression Scale (Palmstierna and Wistedt 1987) was used to measure the physical consequences of restraint. Physical injuries were categorised as; no injury, felt threatened or brief pain (less than ten minutes) with no visible injury, physical pain (more than ten minutes) or visible injury not requiring treatment, injury requiring some kind of treatment but not necessarily by a doctor, and injury requiring some kind of treatment or supervision prescribed or performed by a doctor. Half (n=15, 50%) of staff participants reported that no physical injury occurred as a result of the restraint. Two (n=2, 7%) members of staff felt threatened or brief pain, five (n=5, 17%) members of staff received injuries requiring no treatment or pain for more than ten minutes, one (n=1, 3%) staff participant reported that she required some treatment but not from a doctor, and seven (n=7, 23%) participants required treatment by a doctor. Of the two (n=2, 7%) staff participants who reported feeling threatened or brief pain, these ratings were in relation to themselves and not the patient who was being restrained. They reported that the patient had no physical injuries. For both staff this category

related to brief pain as result of being involved in the restraint as opposed to feeling threatened. The threatening aspect of the impact of restraint was, however, discussed in the subsequent interviews and results will be presented later in this chapter. The member of staff who reported that she required some treatment explained that this was as a result of hot coffee being thrown at her and basic first aid skills were used with no further treatment required. Of the seven (n=7, 23%) staff who reported that the incident of restraint had required intervention from a doctor, three (n=3, 10%) of these were in relation to staff and four (n=4, 13%) were in relation to patients being restrained. For the staff, examples included requiring treatment at Accident and Emergency for a back injury with further time off and referral for specialist intervention, and for patients examples included treatment at Accident and Emergency for suturing deep lacerations.

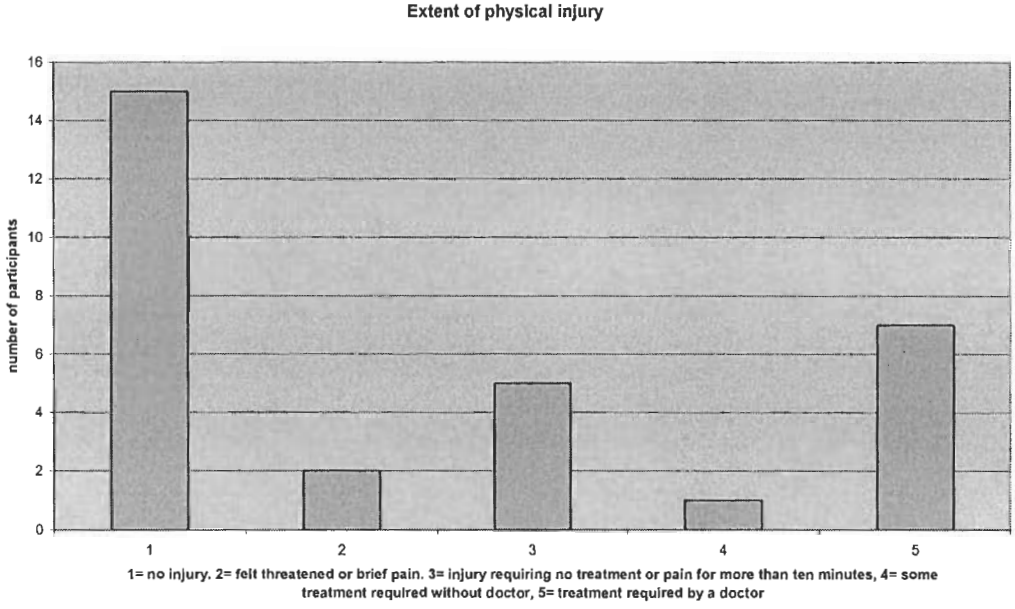

Figure 12. Extent of physical injury

4.6. Use of medication

One of the outcomes of restraint is frequently to use some form of medication to reduce agitation. This study provided an opportunity to examine the extent of medication used and means of administration to patients who were involved in restraint incidents. Medication was recorded as; none used, oral (by mouth) medication offered and accepted, oral medication offered and accepted after persuasion, intramuscular injection offered and accepted, intramuscular injection forcibly administered. For eight (n=8, 27%) of the participants interviewed, no medication was used in relation to the restraint incident. Discussion within the interviews highlighted that situations where medication had not been used were often quickly resolved and medication was not considered an appropriate option. For example, one incident involved an altercation between two patients and staff had to intervene to separate the two. When time was offered to both patients individually to air their grievances, an amicable solution was reached and the situation calmed quickly. Four (n=4, 13%) staff reported that patients were offered oral medication which they accepted. An example of this was for a female patient who regularly self harmed and occasionally was restrained to prevent self harming. She would be offered Lorazepam for her anxiety and agitation, accept this medication readily and then spend a couple of hours in her room quietly with no further self harm. Eight (n=8, 27%) staff reported that patients were offered oral medication which was initially refused but then accepted after some persuasion. Staff accounts of these events related to patients being angry and staff believing that medication may help to reduce agitation. Staff felt that persuasion to take medication was in the best interests of the patient and would prevent further escalation of aggression and violence. Two (n=2, 7%) accounts reported that intramuscular medication was offered and accepted

by patients. Both accounts related to patients that the staff felt they knew well, that patients had not responded previously to oral medication but responded well to intramuscular routes, and were agreeable for this treatment on this occasion. Eight (n=8, 27%) staff reported that patients were given intramuscular injections by force against their will. Examples of this were when staff felt that the situation was dangerous and unlikely to be resolved without drastic interventions, that patients were not responding to verbal interventions during restraint and were refusing offers of medication orally or intramuscularly.

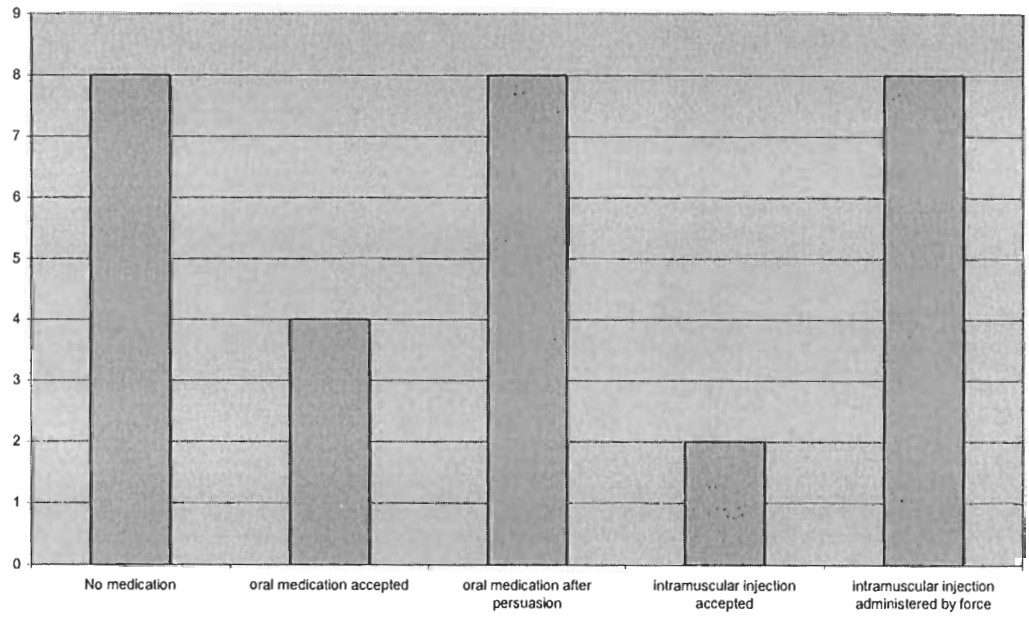

Figure 13. Use of medication - staff

4.7. Antecedents

The literature review has identified that often there are contributing factors which may influence the development of untoward incidents in mental health care and recognition of such factors can frequently prevent situations escalating if suitable approaches are used to intervene as the situation develops. In this study, 23 (n=23,

77%) out of 30 (n=30, 100%) staff reported some form of antecedent or warning had been evident before the incident had taken place. Some staff reported a lack of clarity in relation to antecedent behaviours, particularly those who had come in response to alarm calls from other wards. These staff (n = 4, 13%) felt unable to comment on antecedents as they had not been involved with the patients previously. The two staff (n = 2, 7%) who were involved in incidents within their own clinical areas had recently returned from time off and did not know the patients. They felt that they should have been warned of previous minor incidents that had taken place but were not. Three (n = 3, 10%) staff reported that communication had been poor in relation to patients not taking medication in the day(s) leading up to the event. This information had not been handed over to them and they reported that they only found out after the event that this had been an issue. It is not clear whether these issues had been clearly documented within the system,

"...I was responding to the PIT alarm [personal alarm system in place within this Trust] *to x ward. I didn't know what I was going to really, or what situation I was going to find myself in"*

"...I'd been off for four days. They'd told me to look out for him but they didn't explain how bad he'd been."

"...He hadn't taken his evening meds for three days but that wasn't handed over. If we'd known that, we would have been more prepared or maybe tried to do something about that."

More common antecedents were described directly in relation to mental illness. Eleven staff (n = 11, 37%) stated that the patient's mental state had deteriorated and that the incident had occurred as a result of this,

"...She was manic. This always happens with her. You try and intervene but she gets annoyed. Then you try to give her some space but she gets over stimulated. It's a no win situation."

"...I think on hindsight we could see that his mental state was worsening but I personally don't think we realised just how badly he was deteriorating."

"...I could tell that he was deteriorating. He was pacing the ward and not responding to any [talking] *interventions."*

Other staff (n = 12, 40%) reported clear behavioural antecedents, not necessarily related to mental illness,

"...well his behaviour was getting worse. He kept coming and demanding to use the office phone and he could see we were all busy. I told him to come back later when things were a bit quieter but he wouldn't listen."

Eight (n = 8, 27%) staff reported that earlier minor incidents had taken place which indicated that potentially situations could escalate,

"...He had gone up to x and kept pulling at her arm. She diverted his attention to something else and then he kept coming up to the clinic [clinical treatment room where medication was dispensed on this ward] *when we were trying to give out the meds. We had to shut the door in the end."*

One (n = 1, 3%) patient had taken amphetamines which resulted in him becoming aggressive,

"...well we should have guessed because he's done this before. Soon as he gets some time off the ward he goes down x Road [a notorious area for illegal drug dealing] *and gets amphetamines."*

Some staff (n = 9, 30%) found difficulty in explaining what antecedents were present but reported that they 'just knew' events were escalating,

"...The atmosphere was tense but you couldn't really pinpoint what it was all about. There wasn't anything happening where you could say, "X is going to kick off today and this is why"..."

The findings of this study support current literature related to antecedents. There are some common themes related to worsening mental state, lack of / unsuccessful early intervention, earlier minor incidents, stopping medication, and poor staff communication. Staff experience and intuition also play an important part in recognising early warning signs for the prevention of untoward incidents.

Many of the antecedents in this analysis overlapped. For example, staff described worsening mental state and earlier minor incidents. Where this was the case, these examples have been included in both categories. The theme related to behavioural antecedents includes only situations where staff felt that patient behaviour was not necessarily linked to mental illness. Some staff reported that patients had been angry and abusive prior to incidents happening without this being triggered by mental illness, for example when a social worker had not turned up as planned a patient had become irritated. He paced around the ward and became increasingly more abusive to staff. This was described by the staff participant in terms of his behaviour becoming increasingly disturbed however it is of concern that this behaviour was not interpreted through a framework of understanding that this patient may have been angry at being let down by his social worker.

A chart of the sub-themes related to antecedents is presented below:

ANTECEDENTS	**N = 30**	**%**
Mental state worsened	n=11	37%
Behavioural disturbance	n=12	40%
Intuition 'just knew'	n=9	30%
Unclear / assisting from another clinical area	n=4	13%
Not taking medication	n=3	10%
Use of illegal substance (amphetamine)	n=1	3%
Earlier minor incidents	n=8	27%
No antecedents noted	n=7	23%

Table 4. Antecedents

4.8. Feelings

4.8.1. Feelings leading up to the incident

The management of untoward incidents evokes strong feelings in staff. This has been demonstrated in previous studies and these findings are supported within this study. Feelings within this theme were broken down into sub themes related to before, during and after the event. These will now be discussed.

Seven (n = 7, 23%) staff reported that they had no particular strong feelings in the period leading up to the incident,

"...I was fine, business as usual."

"...Nothing really, quite relaxed. Had just got back from leave so was feeling quite relaxed."

The majority of staff (n = 23, 77%) reported feeling a variety of negative emotions in the time span leading up to the incident itself. While not directly related to antecedent behaviour, these feelings appeared to be contextual and were related to the imminent potential for danger. Anxiety, apprehension and fear were the predominant feelings (n=23, 77%), and a number of participants went to describe physical symptoms of anxiety (n=11, 37%),

"...I could feel the adrenalin."

"...I was scared, my adrenalin was pumping... I was shaking. My heart was racing."

FEELINGS – leading up to the incident	**N = 30**	**%**
No strong feelings	n=7	23%
Anxiety, apprehension and fear	n=23	77%
Physical symptoms of anxiety	n=11	37%

Table 5. Feelings leading up to the incident - staff

4.8.2. Feelings during the incident

During the incident the same staff reported that their feelings of anxiety continued but they were less aware of them while being engaged in the act of restraint. Four staff (n=4, 13%) specifically described feelings of automatically responding to situations and being less aware of emotions,

"...I was on auto pilot...scared."

"...I was aware of the adrenalin but I was more focussed on what was going on."

Other feelings which were reported during the incident were fear of the consequences (n=3, 10%) and concerns regarding the situation becoming out of control (n=5, 17%). These were linked to feelings of fear.

"...I wasn't sure what to expect."

"...It felt out of control, I didn't know what was going to happen next."

"...It was all a muddle, too many people were giving instructions, too many got involved."

"...I was scared."

"...Frightened. I really was worried at this point."

One participant (n=1, 3%) who had been involved in restraining a patient who had thrown a kettle of boiling water at staff expressed concern about practical / environmental safety issues,

"...I was acutely aware of the water all over the floor and we were slipping. I was worried that we wouldn't be able to keep a hold of him because we were slipping all over the place."

Another staff participant (n=1, 3%) was also concerned about practical / environmental safety issues,

"...There was blood everywhere. It was spurting out from her cuts. Before I got involved I took my gloves from my belt (I always keep a pair there, at the start of every shift I get a fresh pair because you can't be too careful). I thought there's blood everywhere and none of them [her colleagues] *are bothered."*

Other emotions described during the incident were of foolishness and humiliation,

"...The main feeling was foolishness and humiliation. I couldn't release myself from her grip on my hair or her teeth in my cheek."

One nurse (n=1, 3%), who subsequently went on to develop Post Traumatic Stress Disorder, summed up her feelings during the incident,

"...Terror."

A summary of feelings of staff during the incident is offered in table 6 below.

FEELINGS – during the incident	**N = 30**	**%**
Anxiety	n=11	37%
Out of control	n=5	17%
Fear / terror	n=6	20%
Fear of consequences / outcome	n=3	10%
Environmental / safety issues	n=2	7%
Foolish / humiliation	n=1	3%

Table 6. Feelings during the incident - staff

4.8.3. Feelings after the incident

Common feelings in the immediate aftermath of the incident were relief (n = 11, 37%), anger (n = 8, 27%), guilt (n = 8, 27%), frustration (n = 4, 13%), concern (n = 4, 13%), and tiredness / exhaustion (n = 4, 13%). Relief was related to the situation being managed and controlled, and was expressed regarding the event concluding with perceived safe closure,

"...Relieved it was over. At one point I thought we were losing it. We were grappling about the floor and it could have went one way or another."

"...Relieved about the fact that she was safe."

"...Relief. At one point I really didn't think it was going to end."

Anger was mainly related to teamwork and resource issues such as poor staffing,

"...I still feel very angry with them [the team]. *They sat in a ward round while I was fighting for my life. I just don't understand why. I trusted them. And x* [a colleague] *just stood and watched. I still can't believe it."*

"...We're not at our full compliment [of staff] *and the ward is over crowded. We can have up to forty patients here during the day, what with people sleeping out [if no beds are available arrangements are sometimes made for patients to sleep in other wards but return to their host ward during the day] all over the place."*

Guilt was related to using restraint as a last resort after other avenues had been exhausted,

"...We'd tried talking to her, hoping she'd come round [to accepting medication] and the doctors were pushing, and we were resisting, but eventually we had to give it. She was becoming more and more unwell and just couldn't reason with us."

One member of staff (n = 1, 3%) related her feelings of guilt to the way that the situation was managed,

"... Guilty about the process in that I thought we should have handled it better."

Frustration was related to relationships with patients and external influences, mainly resources,

"...I was really frustrated with her to tell you the truth. I'd given her a lot of individual time and we'd talked about it, and she still did it."

"...I get very frustrated. We had a full day planned for the ward and then a member of staff was sent to x ward and things just went downhill from there."

Concern was expressed regarding the breakdown of therapeutic relationships and a perceived lack of recognition by line management related to safety and support,

"...I was concerned [long pause while participant considers her response]. *I felt like I'd let her down. We'd been making good progress and she was doing really well until this setback. I think we'll be ok, but at the time I really was concerned that all the good work would have gone to waste."*

"...I just think...well what is it going to take before something really bad happens [participant then goes on to talk in length about faults in wider support systems]."

Four (n = 4, 13%) staff reported to feeling tired and exhausted in the aftermath of the incident,

"...Exhausted. As it went on it got more and more difficult to hold on to her whilst trying to persuade her to come back."

"...I was worn out. I went home and slept."

A summary of feelings in the aftermath of the incident for staff is offered in table 7 below.

FEELINGS – in the aftermath	**N = 30**	**%**
Relief	n=11	37%
Anger	n=8	27%
Guilt	n=8	27%
Frustration	n=4	13%
Concern	n=4	13%
Tiredness / exhaustion	n=4	13%

Table 7. Feelings in the aftermath of the incident - staff

4.9. What was helpful?

Teamwork was described by 50% (n = 15) of staff participants as the most helpful aspect of managing the incident. This was broken down into various descriptions which the teamwork theme encompassed,

"...Teamwork. We are very lucky here in that X [ward manager] *runs a tight ship. We had it planned what we were going to do and how we were going to approach it. She took the lead and that made a difference. We knew who was doing what at all levels."*

"...There was good co-ordination. Everybody worked as a team and that meant that the situation was dealt with quickly and effectively.

"...Planned, co-ordinated, well managed...that makes a big difference when you get a situation like this."

Staff placed great emphasis upon this aspect of managing untoward incidents as crucial in achieving a positive all round outcome,

"..You can't underestimate what a difference that [teamwork and co-ordination] *makes. I've been in both situations and it can leave a bitter taste if the team don't work well together, or if it ends up in bun fight...you know, nobody knowing what the next person is doing...all arms and legs everywhere."*

"...Reliable staff."

Staff support during and after the incident was also specifically mentioned as helpful by nine (n=9, 30%) staff,

"...I had excellent support from my colleagues and that made such a difference."

"...I felt supported [by the staff team]. That was helpful."

Post incident support will be discussed in more depth later in the thesis.

Prompt responses were identified as helpful with nine (n=9, 30%) staff reporting this as a helpful aspect of the incident,

"...There was a very quick response to the PIT [alarm]. Within seconds..."

"...Quick responses helped in this situation. That always makes a difference."

"...The guys from X [Intensive Care Unit] arrived very quickly. That was very reassuring."

Training was also reported as a positive influence in managing untoward incidents (n=6, 20%). Staff felt more confident if they were trained themselves and if they had a team of staff who had previous training in Control and Restraint (C & R),

"...This [C & R training] *has made a difference to our team. Since we've had this chap we're all being supported in getting the further training. That has made a difference. Before, you might have one if you're lucky but now quite often we have three on [duty] and we manage him much better."*

"...Even though I was really shaken up I was grateful that I'd done my C & R before. I don't quite know how I would have managed otherwise...I think the outcome could have been much worse."

"...You have more confidence in approaching the situation. I certainly feel happier if I know the people who are backing me up are C & R [trained]."

Knowing your patient and having good relationships with patients was a feature described as helpful. Six (n=6, 20%) staff described this in a positive way,

"...Afterwards we sat down and talked about it. I was worried that the relationship would be broken down but she apologised to me and, in fact, if anything our relationship is better now."

"...I think the fact that I know X [the patient] *really well helped. I was able to talk her down and I think it could have been a lot worse even though it felt bad enough at the time."*

"...There are issues about how well you know your patients. I've known X for years now and I think we've built up a bit of respect. She'll listen to me whereas one of the newly qualified [nurses] *might not get away with it."*

In some instances patients were transferred from acute wards to intensive care in order to manage challenging behaviour in a more secure environment. Transfer provided its own challenges and was highlighted by four (n=4, 13%) staff as a factor which affected how positively incidents were subsequently viewed. This could be in terms of physical transfer through corridors and heavy doors, as well as availability of beds in PICU,

"...We had a smooth transfer and that was helpful."

"..Transferring patients from here to the other ward can be a major problem but in this instance the transfer went smoothly."

A summary of what was helpful for staff is offered in table 8 below.

WHAT WAS HELPFUL?	**N = 30**	**%**
Teamwork	n=15	50%
Staff support	n=9	30%
Prompt response	n=9	30%
Training	n=6	20%
Nurse patient relationship	n=6	20%
Smooth ward transfer / availability of PICU	n=4	13%

Table 8. What was helpful for staff participants?

4.10. What was unhelpful?

As expected, staff reported some of the opposite to what they had found helpful when asked the question about what was unhelpful. While teamwork was cited as being most helpful, lack of co-ordination was cited as being most unhelpful (n = 6, 20%). Lack of support was reported (n = 5, 17%) as well as poor responses to incidents (n= 3, 10%) although these unhelpful responses were much lower in relation to the same helpful responses.

There were additional factors which staff reported to be unhelpful when being involved in untoward incidents. Staffing (n = 6, 20%) was reported negatively in terms of poor staffing and skill mixes,

"... We have lost a few staff recently and this reflects on how these incidents are dealt with. We have new staff who don't know the patients or the set up well."

"...We were working on low numbers with agency staff."

"...It makes a big difference when we are on our full complement [of staff]."

Poor communication was cited (n = 6, 20%) in relation to nursing staff as well as the multidisciplinary team,

"...The rest of the MDT sat in the meeting room while it was all kicking off. I don't believe that they didn't hear what was going on."

"...I was called over to X ward and they just stood there waiting for me to do something. They think we are telepathic, that all they have to do is ring the phone and we will appear and solve their problems for them. All I did was go up and talk to the lady and she soon calmed down."

Long decision making processes were also cited as a difficult area of communication when deciding management plans for challenging patients, sometimes resulting in situations escalating,

"...Nobody could decide what to do for the best. We all had different views and we all felt strongly about the best way forward. This delayed things which I don't think helped the situation."

Environmental factors were cited as unhelpful (n = 4, 13%). These included manoeuvring heavy doors when trying to transport patients to a safer area (n=2, 7%), location of incident (n=3, 10%), and overcrowding (n = 1, 3%),

"...We can have over forty patients on here at any one time, what with people sleeping over on other wards at night [over bed occupancy] *and others attending for meetings during the day. The place is not built to house that many and we aren't given the amount of staff needed to compensate for the extra."*

A summary of what was unhelpful for staff is offered in table 9 below.

WHAT WAS UNHELPFUL?	**N = 30**	**%**
Lack of co-ordination	n=6	20%
Lack of staff support	n=5	17%
Poor responses to incidents	n=3	10%
Poor staffing / skill mix	n=6	20%
Poor communication	n=6	20%
Environmental factors	n=4	13%

Table 9. What was unhelpful for staff participants?

4.11. Reawakening of traumatic events

In the earlier pilot study it emerged that, for some participants, the experience of restraint reignited the experience of earlier traumatic events. Examples included staff

who had been in previous particularly traumatic restraints where serious injury had taken place, and situations had become out of control. On interviews related to different incidents involving restraints staff had described the previous event being 're-lived' or that the event had been reminiscent of previous encounters. There were some difficulties in examining this phenomenon in terms of distinguishing between the terms used. The description of re-living the event suggested that the more recent event of being restrained activated a process whereby access to stored unconscious memories was triggered and brought to consciousness. This process was not activated at will and was therefore out of the participants' control. This phenomenon could also be described as a reawakening of events resulting from the recent experience of restraint, but not under the conscious choice of the participant. Examples from the previous pilot study (Bonner et al 2002) included a member of staff who had been injured as a result of an assault by a patient some years previously. When she was interviewed in relation to a more recent restraint incident she described feeling as if she was experiencing the earlier event again. This had caused subsequent distress to her and she was reluctant to engage in further restraint situations. From a patient perspective, an example of this phenomenon was regarding a patient who had been raped by strangers fifteen years before the recent restraint incident. She too described feelings of "being back there" during the recent restraint and was very distressed during the event, and for some time afterwards. Use of the term 'remembering' the event is distinguished differently for the purpose of this study. Some participants had described how recent restraint incidents had been reminiscent of earlier incidents. These descriptions were different to the more vivid descriptions of re-living / reawakening and had not carried subsequent distress to those individuals. These terms are therefore distinguished between re-living and reawakening being vivid

recollections which had caused distress, and remembering which had been within the control of the participant and had not caused subsequent distress. This study aimed to explore this phenomenon further and a question was included which asked whether this event had brought back distressing memories of previous traumatic encounters. If participants responded positively further open ended questions were asked to try and ascertain a more comprehensive picture of this phenomenon and how it was experienced. Seventeen (n=17, 57%) out of thirty participants reported that the incident had brought back memories of previous traumatic encounters. For the staff group who responded positively their descriptions were divided into two groups, work related encounters and non-work related encounters. Work related encounters were then broken down further into specific work related events and non-specific work related events. Work related encounters were when the recent experience of restraint had brought back memories of previous work related traumatic events. Specific work related events were identified as events that staff were clearly able to recall that had happened on a previous occasion but that memories of the specific event resurfaced during the more recent untoward incident. For example, one nurse had been involved in a particularly nasty incident over two years previously, whereby a member of staff had been seriously hurt and the situation had taken some time to control. The participant described how this event subsequently sprung to mind on almost every occasion that she was involved in restraint, no matter how 'minor' the incident. Non specific work related traumatic events were categorised as generalised remembering of distressing memories related to experiences of previous restraints. Staff found these difficult to articulate and when asked whether the memories were related to an event in particular they would respond that the memories were of different restraint experiences:

"...It's hard to explain. I just think about lots of the other ones that have happened. Am I going to manage this one alright, what's going to happen, that sort of thing. You might remember one that was similar to this but you don't always."

Non work related encounters were related to memories of traumatic events that had happened to the individual previously but had been remembered during the course of restraint. For the participants who experienced this phenomenon, the events were always clear and specific. For example, a member of staff had been assaulted some eighteen months previously. When being interviewed about the recent restraint experience he described how disturbing images of the earlier encounter had come to mind and that this had happened during other incidents of restraint. Describing the experience for this participant proved difficult and this was in keeping with other participants. The phenomenon was not experienced as a flashback per se, as commonly experienced with PTSD. Rather, participants readily recognised that the memory / experience was disconnected to the current restraint situation and in the heat of the moment the participants still felt in control of their thoughts and feelings. They admitted that they hadn't given these experiences much thought until being directly asked about them. A breakdown of these responses is offered in table 10 below.

REMEMBERING TRAUMATIC EVENTS	N = 30	%
Remembering previous encounters	n=17	57%
Work related - specific	n=3	10%
Work related – non specific	n=10	33%
Non work related	n=4	13%

Table 10. Remembering previous traumatic events - staff

4.12. Trauma Screening Questionnaire (TSQ)

The TSQ was used to ascertain whether participants were experiencing symptoms of trauma and may warrant further screening for PTSD. The results of the staff findings for the TSQ are highlighted in figure 14 below.

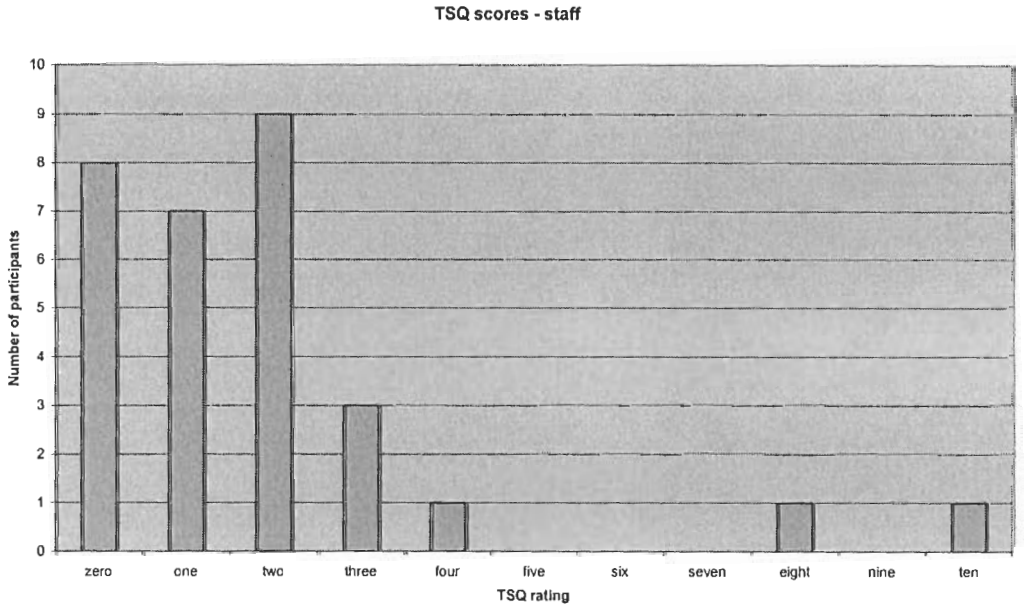

Figure 14. TSQ scores- staff

Out of 30 participants, 2 staff (n=2, 7%) scored above clinical cut off points and warranted further screening for PTSD. Both staff went on to have further assessment and treatment. Although the rest of staff participants were below clinical cut off points, 20 staff (n=20, 67%) still had some existing PTSD related symptoms as indicated in figure 15 below.

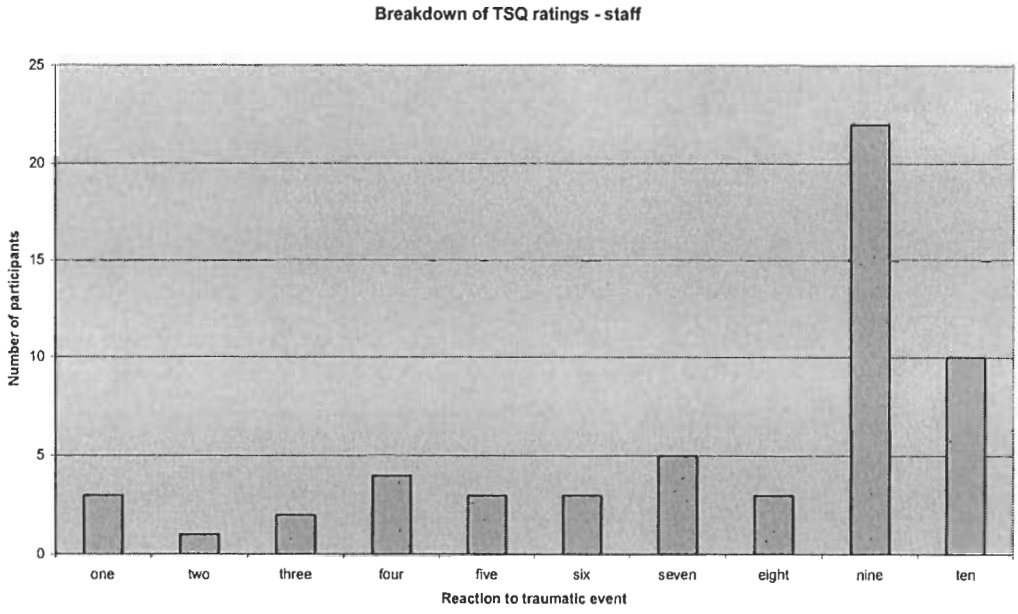

Figure 15. Breakdown of TSQ ratings

The *x* axis indicates the questions listed in the TSQ from 1-10. Question one asks whether the participant has had upsetting thoughts or memories about the event which have come to mind against their will in the past week. 3 staff (n=3, 10%) indicated that this had been the case for them. One member of staff (n=1, 3%) reported positively to the second question which asked whether the participant had upsetting dreams about the event. 2 staff (n=2, 7%) felt as if the event was happening again in response to question three and 4 staff (n=4, 13%) felt upset by reminders of the event in response to question four. Question five asks about physical symptoms such as fast

heartbeat, stomach churning, dizziness; 3 staff (n=3, 10%) responded positively to this. 3 staff (n=3, 10%) had difficulty in falling asleep (question six) and 5 members of staff (n=5, 17%) reported having irritability or outbursts of anger (question seven). 3 staff (n=3, 10%) responded positively to question eight which asks whether the participant has had difficulty concentrating. The last two questions rated more highly over the others. Question nine asks whether the participant has had heightened awareness of potential dangers to yourself or others and 22 (n=22, 73%) reported positively to this. Question ten generated 10 (n=10, 33%) positive responses to whether the participant was jumpy or startled at something unexpected. These last two points were of particular interest. These are recognised symptoms for PTSD but for the majority of participants, overall ratings were below clinical cut off points for further PTSD screening. When completing these forms a number of staff reported informally that they had positively rated the heightened awareness questions in relation to their nursing roles, ie that they were generally more aware of surroundings and risk than they would be outside of the clinical setting. This would be in keeping with policies, guidelines, and training related to observation, risk and safety. Further consideration was given towards the severity of the restraint incident and the score on the TSQ, the untested hypothesis being that the more severe the incident, the greater the risk of trauma. On re-examining all of the incidents in relation to TSQ scores, this hypothesis would be supported. The two staff who went on to develop PTSD had been involved in more dramatic experiences, both members of staff being beaten severely and perceiving risk of severe harm or death during the incident.

4.13 Staff evaluation – Post Incident Review

The Post Incident Review formed the framework for the semi structured interviews. This format had proved helpful in the earlier pilot study and had been positively evaluated but no measurement of these evaluations was taken at that time. This was an opportunity to evaluate more thoroughly to establish whether this may be a framework that could be advocated for use in clinical practice. An evaluation form (appendix 10) was offered to staff at the end of the interview and they were asked to complete this anonymously and return to the researcher. 100% of staff returned the evaluations. The evaluation was made up of six questions which staff were asked to rate on a likert scale of 1-7 where 1 equalled strongly disagree, 7 equalled strongly agree, and anchor point 4 equalled neither agree nor disagree. Four questions asked specifically about the efficacy of the framework and two questions were included which asked whether the incident could have been predicted and whether the incident was managed well. Results are presented as follows:

Question one (figure 16) asked participants whether the framework provided an opportunity to discuss the aftermath of an incident which they may not otherwise have had the opportunity to do. All of the staff participants agreed with this statement.

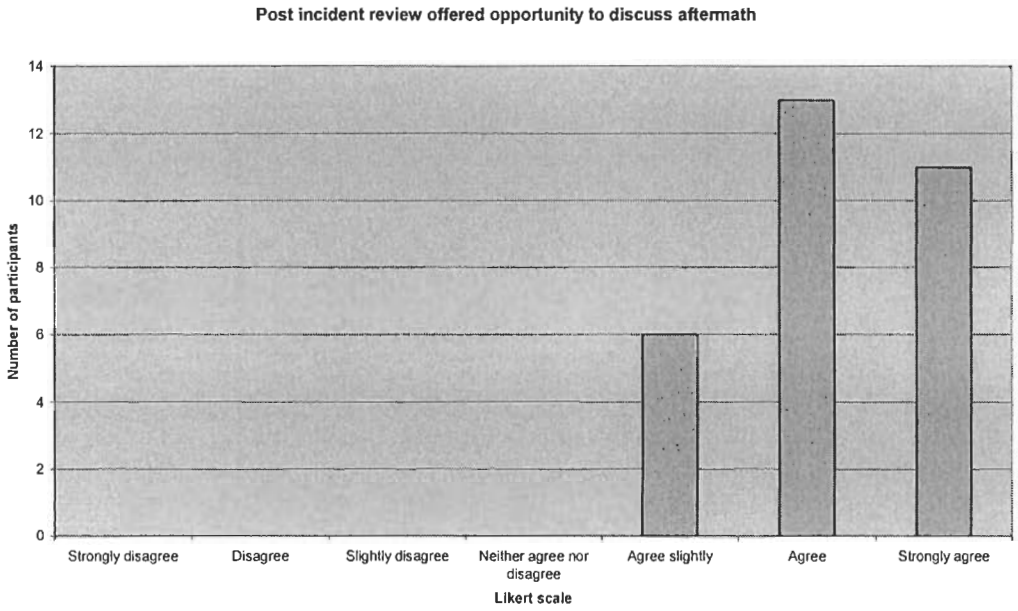

Figure 16. Post Incident Review evaluation question 1 - staff

Question two (figure 17) asked whether the review had allowed the member of staff to think about some of the events leading up to the incident. Two (n=2, 7%) participants neither agreed nor disagreed that the review had allowed them to think about events leading up to the incident, the remaining staff (n=28, 93%) agreed that the review had offered this opportunity, and out of those 37% (n=11) strongly agreed.

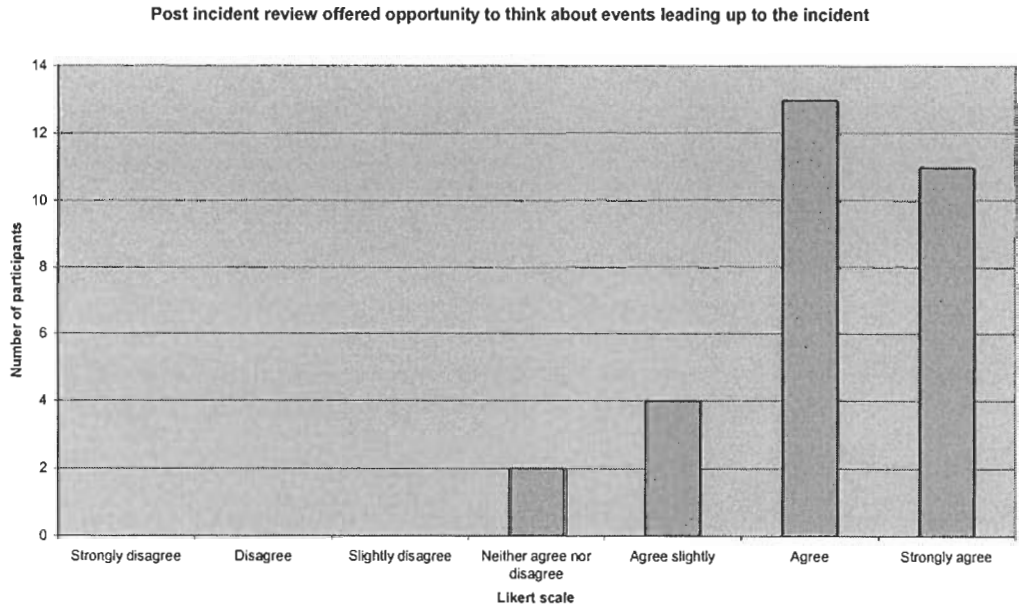

Figure 17 . Post Incident Review evaluation question 2 - staff

Question three (figure 18) asked whether the Post Incident Review had helped the participant to think about how the incident was managed. Four (n=4, 13%) staff neither agreed not disagreed that this was the case and the remaining twenty six (n=26, 87%) agreed that the review had allowed them to think about how the incident had been managed.

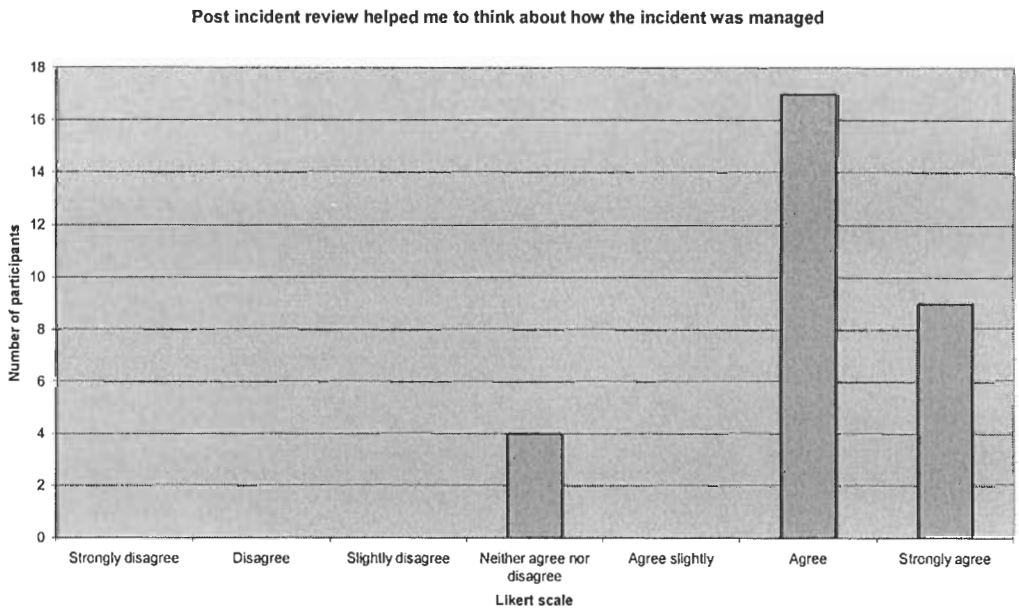

Figure 18. Post Incident Review evaluation question 3 - staff

Question four (figure 19) asked the participant if the framework was a useful way to review incidents of restraint in the practice setting. One participant disagreed and the remaining twenty nine (n=29, 97%) agreed.

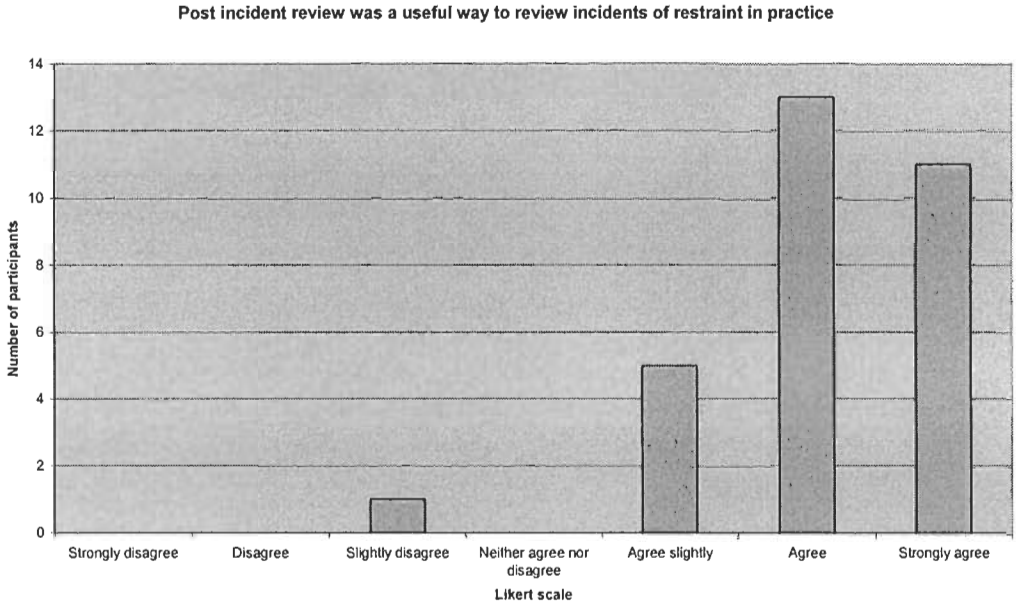

Figure 19. Post Incident Review question 4 - staff

The last two questions asked about management of the incident (figure 21) and whether the participant believed that it could have been predicted (figure 20). These questions were used to provide supplementary data to the qualitative interviews which were being undertaken as part of the wider study. Mixed responses were generated from these questions. 60% of participants (n=18) agreed that, on reflection, the incident could have been predicted, 17% (n=5) neither agreed nor disagreed that the incident could have been predicted, and 23% (n=7) believed that it could not have been predicted.

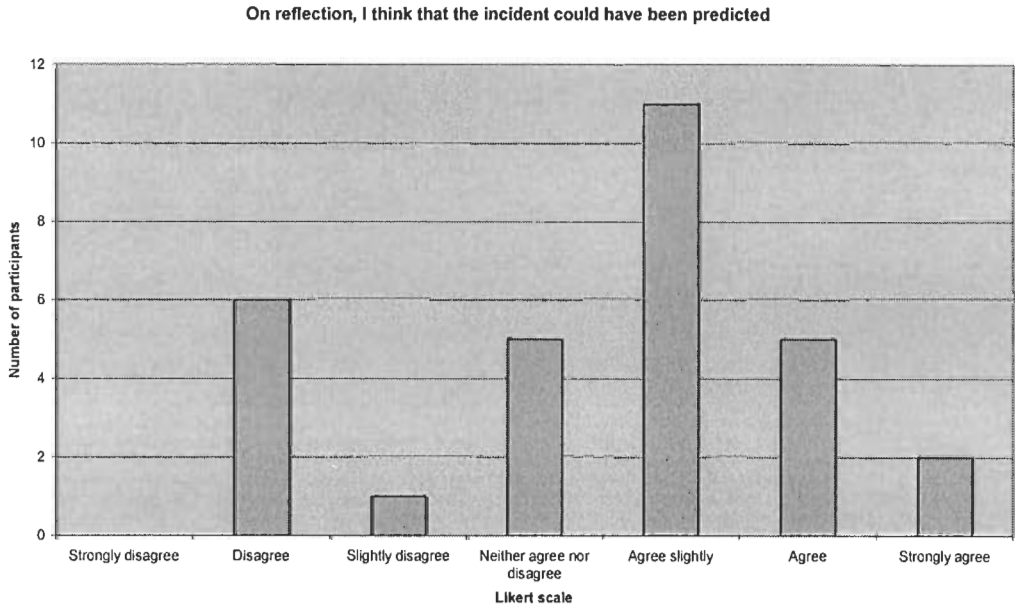

Figure 20. Post Incident Review evaluation question 5 - staff

The final question asked whether the participant believed that the incident had been well managed. 67% (n=20) agreed that the incident had been well managed and 13% (n=4) neither agreed nor disagreed with this statement. Of the 20% (n=6) who did not agree that the incident had been well managed, 6% (n=2) disagreed strongly.

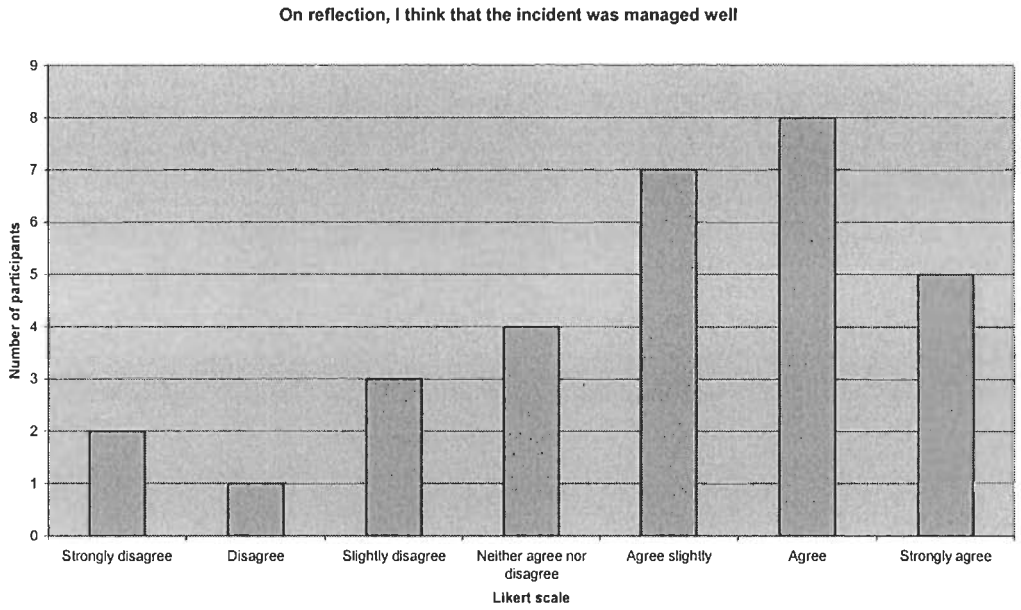

Figure 21. Post Incident Review evaluatiou question 6 - staff

4.14 Staff focus group

Despite my reservations that no staff would turn up I was delighted to have the opportunity to discuss restraint with twelve members of qualified staff. The meeting had been arranged to be slotted in with another training day hence the number of staff available at that time. This focus group proved to be a great source of data and a discussion of the content will now follow. The demographics of the focus group were not noted in depth; however the majority of the group already had C & R training and appeared to be an experienced group of clinicians. Some of the group members had worked in different localities within the Trust and others had been employed previously within another neighbouring Trust therefore they compared their experiences within different areas in relation to their current places of work. This provided a wealth of rich discussion related to the topic of current restraint in a variety of practice settings.

The staff focus group discussed similar antecedent behaviours to the other staff participants. They discussed how sometimes, in their experiences, incidents could be avoided through earlier therapeutic interventions as opposed to waiting while situations escalated,

"Sometimes we create the incident. We're not actually prepared to deal with it so we let it continue. Complacency gives the wrong message."

"The atmosphere is tense. We just look at each other waiting for it to happen."

Training was discussed with mixed feelings. Staff reported that in general they felt safer and more equipped to manage situations of restraint if they were trained in C & R methods and if they had the back up of a trained C & R team on shift. This was in keeping with individual responses from the qualitative interviews. Reservations were expressed within this group in relation to C & R training, however, which were not

evident within the responses from the other staff participants. Staff in this group expressed concern that colleagues used lack of C & R training and updates as a way of avoiding situations involving restraint procedures. There was some resentment within the group surrounding this issue, and some participants expressed anger that they were regularly placed "on the front line", or colleagues went off sick when there were particularly challenging patients on the ward,

"There is a core group who avoid training. Management need to push training or those staff should be redeployed elsewhere."

"You can end up in the situation where the people that avoid restraint end up going off sick if you've got somebody [a patient] *that needs a lot of management* [of aggression] *and they* [the staff member] have *to get involved."*

"People opt out by not doing training but can't respond [to situations requiring restraint]."

In relation to this issue others expressed concern that clinicians who attended C & R training were being assessed as competent in class but were incompetent when applying their newly acquired skills within the clinical area,

"I have been in dangerous situations with one particular member of staff who has attended training but can't do the holds properly. I suspected this for a while because it [staff in restraint situations] *wasn't working as a team, and patients were getting out of holds. I didn't like to say anything but in the end I did to another member of staff and she agreed with me. We had a word with her [the member of staff who they believed was incompetent] and she admitted that she didn't think she was doing it properly. We were lucky enough to be able to talk about it and she has since got much better but we are a good team and I don't think that I would be comfortable doing that in some of the other places that I've worked."*

Another staff member expressed her concern regarding reputation within clinical areas in relation to proficiency at management of violence and aggression,

"I was trained in another area in C & R and I'm blamed for what went wrong [during a previous incident] *so I don't respond. It's handed over discreetly, "Don't let her be involved in C & R, she's not helpful" but nobody has actually said it directly to my face."*

Other issues surrounding training which support some of the issues raised through other individual staff interviews were that training should be provided for whole staff teams at the same time. The group agreed that training with colleagues that you were subsequently working with as a C & R team would make sense in terms of working in coordination with each other in the training environment, and then applying these techniques as a team in practice,

"I know it has practical implications, but it would make it so much more sense if the whole team could be trained en masse. Sometimes if you're in a restraint situation with somebody that you've never restrained with before, you don't quite get the coordination right and it makes it that bit more difficult. I know managers don't want whole teams to go off together but it would probably save them in the long term from injuries and badly handled restraints."

The focus group participants supported comments made within the staff data analysis in relation to issues of the restraint situation having more positive outcomes if there was some semblance of coordination and control. Participants agreed that if one person took the lead in restraint situations the whole team worked better, and as individuals they felt safer and in control,

"If you are a leader you can take over and be on top [of the situation]. One person in control is easy. Don't leave it to somebody to take charge if they're wary – time wasting is risky."

Issues of Post Incident Review for both staff and patients was discussed and the group agreed that Post Incident Review within the areas that they had practised had been inconsistent or non-existent. Ward cultures and management styles were discussed in relation to Post Incident Review with regards to the lack of commitment to Post Incident Review in some camps,

"Following one difficult incident I was complaining that we should have some kind of support and a manager said that everyone gets assaulted in this job and that why should I be treated so special. It gives the wrong message."

"They [some members of staff] *keep it in. They say that it's part of the job and that if you do the training you should be prepared to get on with it."*

As far as support to patients was concerned the group also agreed that this was lacking in the areas that they had worked,

"I believe that it [Post Incident Review and support for patients] *does get forgotten."*

"Well it tends to be a bit like, you go up to the patient, and you ask them if everything is ok, and then you carry on as usual."

"I think in some areas there are favourite patients. Nobody would admit that but for those patients they do get a bit more time to look at what's happened. But it doesn't happen as a matter of course for everybody."

"I think that sometimes it's [Post Incident Review] *done to patients. Often it's about not asking the right questions. The event has passed and it's meaningless, it's discussed in the ward round and the patient can't remember. They don't want to talk about it in the ward round or the MDT* [multidisciplinary team meeting]."

One nurse who was in the group was now working in a post which involved community work with clients who were very recently discharged from inpatient care. She spoke at length about the time that service users who had been discharged discussed some of their experiences in hospital, particularly in relation to restraint incidents,

"It is horrifying to hear their experiences and how professionals abuse their power. This appears to be the norm and needs to be looked at more broadly."

This supported my own experiences as a Community Mental Health Nurse and this issue had underpinned some of my considerations related to the pilot study some years previously.

The discussion of Post Incident Review developed into a recollection of what staff had found helpful or unhelpful on a more personal level. Some staff described some dramatic events that had happened to them in practice, for example one nurse had been aware that a patient had a dislike towards her and had verbally threatened her. Subsequently she was followed into the office by this patient and was attacked physically,

"I found it traumatic. We couldn't get control. I went to staff support [afterwards]. *I went to counselling. It helped me to face work again."*

Night staff had their own particular issues and reported that they had to actively seek support following incidents that happened during the night. They felt particularly vulnerable as a result of lower staffing numbers on nights,

"There is no support at night. It's good to talk about it. I put it in the diary so I can manage to make time. I'll come in a bit earlier to speak to [ward manager]."

"I wasn't offered it [post incident support] *until later. It should be offered sooner."*

The focus group went on to speculate about the consequences of not accessing appropriate interventions following restraint and appeared to be acutely aware of their own, and their colleagues, psychological vulnerability following restraint. They returned to the discussion of colleagues who avoid restraint situations while putting their colleagues at risk, and were more sympathetic towards their colleagues than they had been earlier in the discussion,

"You wonder if they've had some really bad experience and this is why they avoid it now. Maybe the best way for them to cope, maybe it's the only way, is to avoid situations that remind them of it."

"I know one guy who had a really bad time of it. He got badly injured and was off for months. He does talk about it sometimes and I think that had made him more wary."

"I think for some people it has affected their lives in many ways. They're never quite the same after they've had a really traumatic experience [of restraint]. *But some people have been in the job for years and can't really do anything else. They've got their pensions and everything, and maybe they just think they can stick it out."*

One nurse summed this part of the discussion up,

"There for the grace of God go the rest of us..."

The staff focus group was a worthwhile exercise. It provided further opportunity to gather information from a group of staff who had a wealth of experience and training in management of violence. The group was not representative of all of the other staff interviewed as the staff in the focus group were all qualified and had some years of experience amongst them; however they did support comments that were made from individual staff interviews whose demographic data were similar. Many of them had worked in other areas and were able to make comparisons which were not particularly alluded to within the individual staff interviews. This may be because of the group

discussion which generated further thoughts for individuals whereas for individual interviews this element was not built in to the interview questionnaire. The group were also attending a training session which may reflect that they were already motivated to continue to improve their practice and as such were more willing to engage in the research process. The focus of the group tended towards the negative aspects of restraint, and lack of support. During facilitation attempts were made to establish positive experiences and some of these aspects have been highlighted above, for example access to staff counselling; however the group were inclined to return to more negative experiences throughout the discussion. The group also focussed more on staff issues than concerns regarding the patient experience. Reflecting in action during the group process I considered offering this observation back to the group for further discussion; however I was aware that I did not want to influence the group any more than was necessary to respect the parameters of the research study design. Reflecting on this dynamic subsequently with my co facilitator, we agreed that perhaps this was a fairly unique opportunity that this group had been offered to share their experiences and that they placed their own personal experiences as the priority for discussion. This supported the notion that perhaps staff do not feel cared for, are not a priority, and unless their needs are addressed they are unlikely to be able to fully address the needs of patients in their care. The assistance of my co facilitator was of great value in terms of maintaining boundaries in the group, steering conversations back to the topic in hand, as well as taking extensive notes. I had hoped that the group would allow me to tape record the meeting but some members were reluctant for this to happen therefore this method was not used. Detailed field notes assisted in the subsequent analysis of the discussion and provided a tool for comparison for

myself and my colleague when discussing the various themes which emerged within the group discussion.

4.15 Conclusion

This chapter has presented findings related to staff participants and has offered a number of themes which support some of the issues identified within the literature review as well as offer fresh insight into the complexities of the experience of restraint for staff. Restraint is multifaceted and section 3.2 highlighted how some of the complexities involved in defining the term can be teased out among clinical colleagues to provide a working definition which has helped to underpin the research approaches used within this study.

Demographic data which were gathered from staff participants highlighted that the group were mature clinicians, largely Staff Nurse Grades who were of a predominantly White British cultural background. The minimum standard of breakaway training had been met by all participants including unqualified staff. Despite this training the findings suggested that the experience of restraint has a broad psychological impact for staff, ranging from viewing the experience as part of the job which has little emotional consequence through to PTSD and its associated disabling symptoms.

The types of restraint which staff discussed were also wide ranging but more obtrusive restraint procedures were dominant with 77% (n=23) of the incidents using C & R techniques in the standing or prone position. 83% (n=25) of staff reported that the length of restraint had lasted for less than the twenty minutes maximum

recommended in current NICE (2005a) guidelines, however this study is a snapshot of one particular Trust in the South of England and may not necessarily represent practice in the wider UK population. It may be that other areas, such as more secure forensic settings use restraint procedures for much longer than the stated guide of twenty minutes and further research is indicated related to lengths of restraint procedures and the physical / psychological impact that his may have upon both the recipient of the procedure and the nurse who engages in this practice.

27% (n=8) of the incidents involved use of seclusion. The study did not aim to examine experiences of seclusion but qualitative interviews with the patient group highlighted that this was an area worthy of further attention. The staff group did not discuss aspects of seclusion in depth but some staff on acute wards where no seclusion rooms were available believed that having a room available could be helpful, particularly in managing aggressive patients within the acute area without having to transfer to more intensive care settings.

Recording extent of physical injury added further understanding related to the dose – response theory discussed in the literature review. Of the two staff who scored highly on TSQ (Brewin et al 2002), both had been recipients of severe physical injuries therefore this would support the notion that the more severe the physical consequences, the more likely trauma symptoms will occur subsequently. Caution must be taken as this study interviewed relatively small numbers of participants, although anecdotally during the course of the research a number of nurses have approached the researcher with stories of trauma symptoms following more physical assaults and there is a need to examine this aspect of restraint on a greater scale. This

small sample does not necessarily represent a true picture of the possible links between physical injury and subsequent psychological sequelae. It may be that a similar study on a different site would find a much clearer link or no link at all therefore replication would be important to support or refute the findings presented within this thesis.

Eight (n=8, 27%) staff reported that no medication was used during the restraint procedure, however this was offset by another eight (n=8, 27%) who reported that intramuscular injections were administered against the patient's will. Administering medication without consent was an ethical dilemma which staff discussed in the course of the interviews with no staff member offering a view that this was a positive aspect of their role. On the contrary, staff viewed this as a part of their role that they disliked most and were very reluctant to engage with this procedure unless absolutely necessary.

The themes generated from the qualitative interviews highlighted further how complex the experience of restraint can be. Antecedents were described by a number of staff and 77% (n=23) reported that, on reflection, they believed that the incident could have been predicted. The literature review identified that aversive stimulation by staff is a factor that can influence the course of aggression and violence in mental health settings; however staff in this study did not report examples of aversive stimulation. The patient findings did report this to be the case therefore it would have been helpful to examine this further in this study. Staff described warning signs more in relation to mental states worsening, often linking this to not taking medication. Staff appeared to use their skills of observation to detect such changes but did not

speak at length about any early interventions which were made to prevent situations from escalating. This may be a weakness in this study as this specific question was not asked of staff however one would expect some discussion of preventative measures which may have been used in the context of reporting antecedents.

Discussion of feelings dominated the qualitative interviews, as was the case in the earlier pilot study (Bonner et al 2002). Feelings of anxiety and apprehension were evident prior to, and during, the experience of restraint. These feelings of anxiety seemed to subside as the situations were controlled, and the aftermath of the restraints were dominated by feelings of relief. In addition, staff had longer lasting concerns following incidents which were not always resolved to their satisfaction. Guilt at restraining patients was a feeling that was described by a number of staff, as well as anger at situations escalating to the point of restraint.

The staff described helpful and unhelpful aspects of incidents in the course of the interviews. Practical issues such as keeping a safe environment (eg., use of gloves during blood spillage) were a factor which had not been considered by the researcher but were a concern to staff involved. Good teamwork and coordination was described as helpful whereas when this did not happen for staff it was viewed as most unhelpful. Staff described having some form of training as helpful, both in terms of feeling more confident in situations as well as being able to physically manage restraint. The focus group, however, highlighted that despite previous training, some staff are still viewed as incompetent by their colleagues. This affects the notion of good teamwork, and can ultimately be a risk factor in managing challenging behaviour.

57% (n=17) staff participants reported that the experience of restraint had invoked memories of previous traumatic encounters. This is an area which warrants much more scrutiny in considering how staff should be supported in acute mental health settings. In addition to the strong feelings which were described by staff, there is a possibility that the act of restraint may be an additional dose of trauma to staff who may already be managing trauma symptoms from previous encounters. If restraint is perceived as a traumatic event by staff then they could potentially become a high risk for more serious psychological consequences of restraint. This study has identified that previous events take many forms, and are not necessarily linked to earlier restraint procedures, which would suggest a need for a holistic approach to managing staff who are using restraint procedures on a regular basis.

The TSQ highlighted trauma symptoms evident within the group during the course of the study. Use of this method was a helpful supplement to the data collected, particularly in light of the experience of restraint triggering memories of earlier traumatic events. Two out of thirty (n=2, 7%) staff scored above clinical cut off points on the TSQ. While this may seem a relatively small number, there is a possibility that in real terms the percentage may be higher. Staff do not always report psychological effects of their roles. The TSQ asked staff specifically about psychological symptoms and there is potential to use this tool in a larger study to establish a better understanding of trauma symptoms in staff following restraint. Asking staff about such symptoms could address the issue of under reporting and provide a clearer picture of the extent of trauma experienced by staff following restraint. A greater number, 57% (n=17) reported that the event triggered memories of earlier traumatic events. It may have been that staff felt more able to talk about

this aspect of restraint as opposed to reporting specific symptoms. There is a need to examine this on a much larger scale before coming to any clear conclusions in relation to traumatic effects of restraint.

Finally, these findings suggest that use of a structured, Post Incident Review can be helpful for staff. The evaluation of the Post Incident Review was positive and this framework was acceptable to the group of clinicians who were interviewed for this study. The literature review highlighted that there is a lack of guidance and clinical models for Post Incident Review and the framework used for this study could address this issue. The framework avoids in depth re-living of the experience, as contraindicated by NICE PTSD (2005b) guidelines, but provides a more informal consideration of events which may offer staff an opportunity to review incidents in a non-threatening way. These findings should be considered with caution. Evaluation questionnaires were completed straight after the interviews took place and it may be that this approach facilitated a more positive response than if participants had completed the evaluations at a later date. It could be that my role in facilitating the research interviews may have skewed participants' perceptions of the efficacy of the Post Incident Review in a more positive way. It would be of value to conduct wider evaluation to larger groups after allowing some time for reflection following the Post Incident Reviews to establish whether these positive responses would be replicated.

CHAPTER FIVE - FINDINGS – PATIENT PARTICIPANTS

"..I almost felt like it was him on top of me. I thought I was going to suffocate, I could almost smell him. I just wanted to get in to the bath afterwards..." (Anon 2006)

5.1. Introduction

This chapter will present findings in relation to the thirty (n=30) patient participants who took part in the study. The same methods that were used for staff data collection and analysis were also applied to patient participants. These techniques have been described in depth in Chapters two and three, and data will now be presented in relation to the information that was collected from patient participants. The grounded theory process applied to the data enabled a qualitative analysis of the transcribed interviews using Straus and Corbin's (1998) description of content analysis and themes were similar to those identified within the content analysis of staff interviews. The core categories identified through the analysis process for patients were in relation to antecedents; feelings; helpful and unhelpful aspects; and reawakening of earlier traumatic events. The format of the interview questionnaire for patients was the same as the format used for staff and this may be why these themes occurred more frequently within the analysis. Using the mixed method approach described earlier, supplementary data was gathered to support the qualitative analysis as well as provide a wider picture of the patient group and these findings will be presented within this chapter, with bar charts offered to support the presentation. Section 5.2. will outline the restraint incidents being reflected upon by patient participants and highlight any differences which may not have been evident within the staff data analysis. Section 5.3. will present demographic data gathered from patients during the research process.

This will be divided into sections related to gender and age; ethnicity; diagnosis and legal status; and previous admissions, length of contact with mental health services, history of violence. Section 5.4. will outline type of restraint, length of restraint, and use of seclusion described by the patient participants. Section 5.5 will present physical consequences of restraint for patients and section 4.6 will offer findings related to medication. The core categories identified within the qualitative analysis will then be presented within section 5.7. which will be broken down into separate themes. Section 5.8 will go on to present findings related to the TSQ (Brewin et al 2002) which was applied to patient participants in a similar process to staff. Following the research interviews and use of TSQ (Brewin et al 2002), patient participants were also asked to complete an evaluation form related to the format that had been used for the research interview as a method of Post Incident Review. The findings related to the evaluations for patients will be offered in section 5.9. Section 5.10 will conclude the chapter with a summary of the main points presented in relation to patient findings.

5.2. Restraint incidents

The definition of restraint illustrated in findings related to staff was applied to incidents which patients described in this study (see chapter 4.2). Restraint ranged from gentle hands on intervention to guide a patient to a place of safety to full application of C & R techniques by a trained team. Some of the patient interviews related to the same incidents that some staff interviews related to, however there were other incidents which took place that only patients were interviewed about. This was done for practical reasons as staff were not always available to be interviewed, and similarly patients were not always well enough to be interviewed, or refused to

participate. Some insight was offered by patients in terms of other professional groups who were involved in restraint, namely police who had brought individuals in to hospital. Two patients who described this experience expressed mixed feelings. One patient described the experience as "humiliating and degrading" however he went on to say that one of the officers had been "understanding and kind". Another patient stated that "the hospital staff were a bit better than the police; at least they didn't cuff me up".

5.3.Demographic data

Demographic data for patients were made up of gender, age, ethnicity, diagnosis, legal status, number of previous admissions, and length of contact with mental health services. These categories were chosen to try and build up a picture of the patient group who were involved in incidents of restraint and to establish whether particular demographic profiles experienced any different psychological responses to restraint within the patient group. There was also opportunity to consider whether legal status or length of contact with mental health services were factors which may have any influence upon the consequences of restraint.

5.3.1. Gender and age

Thirty (n=30, 100%) patients were interviewed with a split of seventeen (n=17, 57%) female patients and thirteen (n=13, 43%) male patients. This was a similar gender split to the staff participants. The age range for the whole group was between 18 – 58 years, the mean age being 35. Female patient participants ages range from 24-53, the mean age being 36. Male participants' ages ranged between 18-58, the mean being 32.

A summary of ages is highlighted in figure 22 below.

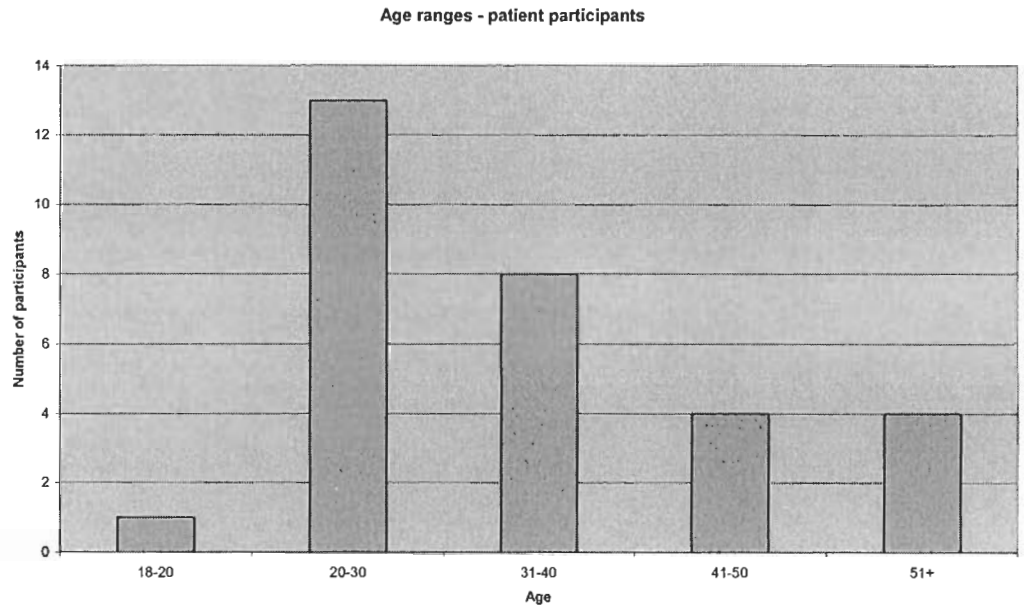

Figure 22. Ages of patient participants

5.3.2. Ethnicity

Ethnicity was included among demographic data for the patient group. The majority of patients (n=21, 70%) interviewed were white British, thirteen (n=13, 43%) of whom were female and eight (n=8, 27%) of whom were male. Three (n=3, 10%) female patients were of black Caribbean ethnic origin and one (n=1, 3%) was black African. Of the male participants, two (n=2, 7%) were black Caribbean, two (n=2, 7%) were black African, and one (n=1, 3%) was Asian. The male participants reflected more of the local catchment area however, due to the small participant group; it would prove difficult to replicate the local general population.

Ethnicity of patient participants is highlighted in figure 23 below.

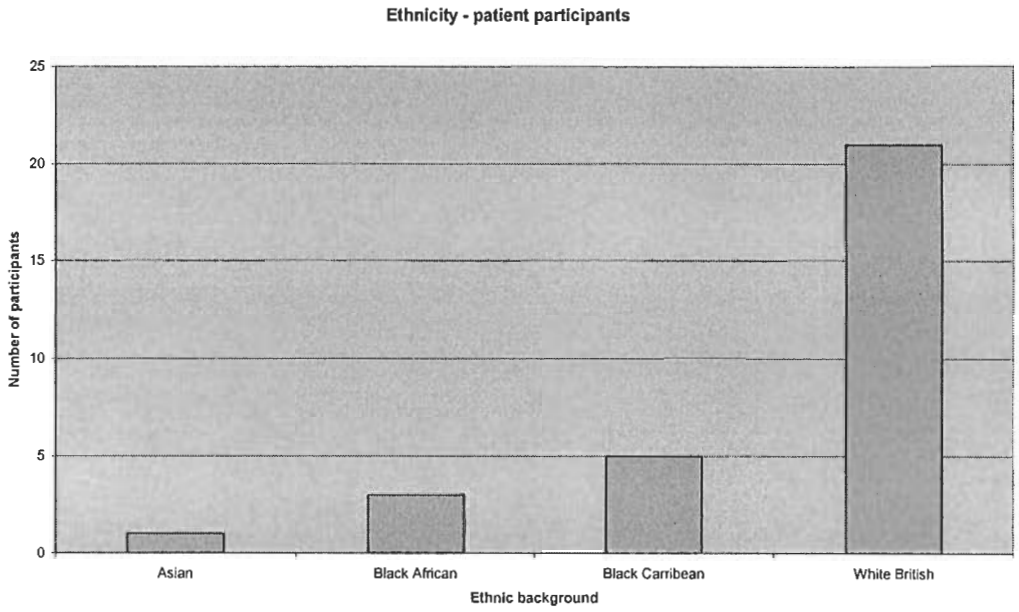

Figure 23. Ethnicity – patient participants

5.3.3. Diagnosis

In terms of diagnosis, 14 (n=14, 47%) patients had a dual diagnosis, 14 (n=14, 47%) had a single diagnosis, and 2 (n=2, 7%) were not diagnosed. The latter were being assessed under a Section 2 assessment order of the Mental Health Act 1983. Within the dual diagnosis group, 6 patients (n=6, 20%) had a diagnosis of schizophrenia and substance abuse / misuse. The gender breakdown of this group was 3 (n=3, 10%) female and 3 (n=3, 10%) male patients, with one (n=1, 3%) male patient having alcohol as his substance of choice, the others being illegal drugs which included cannabis, amphetamine and crack cocaine. 5 (n=5, 17%) of the dual diagnosis group had a diagnosis of depression and personality disorder. This group consisted of 3

(n=3, 10%) female patients and 2 (n=2, 7%) males. The remaining patients with a dual diagnosis were one (n=1, 3%) female with a diagnosis of bipolar illness and personality disorder, one (n=1, 3%) male with depression and alcohol misuse, and one (n=1, 3%) female who had a diagnosis of schizophrenia and personality disorder. A summary of dual diagnoses is offered in figure 24 below.

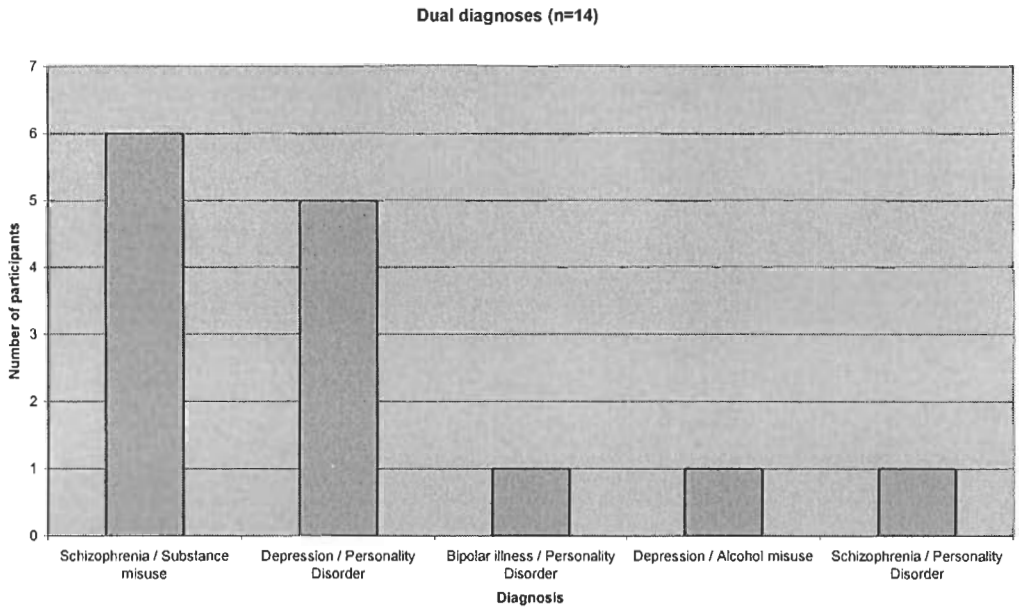

Figure 24. Summary of dual diagnoses

The fourteen patients who had a single diagnosis consisted of 6 (n=6, 20%) who had bipolar illness, 4 (n=4, 13%) of whom were female and 2 (n=2, 7%) of whom were male; 5 (n=5, 17%) had schizophrenia, 3 (n=3, 10%) of whom were female and 2 (n=2, 7%) of whom were male; 2 (n=2, 7%), one (n=1, 3%) female and one (n=1, 3%) male, had a diagnosis of personality disorder; and one female (n=1, 3%) patient had a diagnosis of schizoaffective disorder.

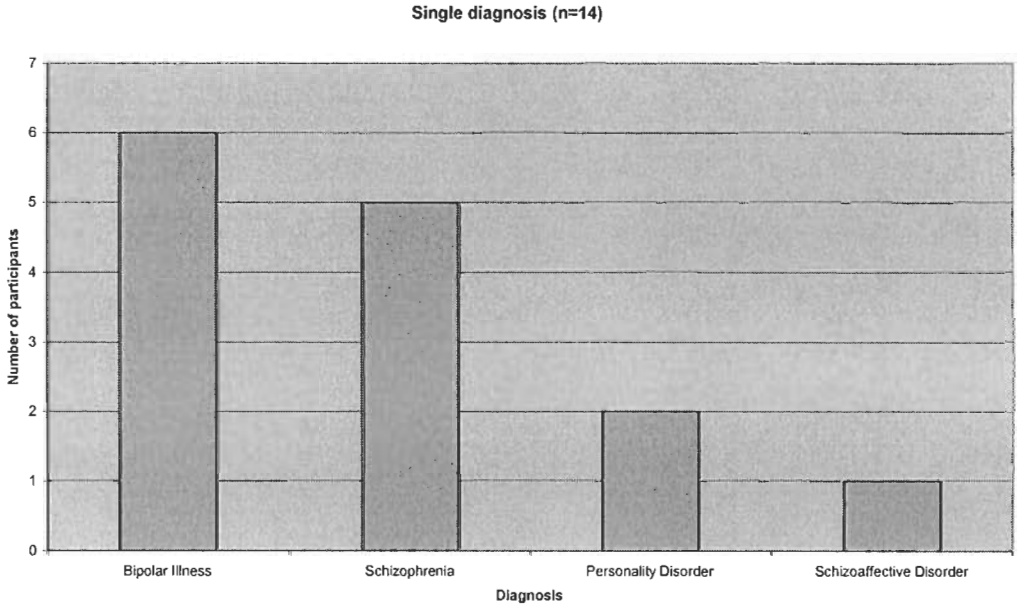

Figure 25. Single diagnoses

5.3.4. Legal status and diagnoses

In terms of legal status, 5 (n=5, 17%) were informal patients. All of these informal patients were male. Three (n=3, 10%) of these patients had a dual diagnosis, 2 (n=2, 7%) being depression and personality disorder and one (n=1, 3%) being depression and alcohol misuse. The remaining 2 (n=2, 7%) patients had a single diagnosis of bipolar illness. The informal patients therefore all had mood disorders of different

natures and were all male. Four (n=4, 13%) patient participants were being held under Section 2 of the Mental Health Act 1983. One (n=1, 3%) of these patients had a dual diagnosis of schizoaffective disorder and substance misuse, one (n=1, 3%) had a diagnosis of schizophrenia, and 2 (n=2, 7%) patients were being assessed with no formal diagnosis made. The gender of this group was evenly shared between 2 (n=2, 7%) females and 2 (n=2, 7%) males. The remaining patients (n= 21, 70%) were being treated under Section 3 of the Mental Health Act 1983. Ten (n=10, 33%) of the patients detained under Section 3 had a dual diagnosis. Three (n=3, 10%) of this group were male with a diagnosis of schizophrenia with drug (n=2, 7%) or alcohol (n=1, 3%) misuse, and the remainder (n=7, 23%) were female. Three (n=3, 10%) of the female participants within this group had diagnoses of depression and personality disorder, 2 (n=2, 7%) had schizophrenia with drug misuse, one (n=1, 3%) had schizophrenia and personality disorder, and one (n=1, 3%) had bipolar illness and personality disorder. Eleven (n=11, 37%) patients who were under Section 3 of the Mental Health Act 1983 had a single diagnosis. Five (n=5, 17%) of these patients had a diagnosis of bipolar illness and were made up of 4 (n=4, 13%) females and one (n=1, 3%) male; four (n=4, 13%) had a diagnosis of schizophrenia and were made up of equal groups of 2 (n=2, 7%); one (n=1, 3%) female had schizoaffective disorder; and one (n=1, 3%) female had personality disorder.

A summary of legal status and diagnoses is offered in figures 26, 27, 28, 29, and 30 below.

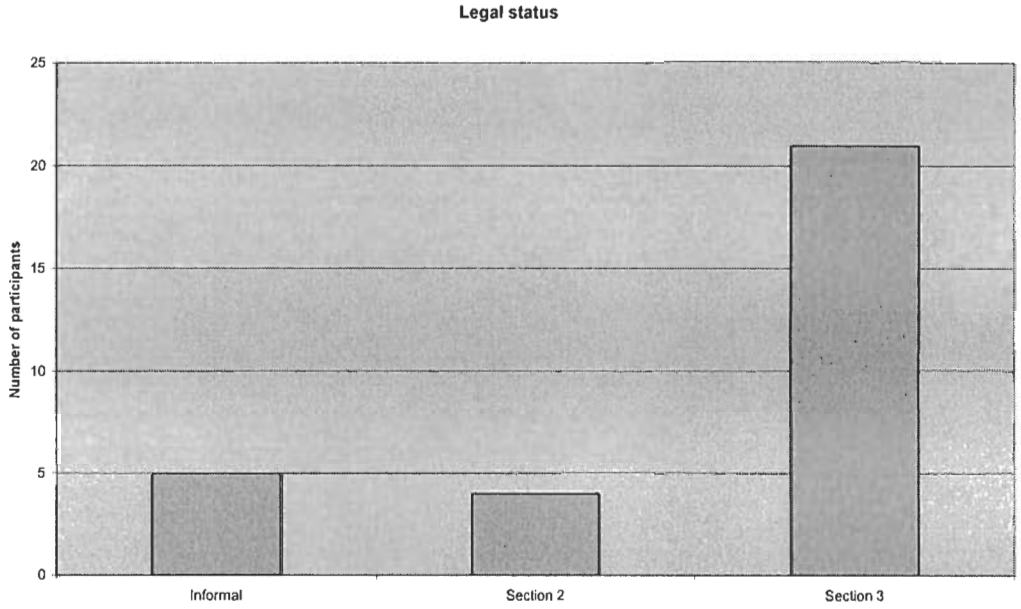

Figure 26. Legal status all participants

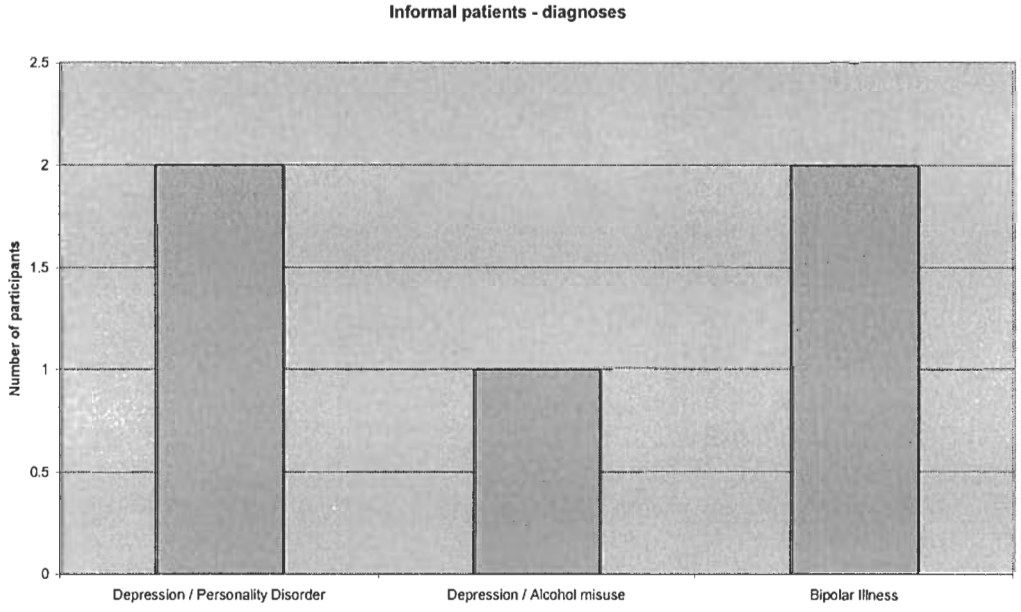

Figure 27. Informal patients -- diagnoses

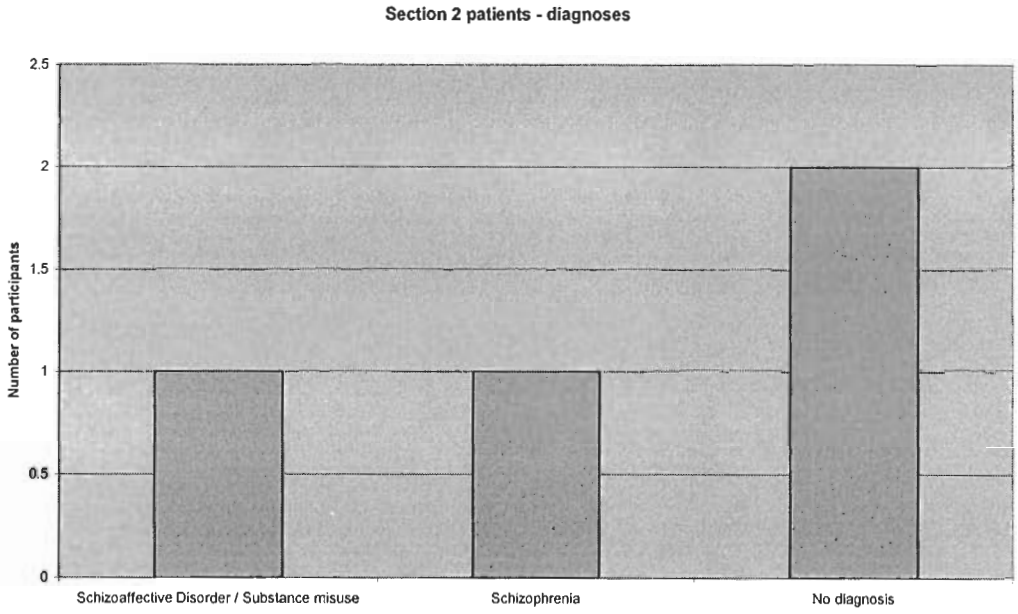

Figure 28. Section 2 patients – diagnoses

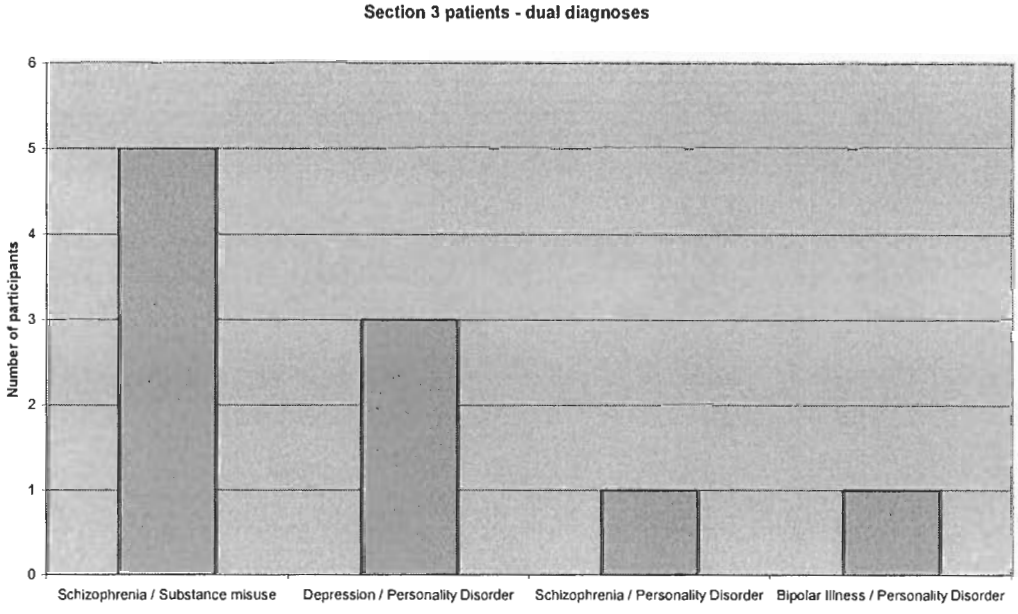

Figure 29. Section 3 patients – dual diagnoses

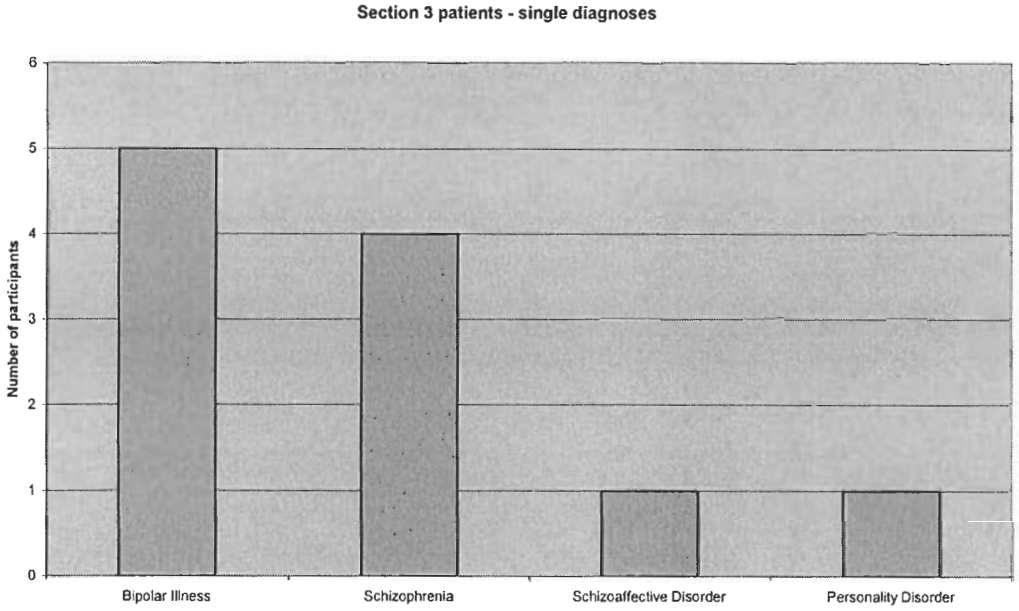

Figure 30. Section 3 patients – single diagnoses

5.3.5. Previous admissions, length of contact with mental health services, and history of violence.

Data around previous admissions, length of psychiatric history, and history of violence were gathered in order to build up a fuller representation of the client profile of the patient participant group, as well as to ascertain whether there may be any significant factors in terms of experiences of restraint. For example, if a patient had a lengthy psychiatric history with numerous admissions would this have any influence upon the psychological impact of restraint. These data helped to provide a contextual picture of the group being studied. Numbers of previous admissions were recorded for each individual and those with more than 10 admissions were recorded as 10+. The reason that this method was chosen was due to time constraints of the researcher and to suit practical purposes. Patients who had more than 10 admissions usually had

more than one set of case notes which were not always available. Clear summaries of psychiatric timelines were not always available within patient case notes, and often patients were not able to recall exactly how many admissions they had. To establish a clear number of admissions would have been labour intensive and this time was not accounted for when designing the project. After discussions with supervisors it was agreed that if an individual had 10 or more admissions this was sufficient enough to highlight that his person had a greater experience of the admission process than others, and it was unlikely that if somebody had 14 admissions as opposed to 10, the impact of this upon this study would illuminate the findings any further. Of the 30 participants, 27 (n=27, 90%) had one or more previous admissions. 3 (n=3, 10%) had no previous admissions, however one (n=1, 3%) of this group had recently moved in to the area, and the multidisciplinary team were of the impression that this patient had a previous history elsewhere, but at that point had no evidence to support this. Number of previous admissions ranged from 0-10+. 3 (n=3, 10%) had one previous admission, 6 (n=6, 20%) had two previous admissions, 4 (n=4, 13%) had three previous admissions, 5 (n=5, 17%) had four previous admissions, 2 (n=2, 7%) had six previous admissions, 1 (n=1, 3%) had nine previous admissions, and 6 (n=6, 20%) had ten or more previous admissions.

The data therefore highlighted that a high proportion (n=27, 90%) of the patients interviewed in this study had some experience of the process of being admitted to an acute mental health facility. A breakdown of these figures if offered in figure 31,

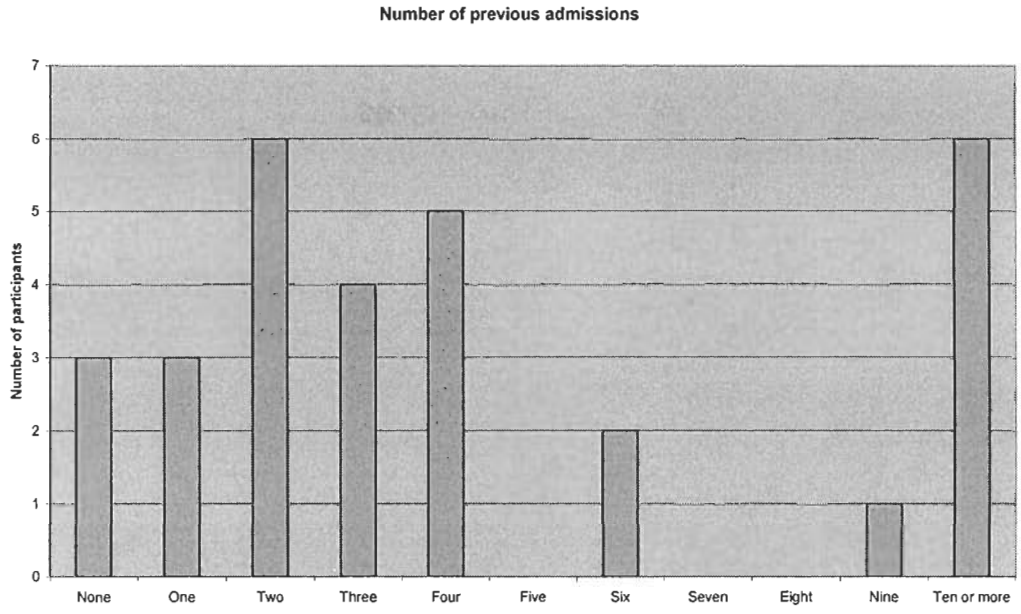

Figure 31. Number of previous admissions

Length of contact with psychiatric services was long and varied. This measurement was included within the study to supplement the information gathered around number of previous admissions. This again, was to assist in building up a contextual profile of the patient group. It was hypothesised that individuals may have a small number of acute admissions, but may have had lengthy contact with the services outside of the admissions ward. This was indeed the case when information was examined. For example one participant had two previous admissions, but had been in contact with various community services over a period of 19 years. Only two (n=2, 7%) had no previous contact with mental health services before admission. One (n=1, 3%) had been admitted for assessment after being arrested for criminal damage, but had been assessed via court liaison services and was admitted directly from there. The other (n=1, 3%) person had recently moved to this area and it was suspected that previous contact had been facilitated through services elsewhere but no proof of this had yet

been established. Length of contact varied from none to 35 years, the average length of contact being 9.6 years. These data are broken down further in figure 32.

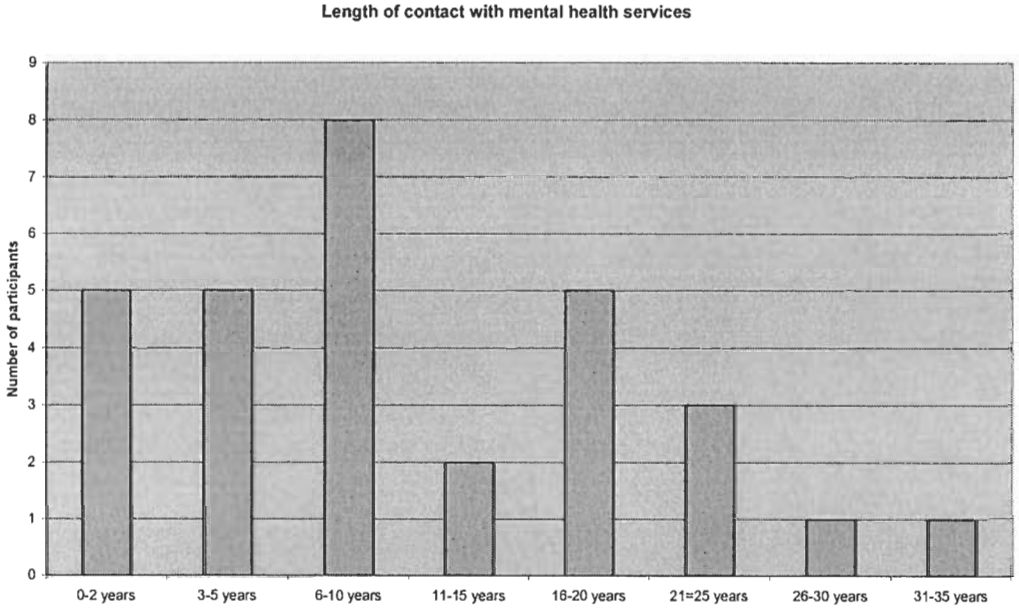

Figure 32. Length of contact with mental health services

Previous history of violence was recorded as a simple yes or no. This aspect of the study would be of interest to consider types of previous history of violence and aggression for this group and establish whether there may be any unique patterns for particular units, or individual clients. This information was already being collected through Trust audit systems and being examined in other arenas, and on an individual basis work was happening with some patients to examine their aggression in a therapeutic way. The reporting of untoward incidents within this Trust was an issue that had been highlighted through audit systems and there were some concerns regarding the consistency of reporting. This study was able to support the concerns raised within the Trust. For example, it was clear that one particular area were keen to report incidents to the author as they happened, and staff and patients were encouraged to take part in the research. This same area had much higher rates of

reporting incidents of aggression to the Trust compared to other areas. Through my work within the clinical areas I was able to feedback to the Clinical Governance Lead that this area was proactive in reporting a wide range of aggressive incidents, for example verbal abuse and threats which may not necessarily result in incidents of restraint, but that the team strongly believed that these incidents were also of concern. Other teams felt that unless an incident had been of a severe nature requiring restraint, then there was little point in, "wasting more valuable time on unnecessary paperwork". These concerns have implications for staff training and are worthy of further investigation through further research. Twenty (n=20, 67%) patient participants had a previous history of violence in this study. Although this was not documented in depth for this study, the incidents of violence ranged from threatening behaviour, property damage, through to physically attacking staff and other patients.

5.4. Type of restraint, length of restraint and use of seclusion

The same measurements which were used for staff were applied to patients in this study to measure type of restraint, length of restraint, and use of seclusion. Type of restraint was broken down into four categories; gentle guidance to a place of safety with minimum force used, guidance to a place of safety with some force used (eg., taken by each arm to a quieter area), restraint involving two or more staff with force using C & R techniques while remaining upright, restraint involving two or more staff using C & R techniques with force in the prone position (ie., lying on the floor). There are some concerns in relation to some of the restraint methods used. C & R training programmes advocate use of a "three man team". The team should complement each other with the methods used and these are advocated as the safest methods for restraint. I was aware through my own clinical experience and

anecdotally that these methods were not always employed, for example if only two staff were available they would use holds taught in C & R to contain an escalating situation. I therefore widened the term to include use of these methods using less than three people. This would further illuminate whether taught C & R procedures were always followed in clinical settings.

Length of restraint was noted for each incident and participants were asked if seclusion was used and, if so, for how long. Patient participants were less clear in their responses to this part of data collection and required some assistance in translating the content of the questionnaires. For staff participants they readily applied a category to the situation that they were describing but for patients some assistance was sought from the researcher. For the patients who did struggle with questionnaires the researcher assisted them in identifying the category by reflection upon the incident and asking which category they thought may be best used to describe their experience. For example, one participant described being restrained by a number of male nurses with whom she was unfamiliar. Gentle questioning enabled her to identify how many were involved, that she was manoeuvred into a side room, and forcibly administered an injection while lying down. Although she was unfamiliar with the terminology of C & R, it was clear that these techniques had been applied and the appropriate category was identified within the questionnaire. For other patients, psychiatric terminology was a language in which they appeared to be fluent, "...Oh, I got the full works. The C & R team were straight in there...I was put in seclusion for about an hour while I calmed down".

Within the first category, 3 (n=3, 10%) of the patient participants reported that they had been gently guided to a place of safety by use of minimum force. An example of this was when a patient described that she had been arguing with another patient, a member of staff had intervened and led her back to her bedroom to calm down. Within the second category, 3 (n=3, 10%) patients reported that some force had been used, and example being when a patient had refused to leave the staff office and two members of staff had removed her from the area by taking an arm each and guiding her towards the day room.. Thirteen (n=13, 43%) of patient participants reported that restraint had been applied by two or more staff using C & R techniques while remaining upright. Of the thirteen (n=13, 43%) who reported the restraint to be in this category, ten (n=10, 30%) of the patient participants reported that only two members of staff had applied the holds. An example of this was a patient who had been fighting with another patient and had to be separated by staff who used C & R interventions to remove him from the situation against his will. The remaining 11 (n=11, 37%) reported that they had been restrained in the prone position using C & R techniques by three or more staff. An example of this was a patient who had wanted to leave the ward but was told by staff that he could not. He became very angry and physically assaulted the nurse who had told him that he could not leave. This resulted in him being restrained by three members of staff who manoeuvred him to the floor to prevent him from continuing to attack them. C & R interventions were therefore applied in 80% (n=24) of the restraint situations identified within the patient interviews, either while patients remained upright, or in the prone position. Types of restraint are highlighted in figure 33 below. These figures should be viewed with caution as all patients may not be familiar with specific C & R techniques, however where the patient reported that they were restrained by two or more staff they were

prompted to describe this further and categories were then assigned by the researcher and supported through investigator triangulation.

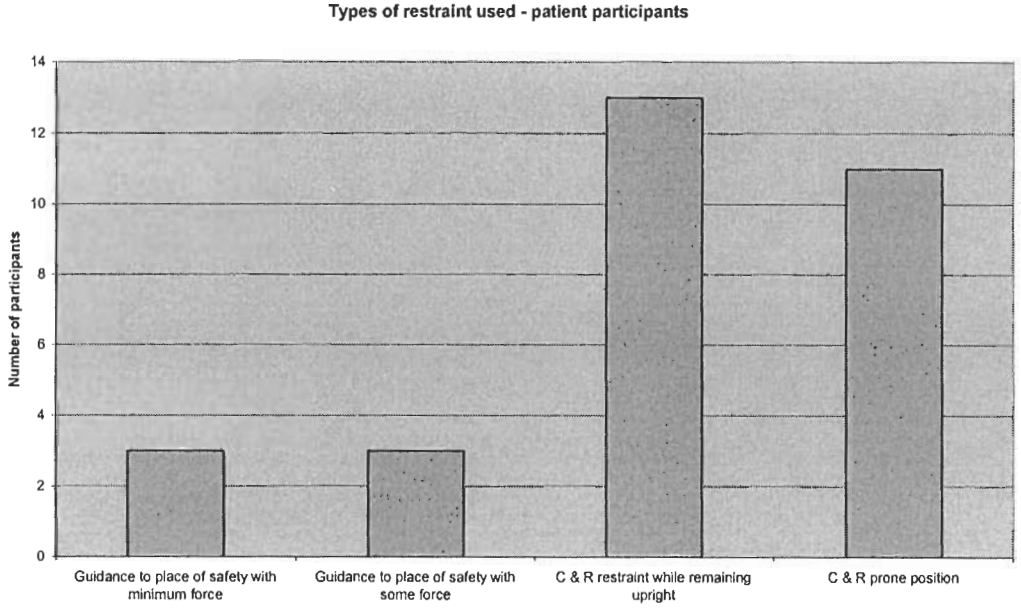

Figure 33. Type of restraint used – patient participants

Length of restraint was measured in minutes. Participants were asked to recall the length of time approximately in minutes that restraint was directly applied. Responses were broken down into five categories; less than five minutes, five to ten minutes, ten to twenty minutes, twenty to thirty minutes, and thirty to sixty minutes. Some patients were not clear about the length of time that restraint lasted and in these cases were asked to guess how long they thought it lasted. These figures, therefore, should be viewed with some caution. Twelve (n=12, 40%) patient participants reported that direct application of restraint techniques lasted five minutes or less, ten (n=10, 33%) of patient participants reported that restraint lasted between five and ten minutes, five (n=5, 17%) of patient participants reported that restraint lasted between ten and twenty minutes, two (n=2, 7%) of patient participants reported that restraint lasted between twenty and thirty minutes, and one (n=1, 3%) patient participant

reported that restraint lasted between thirty and sixty minutes. These figures were similar to staff data in that only three (n=3, 10%) patient participants reported that restraint had lasted over the recommended guidelines of twenty minutes, slightly lower than the staff figure of five (n=5, 17%). A breakdown of length of restraint for patient participants is offered in figure 34 below.

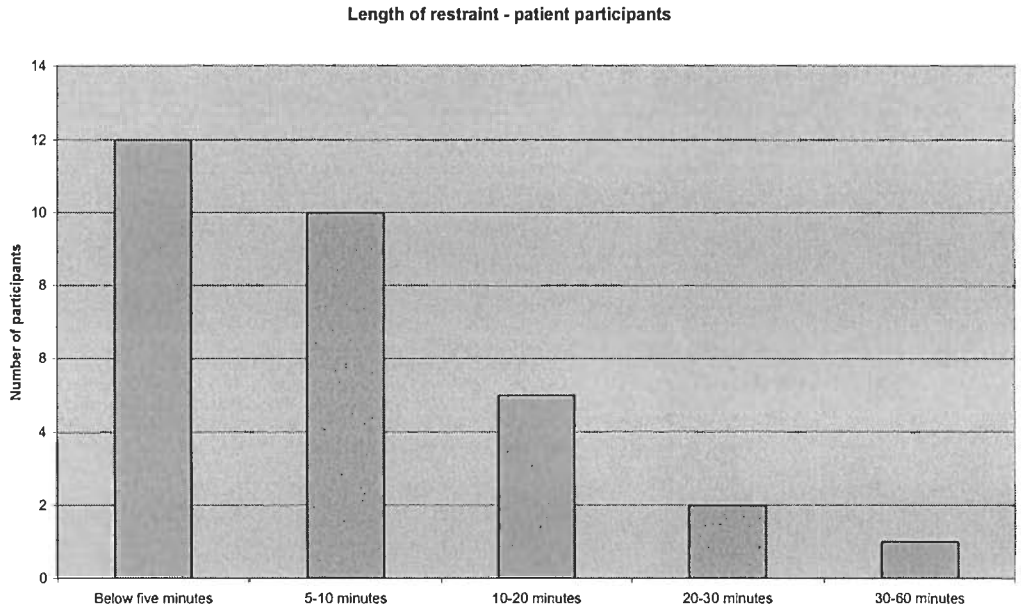

Figure 34. Length of restraint – patient participants

Ten patients (n=10, 33%) of patients reported that they had been secluded as a result of the restraint incident. Eight (n=8, 27%) of these patients were being cared in an intensive care setting when the incidents took place, one (n=1, 3%) was admitted directly via police custody to a seclusion room, and the other patient participant (n=1, 3%) was secluded after being transferred from an admissions ward to the intensive care unit on the same site. Length of seclusion was measured in hours, with figures being rounded up or down to the nearest hour. Two (n=2, 7%) participants were secluded for up to one hour, four (n=4, 13%) were secluded for up to two hours, one

(n=1, 3%) participant was secluded for up to four hours, one (n=1, 3%) participant was secluded for up to six hours, one (n=1, 3%) participant was secluded for up to eight hours, and one (n=1, 3%) participant was secluded for approximately twenty four hours. Some patient participants had difficulty in recalling the length of time that they had spent in seclusion and these figures were checked via the patients' notes to enable further accuracy. Within this study, one in three (33%) of the patient participants who had been restrained were subsequently secluded, and length of seclusion averaged 5.2 hours. One of the participants had a more lengthy seclusion of 24 hours and if this figure is not included, the average length of time for seclusion would have been 3.1 hours. The participant who had the lengthy seclusion had been taken out of seclusion briefly on three occasions during that 24 hours, but had became aggressive very quickly and was taken straight back into seclusion on these occasions. Length of seclusion is summarised in figure 35 below.

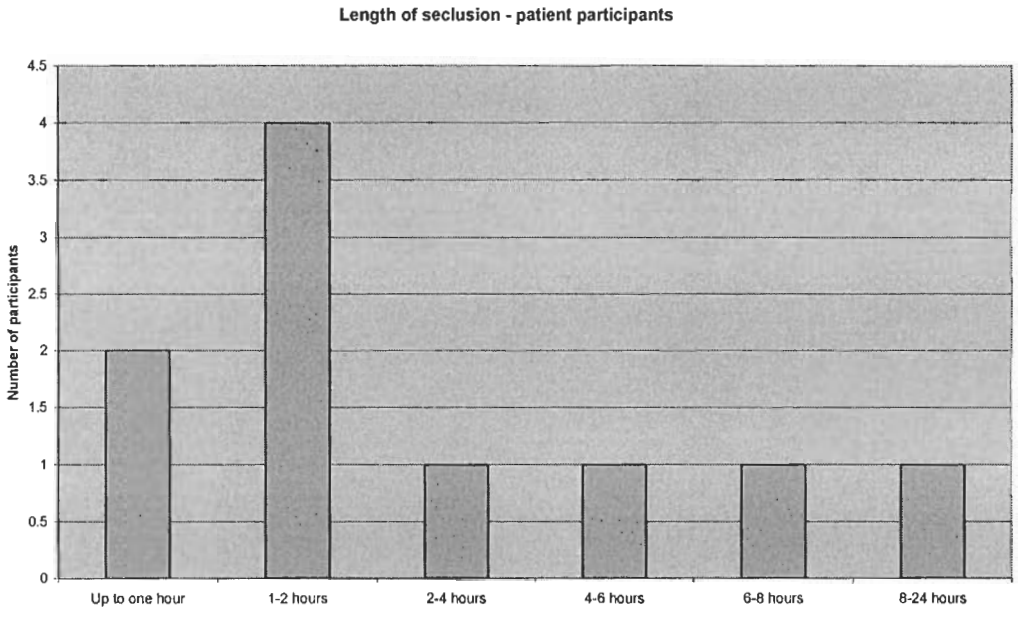

Figure 35. Length of seclusion – patient participants

5.5. Physical consequences of restraint

The same methods which were used to ascertain physical consequences of restraint to staff participants were applied to patient participants. An adaptation of the Staff Observation and Aggression Scale (Palmstierna and Wistedt 1987) was used to measure the physical consequences of restraint. Physical injuries were categorised as; no injury, felt threatened or brief pain (less than ten minutes) with no visible injury, physical pain (more than ten minutes) or visible injury not requiring treatment, injury requiring some kind of treatment but not necessarily by a doctor, and injury requiring some kind of treatment or supervision prescribed or performed by a doctor. Half of the patient participants (n=15, 50%) reported that they had no physical injury as a result of the restraint incident. Eleven (n=11, 37%) of patient participants reported to feeling threatened or brief pain for less than ten minutes with no visible injury. Three (n=3, 10%) patient participants reported that they had experienced physical pain for more than ten minutes or a visible injury which did not require treatment, and one (n=1, 3%) reported that he had an injury which had required treatment but not by a doctor. No patients reported injuries which would have required treatment prescribed by a doctor. The majority (n=26, 87%) of patient participants therefore had no or minimal injury as a result of restraint incidents. Examples of injuries were related to holds being used on patients through C & R techniques, *"my wrist didn't half hurt for a while afterwards"*, to incidents which patients reported to have been harmed during the process of being moved to an area of safety, *"I had a bit of a bruise where my leg had bashed against the bed"* (patient then went on to show this evidence to the researcher), to incidents of self harm which had been treated by nursing staff, *"I had some scratches to my arms but they just bandaged them up for a couple of days"*. Extent of physical injury to patients is highlighted in figure 36 below

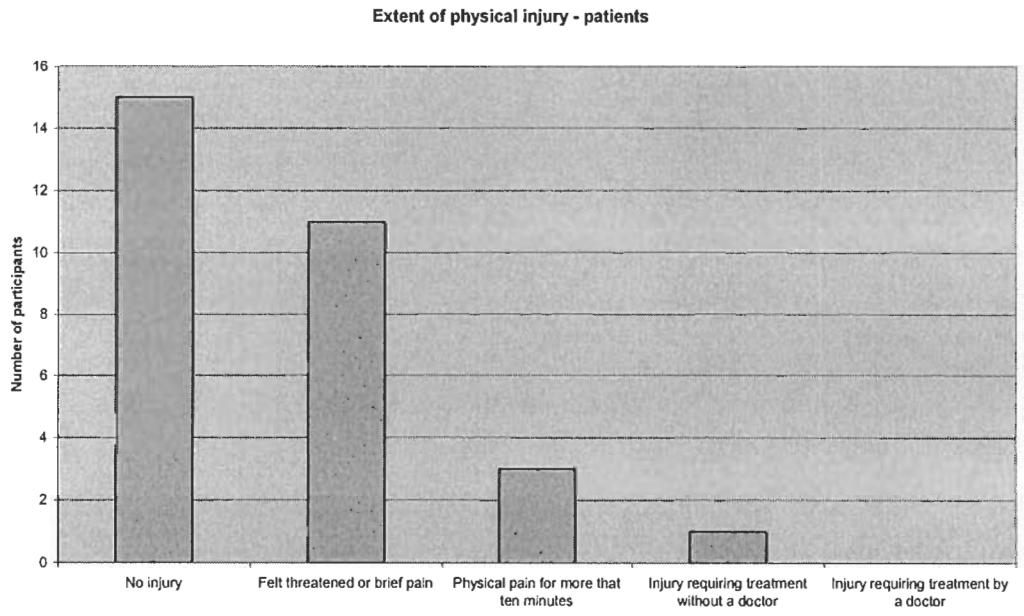

Figure 36. Extent of physical injury – patients

5.6. Use of medication

The same process for recording of medication that was used for staff participants was also used for patient participants. Medication was recorded as; none used, oral (by mouth) medication offered and accepted, oral medication offered and accepted after persuasion, intramuscular injection offered and accepted, intramuscular injection forcibly administered. The context of medication use was similar within the patient data to the staff data. In situations where medication had not been used, patients reported that they had discussed their reasons for being distressed and that had been enough to facilitate resolution to the situation. Some patients believed that they never really had a choice in medication and that they opted to take it when offered orally as they would only be forcibly given intramuscular medication if they refused the offer of oral medication. One participant summarised this scenario by recalling, *"..well I*

just took the Lorazepam [that had been offered]...*otherwise I know what would have happened. Before you've got time to try and tell them what's happened, they've jumped on you with the needle* [intramuscular injection]". For other patients who had received intramuscular medication by force similar views were aired, *"...I've been there more times than you could imagine. I kick off, they get the heavy boys in, and away they go, next thing I know I'm on the floor with the heavies on top of me* [administering intramuscular injection]". Patients who were offered intramuscular injections which they accepted reported that this had worked more quickly for them on previous occasions and that they preferred this route to oral when they felt particularly agitated. Six (n=6, 20%) of patient participants who took part in the study did not receive medication during or following restraint incidents. Three (n=3, 10%) of patient participants reported that they were offered oral medication which they accepted. Five (n=5, 17%) patient participants reported that they had initially refused oral medication but went on to accept the offer after persuasion. Two (n=2, 7%) patient participants reported that intramuscular medication was offered and accepted by them, and fourteen (n=14, 47%) patient participants reported that they had received intramuscular injections against their will.

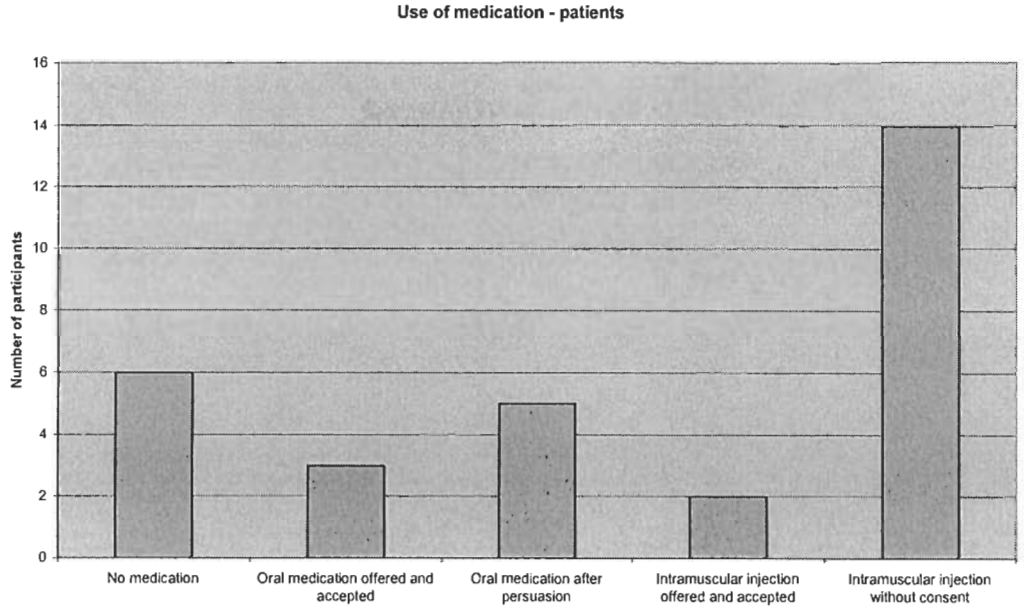

Figure 37. Use of medication – patients

5.7 Antecedents

Similarly to staff interviews, patient participants reported some form of antecedents although their descriptions and concerns were different to those of staff. Staff described previous circumstances in terms of observations of mental states worsening, behavioural disturbances, patients not taking medication, and earlier minor incidents, whereas patients describe antecedents more in terms of unhelpful interactions with staff, boredom, frustration and negative interactions with fellow patients. Patients were less clear in their descriptions of antecedents however on analysing the content of their responses it was evident that antecedent issues were a strong collective theme. Twelve (n=12, 40%) of the patient participants reported that there had been some form of antecedent prior to the incident of restraint. Of these, six (n=6, 20%) reported that they had given staff clear and specific warning that situations were escalating. Comments to support this element of the analysis included the following,

"I got angry because they [the staff] *wouldn't listen to what I was trying to tell them. Telling them that I needed help, wanted to hurt myself. I had cuts on my hand. The bloke [nurse] from another ward said that my cat did it. He didn't believe me. It was horrible. I never want it to happen again."*

"They should have got him [another patient] *out of there or got me out until he was gone. I was saying, "I'm going to smack him when he comes out of that room.. It's going to kick off". I warned* [the staff nurse]."

Six patients (n=6, 20%) reported that there mental state had been a contributing factor to situations escalating,

"I was ill. I was very distressed."

"I was manic at the time. I was high."

"I hadn't been well for a while. This is what happens, I get worse and on it goes."

Denial of requests made to staff was another example given by patients as a contributor to situations worsening and was reported by five (n=5, 17%) participants,

"I'd been running off a lot, I just needed to get out but they wouldn't let me go"

"I wanted to make a phone call and I kept going to the office to ask [a male nurse]. *He kept saying he'd sort it out later but every time I went back I got another excuse."*

"I wanted to see my Social Worker but they said that wouldn't be possible. I wanted to know what was happening with my stuff at home. The more I kept on, the more they said I wasn't well enough yet. I just wanted to make sure everything was ok at home."

Observation was a recurrent theme within the patient interviews and for some (n=3, 10%) was related to the build up of tension before situations developed into restraint scenarios,

"I felt like a prisoner [during observation]."

"They even left the door open when I went to the bathroom."

"They wouldn't leave me alone. I knew I was under obs (observations) *but they didn't actually tell me that and I was just getting angrier and angrier."*

Boredom was cited by three (n=3, 10%) of patient participants as an antecedent to restraint,

"There's nothing to do. You just sit about there all day getting more and more wound up. You can't go out and the staff are busy in the office."

"I actually think that boredom has a lot to do with it. You are sat around with too much time on your hands and you get a bit fed up with some of the patients."

"Often people just get bored. They wind up the staff to try and get them going. It's usually the same people, you can see it happening."

Frustration was also a recurring theme throughout the patient interviews and was usually as a result of the other issues highlighted above, such as denial of requests.

A breakdown of more common antecedents described is highlighted in table 11 below.

ANTECEDENTS	**n = 30**	**%**
Specific warnings given to staff	n=6	20%
Illness / mental state	n=6	20%
Denial of requests	n=5	17%
Observation	n=3	10%
Boredom	n=3	10%

Tabl;e 11. Antecedents – patients

5.8 Feelings

Strong feelings were expressed by the patient participants as well as staff. Within the patient group there was a sense of powerlessness and negativity, reflected both within the transcript contents and observed during the interview process. Feelings were described by patients in terms of how they may have been feeling before the incident, during the incident, and subsequently. For some individuals similar feelings were expressed in relation to before, during, and after the event, and for others the predominant feelings were either before or after the event. These findings are now presented.

Anxiety was a prevailing theme before (n=14, 47%), during and after the event for patients as well as staff. Patients (n=7, 23%) also described physical symptoms of anxiety leading up to the incident of restraint,

"My heart was racing and I was hot. I thought my head was going to explode."

"I was shaking all over."

"I was tense... ready to snap."

Linked to anxiety was fear expressed by four (n=4, 13%) participants,

"I was scared, I didn't really know what I was doing."

"Frightened. I was frightened about what was going to happen next."

Three (n=3, 10%) patients reported feeling suicidal before the event and a further nine (n=9, 30%) described feeling low in mood, upset, or distressed.

"I was suicidal"

"Desperate, just wanted to kill myself, suicidal."

"My mood was at an all time low. I was feeling desperate."

"Upset and distressed. I didn't know how I had got this bad."

Anger was expressed by five (n=5, 17%) participants as a strong emotion they had leading up to the incident,

"Angry, frustrated."

"Annoyed and angry. I didn't think that I was asking for much."

"I was still angry, distressed."

A summary of the most common feelings described leading up to the incident of restraint is included in table 12 below.

FEELINGS – leading up to the incident	**n = 30**	**%**
Anxiety	n=14	47%
Physical symptoms of anxiety	n=7	23%
Fear	n=4	13%
Suicidal	n=3	10%
Low, upset, distressed	n=9	30%
Angry	n=5	17%

Table 12. Feelings leading up to the incident – patients

During the incident patients reported similar feelings to events leading up to the incident but for some, even more disturbing feelings were expressed. Some patients' (n=4, 13%) feelings mirrored those of staff in that they felt less aware of their emotions, responding in detached ways,

"It's a bit of a blur. A bit like watching a film, I didn't really feel like I was there."

"I was going through the motions. They were holding me back but I was still struggling. I felt numb."

Nineteen patient participants (n=19, 63%) reported feelings of anxiety and fear during the incident,

"I was worried and scared at this point, I didn't know what was going to happen."

"Frightened."

"Scared. I thought I was going to get hurt, I was really scared then."

"I was still distressed and frightened."

Six (n=6, 20%) patient participants described feeling out of control / overwhelmed by the situation,

"I felt overwhelmed."

"It got out of control then. We were all over the place, I didn't feel safe."

"Things got out of control very quickly and before I knew it I was on the ground and they were on top of me. There was no need to inject me. I was overpowered."

Feelings of humiliation, embarrassment and lack of dignity were also expressed by patient participants (n=5, 17%),

"The whole experience was humiliating; to see it getting that far was humiliating."

"I was intimidated. Embarrassed."

One (n=1, 3%) patient participant echoed the response of one of the staff participants,

" I was terrified"

A summary of key feelings during the event is included in table 13 below.

FEELINGS – during the incident	**n = 30**	**%**
Anxiety and fear	n=19	63%
Out of control / overwhelmed	n=6	20%
Humiliation and embarrassment	n=5	17%
Emotionally detached	n=4	13%
Terror	n=1	3%

Table 13. Feelings during the incident – patients

In the aftermath of restraint patients' feelings were similar to staff. Anger was expressed by nine (n=9, 30%) of patient participants,

"I was still angry, distressed."

"I was angry with myself that it had gone that far".

"Angry and humiliated."

Guilt was another theme which was evident when analysing the transcripts of patient data. Seven (n=7, 23%) patient participants felt guilty following the incident,

"I felt that I'd let them [the staff] *all down. They were trying their best with me and* [a female nurse] *must have been frustrated that it happened again."*

"I felt bad that I'd caused all this."

"Disgusted and disheartened. I was upset that the nurses felt that it was necessary."

Seven (n=7, 23%) of patient participants were relieved in the aftermath of restraint incidents,

"Relief, glad it was over."

"I felt relieved that it had ended and I was ok."

"I was glad it was finished. I didn't want it to happen again."

Feelings of humiliation, intimidation and embarrassment were evident in the aftermath of incidents and four (n=6, 20%) talked about these feelings in depth,

"I was embarrassed. Devastated that I had got this bad."

"It was humiliating. I was left in seclusion and nobody spoke to me."

"Upset and humiliated. I wanted to go home."

Three (n=3, 10%) reported feelings of fear continuing after the incident,

"Low, anxious, and scared. I was put in a side room and they kept checking up on me."

"Frightened and scared. I didn't know what to do with myself."

More positive feelings were expressed by two (n=2, 7%) people in relation to feelings of safety afterwards,

"I felt safe in seclusion."

"I felt calm and safe afterwards. He's great [a male nurse]. *He really made me feel better just by talking to me after it had all calmed down."*

A summary of patients' feelings in the aftermath of restraint is included in table 14 below.

FEELINGS – in the aftermath	**n = 30**	**%**
Anger	n=9	30%
Guilt	n=7	23%
Relief	n=7	23%
Humiliation, intimidation and embarrassment	n=6	20%
Fear	n=3	10%
Safe	n=2	7%

Table 14. Feelings in the aftermath of the incident – patient participants

5.9 What was helpful?

Each patient participant reported their own unique experience but there were some common themes which were generated. Good relationships with nursing staff and being accepted with positive regard appeared to have an impact upon how patients perceived the management of the aftermath of restraint. The patients who reported helpful aspects during interview had less negative views of the incidents in general, and were less critical of the restraint procedure. Eleven (n=11, 37%) patient participants reported that the positive relationship that they had with nursing staff had been helpful in the aftermath of restraint. They described positive qualities of nursing staff such as kindness and caring, making time for them, listening, familiarity, and being approachable as being helpful. Patients found some of these elements difficult to articulate but spoke with feeling during interviews about how much they valued positive responses from nursing staff,

"She [female nurse] *doesn't get in a flap. She's calm but she listens to what I've got to say when I calm down. She tried to sort things out for me."*

"[Female nurse] *always takes the time to talk to me. She's got the patience of a Saint."*

"[Male nurse] *is my key nurse. He talked to me about how it all blew up. He did listen to where I was coming from. He does seem to care about how I felt about it. They're not all like that but* [male nurse] *does care."*

"I trust [female nurse]. *She's not like the bully boys from [another ward]. They come down and they just wade in. You don't get a chance even to try and say what the problem is but she gives you time and listens."*

Medication was viewed positively by some (n=8, 27%) patient participants,

"They offered me my PRN [as required medication*] which I took. That was helpful."*

"Medication. I can sleep it off in peace then."

"Pills. Largactil and Lorazepam. It meant that I could just lie down and fall asleep."

Closer observation was regarded by four (n=4, 13%) of patient participants as helpful. Three (n=3, 10%) of these participants had been restrained during episodes of self harm,

"They upped my level of obs [observations] *and that helped. Made me feel a bit safer."*

"I was put on close observation for a couple of days after that. That was helpful. I had a bit more one to one time which I think I needed at the time."

Not inflicting pain during restraint was reported by three (n=3, 10%) patient participants as helpful during the process,

"Not fucking hurting when they are restraining you would be helpful," was the response to this question by a participant who described a number of restraint experiences during a recent admission, and who was still clearly angry with staff during the research interview.

"They didn't hurt me when they were pulling me away. They tried to be quite gentle with me."

WHAT WAS HELPFUL?	**n= 30**	**%**
Good relationships with nursing staff	n=11	37%
Medication	n=8	27%
Close observation	n=4	13%
Not hurting during restraint	n=3	10%

Table 15. What was helpful? Patient participants

5.10 What was unhelpful?

Patients spoke at more length about what they had found to be unhelpful as opposed to helpful. They spoke in depth about specific aspects of experiences that had been troubling to them, whereas when staff discussed helpful and unhelpful aspects, they had spoken in a much more detached and dispassionate way. While staff recollections regarding unhelpful aspects of restraint had been related to more organisational issues, the patient participant interviews provided a more personal insight into the experience. Staff attitudes came high on the list of unhelpful aspects of restraint, with fifteen (n=15, 50%) patient participants reporting that negative staff attitudes had worsened an already unpleasant experience. Within this theme, being ignored was reported by twelve participants (n=12, 40%), and specific denial of requests was highlighted by ten (n=10, 33%) participants, as unhelpful to them,

"I was ignored until I deliberately sought somebody out."

"It was not helpful being ticked off on a board to make sure that you were there, instead of being spoken to."

"They never talked to me about it. If somebody had sat down and talked it through, that would have helped."

"I asked [the nurse] *to use the shower and he said, "You can't do that on your own, you have to wait," and I was just ignored. He kept saying they were too busy. In the end it wasn't until I was screaming the place down that they actually listened to me."*

"I wasn't allowed to go back [home for money and cigarettes] *and I didn't know anybody, I felt more like a criminal than a mental health person."*

Male nurses being present during restraint was referred to as unhelpful by seven (n=7, 23%) of the female patient participants. No male participants reported this to be an issue,

"Disgusted that a male nurse was present. It was bad enough having the injection without the embarrassment of having a male nurse present. Only female nurses should be present when restraint or injections are given to female patients."

"I didn't like the male nurses from the other ward being there. They are strong and they hurt you."

While medication had been viewed as helpful by some patient participants, it was viewed as unhelpful by six (n=6, 20%) participants,

"I am very much against injections. It goes against my beliefs [goes on to describe physical and psychological effects of medication].. *I prepared myself for them and I've been on a depot ever since. I've made a lot of progress but I'm not allowed to return to oral. The consultant has made that decision."*

"They wouldn't give me a chance to calm down. They kept giving me Lorazepam. I was very dopey."

Similarly with observation, while some patient participants found this aspect of restraint helpful, five (n=5, 17%) reported this experience to be unhelpful,

"It's like being in prison and you've done nothing wrong,"

"I found the observation afterwards intrusive. I couldn't even go to the bathroom in peace."

One patient summed up her experience of what she found unhelpful,

"Being in hospital."

A summary of the key themes related to what patient participants found to be unhelpful is presented in table 16 below.

WHAT WAS UNHELPFUL?	n = 30	%
Negative staff attitudes	n=15	50%
Being ignored	n=12	40%
Denial of requests	n=10	33%
Male nurses in restraint procedures	n=7	23%
Use of medication	n=6	20%
Observation	n=5	17%

Table 16. What was unhelpful for patient participants?

5.11 Reawakening of traumatic events

The pilot study had highlighted that both staff and patients had recollections of earlier traumatic or upsetting events during more recent incidents of restraint. This had been emergent data from the earlier study which had been unexpected and the study design had not allowed for further examination at that point. Examples from the earlier study included recent experience of restraint resurrecting memories of rape for one woman, previous traumatic restraint incidents for others, and childhood sexual abuse for another male participant In order to explore this phenomenon further within this study, a question was included which asked whether this restraint incident had brought back distressing memories of previous traumatic or upsetting encounters. If participants responded positively, Part B (appendix 5) of the Post Incident Review was completed with further open ended questions being asked to try and ascertain a more comprehensive picture of this phenomenon and how it was experienced. Gender of participants has been further broken down within this section due to the nature of the experiences that patients reported. Seventeen (n=17, 57%) out of thirty

participants reported that the incident had brought back memories of previous traumatic encounters. In terms of gender, eleven (n=11, 37%) female patient participants and six (n=6, 20%) male participants responded positively to this element of the study. This sensitive aspect of the interviews provided unique stories, some of which went in to much depth, while others were discussed on a very superficial level. Rape and sexual abuse was a theme which encompassed seven (n=7, 23%) women patient participants' responses. Of these women, two (n=2, 7%) had experiences of rape by a stranger, the rest (n=5, 17%) experienced sexual violence by a partner, family, or other person(s) known to them. A further two (n=2, 7%) reported domestic violence without sexual abuse. One (n=1, 3%) male patient participant discussed childhood sexual abuse in relation to restraint. While some participants had difficulty in articulating how the experience of restraint invoked recollections of earlier traumatic experiences, others were quite clear about the links,

"Do you [asking researcher] *imagine what its like to come in here? Because you've been fucked up in the head by years of abuse and then you get big strapping blokes that you've never met in your life before holding you down while somebody else gives you the needle* [intramuscular injection]? *It was like going over it all* [previous sexual abuse] *again."*

"I almost felt like it was him on top of me [participant linking restraint to earlier experience of rape]. *I thought I was going to suffocate, I could almost smell him. I just wanted to get in to the bath afterwards. I don't know if it was* [be]*cause I was all hot and sweaty because I'd been struggling or whether it was because that's what I did back then* [referring to the aftermath of rape]."

Other links were related to violent encounters outside of the hospital setting for five (n=5, 17%) of the male patient participants and two (n=2, 7%) of the female

participants. These situations included being attacked, mugged, and witnessing violence to others,

"I got attacked in [notorious street in the local area] *about two years ago. It was like that. They were all on top of me with arms everywhere."*

"A friend got stabbed in a nightclub. I didn't know what was happening. Chaos. It [restraint experience] *reminded me of that night."*

The patient participants had even more difficulty in articulating the links between restraint and earlier experiences than staff. Where staff had still felt in control of thoughts and feelings and were aware that the restraint situation was not connected to earlier events, some patient participants were less clear about this.

During interviews, the experiences of patients in relation to restraint were described in a more harrowing way than with staff, and the discussion of restraint reigniting earlier experiences was more upsetting during recollection with this group than with the staff group. A breakdown of these responses is offered in table 17 below.

REAWAKENING OF TRAUMATIC EVENTS	**n = 30**	**Female patients**	**Male patients**
Reigniting of previous encounter	n=17 (57%)	n=11 (37%)	n=6 (20%
Rape, sexual assault / abuse	n=8 (27%)	n=7 (23%)	n=1 (3%)
Rape by a stranger(s)	n=2 (7%)	n=2 (7%)	-
Domestic violence (not including sexual assault	n=2 (7%)	n=2 (7%	-
Other violent encounters	n=7 (23%)	n=2 (7%)	n=5 (17%)

Table 17. Reawakening of traumatic events – patient participants

5.12 Trauma Screening Questionnaire (TSQ)

The TSQ (Brewin et al 2002) (appendix 5) was applied with patient participants in the same way as it was in collecting staff participant data. The TSQ is a ten point, tick box yes / no, self report questionnaire which identifies current symptoms for PTSD and is indicated for use in acute settings such as primary care and liaison but is not in routine use in management of the aftermath of restraint in mental health settings. Indications for using the TSQ have been described in the presentation of staff findings in chapter four. Presently there is not enough evidence to support use of the TSQ in inpatient mental health settings following restraint and this was a unique opportunity to establish whether if may be helpful in examining the aftermath of restraint. The TSQ is not indicated for use for up to four weeks following a traumatic event, and arrangements were built into the research design to revisit patients to complete the TSQ if necessary at a later date to adhere to this criteria, however this was ultimately unnecessary as all interviews took place four weeks or more following the incident of restraint. The study design allowed for participants to be interviewed seventy two hours or more after an event, as ethically some time was needed to allow participants to consider taking part in the study. In reality, all of the patient participants were interviewed more than four weeks after the event when their mental states were much more stable and they were clearly able to consent in a fully informed manner. Patient participants found the TSQ an easy to understand tool which they were able to complete quickly and independently. Twelve (n=12, 40%) of patient participants had trauma symptoms which were above the clinical cut off point of six, and warranted further screening for PTSD. Of the eighteen (n-18, 60%) of patient participants who were below the clinical cut off point, eight (n=8, 27%) score zero. The remaining ten patient participants' (n=10, 33%) scores were fairly evenly spread from one to five.

The TSQ ratings were also examined in relation to the severity of the restraint incident to establish whether the more severe the incident, the more likelihood there would be of experiencing trauma symptoms. For patient participants who rated more highly on the TSQ the restraint incidents were varied, some being from the less intrusive end of the scale to incidents involving C & R and forcibly administered medication. A breakdown of TSQ scores is offered in figure 38 below.

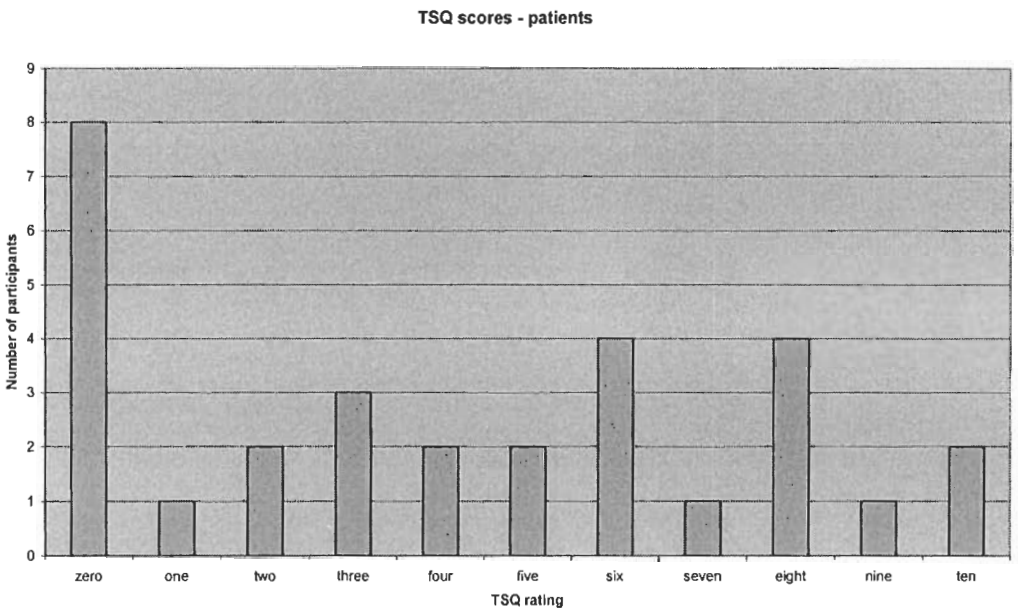

Figure 38 . TSQ scores patients

5.13 Patient evaluation – Post Incident Review

The evaluation of the Post Incident Review (appendix 10) that formed part of the research interviews was also offered for patients to complete at the end of the interview. This was the same form that staff were asked to complete, however where staff had been asked to complete the evaluation independently and return by internal post to the researcher, patient participants were asked to complete the evaluation at the end of the interview in the presence of the researcher. This method was built in to

the study to allow patient participants the opportunity to ask questions or for clarification of the items within the evaluation that were to be rated on the likert scale. An explanation of how to complete the evaluation was offered and all participants participants completed the evaluations. This part of the data collection took longer to complete than anticipated but did prompt further reminders to participants around the issues that had been discussed in the earlier tape recorded interviews. This offered a slight dilemma in that the interviews were complete and the tape recorder was switched off but further valuable information was being offered which could assist in developing depth and context to the individual interviews. With the agreement of participants, the researcher made additional notes in response to these comments in order to capture this additional information. These comments were subsequently used to supplement the analysis of the tape transcripts. Additional time was necessary to allow time for participants to think about their responses which had not been anticipated by the researcher, as well as explaining some of the statements which were included on the evaluation form. The evaluation was made up of six questions which patient participants were asked to rate on a likert scale of 1-7 where 1 equalled strongly disagree, 7 equalled strongly agree, and anchor point 4 equalled neither agree nor disagree. Four questions asked specifically about the efficacy of the framework and two questions were included which asked whether the incident could have been predicted and whether the incident was managed well. Results are presented as follows:

Question one (figure 39) asked participants whether the framework provided an opportunity to discuss the aftermath of an incident which they may not otherwise have had the opportunity to do. Twenty eight (n=28, 93%) of patient participants agreed with this statement, two (n=2, 7%) neither agreed nor disagreed with this statement,

and no participants disagreed that the framework provided an opportunity to discuss the aftermath of the incident.

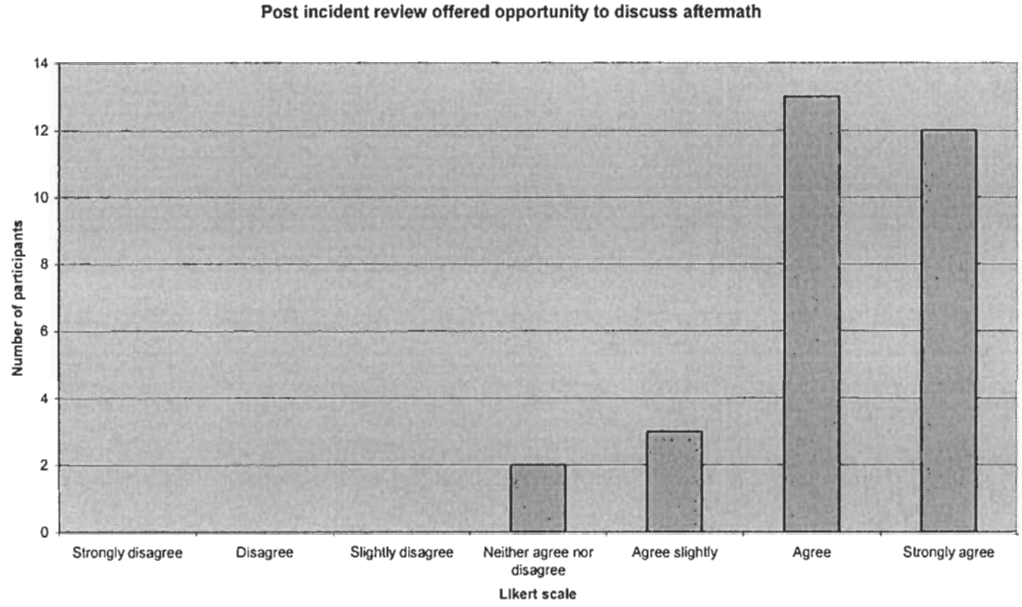

Figure 39. Post Incident Review evaluation question one – patient participants

Question two (figure 40) asked whether the review had allowed the participant to think about some of the events leading up to the incident. One participant (n=1, 3%) strongly disagreed that this was the case. Two (n=2, 7%) participants slightly disagreed that the review had allowed them to think about some of the events leading up to the incident, and one (n=1, 3%) neither agreed nor disagreed that the review had allowed them to think about this aspect. The remaining patient participants (n=26, 87%) agreed that the review had offered this opportunity, and out of those nine (n=9, 3%) strongly agreed

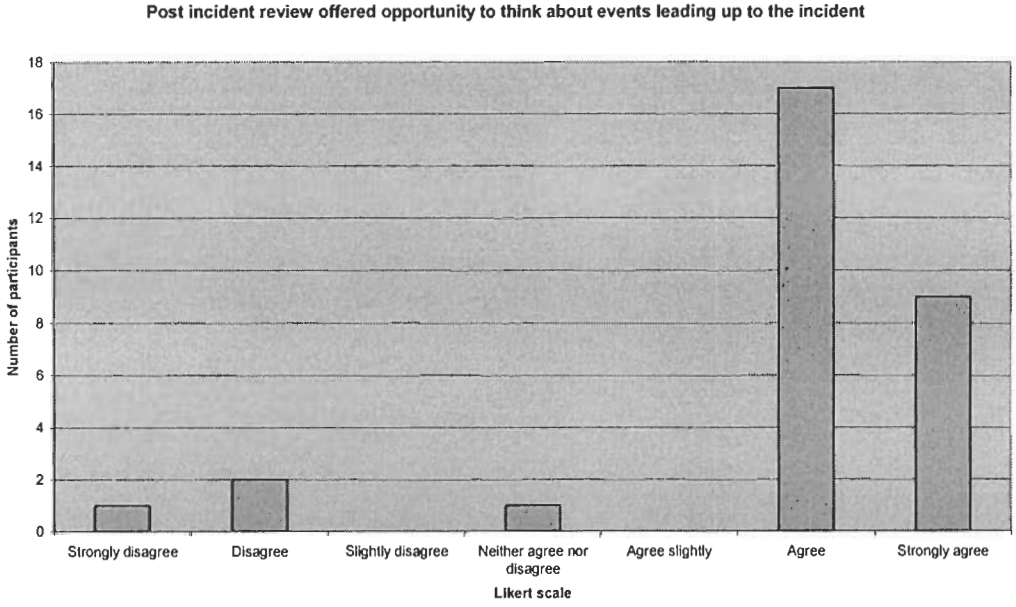

Figure 40. Post Incident Review evaluation question two – patient participants

Question three (figure 41) asked whether the Post Incident Review had helped the participant to think about how well the incident was managed. Three (n=3, 10%) patient participants slightly disagreed that the review had helped them to think about how the incident had been managed, nine participants (n=9, 30%) neither agreed not disagreed that this was the case, and the remaining eighteen (n=18, 60%) agreed that the review had allowed them to think about how the incident had been managed.

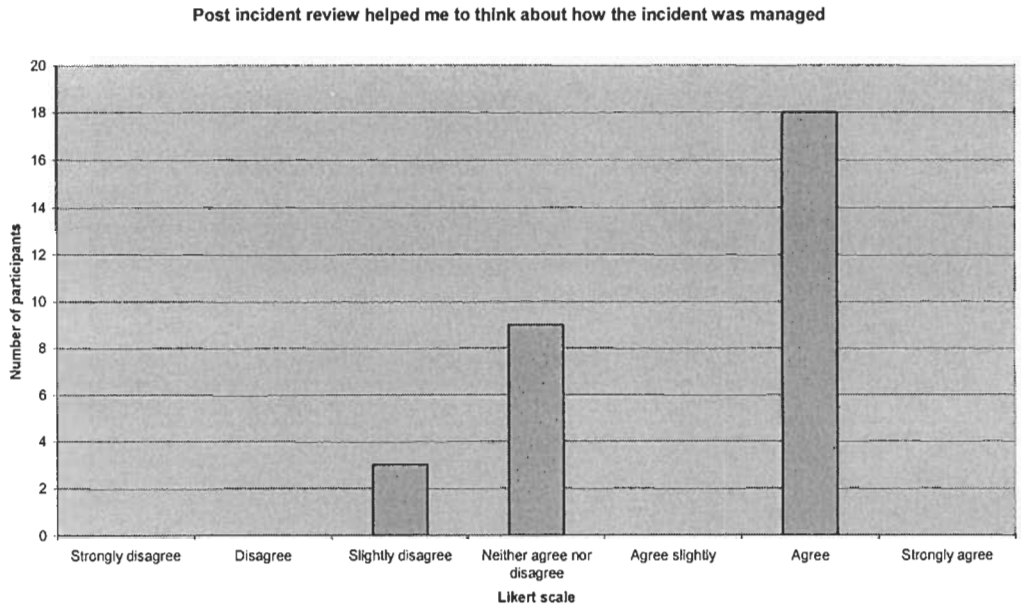

Figure 41. Post Incident Review evaluation question three – patient participants

Question four (figure 42) asked the participant if the framework was a useful way to review incidents of restraint in the practice setting. Two patient participants (n=2, 7%) strongly disagreed that the framework was useful, eight participants (n=8, 27%) neither agreed nor disagreed, and the remaining twenty (n=20, 67%) agreed this was a useful way of reviewing incidents of restraint in practice.

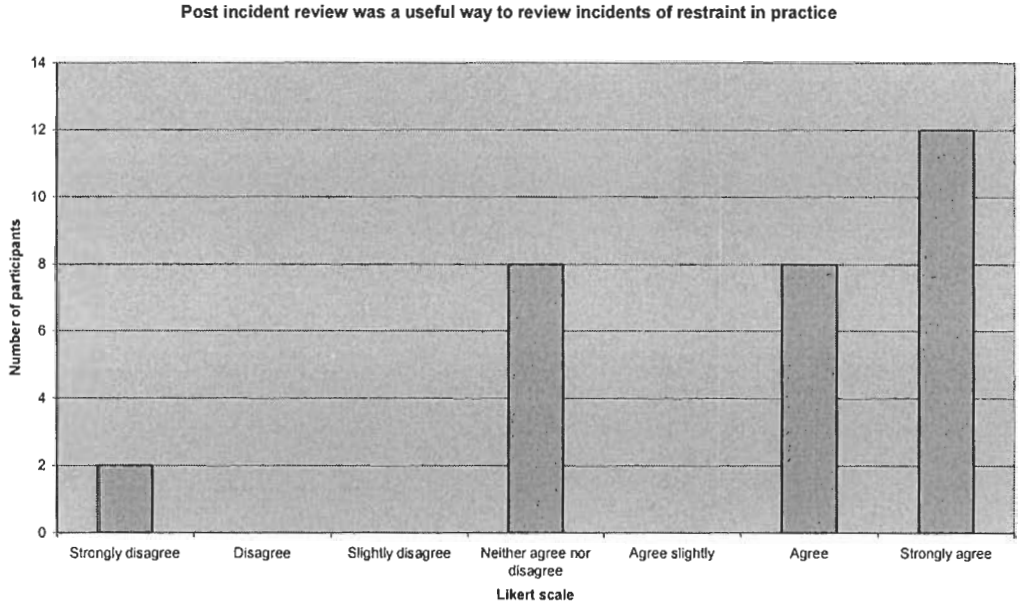

Figure 42. Post Incident Review evaluation question four – patient participants

The last two questions asked about management of the incident (figure 44) and whether the participant believed that it could have been predicted (figure 43). These questions were used to provide supplementary data to the qualitative interviews which were being undertaken as part of the wider study. Mixed responses were generated from these questions for staff participants with eighteen (n=18, 60%) agreeing that the incident could have been predicted. For the patient participants, a higher proportion (n=20, 67%) disagreed that the incident could have been predicted. Four (n=4, 13%) of patient participants neither agreed nor disagreed that the incident could have been predicted, and six (n=6, 20%) believed that it could have been predicted.

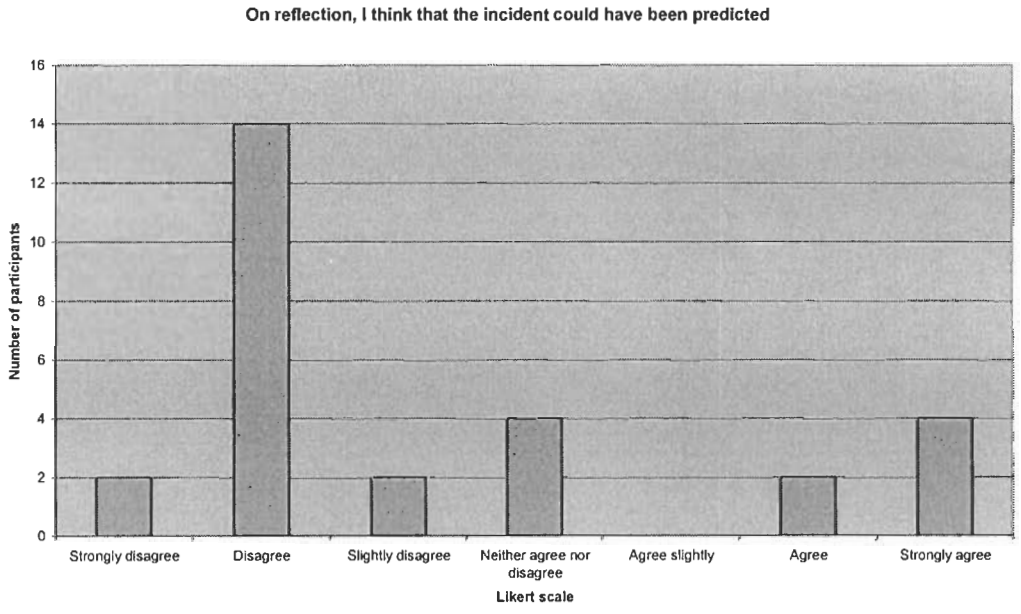

Figure 43. Post Incident Review evaluation question five – patient participants

The final question asked whether the participant believed that the incident had been well managed. Despite some of the content of the interviews highlighting that patients had negative views regarding staff attitudes and interventions in relation to restraint, half of the patient group (n=15, 50%) agreed that the incident had been well

managed. Seven (n=7, 23%) neither agreed nor disagreed with this statement that the incident had been managed well, and eight (n=8, 27%) reported that they believed that he incident was not managed well.

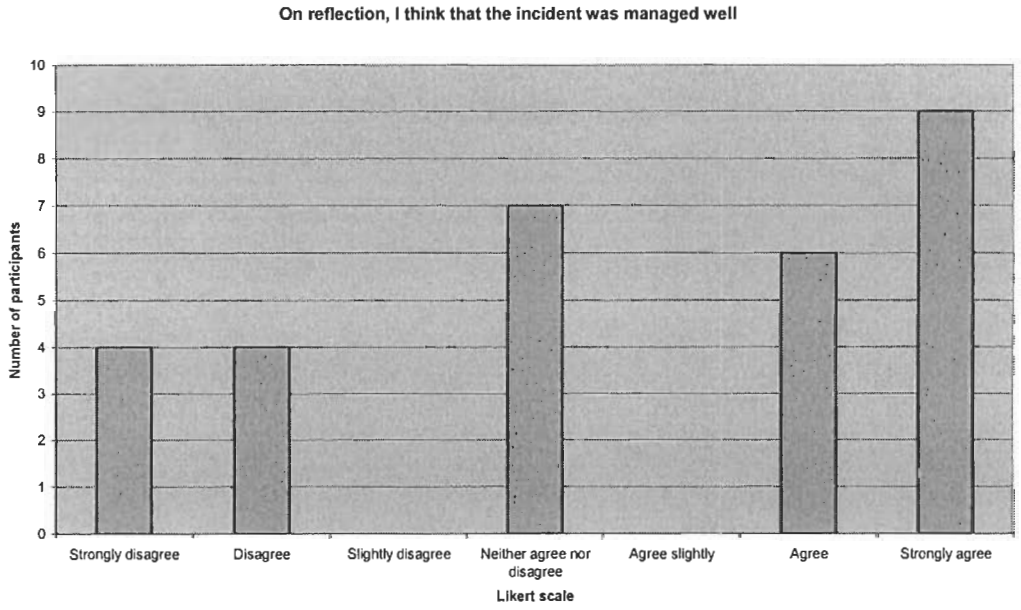

Figure 44. Post Incident Review evaluation question six – patient participants

5.14 Conclusion

This chapter has presented findings related to the patient participants (n=30) who were interviewed as part of this study. They offered further insights into the complexities around the experiences of restraint by adding other dimensions which staff participants may not have been aware of or thought to be of particular significance, for example in relation to the traumatic impact of restraint for patients who already have trauma histories.

Patients' recollections of restraint incidents in section 5.2. provided further thought to the wide range of restraint procedures that are used which include restraint while in police custody. Police have different restraint procedures using mechanical restraints

such as hand cuffs and these are not currently in use in nursing practice in the UK. Whether this may have additional psychological impact upon patients is unknown. There are studies of restraint in other countries which use these methods such as US and other European countries, however no comparison has been made to examine whether mechanical restraints have a greater of lesser psychological impact than UK traditional C & R procedures.

Demographic data highlighted that there was a fairly equal distribution of gender in the patient group providing a balanced representation of gender for this study. Ages ranged from 18-58, the majority (n=21, 70%) falling within the 20-40 category. As regards ethnicity, the majority (n=21, 70%) of the patient participants were White British which was slightly less than the staff group (n=24, 80%).

Diagnosis reflected the changes in recent years within the client group in acute care. 47% (n=14) had a dual diagnosis with substance misuse and personality disorders being comorbid to other serious mental illness such as schizophrenia. It is of note that none of the patients had a diagnosis of primary or secondary PTSD despite recent studies identifying that up to 40% of the inpatient population may have this diagnosis (Meuser et al 1998; McFarlane et al 2001; Purves et al, in preparation). These diagnoses offer complex challenges in this area of care, often presenting with associated aggressive and violent behaviour which result in restraint. 83% (n=25) of the patient participants were under a section of the Mental Health Act (1983), with 70% (n=21) of them being detained under Section 3. This section is lengthier, has powers to treat, and is used in more severe cases which again reflects the changed population in current acute care. 90% (n=27) of patient participants had previous

admissions to acute mental health settings and 67% (n=20) had a previous history of violence. This may help in planning of care when arranging admission for patients who have previous histories in terms of staffing in anticipation of untoward incidents. For example using the demographics in this study, a patient who has a dual diagnosis and is being admitted under a section 3 of the Mental Health Act (1983), has a previous history of violence, and has previous admission(s) may be a high risk for untoward incidents which may require restraint. Staffing may need to reflect the potential challenges that this scenario may create by having more experienced, and higher numbers of staff to manage such challenges effectively.

80% (n=24) of patient participants reported to being restrained either in the standing position or the prone position with C & R procedures being used. This was similar to the staff figure of 77% (n=23). These figures indicate that restraint procedures within this study reflected the more extreme end of the definition for restraint and the subsequent consequences. 10% (n=3) of the incidents reported by patients were above the recommended time guideline of 30 minutes and this reflected staff reporting. One third (n=10, 33%) of patient participants reported to being placed in seclusion with times varying from less than one hour to twenty four hours. This was slightly higher than staff reporting. Staff had not gone on to discuss seclusion in depth, however the patient group did discuss this aspect of the aftermath of restraint. They reported the experience of seclusion being degrading and humiliating, often feeling ignored and neglected by staff while in seclusion.

The physical consequences of restraint were fairly minimal for patients. 87% (n=26) of patients had either none or minimal injury. 50% (n=15) reported no physical injury

at all mirroring staff figures for this category. Patients reported that 47% (n=14) of the incidents involved more extreme interventions of restraint using C & R either in the standing or prone position. 47% (n=14) of patient participants reported receiving intramuscular injections during the course of restraint against their will. This was much higher than the staff group who reported 27% (n=8) of restraints requiring this intervention with medication. Despite these invasive interventions minimal physical damage was reported. This could suggest that safe techniques of restraint are being used within this particular Trust and that C & R training is effective, certainly in the physical management sense of the experience. The qualitative interviews however found that, despite minimal physical injury, the psychological impact for patient participants was great.

The core categories generated from the qualitative interviews provided thought provoking material which informs existing evidence regarding the psychological impact of restraint for patients. While staff described antecedents in relation to mental states worsening and not taking medication, patients described a wider variety of antecedents which were described in a passionate way. Some patients agreed that mental states had worsened in the lead up to untoward incidents; however other issues such as denial of requests, observation which was perceived as counter-therapeutic, and boredom were also described in detail as important components in the escalation of restraint situations. These themes support current literature related to antecedent behaviours.

Patients also described feelings in depth with anxiety, fear, distress, anger and suicidality being evident in the lead up to restraint. Intervention may have prevented

situations escalating had these feelings been attended to at an earlier stage. During the incident patients described feelings of being out of control and overwhelmed emotional detachment, and terror. These descriptions are reminiscent of trauma related phenomena and symptoms of PTSD, and are worthy of much wider consideration in light of the links raised within the literature between mental illness, trauma, and PTSD. In the aftermath of restraint feelings of anger, relief, guilt, humiliation, fear and safety were described. These are strong emotional reactions which were often ignored in the aftermath of restraint. These emphasise the importance of Post Incident Review to address the strong emotional impact that restraint can have for patients.

Patients presented mixed views of what was helpful and unhelpful. Therapeutic relationships with staff were helpful in limiting the severity of emotional consequences of restraint. For some patients medication was helpful in calming their feelings, while others found medication most unhelpful, counterproductive, and perceived it to be used as a punishment. Some patients found observation, particularly in the aftermath, to be helpful and reassuring. Others, however, found observation to be intrusive and humiliating. Although physical impact was not rated highly using the measurement scale, the qualitative interviews highlighted that physical consequences were important to patients, and that not hurting was an important aspect of restraint. Denial of requests and being ignored was viewed as unhelpful and more comprehensive and consistent Post Incident Review could address this. For female patients, using male nurses for restraint procedures was perceived as unhelpful, and for some traumatic. Patients with a history of rape and sexual abuse, in

particular, found the experience of restraint by men very distressing and reminiscent of their earlier traumatic experiences.

57% (n=17%) reported that the experience of restraint had reawakened memories of earlier traumatic events. These figures mirrored staff reporting however the content of the earlier experiences was different for patients and patients appeared to be more willing than staff than describing these events in depth. Examples of earlier traumatic events for patients were mainly around rape, sexual abuse, domestic violence, and other violent encounters.

Using the TSQ (Brewin et al 2002) was helpful in this study to highlight patients who had trauma symptoms. 40% (n=12) of patients scored above clinical cut off points and warranted further screening for PTSD. This aspect of the study was reported back to ward teams in order for patients to have further assessment. It would have been helpful for this to be followed up to establish whether those who were further assessed were eventually diagnosed with PTSD however this element was not designed within the study and would have proven too time consuming to pursue. Furthermore ethical approval had not been sought to follow up this aspect of the study. The early indicators, however, support current limited literature that around 40% of inpatients may have PTSD as a primary or comorbid disorder. The TSQ scores were varied in relation to physical extent of intervention. Some patients who reported minimal restraint interventions still scored highly on TSQ ratings and other who had extreme interventions also had both high and low scores. This may support the dose – response theory discussed earlier but warrants a more thorough examination.

The framework for Post Incident Review which was applied in this study was evaluated very positively by patients, as presented in section 5.9. This adds further weight to the patient data which suggests that a simple, non threatening framework would be a welcome adjunct to current practice in Post Incident Review.

CHAPTER SIX – MOVING THE FINDINGS FORWARD

"...I will recommend this technique to anyone who wants a way out of that dark place and to safety, love and happiness again...." (Anon 2006).

6.1.Introduction

During the grounded theory process of data generation and analysis it became clear fairly early on in the study that post incident support was an area which was inconsistent and patchy within this Trust, and that both staff and patients welcomed the opportunity to engage in Post Incident Review. This shorter chapter will highlight how the findings which were emerging from this study informed an initiative in practice to address some of the inconsistencies related to Post Incident Review and support for staff.

Section 6.2. will outline how a proposal to set up more formal mechanisms within the Trust was implemented to offer Post Incident Review for staff, taking into consideration some of the concerns raised within the findings of this study. Section 6.3. will detail a case study of a member of staff who experienced PTSD following an untoward incident in practice. The member of staff was not a participant in this study but was referred to the local Trauma service after developing PTSD following an incident in her workplace. This chapter is included to illuminate some of the findings and emphasise how research findings can be implemented to change and inform practice for the better. The case study draws together the many points raised in relation to staff within the literature review, as well as highlighting how staff can be

successfully treated following untoward events and enabled to return to practice. The chapter will conclude with main points being summarised in section 6.4.

6.2. Implementation of Post Incident Review in practice for staff

A proposal was presented to representatives from the Trust outlining a system of Post Incident Review and support to be set up for all localities within the Trust. The aim was to have a list of practitioners who would be provided with in-house training in post incident staff support who could be accessed by staff groups following untoward events to facilitate Post Incident Review. Providing a list of practitioners would enable choice for staff in recognition of some of the issues which had been raised within this study in relation to inappropriate facilitation of Post Incident Review. An example of this included Post Incident Review being imposed upon one staff group by a manager who was simultaneously conducting an investigation into the incident for which the review was taking place. This had resulted in that particular group feeling angry and victimised and individual staff within this group felt that this experience had tainted their views of the benefits of Post Incident Review and support. By offering a list of facilitators from a variety of areas, this would be a less threatening approach to staff who may already be in fear of recrimination.

A number of issues had to be considered when setting up this initiative. There were already systems in place for staff support in a variety of forms. These included staff support groups which were already running in some clinical areas, staff occupational health services, and staff counselling services. The staff support groups were facilitated by very experienced practitioners who were already engaging in post incident support through these mechanisms. Occupational health services were seeing

staff on the more severe end of untoward incidents who may already have been on sick leave and this service was helpful in ongoing referral for staff who were exhibiting trauma symptoms. Staff counselling services were a confidential contracted external agency which staff could access for a maximum of four sessions but the remit of this service was not around trauma focussed interventions. Discussion with all of these parties allowed for an open exchange of potential problems and overlaps which enabled a clear pathway specifically related to the implementation of Post Incident Review within the Trust (figure 47). This pathway would work in collaboration with the other support networks which were already in place to provide an additional system which could be accessed if necessary. More importantly, this new initiative would provide a mechanism of Post Incident Review for the many areas which did not have support systems in place.

In preparing practitioners to facilitate Post Incident Review some fundamental issues were made explicit in the process. The literature review has highlighted the potential for exacerbating trauma symptoms through critical incident stress debriefing, and the model which was being advocated in this initiative was through an educational approach. This would involve a facilitator being chosen by the staff group from a list of trained practitioners. These practitioners were senior clinicians within the Trust with a wealth of experience and knowledge in many areas of mental health, including facilitation. Arrangements would be made for the facilitator to meet with practice staff at a suitable time and a review of the incident would be conducted using the psychological first aid model. This is a health promotion approach to post incident support which places emphasis upon the natural responses that are evoked during and following a traumatic event. Staff are prepared to expect some upsetting symptoms

which usually subside within two to four weeks, or less for many individuals, and additional educational material, such as leaflets, are offered to supplement the discussion. The TSQ can be used subsequently to screen for trauma symptoms and provide evidence to support onward referral for further assessment of PTSD, if necessary.

As this approach to Post Incident Review had not been implemented previously in this Trust, and no research evidence of similar initiatives was available in the literature, arrangements were made for the project to be evaluated and reviewed on a six monthly basis following implementation. Figure 46 highlights the process of Post Incident Review proposed.

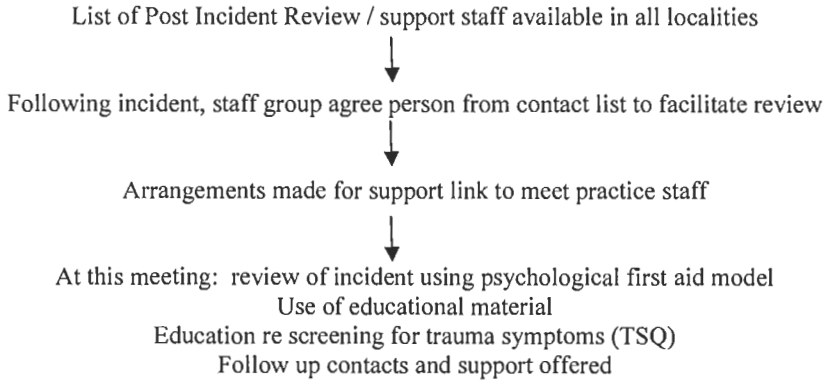

Figure 45. Implementation of Post Incident Review for staff

This model was embraced by staff and, although in its early stages, it is anticipated that this will be a successful approach to addressing the existing gap in Post Incident Review and support in acute mental health care.

Sadly for some staff, this initiative came too late. The following case study highlights how staff who have not been well supported following incidents in practice can go on to develop PTSD. The case study highlights the assessment process and the subsequent interventions which were used to treat a member of staff who developed PTSD as a result of being the victim of assault by a patient in her clinical area.

6.3. CASE STUDY

The study aimed to examine the psychological impact of restraint and this overlaps into the arena of PTSD. The findings have highlighted that although the majority of staff did not score highly on the TSQ which would warrant further screening for PTSD, staff still scored above zero in many cases. As data was emerging it was clear that restraint did have a psychological impact upon staff. Thought must then be given to how this issue is addressed. The Post Incident Review was very positively evaluated and would be offered as framework for clinical practice as a result of this study. I was mindful of what does happen to staff who go on to develop PTSD as a result of restraint and undertook further training to enhance my skills in assessing and treating individuals with trauma related symptoms. This training included an enhanced clinical skills based course which broadened my theoretical understanding and offered the opportunity for supervised clinical assessment and treatment (Berkshire Healthcare Trust 2005). In addition, I completed training in Eye Movement and Desensitisation Reprocessing in order to gain further clinical skills and be in a position to offer treatments recommended with NICE (2005b) guidelines for PTSD (EMDR Workshops 2006). I subsequently continued sessional work with the Trauma service based within the Trust in which the study took place to further enhance my clinical skills. I had taken a special interest in working with staff who

had been referred to the service as I wanted to develop my clinical skills and understanding related to this group. This was an area which I aimed to pursue in my future career following completion of this study. My role within the Trauma service was quite distinct from my role as researcher. This clinical role involved use of specific skills and techniques which will be discussed, and was markedly different from the role that I undertook as a researcher interviewing participants about their restraint experiences. The clinical role involved an in depth facilitation of trauma focussed interventions under supervision with clients who had specific traumatic material for which they were seeking assistance to address through therapy. I viewed this role quite separately to my other roles as researcher and lecturer, and any conflict which could potentially arise was discussed through supervision within the Trauma service and through supervision with my research supervisors.

The following case study highlights how staff who have gone on to develop PTSD can be successfully treated and return to work following treatment. The person described in this case study was not a participant in the research study but did work on one of the wards where the study was taking place. She had heard about the study but had not been approached to take part in the study following the incident which precipitated her developing PTSD. She was referred to the Trauma service by the Occupational Health Service for assessment and treatment during a period of sick leave.

Anne (pseudonym) was a staff nurse on an acute ward who was attacked by a patient. The circumstances surrounding the incident had been that Anne had returned from leave and been given a handover of the new admissions to the ward. She had noticed

that Peter (pseudonym) had been agitated, restless, interfering and was not responding to any verbal attempts by her to try and ascertain the reasons for his agitation. She was also aware before the incident that staff on duty were avoiding Peter and were reluctant to engage with him. His agitation escalated and still no interventions were offered. She reported her concerns to the nurse in charge but the ward was particularly busy; a multidisciplinary meeting was about to take place, medication round was underway, and a number of other demands were being made upon the staff available. Shortly after the meeting began Anne was attacked by Peter. She was offered little assistance during the attack. Following the attack Anne was taken to the ward office and she asked to go home. She called her husband who came to pick her up. She remained on sick leave for her physical injuries, mainly as a result of the patient punching her head. She developed symptoms of PTSD over the coming weeks and was eventually referred to the local Trauma service by Occupational Health. On assessment Anne completed a variety of assessment measures (table 18) to ascertain the extent of her symptoms and establish whether she fulfilled DSM-IV criteria for PTSD. As well as the Semi Structured Clinical Assessment used within the service, Anne completed the Impact of Event Scale-Revised (IES-R) (Horowitz et al 1979), Beck Depression Inventory II (BDI-II) (Beck 1996), PTSD Symptom Scale – Self Rating (PSS-SR) (Foa et al 1993), General Health Questionnaire-28 (GHQ-28) (Goldberg 1981), and Hospital Anxiety and Depression Scale (HADS) (Snaith and Zigmond 1983). The IES is a tool which identifies fifteen statements related to the traumatic experience which must be rated from not at all to rarely to sometimes to often. Scores are assigned to each rating and added up. The clinical cut off point for this scale is 26 and Anne scored 55. The BDI-II is used to assess levels of depression with scores rated by the patient regarding a number of different depressive symptoms.

The clinical cut off points range from 10-15 being mild, 16-19 being mild to moderate, 20-29 being moderate to severe , and 30-63 being severe. Anne scored 17 on this scale which indicated that she had mild to moderate depressive symptoms. The PSS-SR is a diagnostic tool for PTSD which is based on DSM-IV criteria. The tool is broken down into different sections which include questions related to re-experiencing symptoms, avoidance symptoms, arousal symptoms, perceived or real life threat during the event, effects upon levels of functioning, feelings of guilt, homicidality, and disillusionment. To fulfil DSM-IV criteria, scores of at least one or more re-experiencing symptom, 3 avoidance symptoms and 2 arousal symptoms would be needed. Anne scored 13 for re-experiencing symptoms, 10 for avoidance symptoms and 13 for arousal symptoms. The HADS is used for measuring levels of anxiety and depression. Scores range from 8 to 10 for mild anxiety or depression, 11 to 14 for moderate anxiety or depression, and 15 to 21 for severe anxiety or depression. Anne scored 11 for anxiety and 11 for depression which indicated that she had moderate levels of both. With the evidence gathered via the battery of assessment tools and through subjective assessment of Anne's presentation, she clearly fulfilled assessment criteria for PTSD and further treatment was warranted. She was keen to engage in treatment as soon as possible and a course of treatment was agreed with her.

Assessment scale	Type of assessment	Clinical range / cut off points
Impact of Event Scale (IES) (Horowitz et al 1979)	Scores related to impact of the traumatic experience	Clinical cut off 26
Beck Depression Inventory (BDI) (Beck 1996)	Depressive symptoms	0-9 Normal 10-15 Mild 16-19 Mild-moderate 20-29 Moderate-severe 30-63 Severe
PSS-SR (Foa et al 1993)	Diagnostic tool based on DSM-IV criteria	At least one re-experiencing symptom At least 3 avoidance symptoms At least 2 arousal symptoms
General Health Questionnaire-28 (GHQ-28) (Goldberg 1981)	Measures somatic symptoms, anxiety, social dysfunction and depression	Clinical cut off 4/5 for each section
Hospital Anxiety and Depression Scale (HADS) (Snaith and Zigmond 1983)	Anxiety and depression	0-7 Normal 8-10 Mild 11-14 Moderate 15-21 Severe

Table 18. Assessments used for PTSD

According to NICE (2005b) guidelines for PTSD, the first line of treatment would be trauma focussed Cognitive Behaviour Therapy (CBT) which is a well established, evidence based approach. CBT can be supplemented with Eye Movement Desensitisation and Reprocessing (EMDR) which is also a recommended treatment within NICE (2005b) guidelines. Ehlers and Clark (2000) describe a cognitive model of PTSD as related to the manner in which the trauma has been processed by the individual. Two key processes impact upon the development of PTSD, one relates to the way that the individual has appraised or interpreted the trauma, and the second process involves the nature of the memory of the event and how it is linked to other memories. Brewin (2001) explains that experiences of trauma are encoded in

Situational Accessible Memory (SAM) which encodes non verbal data such as smells, pictures and sounds, and Verbally Accessible Memory (VAM) which is narrative based. VAM is linked to abilities to evaluate and integrate past and present experiences, as well as future consequence. When an individual experiences trauma these processes can be encoded differently to other experiences as a result of the autonomic responses that the individual experiences during the trauma. The fight, flight, or freeze response to stress results in distortions in focus and the encoding of the experience can be limited. In terms of SAM the amount of detail may be distorted, for example small details, such as a smell, which may have been present at the time of the trauma, is interpreted with more significance than in more normal circumstances. Other detail may be missed, for example images of the scene.

To illustrate these points, in the case of Anne's recollection she could clearly remember the smell of the patient's clothes when he was attacking her but had difficulty in remembering other people who were present on the periphery during the attack.. In terms of VAM, recollection of the memory may be inadequately integrated within the autobiographical memory, in other words the memory does not fit with that person's running narrative of their life view and experience. They are subsequently unable to place the experience within a context of time, place and person. To illustrate this in relation to Anne, she had felt overwhelmed by the attack and feared for her life. She had no prior experiences with which she could integrate this event and was therefore unable to find a metaphorical hook within her mind to hang the experience upon. The result was that she could not assimilate that this was an event which had been time limited, was now over, and she was now safe.

The effects of these processes can result in symptoms of PTSD. These symptoms include; re-experiencing of the event which may take the form of intrusive thoughts or images of the event; avoidance of stimuli associated with the event which may take the form of avoiding thoughts and activities which are associated with the trauma; numbing of general responsiveness which may be depicted as restricted affect such as feelings of detachment or inability to experience feelings such as love; and increased arousal which may manifest as irritability, hyper vigilance or exaggerated startle response. Anne's assessment had highlighted that she was experiencing symptoms related to all of these criteria. She had re-experiencing of the event which took the form of nightmares and images of her attacker on the faces of strangers she passed on the street; she was avoiding work since the experience; she felt numb and felt unable to experience feelings of joy or happiness which was unusual for her; and she felt hyper vigilant, on edge, and jumpy most of the time. The aim of trauma focussed CBT is to facilitate integration of incompletely processed material related to the trauma and to challenge negative appraisals of the event through restructuring of the narrative with the client.

Ehlers and Clark (2000) suggest that the trauma memory needs to be integrated within the clients preceding and subsequent experiences in order to prevent continued re-experiencing of the event. This can enable the client to incorporate the trauma within the here and now thus providing a context within which the experience can sit, in other words assist the client to find a metaphorical hook within their own mind set on which to hang the experience. Working through the narrative, or the client's story, with the help of a trained clinician can assist in restructuring material through integrating the narrative within the here and now, highlighting hotspots (problematic

appraisals of the event) through cognitive reprocessing, and challenging negative appraisals through cognitive reframing. EMDR can assist in the processing of hotspots as well as reducing some of the more distressing symptoms of re-experiencing associated with these idiosyncratic appraisals. Homework exercises, methods of relaxation and educational material are provided at the outset in order to supplement therapy and assist the client in moving forward as quickly as possible.

An explanation of the treatment was offered to Anne and education material had been provided at earlier assessment. This had been helpful to her in terms of trying to normalise her feelings and symptoms, but she had not been given this material until three months after the incident when her symptoms of PTSD were well established. She was provided with further self help references which she was agreeable to access independently.

Anne was particularly distressed with a recurring nightmare which involved her waking with her attacker's hands around her throat. This happened most nights and she had difficulty in bringing herself back to reality when this happened, feeling as if she was still experiencing the event even though she was awake in her own bedroom. Her sleep was greatly affected by this and she saw this as one of her main problems. We discussed grounding techniques which involve use of an external stimulus which can help to revive individuals from this trance like state and return to reality. Grounding involves use of distraction as a strategy to detach from emotional pain by focussing upon an external stimulus using mental, physical, or soothing techniques. Mental distraction can involve focusing the mind on activities such as counting; describing surrounding environment; or describing activities to divert attention from distressing thoughts. Physical grounding involves focussing upon the senses for

distraction, for example by running cool water over the hands or smelling essential oils. Soothing grounding involves focussing upon soothing thoughts or statements such as "I am a good person, I will get through this" (Najavits 2002). Anne agreed that use of an essential oil such as lavender (the smell of which had no connection reminiscent of the incident) may help with this.

We discussed using a narrative approach initially with a view to using EMDR if necessary at subsequent sessions. In addition, I used a technique commonly used in EMDR which can be helpful both in therapy and used outside of the therapy room to reduce symptoms of anxiety, visual imagery. Before embarking upon this exercise I asked Anne to rate her Subjective Units of Distress (SUDS). This is a way of measuring distress when working with clients individually to ascertain levels of anxiety and discomfort. These units are usually ranked from 0-10, where 0 means that the client is experiencing no distress whatsoever and 10 means that they are extremely distressed. At the start of this exercise Anne rated her SUDS at 7. I encouraged Anne to think of a 'safe place' that she may be able to recall. It is preferable that the safe place is not connected to any memories which may later affect the client's progress. For example if the client remembers a seaside resort as a child and recalls feelings of happiness and relaxation but at a later session discusses how she was raped on a beach, the 'safe place' may no longer be symbolically safe and may worsen symptoms. The image of the beach would now represent a reminder of trauma and would not be viewed with safety. It is also encouraged that family or close friends should not be included in the scene for similar reasons, for example a happy event with a husband may not be as helpful if it subsequently transpires that the client's husband is being unsupportive to the client at the present time. Anne was able to recall a landscape from her childhood which she had found relaxing and invoked

warm memories for her. She was able to recall smells and sounds which were later to be helpful to her when using the technique. After the exercise she rated her SUDS as 2, quite a reduction. Her homework was to read some of the material that she had been provided with and start work on her narrative which we would then look at the following week.

Anne returned the following week and we began the challenging task of working through her narrative to integrate the trauma. We looked at facts, thoughts and feelings around her narrative, keeping the discussion within the present tense. This assists in the process of contextualising the event. She was able to recall many aspects of the trauma in great detail but other aspects were patchy. She was very angry with colleagues and we were able to look at facts, thoughts, and feelings in relation to this which assisted in her depersonalising some of her colleagues' actions. Over the weeks, she began to tackle some of the areas of her life that she had been avoiding since the trauma, such as socialising with friends and family. After working through Anne's narrative she still had some negative cognition which proved difficult to shift, for example where she had felt confident and successful in her work before the incident she now felt that she doubted herself and she was unsure if she could succeed. She was still experiencing some sleep disturbance. We used EMDR techniques to target the remaining symptoms which had been proving difficult to shift through CBT. EMDR involves use of bilateral stimulation to free information processing systems which in turn allow links to more adaptive information within the memory (Shapiro 2001). The client focuses upon disturbing images related to the trauma while simultaneously focussing upon an external stimulus such as visually following set hand movements of the therapist, or simultaneous hand tapping. According to Shapiro (2001) this procedure activates the information-processing

system and allows adaptive processing of the disturbing material. Homework exercises, methods of relaxation and educational material are provided at the outset in order to supplement therapy and assist the client in moving forward as quickly as possible.

The assumption within this model is that the processing of the trauma that was ineffectively coded through SAM and VAM can be spontaneously processed through use of EMDR to reconnect the networks, facilitating insight and change. Measurements of SUDS are taken throughout the process, the aim being to reduce them to zero. EMDR had a remarkable effect upon the residual symptoms that Anne was experiencing. Within two sessions her SUDS ratings were zero and she was actively planning her future with renewed confidence. Anne's ratings on all of the assessment scales had also reduced significantly and were all below clinical cut off points.

A summary of her pre and post treatment ratings are highlighted in table 19.

Assessment scale	Before treatment	After treatment
IES	55	6
BDI-II	17	11
PSS-SR	13 (re-experiencing)	2
	10 (avoidance)	2
	13 (arousal)	5
GHQ-28	5 (somatic symptoms)	2
	7 (anxiety)	2
	6 (social dysfunction)	2
	0 (depression)	0
HADS	11 (anxiety)	4
	11 (depression)	8

Table 19. Pre and post treatment scores.

She was able to reflect upon the event without the distress that she had previously experienced and although she still wished that it had not happened, she was able to think about some of the positive aspects that had resulted in relation to her "not taking life for granted", a common response from people who have successfully come through a life threatening experience. Anne wrote a brief account of her experience of therapy which is included below with her consent.

"Quite a few of us have experienced trauma either as a child or as an adult and sometimes both. We freeze certain parts of ourselves after trauma, pushing the memories back out of sight. From this place, we lose our connection to all of who we are. Our fullness is repressed, our creativity suppressed. After the incident I never thought I was going to be affected that badly. I started counselling for my traumatic experience, which I found to be very helpful. After a couple of weeks the counsellor spoke to me about EMDR, wanting to know if I had heard about this technique. I replied no, so she explained the process and procedure to me. I was very sceptical about the whole process and being negative about the procedure. I went away and did my own research and was impressed... the treatment had its positive and negative sides but the comments were more on the positive side. The process helped me to bring to mind negative thoughts caused by the incident, for example your mind acts like a moving train bringing the negative thoughts forward and changing them to positive and new thoughts you want to have. It also helped me to always return to my safe place at any given time when I am distressed or finding it hard to cope and deal with my thoughts on an everyday basis. I found EMDR to work safely and rapidly. It helped me to restore normal ways of dealing with my problems. EMDR is a creative and safe way to see what is in the way of living a full, joyful life. Therefore I will recommend this technique to anyone who wants a way out of that dark place and to safety, love and happiness again." (Anon 2006).

6.4. Conclusion

A criticism of research activity for academic purposes is that the research is undertaken and then not developed to full potential when the purpose, such as PhD, has been met. As emerging findings from this study were considered it was clear that

there were gaps in practice which could be addressed. This chapter has highlighted how one of these gaps, providing meaningful staff support, can be addressed with further systems put in place to evaluate the changes. It would have been tempting to delay this initiative until the thesis had been completed; however it would have been unethical to ignore this aspect of the study when the demand was obvious. Although there were also issues related to Post Incident Review for patients, the research design allowed for feedback to staff to mobilise further assessments and support for patients if necessary therefore this aspect was viewed as less urgent than the need to organise staff supports.

Presenting the case study within this chapter has highlighted the extent to which the psychological impact of restraint can affect the lives of staff. Furthermore, the case study has shown how staff can be assisted to return to work using recognised treatments for PTSD, in order to re-engage with their careers in a meaningful way.

CHAPTER SEVEN – DISCUSSION

"...one of the most hazardous work settings for employees' mental health is the local mental health facility..." (Caldwell 1992, p839)

7.1 Introduction

The data generated by a study which has a large qualitative element can be difficult to manage and clear structures and processes are needed to analyse and interpret such data. Within this study the findings of the data have been presented in a structured way with discrete themes being offered to the reader as well as presentation of quantitative elements such as measurement of physical impact of restraint and use of TSQ (Brewin et al 2002). In order to present a comprehensive debate related to data findings a similar approach to the discussion has been taken.

The findings of staff and patient data have been presented within chapters 4, 5, and 6. A discussion related to the findings will now be offered. The themes identified within the findings will be reflected upon and considered within the context of the literature review and what is already known about the topic. Further observations related to the data will be offered as new insight for consideration within the study of the aftermath of restraint. Section 7.2. will offer a discussion related to the restraint incidents which were the focus of this study. Section 7.3. will discuss further consideration given to the demographic data presented for both staff and patients. Section 7.4.will discuss diagnosis and legal status which applied to the patients interviewed in the study. Section 7.5. will discuss previous admissions, length of contact with services, and history of violence which were also data collected from patient participants. Section

7.6. offers a discussion related to type of restraint used, length of restraint and use of seclusion related to staff and patient participants. Section 7.7. considers the physical consequences of restraint and offers discussion related to the data presented for staff and patient participants. Section 7.8. offers a discussion related to medication issues which were identified within the study by both staff and patient participants. Section 7.9 then goes on to consider the themes of the qualitative interviews which were identified for all participants. This section will be broken down further into individual categories which were identified within the presentation of findings. Section 7.10. offers a discussion around the findings of the application of the TSQ (Brewin et al 2002) to staff and patient participants and section 7.11 goes on to discuss the positive responses gathered in the evaluation of the Post Incident Review framework. Section 7.12. will discuss further elements of the staff focus group which must be considered, and section 7.13 will provide a discussion related to chapter six which offered a way forward in integrating some of the findings of this study to effect positive changes to mental health practice. Finally, a discussion of the study limitations will be summarised at the end of this chapter in section 7.14.

7.2 Restraint incidents

The literature review identified that restraint has been a method of managing aggressive and violent behaviour for centuries. In 1885, Dr Gilland reported the positive effects of using a wet sheet for four hours to calm a violent female patient, however more sophisticated techniques have been developed over the centuries with Control and Restraint (C & R) being the dominant method in current UK mental health care (NICE 2005a). There is currently no nationally agreed definition in relation to what a restraint incident consists of, however the concept clarification

identified within the earlier pilot study (Bonner et al 2002) proved helpful in this study. By allowing consideration of a wide range of 'hands on' approaches to managing untoward incidents this allowed a greater scope within the recruitment to the study. This in turn generated a wealth of qualitative data around restraint.

The literature considered whether there was a relationship between the severity of an incident of restraint and the subsequent psychological impact. It was highlighted that traumatic incidents which involved physical injury were more likely to result in subsequent psychological injury (Stretch 1985; Goldberg et al 1990; Basile et al 2004), however the literature review also highlighted that violent incidents in mental health settings which did not result in physical injury could also have subsequent psychological sequelae if they were perceived as life threatening or a threat to self integrity (Richter and Berger 2006).

The findings in this study have highlighted that for some individuals who had experienced more severe physical effects, this did equate with more severe trauma symptoms, but this was not the case for all participants. Conversely, some participants had experienced high ratings for trauma symptoms with none or minimal physical impact of restraint. The physical impact of restraint will be discussed in more detail in section 7.7., however the findings in this study support the notion of the non-linear dose response relationship. This would suggest that a wide ranging definition of restraint, similar to the definition discussed in section 2.2.1., is necessary when considering the aftermath of restraint. There are a broad range of psychological responses during and following restraint incidents, along a wide spectrum of severity of incidents. This also supports the decision to use the DSM IV-TR (APA 2000) to

define PTSD for the purpose of this study as these criteria include the subjective perception of the event as a precursor to PTSD.

Although a wide range of restraint incidents were examined in this study, these examinations were in the context of one-off events. The psychological impact of regular, persistent physical interventions was not addressed within this study and warrants further attention. It may well be that regular altercations provide ongoing 'doses' of trauma similar to those who experience systematic violence as described by Herman (1992) which often results in complex PTSD.

In addition, a greater trauma history could have been taken from participants to examine ongoing / multiple trauma histories and their relationship to current symptoms following restraint. This is an area which would benefit from much wider exploration in a subsequent study.

7.3. Demographic data

Gender differences were fairly evenly split between both staff and patient participants. The staff demographic data was fairly representative of a generic UK mental health Trust. The mean age of staff interviewed was 40 years and the skill mix ranged from Ward Manager to Health Care Assistant. There were varied lengths of service ranging from 6 months to 24 years, the mean being 9 years and 6 months. All staff had reached the Trust benchmark of minimum training in management of aggression being breakaway skills. In terms of demographics for staff, this was a mature group of fairly experienced staff who had some form of training in management of aggression.

While training in breakaway skills within this Trust is a minimum benchmark that is being maintained, there is a need to further audit the efficacy of this training. If, as Rogers et al (2006) suggest, taught breakaway skills are not subsequently used in practice, it may be timely to review the content of these training days. This study has found that Post Incident Review needs to become a recognised element of everyday practice and it may be more cost effective to provide further training in Post Incident Review in place of breakaway skills. This would prevent a waste of training resources if breakaway training is ineffective and equip staff to address the aftermath of restraint in a much more comprehensive way. This may ultimately save further resources in terms of prevention of sick time for staff and psychological injury to staff and patients. C & R training is a longer programme and has more formal mechanisms of assessment and this may be the most appropriate avenue that practitioners take to develop skills of physical intervention. The extent of Post Incident Review and support that is offered within C & R training programmes varies across the UK and this is another avenue where more explicit approaches to teaching skills of Post Incident Review could be addressed.

The majority of staff interviewed in the study were white British and this did not represent the population of the county that the Trust serves. The predominance of white British nursing staff who were interviewed within this study may have some impact upon the findings. Cultural issues have long been a concern within UK mental health care with a need for issues of diverse cultures to be considered. It is known that Black Caribbean males are more likely to be compulsorily detained under the Mental Health Act (1983), are more likely to receive a diagnosis of schizophrenia,

and are more likely to be restrained (Department of Health 2005). It may be that cultural differences between these groups result in poor communication and misinterpretation, resulting in more frustration and aggression, and consequently restraint. Within this study, this was not reported by staff or patient participants however within the demographics there were clearly more white British participants than other ethnic groups.

The demographics should be viewed with caution as this was a small study group and generalisations cannot be made upon such a small sample. It may also be that White British participants were more likely to volunteer to take part as the researcher is White British.

7.4. Diagnosis and legal status

Almost half (n=14, 47%) of the patient participants had a dual diagnosis with an equal number (n=14, 47%) having a single diagnosis. Of the group who had a dual diagnosis, 20% (n=6) had a diagnosis of schizophrenia and substance misuse. This would suggest that this client group may be more likely to be restrained and would support current literature related to the inpatient population in current UK mental health care. Of the group who had a single diagnosis, 20% (n=6) had a diagnosis of bipolar illness which would suggest that this group may be more likely to be restrained. None of the patients in this study had a case note diagnosis of primary PTSD or co-morbid PTSD. Bearing in mind that previous studies have found that around 40% of inpatients fulfil criteria for PTSD but have little or no case note diagnosis (Meuser et al 1998; Purves et al, in preparation), these figures may not be a true representation of the study group. A number of patients had trauma symptoms on

the TSQ (Brewin et al 2002). These symptoms may have been related to undiagnosed PTSD, as opposed to the psychological consequences of the restraint incidents for which they were being interviewed. From this data, it is concluded that the behavioural and cognitive problems associated with the diagnoses identified in this study, and the possibility that some patients may have had undiagnosed PTSD, may play a part in the instigation of restraint procedures and may also play a part in subsequent psychological impact of such procedures.

An inpatient with a dual diagnosis of schizophrenia and substance misuse or a single diagnosis of bipolar illness may prove to be at greater risk of being restrained. The reasons for this are manifold. The mental state of an individual with these diagnoses may be highly symptomatic therefore communication can prove more difficult. Use of de-escalation techniques may be less successful as a result. For example a patient with a diagnosis of schizophrenia and substance misuse may be experiencing positive symptoms such as hallucinations, and may be less able to engage in a coherent dialogue as a result. Sensitivity must be given to this situation and assumptions should not be made that communications have been understood. It may be that conversations need to be repeated or more time taken to communicate and to check out understanding. The individual with a single diagnosis of bipolar illness may be less tolerant of aversive staff interventions than patients with a different diagnosis such as depression. For example the individual in a manic state may not be happy with being confined to a ward area when he or she would prefer to be active in a more stimulating environment. Attempts to restrict his or her movements may not be welcomed and frustrations raised as a result. Sensitivity on the part of the nurse is

also indicated in this scenario and some form of compromise necessary to prevent escalation of frustration on the part of the patient.

Patients who have an unrecognised trauma history may have similar behavioural and cognitive disturbances. Use of restraint with this patient group is likely to cause further trauma, thus increasing the likelihood of further psychological sequelae. This further emphasises the need for a trauma history to be taken and a diagnosis made early in the process of psychiatric assessment.

In legal terms, 17% (n=5) of the study group were informal male patients. Of the remainder, 13% (n=4) were under Section 2 of the Mental Health Act 1983 and 70% (n=21) were under Section 3 of the Mental Health Act 1983. The exclusive proportion of male informal patients was unexpected and raises some points for consideration. It may be that female informal patients are less likely to become aggressive therefore they would not have come to the attention of this study. All of the informal patients had diagnoses of mood disorders. This would suggest that this diagnosis is likely to be less risky in terms of restraint incidents for females and would support the issues discussed earlier in relation to people with diagnoses of schizophrenia with substance misuse and bipolar illness being more likely to be involved in restraint incidents. It may also be the case that female informal patients receive less aversive responses from staff, and more therapeutic interventions than their sectioned counterparts.

7.5. Previous admissions, length of contact with psychiatric services, and history of violence

The findings highlighted that clear summaries of psychiatric timelines were not available in most patients' notes. This would have been helpful for this study, but perhaps more importantly, this is essential in considering risk in terms of management of violence and aggression to reduce incidents of restraint. This aspect of assessment should be incorporated at all levels of training and is beginning to be addressed in some training programmes but needs to be made much more explicit within management of restraint. 90% (n=27) of the participants within this study had at least one previous admission and 20% (n=6) had ten or more previous admissions. It could be that the participants who had a higher number of previous admissions had more severe levels of symptoms which resulted in higher levels of physical interventions.

Length of contact with psychiatric services ranged from 0-35 years, the average length of contact being 9.6 years. The data highlighted that length of contact with services did not always equate with number of admissions. For example, one participant had been in contact with services for 19 years but had only been admitted twice during this lengthy period. Assumptions cannot be made in relation to this part of the study as the length of contact was varied and individual. For some individuals regular admissions had taken place throughout their psychiatric histories and for others admissions had been few. It may have been that some individuals had built up good supports outside of the hospital through community services, only needing admission in crisis, whereas this may not have been the case for others.

67% (n=20) of patient participants had a previous history of violence ranging from verbal threats, property damage, to physical assault. It was noted during data collection that reporting systems were not consistent and this was supported via Trust data records. It is not known if this is an issue for this particular Trust or whether this should be a wider consideration for practice. The inconsistent reporting of incidents has a number of implications at local and organisational levels. If reporting systems are inconsistent at local levels this could impact upon staff. For example, in this study one clinical area reported all incidents including verbal threats, while other areas only reported more 'severe' incidents. The repercussions of perceived over reporting could be that this particular area is not taken seriously and when a more serious event does occur, responses are not forthcoming. Conversely, if areas are perceived to have fewer serious incidents as a result of less reporting, they may be budgeted to have less provision of resources in managing aggression and violence. No clear evidence was generated to support these scenarios within this study however the impact of inconsistent reporting could prove dangerous. The implications of these issues are warranted at an organisational level. Further training and development for staff is indicated to facilitate a more explicit, shared understanding of levels of seriousness in terms of reporting of untoward incidents.

7.6. Type of restraint, length of restraint, and use of seclusion

Types of restraint were divided into four categories; gentle guidance to place of safety with minimum force, guidance to a place of safety with some force, restraint involving two or more staff with force using C & R techniques while remaining upright, and restraint involving two or more staff in the prone position. For both of the participant groups, the majority of restraint situations that were described by

participants fell into the latter two categories. It would be expected that a high number of incidents would involve more extreme measures of restraint as the aim of the study was to examine the aftermath of restraint. It was explained to staff that inclusion into the study involved a wide variety of restraint approaches but it may be that staff only referred more serious restraint situations to the study. The less extreme examples of restraint within this study were referred from clinical areas that had higher reporting of untoward incidents and this would support the notion of inconsistency regarding perceived severity of incidents and reporting of said incidents.

If this sample of incidents is representative of restraint episodes in general then a high proportion of untoward incidents on acute admission wards would require intervention from a restraint-trained team of staff to contain the situation. This has implications for training and resource management in terms of ensuring adequately trained staff and adequately resourced staffing are available in these areas. The literature review highlighted that incidents rise in wards when staff are attending training (Bowers et al 2007) therefore this creates a dilemma which must be considered in relation to ward cover when staff are receiving training in these areas. The focus groups indicated that despite training, some nurses were perceived as unskilled therefore there is also a need to further address competency within training programmes that nurses attend. Despite these concerns, the techniques that were used inflicted minimal physical injury which would suggest that staff were using these procedures in a safe manner.

Use of restraint in the prone position is a current concern in mental health care with positional asphyxiation contributing to deaths of patient recipients of these procedures (Sallah et al 2003). No deaths occurred as a result of positional asphyxiation during this study and it is noteworthy that nurses did not raise this issue in the qualitative interviews. One would have expected this to have been an issue of concern due to the current high profile of positional asphyxiation. It would be worth pursuing this issue in further follow up studies to establish whether nurses have a raised awareness as a result of recent public enquiries and publication of NICE (2005a) guidelines. In this study it would appear that nurses were not particularly concerned about positional asphyxiation and this may be a matter of concern.

Length of restraint was measured in minutes and broken down into five categories; less than five minutes, five to ten minutes, ten to twenty minutes, twenty to thirty minutes, and thirty to sixty minutes. Reporting between groups varied in relation to length of restraint. This may have been due to the wide variety of restraint incidents that were being discussed. Data was not collected regarding which staff and patients were involved in particular individual incidents therefore comparisons of time estimations were not able to be made for the same incidents and this is a limitation to this study. One could question whether staff underestimated timing of restraint in order to stay within guidelines; however the patient participants appeared to support staff reporting, albeit within the limitations highlighted above. This group was taken from an acute generic psychiatric inpatient setting and may differ widely in proportion to other settings such as secure forensic hospitals where, according to forensic colleagues, restraints can last for much longer periods than those reported within this study.

The majority of the incidents which involved seclusion took place in an intensive care setting. It would be expected that a more challenging group of patients would be placed within this setting and therefore a higher need for seclusion would be required. These units are also purpose built with seclusion rooms whereas the newer admission wards do not contain seclusion rooms. Some staff (n=5, 17%) did express an opinion regarding this in terms of having a seclusion room available for use. They felt that this would be more helpful than taking patients to their bedroom for time out and they would have felt more confident in observation in this setting.

The term seclusion is open to interpretation. Although use of seclusion is framed by set guidelines and procedures, other methods of isolating patients were described within this study. "Time out", "being kept in open bedroom to calm down", "kept away from other patients until the situation was settled", were terms that were referred to by some staff, and patients certainly reported that having quiet time alone in their bedrooms was helpful. One could argue that these are forms of seclusion which are being used outside of the standards and guidelines meant to support these approaches and protect the patients to which they are being applied. Uses of covert forms of seclusion are illegal and unethical, and the extent to how much these forms of isolation are used is unknown. It may well be that they are used in the patients' best interests with good effect, however an open debate regarding these practices is warranted within the wider mental health field.

The average length of seclusion in this study was 1.5 hours and this was recorded through formal seclusion procedures. Records of 'time out' and other ways of isolating patients were not recorded. This would be worth investigating in more depth

in a subsequent study. It may be that these less formal methods of isolation are another form of aversive staff intervention and another example of avoiding meaningful engagement.

7.7. Physical consequences of restraint

In terms of physical injury, half of the study participants reported no physical consequences, and those who did report injuries generally had physical consequences on the lower end of the scale. Two members of staff who went on to develop PTSD had been physically injured and their presentations fit well into the dose response theories described by Stretch 1985, Goldberg et al 1990, and Basile et al 2004. These figures should be viewed with caution as each situation had its own unique circumstances and although a high proportion of participants were not physically injured these figures highlight that risk of injury remains an issue when using restraint techniques. Despite minimal physical injuries, this study has highlighted that the psychological consequences of restraint can be great and even situations which have resulted in no physical injury can have a severe psychological impact on those involved.

7.8. Use of medication

Responses to medication varied between groups. Staff discussed how the situations where medication had not been used were managed through therapeutic interaction with patients, using good communication and problem solving approaches to address escalating situations. Patients supported these views in respect of situations where medication was not used or was offered and accepted. Some patients were happy to take oral medication and viewed this as the preferred choice of calming escalating

situations. One may question whether this was as a result of being socialised within the medical model of the mental health care system or whether for some patients, medication was the only option which they felt could resolve high tension situations.

It would have strengthened this study to explore some of these issues in more detail, for example by observing staff-patient interactions during situations of tension to establish whether any therapeutic communication techniques were used to diffuse situations, thus negating the need for medication. Bowers et al (2007) have highlighted that use of high levels of therapeutic interaction in acute areas reduces aggression and creates a more therapeutic environment and it would have been helpful to examine whether the principles of Bowers et al's (2007) research were being applied within this study group.

The incidents that had involved use of forcibly administered intramuscular injections were fraught for both staff and patients; however patients described these situations more vividly than staff, and displayed greater emotional depth when recounting their understanding of these events during interview. Staff reported that they viewed forcibly administering medication as a last resort, and that this was an aspect of their role that they found difficult. They believed that it conflicted with their perceptions of what a good nurse was, and that they were not prepared during training for some of the feelings that they would subsequently experience when becoming involved in these procedures.

Enforced medication was discussed in depth during subsequent interviews with patients and was reported to be highly distressing for some, and for others being

reminiscent of previous violent encounters. Patients who had been the recipients of enforced medication expressed the opinion that some staff enjoyed this aspect of their role and that this was part of a game of power that was commonplace. These patients expressed anger at their predicament and felt helpless to challenge staff as they believed that this would result in further use of restraint and more use of medication by force.

These polarised views highlight the complexities of mental health care. Communication in these circumstances had broken down and a vicious circle of anger, conflict, and restraint was the result. The patients who expressed these views were patients who reported that they had not been offered any form of Post Incident Review, and perhaps this could have been a mechanism that would have addressed these situations and broken a self-perpetuating vicious circle.

7.9. Qualitative interviews

7.9.1. Antecedents

A wide variety of antecedents were identified by both staff and patients within this study related to situations which eventually resulted in restraint. Many of the antecedents identified support the points raised within the literature review, for example patients reported aversive experiences with staff such as denial of requests. A common theme identified within the antecedent categories expressed by both groups was that of mental state worsening, reported by 37% (n=11) of staff and 20% (n=6) of patients. This raised a number of dilemmas expressed by nursing staff during interviews. Early intervention may have prevented some of these events from escalating but some staff felt unable or unwilling to intervene. One nurse, who

subsequently was attacked by a patient, did not feel supported by her colleagues to intervene. Although the patient's mental state was deteriorating there was a reluctance to communicate with the patient, perhaps through fear or perhaps in the hope that ignoring him would make him go away. It may be that the patient's symptoms were worsening and that the situation would have happened whether staff had intervened or not. That particular nurse, however, felt that earlier intervention should have happened. If the violent situation had arisen despite efforts to communicate with this patient, perhaps the psychological effects for that nurse may have been lessened.

Some staff expressed a reluctance to offer medication but on reflection these staff believed that doing this may have prevented rising tensions. It is of interest that the nurses who discussed medication did not discuss using talking interventions as an alternative, however this was not fed back to them during interview and it may be that there was an assumption on the part of the participant that this was a given, and did not need to be expressed to the researcher.

Other reporting of antecedents was quite different from both groups. Staff discussed intuition and more advanced practitioners were able to articulate that this intuition was related to their existing knowledge, skills and experience. Benner's (1984) influential work on reflective practice in nursing describes how advanced practitioners appear to make decisions based on intuition and nurses in mental health often talk about 'gut feelings' in relation to this phenomenon. Benner (1984) highlighted how nurses were able to articulate prior knowledge that triggered these gut feelings through reflection. The practitioners interviewed within this study demonstrated how

reflecting upon the incidents enabled them to examine components that had contributed to their raised awareness of escalating tensions. This reinforces the value of using reflection, particularly through the Post Incident Review process, to identify how and why decisions have been made. This approach can help to reinforce strengths and address weaknesses in decision making in a supportive way.

Related to this, staff reported earlier minor incidents which were not viewed at the time as particularly serious but subsequently developed into more serious events. Earlier interventions in these cases may have prevented escalation of these situations. 20% (n=6) of patient participants reported that they had given specific warnings to staff which had been ignored and this finding should be considered for training in the prevention of untoward incidents. Not responding to specific warnings is unacceptable unless there is a sound rationale and agreed plan of care among the multidisciplinary team to respond in this way. While staff may be very busy with competing priorities, surely avoiding an incident of restraint will save a lot of time, resources and upset in the long run?

Observation was reported by some patients to contribute to incidents developing. Jones et al (2000) have reported that lack of information sharing and lack of therapeutic engagement during the process of observation creates an unwelcome experience for patients. The patients in this study reported that these elements of observation had been factors that had led to frustration, aggression, and ultimately restraint despite Trust guidelines placing emphasis upon the therapeutic aspects of engagement during observation.

Boredom was also viewed by patients as contributory to situations escalating. Bowers et al (2007) have shown that structured activities in a low conflict environment can reduce levels of aggression and violence, and it would appear that this type of environment was not available for a number of the patient participants interviewed in this study. There is a need to examine this in further depth to establish the nature and extent of structured activities, and the impact that they have upon the patient experience of acute care within this Trust.

Aversive staff-patient interactions were highlighted in the literature review as a precursor to aggression and violence (Sheridan et al 1990; Whittington and Wykes 1996; Wright 1999; Lee et al 2003; Secker et al 2004) and this has been identified as an issue within this study. Some patients described requests being ignored or denied, others described being "fobbed off", and a general lack of empathy was described by other participants. This suggests that, on at least some occasions, the issues raised in Addressing Acute Concerns (SNMAC 1999) still hold true, and that we have some way to go in redressing the balance. Kindness, empathy, and politeness cost nothing and should be evident in all aspects of mental health care but it would appear that these basic forms of engagement need to be re-emphasised in some areas of acute care. Poor manners need not necessarily be addressed in a punitive manner, however they cannot be ignored. Positive cultures can be fostered by role model example, as well as through clinical supervision and performance appraisal.

The evaluation of the Post Incident Review highlighted that 60% (n=18) of staff and patients believed that the incidents could have been predicted. This suggests that

identifying antecedents and establishing ways of addressing early interventions could prevent untoward incidents happening in practice.

The City 128 project (Bowers et al 2007) has encapsulated many of the points raised within the antecedents discussed here. They have highlighted how a low conflict, high therapeutic environment can reduce many of the risks which nurses work with on a daily basis. Brennan et al (2006), however, have stressed that effecting change in acute care is a complex process and commitment must be made at the highest organisational levels. During the course of this study I have been impressed at the commitment within this Trust at all levels and agree with Brennan et al (2006) that change can happen but takes time and sustained commitment.

7.9.2. Feelings

The pilot study (Bonner et al 2002) had established that strong emotions were experienced by staff and patients before, during, and in the aftermath of restraint. The findings of this study supported the evidence generated by the earlier pilot study. Fear and anxiety dominated both groups, with specific physical symptoms of anxiety also being reported. Feelings of being out of control, terror, and humiliation were also expressed by both groups. These feelings can be interpreted within current theoretical understanding of trauma and have serious implications for practice. The feelings expressed within this study mirror those articulated by individuals who have experienced a traumatic event. In response to trauma, an educational approach would be used as an intervention to assist individuals to process the traumatic event. For example, following a major disaster the current model would be to offer social support and psychological first aid, providing practical help and information

regarding normal reactions which people experience following these events. Watchful waiting would then be suggested and psychological supports mobilised if necessary after a minimum of four weeks (NICE 2005b).

This response avoids medicalisation of symptoms and reinforces the notion of a natural response to an unnatural or unexpected event which is time-limited. If symptoms continue unchecked there is a possibility that the individual may go on to develop PTSD, and specific assessment and intervention would then be required. Within this study, if trauma theory is applied, the participants who expressed these strong emotions may not have been prepared for them and had not been offered the opportunity to discuss them subsequently. Bowers et al (2006) found that staff had little time to process events following an untoward incident as a result of the busy ward environment and in this study staff expressed feelings of tiredness and exhaustion after the event; however some had been expected to complete their shifts without a break. These issues could contribute towards subsequent development of trauma symptomatology if natural assimilation is hampered in this way. The case study presented within chapter six illustrates how these psychological effects can result in PTSD, the effects of which were devastating for that particular member of staff. There is a need to ensure that the examples set within NICE (2005b) guidelines for PTSD should be routinely practiced in mental health care following incidents of restraint to minimise risks of longer lasting psychological injury.

Following the event more positive feelings of relief were expressed by both groups and a sense of regaining control was conveyed. Some staff had been offered brief time out for a short break and this had been helpful to them. Staff who felt tired and

had not been offered a break felt angry and resentful. They reported that they felt undervalued and there are issues here to be considered from an organisational point of view. Emphasis needs to be made at the highest level and clearly filtered through all levels of accountability, that nurses' efforts should be valued. In some areas, ward managers conveyed this message clearly as a matter of course, however this was not standard. Even at very busy times, acknowledgement that staff have undertaken difficult tasks which have been appreciated helps to reinforce feelings of being valued for these staff. This negates feelings of anger and fosters feelings of worth. Fostering a sense of value and worth does not require a great effort, nor does it require any additional resources, however this approach reaps benefits in terms of staff morale and team cohesion. This may ultimately reflect a sense of value and worth towards the patients in their care.

Both staff and patients spoke at length about feelings of anger and guilt. These strong feelings were expressed during research interviews but the opportunity to discuss their feelings had not always been routinely offered to staff or patients following incidents. Had this opportunity been part of routine practice, this may have facilitated venting of some of these strong emotions and allowed opportunity for communication and growth on both parts.

7.9.3. What was helpful and unhelpful?

Some common responses were reported by both groups in reply to being asked what may have been helpful and unhelpful in relation to the incidents of restraint. The positive themes were related to good relationships between nurses and patients as reported by 37% (n=11) of patients and 20% (n=6) of staff. Conversely, 50% (n=15)

of patients reported that negative staff attitudes were unhelpful as well as 40% (n=12) who reported that being ignored was unhelpful. These findings support the importance of facilitating therapeutic relationships and underpin the process of care in mental health settings.

Observation was not reported by staff within this theme however patients expressed mixed views. Some patients (n=4, 13%) found the experience of close observation following restraint helpful, and this may have provided an opportunity for some form of review and resolution during this process. Other patients (n=5, 17%) viewed observation as punitive, feeling that this experience was intrusive and invoked further feelings of humiliation. These mixed views would be supported by current literature. There is an abundance of literature which would suggest that observation is often not therapeutic and this is beginning to be addressed following publication of reports such as Addressing Acute Concerns (SNMAC 1999) and more stringent guidelines for observation have been developed within Trusts. It may be that the more positive experiences reflect a change in practice as a result of raised awareness and training around observation.

23 % (n=7) of female patient participants reported that having male nurses applying C & R to them was unhelpful. For some, this was reminiscent of previous traumatic encounters and this will be discussed later. Other patients felt embarrassed and humiliated that male nurses were present. Having a choice of gender of therapist is promoted as best practice, however in the restraint scenario this is rarely possible. The experience of restraint rarely happens through choice and is often in response to unmanageable behaviours. It could be argued that it would be inappropriate in this

case to request a preference. If an individual is rational enough to discuss which gender of nurse they would prefer to be restrained by, then they must surely be rational enough to have a dialogue about what is upsetting them and how it may be overcome. There is some room for compromise, for example by using advanced directives. These could be negotiated during a period of recovery and applied during times when consent is tenuous. Another alternative would be to ensure that enough female trained C & R staff are available to cover admission wards; however this is not always practicable and could be resource intensive. Often admission wards can have periods where restraint is not required for lengthy periods and it may not be necessary to have such a skill mix. It is possible, however, to be proactive when a situation such as restraining a female patient in anticipated. This study has highlighted that advance warning can be identified in a variety of ways and forward planning could allow for extra female staff to be made available at these times.

Within the Trust in which this study took place, there are no single sex wards. In contravention of government policy, the predecessors of the existing Trust executive team rejected plans for single sex wards in the planning of reprovision. This was an opportunity to create purpose built facilities when the large institution which housed inpatient services was closed and a new hospital was built within the local catchment area. Although the new build was a great improvement with single rooms and ensuite facilities, wards remained mixed sex. At an organisational level this may need to be reconsidered, particularly in clinical areas where vulnerable female patients with trauma histories are being nursed such as acute admission wards and psychiatric intensive care units. In other neighbouring Trusts the single sex model is implemented and a study to examine differences between how restraint is managed in

these environments compared to mixed sex wards is warranted. This may establish whether the single sex approach reduces the psychological consequences of restraint, particularly for vulnerable female patients, and whether this may be a more cost effective approach to reducing restraint incidents.

Trusts also have a duty not to harm patients in their care. It could be viewed by a Court of law that by not providing single sex environments for such vulnerable patients, Trusts have not made reasonable arrangements to prevent foreseeable harm. This has not been tested in a Court to date, however it may only be a matter of time before such a test case of negligence is brought before a UK Court.

Staff were able to identify a number of factors that could be improved. Good teamwork was identified as helpful by 50% (n=15) of staff and this appeared to underpin the subsequent themes. Staff support was another strong theme which appeared to be valued and the staff who were more positive around the impact of restraint were linked to clinical areas where there was more evidence of post incident support taking place. Poor communication and lack of co-ordination were identified as unhelpful by staff and this supported the notion that good teamwork is invaluable to staff when managing restraint situations.

Other issues of note from a staff perspective were environmental factors such as movement between areas during restraint, and safety issues such as blood spillage. While these examples were reported in relation to a small proportion of the incidents reviewed within this study they are worthy of further consideration. Training refreshers could include such issues to raise awareness for staff, for example to

remind staff about the necessity to maintain universal precautions at all times. Proactive consideration of environmental factors such as opening heavy doors during movement could be made in training situations and strategies identified for overcoming some of these difficulties, for example through role play exercises.

7.9.4. Reawakening of memories of trauma

The pilot study identified that for some people who experience restraint; memories of previous distressing events can be brought to the surface during, and in the aftermath of, restraint. The pilot study (Bonner et al 2002) highlighted that 50% of staff and patients experienced this phenomenon. In this study 57% (n=34) of participants from both groups reported that the experience of the restraint, which was the focus of the research interview, had reminded them about other previous traumatic events. These figures must be viewed with caution as this was a small sample which may not necessarily be representative of the general acute inpatient / staff population.

Articulation of this phenomenon was difficult for both groups, although the staff were more able than the patient participants to describe their experiences. Staff appeared to be able to maintain some distance and control during and after events, whereas this appeared to be more difficult for patients. Lowe (1992) has described an element of personal control within the nursing role in challenging behaviour. The nurse remains calm and avoids identifying with personal feelings related to the incident. This may have been an approach that nurses maintained during the qualitative interviews when examining their recollection of events, and would offer further explanation to my sense of nurses being more detached from the experience than patients.

The design of the study was to ask staff and patients about recent incidents involving restraints. This prompted some staff to relate to other encounters in which they had been involved both inside of work and outside of the work setting. These reminders of other encounters were broken down into three areas; reminders of previous more dramatic restraint incidents, previous incidents that were similar in nature to the current incident, and reminders of other distressing events outside of the workplace.

A number of theories may be applied to explain these points. In nursing theory the explanation of intuition, as described by Benner (1984) would support the nurse relying upon earlier experiences of nursing events to inform current practices. These are not always recognised by experienced nurses and not always easy to articulate, as discussed earlier, hence use of the word intuition to explain advanced skills of decision making. Decision making for the novice practitioner is based upon linear reasoning. For example, if a patient is admitted to an acute ward a novice practitioner may rely upon a clear checklist for risk assessment. This may include consideration of previous history, weighing up other risk factors such as age, diagnosis, and use of substances. Through a process of identifying these factors on a surface level, the novice practitioner makes a decision regarding the risks applicable to this patient. This process can take some time in gathering clear evidence to inform decision making. The advanced practitioner is more likely to use non-linear reasoning. This is based on a deeper understanding of relevant factors which influence decision making, as well as more tangible surface issues. Using the example of risk assessment, the advanced practitioner is more likely to quickly draw conclusions without necessarily following a clear checklist to inform the decision making process. The advanced practitioner may not be aware on the surface that previous experiences

of observing non-verbal behaviour, for example, may influence a decision regarding risk for a patient who is presenting with threatening body language. On describing the decision making process the advanced practitioner may say that this has come with experience, that they have a 'gut feeling' about these situations, however Benner (1984) would argue that these 'gut feelings' are based upon deep learning which has developed over time in relation to caring for a number of people with similar presentations. This explanation could be applied to the theme which emerged from nurses' descriptions of current restraints reminding them of other similar encounters. It may be that reminders of other incidents, which are not directly related to the current experience, are triggered by the event without conscious reasoning. While nurses described these reminders as being unexpected, it may be that the experiences were being accessed through a deeper process not readily recognised during the event.

Nurses are also taught throughout their training to maintain professional distances, the aim being to sustain an objective relationship with the patients in their care. It could be that these professional boundaries prevent nurses from considering their own feelings related to restraint. Clinical supervision and Post Incident Review allows nurses time and space to examine these experiences in more depth to facilitate a greater understanding of how their own experiences may influence feelings that they have had difficulty in articulating following restraint incidents.

The other themes, current restraint incidents reminding nurses of more dramatic earlier events and memories of traumatic encounters experienced outside of the workplace, may be more related to theories of trauma discussed in the literature review (Chapter 2) and case study (Chapter 5). For example a smell, such as cigarette

smoke or aftershave on a patient or another member of staff during the restraint incident for which they were being interviewed may have triggered situational accessible memories related to a previous distressing event. Nurses did not articulate these triggers in depth and this may be a weakness within part B of the interview questionnaire which had been deliberately left open ended to support the grounded theory philosophy underpinning the study. A more detailed interview questionnaire related to trauma theory would be suggested for a subsequent study to examine this in more depth.

Patients' recollections of the current incident being reminiscent of previous encounters were more harrowing, and patients were subjectively more distressed when discussing this aspect of restraint. This may have been because they do not have the professional protective mechanisms described above. It could be that the patients interviewed had more dramatic trauma histories than the staff and that the feelings experienced had more intensity than those of staff participants. Furthermore, patients may have felt more comfortable in sharing their feelings around restraint than staff participants.

The element of control was identified by staff as a positive outcome when managing restraint situations, however disempowerment and lack of control was identified by the patient group as a negative aspect of the experience. In trauma theory the element of control during trauma is a predictor for subsequent development of PTSD. The more control that an individual believes that he or she has during a traumatic experience usually affects psychological outcomes, the more control meaning the better outcome (Herman 1992).

Some patients felt that they were reliving earlier traumatic experiences during restraint, for example one patient described in vivid detail how being restrained had felt as if she was being raped in relation to an earlier rape trauma. It has been highlighted that for over half of participants in this study, the experience of restraint invoked distressing reminders of previous traumatic events. For some individuals this experience was vivid and graphic, for others it was less so. Again, a more detailed interview questionnaire would be recommended for future studies to establish a wider description of this phenomenon.

The implications of these findings are numerous. Awareness of previous trauma history is essential in managing individuals in acute care. Sensitivity to these traumas must be made in managing patients who have challenging behaviour and appropriate responses should be considered in advance. Nursing staff are also vulnerable and there is a need to facilitate awareness at all levels related to the potential psychological impact of restraint for nursing staff, particularly those who have a previous trauma history. This is fraught with difficulty as many nursing staff are unlikely to disclose such histories to employers or colleagues. Indeed in this study, it may be that numbers of nursing staff interviewed with trauma histories may have been greater than those identified for this specific reason.

The current culture in some inpatient areas does not embrace such types of disclosure. Within some units, discussion of the psychological consequences of restraint goes against the grain of the macho approach to managing violent patients. Stigma is attached to acknowledging 'professional' frailty resulting in a reluctance to examine

the after effects of restraint in a formal or structured way. This is a challenge to practice which may take some time to overcome, however it is not insurmountable. The evaluation of the non-threatening approach to Post Incident Review used within this study may be a step towards addressing this issue. The observations made within this study in relation to experience of restraint reawakening memories of previous traumatic encounters provide food for thought and are worthy of a much more in depth examination on a greater scale.

7.10. Trauma Screening Questionnaire (TSQ)

The TSQ (Brewin et al 2002) (appendix 9) was used to screen participants for current PTSD symptoms. This tool is not indicated for use within four weeks of a traumatic event as the authors' highlight that natural responses must be allowed to take their course within this timescale. This tool had never previously been used for screening in the aftermath of restraint and was administered with caution under the supervision of one of the authors of the TSQ (Brewin et al 2002). The reason for using this instrument was to ascertain a measure of the extent of trauma related symptoms within the study groups. Results should be considered with caution as some participants completed the instrument soon after the four week window. These participants may have still been processing events therefore scores may have been higher as a result.

The TSQ does not assess for PTSD but does highlight whether further assessment is warranted, the cut off clinical point being 6 out of a potential 10 positive responses. The results for staff highlighted that 7% (n=2) of these participants scored above clinical cut off points and warranted further screening for PTSD. Despite the majority

of staff being below clinical cut off points, 67% (n=20) of staff reported some positive responses. A high proportion of these were related to heightened awareness of potential dangers which one would expect to be present for clinical staff who are working in acute areas. This response therefore should be interpreted in a positive way. Other trauma symptoms were highlighted, however, for example 10% (n=3) of staff indicated that they had upsetting thoughts or memories of the event in the last week. Although these symptoms may not necessarily warrant an assessment for PTSD, they are still distressing to the recipient and may influence their performance in the workplace. A nurse who may be distracted by upsetting events may be less likely to participate in other situations which could exacerbate these feelings, for example using restraint to manage other challenging behaviours.

Although these staff were in the minority they support the findings within the literature review in that staff are at risk of developing trauma related symptoms following untoward incidents at work (Needham et al 2005; McKenna et al 2003; Caldwell 1992). It may also be the case that staff who do not go on to experience symptoms have higher resilience factors (Bonnano 2004). Conversely, avoidance is a trauma related symptom and could also have been a factor in staff failing to disclose trauma symptoms.

Of the two staff who warranted further screening, both were subsequently diagnosed and treated for PTSD. The implications of these findings are of concern. Staff who have acute PTSD will be symptomatic and should not be working in clinical areas. Some symptoms of PTSD would directly affect performance leaving those individual members of staff, their colleagues, and the patients in their care, in danger. The

findings must however be viewed with caution as this was a small sample which does not necessarily represent the wider picture in acute mental health care. A larger study to examine this further would be indicated.

The symptoms of PTSD; re-experiencing of the event, avoidance, numbing of general responsiveness, and increased arousal, would affect interaction and performance at all levels of clinical work, and a nurse who has PTSD cannot be a fully competent member of the team. Anecdotally, during the course of this research study, other colleagues and students reported related issues to me. These issues were not identified during the course of the formal study, but were brought to my attention in other arenas and are noteworthy of further consideration. Student nurses, who were not included in this study, also described traumatic experiences that had deeply affected them during the course of their duties either on placement or when working as part time agency staff. When presenting some of the early findings in other settings, colleagues from a variety of different areas, such as forensic settings, reported similar issues. Crudely working out the informal figures which were anecdotally reported, a similar percentage of staff (7%) may have warranted further screening for PTSD. These considerations are offered cautiously. It may be that students and colleagues who had been recipients of trauma actively sought me out as they were aware of my research interests.

Patient participants reported higher positive responses to the TSQ. 40% (n=12) of patient participants scored above clinical cut off points and warranted further screening for PTSD. Analysis of these responses is complex. The literature review has highlighted that approximately 40% of inpatients may have an undiagnosed PTSD

therefore this screening tool may have been identifying those patients who had PTSD prior to the experience of restraint for which they were being interviewed. It is unclear whether these symptoms therefore were directly related to the recent experience of restraint or an undiagnosed PTSD. Mechanisms to examine this complex area in more depth were not built in to the study and this is a weakness in the study design. It is clear, however, that 40% of the patient participants in this study had symptoms of trauma which warranted further screening for PTSD. Ward staff were alerted to patients who scored above clinical cut off points and arrangements facilitated for further assessment outside of the research study. A limitation to this study is that these instances were not followed up by the researcher to establish outcomes. Further examination of this would be indicated for future consideration.

Similar consideration should be given to the implications for this group as the discussion related to the staff group. If the patient group has high rates of trauma symptoms then reformulation of care may be indicated. Consideration of trauma focussed interventions should be made, and explanations of challenging behaviour examined, through a framework of trauma and recovery in addition to other models of psychiatry such as the dominant medical model.

Thorough assessment of trauma histories on admission would establish whether this should be pursued for further intervention. By establishing trauma focussed interventions at an early stage, the causes of challenging behaviours could be addressed, thus preventing potentially lengthy, repeated hospital admissions for individuals who would otherwise remain in the psychiatric system for years to come.

7.11. Evaluation of Post Incident Review

The literature review has highlighted that Post Incident Review and support is under researched with no clear guidelines as to how Post Incident Review should be operationalised. Reviewing incidents in practice is complex and some understanding of these complexities is necessary before engaging in review and support.

Guidelines that are available are contradictory which at best may be confusing to staff, and at worst may discourage staff from attempting to review incidents in practice. The earlier pilot study (Bonner et al 2002) highlighted post incident support as an area in need of development; currently there is little guidance available as to what form the provision of post-incident support should take (Wright et al 2000). Some recent UK guidelines have addressed the aftermath of incidents; but this guidance has limitations. For example, NICE (2005a) guidelines suggest that serious untoward incidents should be reviewed within 72 hours with appropriate reporting procedures. Structures to accomplish this are now in place within most UK mental healthcare providers at the organisational level; however, at more local ward/unit levels, and particularly for less 'serious' incidents, (i.e. for the much more frequent incidents which do not directly result in death or serious bodily injury) post-incident support remains patchy. This study has highlighted that there appear to be strong links between restraint and PTSD, however NICE (2005b) guidelines for PTSD emphasise caution in the aftermath of traumatic events.

A technique used for managing the aftermath of trauma in the general public until recently was Critical Incident Stress Debriefing (CISD) (Mitchell 1983). This

technique involved participants being facilitated and encouraged to vividly relive the incident and to talk through their feelings about what had happened during the incident. This intervention was in use for many years but has recently been revealed to be at best neutral in its effects and at worst harmful for participants, with a Cochrane review (Rose et al 2004) suggesting that people who receive the intervention are at increased risk of developing PTSD. The mechanism for this may be related to the non-linear dose-response relationship between exposure to traumatic events and subsequent risk of developing PTSD. This means that dramatically 'reliving' traumatic events soon after they have happened may re-expose participants to the feelings of helplessness and terror they experienced during the incident so increasing the 'dose' of trauma they have received and their subsequent risk of sustaining lasting psychological injury (Rose et al 2004). This intervention is now contraindicated by NICE (2005b) guidelines for PTSD and should be avoided in light of this current direction.

The literature on critical incident stress debriefing suggests that an unambiguous distinction between 'debriefing' and 'post-incident review' needs to be made when addressing the aftermath of the physical restraint of patients in psychiatric settings. It is clear that critical incident stress debriefing can no longer be viewed as a beneficial therapeutic intervention and therefore both the use of this term and the use of review methods likely to generate high levels of emotional distress should be avoided. Ideally, post-incident reviews should also serve to identify areas where organisational processes and professional practice can be improved. This would mean that reviews would not be seen as one-off exercises so that issues arising from a review can be addressed at the organisational level and for example, adjustments made to the

assessment of patients, to staffing levels, to staff training, or to the availability of particular mediations or ongoing support for injured staff and patients. This study provided an opportunity to test a form of low emotional intensity post-incident review which was positively evaluated by staff and patients, however there is a need to further test this intervention to a wider participant group to support or refute the findings presented within this thesis.

The Post Incident Review framework was designed to be used as a method of acknowledging that an incident had happened, recognising what could be learned from the situation, and acting as a means to address the aftercare of staff and patients following the physical restraint of patients. The review also provided the opportunity to consider what, if any, longer term interventions or changes may be necessary to address concerns raised within the consultation.

The findings (sections 4.13 and 5.9) have highlighted that the format of the Post Incident Review used within this study was positively evaluated by staff and patients. The Post Incident Review framework is plain and simple and this user friendliness may have helped generate such positive responses.

The review gave participants the opportunity to think about events leading up to the incident and in the evaluation 60% (n=18) of staff participants reflected that the incident could have been predicted. This raises a number of points for consideration. Firstly, if participants had not been offered this formal opportunity to review events, to what extent would they have reflected upon the incidents anyway? This was a comparatively small study, however if the participants were right about predictability

of the incidents in which they were involved and these figures are generalisable, then potentially 60% of incidents which involve restraint may possibly be prevented if earlier interventions are mobilised when predictors are recognised. The literature review (chapter two) and discussion of antecedents (section 7.9.1) have highlighted that a number of factors contribute to the escalation of incidents involving restraint and this evaluation further supports current evidence that a high proportion of incidents may be prevented by staff being alert to early predictors, and responding in a non-aversive way.

A limitation to the research design is that further exploration of predictors would have provided a more comprehensive overview. Consideration of what those predictors may have been and their clinical utility in preventing incidents may be positive both for the individual reflecting on their own practice and that of their colleagues and for shaping future clinical practice. The evaluation did not allow for wider discussion of the statements that were rated, for example what components the participant believed made the difference between an incident of restraint being managed well or not. Wider exploration of these factors may have provided a fuller picture of how such incidents can best be managed.

The responses captured within the evaluation data were from staff and patient participants that were keen to contribute, and this participation was voluntary. It may be that the data presented here did not reflect the views of those staff and patients who did not participate in the study.

7.12 Staff focus group

The focus group was used as method of data collection to supplement the individual interviews for staff and as a method of validating emerging data during the grounded theory process. The group discussion was semi structured and themes which had been raised within the analysis were used as a framework to guide the discussion. The group supported the notion that some incidents could be avoided through earlier interventions and de-escalation of potentially aggressive situations. These findings add further weight to the issue of training in identifying techniques of de-escalation for staff and mobilising early interventions.

Training was discussed in depth with this group. They reported that they felt safer and more in control if they had previous training in C & R which supported the findings of the staff individual interviews. In considering these findings within a trauma theoretical framework these feelings of safety would be important in the outcomes of perceived traumatic events such as restraint. If the individual has maintained a sense of control and safety they may be less likely to subsequently develop psychological disorders such as PTSD. This would support the argument that training in C & R should be made available to practitioners within acute care, if only to promote feelings of safety and control as a preventative measure.

There is a counterbalance to this argument. In Bower et al's (2007) study, they found that adverse incidents were more likely to arise when there were high rates of staff absence such as sick time and unfilled staff vacancies. If staff take leave for a full week for C & R training this will have an impact and if, as some individual participants suggested, whole teams are trained en masse while other staff look after

the ward, there is potential for chaos. The positive effects and psychological protection that will be facilitated by staff attending C & R training could result in serious negative effects upon the patient group that they have left behind on the ward, with a possible rise in untoward incidents directly resulting from their absence. Furthermore, if staff feel confident in newly taught C & R procedures they may be more willing to use these methods to contain high tension situations rather that using de-escalation techniques to avoid restraint. This is a speculative assumption however it would be worth evaluating whether use of C & R rises in clinical areas where staff have been recently trained to establish whether rates of restraint rise as a result. Baker and Bissmire (1994) found that staff working in learning difficulties who had recently been trained using the SCIP model used more physical interventions following training. In the earlier pilot study which underpinned this thesis (Bonner et al 2002), staff in one learning disability unit were interviewed about their experiences around restraint. These staff had been trained in both C & R and SCIP and they reported that their training in SCIP had greatly reduced their physical interventions. A much wider study would provide a clearer picture of whether different training models increase or reduce rates of restraint.

Other issues around staff competence following C & R training were discussed within the staff focus group which were not alluded to within individual interviews. While staff reported the positive effects of training in individual interviews, there were concerns within the focus group that staff who had received training were not always competent in performing restraint procedures. The impact of this was that teams did not feel confident if a member of staff formed part of that team who was not perceived as competent. This would negate the feelings of safety and control that

staff had reported as a result of training and possibly contribute to adverse psychological effects of restraint at a later date. There is a need to examine this aspect of restraint in much more depth in order to provide clarity to inform training programmes.

The focus group also highlighted that some staff avoided situations which may require use of restraint. They believed that for some staff this was as a result of earlier traumatic experiences of restraint and this could be explained using the theory of PTSD, with avoidance being a prominent feature.

The staff focus group supported many of the issues related to Post Incident Review which had been identified within the individual interviews. For most, experiences of Post Incident Review had been patchy and inconsistent. Staff who had received the opportunity for Post Incident Review presented mixed views of their experiences. Some staff had felt that the person who facilitated the review had been inappropriate, bringing their own agenda which influenced the group process. For example, one nurse described that a line manager had "made" all staff participate in a "debriefing" following a particularly harrowing incident. Staff had felt that the manager was looking for someone to blame for the incident and left the meeting feeling angry and undervalued. Other staff had found the experience a helpful process which had allowed them the opportunity to take stock in a supportive environment to discuss their distress and concerns related to the incident. These points underline the necessity for the facilitation of Post Incident Review to be undertaken by a person who has a wide repertoire of skills, as well as a measure of objectivity to the situation. If staff feel threatened and intimidated, they may be less likely to engage in the

process of Post Incident Review. This may perpetuate the culture in some areas of non-disclosure and reluctance to share any subsequent feelings related to restraint experiences.

Some raised the issue of macho cultures within inpatient units and the notion that restraint was a necessary evil. Within these environments staff were discouraged from reflecting upon incidents and were encouraged to view restraint as part and parcel of their workload. The staff within this focus group resented working in cultures where reflection and acknowledgement of distress were avoided. This again introduces the tension between the roles of custodian versus therapist. Some staff in acute care may view their role in relation to management of violence as that of enforcer of boundaries and rules, for the greater good of the patient(s). A dominant ward leader can influence how this view impacts upon the team by encouraging this approach as the norm for all patients. Challenges to this view may be scorned and some staff who are not prepared to fit into this view of nursing either leave to an area which supports their own philosophies, or fits in with the team 'view of care'. There is limited research which examines the ward culture in relation to post incident support and there is a need to examine the impact that such negative cultures have upon the staff working within them.

The staff focus group presented similar views on post incident support for patients. They supported the points raised in individual interviews that post incident support was not readily available for patients and that there were no clear systems as to what form this should take. Within the focus group additional comments were made in relation to some patients receiving informal support following incidents and that this

was more likely to be offered to more favoured patients. This may be as a result of better nurse / patient relationships which were perceived by both individual staff and patient groups to have more positive outcomes following restraint. Where the focus group had viewed this support as only being offered to patients who were favoured above others, staff and patient interviews related this to already existing positive relationships. This raises the question of malignant alienation and the unpopular patient (Watts and Morgan 1994). Is there a likelihood that patients who are less popular with staff are more likely to be restrained? It may be that patients with particular diagnoses, for example personality disorders, or with a history of violence, may be less popular than others. It may be that these patients have more severe boundaries set by staff therefore there is more tension within these relationships.

There is anecdotal evidence to suggest that certain diagnoses impact upon relationships, for example patients with a diagnosis of personality disorder are not always offered the same therapeutic time as patients with a different diagnosis. This study did not explore whether nurses who described more positive relationships were with regard to patients with a specific diagnosis. For the patient participants who discussed positive post incident support, their diagnoses were varied, and not significant enough to support the notion that patients with a specific diagnosis may be treated less favourably than others. There is need to examine this in further depth through more explorative studies which look at the relationship between diagnosis, history of violence, instigation of restraint, and post incident support.

Finally within the staff focus group, support to night staff was offered as a neglected area of practice. The member of staff within the group who was most vocal around

these issues described how she actively sought out support from day staff and that there was not a clear avenue for Post Incident Review on night duty. Night shift concerns were not raised by the individual interviews and this is a weakness within this study. All of the participants were interviewed in the course of day shifts therefore views of night staff were not actively sought. Although the majority of staff interviewed had worked nights, it may be that they were more focussed upon day shift issues and prompts were not offered to generate responses related to night shifts.

7.13. Moving the findings of the study forward

The findings in the study identified that Post Incident Review and support was welcomed by staff and patients but that there were severe inconsistencies within this Trust. An opportunity was made to start to move this aspect of the study forward in terms of mobilising more formal and consistent support systems for staff. This had not been built into the design of the study but was an example of how the evolving nature of generating grounded theory can offer flexibility within the analysis. A limitation to this aspect of the study is that the initiative is yet to be fully evaluated however this has offered an early glimpse of how research findings can be addressed quickly and effectively in the practice setting to effect positive change.

The case study brought to life some of the more severe psychological consequences which can result from managing untoward incidents in acute mental health care. Anne was an example of how restraint can have a life changing impact upon staff, and how poor post incident support can influence the extent of that impact. Anne was not well supported in the immediate aftermath of the incident and she subsequently felt angry and bitter towards the establishment. It may be that Anne would have gone on

to develop PTSD whether she had received some form of post incident support or not, but the sense of being valued was missing from Anne's narrative. Had that sense of value been acknowledged, her anger towards the organisation may have been less evident. Presenting a clinical case enabled a clear understanding of the theories and treatments of PTSD, and how they can be applied successfully in the clinical setting to enable staff to return to work following a traumatic experience of restraint.

7.14. Limitations to the study

A number of limitations have been raised within the discussion and further limitations will now be highlighted. This study has a large qualitative component which is fraught with difficulties in addressing the subjective nature of the work. The research design has identified ways of addressing many of these issues and methods of overcoming these limitations have been employed in the gathering of data and analysis of the work as described in preceding chapters.

The study took place in one mental health trust in the south of England and the sample may not be representative of every mental health trust in the UK. Quantitative theorists would emphasise that overall this is a very small sample, and a much larger study would be indicated to provide a more robust examination. There was opportunity in the early stages of the study to collaborate with another comparative Trust in central Scotland and two forensic secure hospital sites, one in the south of England and one in central Scotland. Unfortunately, the logistics of moving this collaboration forward without additional finances proved unwieldy and although applications were made in the early stages to secure additional finances, these were unsuccessful. It is hoped that the new evidence that this study has generated will

spark wider interest and that some of these earlier collaborations may be developed in the future. It is important that this study is replicated to establish whether this snapshot of restraint experiences in one Trust is representative of a wider UK population.

Supporters of grounded theory would advocate that the nature of qualitative work is unique to that particular subject area and that replication of studies is unnecessary (Charmaz 2006). Mixed methods advocates, however, would promote a pragmatic approach to using a variety of methods to establish a clear picture of the research topic. The findings in this study provide a concerned picture of the aftermath of restraint; however they also raise many positive points to address these concerns. These findings must be shared with wider audiences and examined further in other areas to support or refute the points raised.

The data was collected over a period of eighteen months and offer a snapshot of the participant groups' experiences during this time. Follow up of the participants involved would have identified longer term outcomes for these groups, particularly in relation to developing subsequent PTSD for both groups, and regarding further intervention and treatment for patients who scored highly on TSQ (Brewin et al 2002). Further work is planned to address this limitation at a future date.

This study sample was mental health nurses and inpatients and while rich data was gathered from the participants involved, views of other allied professionals and other agencies were not elicited. Ryan and Bowers (2006) suggest that the views of these other groups are important in widening our understanding of the management of

restraint situations and this study would support those views. One patient in this study discussed his experience of being restrained by police and brought to hospital and there is a need to consider these wider perspectives. Occupational therapists have historically collaborated with nurses and patients to provide structured activity within inpatient settings. In some acute areas the role of the Occupational Therapist has been eroded and diminished, often due to financial cutbacks. It is important that the skills and support that other professionals can provide are embraced within acute care. The role of the Occupational Therapist in particular could assist in addressing issues of boredom which often contribute to rising tensions within acute care. That is not to say that the historical stereotypical role of the Occupational Therapist as a redcoat / basket weaver who is mocked by other members of the team should be reintroduced. There is much to be learned from the Occupational Therapy profession in terms of assessing and addressing skills deficits in our patients. Full programmes to promote recovery in these areas can prevent tension in acute care and prevent some of the antecedents which were identified in this study.

Additional attention was given to some elements of this study for staff which were not fully addressed for patient participants, namely use of focus groups and implementation of a strategy for Post Incident Review. The focus groups were arranged for staff participants to provide concept clarification of restraint, and to validate data generated from individual interviews, as well as provide an opportunity for fresh insight during the research process. This method of data collection and validation was not offered for patient participants for a number of reasons. It was felt that inviting patients who had already been interviewed may have subjected them to distress in revisiting events that had already been discussed in depth. Alternatively,

patients who had not been individually interviewed were considered to take part in a focus group; however in practical terms it proved logistically impossible to facilitate a meeting of a cross section of patients from the various areas of the Trust. Some patients would have needed to be escorted across county to attend such a group and a budget had not been identified to meet the additional costs to support this. This could have been overcome by facilitating smaller groups in more local areas. This was considered, however numbers who would have been able to attend without additional supervision would have been limited and a decision was made not to pursue this avenue as it could have proven to be a time consuming exercise which may not have added additional insights into the area being researched.

A strategy for implementation of Post Incident Review and support for staff was discussed in chapter five and a limitation to this aspect of the study was that a strategy for patients was not identified at this point. This decision was made after much thought and discussion with colleagues and supervisors. Practical issues, mainly time and human resources, did not allow for formal mechanisms of training for Post Incident Review to be rolled out simultaneously for staff and patients. It was highlighted during this study that both staff and patients may prefer a more comprehensive approach to Post Incident Review and support. Some mechanisms were in place for patients who were identified as having trauma related symptoms to be referred to trauma focussed services; however this was not the case for staff. My concern was that if staff needs were not addressed they would not function effectively in terms of offering comprehensive support to patients in their care. A decision was therefore made to address Post Incident Review and support for staff first, with a view to implementing a robust system for patients when the mechanisms for staff support

were in place. At the time of submission, Post Incident Review for patients is now being rolled out across the Trust through breakaway and C & R training. Following completion of this study, the implementation of Post Incident Review and support for staff and patients will be evaluated for efficacy to further inform this area of practice.

Time and resources have been major forces which have influenced decision making within this study. Justification has been offered throughout the work to support decision making processes made during the study. However many decisions have ultimately been made for practical reasons. Despite many setbacks which have been encountered in relation to time and resources, earlier chapters have considered a variety of approaches to overcome these obstacles, however the limitations which have been identified must be considered with caution when reviewing the findings of this study.

CHAPTER EIGHT – CONCLUSIONS AND RECOMMENDATIONS

"*...long-term, far-ranging and sustainable change can only become reality if the organizational agenda is addressed...*" (Brennan et al 2006, p481)

8.1. Introduction

In concluding this work I have reflected on the content of the thesis while asking myself three questions:

- Did I answer my research questions which were offered in the introduction to this work?
- Was my chosen methodology an appropriate way to examine the aftermath of restraint for staff and patients in acute mental health settings?
- Have I made an original contribution to the field of mental health practice?

This chapter will now go on to consider the questions above in light of the research presented in earlier chapters. Section 8.2 will consider the original research questions and offer conclusions related to whether these questions have been addressed. Section 8.3. will reflect upon the efficacy of the chosen methodology for this study and the sensitive area which has been examined, and Section 8.4. will go on to highlight the original contribution that this study has made to mental health practice. Section 8.5. will conclude the chapter with recommendations for education, research and practice, and section 8.6 will offer a final personal reflection..

8.2. Answering my research questions

The first research question considered what is the psychological impact of restraint for staff and patients in acute mental health settings? I cannot conclusively take credit for answering this question completely. The literature review highlighted that there was a lack of empirical evidence related to the experience of restraint for staff and patients but that there were psychological consequences which needed to be considered and examined in more depth. This study has supported the issues raised in the literature review and extended further contextual understanding of the psychological impact of restraint. The study highlighted that restraint situations are wide and varied, that the more severe restraint situations can have a severe impact such as PTSD, but that less severe restraint situations can also have far reaching psychological effects for staff and patients. These psychological effects include a wide range of feelings such as anxiety, distress, anger, and guilt through to trauma related symptoms and PTSD.

Within this study the majority of restraint incidents involved minimal physical injuries with 50% (n=30) of all participants reporting no injury at all. A larger UK wide study to examine physical and non-physical consequences of restraint, and any subsequent psychological impact, is indicated. Issues of reporting bias have been identified in section 2.2.1. in relation to whether incidents involving non-physical injury are under reported. Participants recruited into this study had not necessarily reported the incidents through more formal channels therefore it is probable that this section of staff and patients would often be missed through Trust audit processes.

The second research question asked whether the experience of restraint reawakened distressing memories of earlier traumatic encounters for staff or patients. 57% (n=34)

of the participants in this study, split evenly between staff and patient groups, reported that they did experience a reawakening of previous traumatic events from past experiences. These experiences were often related to highly traumatic events, such as rape for patients and assault for staff. The impact of this has been discussed in earlier chapters and there is an urgent need to examine this in more depth. If this figure is representative of the general population for patients and staff then training programmes, staff support, and access to trauma focussed services for both patients and staff need to be radically reconsidered, not only at local levels but at a national level. While current guidelines such as NMC (2002) and NICE (2005a) are a helpful step forward, they need to be expanded to consider the aftermath of restraint in much more depth.

The third question asked if using a structured Post Incident Review served a purpose in the examination of experiences of restraint for staff and patients. This study has evaluated a clinical framework for use in the aftermath of restraint and has reported very positive findings in relation to the efficacy of this approach. This framework bridges the gap between the current conflicting direction offered in the form of NICE (2005a) guidance related to violence and aggression and NICE (2005b) guidance related to PTSD. These guidelines offer opposing views which are unhelpful in addressing the aftermath of restraint. While NICE (2005a) guidance for violence and aggression suggests a Post Incident Review following untoward incidents, NICE (2005b) guidance for PTSD advises caution in early psychological intervention and that critical incident stress debriefing should be avoided. The framework evaluated within this thesis has avoided the systematic reliving of experiences advocated in Mitchell's (1983) critical incident stress debriefing model which has subsequently

been discounted as having the potential to re-traumatise individuals. Rather, this framework has provided a less intrusive approach to review events in a non-threatening way to allow staff and patients to discuss events leading up to the incidents and any subsequent psychological effects which the events may have triggered. Using this approach also enables early identification of trauma symptoms which may warrant further screening for PTSD. There are currently no published trials, related literature, or pilot studies which examine Post Incident Review in depth and the review framework that has been evaluated in this study offers a way forward in addressing this crucial gap in current acute mental health practice.

8.3. Using an appropriate methodology to examine the aftermath of restraint for staff and patients

Chapter two offered a discussion of the methodology which supported the research study, and a constructivist paradigm was offered as the philosophical stance that I had chosen to underpin the work. This paradigm has suited the nature of the study and allowed me to engage with the research participants in a reciprocal process which has helped to facilitate depth to the qualitative aspects of the study to enable a wide understanding of the experiences of the participants.

Using grounded theory to generate fresh insight and further examine existing knowledge is open to criticism due to the subjective nature of this approach, however this study has highlighted that mechanisms can be built into the research design to address subjectivity. Use of investigator triangulation methods in the data analysis provided a mechanism to step back from the data. Employing other qualitative analysts to examine the data offered an opportunity to generate objective insights

which supported my own thematic analysis. While the prospect of using grounded theory methods was daunting, the flexibility within the approach facilitated revisiting material and prompted further investigation to support and refine insights into the experience of restraint.

The earlier pilot study (Bonner et al 2002) (Appendix 1) was a qualitative study which generated contextual insights into the psychological impact of restraint. The mixed methods design of this subsequent study has allowed for a much wider investigation of the experience for participants. The qualitative interviews provided the opportunity to examine experiences of restraint in depth, as well as to establish whether the Post Incident Review framework which was being used as a prompt for the interviews was a helpful clinical tool. The evaluation which was used for participants provided measurable data which confirmed its efficacy and this framework will be offered as a clinical model for future practice. Use of other methods, such as TSQ, helped to identify extent of trauma symptoms for participants to establish whether the experience had been influential in the development of more serious psychological effects which warranted further screening for PTSD. Although demographic data were not significant in the analysis within this thesis, they nevertheless offered a full picture of the participant groups who informed the study.

Ethical considerations were also highlighted within chapter two and a number of issues were influential in the study design. The nature of the study could have potentially caused distress and upset to the participants and I was mindful of this throughout the process. Embarking upon a study of this nature is challenging and the ethical issues which must be considered may be a reason why there is such limited

qualitative research in the literature around the psychological impact of restraint. This study has shown that aspects of mental health which are fraught with ethical dilemmas can be researched if sensitivity is used within the design. Research studies such as this can help to inform our understanding of patient and staff experiences and if we are not prepared to ask the questions, then the answers may not be forthcoming. It transpired during the course of the study that participants found the research interviews to be helpful, as reported in the evaluation of the research questionnaires and reported subsequently following interviews.

8.4. Original contribution to the field of mental health practice

This study has contributed a number fresh insights into the psychological impact of restraint. The literature review highlighted that restraint appears to invoke strong feelings for staff and patients but research evidence around this area of mental health care was scant. This study has expanded and supported the current evidence base and found that the psychological impact for staff and patients can be profound, ranging from feelings of anxiety through to symptoms of trauma, and at the far end of the scale, PTSD.

Post Incident Review is now advocated following untoward incidents involving restraint (NICE 2005a) but this study has highlighted some of the difficulties that prevent effective Post Incident Review from being implemented in practice, indeed in many areas Post Incident Review does not happen at all. At the time of writing, there are no published studies which address the practical implementation of Post Incident Review in practice. This study has offered an original contribution to mental health practice in this respect. A framework for Post Incident Review (appendix 5) has been

evaluated positively by staff and patients and this framework provides an opportunity to offer a flexible, non-threatening way to consider the effects of restraint for both staff and patients. This approach to Post Incident Review and support is simple and effective, and can be routinely integrated into practice with no costs and sound benefits. The framework used within this study has been evaluated positively and is offered as way of addressing some of the current lack of guidance in relation to Post Incident Review and support. Use of this approach also ensures an opportunity for early intervention should symptoms of trauma be identified.

The study found that systems to provide further support, should trauma be detected for staff and patients, was varied with no clear channels for onward referral for staff. As a result, within this Trust, there is now a clear process for post incident support for staff following untoward incidents which will continue to be evaluated. In order to address some of the issues raised within this study, a comprehensive proposal (appendix 13) to streamline Post Incident Review and support was developed and is now in the early stages of implementation (chapter five). A number of clinicians have been trained to facilitate Post Incident Review for staff and are now easily accessible to clinical areas should the need arise. The initiative will be evaluated with interest, and results will be disseminated widely both within the Trust and the wider mental health arena through publication and conference presentation.

In respect of moving forward the findings of this study to improve the patients' experience of services, similar initiatives are being planned at the time of writing. This has been a slower process because of the wider consultancy which has had to take place. Post Incident Review is now included in training for breakaway skills and

C & R within this Trust and close links have been forged between the leads for prevention and management of aggression and leads for Post Incident Review to ensure that this is seamlessly rolled out. It is anticipated that the evaluations of these initiatives will be of interest to wider audiences within mental health care and results will be written up for publication in due course.

The earlier pilot study (Bonner et al 2002) found that for some staff and patients, the experience of restraint invoked memories of other traumatic encounters. This study aimed to examine this phenomenon further and has produced findings to support that this was the case for 57% (n=34) of participants. This is an area of mental health practice that has received very little attention in the literature with only three other small studies reporting this aspect of restraint (Brase-Smith 1995; Gallop et al 1999; Sequeira and Halstead 2002). This study has provided a greater understanding of this phenomenon, although there is a need to research this in much more depth. The study found that restraint can trigger memories of other distressing encounters which may have a re-traumatising effect for individuals with a trauma history. This must be considered in training programmes for staff in the future.

While this study has effected positive change within this Trust, the original contribution that this work offers must be shared with wider populations. The findings of the study have been presented to a variety of audiences, from local to international arenas, and have been well received. Publications of other findings are planned following successful completion of the thesis.

8.5. Recommendations

A number of recommendations are offered as a result of this study in three areas – education, further research, and clinical practice (table 20). For education, the following recommendations are suggested:

- Training programmes must consider the psychological impact of restraint and this should be made explicit in terms of learning outcomes in pre-registration professional programmes, post qualifying programmes, and aggression and violence focussed training.
- Post Incident Review as it currently stands is unclear, and clarity can be made through education programmes. The framework evaluated within this study is advocated as a model which can address Post Incident Review for staff and patients.
- Training programmes must embrace the issues of trauma which have been highlighted within this study. Many training programmes do not place emphasis upon the extent of trauma histories for patients and consideration towards trauma histories in staff is non-existent. This needs to be included in training programmes across the board for all professionals, and for untrained staff through induction and in-service training programmes.

This study has barely scratched the surface of the psychological impact of restraint for staff and patients. It has, however, established that there are a number of areas which would benefit from further research initiatives to explore the issues raised in this study further. The following recommendations for research are offered:

- A larger multi site study would identify whether the results produced within this study are representative of the experiences of staff and patients throughout the UK.
- This study has identified a framework for Post Incident Review which has proved helpful to the participants. This will continue to be evaluated and it is recommended that this be further evaluated on other sites, and in other services, for example community settings.
- Further exploration is recommended in relation to the experience of restraint reawakening distressing memories of previous traumatic events. This study has highlighted that this is a common phenomenon but the extent and nature of this phenomenon is relatively unknown and there is an urgent need to develop a large study to examine this further.

In terms of clinical practice, this study has offered valuable insights into deficits in practice in relation to the experience of restraint. The following recommendations should be embraced urgently in practice settings:

- The potential psychological consequences of restraint can be great, and this must be considered by practitioners as routine and not as an afterthought.
- Trauma histories must be given much greater consideration in practice and clear documentation of such histories should be explicit within notes, care plans, and through existing channels of verbal communications.
- Post Incident Review is in urgent need of implementation throughout the UK for both staff and patients. This study has offered a practice model which can be implemented effectively in other areas.

- Post incident support to staff needs to be defined with clear channels for onward referral should trauma be identified. This will involve a cultural change for some groups and there is a need for this to be facilitated in a non-threatening way.
- Post incident support for patients should also have clear channels for onward referral. This does not always happen in all areas and there is a need for a more systematic approach to onward referral for patients should the need arise.

The table below summarises the recommendations arising from this study.

EDUCATION
Learning outcomes in all programmes of training related to management of untoward incidents should explicitly address the psychological impact of restraint
Post Incident Review should be clearly considered within training programmes with models of review and support explained within these programmes
Clearer emphasis related to early identification of trauma history should be integrated within training programmes
RESEARCH
Larger multi site study to extend the findings of this study further
Further evaluation of Post Incident Review framework used within this study
Wider exploration of the phenomena of restraint reawakening distressing memories of earlier traumatic encounters
PRACTICE
Routine consideration of the psychological impact of restraint
Clear documentation and communication of trauma history
Implementation of clear models of Post Incident Review and support for staff and patients
Clear channels of onward referral for staff and patients who develop trauma related symptoms

Table 20. List of recommendations for education, research and clinical practice

8.8. Personal reflection

Asking individuals about their experiences of restraint is an intrusive and emotive task. This thesis has considered that the psychological impact of restraint is an area which is easier to avoid than to examine. Taking into account the ethical implications of the research study I had given much thought to the intrusion that I may be imposing and the emotions that I may be triggering for the participants. The quote highlighted by Tennant (1997) at the introduction to this work highlighted his struggle in attempting to implement group therapy in acute inpatient care in the mid 1980's. His words echoed my own concerns at the beginning of this project. I was unsure as to whether my interest in the experience of restraint would be welcomed. On reflection, these stories needed to be told. The participants embraced the opportunity to share their experiences and, at times, emotions ran much higher than I had envisaged. I was touched by the depths of feelings that were shared by staff and patients, and was moved on many occasions by the experiences that I had the privilege to hear. This study has reinforced my compassion for both the recipients of acute mental health care and the providers of that care. Acute mental health care is arguably at its most challenging ever, and nursing staff are continuing to embrace these challenges in a caring way. Occasionally these interventions cause more harm than benefit, particularly where restraint is concerned, however the harm is unintentional and inflicted with benefit in mind. In years to come perhaps we will look back upon our current interventions, as I have done in the historical discussions within this study, with horror at the interventions that we have applied.

Before embarking upon this study I believed that post incident support was lacking in mental health care and this study has reinforced that belief, however I have had an opportunity to examine how supports can be mobilised fairly easily with good effect. A change in culture is needed to allow staff to discuss the psychological impact of working in acute care. A small step has been taken in moving this issue forward in this study and I hope that this is a start of something much greater in terms of effecting quality support to staff and patients, both within this Trust and in the wider mental health community.

It is striking that use of a trauma related framework to view acute mental health care is so lacking in current practice. I had always considered prior to this study that trauma histories usually preceded referral to mental health services, whether the trauma had been ongoing many years previously or more recent. I had made assumptions that this view was shared by most practitioners but having the opportunity to examine this in more depth has proved me wrong. In my lengthy experience in acute care and community services I had always considered trauma histories, although had not applied the comprehensive tools for assessment or the trauma focussed interventions that I have since become familiar with, relying on more eclectic models tailored to suit the presenting problems or to suit the service in which I found myself. I now firmly believe that trauma histories must be comprehensively considered from the very earliest stages of referral for patients, and for staff who are working in mental health services. While a trauma focussed approach should not replace other models, it must be at the forefront of services alongside other models to provide a much greater understanding of the needs of people who are referred to our services.

The research process has been long and frustrating at times. Before embarking upon this study I believed that using quantitative methods was much more difficult than using qualitative methods however I have been proven wrong again. Qualitative methods are extremely complex and require an incredible depth of thought. Each step of the way has to be justified and because of the differing approaches and viewpoints described in chapter three, this has been extremely challenging. The depth of examination of research methods for this type of study requires much rigour. I expected to be an expert in mixed methods by the time of completion, however this process has highlighted to me that I have much to learn still. Although our methods continue to be refined and sophisticated, the complex nature of the human being will probably never be completely understood whatever methods we apply.

In terms of professional development this project has enabled me to develop my clinical skills further in relation to assessment and treatment of PTSD. In turn I have been able to influence pre and post registration education particularly for nurses in terms of curriculum development as well as face to face teaching. I have had the opportunity to share findings of the study in both local and international arenas and I have been impressed by the compassion and commitment to mental health care shown by the people that I have encountered in these venues. I have collaborated with colleagues to widen understanding of the psychological impact of aggression and recently published an article related to this thesis and the work of a colleague around verbal abuse (Bonner and McLaughlin 2007) (appendix 14) as well as submitting a book chapter which is due for publication in December 2007 (Bonner, in press). I intend to publish further findings on completion of the thesis.

I have discussed in depth, and offered personal views on, the lack of support available to staff in acute mental health care, particularly in relation to the psychological impact of restraint. Early on in research design for this study, I considered that I would need to identify my own supports. At times the process was upsetting, indeed emotionally exhausting, and without the supports made available to me through the supervision process, as well as through friends and colleagues who are acknowledged at the start of this work, I would not have completed this thesis. These role models have proved that support is fundamental to remaining psychologically intact when working with vulnerable people, and when undertaking academic study.

This has been an incredible journey. Undertaking PhD study can be a lonely process which, on reflection, I would equate with childbirth; unless you have experienced the process it is impossible to describe it to another. Would I do it again? Absolutely yes.

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APPENDIX ONE

PILOT STUDY

Bonner G., Lowe, T., Rawcliffe, D. and Wellman, N. (2002) Trauma for all: a pilot study of the subjective experience of physical restraint for mental health in patient and staff in the UK, Journal of Psychiatric and Mental Health Nursing 9(4), 465-473

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Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK

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Violence and aggression is common in psychiatric inpatient units. Despite the near universal prevalence of restraint, there is very little published research on either the efficacy or the subjective effects of restraint on staff or patients. In this pilot study, semi-structured interviews were given to the patients and staff involved in six untoward incidents in which the patient participant had been subject to manual physical restraint. Participants were interviewed as soon as possible after the occurrence of the incidents. The interviews asked the patient and staff participants to identify and discuss the factors that they found helpful and unhelpful during and in the immediate aftermath of these incidents. The incidents generated strong emotions for all concerned. The patients valued staff time and attention but felt that they received too little attention. Both nurses and patients discriminated between permanent and temporary staff. Patients reported feeling upset, distressed and ignored prior to the incidents and isolated and ashamed afterwards. Postincident debriefing was valued by all but was patchy for staff and rarer still for patients. Patients feared the possibility of being restrained. Half of the patients and several staff members reported that the incidents had reawakened distressing memories of previous traumatic events. Further research on the subjective effects of restraint is urgently needed.

Keywords: control and restraint, patient experience, physical restraint, post-traumatic stress, psychiatric inpatients, staff experience

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Introduction

Definition of restraint

For the purposes of this study, an incident involving restraint was defined as any incident where staff physically laid hands on a patient in the course of managing an untoward incident. Mechanical restraints are not in routine use in the UK and are not considered in this study.

Literature review

Wright (1999) has described current guidance regarding effective systems of physical restraint as 'sketchy' as a result

of a lack of research into the efficiency and safety of methods used. A Cochrane review of the literature on the use of seclusion and restraint for people with serious mental illnesses (Sailas & Fenton 2001) was unable to find any randomized controlled trials, which examined the efficacy and/or safety of manual restraint techniques.

In the UK, the dominant model of physical intervention used in NHS psychiatric services is known as control and restraint (C & R; Parkes 1996). This was developed by the UK Prison Service in 1981 and was exported into health and social care in the mid 1980s following recommendations made by the Ritchie Report (Ritchie 1985) that training in C & R should be provided for nursing staff in the high security psychiatric hospitals.

C & R involves the use of techniques which endeavour to contain violent or potentially violent situations in a safe manner. The actual intervention techniques have been modified over time, and variant models such as C & R General Services have also emerged. This variant was developed independently of the UK's forensic services, because of concerns about the aversive nature of C & R and the appropriateness of the use of C & R techniques in non-forensic settings (Gournay 2000). The UK has also recently seen an attempt to 'rebrand' C & R as 'care and responsibility' rather than 'control and restraint' (McDougall 1996).

Gournay (2000) has stated that the main benefit of C & R approaches is that they increase staff confidence. Although Mortimer (1995) found an eventual reduction in violence towards staff after the introduction of C & R, overall levels of violence were not reduced and Parkes (1998) found that the use of injections increased. Gournay (2000) concluded that C & R is a relatively effective method, but it remains controversial because it involves the use of holds, which use pain to control behaviour. According to Gournay (2001), the Department of Health Services research team responsible for a recent consultation document were unanimous in their opinion that the use of pain in this way breaches patients' rights and should be immediately abandoned.

There are a number of alternatives to C & R which are in use in the UK. These include Studio 3, Therapeutic Holding (Stirling & McHugh 1997) and Strategies for Crisis Intervention and Prevention (SCIP; OMRDD 1988). SCIP is used most frequently in learning disability services but has a growing following in mental health services in the UK, though there is a paucity of published research into its efficacy within mental health care. SCIP holds do not rely on pain to control the individual under restraint and SCIP training places much greater emphasis on early intervention and on de-escalation than C & R, which primarily consists of a set of reactive techniques.

In an observational study published in 1996, Whittington & Wykes (1996) reported that 86% of assaults to staff were preceded by aversive encounters between patients and staff. These encounters often took the form of staff members frustrating patients' wishes, making activity demands on patients or making unwanted physical contact with them. These findings supported an earlier study by Sheridan *et al.* (1990) who found that events leading to assaultive behaviour by patients towards staff often involved patient–staff conflict.

Violent and other untoward incidents which lead to restraint tend to generate strong emotions in all concerned. Fisher (1994) has described the difficulties involved in working with people with severe mental illnesses without using restrictive methods, but the use of such methods are fraught with legal and ethical concerns. According to Gournay (2000), the central issues are: what constitutes the use of reasonable force; what constitutes acceptable methods of intervention; and the duty of care to safeguard employees. Postincident support has also been highlighted within the literature as an area in need of consideration; however, there are few guidelines as to what form postincident support should take (Wright *et al.* 2000). Nolan *et al.*'s (1999) study of nurses' and psychiatrists' experiences of violence in mental health care found that although both groups felt a need for after care support, few received any such care. Nolan *et al.* (1999) were also unable to find any published research regarding after-incident support to patients. Wright *et al.* (2000) have highlighted a widespread failure of NHS policies to address this issue.

Aims of the study

The aims of the study were, first, to establish the feasibility of using semistructured interviews with patients and staff in the aftermath of untoward incidents involving physical restraint. Other aims were, second, to gather information on the factors patients and staff groups found helpful and unhelpful, during and in the aftermath of restraint and, third, to explore the lived subjective experience of restraint.

Method

All procedures were approved in advance by the relevant NHS Local Research Ethics Committee. The medical and nursing staff of the units where data collection was to take place were briefed in advance about the study. The occurrence of untoward incidents involving restraint were ascertained by a daily phone call to each of the participating wards made by the secretary of one of the researchers (NW). The researchers were contacted by the secretary and

informed of the occurrence of incidents. The researchers subsequently liaised with ward teams to check the nature of the incident and the identities of the participants. It was decided in advance that no patient would be interviewed about more than a single incident.

Once an incident had been identified, and before any approach was made to a patient, consent was obtained from the patient's consultant psychiatrist. Patients were approached at the discretion of their key- or associate-nurse who was asked to assess the patient's fitness for interview and ability to give informed consent. If the medical staff and the key/associate nurse both judged that the patient was able to consent and could be approached without causing undue distress, the key/associate nurse was asked to approach the patient about the study. Patients who expressed an interest in the study were then provided with a copy of the patient information sheet/letter of invitation by their nurse. After receiving the written information, patients were given a minimum of 24 hours to decide whether or not they might wish to participate, before being approached by one of the research team. The researcher gave the patient a further verbal explanation of the study and answered their questions. After satisfying themselves that the patient was able to give valid informed consent, the researcher asked the patient to sign the consent form. A member of the nursing staff witnessed these signatures and the patient was subsequently interviewed using a semistructured interview schedule.

Members of staff who were involved in the untoward incidents were directly approached by a member of the research team and provided with a copy of the information sheet. After receiving the written information, staff members were also given a minimum of 24 hours to decide whether or not they wished to participate in the study. Staff members who wished to take part in the study were also given a further verbal explanation and a chance to ask questions before being asked to sign the consent form.

The semistructured interviews each took about 30 minutes to complete. After the collection of some basic demographic and clinical data, each participant was asked to briefly describe what had happened in the recent incident and also to describe any precipitants to that incident as well as detailing their emotional state prior to the incident's occurrence. They were then asked to identify the particular factors that they found helpful or unhelpful during the incident. After being asked to reflect on their emotional state in the aftermath of the incident, they were then asked to identify helpful and unhelpful factors in the aftermath of the incident. Participants were then given an opportunity to volunteer further information and to ask questions of the researcher.

The researchers recognized that there was a risk that the research study might re-ignite recent untoward incidents or be instrumental in releasing distressing emotions surrounding these incidents, and the procedures outlined above were partly designed to protect against this. The research team agreed before commencing the study that interviews would be terminated should patients or staff members become distressed and appropriate support mechanisms for the distressed individual would be mobilized if necessary. In practice, this did not prove necessary and most participants commented that they found that the interview process helped them to clarify and resolve their thoughts and feelings about the untoward incidents.

All participants were asked for permission for their interview to be tape-recorded and all agreed to this. The tape-recordings of the interviews were transcribed verbatim. All participants entering the study were assigned anonymous code numbers and the tape-recordings, interview schedules and transcripts were stored and analysed only under these anonymous code numbers.

The transcripts of the interviews were analysed independently by three members of the research team using the technique of Miles & Huberman (1984). A first-level coding of the data was undertaken and these initial codes were then organized into a smaller number of themes in a second-level coding exercise. The data were examined in two ways: individual incidents were examined one by one to establish themes specific to each incident. The transcripts were then analysed as a whole to establish an overview of the data. The three different evaluators then compared their codings and interpretations and agreed a consensual coding of the data.

Results

Because of time constraints, in this pilot study six incidents were analysed in which both the patient and two staff members were interviewed. While analysing individual incidents, it quickly became apparent that the factual accounts from the different individuals interviewed generally supported each other. There were some discrepancies in the way that events leading up to the incidents were perceived by patients and staff and also some minor discrepancies between patient and staff accounts related to the aftermath of events, but the core chains of events were generally agreed by all. To maximize the coherence of the results, the presentation of the themes which emerged in the analysis are presented here in a sequential order that matches the order of occurrence of the events analysed.

Antecedents

The ward atmosphere: disturbed wards and disturbed patients

The admission wards at the research site were extremely busy with high levels of bed occupancy and many behaviourally disturbed patients. Both patients and staff identified antecedent factors relating to the concentration of disturbed patients on the wards creating a noisy and unsettling environment:

> I was ill… I was very distressed… I was manic and high at the time.
>
> We had a manic patient harassing and shouting abuse at [the patient].
>
> [I was feeling]… desperate. Just wanted to kill myself… suicidal.
>
> … the ward was very, very disturbed.
>
> At the time we'd had an awful lot of incidents, of different types, not usually involving restraint but things like self-harming, superficially coming free to the ward.

Seven of the 12 staff members highlighted that there had been events leading up to the index incident that had increased their awareness of the likelihood of further incidents occurring. That is, they acknowledged the effect of the disturbed environment on the patients:

> I know that staff on the ward was upsetting him but there was nothing I could do about it.

Failed communication

Much of what patients found unhelpful and unsettling in their experience on the wards related to the feeling that staff members did not speak to them or approach them or sometimes gave conflicting messages:

> I was told that I wasn't allowed out. Then [Doctor A] gave me a new medicine card and told me to go to the pharmacy, so I went to pharmacy for my drugs and came back and they were searching for me. [The doctor] has sent me to the pharmacy because she's known me so long, and yet I'm not supposed to be allowed out. So what do you do? You don't know where you stand here.
>
> They didn't want to know much. They should sit and talk to the patient. They should understand that you're in hospital because you're unwell.

Three of the six patients interviewed felt strongly that they had explicitly warned staff that their disturbing feelings and behaviours were escalating out of control. For one patient this was addressed through staff awarding extra individual time to her; however, despite this she still attempted a serious act of self-harm. Another patient emphasized how he felt that he had repeatedly warned staff that he was about to become aggressive but felt that his warnings were ignored:

> I got angry because they wouldn't listen to what I was trying to tell them. Telling them that I needed help, wanted to hurt myself… it was horrible, I never want it to happen again.
>
> They should have got him [another patient] out of the ward or got me out until he was gone. You warn them. I was saying, 'I'm gonna smack him when he comes out that room… It's going to kick off'. I warned [the agency nurse].
>
> I asked [the nurse] to use the phone and he said, 'use the pay phone', and I said to him, 'it's private and not for everyone to hear', and I was basically ignored. He says, 'Sorry, we're too busy' [for you to use the phone in the office], and it's not until I start the screaming and the shouting and losing my temper that anything is done.

In the midst of conflict

Fear and embarrassment

Patients reported a range of powerful and distressing emotions during the time of actual conflict with staff; in some cases these emotions were exacerbated by paranoid ideas about the ward staff:

> I didn't feel like I was a human being. I felt I was just a number. I thought they were going to kill me.

Two female patients reported being upset by the presence of male nurses during the incidents when they were restrained:

> It was unfair males restraining me. I didn't like that. Males are stronger than females and hurt more when they're restraining you.
>
> Disgusted that a male nurse was present… it was bad enough having the injection without the embarrassment of having a male nurse present. Only female nurses should be present when restraint or injections are given to female patients.

The last resort

Three nurses emphasized their distress and discomfort in implementing restraint when the team had decided that medications had to be compulsorily administered or other boundaries enforced:

> I don't like doing it. I hate face-to-face confrontation. I don't like resorting to force. It makes me feel like we've failed and it frightens me.
>
> It's one of those things that personally I don't like and any other way of dealing with it would be better. It's the last resort.
>
> I don't like incidents. I don't get any enjoyment out of them. They're an absolute last resort.

Planning, containment and support

Planning and talking about how imminent incidents would be managed was identified as important by four staff members:

> They talked beforehand about what they were going to do.
>
> The staff knew the patient well. They spent a lot of time with her. There was good communication before, during and after the incident. There was an awareness of how the patient had been because of previous incidents that weekend so we were able to talk about potential future difficulties as well as the problems that had been occurring over the weekend.

Five staff participants highlighted the importance of helping each other out, while a further four found the practical support from staff from another ward (the intensive care unit) helpful:

> I can only say that generally I have been very happy working with the team that I've been with, and I didn't feel that anybody was doing less than they should be expected to do.

Good teamwork was also viewed as important as was having policies in place to support and guide decision-making in respect of incident management.

The aftermath

Distress in the aftermath

The patients reported that the powerful and distressing emotions which had driven the incidents persisted in their aftermath:

> I was still angry, distressed.
>
> Disgusted… disheartened that I had stooped so low. I was upset that the nurses felt it was necessary to restrain me.
>
> Embarrassed… furious at reaching that point.
>
> Low, anxious, scared. I was in a side-room and they shut the door.

The staff mirrored many of the feelings expressed by patients, reporting anger, distress and frustration both at the failures of communications between themselves and the patients and at failures to meet patient needs:

> [I felt]… angry that he even contemplated doing it because we'd been talking over the previous few days and he had done other things.
>
> It's the frustration of not meeting her needs, although I try.

One of the incidents was particularly serious, involving an attack on staff members by a patient armed with a weapon. This incident generated proportionally strong emotions in staff members:

> I was terrified. I've never been so scared in all my life. The incident happened at 13.30. I didn't sit down until 16.20. I had wet myself because I was so terrified and I couldn't go home to change my trousers. The duty senior nurse wouldn't let me go because she said that she couldn't find a free trained member of staff throughout the hospital. I didn't want to tell her or anybody else that I'd wet myself so I had to stay in wet trousers until the end of my shift.

Resolution: patients – the need for understanding and support

The common content of what patients found helpful in the aftermath of the incidents was what they perceived as kindness in the staff and attention from staff. One patient, who had felt ignored and isolated from ward staff prior to and in the immediate aftermath of the event, described how a student nurse approached her:

> I don't know why they didn't sit down and talk to me. I'd been in a manic state. I thought that they'd try to come and speak to me. After [the incident] a student nurse came and spoke to me. It was the first conversation I had in days. I found that helpful. The ward staff involved were unapproachable.
>
> Crying on [Nurse F's] shoulder was helpful. The fact that he just let me cry on his shoulder.

One participant spoke at length about how staff had allowed time for her to examine her records and their observations of her after the incident. While at the time she had found nothing helpful, she later felt that this had enabled her to build up a more objective understanding of the incident:

> I've seen some of my records. It's helped to look at the impression that they had of me at the time. It's helped to build a better picture. The nurses have sat down with me and gone through my records with me. It feels better to look back with a better insight. You can see where you were going wrong. You can see where to make changes or where you've made changes. The nurses talking to me [subsequently] had helped. [Nurse C] just talking through incidents with me helps you feel calmer about it. It was good to talk it through afterwards especially if there has been awkwardness during the restraint.

However, despite the above, not all of the patients had experienced any therapeutic debriefing in the aftermath of their restraint:

> They never talked about it to me. That would have helped. If somebody had sat down and talked it through with me.
>
> They haven't discussed it with me, they haven't asked me how I felt or why I did it.

Resolution: debriefing

Staff members viewed debriefing as helpful whether it occurred formally or informally. They used the term debriefing principally to describe reviewing the events which had happened and evaluating their decisions and actions taken at each point of the proceedings:

> You are always thinking, 'could I have done something before the event or caught it before we had to do that?', and I think that once you can sit down and talk that reassures you when you've had that chance.
>
> Debriefing, even if it's only in the form of a cup of tea. Nothing major, but still useful. You never know how it's going to go and it's helpful to look back over it to see if you have done everything that you should.
>
> After support. I have very strong feelings about this. A more outside view can provide a more overall picture to help understand the situation…Having the opportunity to discuss the situation as soon as possible.

While debriefing was generally viewed positively, there were also issues of concern around possible harm that might arise from poorly managed debriefing. Two nurses described unhelpful experiences relating to a serious incident which occurred some months before, where debriefing had been set up some 6 weeks after a particularly disturbing incident:

> It was very unhelpful. It was poorly facilitated…[Manager X] wasn't the person to do it but she was the only one who offered. It felt as if we were going through the motions, but only one member of the team had the courage to tell her at the end of the session that he felt it had been poorly managed.

Another staff participant felt that you had to 'get on with it' and saw no need for debriefing; however, this was contrary to the view of the majority of staff participants who described debriefing as helpful for support and learning. One participant raised the issue that violent incidents always disrupt planned ward activities. Others reported frustrations from having to deal with a raft of pressing issues in the aftermath of incidents, such that talking to patients after events could be neglected:

> They want to talk about things afterwards and I think it can damage the relationship if you don't. Patients don't want someone just to come along, shout orders or whatever, or grab them without then going back and explaining or talking it through. You can end up with a lot of resentment.

This latter point certainly echoed the patients' feelings of being ignored in the aftermath of incidents and perhaps offered some explanation of why this may occur.

Other issues: patients

Fear of restraint

Two patients who had experienced previous admissions reported a fear of being restrained. Both of these patients stated that they realized that they were becoming unwell prior to admission, but had avoided contact with services because of their fear that if admitted they would get into conflict with staff and be restrained. This in turn had resulted in their situations escalating and their worst fears being confirmed by being admitted against their will, coming into conflict with staff and being restrained in hospital:

> My biggest fear before coming into hospital is being restrained. It puts me off seeking help because I'm frightened. I then become ill and end up being admitted and restrained anyway.

Restraint and re-traumatization

Disturbingly, three patients reported that being restrained brought back memories of previous violent incidents, including in one case the experience of having been raped, and in another case the experience of having been abused in childhood.

Agency staff

Throughout their interviews, the patients drew a distinction between regular ward staff and agency staff, the general sense being that ward staff had more invested in patient care than agency staff:

> They [the agency staff] are only in it for the money. They sit and watch telly, play pool and basically ignore the patients.

Other issues: staff

Ethical issues

Three nurses raised ethical concerns related to restraint. One also described her difficulties in balancing manipulation vs. coercion vs. persuasion:

> The use of restraint is unpleasant and undignified. The dilemmas that it causes add a lot of friction for the staff. You have to weigh up whether you're using manipulation, coercion or persuasion in managing difficult patients.

Re-traumatization

Members of the nursing staff also reported experiences of re-traumatization by the occurrence of violent incidents:

> Even smaller incidents like this can trigger thoughts of previous incidents [the nurse then went on to describe a particularly harrowing incident in which she had been involved].

Despite the many negative experiences highlighted both for staff and patients, it was clear from the interviews that the nurses felt a strong sense of a strong commitment to those in their care.

Discussion

The findings of this study present a grim picture of the experience of physical restraint for both staff and patients. Patients reported feeling ignored and unheard both before and, particularly, in the aftermath of untoward incidents. The study highlighted that patients often felt that they had given tangible and specific warnings of how they were feeling, and that they felt that these warnings were either ignored, not recognized or not adequately acted on by staff.

Most of the patients in this pilot study felt ignored in the aftermath of incidents and, while staff valued postincident debriefing, its provision was patchy and of variable quality. The staff experience of postincident debriefing ranged from informal debriefings over a cup of tea in the ward office through to more formal, externally facilitated meetings. The study illustrated a clear need to establish policies and mechanisms to ensure that adequate and professional after-incident debriefing is routinely offered to all staff and patients involved in untoward incidents in acute psychiatric inpatient units.

Patients viewed agency staff differently and much more negatively than permanent ward staff. Permanent ward staff were also critical of some agency staff. Although no agency staff were interviewed in this study, from the personal experience of the researchers it seems likely that agency staff were aware of these negative views. Given the current dependence of large sections of the UK psychiatric service on temporary staff (Gournay *et al.* 1998) there seems to be an urgent need to examine these issues in more detail and implement standardized training, orientation and accreditation protocols for these staff. The adoption of such an approach would ensure that all parties would be aware of what is expected of temporary staff. Temporary staff would be enabled to work more cohesively with permanent staff and have a greater sense of belonging and value, while patients might also feel safer and more valued as a result.

Current nurse training in the physical management of aggression in the UK predominantly means training in one of the several forms of C & R. These C & R courses teach aversive and reactive techniques of physical intervention which are unpopular with staff and, from the evidence of this study, sometimes actively feared by patients. Wright (1999) has stated that attempts to use these techniques by unskilled staff may lead to escalation and injury to staff and patients. These techniques ignore the importance of engagement, of surveillance and of taking patients seriously and acting on early warning signs to prevent aggressive and other untoward incidents from ever occurring.

Commenting on the ethical issues posed by the use of restrictive methods, Hopton (1995) has suggested that the use of force should be proportional, but also that the failure to use these methods may be harmful if patients, staff and others are not protected. He pointed out though that those subject to the use of these methods often feel a justifiable anger at their treatment, feeling that they have been oppressed and have had their privacy invaded.

C & R interventions are required to be carried out by trained three-person teams. The research site where this pilot study was undertaken has not been exempt from the staffing crisis affecting UK acute psychiatric services (Gournay *et al.* 1998). With the exception of the intensive care unit, there was rarely a full complement of three C & R-trained staff available on any single acute admission ward at the study site. This situation is not unique to the research site and lends further urgency to the task of reorienting training in the management of aggression away from the use of the effective, though unpleasant, intervention techniques of C & R and towards preventive techniques for defusing and calming aggression and distress.

Holzworth & Wills (1999) reported finding significant differences between individual nurses when making judgments about the imposition of seclusion or restraint. These differences were both in how they interpreted cues and in their choice of intervention strategies. Morrison (1992) has also reported that nurses often disagree about the potential seriousness of the risks posed by patient behaviours. This opens up the possibility that not all instances of restraint are inevitable and unavoidable, and Bunch & Shore (2000) have described programmes which have been successful in reducing incidents of restraint. Oberleitner (2000) has argued that seclusion and restraint approaches are invariably psychologically damaging and that alternative measures should be used.

By far the most disturbing finding of this study was that three of the six patient participants reported that being restrained brought back traumatic memories of previous incidents of abuse and violence. This finding in patients partly replicates the results of a study carried out in the USA by Smith (1995) which examined the psychological impact of being manually restrained and subsequently put in mechanical restraints (i.e. restrained on a bed or trolley via leather straps), on patients who had earlier traumatic

experiences of rape. Two out of the three patients in Smith's (1995) study experienced a 're-living' of their earlier experiences while they were in restraints. One of these subjects likened the experience of being restrained to that of being raped without the vaginal penetration. Echoing the experience of the patients, several members of the nursing staff in the current study also reported that the restraint incidents triggered memories of previous disturbing incidents.

While it is difficult to generalize from such a small sample, it is clear that further research is urgently needed to establish the extent to which this experience is common to patients who are restrained and to staff members who are involved in managing violent incidents in the UK. If replicated in wider studies, these findings would clearly have major implications for the management of aggression in psychiatric inpatient units. Smith (1995) linked the restraint experiences of the patients in her study to post-traumatic stress disorder, which further emphasizes the poverty of our understanding of the long-term impact of the experience of restraint on the mental health of both staff and patients. It seems astonishing given the frequency with which patients are restrained in psychiatric units throughout the world that this subject has been almost wholly ignored by nursing researchers.

Conclusion

This pilot study has demonstrated the feasibility of using semistructured interview techniques to explore the views, experience and feelings of patients and nurses involved in incidents in which the patient participants had been restrained. It was clear that the incidents generated strong and often disturbing emotions for all concerned. Half of the patients and several nurses reported that the incidents had reactivated distressing memories of earlier traumatic events. More research is urgently needed on the psychological effects of violent incidents and restraint in acute psychiatric units. The focus of this research should be both to chart the extent of the psychological distress and damage caused to patients and staff and to explore ways to protect against these effects. Also evident is the need to emphasize close engagement, prediction and prevention in training on the management of aggression and to move away from aversive intervention techniques.

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APPENDIX TWO

DSM IV-TR (APA 2000) CLASSIFICATION PTSD

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others

6. Restricted range of affect (e.g., unable to have loving feelings)

7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating

4. Hyper-vigilance

5. Exaggerated startle response

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or Without delay onset: Onset of symptoms at least six months after the stressor

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR (Fourth ed.)*. Washington D.C.: American Psychiatric Association.

Source: United States Department of Veterans Affairs, www.ncptsd.va.gov, accessed 22.08.07

APPENDIX THREE

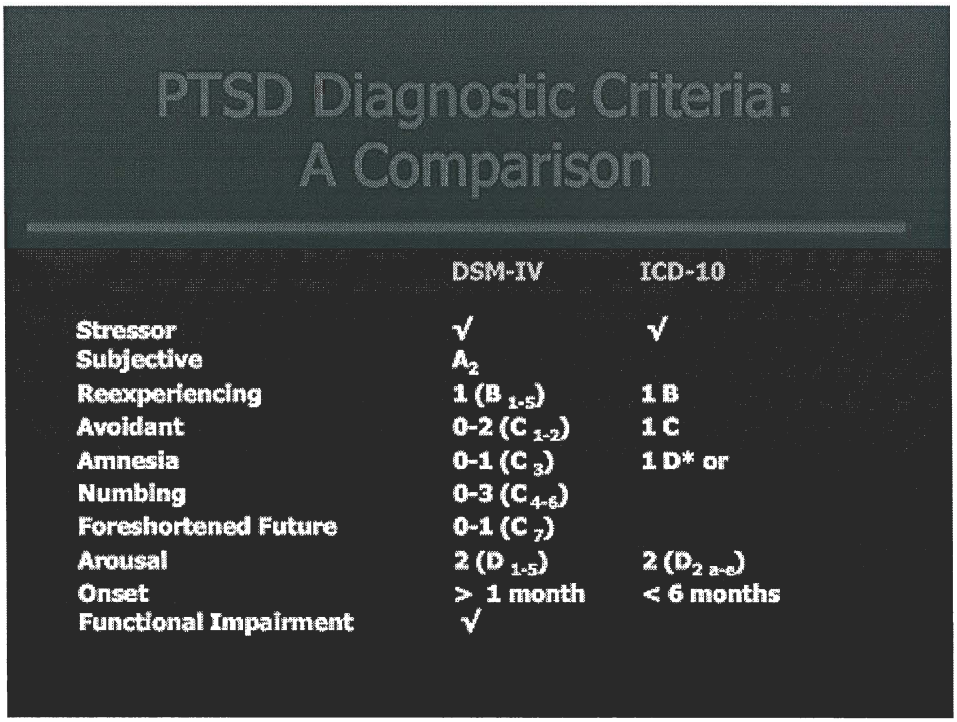
DIFFERENCES BETWEEN ICD-10 (WHO 1992) AND DSM IV-TR (APA 2000) CLASSIFICATIONS

Comparison of the ICD-10 PTSD diagnosis with the DSM-IV criteria

The DSM-IV is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), the criteria most widely used in the United States to classify mental disorders.

The International Classification of Diseases (ICD) is the classification used since 1994 by the World Health Organization (WHO). It has become the international standard diagnostic classification for most general epidemiological purposes. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines provides international guidelines for the diagnosis of PTSD.

The DSM-IV and ICD-10 criteria for diagnosis of PTSD are similar but there are also some differences.



Both diagnostic criteria for PTSD include a history of exposure to a traumatic event and symptoms from each of three symptom clusters and include intrusive recollections, avoidant symptoms, and hyper-arousal symptoms. An additional criterion concerns duration of symptoms. Differences are outlined below.

Criterion A: stressor

Exposure to a stressor. Unlike DSM there is no subjective stressor criterion (A2).

Criterion B: re-experiencing

Persistent remembering of the stressor in **one** (as is true in the DSM-IV) of:

- Intrusive flashbacks
- Vivid memories or recurring dreams
- Experiencing distress when reminded of the stressor

Criterion C: avoidance

Requires only **one** symptom of actual or preferred avoidance (DSM requires three and includes numbing and avoidance symptoms whereas the ICD-10 does not).

Criterion D: hyper-arousal

Either D1, or two of D2 (DSM requires two from this entire hyper-arousal cluster).

D1: Inability to recall

D2: Two or more of:

- Sleep problems
- Irritability
- Concentration problems
- Hypervigilance
- Exaggerated startle response

Criterion E:

Onset of symptoms within 6 months of the stressor. (Differs from DSM-IV that specifies symptom duration of greater than one month).

The ICD-10 also does **not** specify a functioning criterion. Plans for future revisions include a merging of DSM-IV and ICD-10.

References

World Health Organization. (1992). The ICD-10 Classification of Mental and Behavioural Disorders. Geneva, Switzerland: World Health Organization.

Source: United States Department of Veterans Affairs, www.ncptsd.va.gov, accessed 22.08.07

APPENDIX FOUR

COMPLEX PTSD (HERMAN 1992)

1. A history of totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organised sexual exploitation.

2. Alterations in affect regulation, including

- Persistent dysphoria
- Chronic suicidal preoccupation
- Self-injury
- Explosive or extremely inhibited anger (may alternate)

3. Alterations in consciousness, including

- Amnesia or hypermnesia for traumatic events
- Transient dissociative episodes
- Depersonalisation / derealisation
- Reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

4. Alterations in self-perception, including

- Sense of helplessness or paralysis of initiative
- Shame, guilt, and self-blame
- Sense of defilement or stigma

- Sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alterations in perception of perpetrator, including

- Preoccupation with relationship with perpetrator (includes preoccupation with revenge)
- Unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- Idealization or paradoxical gratitude
- Sense of special or supernatural relationship
- Acceptance of belief system or rationalisations of perpetrator

6. Alterations in relations with others, including

- Isolation and withdrawal
- Disruption in intimate relationships
- Repeated search for rescuer (may alternate with isolation and withdrawal)
- Persistent distrust
- Repeated failures of self-protection

7. Alterations in systems of meaning

- Loss of sustaining faith
- Sense of hopelessness and despair

Source: Herman, J. (1992) Trauma and Recovery: From Domestic Abuse to Political Terror, Pandora, London

APPENDIX FIVE

POST INCIDENT REVIEW

TVU

Room 2.2.30,
Prospect Park Hospital,
Honey End Lane,
Reading
Berks
RG30 4EJ

RESTRAINT AND TRAUMA IN MENTAL HEALTH CARE – AN EXAMINATION OF THE AFTERMATH OF RESTRAINT

Researcher:

Mrs Gwen Bonner, RMN, BA(Hons), MSc, PG Dip Ed. Senior Lecturer in Mental Health Nursing, room 2.2.50, Prospect Park Hospital, 01189 605625 or 07904 891205 891205891205

Instructions for use: please use the following questions as a guide to discussing the incident in which the participant was involved. Please use the prompts in brackets as guide to framing the questions. Please make brief notes to document the main points raised.

POST INCIDENT REVIEW – PART A

1. **I'm interested in what happened on** (date/time of incident) **when** (outline brief details of incident)

Notes:

2. **Can you describe to me what happened?**

Notes:

3. **Can you describe to me anything that was happening before this or which led up to it?**

Notes:

4. **Can you describe to me how you were feeling before** *(use patient / staff member's words to describe the incident)***?**

Notes:

5. **How did you feel during** *(use patient / staff member's words to describe the incident)*

Notes:

6. **Was there anything that you found <u>helpful</u> during** (*use patient / staff member's words to describe the incident)*

Notes:

7. **Was there anything that you found <u>unhelpful</u> during** (*use patient / staff member's words to describe the incident)*

Notes:

8. **How did you feel after** *(use patient / staff member's words to describe the incident)*

Notes:

9. **Was there anything that you found <u>helpful</u> afterwards?**

Notes:

10. **Was there anything that you found <u>unhelpful</u> afterwards?**

Notes:

11. **Do you think that there is anything that the staff or anybody else could do to help prevent something like this from happening again?**

Notes:

12. **Is there anything else that you would like to tell me about** *(use patient / staff member's words to describe the incident)*

Notes:

13. I am particularly interested in how this incident may have reminded you about other upsetting events that may have happened to you in the past. Can you tell me if this happened to you?

Notes:

If the participant responds negatively (ie, the incident did not remind him / her of any past events), ask if there is anything else related to the incident that they would like to tell you about and then finish interview.

If the participant responds positively, proceed with the following questions:

<u>PART B</u>

14. **Can you tell me a bit more about the earlier incident(s)?** (prompt: the interviewer should allow the participant to recount event(s) in their own words but should clarify any points as necessary, eg who was involved, how old were you, details of the event)

Notes:

15. Do you think that this / these earlier event(s) have had an effect on your life since they happened?

Notes:

16.Can you tell me about how your life has been affected? (prompt: allow the participant to describe in their own words how their life has been affected)
Notes:

17.Moving on to the recent incident that happened on the ward, can you tell me how it reminded you about the earlier event(s) that we were discussing? (prompt: for example some people have described being restrained as if they were reliving experiences of violence in earlier encounters. Clarify what role individuals involved in restraint took and who they may have represented from earlier incident(s)
Notes:

18.Did you feel as if you were re-living the earlier experience when the incident happened on the ward? (if so, clarify details of how long the experience lasted, the nature of the experience, did the participant continue to re-live the experience following the immediate period of restraint)
Notes:

19.Has the recent incident made you think about earlier events more than you would normally? (prompt: ascertain how much more, how regularly)
Notes:

20.Has the recent incident brought back memories that you had forgotten about or were not aware of previously? (prompt: ascertain details (if possible) of the participant's perception of how / why these memories may have resurfaced)

Notes:

21.Have you told anybody on the ward, for example a member of staff, about how the incident has reminded you of earlier upsetting events in your life? (prompt: the aim of this question is to ascertain whether the participant has discussed the experience apart from the earlier post incident consultation within this study)
Notes:

22.Has anybody on the ward, for example a member of staff, asked you whether the incident has upset you or reminded you of previous upsetting events? (prompt: the aim of this question is to ascertain whether the participant has been offered the opportunity to review events apart from the earlier post incident consultation within this study)
Notes:

23.Is there anything else that you would like to tell me?

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY

APPENDIX SIX

DEMOGRAPHICS PATIENTS

RESTRAINT STUDY – DEMOGRAPHIC DATA – SERVICE USERS

Name:

Sex:

Age:

Ethnicity:

Place of birth:

Status:

Diagnosis:

Number of previous admissions:

Length of contact with mental health services:

Previous history of aggression / violence (brief details):

APPENDIX SEVEN

DEMOGRAPHICS STAFF

RESTRAINT STUDY – DEMOGRAPHIC DATA – STAFF

Name:

Sex:

Age:

Ethnicity:

Place of birth:

ROLE / GRADE:

LENGTH OF SERVICE:

PREVIOUS TRAINING IN PREVENTION AND MANAGEMENT OF VIOLENCE:

APPENDIX EIGHT

PHYSICAL CONSEQUENCES OF RESTRAINT

PHYSICAL CONSEQUENCES OF RESTRAINT INCIDENT

Please highlight which of the following statements best describes the consequences of the recent incident in which you were involved:

Type of restraint used:

Gentle guidance to a place of safety with minimal force used.

Guidance to a place of safety with some force used (eg, take by each arm to a quieter area.

Restraint involving 2 or more staff while remaining upright.

Restraint involving 2 or more staff in the prone position (ie, lying on the floor.

Was seclusion used? Yes / no

If so, for how long?

Length of restraint (from beginning to end of 'hands on' restraint:

Less than 5 mins

5 – 10 mins

10 – 20 mins

20 – 30 mins

30 – 60 mins (please state length of time)

over 60 mins (please state length of time)

Physical injury:

No injury

Felt threatened or brief pain (less than 10 mins) with no visible injury

Physical pain (more than 10 mins) or visible injury not requiring any treatment

Injury requiring some kind of treatment but not necessarily by a physician

APPENDIX NINE

TRAUMA SCREENING QUESTIONNAIRE

THE TRAUMA SCREENING QUESTIONNAIRE

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened a few weeks ago. Please indicate whether or not you have experienced any of the following AT LEAST TWICE IN THE PAST WEEK:

	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Upsetting thoughts or memories that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		

APPENDIX TEN

EVALUATION OF POST INCIDENT REVIEW

Please complete this form after completing the post incident consultation with staff member / service user

EVALUATION POST INCIDENT CONSULTATION

On a scale of 1-7 where 1 = strongly disagree, 4 = neither agree nor disagree, and 7 = strongly agree, please rate the following statements:

1. **using this consultation framework provided me with an opportunity to discuss the aftermath of an incident of restraint which I may not otherwise have had the opportunity to do.**

   (Strongly disagree) 1……..2……..3……..4……..5……..6……..7 (strongly agree)

2. **this consultation allowed me to think about some of the events leading up to the incident.**

   (Strongly disagree) 1……..2……..3……..4……..5……..6……..7 (strongly agree)

3. **this consultation helped me to think about how the incident was managed.**

   (Strongly disagree) 1……..2……..3……..4……..5……..6……..7 (strongly agree)

4. **on reflection, I think that the incident could have been predicted.**

   (Strongly disagree) 1……..2……..3……..4……..5……..6……..7 (strongly agree)

5. **on reflection, I think that the incident was managed well.**

   (Strongly disagree) 1……..2……..3……..4……..5……..6……..7 (strongly agree)

6. **I think this consultation would be a useful way of reviewing incidents of restraint that happen in practice.**

   (Strongly disagree) 1……..2……..3……..4……..5……..6……..7 (strongly agree)

Any other comments:

Thank you for the time that you have taken to complete this form

APPENDIX ELEVEN

PARTICIPANT INFORMATION SHEET

TVU

MENTAL HEALTH STAFF AND SERVICE USER INFORMATION SHEET AND LETTER OF INVITATION

RESTRAINT AND TRAUMA IN MENTAL HEALTH CARE – AN EXAMINATION OF THE AFTERMATH OF RESTRAINT

Researcher: Gwen Bonner, Senior Lecturer in Mental Health, Thames Valley University, Telephone 01189 605625 mobile 07904 891205
Email: gwen.bonner@tvu.ac.uk

You are being asked to take part in a research project. Please do not be put off by the title. This is a study about what happens to mental health service users and staff after incidents that happen during a hospital admission. An incident may be something upsetting that has happened – a person may have harmed themselves or someone else. A member of staff or another service user may have done something upsetting which could have made things worse for you or somebody else on the ward.

I would like to find out more about how these incidents affect people and about what is helpful following these incidents on the ward. If I can gather enough information it may help to understand the best way to deal with what happens after these incidents. This would help staff in caring for service users in the future by learning ways of managing the aftermath of these incidents more effectively.

I would like to invite you to help me with this study. If you agree, a member of staff will ask you some questions about an incident that has happened to you. You will also be asked to complete a simple form about how the incident has affected you.

What will I have to do if I want to take part?

If you agree to take part, a member of staff will come and see you in a private area on the ward. If you would like another nurse, family member, or friend to sit with you this can be arranged. The member of staff will ask you to complete a simple form asking questions about how the incident has affected you and will then go on to ask some questions about the incident. If you decide during the meeting that you do not want to take part or you want to leave then you can do so.

APPENDIX TWELVE

CONSENT FORM

Room 2.2.30,
Prospect Park Hospital,
Honey End Lane,
Reading
Berks
RG30

Telephone: 011189 605242
Mobile : 07904 891205

CONSENT FORM FOR PARTICIPANTS

RESTRAINT AND TRAUMA IN MENTAL HEALTH CARE – AN EXAMINATION OF THE AFTERMATH OF RESTRAINT

Researcher:
Mrs Gwen Bonner, RMN, BA(Hons), MSc, PG Dip Ed. Senior Lecturer in Mental Health Nursing, Thames Valley University

Have you read the Invitation Letter/Information sheet? **Yes/No**

Were you given an opportunity to ask questions and discuss this study? **Yes/No**

Are you satisfied with the answers to your questions? **Yes/No**

Do you consider that you have received enough information about the study to make your decision?

Have you spoken to Mrs Bonner, researcher? **Yes/No**

Do you understand that you are free to decline entry into the study and to leave the study at any time without having to give a reason for leaving and without affecting the standard of your medical care?

Yes/No

Do you agree to this interview being tape recorded for the benefit of the researcher ? (please note that recordings will be kept in a locked cabinet which will only be accessed by the researcher, her assistants and her PhD study supervisors)

Yes / No

Do you agree to any points made in your interview to be used as quotes in any papers that are published after the study?
(please note that any quotes will be made anonymous with no reference to your identity)

Yes / No

Do you agree to take part in the study ? **Yes/No**

Signed..... **Date**.....
Name (in block letters).....

APPENDIX THIRTEEN

TRUST PROPOSAL FOR POST INCIDENT REVIEW IMPLEMENTATION

DRAFT PROPOSAL FOR IMPLEMENTING POST INCIDENT REVIEW AND SUPPORT TO STAFF – BERKSHIRE HEALTHCARE NHS TRUST

Background:

Post incident support for staff is a growing area of concern in mental health settings. There is an emergent evidence base which suggests that there is a patchy and inconsistent approach within the UK to organisations offering accessible mechanisms for staff to access support (Wright 2000). For serious untoward incidents, reporting systems are in place but there is much less clarity at a more local level for less serious events that happen in practice. The NICE (2005) guidelines on Prevention and Management of Violence and Aggression, for example, suggest that some form of review should take place and that supports should be mobilised if necessary but these guidelines are not clear about how this should be operationalised or what form it should take. While Occupational Health and Staff Counselling Services offer some mechanisms to address staff psychological needs, these are often not accessed, not always cost effective, and do not always provide the less formal approach which staff within mental health settings appear to prefer (Nolan et al 1999; Bonner et al 2002; Lee et al 2003).

Proposal:

It is proposed that a system of easily accessible post incident support be set up for all localities within the Trust. The aim would be to have a list of practitioners who have received in-house training in post incident staff support. They would be nominated staff representatives from different localities that may have an interest in participating. A training session in post incident review and support would be provided to these staff and their contact details would be kept on a central list of trained post incident review staff. These practitioners could be accessed by staff groups within all of the Trust localities to come and review incidents in a non-threatening way. Providing a list of accessible staff would enable a system of choice for practice areas and overcome some of the issues which have been reported in relation to staff not accessing support because of fear of recrimination. Staff could choose a trained practitioner with whom they feel comfortable.

Implementation of review:

List of post incident review / support staff available in all localities

↓

Following incident, staff group agree person from contact list to facilitate review

↓

Arrangements made for support link to meet practice staff

↓

At this meeting: review of incident using psychological first aid model
Use of educational material
Education re screening for trauma symptoms (TSQ)
Follow up contacts and support offered

APPENDIX FOURTEEN

CASE STUDY

Bonner, G. and McLaughlin, S. (2007)

The psychological impact of aggression on nursing staff, British Journal of Nursing, 16(13), 810-814

The psychological impact of aggression on nursing staff

Gwen Bonner, Sue McLaughlin

Abstract

Aggression and violence towards nursing staff in UK health care is a growing problem. While the National Institute for Health and Clinical Excellence's (NICE, 2005a) guidelines *'The Short-Term Management of Disturbed/ Violent Behaviour in In-Patient Psychiatric Setting and Emergency Departments'* offer a way forward in managing aggression for healthcare staff, the psychological impact of aggression remains an area of concern. Post-incident review has been identified as an approach to considering untoward incidents of aggression, yet post-incident support and interventions for staff experiencing the psychological effects of aggression remain inconsistent and curtailed in many areas. This article discusses the case of a nurse who experienced post-traumatic stress disorder as a result of aggression in the workplace. The process of assessment and treatment is presented with underpinning theories of trauma used to illuminate the discussion. Practical use of current recommended treatments of cognitive behavioural therapy and eye movement desensitization and reprocessing is offered as a method of addressing a growing problem in UK health care.

Key words: Aggression ▪ Cognitive behavioural therapy ▪ Post-traumatic stress disorder ▪ Post-incident review ▪ Violence

Aggression and violence in UK health care is a growing problem which is being addressed in a variety of ways – from local initiatives through to Government level in the form of the zero tolerance approach to aggression and violence (Department of Health, 1999; Health and Safety Commission, 1999; Whittington and Higgins, 2002; Farrell et al, 2006; Health and Safety Executive, 2006; National Health Service Employers, 2006). The focus of such policies is towards the prevention of aggression and the success of these initiatives will be measured over time. Despite attention being given to prevention of aggression and violence, it is unlikely that aggression will be eliminated and the psychological impact for staff remains under researched.

Aggression takes many forms, the most obvious being physical assault; however, less tangible and more common forms of aggression, such as bullying and verbal abuse, are gaining recognition as having as great a psychological impact upon staff as physical violence, with victims often experiencing, at the very least, fatigue, irritability, embarrassment, humiliation, low self-worth and anxiety (Whittington and Wykes, 1992; Walsh and Clarke, 2003; Needham et al, 2005; Rowe and Sherlock, 2005). The aftereffects of aggression for staff who have been involved in such encounters can range from being slightly shaken, through to being distressed and upset for some days or weeks, through to post-traumatic stress disorder (PTSD) (Bonner et al, 2002; Needham et al, 2005; Inoue et al, 2006).

Post-incident support for staff has been highlighted as an area worthy of attention, yet there remains little guidance as to what form of support should be offered (Nolan et al, 1999; Lee et al, 2003). National Institute for Health and Clinical Excellence (NICE) (2005a) guidelines for prevention and management of violence suggest that a review should take place within 72 hours for all parties involved, but offer little guidance as to how this should be implemented in clinical practice. While staff value post-incident review and support, it is not often available to them and clear systems of review and support are non-existent in some clinical areas.

Gwen Bonner is Senior Lecturer and Sue McLaughlin is Developmental Lecturer, Thames Valley University, Reading

Accepted for publication: June 2007

Case study

Anna (pseudonym) was a staff nurse on an acute mental health ward who was attacked by a patient. The circumstances surrounding the incident had been that Anna had returned from leave and been given a handover of the new admissions to the ward. She had noticed that Peter (pseudonym) had been agitated, restless, interfering and was not responding to any verbal attempts by her to try and ascertain the reasons for his agitation. She was also aware before the incident that staff on duty were avoiding Peter and were reluctant to engage with him. His agitation escalated and she was subsequently attacked by Peter. She sustained physical injuries for which she had to take sick leave and she developed symptoms of post-traumatic stress disorder over the coming weeks, eventually being referred to the local trauma service by occupational health.

Studies have found that 7–17% of staff may experience PTSD as a result of aggression (Caldwell, 1992; Richter and Berger, 2006), as part of the first author's current PhD study it has been found that 67% of staff interviewed following an experience of restraint had sub-clinical trauma symptoms following the incident. Although these symptoms were not rated highly enough to warrant further assessment for PTSD, nevertheless they were distressing to the staff involved. This supports Caldwell's (1992) study which found that 61% of staff had PTSD symptoms but did not meet full criteria for clinical diagnosis following assault (see Case Study for how staff who have gone on to develop PTSD can be successfully treated and return to work following treatment).

Assessment and treatment

Anne completed a variety of assessment measures (Table 1) to ascertain the extent of her symptoms and establish whether she fulfilled diagnostic and statistical manual of mental disorders (DSM-IV) criteria (American Psychiatric Association, 2004) for PTSD. With the evidence gathered via the battery of assessment tools and through subjective assessment of Anne's presentation, she clearly fulfilled assessment criteria for PTSD and further treatment was warranted. She was keen to engage in treatment as soon as possible and a course of treatment was agreed with her.

According to NICE (2005b) guidelines for PTSD, the first line of treatment would be cognitive behavioural therapy (CBT), which is a well-established, evidence-based approach. CBT can be supplemented with eye movement desensitization and reprocessing (EMDR), which is also a recommended treatment within NICE (2005b) guidelines. Ehlers and Clark (2000) describe the cognitive model of PTSD as related to the manner in which the trauma has been processed by the individual. Two key processes impact upon the development of PTSD, one relates to the way that the individual has appraised or interpreted the trauma, and the second process involves the nature of the memory of the event and how it is linked to other memories.

Brewin (2001) explains that experiences of trauma are encoded in situational accessible memory (SAM) which encodes non-verbal data, such as smells, pictures and sounds; and verbally accessible memory (VAM) which is narrative based. VAM is linked to abilities to evaluate and integrate past and present experiences, as well as future consequence. When an individual experiences trauma these processes can be encoded differently to other experiences as a result of the autonomic responses that the individual experiences during the trauma. The fight, flight, or freeze response to stress results in distortions in focus and the encoding of the experience can be limited.

Table 1. Assessment scales used

Assessment scale	Type of assessment	Clinical range/cut off points
Impact of event scale (Horowitz et al, 1979)	Scores related to impact of the traumatic experience	Clinical cut off 26
Beck depression inventory (Beck, 1996)	Depressive symptoms	0–9 Normal 10–15 Mild 16–19 Mild-moderate 20–29 Moderate-severe 30–63 Severe
Post-traumatic stress disorder symptom scale- self report	Diagnostic tool based on DSM-IV criteria	At least one re-experiencing symptom At least 3 avoidance symptoms At least 2 arousal symptoms
General health questionnaire (Goldberg, 1981)	Measures somatic symptoms, anxiety, social dysfunction and depression	Clinical cut off 4/5 for each section
Hospital anxiety and depression scale (Snaith and Zigmond, 1983)	Anxiety and depression	0–7 Normal 8–10 Mild 11–14 Moderate 15–21 Severe

In terms of SAM the amount of detail may be distorted, for example, small detail, such as a smell which may have been present at the time of the trauma is interpreted with more significance than in more normal circumstances.

Other detail may be missed, for example, images of the scene. To illustrate these points, in the case of Anne's recollection she could clearly remember the smell of the patient's clothes when he was attacking her but had difficulty in remembering other people who were present on the periphery during the attack. In terms of VAM, recollection of the memory may be inadequately integrated within the autobiographical memory, in other words the memory does not fit with that person's running narrative of their life view and experience. They are subsequently unable to place the experience within a context of time, place or person. To illustrate this in relation to Anne, she had felt overwhelmed by the attack and feared for her life. She had no prior experiences with which she could integrate this event and was therefore unable to mentally place or store the experience.

The result was that she could not assimilate that this event, which had been time limited, was now over, and she was now safe. The effects of these processes can result in symptoms of PTSD. These symptoms include a re-experiencing of the event, which may take the form of intrusive thoughts or images of the event; avoidance of stimuli associated with the event, which may take the form of avoiding thoughts and activities that are associated with the trauma; numbing of general responsiveness, which may be depicted as restricted affect, such as feelings of detachment or inability to experience feelings such as love; and increased arousal, which may manifest as irritability, hyper vigilance or exaggerated startle response.

Trauma-focused interventions

Anne's assessment had highlighted that she was experiencing symptoms related to all of these criteria. She had a re-experiencing of the event which took the form of nightmares and images of her attacker on the faces of strangers she passed on the street; she was avoiding work since the experience; she felt numb and felt unable to experience feelings of joy or happiness which was unusual for her; and she felt hyper vigilant, on edge, and jumpy most of the time.

The aim of trauma-focused CBT is to facilitate integration of incomplete processed material related to the trauma and to challenge negative appraisals of the event through restructuring of the narrative with the client. Ehlers and Clark (2000) suggest that the trauma memory needs to be integrated within the client's preceding and subsequent experiences in order to prevent continued re-experiencing of the event. This can enable the client to incorporate the trauma within the here and now, thus providing a context within which the experience can sit.

Working through the narrative or the client's story with the help of a trained clinician can assist in restructuring material through integrating the narrative within the here and now, highlighting hotspots (problematic appraisals of the event) through cognitive reprocessing, and challenging negative appraisals through cognitive reframing. EMDR can assist in the processing of hotspots as well as reducing some of the more distressing symptoms of re-experiencing associated with these idiosyncratic appraisals. EMDR involves the use of dual attention stimuli to facilitate information processing (Shapiro, 2001). The client focuses on disturbing images related to the trauma while simultaneously focusing on an external stimulus, such as visually following set hand movements of the therapist or simultaneous hand tapping.

According to Shapiro (2001) this procedure activates the information-processing system and allows adaptive processing of the disturbing material. Homework exercises, methods of relaxation and educational material are provided as the means to supplement therapy and assist the client in moving forward as quickly as possible.

An explanation of the treatment was offered to Anne and education material had been provided at earlier assessment. This had been helpful to her in terms of trying to normalize her feelings and symptoms, but she had not been given this material until 3 months after the incident when her symptoms of PTSD were well established. She was provided with further self-help references to which she agreed to access independently. Anne was particularly distressed with a recurring nightmare which involved her waking with her attacker's hands around her throat. This happened most nights and she had difficulty in bringing herself back to reality when this happened, feeling as if she was still experiencing the event even though she was awake in her own bedroom. Her sleep was greatly affected by this and she saw this as one of her main problems. Grounding techniques were discussed as a method of introducing an external stimulus which can help to revive individuals from this trance like state and return to reality.

Use of grounding techniques

Grounding involves use of distraction as a strategy to detach from emotional pain by focusing upon an external stimulus using mental, physical, or soothing techniques. Mental distraction can involve focusing the mind on activities, such as counting, describing surrounding environment, or describing activities to divert attention from distressing thoughts. Physical grounding involves focusing on the senses for distraction, e.g. by running cool water over the hands or smelling essential oils. Soothing grounding involves focusing on soothing thoughts or statements such as 'I am a good person, I will get through this' (Najavits, 2002).

Anne agreed that the use of an essential oil such as lavender (the smell of which had no connection reminiscent of the incident) may help with this. A narrative approach was discussed initially with a view to using EMDR, if necessary at subsequent sessions. In addition, use of visual imagery techniques were facilitated to help Anne reduce symptoms of anxiety through a 'safe place' exercise.

Creating a safe place

Before embarking on this exercise Anne was asked to rate her subjective units of distress (SUDs). This is a way of

measuring distress when working with clients individually to ascertain levels of anxiety and discomfort. These units are usually ranked from 0–10, where 0 means that the client is experiencing no distress whatsoever and 10 means that they are extremely distressed. At the start of this exercise Anne rated her SUDs as 7.

Anne was encouraged to think of a 'safe place' that she may be able to recall. It is preferable that the safe place is not connected to any memories which may later affect the client's progress. For example, if the client remembers a seaside resort as a child and recalls feelings of happiness and relaxation but at a later session discusses how she was raped on a beach, the 'safe place' may no longer be symbolically safe and may worsen symptoms. It is also encouraged that family or close friends should not be included in the scene for similar reasons, for example, a happy event with a husband may not be as helpful if it subsequently transpires that the client's husband is being unsupportive to the client at the present time.

Anne was able to recall a landscape from her childhood which she had found relaxing and invoked warm memories for her. She was able to recall smells and sounds which were later to be helpful to her when using the technique. After the exercise she rated her SUDs as 2, a positive reduction from the previous assessment. Her homework was to read some of the material that she had been provided with and start work on her narratives which would be examined the following week.

Use of eye movement desensitization and reprocessing (EMDR)

Anne returned the following week and the challenging task of working through her narrative to integrate the trauma began. Facts, thoughts and feelings around her narrative were considered, keeping the discussion within the present tense. This assists in the process of contextualizing the event. She was able to recall many aspects of the trauma in great detail but other aspects were still curtailed. She was very angry with colleagues and through looking at facts, thoughts, and feelings in relation to this anger, she was assisted to depersonalize some of her colleagues' actions. Over the weeks, she began to contend with some of the areas of her life that she had been avoiding since the trauma, such as socializing with friends and family.

After working through Anne's narrative she still had some negative cognition which proved difficult to shift. For example, where she had felt confident and successful in her work before the incident she now felt that she doubted herself and she was unsure if she could succeed. She was still experiencing some sleep disturbance. EMDR techniques were used to target the remaining symptoms which had been proving difficult to shift through CBT. EMDR involves the use of bilateral stimulation to free information processing systems which in turn allow links to more adaptive information within the memory (Shapiro, 2001). The eye movements stimulate both hemispheres in the brain which enable processing in a similar way to rapid eye movement (REM) sleep on the unconscious mind. The assumption in this model is that the processing of the trauma that was ineffectively coded through SAM and VAM can be spontaneously processed through use of EMDR to reconnect the networks, facilitating insight and change. Measurements of SUDs are taken throughout the process, the aim being to reduce them to zero.

Table 2. Pre- and post-treatment scores

Assessment scale	Before treatment	After treatment
Impact of event scale	55	6
Beck depression inventory	17	11
Post-traumatic stress disorder symptom scale – self report	13 (re-experiencing) 10 (avoidance) 13 (arousal)	2 2 5
General health questionnaire	5 (somatic symptoms) 7 (anxiety) 6 (social dysfunction) 0 (depression)	2 2 2 0
Hospital anxiety depression scale	11 (anxiety) 11 (depression)	4 8

EMDR had a significant effect on the residual symptoms that Anne was experiencing. Within two sessions her SUDs ratings were zero and she was actively planning her future with renewed confidence. Anne's ratings on all of the assessment scales had also reduced significantly and were all below clinical cut off points (Table 2). She was able to reflect on the event without the distress that she had previously experienced and, although she still wished that it had not happened, she was able to think about some of the positive aspects that had resulted in relation to her 'not taking life for granted', a common response from people who have successfully come through a life-threatening experience such as this.

Conclusion

With Anne's agreement she wrote a brief account of her experience of therapy which is included below with her consent:

> 'Quite a few of us have experienced trauma either as a child or as an adult and sometimes both. We freeze certain parts of ourselves after trauma, pushing the memories back out of sight. From this place, we lose our connection to all of who we are. Our fullness is repressed, our creativity suppressed. After the incident I never thought I was going to be affected that badly. I started counselling for my traumatic experience, which I found to be very helpful. After a couple of weeks the counsellor spoke

to me about EMDR, wanting to know if I had heard about this technique. I replied no, so she explained the process and procedure to me. I was very sceptical about the whole process and being negative about the procedure. I went away and did my own research and was impressed... the treatment had its positive and negative sides but the comments were more on the positive side. The process helped me to bring to mind negative thoughts caused by the incident, for example your mind acts like a moving train bringing the negative thoughts forward and changing them to positive and new thoughts you want to have. It also helped me to always return to my safe place at any given time when I am distressed or finding it hard to cope and deal with my thoughts on an everyday basis. I found EMDR to work safely and rapidly. It helped me to restore normal ways of dealing with my problems. EMDR is a creative and safe way to see what is in the way of living a full, joyful life. Therefore I will recommend this technique to anyone who wants a way out of that dark place and to safety, love and happiness again' (Anon, 2006).

The psychiatric impact of aggression towards nursing staff remains under researched and post-incident support remains curtailed in many areas. This case study has highlighted how staff who have developed PTSD as a result of aggression can be treated successfully and return to work to resume their careers. BJN

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KEY POINTS

- Many nurses face aggression and violence in the course of their everyday work.
- The psychological impact of aggression can be great for some nursing staff.
- Post-incident review can identify nurses who may have experienced psychological effects following an incident of aggression.
- Trauma focused treatments, such as cognitive behaviour therapy and eye movement desensitisation and reprocessing can help nurses who have developed post-traumatic stress disorder as a result of aggression and violence in the workplace.