A THEMATIC ANALYSIS OF FACTORS INFLUENCING DECISIONS TO USE PHYSICAL RESTRAINT IN ACUTE MENTAL HEALTH SETTINGS

by

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ABSTRACT

This study investigates the factors that influence nurses' decisions to use physical restraint or to attempt alternative interventions within acute mental health inpatient settings. The objective was to better understand the background to these decisions in the hope that this will lead to the development of more consistent and justifiable approaches to challenging behaviour displayed by some mental health patients.

Eight nurses working or recently working in acute mental health services in two different District Health Boards were interviewed using a semi-structured interview technique. The sample was purposive, with participants being asked about their experiences with physical restraint, using specific events from their clinical practice. These interviews were then reviewed by the researcher and note taken of areas for further exploration or clarification. A second interview focussed on the areas identified as of particular interest to this research. 32 events of restraint use or near–use were related to the researcher, giving a significant amount of data for analysis. A thematic analysis approach was used to identify and examine themes within the data.

The central thesis emerging from the data and its analysis is that much of what influences nurses' decisions relates to intrinsic factors such as their attitudes towards the patients in their care, whether the patients are appropriately domiciled in mental health services, and assessments of the causes of the challenging behaviour. The importance of working as a team and trusting colleagues emerged as a strong yet previously under-researched theme. Implications for nursing practice are discussed. Particular emphasis is placed on the further development of Calming and Restraint programmes for nurses working in acute mental health settings. The need to address the background attitudinal factors from both a training and service delivery perspective is strongly evident.

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The participants in this research are thanked without limit for their incredible honesty and willingness to share not just their thoughts but their feelings regarding the use of restraint. The fact that restraint remains controversial and the subject of considerable scrutiny makes their contribution all the more outstanding. To my nursing colleagues who listened to my thoughts about the direction of this thesis and its content I am grateful. In particular, Katie Bolton, who shares an office with me and therefore cannot escape, has provided much needed support and encouragement. Keith Roffe provided invaluable information and insight into the background of Calming and Restraint and its introduction into New Zealand. My good mate, Charles Brown, always believed this thesis was important and would be completed. Charles provided immense psychological support throughout: I couldn't have done it without him.

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Chapter I

Introduction

This study investigated the factors that influence nurses' decisions about whether or not to use physical restraint. The area of practice studied is that of acute mental health services within New Zealand. A thematic analysis approach was used to analyse data collected through interviews with nurses who were working in mental health services. The findings were discussed and compared with the extant literature in this field of enquiry.

Nursing regards itself as 'the caring profession' (Arman & Rehnsfeldt, 2006) yet in mental health nursing patients are, on occasions, physically held and prevented from having freedom of movement, an intensely disempowering act. That this happens in other areas of health service delivery is beyond dispute, however the justification that this is done in the best interest of the patient (Gilbert & Counsell, 1999; Minnick, Mion, Leipzig, Lamb, & Palmer, 1998) appears to hold sway and minimises the scrutiny of this practice, compared to the practice of restraining in mental health. Much of this may be related to the perceptions of the nature of illness a clinician observes and the intensity of the physical intervention. Perhaps there is also a greater acceptance of paternalistic approaches to 'what is needed' than exists within the contextually, socially, legally and philosophically complicated scope of mental health. Lakeman (2000), speaking in context of mental health services, asserts that "whenever coercive methods are used there is a potential ethically problematic situation in that the person's autonomy is compromised" (p44). Belkin (2002) further contends that psychiatric work involves "coercion and authority over the actions of others," (p 664) and that therapeutic advances are, in effect, just reconstituted forms of restraint. These views appear as common themes throughout much of the literature on restraint use in mental health and aged care settings, giving rise to the challenge of justifying the decision to reduce a person's (patient's) autonomy.

The underpinning concept of viewing disturbances of the psyche as 'mental illness' is itself open to challenge. From outside the traditional mental health services, and often perpetuated in popular press with support from agencies such as the Church of Scientology and their high profile celebrity advocates, anti-psychiatry and 'survivor' movements, there are strong views about the nature of mental illness, whether it actually exists at all, and the ways in which society deals with the problems of disturbed psyches (Richards, 1985; Rissmiller & Rissmiller, 2006; Stevens, 1995, 1997). From within the associated professions, most notably from (seminal) authors such as Dr Thomas Szasz (1970), similar questions as to the reality of the concept of mental illness arise. More recently Professor Nancy Andreasen (2005), one of the authors of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM IV), challenged the medical, neurological, and pharmacological approach to what is known as 'mental illness.'

Historically, nursing has struggled to identify itself independent of medicine (Cook & Webb, 2002), further complicating the environment in which mental health nurses operate. In the midst of this complicated environment exists a group of people, identified as mental health patients (or clients or consumers, though those terms suggests a significant choice in the matter) who, for a variety of reasons, may be physically restrained during their involvement with mental health services, often in a manner which would not usually be seen in general medical settings.

The Historical Context of Calming and Restraint in New Zealand

Restraint of mental health patients has long been a part of landscape of providing 'care' for those deemed mentally unwell. Whether by the mechanism of enforced detainment in lunatic asylums, the use of mechanical devices, or the application of physical force, people were made to conform to standards of behaviour considered to be contextually acceptable within the institutions for people with mental illness. As far back as 1883 George Graham in his report to the Colonial Secretary of the New Zealand Department of Lunacy on Lunatic Asylums of the Colony (in Hansard, 1883) referred positively to the minimal use of physical restraints in the various asylums, which was seen as something to be

applauded but also recognised that restraint was a part of the landscape of asylum life. He was also critical of the attendant's (staff member) response to an escaped man, to whom the attendant used bad language and "unnecessary violence" (p89). The attendant was subsequently suspended and an investigation occurred. The acceptance that restraint is necessary at times, but that its use should be controlled and subject to scrutiny has existed for an extended period, at least within the departments and politicians involved in the administering of mental health services, and been the subject of numerous inquiries and research, both locally and internationally (Blom-Cooper, Brown, Dolan, & Murphy, 1992; Mason, 1988, 1996; Milliken,1998; Paterson, Bradley, Stark, Sadler, Leadbetter, & Allen, 2003).

A personal correspondence (dated 1989) from a psychiatrist with many years experience of both institutional care and mental health services associated with general hospitals is enlightening in terms of its context and the beliefs which appear to underpin it. Much of this communication focuses on the containment and control of patients who may be regarded as dangerous to themselves or others. There is no emphasis on attempts at calming or defusion and the emphasis is on the application of sheer force in numbers:

> Most head nurses selected the (patient's safety) team as they would select moderately large muscular men in their prime for the hospital's fire brigade. Each member of the team had to be happy with every other member of the team. Each needed to know that there was not a man among them who would fail to give support in an emergency.

There are some significant differences in this statement compared to current practice, in that muscular strength and gender are considered important, in contrast to more recent training that emphasises technique. The telling similarity between older and current approaches however, is that members of the team must have confidence in each other and their commitment to the process of maintaining safety. Given the diverse opinions about the place of restraint in mental health nursing, this has become increasingly complicated over the years, rather than simpler. The language of the communication is significant in that the terms such as "attack" and "dangerously violent" were used, and nurses were advised to have a hypodermic syringe with 10cc of Paraldehyde at the ready for

the "inevitable" calming injection. In previous times the options were more limited than today, in terms of treatments for acute agitation (possibly leading to violence), facilities for safe containment, and the level of training of the attendant staff. That this method encouraged a rather 'macho' approach is further exemplified by the following comment from the same correspondent;

> [the patients]....might fight back by grabbing one finger of the first nurse approaching with the soft mattress and dislocate the finger by forcing it straight backwards. Such events make it important that the men in the team are of a type who keep advancing undeterred.

This is not too dissimilar to my personal experience in the early years of my mental health nursing, with value being placed on those nurses who were capable, confident, and committed to action at times when restraint was seen as necessary.

Development of Calming and Restraint in New Zealand

The use of formalised Calming and Restraint methods is a relatively new phenomenon in New Zealand, starting in the early 1990s. This was largely driven by the unfortunate death of a mental health patient in the early 1980s following his restraint, transportation, and placement into seclusion (Gallen, 1983). The circumstances around this incident have been described as something akin to mob rule with all the chaos inherent in such settings (Gallen, 1983). My experience of mental health nursing in the 1970s and 1980s in New Zealand would support such a conclusion: the main method of managing potentially violent behaviour was to call in as many (preferably large) male staff as were readily available, who would adopt an approach that reinforced what was a "rugby team" culture in the institution concerned. Patients were tackled to the ground and contained with force of numbers in a not particularly co-ordinated manner, often resulting in injury (usually minor) to patients or staff members. It was rare for there to be much preparatory planning in terms of which staff would contain which limb, or how they would go about effecting that containment. The culture of the institution was such that these events were reported but minimised, and expectations of an enforcement type role were placed on male staff. Debriefing usually consisted of a cup of tea and a cigarette in the staff room

following the event with little reference to, or analysis of, what had actually occurred.

Control and Restraint (C&R) methodology was originally developed by the (British) Prison Service Physical Education Department in 1981 to assist in dealing with violent inmates who may be self injurious, a risk to others, or who may seriously compromise the security of the prisons (Wright, 1999). Previous methods of managing these situations were felt to use too many staff and represent a risk to both the inmates and the staff involved. The similarities between that justification for the development of such approaches in both prisons and mental health services are obvious, with justifications for restraint in both services being closely aligned.

In response to aspects of the Mason Psychiatric Report (1988) a systematic approach to restraint, lightly adapted from the British Home Office (Prison Service), was beginning to be introduced into the New Zealand Mental Health Services scene in the early 1990s. The C&R approach was supported by the Department of Health Procedural Guidelines for Physical Restraint (June 1993). This approach offered training in techniques that were proven effective, relied on technique rather than strength, and, it was claimed, was safer for all concerned. This system appears to have been embraced with enthusiasm throughout the country, and is evolving into a training methodology more suitable for a non-punitive approach to the management of aggression and violence.

Mason's (1988) original recommendation however, was that this training should be available to forensic mental health services, with no recommendation that it be implemented more widely into general mental health services. From my investigation into the introduction of restraint training it has become clear that Mason's intent was implemented almost by accident; the staff member (Keith Roffe) recruited to New Zealand to manage forensic services arrived to find that a hospital management change had resulted in no clear position for him. Despite being brought to New Zealand primarily in response to Mason's recommendation, Roffe found himself working in a psychogeriatric ward, and in

conflict with many of his colleagues due largely to his challenging the current management of aggression in the facility concerned (Roffe, K., personal communication, 25 November, 2005). After a period of dissatisfaction with the status quo and associated challenging of current practices, Roffe was challenged by the hospital management to come up with a better way to deal with aggression, and a version of Control and Restraint was introduced and taught in the institution concerned.

It should be noted that the environments in which Control and Restraint was originally developed were relatively highly staffed and specialised in the management of people with a high propensity for violence. This raises questions about the general applicability of this training in other arenas. Currently the demands for training in the use of "Calming and Restraint" (note the subtle change of name whilst the abbreviation remains unchanged) have expanded to include many areas within health, education, and security services. Some of this demand has been driven by the inclusion of restraint in accreditation and certification processes undergone by a wide variety of services, and mandated for many.

In 2001, Standards New Zealand and the Ministry of Health released NZS8141; "Restraint Minimisation and Safe Practice." This document, which is intended for application across all Health and Disability sectors, "reflects the hope of the expert working group that the Standard will promote a culture wherein, over time, restraint usage within the health and disability sector will gradually decrease"(Poutasi in NZS8141, p3). This goal is generally accepted as desirable, with much of the restraint literature focussing on attempts to reduce its use (Gilbert & Counsell, 1999; Johnson, 1997; Marengos-Frost & Wells, 2000; Mayhew, Christy, Berkebile, Millar, & Farrish, 1999; Retsas & Crabbe, 1997; Testad, Aasland & Aarsland, 2005).

Much of my interest in this area was stimulated by a concern expressed by some members of the expert committee that produced NZS 8141; that training staff in Calming and Restraint methods may lead to an increase in restraint usage or in staff engagement in violent incidents. Most literature does not seem to support

that assertion, (Infantino & Musingo, 1985; Testad et al, 2005) however the potential for the abuse of power remains, and a concern that the C&R methodology relies on an ability to inflict pain as a means of compliance has become apparent in current nursing discourse (Lee, Wright, Sayer, Parr, Gray, & Gournay, 2001).

A letter from the then Deputy Director of Mental Health, Dr Anthony Duncan, to all Directors of Area Mental Health Services dated 6 April 2001, highlights the continued interest in the issue of restraint in New Zealand. In this he states, "...the Ministry considers it timely that services review their restraint procedures..." Despite this guidance from the Ministry there appears to be only limited engagement in the review of restraint practices occurring at this time, and no national approach to the development of training has been developed in the intervening six years. Despite it appearing that much of the expertise available in New Zealand originated in Britain, it is worth noting that there continues to be dissatisfaction with the level and consistency of training provided there. In April 2004 it was reported that the National Institute of Mental Health Nurses was launching a scheme to ensure all mental health nurses in England would be trained to a recognised standard by 2005 (Psychminded, 2004). This has subsequently been enlarged to include staff working in Emergency Departments in the British National Health Service (Harrison, 2005). So, New Zealand is not alone in grappling with the issues around restraint training and, by implication, restraint use.

Motivation for this study and statement of the problem

Physical restraint is an intensely disempowering act on the part of those applying it. The need for good justification for its use and consistency in application appears self evident. This however does not seem to be represented in the literature relating to restraint use, or a feature of my personal observations during clinical practice.

Defining the phenomenon of restraint

This study explores the decisional factors involved in the use or avoidance of physical restraint in acute mental health settings. For the purpose of this study,

physical restraint refers to the techniques used to restrict the movement of a person by means of manipulation of their limbs, and by controlling their head, by health service staff. These techniques are referred to as 'personal restraint' in the New Zealand Standard (NZS8141:2001, Restraint Minimisation and Safe Practice), however the terminology generally used for this approach in mental health services in New Zealand is 'physical restraint.' The mechanisms to effect this restraint are taught through various courses nationwide, with some variation in content and emphasis. The basis of mechanically manipulating limbs to move in ways they are designed to do so and making use of unbalanced strength of adjacent muscles remains the underpinning control mechanism. That this results in a degree of pain and discomfort appears to be an accepted part of this practice, but a cause for ongoing concern to reduce occurrence (United Kingdom Parliament, Joint Committee on Human Rights, 2007; Winship, 1998). Other forms of restraint, such as seclusion in locked rooms and (more rarely) the application of equipment to restrict movement, are identified in the New Zealand Standard and may be used at times in health services, however these form of restraint are usually carried out in the context of using physical restraint to bring them into effect. Chemical restraint, to the point of rendering "a person incapable of resistance," is not sanctioned in the New Zealand Standard (NZS8141:2001, Restraint Minimisation and Safe Practice, p18). Medication is to be used with sound clinical assessment and indications only, and is therefore outside the description of restraint in this context. Medication is, however widely recognised as a means of restraint in the international literature (Cannon, Sprivulis, & McCarthy, 2001; Currier & Allen, 2000; Pinals & Applebaum, 2004; Sloane, Mathew, Scarborough, Desai, Koch, & Tangen, 1991) in various health service settings including acute and emergency mental health.

Why study restraint and associated decision making?

My interest in this area has been longstanding, dating back to my commencement in mental health nursing over 29 years ago. I have always experienced the philosophical, ethical and emotional dilemma of a supposed caring profession accepting the need for such a controlling measure as physical restraint, and experienced great concern at the uncontrolled and chaotic nature of restraint in the early years of my career. Further there are nurses who find the

whole physical restraint area personally distressing and a challenge to some strongly held core beliefs about why they engage in nursing as a profession (Bonner, Lowe, Rawcliffe, & Wellman, 2002). This can reach the point where these people become so conflicted that they leave the profession. Being entirely honest, I must also acknowledge my own apprehension in dealing with aggressive and violent behaviour, a fear that I believe is shared by quite a number of my colleagues, however difficult it may be for them to admit to it. By acknowledging my own fears in this area I hope to validate the experience of others who find confrontation difficult, yet continue to work in an area where it appears almost inevitable. Anecdotally, I am aware that a number of my colleagues, including those who are advanced practitioners, share my apprehensions in this area of their practice.

More recently I have been involved in the training of other staff in systematised forms of restraint, the development of New Zealand's National Standards for Restraint Minimisation and Safe Practice (NZS8141:2001), and the development and delivery of training to assist staff to manage behaviour that is challenging. Throughout I have been concerned that, as trainers, we provide people with a set of skills that allow them to take power and control away from vulnerable individuals and that the potential for misuse is great. Despite the naming of current training (Calming and Restraint) the emphasis is still on the provision of technical skills, which should be utilised 'as a last resort.' My continued involvement in such training has been based on the belief that this is better than having no regulation or standards of training, my knowledge of the historical determinants that lead to the development of restraint training in New Zealand, and the thought that what we have now is not perfect, but is far superior to what had previously existed.

Another of my observations has been that there is a huge variance in the approach to the use of restraint between different nurses and in different settings, which on initial observation, appears to be independent of the characteristics and behaviour of the patients being restrained. This is occurring despite an increasingly standardised approach to the provision of training. A situation such

as this gives rise to the question "what really is happening with nurses' decision making about restraint?"

These observations form the motivation for this study. If we can better understand the way in which decisions to take the extreme step of physically restraining another person are made, then we may be able to develop new ideas to minimise these actions. Inherent in this is a belief that the individual has the right of autonomy except in the most extreme of situations where others will take responsibility for their actions and, if necessary, restrict them. This may have benefit to the wider community and the individual themselves, restricting the opportunity for damage to the self in many forms; physically, mentally, emotionally and relationally. This of course infers a degree of paternalistic 'knowing what is for the best' which is open to question and debate and in itself challenges the concepts of individual autonomy. However the alternative of a total laissez-faire, hands off approach appears to be untenable also due to the concepts of duty of care inherent in any relationship in the context of nursing, the legal requirements of mental health legislation, and the expectations of the community in which we operate. Legal assumptions of competent adults are often overridden in the context of mental illness, through mechanisms such as the Compulsory Assessment and Treatment (Mental Health) Act (1992), the Crimes Act (1961), and the Protection of Personal and Property Rights Act (1988). Nurses are often the professionals who end up taking forceful control of those nominally deemed to be 'incompetent.'

Even in the absence of a clear assessment of incompetence, every citizen has the right to act to prevent harm to themselves and others through the mandates embodied in the New Zealand Crimes Act of 1961 (Section 41; Prevention of suicide and certain other offences). Similarly, duty of care concepts exist within both professional and legal constructs (Crimes Act, section 151) that impose responsibilities for keeping people safe when in the role of a mental health nurse. These requirements are often in opposition to models of care that seek to develop patient responsibility for self management such as seen in the Recovery Model as promoted by New Zealand's Mental Health Commission in their document Recovery Competencies for New Zealand Mental Health Workers

(Mental Health Commission, 2001). There is therefore a significant tension between autonomy and control, and uncertainty about what constitutes 'caring,' which often challenges individual nurses' understanding of their purpose in working with others.

Aim of the study

The aim of this study is to better understand the factors that influence nurses decisions to physically restrain or use alternatives to restraint in situations where a patient is presenting with behaviour perceived as 'challenging,' 'dangerous' or 'resistive.' By doing so I hope to inform the development of new training approaches that may reduce or even eliminate the need for such controlling measures as personal restraint, or ensure that when used, restraint is justifiable and the decisions made stand up to scrutiny.

A brief comment on terminology

Currently there are various ways of referring to people who use health services. The popularity of business derived titles such as 'client,' 'customer,' and 'consumer,' is in the ascendency at the present time. The implicit message with these titles are notions of willingly engaging in the relationship with the health service, having a choice about the provider of such services, and an equality of power in the relationship, including having something of equal value to contribute to the 'contract' between the parties concerned. In all of the situations outlined in this research such assumptions would be erroneous. The people being restrained lack all of the opportunities mentioned above, and are therefore not freely engaging in a contractual arrangement of the sort typified by the titles used. They are, by the very nature of the encounter, disempowered, unwilling participants in what occurs. Indeed, some mental health service patients (past and present) refer to themselves as 'survivors' or 'victims,' (Minkowitz, 2006) hardly terms used in the context of feeling empowered or an equal participant. For this reason I have chosen to use the traditional term for people accessing mental health services; i.e. patients. This is not intended to in any way minimise their personhood, but to acknowledge that, at the time restraint occurs, they have significant choices removed from them and made by others (usually nurses) on their behalf, usually without their assent. The nurse assumes the role of both

carer and controller and has legal mandate to control the patient by means of physical force when the patient is assessed as being at, or representing, a significant risk (NZ Crimes Act, 1961, Section 41).

Overview of the study

In chapter two, the literature around restraint use in health settings, decision making and risk assessment is reviewed. Restraint use in medical, aged care, and mental health settings is reviewed, identifying gaps in what is currently known about the decision making process in practice. Decision making theories and in particular, factors that affect the quality of decision making are presented. Finally, risk assessment processes mandated by New Zealand agencies are reviewed along with a critique as to their potential effect on decision making.

In chapter three, the methods and procedures followed in this study are outlined, including the journey to selection of the analysis methodology and ethical approval processes. The selection of study participants and the interview data gathering approach is described, followed by the method of analysing the data produced.

Chapters' four to seven present the data, each chapter representing broad groupings of themes revealed by analysis of the data. Chapter four introduces two diverse types of restraint event and an initial model representing decision steps. Chapter five investigates attitudinal factors relating to restraint use and the perception of risk. Chapter six looks at the effects of various levels of resources on the decisions made, whilst chapter seven specifically addressed some of the issues involved in working with others in situations of potential restraint use.

Chapter eight discusses the findings in the context of mental health services. Implications for practice are presented along with recommendations pertaining to Calming and Restraint training. Limitations of the study are presented with recommendations for further research. A final summary of the study is included.

Chapter II

Literature Review

Introduction

My involvement in the field of restraint is in development and delivery of training in the management of aggression and violence for mental health and associated staff within the geographical region, including responding to frequent requests for training that arises from areas such as residential care facilities for the elderly. This literature search is therefore not restricted to the body of knowledge that applies to the mental health specialty, but also encompasses other areas of health services that use restraint, where these areas provide additional insights that may be applicable to the area of acute mental health services or the body of knowledge pertaining to the use of physical restraint as a whole.

At its commencement the greater purpose of this review of the current literature on the subject was to identify approaches taken and efforts being made in the area of restraint reduction, and where possible, to investigate their efficacy. To assist in this task it was important to also look at the research that seeks to understand the decision making that results in the use or non-use of restraint. From this it becomes clear there is a gap between what is thought to be the factors that lead to restraint use and what happens in practice. As the study progressed it became clear that other areas needed further exploration; a study of decision making in a broader sense was required, and also the way in which risk is assessed in clinical practice.

In this chapter literature relating to restraint use across many areas of health care is presented, the vast majority being international as there appears to be little local literature on the subject, and none specifically about the decision making processes involved. Additionally, the literature relating to the development of current practice within New Zealand mental health services is presented to place this practice within the international context of restraint methodology. Reference

is made to the development of current Calming and Restraint (C&R) practice, which was driven through ministerial inquiries into mental health services in the 1980s. The ongoing international concern about restraint, its use in mental health services, and the potential for it to be abused is briefly discussed. The development of the New Zealand standard for restraint and its position within health services is presented. An overview of decision making study is provided with reference to the types of biases and processes that occur within naturalistic decision making (i.e. decisions that are made in real life situations). Finally, a brief review of literature relating to risk assessment is given, with particular emphasis on clinical risk assessment in mental health services.

Literature Retrieval

Restraint, by its very nature, is most frequently administered by nurses or nurse assistants. The databases used to access information were therefore those that related most directly to Nursing. CINAHL and Journals@Ovid Full Text were used to access current literature in this field. Additional searches using Google Scholar and FindArticles were also undertaken using similar search terms with significant results for more recent literature. The search strategy centred on the key words of *Mental Health, Violence, Violence Control, Restraint and Physical Restraint*. The abstracts (where available) from the search results (over 150 articles) were then assessed for direct applicability to the aims of the study. A decision was made early on in the retrieval process that only research published within the last ten years would be used in this review. The rationale for this relates to the rapidly changing environment in which restraint occurs. Background information from resources available in my work role that relates to the training of others in management of challenging behaviour, is used in the introductory section for the purposes of providing historical context to the New Zealand situation, and later in the study to confirm findings and ensure validity and robustness.

Directly following the review of restraint literature it became clear that the other important areas of knowledge related to the way in which decisions are made and the manner of risk assessment. Broad search terms of *Decision making*, *Risk,* and *Risk Assessment* were used with the search engine Google Scholar. The use of a

non - nursing specific search engine was necessitated by the lack of adequate nursing literature specific to these topics, and the need to gain some understanding of the underpinning theories, particularly in relation to decision making. As demonstrated by the selection and emphasis of the literature chosen relating to decision making I have focussed mainly on decision making in what is known as 'naturalistic' as opposed to 'experimental' conditions as this better informs knowledge of what happens in the situations faced by clinical staff. Risk Assessment was somewhat better represented in the nursing literature than decision making. To provide additional contextual information components of the risk assessment tools mandated for New Zealand mental health services are presented in this section.

Restraint

Broad categories of restraint literature

Apart from two articles written specifically for medical practitioners the literature examined fell into three broad categories;

- Aged care facilities
- Acute Care situations in Medical Hospitals and
- Mental Health services, including those services for people with intellectual disabilities.

In the first two categories the issues are similar and relate mostly to the use of mechanical devices to restrict movement, either in continuing care situations or in response to perceived acute medical need. The Mental Health literature was divided into three main themes; articles were focussed on the use of seclusion in Mental Health settings, articles written by and for medical practitioners, with the remaining articles (and some of those dealing with seclusion) concerned with the decision making processes used by nurses in determining the need for restraint in its various forms, and patient's perspectives of seclusion or restraint.

The Medical Practitioners' Approach

Standing out alone from the other literature examined were two articles written by medical practitioners for other medical practitioners. Arya (1999), and Berg,

Bell and Tupin (2000) offer advice to practitioners on how to manage violent behaviour exhibited by patients. These articles contrast with the remaining articles due to their focus on clinician safety with little reference to beneficence for the patient concerned. Indeed, Berg and his co-authors state that "personal safety should always be a prime concern" (p11) and that staff meetings prior to the admission of "violence-prone patients" may be useful. This writer's experience would suggest that this approach does more to heighten anxiety and leads to more restrictive approaches. The authors' use of terms such as "autopsy" to describe the debriefing and review process is of concern, given the importance others place on the use of verbal interventions for defusion and the contextual situation where injuries and deaths have occurred following or during restraint. The role of defusion and calming was lacking in this article with greater focus on the environment, medication approaches and physical restraint techniques. Current training offered in New Zealand does not support the techniques proposed for physical restraint; in particular their proposal that a clinician should "bear hug" a violent client when alone in a situation is in direct opposition to the accepted practice of avoiding all physical contact unless adequately supported by others. Arya's (unreferenced) article falls more into the category of "expert opinion" and offers some basic instruction for practitioners who infrequently face patients who are violent. The lack of identified research and evidence basis limits its usefulness to this exercise, despite some of the approaches given being consistent with accepted, current, best practice.

Aged Care and Acute Medical Settings.

Despite their apparent diversity these two areas share common approaches to restraint in that they both rely heavily on the use of devices to restrict movement of patients. It is therefore useful to look at the research produced in these settings as one entity. The predominant theme in the literature seems to relate to the reasons put forward by nurses as justification for using restraint. This appears consistent across the acute and elderly care settings, and is the starting point for much of the research around restraint reduction attempts.

The most common reasons given for restraining were falls prevention and the management of confusion (Chien, 2000; Hantikainen & Kappeli, 2000; Mayhew

et al., 1999; Morrison, Fox, Burger, Goodloe, Blasser & Gitter, 2000; Retsas and Crabbe, 1997; Sullivan-Marx, Strumpf, Evans, Baumgarten, & Maislin, 1999). Other rationales that emerge, particularly from the acute medical settings relate to patients with intravenous lines or tube feeding lines, catheters, and sutures, who may be at risk of pulling these out (Gilbert & Counsell, 1999; Minnick et al., 1998).

These reasons for restraining are somewhat superficial in their ability to reveal why nurses restrain in actual practice. Many of the listed studies used interviews of staff and other more formalised tools to assess the attitudes that lead to restraint such as the Physical Restraint Questionnaire (Janelli, cited in Morrison et al., 2000) and the Revised Restraint Questionnaire (Matheson, Lamb, McCann, Hollinger-Smith & Walton, 1996) to assess the attitudes that lead to restraint. A heavy reliance on patient record reviews limits the amount of information accessible to researchers, given the abbreviated nature of such records, and their purpose being to record care delivered and response to it, rather than investigating nurses' decision making.

Acute Mental Health Services and Restraint

There are significant practical difficulties in taking an approach of direct observation of restraint in an acute mental health setting, however research in acute care settings such as that of Morrison et al., (2000) found that reported rates of restraint use were significantly lower than observed rates. This highlights the importance of careful procedural design to ensure the information gathered represents the real situation. The potential ethical issues of approaches that involve direct observation are myriad and would, in themselves, represent a significant challenge. How, for example, would a researcher respond to a situation becoming unsafe if they were capable of effective intervention? This should not deter potential researchers from investigating actual incidences of restraint, given Morrison et al's findings; it does, however, produce significant challenges in the construction and undertaking of such research.

Chien (2000) highlighted the moral imperative that nurses face: that of allowing no harm to come to patients under their care. This moral imperative is the basis

of the dilemma many nurses face in deciding whether or not to restrain patients who present as being at risk to themselves or others, in the light of a set of values that identifies nursing as being a caring role. This applies whether investigating medical or aged care settings or mental health settings. However Chien's earlier study (1999) also made strong statements about nurses' "insensitivity to patients' rights" being based on this imperative. Statements such as this would represent a significant challenge to the core beliefs of many nurses and may make acceptance of this finding difficult. Marengos-Frost and Wells (2000) further studied these dilemmas and considered the additional dynamic of internalised values that nurses held and their emotional responses to the restraint situation. Their ethnographic study looked at nurses' perceptions of imminent risk, their available repertoire of alternative interventions, and environmental factors. The findings of their study extended previously identified knowledge in the area of characteristics of those people restrained, and drew attention to the complexity of issues that need to be considered in any restraint situation. A theme that emerged from this study was the reward to nurses for keeping control, either of situations or individual patients. These rewards come from the institution and fellow nurses in the form of recognition as being able to cope well with difficult situations, and were influential in decisions to restrain.

Similar to the literature relating to aged care and medical settings, much of the literature relating to restraint in mental health services focuses on the desire for reduction in the use of restraint (Blom-Cooper et al., 1992; Bowen, 2004; Knight, 2005; Milliken, 1998; Paterson, Bradley, Stark, Sadler, Leadbetter, & Allen, 2003; Taxis, 2002). These studies identified the need for robust systems of recording the use of restraint so that adequate review of its usage is possible, and the identification of patient characteristics and circumstances of restraint can be investigated. Gerolamo (2005) takes the position that restraint has no established therapeutic value and should therefore be regarded as an adverse outcome indicator that is sensitive to the way in which nursing care is delivered and organised.

A dissenting view is that of Ziegler (2001) and Ziegler and Silver (2005) who challenge the "locomotive of opinions and pressure tactics that may lead mental

health treatment in the wrong direction" (p7). Their concern is that there is an apparent assumption that restraint is harmful; an assumption they assert is not universally supported by literature, and not adequately debated by the mental health professions. Ziegler and Silver's contention is that much of the support for restraint reduction or elimination emanates from the distastefulness of restraint intervention. As they rightly point out, interventions in many areas of health care are distasteful, unpleasant, and even painful, yet they are not challenged in the same way as restraint.

Knight (2005) found that restraint and seclusion events occurred later, on average, in a patient's admission than was estimated by clinicians. She found that restraint and seclusion events first occurred at a mean of 5.3 days after admission. The significance of this finding is that it provides a window of opportunity to engage the patient therapeutically and begin to plan strategies that could contribute to eliminating the need for restraint or seclusion. Similarly, the Pennsylvania Patient Protection Authority (2005) identified opportunities for individuals and organisations to develop more humanistic approaches to managing escalating and potentially dangerous behaviour. They support this by developing service cultures that encourage clinicians to put themselves in the patient's place, proactively seeking alternatives from patients who are escalating, identifying alternative, non - force strategies with clinician peers, looking at the root causes of violent behaviour, and establishing a culture of debriefing and review following restraint events.

A number of authors have written about the physical risks of restraint, particularly when restraint has occurred and the patient concerned has subsequently died (Ball, 2005; Langslow, 1999; Mohr, Petti, & Mohr, 2003). These articles have highlighted the physiological processes that are suspected to result in the death of recently restrained patients and identify some safety approaches such as taking baseline cardiovascular recordings for all psychiatric patients (Mohr, et al., 2003). In recent times a greater understanding is developing of the physiological effects of restraint, particularly in individuals who are not usually physically active. The effects of positional asphyxia, psychotropic medication use, intoxication with illicit substances,

rhabdomyolysis (muscle breakdown causing toxicity), and electrolyte disturbances, are now better understood (Ball, 2005; Langslow, 1999). This has resulted in calls for greater observation during and post restraint, with access to, and training in the use of, resuscitation equipment (Ball, 2005). This knowledge and the recommendations resulting, appear to echo the situation investigated by the Gallen report (Gallen, 1983) in which a patient died shortly after restraint and placement in seclusion.

What constitutes restraint?

There is no absolute agreement in the literature about what is or is not restraint (Johnson, 1997), and this is important to note when looking at the terms used. Of greatest contention are the interventions that involve devices that are regarded as enabling through the restriction of movement or realigning of posture. This is certainly an issue that is frequently raised locally when undertaking training in the use of restraints, with the particular issues of bedrails, belts and vests being difficult for many care providers to work through and decide whether they should view their actions as restraint. Authors such as Gilbert and Counsell (1999) and Hantikainen and Kappeli (2000) make considerable efforts to clearly define what they mean by restraint, however many of the other studies have been lacking in this area, leaving the reader to discern the definition from analysis of the material presented. This could potentially lead to confusion, particularly in areas where the intervention is primarily viewed as protective of the patient as opposed to areas where behavioural management is the motivator for restraint. This also may contribute to the denial of restraint use in services other than mental health, who view restraint as occurring in the context of violent behaviour, often associated (erroneously) as generally happening in the context of a mental illness. This is sometimes referred to colloquially as the 'restraint is for the mad and the bad' approach, which is articulated in more informal discussions with clinicians from non - mental health services, and has proved a stumbling block in the implementation of Restraint Minimisation and Safe Practice (NZS8141:2001) processes in services that do not have an historical acknowledgement of the practice. Some services continue to have difficulty accepting that they practice restraint if they believe they are operating within a

framework of beneficence which, by their definition, means they can restrict others for their own good and not feel like this is restraint.

Decision-making

The central question of this thesis is about the process of decision making in a particular set of circumstances (nurses and patients in mental health services), which may potentially lead to a particular response (that of physically restraining). Fundamental to the investigation of this subject area is an understanding of the ways in which people make decisions, the processes they employ to reach a decision, the factors they consider important and the ones they may ignore, and external influences that exist.

Although many of the studies looked at the knowledge issues relating to a nurses' decision to restrain, these tend to be focussed on general principles around situations that would require restraint use, rather than specific events where restraint had been used or avoided. Holzworth and Wills (1999) sum up the issues around decision making when they state that any such decision to restrain or seclude reflects a clinical judgement of considerable importance, given the potential impacts on the relationship between nurses and patients, and the patients' functioning and well-being. This statement is supported across all areas of the literature, not just mental health settings. What Holzworth and Wills have managed to identify in their study is the inconsistency of decision making when nurses are confronted with specific scenarios to consider. Despite a high level of agreement around the general types of situations in which restraint was indicated, there was no agreement about the level or type of intervention required in any given situation. This represents a considerable challenge for future research, and is one of the foundations of this particular thesis. The researchers acknowledge the limitations of their study, in particular their inability to cover many of the less tangible environmental and contextual aspects; however their work is valuable in establishing the need for a better understanding of the decisional processes involved.

But what does it mean to decide? A simple dictionary definition is "to reach a decision," or "to settle a contest or question." (The New Collins Concise

Dictionary 1986, Gordon, Ed.). These seemingly simple definitions fail to address the many underlying functions and considerations that must occur before the conclusion of the process: the reaching of a conclusion or determination of the course of action that will be undertaken. It is clear that in the complicated social situations that lead nurses to use physical restraint there are myriad factors, overt and covert, immediately obvious and contextual, in the here and now and rooted in past experience and attitudes that influence the types of decisions made. Not only that, but the future outcomes are not clearly defined either. Raynard, Crozier, and Svenson (1997) express it thus; "..most real life risks are ill-defined. That is, the probabilities of uncertain events which may follow a decision are imprecise, vague, or ambiguous, and are essentially subjective," (p 109).

Grohol (2005) defines decision making as "the cognitive process of selecting a course of action from among multiple alternatives" (p 1). This definition captures much more about the nature of decision making than the simple dictionary definition by referring to cognitive processes that must take into account a range of options available. Clearly even within a straightforward set of circumstances we will not all reach the same decisions with these many variables influencing the final outcome. Add the complexity of multiple situational factors and there exists the potential for huge variation of action. This has been demonstrated throughout the literature on the use of restraint (Morrison et al., 2000; Holzworth & Wills, 1999). Many of the situations also present with the need for immediate action: considered approaches to decision making which allow time for analysis of options are relatively rare.

Decision Making Processes and Influences

Classical experimental decision making theory

Decision Making has been studied extensively, with many experiments focussing on risk taking behaviour within the context of gambling and relatively simple choice selections. These experiments have often resulted in complex statistical formulae that are of limited use in this study due to the limited number of choices and risks involved. However, no matter what the situation, some amount of information is needed in order to make a decision (Baudry &Vincent, 2002), but

in the context of a human interaction the volume will be great and nature of that information will be complex and affected by external and internal factors. From the exploration of gambling behaviour though, there are some useful findings to consider, in particular what is known as the gambler's fallacy. This occurs when people expect to strike it rich following a losing streak in the belief that things must 'even out' at some point. This leads them to continue with risky behaviour despite it having a past track record of being unsuccessful. Researchers in the area have speculated that this type of high risk, split second decision making may also be present in professions such as firefighters and the police where rapid decision making with high risk outcomes occurs frequently (Schulman, 2002). Similar situations exist within the profession of mental health nursing, where rapid responses to dangerous situations are required.

Naturalistic decision making theory

Kahn (2004) rejects these classical experimental theories of decision making based on artificial tasks and situations. He discusses a naturalistic decision making model which explores how humans really make decisions in complex situations. Kahn demonstrates this in the context of selecting a spouse, a particularly complicated and potentially high risk decision which it appears many people get 'wrong.'

A key difference between naturalistic and classical models of decision-making is the tendency for people, when operating in the real world (as opposed to experimental conditions), to find solutions that may not be optimal, but which meet a criterion of adequacy. This is often referred to as 'satisficing,' (Kahn, 2004) where a premature end in the search for alternatives occurs when we encounter an alternative that looks like it might work, or one that meets a predetermined set of criteria that may be set at the level of 'good enough' rather than 'ideal' (Grohol, 2005). This is one of a set of biases that Grohol identifies as possible influences on our decision-making that may lead to questioning by others of the correctness of our decisions. This is often seen in post event analysis where ideal solutions are often postulated as the desirable course of action, often by those not directly involved in the event.

Biases and limitations to decision making

Many other biases exist, particularly when operating within time constraints and perceived limited sets of options. In ideal situations these may be seen as decreasing the quality of decision making, however they represent what is 'do-able' in real situations where time and options are not endless.

A selective search for evidence often occurs, where we tend to be more willing to gather facts that support certain conclusions but may not seek facts that suggest an alternative conclusion (Grohol, 2005). In addition to this, other authors have noted that this is a necessity (Eiser & van der Plight, 1988) in order to effect action. Without a selective search for evidence we would be simply overwhelmed by the sheer volume of information available and unable to decide then act within a reasonable timeframe. It does however lead to limited options being considered.

Conservatism and inertia may exist, where there is unwillingness to change thought patterns we are familiar with even when circumstances change. This is seen in the preservation of traditions that are no longer useful and whose purpose may be unknown to those who perpetuate them (Grohol, 2005). Garling, Karlsson, Romanus and Selert (1997) assert that even expert decision makers demonstrate this behaviour, albeit to a lesser degree, when they are influenced by the outcomes of previous decisions. In nursing there is a significant culture of doing things because of history, often referred to as "Sacred Cows" (Girard, 2006). This is closely related to 'experimental limitation,' which refers to an unwillingness to look at unfamiliar approaches but to rely only on previous experience. Part of this may be influenced by the scrutiny of practice which occurs following negative outcomes, in which unfamiliar or untested approaches will be regarded as irresponsible if not found to be successful.

Selective perception occurs when we screen out information we do not think is important, however we may not be able to judge that importance at the time this occurs (Grohol, 2005). Given that decisions result in events unfolding in the future and that there is no way of actually knowing what will become reality (Halvor, Brun & Brun, 1997), decision makers have the difficult task of

determining which information will be given attention. Retrospective analysis allows for the assessment of the relevance of information considered or ignored, however that luxury is not available to the decision maker operating in real time. Crozier and Raynard (1997) also emphasise that this post event analysis influences the nature of decisions made, in that the decision maker will consider "how justifiable their decision will be in the future" (p10) and thus limit their attention to information that will support a more easily argued justification, rather than looking for an optimal solution. In this way, nurses may take more restrictive action that holds less risk than an approach that may allow greater patient autonomy or selection of alternatives.

Inconsistency of decision-making occurs when we do not apply the same criteria in similar situations. Clearly we are all individuals and will not necessarily attend to the same factors, or even have the same outcomes envisaged, in any given situation. This leads to a variety of decisions being made even when confronted with very similar scenarios in clinical settings (Wolff, 1989). This is the very situation which was identified in the restraint literature (Holzworth & Wills, 1999; Marengos-Frost & Wells, 2000; Morrison et al., 2000) and which largely stimulated this study.

Anchoring refers to decisions being unduly influenced by the first impressions we gain of a situation (Grohol, 2005). This supports the old adage of 'first impressions count,' and should be considered carefully when taking into account the situations we are looking at in this research which occur in relatively short periods of time with reduced opportunities to challenge initial assessments of any situation and those participating in it.

Source credibility bias occurs when we tend to reject something if we already have a bias against the person, organization or group (Grohol, 2005). Clearly, an attitudinal bias can occur here when assessing the intent of a patient's behaviour. Faulty generalisations occur when we group people or things in order to simplify complex situations. This can be seen in stereotyping, and particularly within the field of mental health, this occurs with those individuals ascribed a label of personality disorder, or who are identified as 'knowing what they are doing.'

The effect of 'Groupthink'

Important in any consideration of decisions relating to restraint is the concept of 'Groupthink.' Given that restraint occurs within the context of a relatively close knit group of mental health professionals, and a further limited group of the team that restrain, it is important to consider the possibility of Groupthink occurring. Groupthink occurs when there is pressure to conform to the attitudes and opinions of a close-knit group This phenomenon was first described and named by Irving Janis in 1972 and essentially identifies the tendency for groups to make poor decisions as a result of a desire for consensus which overwhelms effective and thorough decision-making. Associated with Groupthink, elements of role fulfilment may occur when we undertake to do what we believe others expect of us in our role, and pressure is applied to dissenters to comply (Griffin, 1997). Griffin also identifies that groups will display a great sense of belief in the inherent morality of what they are doing, and of stereotyping of those in the "outgroups." In the context of mental health nursing, patients are often viewed as such a group; those who are different from the norm. Pilette (2005) identifies this in nursing when she poses the situation of nurses agreeing with the majority of their team because it will hasten a decision, or the risk of being seen as not 'in the group' is too great if a divergent opinion is expressed.

From these descriptions of some of the biases that can occur when making decisions it is clear that this is an incredibly complex process with multiple factors, both intrinsic and extrinsic to be considered in even relatively simple situations. Deciding to use physical restraint cannot be described as a simple situation by any means, so the challenge to 'get it right' (however that may be defined) is considerable. The stories provided by the nurses involved in this research are therefore a beginning to understanding what they considered to be some of the critical factors in making the decision to restrain or not restrain.

Risk Assessment

Risk assessment has become an integral part of working in mental health services, to such an extent that clinicians who fail to undertake risk assessment are regarded as having failed in their duty to protect the patient, the organisation

employing them, and the community as a whole (Crowe & Carlyle, 2003). This raises a critical question; what is the purpose of risk assessment?

Risk assessment in mental health services

The premise of the New Zealand Ministry of Health Guidelines for Clinical Risk Assessment and Management (Risk Guidelines) tool (New Zealand Ministry of Health, 1998) is that risk assessment is only useful if it leads to better management of those risks identified. 'Better' in this context is defined as minimising "the likelihood of adverse events within the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care"(p2). So, in this view, risk is defined in terms of avoidance of negative outcomes (Matthewson, 2002), and responsibility for it rests not with an individual patient but with clinicians and services. Certainly, this guideline reflects the community's expectations that patients be kept safe, and the community safe from them. This could easily lead to restrictive practices that offer little benefit to the individual patient (from their perspective) in the community's quest for security. Another group of people identified by the community as posing a risk, convicted criminals, are incarcerated and their liberty carefully controlled. The goals of the justice and health services may be disparate (punitive/rehabilitative as opposed to treatment) but the community expectations are similar, and risk assessment can become a tool for effecting that goal. As Matthewson (2002) states media attention can lead to unrealistic expectations to such an extent that "the expectation generated is that harm will be eliminated" (p36). Crowe and Carlyle (2003) found that social concerns could well be positioned as being of greater priority than clinical judgement, such that the needs of individual patients may be subsumed by organisational needs and expectations. Beck (1999) suggests that risk assessment attempts to control the actions of individuals, to benefit the wider organisations and communities they operate within, as opposed to benefiting the individual. Individual clinicians find themselves in this conflicted position of having to undertake risk assessment which, despite assertions that it is about individual patients, may be more to do with protection of services from undue scrutiny by the media in the context of an unrealistic set of expectations. Crowe and Carlyle see this as leading to defensive practice on the part of clinicians, encouraged by a "culture of fear and

watchfulness' (p25). It is easy to see how patients can become passive participants in this process, the object of assessment, representative of potentially negative events, with adverse consequences not just for themselves but for all involved in delivering mental health services to them.

The New Zealand mental health services' risk assessment approach

In the context of New Zealand mental health services risk is identified as being categorised broadly in four ways;

- The risk of progression of illness – risk to health of the individual
- The risk of deliberately induced harm to self including suicide
- The risk of unintentional harm to self, or exploitation
- The risk of intentional or unintentional violence, or fear-inducing behaviour towards others.

(Guidelines for Clinical Risk Assessment and Management, New Zealand Ministry of Health, 1998).

Figure 2.1 shows examples of these broad categories of risk:

RISKS TO SELF	**RISKS TO OTHERS**
• Safety (including suicidal acts, deliberate self harm) • Health (including drug and alcohol abuse, physical harm, psychological harm) • Quality of life (including dignity, social and financial status) • Self neglect • Cultural/spiritual	• Violence (including emotional, sexual, and physical violence) • Intimidation/threats • Neglect/abuse of dependants • Stalking/harassment • Property damage (including arson) • Public nuisance • Reckless behaviour (including driving)

Figure 2.1: Guidelines for Clinical Risk Assessment and Management. (New Zealand Ministry of Health,1998, p3)

This further exemplifies the negative nature of risk assessment in that it demonstrates an expectation that bad things will happen if 'others' do not act, and an associated expectation that 'others' will prevent adverse outcomes. Despite allowing patients to take risk being a component of recovery approaches promoted by the New Zealand Mental Health Commission (Recovery Competencies for Mental Health Workers, 2001), the decision about the acceptability of risk lies solely with the health practitioner or team within the construct presented in the Risk Guidelines. Additionally the Risk Guidelines contain nothing about patient factors, attributes, or supports that may mitigate risk, and thus appear to function from a model of weaknesses without identification of the possibility of strengths in the individual assessed. The process of risk management planning identified within the Risk Guidelines (see Appendix 2) does not identify a role for the patient (consumer in their terminology) in developing an initial risk management plan; they are the subject of the plan but not an active participant. In the model presented, patient involvement is not required until the plan is activated.

The section "Risk of harm to others" (Appendix 1) highlights that the best predictor of offending is the same as for the general population; "such as their previous record of offending, or threats." Also, increased risk is associated with "active, untreated symptoms, including non-compliance with medication" (p14), and that the best way to control risk is deal with such changes promptly. Whilst there is no argument that this is a sensible approach it appears to direct clinicians down a path of early intervention which, by the nature of our understanding of mental illness, the expectations of our community, and the models of care available, will be coercive at times.

Types of Risk Assessment

Fundamentally there are two types of risk assessment in action in mental health services; what is known as the acturial approach, and the clinical approach. Acturial approaches use quantifiable factors such as age, gender, previous history of violence, drug and alcohol abuse, and the presence of acute psychiatric symptomology (Trenoweth, 2003). These factors have been shown to raise the risk of violence, are assessed from both a current and historical perspective, such

that factors from a patient's previous presentation will be considered at a later date when further risk assessment is undertaken. Clinical approaches use components of the acturial approach but also more current information about the patient. Mental status, including delusions, affective state, and hallucinatory processes are incorporated, along with information about current stressors, recent and distant history of violence, and the nature of that violence (Mason 1998; Snowden 1997). This allows for a more contemporary assessment of the risk a patient represents. As such its validity is time limited and regular reviews are required to ensure it remains current. New Zealand Risk Guidelines (Ministry of Health, 1998) suggest that reassessment of risk should be ongoing, but also occur at particular critical points such as:

- First contact with a service
- Change or transfer of care
- Change in legal status
- Change in life events (eg. loss)
- Significant change in mental status
- Discharge, or move to a less restrictive environment

(Guidelines for Clinical Risk Assessment and Management in Mental Health Services, 1998, p4).

Bjorkly (1997) warns against over reliance on single indicators for violence or using limited numbers of indicators, as this corrupts the validity of the risk assessment. He acknowledges the complexity of the task of risk assessment and the need for comprehensive analysis of the clinical indicator set. This is further reinforced in the Guidelines for Reducing Violence in Mental Health Services (Ministry of Health, 1994) which refers to violence as being contextual and not necessarily inherent in the individual. "Violence occurs in response to an interaction and so cannot be dealt with solely by addressing the narrow issue of the consumer's behaviour" (p3).

Summary of the literature

The literature relating to restraint use in health services highlights the inconsistency of practice between individual clinicians. It also identifies that rates of restraint use are higher in practice than theoretical indicators would suggest they should be. There is a strongly espoused value of protectiveness of patients; however the challenge to achieve this comes at the cost of overriding patient autonomy in many cases. Much of the literature is focussed on efforts to reduce or eliminate the use of restraint. The values of keeping people safe and of maintaining control were identified as motivators for using restraint, and for some, the hallmark of responsible and effective nursing.

New Zealand has largely followed the Control and Restraint methodology of the United Kingdom, with significant development of systematised approaches to restraint being introduced over the past decade, along with standards of performance. This resulted from building pressure as a result of patient deaths and injuries that led to several Ministerial Inquiries, particularly during the 1980s. Prior to the introduction of training in restraint there was a greater reliance on the strength of (usually) male staff to contain patients who were viewed as violent, further reinforcing a culture of custodial care and of the need for control by others. Internationally there is greater scrutiny of all aspects of health service delivery and restraint is no exception. Despite this there are moves to expand training in the management of violence, often with recourse to the use of restraint, so that staff working in many areas of health services are trained in restraint methodologies.

Decision making literature identified the complexity of the process of deciding on a course of action. Theoretical decision making in artificial situations was seen to be divergent from what generally occurs in the 'real world.' The need to consider many variables, possible courses of action, and relative risks and benefits was highlighted. Much of the literature examined focussed on the biases which can affect the quality of decision making, the selection of choices and therefore the outcomes.

Risk Assessment, a specific kind of decision making, was examined largely in the context of mental health service guidelines, as these are the relevant working documents for clinicians. Evident was a conflict between models of care that focus on patient strengths and therapeutic need to allow risk taking and the approach that elimination of risk is what the community expects of mental health services, both for itself and the individual patient. Defensive practice occurs in the context of these expectations, and this can lead to viewing the patient as subject of the risk assessment process rather than an active participant in it. Risk is solely defined in terms of negative outcomes.

Chapter III

Methods

Introduction

This chapter presents the background to the commencement of this research. There is brief discussion about the methodologies considered prior to commencement of the research proper, in order to demonstrate the influences of these methodologies on the final approach taken. Ethical approval processes and management consent for the research are discussed, along with the development of the research interview questions and subsequent decision on analytical approach. The issues of reliability and validity and the approach taken to ensure these are presented.

Research Process Considerations

Initial considerations regarding this research

The framing of this research commenced in 2001, as I became more interested in the gaps that were apparent in the literature around the use of physical restraint in mental health settings. As previously identified there appeared to be a dissonance between what nurses identified as the indicators for the need for restraint and the actual incidence of restraint use. Whilst I was not interested in the number of times restraint was used in any given setting per se, this dissonance did raise the question studied in this thesis. If there was a gap between what nurses indicated as their theoretical basis for restraint use and what happened in practice, then exploring the actual reasons for restraint would inform researchers and clinicians about how to reduce the dissonance and have more consistent practice with decisions better able to withstand critical scrutiny. Clearly, I was not intending to count restraint incidents, or to use the artificial situations presented in scenarios, but rather attempt to uncover some key factors that influence the decisions nurses make to use or avoid physical restraint through investigation of their own experiences of restraint use. By using actual events experienced by the participants it was anticipated that knowledge would be gained about what really

happened, as opposed to an abstract, idealised view of how decisions to use restraint were made.

The limited amount of existing knowledge in this area leads researchers into methodologies that enable formative knowledge to be developed: this is not an area able to be tested in a formalised manner until we have further established the types of issues to be investigated. It was therefore proposed that qualitative, interpretive approaches would be of greatest benefit at this stage of research into the subject. Until some greater clarity exists around the processes involved in restraint decision-making any testing of hypotheses could be regarded as guesswork, potentially unethical, and wasteful of resources.

Early in the development of this research consideration was given to the methodology that would best allow uncovering of the subject matter under study. Initially Sense Making (Dervin, 1983) was considered as the approach to this research, and indeed the basic structure of the interviewing process owes much to the approach of Sense Making and the use of second interviews to allow greater depth of analysis and reflection on the part of the participants. There is heavy emphasis on the contextual nature of this process, viewing space and time as not only external contexts, but as intrinsic factors in the whole (Dervin, 1999). Another driving force for this research was my desire to ensure that it should be "real" in the sense that it acknowledges the context and influences that exist within mental health nursing and that what is learned can then be applied to real situations encountered.

Initial Research Development

The initial development involved the construction and trialling of a semi-structured interview, which covered some key areas of restraint relating to participants' actual experiences. By asking initially for a straightforward description of an event participants were able to indulge in the story telling tradition of nursing without the constraint of trying to make sense of it as they went. This allowed for a steady flow of ideas that were then later examined in more depth at the second interview. This initial interview was also important in developing rapport with the participants, so that they would feel more

comfortable in examining often emotionally charged and challenging situations. Apart from the presence of audiotaping equipment, the interview setting was conversational in nature, neutral, and encouraging of spontaneous comment. Taking a lead from Sense-Making methods, second interviews were conducted which focussed in more depth on the particular aspects of decisions made, the influences on those making the decisions, and the subsequent impacts of those actions.

As data gathering and analysis commenced it became clear that the approach that would best answer the "how" question regarding decision making would be entirely data driven and rely on quite large chunks of that data in order to ensure context and participant attributes were not lost. The data had diverse styles of interaction inherited from the diversity of the participants involved, their own levels of reflection and analysis, and their attitudes towards the research question and process. Initial reading of the data was somewhat daunting because of this diversity. Here the question arose; what does one do with data which ranges from quite descriptive of events to data which comes with its own embedded interpretations of events, backgrounds and contexts? What were emerging clearly were common themes around the decision making components associated with restraint. By the process of reading, checking transcripts against tapes for accuracy, editing for accuracy, rewriting and rereading, a great deal of familiarity with the data developed. From these initial activities the broad themes were becoming obvious and cross checks for their presence in other participants' data confirmed their validity. This led the researcher to the conclusion that the most useful way to analyse to data was to use a thematic analysis approach.

Thematic analysis

Thematic analysis is a process used with qualitative information which seeks to identify themes or patterns within data (Boyatzis, 1998). The first step, having established the field of enquiry, is to collect the data by means of interviews. These conversations often occur within the context of interviews that are facilitated by the researcher in order to elicit information about the topic studied (Aronsen, 1994). These are transcribed into text from which patterns and major themes can be identified, using either direct quotes or paraphrasing. From this

point the researcher identifies all data that relates to these already classified patterns and gathers this together. This results in quite broad categorisation of the information awaiting the next step of combining and cataloguing related patterns into sub-themes (Aronsen, 1994). This results in the development of a more detailed understanding of the collective experience of the participants. Feedback from participants allows for checking of the validity of the themes (i.e. is that what they meant; does it make sense to them?), and for greater exploration of the detail of the themes. In the case of this research, this occurred by using transcripts and recordings of initial interviews as the basis for second interviews. The final step in the process is to develop a sound argument for the choice of themes (Aronsen, 1994) and develop a story line which accurately reflects the information within the data. Referring back to the extant literature, themes can be further investigated and developed to support the whole of the story. Literature and findings from the research data are integrated into a coherent whole which stands up to academic scrutiny.

Thematic analysis does not require the support of positivist, scientific methods. This approach relies on openness regarding its methods, the processes undertaken, and the degree of subjectivity inherent in the analysis (Lupton, 1999). It acknowledges that any field of research comes with human factors which may influence the process and outcome, but seeks to make the reader aware of these. The resultant story accurately reflects the patterns of experience of the participants within the context in which it occurs.

Authority to Undertake the Research

Research is not without risks for participants, researchers, and the organisations they operate within. It is also costly in terms of time and financial resources. Therefore it is not to be undertaken lightly or without suitable authority from those with interests in the subject matter or the possible implications for those involved.

Management approval and ethics committees.

Consent to undertake the research was sought from health service managers at an early stage, prior to seeking ethical approval. This was very important, as I was

intending to conduct most, if not all interviews within or close to the workplace of the participants, although the offer was made to conduct interviews at any place convenient to the participants. It was also necessary to identify and manage any organisational risks associated with revelations that I may uncover relating to restraint practice; clearly health organizations did not wish to be party to potentially embarrassing activities that put their credibility at risk, or themselves at risk of litigation. Fortunately my position and professional relationships were such that I was able to have direct contact with the appropriate levels of management and address any specific issues that arose.

Ethics approval was sought from the Massey University Human Ethics Committee and the Manawatu - Whanganui Regional Ethics Committee virtually concurrently. I appeared in person at the Manawatu - Whanganui committee to discuss the proposed research. At these meetings the Request for Volunteers sheets and Consent Forms were presented, and at the Manawatu – Whanganui meeting I was interviewed regarding the issues relating to anonymity, impact on Maori, and the question of how to deal with any information relating to unprofessional behaviour in the context of restraining. In particular, the issue of the benefits of this research for Maori were discussed at some length as Maori are over-represented (on a population proportion basis) in mental health services (Dyall, 1997), and ethnic minorities are internationally recognised as being at greater risk of being restrained when in mental health services (Blom-Cooper, Brown, Dolan & Murphy, 1992). This research aimed to better understand the processes in action when decisions are made to restrain (or avoid restraint) thereby leading to greater consideration of the appropriateness of restraint as an intervention. This was hoped to lead to safer practice and better outcomes for mental health patients.

Consent and issues relating to research participation

The consent form outlined the voluntary nature of participation, the maintenance of anonymity, the purpose for which the information was gathered, the option of editing transcripts by participants, and the right to withdraw or suspend the interviews at any time for any reason. Of particular importance was the issue of what to do with any information that I may become aware of that represented

serious professional misconduct, as the potential for professional harm to the participant was great. A section was included in the information sheet and the consent form (see appendices 3-5) to alert participants to my obligations relating to the maintenance of professional standards in these circumstances. As protection, it was proposed that any such incidents would be dealt with through both academic and professional (clinical) supervision before the researcher would take any action. It was also important to identify the existing processes within the organizations employing the participants that would normally address any issues of unprofessional behaviour. The management of this issue was significant, in that it was difficult to assure anonymity to participants, but then to attach limits to that anonymity. To be effective research, it was imperative that participants would feel free to be completely open about the events which they were describing, but at the same time there was a need to recognise that professional standards had to be maintained, and that the research process could not be used to avoid scrutiny of behaviour that may be deemed unprofessional.

Data security and confidentiality arrangements.

Security and confidentiality arrangements were clearly articulated, including arrangements for keeping raw data material secure. Audiotapes and all written information, including consent forms and transcripts are secured in a locked desk at the researcher's residence. Any additional copies of transcripts that were not required for the research were destroyed by shredding, using a specialist document destruction service. The transcriber, who was experienced in the field of research transcription, signed a confidentiality agreement.

Ethics committees' outcomes.

Thanks to the thorough critiquing of my application by a colleague with experience in the area, the process of ethics approval was achieved with little alteration to the original submission. There were no conflicts between the requirements of the two Ethics Committees, and approval was achieved virtually concurrently, and within a short timeframe. Feedback from the Manawatu – Whanganui committee was particularly encouraging, supporting the value of this research topic.

Data Collection and Analysis

Participant selection

The selection of participants for this study was purposive in nature; I was seeking to interview people who had been involved in decision making relating to restraint use, so those who had not been involved in restraint use were not included. It could be argued that these people would perhaps yield insights into how they managed to avoid restraint use; however the need to be able to investigate both restraint use and non-use from the perspective of the same participants was considered to be more useful.

A request for volunteers was distributed at professional nursing forums at two separate health service providers, and any immediate questions were addressed at those venues. To maintain anonymity I did not seek immediate response from potential participants, rather asking that they contact me by telephone if they wished to have additional information or to offer to participate. In the information sheet I acknowledged the contentious nature of restraint use, and the need for participants to feel free to speak openly and honestly with me. Despite not seeking immediate decisions to be involved with this research, a number of nurses approached me during these open meetings to offer their participation.

There were two key qualifications for inclusion in the study, the first being that the participants were Registered Comprehensive Nurses or Registered Psychiatric Nurses. The reasons for this are that Calming and Restraint training emphasises that restraint is a clinical decision that should be made by a Registered Health Professional. Nursing, by virtue of the nature of service structures makes most restraint decisions; it provides the 24 hour a day, seven day a week input, has the most frequent contact with patients, and represents the greatest proportion of the mental health workforce. The Nursing Council of New Zealand limits nursing in mental health services to those people with Comprehensive or Psychiatric registration, so other categories of nurses were excluded from this study, which was solely interested in mental health service delivery settings.

The second qualification was that participants must have been trained in Calming and Restraint or its equivalent. The research relies on accessing the decision making of people who have physically restrained mental health patients, and it is a matter of policy in all New Zealand mental health services, and mandated in the New Zealand Standard (Restraint Minimisation and Safe Practice, NZS8141; 2001) that staff should be trained in the appropriate techniques before being placed in a situation that may require recourse to the use of restraint. Training also provides the set of skills required to restrain in an organised and lower risk manner, thereby supplying staff with an additional set of responses to consider when confronted with high risk behaviour.

Emphasis was placed on the desire to interview a range of nurses, those who were significantly experienced or those who were less experienced. This was to explore differences in decision-making and levels of comfort with the use of restraint in a variety of people with differing levels of experience.

Although not involved in the interviewing process, key informants have been accessed from local mental health services to review findings and discuss issues that arose through the course of the research. These informants have over 30 years combined experience in training others in the use of C&R, the ongoing development of behavioural management programmes and hold senior roles within the mental health service.

Eight nurses working within general mental health services were interviewed. This sample represented an even mix of gender, a variety of experiences in clinical settings, and a balance between employing authorities. Ages ranged from mid-twenties to early fifties. Analysing the data further suggested that saturation of the dominant themes had been achieved with this sample. All were working or had recently worked in inpatient settings. Most recent or current inpatient experience was in general hospital based mental health units, however three of the participants had experience of working in large stand-alone psychiatric hospitals prior to their closures through the deinstitutionalisation process occurring in New Zealand in the 1980s and 1990s. The length of experience as a Registered Nurse ranged from six months to over 20 years. All were Registered

Comprehensive Nurses, and some participants had worked for varying lengths of time as Psychiatric Assistants (unqualified nurse assistant roles) or as Enrolled Nurses prior to completion of their Comprehensive Nurse training. One of the participants had hospital-based training as their initial preparation, and had then gained the Comprehensive Nurse qualification. None of the initial group of participants chose to withdraw or place any additional restriction on the use of the data.

The interviews

Initial interviews took place in areas adjacent to the participant's workplaces at their request, and at a time that suited their work schedules. These interviews were audiotaped and focussed on four key areas of restraint use. Participants were asked to relate specific incidents in the following categories:

- Times when they used restraint and they thought it went well.
- Times when they used restraint and they thought it did not go well.
- Times when they considered using restraint but tried another approach and it went well.
- Times when they considered using restraint but tried another approach and it did not go well.

It was left to the participants to define what they considered to be the positive or negative outcomes as I considered this to be informative regarding the nature of their thinking about restraint and its place in mental health nursing. Additionally, at the conclusion of the exploration of the four different scenarios, participants were asked to talk about their general beliefs about what mental health nursing is about and where they saw restraint fitting into those beliefs. This was to attempt to determine if there were consistent beliefs that underpinned or informed their decision-making. Most interviews lasted between 45 minutes and one hour. Despite making arrangements to assure the anonymity of participants in the research, three later approached me seeking formal recognition of their involvement for use in their professional portfolios.

Following the initial interview an appointment was made for a second interview within two weeks. In the interim each tape was reviewed and notes taken to guide the more in-depth discussion of the second interview. The second interviews took the form of reviewing the audiotape of the initial interview, with the tape being stopped at points I identified as being particularly significant or of being in need of additional comment or clarification. Throughout this interview a second tape recorder produced an audiotape of the total. This audiotape was then transcribed by an experienced typist, and transferred to floppy disk. The transcriber had considerable experience in the transcription of research data and had signed a confidentiality agreement with the researcher. These were then reviewed for accuracy against the audiotape, which resulted in the need for considerable editing due to the use of technical and vernacular language peculiar to the mental health field. This corrected transcript of each second interview, with the first interview included as the interview progressed, forms the raw data of this study.

The data and presentation

Whilst the number of participants is not large, the resultant quantity of data is significant. 16 interviews were undertaken in total, during which 32 events of restraint or near restraint were described, with some overlap of events where people had participated in the same event. Due to the nature of the events explored, it was, in retrospect, inevitable that those with significant impact on the participants would be more frequently related, and the relatively small mental health nursing community would share some common experiences and have participated in the same events. The resultant transcripts comprised close to 100,000 words of text, including descriptions of the participants' personal beliefs about the nature of psychiatric/mental health nursing. All of the events described had occurred within four years of the date of the interviews. All restraint events occurred within the environment of mental health units attached to general hospitals. All participants and any others named within the interviews were assigned pseudonyms to protect their identities.

For the purposes of academic audit each section of data is followed by a bracketed reference which identifies the location of that piece (within each participant's transcript) using the pseudonym assigned to the participant followed by a number which refers to the page number in the completed final transcript. This transcript includes the initial interview and the second interview in an integrated whole. If there is an apparent need to identify where in the interview process the data originates this is noted in the bracket.

Due to the conversational nature of the interviews the data was interspersed with the usual hesitations and personal idiosyncrasies; these have been removed where this does not affect the sense of what was being said. If any additions have been made for the sake of clarity these are indicated by the use of a square bracket [ ]. Where vernacular or mental health specific terms have been used an explanation within a square bracket is provided. Data sections longer than a few words are presented indented to assist in differentiating them from other text.

Data analysis

The stories within the interviews were rich with detail and relatedness. Many components existed within the whole of each story, each contributing significantly to the total episode. The breaking down of stories into small components was the initial approach taken in this research, however much of the integrity of the stories was lost in doing so; such was the need to identify contextual detail and the inter-relatedness of the factors in any given situation. An approach that preserved the 'sense' of each story was needed, hence the approach of presenting large sections of interview transcript in the data chapter, allowing the reader to form a picture of what was happening at the time of the event, before exploring in more depth the details that influenced the decision made. The analysis is based on categorising quite significant themes and large chunks of data, before analysing in more detail. This has lead to some complications as the multi-factorial nature of the events and the need to maintain integrity of the whole is, at times, in conflict. For this reason, the reader may become aware of occasional repetition of parts of the data in different themes and categories. An attempt has been made to minimise these overlaps, but of itself, this situation highlights some of the difficulties of unpacking such interwoven

events and the challenges of participants when working with these situations. Following identification of major themes an analysis of how these fit within the various sources of literature was undertaken, resulting in discussion of what is newly known, and what relates to the extant literature regarding (in particular) decision making and risk assessment. The need for the outcome to be real and recognisable to the participants and others who may access the resultant understandings was paramount. In the highly charged context of restraint there is little purpose in creating a theory - practice dysjunction if there is a desire to retain credibility as a resource in the area. What is presented must remain true to its origin to be of use.

Credibility, Auditability, and Fittingness

As with all research it is important that the conclusions drawn are considered to be credible. Credibility refers to the relationship between the participants and the data and findings. The key question is; "do the participants recognise the experience as their own?" (LoBiondo-Wood & Haber, 1998, p238). The use of second interviews to clarify participants' perspectives and to allow them an opportunity to correct, explain, or interpret anything they said in the initial interview ensured the credibility of what was reported in the data and ongoing analysis (Marcus & Liehr, 1998). At the conclusion of the analysis participants still able to be located were supplied with a summary of the findings for their perusal and comment if desired.

Auditability refers to the reader's ability to follow the thinking and approach used by the researcher. This is achieved through description of the steps undertaken in completion of the research. Auditability allows for replication of the study undertaken to allow further investigation the phenomenon in question. In this thesis, this is achieved by the content of this chapter.

To further strengthen this research the approach of triangulation is used; the process by which the "same issue is investigated in a variety of ways so that different types of evidence are produced to support a particular finding" (Minichiello, Fulton & Sullivan, 1999, p45) Themes that were identified and analysed came from several different sources (participants), and from services

with different organisational structures and locations. Reference was made to relevant literature to further support the development of the themes. As the study progressed it was clear that significant themes were present in all of the participant's stories, despite their diversity of age, experience, preparation, and attitudes.

Fittingness refers to the ability of the research findings to be applied in contexts other than those of the actual research itself. To ensure the fittingness of the findings, senior colleagues with experience in the area of C&R were asked to comment on them to assess whether or not they seemed reasonable. This ensured fittingness, as these colleagues were able to recognise the findings as meaningful and able to be applied in other situations.

Summary of methods

This research commenced in 2001 with my realisation that there was a gap in current knowledge relating to the actual (as opposed to theoretical) factors considered in deciding about using physical restraint in mental health services. Following a literature search application to conduct this research was sought from the relevant ethics committees and management of the mental health services in which participants were employed. Semi-structured interviews were used to investigate the factors considered in restraint use or avoidance. Thematic Analysis was the research methodology selected for this study, after a somewhat circuitous decision making process. The data was searched for broad themes initially, which were further explored in greater detail with the participants concerned. The complete transcripts were then broken down into themes and subthemes, seeking support for these groupings from multiple sources within the data. The themes were then analysed in the context of extant research of the subject area. Expert opinion was used to support the fittingness of these findings.

Chapter IV

Introduction to the Data

Introduction

In this chapter two episodes of restraint are presented which represent different types of response, although both result in the patient being restrained. The events have quite different origins, and represent opposite ends of the spectrum of restraint events. No two restraint events are the same, not only are the participants different in each case, the settings, the experiences, the knowledge of each other and multitude other factors contribute to the whole. Despite these variations it is useful to be aware of two major differences in types of restraint event identified in the data – the planned use of restraint to allow a particular intervention or to manage an ongoing problematic behaviour, and the immediate, reactive event where action "must be taken at once" for reasons (usually) of acute physical risk. The following examples, from the narratives of Dave and Carroll respectively, are used to provide the reader with an overall picture of what events are likely and to identify some of the key differences between these two events. For reasons of clarity and to protect the anonymity of participants, incidents have been taken from the interviews and distilled, such that the essence is preserved without extraneous or identifying information.

Planned Restraint Intervention

One participant, Dave, was positive about the handling and outcomes of the following restraint event:

> A restraint that went well I would say, would be the restraint of a younger female client in the [high needs unit of an acute setting], well over a year ago, where she was presenting as hypomanic. She had been admitted the day before; she was winding up, aggressive. It was one of those situations where you come onto the afternoon shift and at handover by the morning shift, [you are told] "this person's been winding up all day, we know something's going to happen."

> And you think to yourself "Oh, crap, why has this been left to the afternoon shift? Why haven't they done something about it rather than telling us all through handover that they should have done something this morning?" So, when you walk into the [high needs unit] knowing that this client is highly aroused, agitated, aggressive, threatening violence towards others, that we need to deal with it. So we went in there quite prepared, with three people who were C&R trained. We went into the lounge where she is, removed other clients from the room and then restrained her. Prior to that we discussed it with the doctor that we needed to give this lady an injection of Clonazepam, and that was decided, and we let her have some quiet time to wind back down in our seclusion area. So we approached her, negotiated with her. Her first response was basically "Back off, don't come anywhere near me." Her personal space was actually huge at that point in time. So we did that and it almost looked a little bit comical; she was on one side of the lounge, we were right on the other side of the lounge; a big, long room. We were talking quite loudly to talk to each other, and we just talked to her reasonably passively for about 10 minutes, and within that she got to the point where it was reasonable she was going to come with us. We ended up doing safe holding techniques where the person doing the communicating, which wasn't me, it was a lady who knew her reasonably well was saying "we are just going to hold your arms as we walk you through," and we used safe holding. While we were doing that she did become a little more agitated and a bit more aggressive, so we did use firmer safe holding which is all part of our technique, and that worked really well. She responded well to that, and she had the injection. Whereas if we actually went in there thinking, with all our history of knowing what's happened in the past, she's going to end up being restrained, it's going to be horrible for her, horrible for us. She ended up lying down, having an injection and we stayed with her for a while, she had a sleep for a couple of hours, and she was great. That was a great restraint I think. (Dave 1-2)

Further exploration of this event reveals additional detail about its nature, including the composition of the team approaching this patient:

> There was one female staff member who was non-registered and one RN (Registered Nurse) and he was male. Both of them had been trained through the [C&R] course; however they had long experience in mental health. So they had a lot of experience. (Dave 2)

This particular team had decided to use a less confrontational approach to that suggested by the morning shift (but not followed through with). They appeared confident in their skills and in the decision to try negotiation first, and to use as little restraint as possible:

> We as a team, talking about it earlier, felt quite confident that the training that we were going to use, that everyone brings together, would work and we went in there confident that we were going to achieve something, so there was a definite spirit within our team of "this is great, this is going to work, this is going to achieve a better outcome." I think that in itself does make a difference in approaching a person, of where we have got a good belief in what we are doing. (Dave 1)

In this situation, the patient was previously known to the mental health service, and had been involved with one of the staff concerned during a previous admission. This knowledge of the more distant and the more immediate history contributed to the team's ability to choose a particular intervention approach:

> Knowledge of her presentation that morning and a longer knowledge about her prior presentation, prior to the admission process, that was important, and I think that is crucial in assessing risk and assessing what approach to take. (Dave 2)

The influence of knowing if a patient had previously been restrained and their reaction to that was raised. Although not a factor in this particular incident, the nurse concerned did factor it into decisions about the style of approach taken:

> Obviously a person with experience of what happened in that when they are feeling in a particular way is going to make a big difference to the way they are going to respond to people approaching them. It didn't seem too distinctly a factor in this case, but in other cases it definitely has been a factor. It really depends very much on the individual case. If it is

somebody big and strong and is looking for a fight, definitely err on the side of caution anyway, but if someone knows what it is like to be restrained and we know that they are going to respond in a way that they are going to be aggressive as opposed to simply defensive, we would exercise a lot more caution. In a case like this of somebody who isn't presenting a huge danger towards people realistically, so long as you gave her space, I think it is more coming down to thinking about what we are going to be saying to the person. Is it making it very clear and getting - trying to get a picture from them of what they think is going to happen next, because if they are thinking "I need to go with these people because they know what they are doing" that is great, but if the person is thinking "I am going to have to defend myself here" it is a whole different outlook basically. So part of the assessment is trying to set the scene. (Dave 2)

Three key factors were identified in this situation as contributing to a positive outcome for the patient and the staff involved;

"Team commitment to the least restrictive approach," and

"....the key thing was having had training, and all three of us having had training and knowing it. ... and utilising it," and

"risk assessment at the time" (Dave 3).

The hierarchy of risk assessment undertaken is articulated by Dave in the following section, along with the multiple considerations to be accounted for.

Firstly, risk to myself, and my team, as in physical risk of physical danger. Risk to person of physical risk, that is firstly and then to other people around, other clientele. Once you get past all that, and that is a big area to get past, there is the danger of what happens if we intervene, what happens if we don't intervene? So I believe that is part of the risk. What is the risk of leaving the person and let him go through it? Because in some cases it can be appropriate to just leave them to have that time and space, and I have seen them, they come back down. So there is the risk whether or not to do that. There is the risk of what happens and the damage occurring in the relationship through restraining a person. And that is what it comes down to if we are going to restrain them it needs to

be less restrictive, and it needs to be considered very seriously, because there is a risk of over-restraining which does still happen to a lot of people that take that lowest common denominator of it. It is not worth the chance that you do maximum and then worry about it later. Because that healing doesn't always occur. There is also a whole area of things within physical risk, like what is the medical condition of the person, have they got any other problem, diabetes, broken bones risk, all of those things. (Dave 2)

Within this situation, identified as having been positive by the participant, there are several important contributing factors;

- The patient's history was known to the staff.
- The risk was not particularly acute, the situation having been allowed to continue without much intervention since admission.
- There were adequate resources to allow staff to concentrate on resolution of this particular situation.
- The team had a coherent plan and goals they wished to achieve.
- All team members had been trained in the same Calming and Restraint methodology.
- There was commitment to taking the least restrictive approach possible in the circumstances.
- There was commitment to ensuring the patient's wellbeing after the restraint and medication event.

In circumstances such as these, participants identified that positive outcomes can occur, and that restraint plays a role in achieving those outcomes. Restraint itself however, is not the entirety of the intervention, and often is only applied lightly, for a short period, and when the calming interventions have not achieved the desired result. Risk assessment is focussed around physical danger in the first instance but also includes risk of damage to the relationship between the patient and the clinicians, with identification of the need for healing to occur following any coercive intervention.

Urgent Restraint Intervention

In contrast to the situation described earlier, many restraint events are identified as being unexpected, in response to a serious physical threat, and requiring immediate action. These kinds of events were often represented by circumstances where a staff member has been attacked and others come to intervene. Every one of the eight participants had stories where they had been left isolated or let down by their colleagues in the immediate area, leaving them in physical danger. Whilst this side of the equation is of interest in terms of how it affected them in their future dealings with situations, it revealed little about the nature of decision making used when one comes across a situation already in play, and an immediate response is required to protect the safety of others. To gain a better understanding of these processes it is necessary to look at events from the perspective of those staff that intervene immediately, often without seeking additional support from other colleagues. Carroll related this incident:

> [There was] one incident where I walked into a room in (the) high needs (unit) and my colleague was fighting with this patient, and of course I went in to help my colleague because I didn't like to see what I was seeing. (Carroll 2)

The immediate response in this situation was to help her colleague who was fighting with a patient. There did not appear to be any questioning of the need for an immediate response or the need to wait for additional support before intervening. Carroll's initial response sums up her thoughts:

> Oh, yuk, I can't walk out, I have got to help my colleagues, and which I did, and then we took the young man out to the high needs courtyard and I sat with him and talked him through certain things, where, that again I think was a personality issue. This young boy had a behaviour problem and with men, male nurses. He looked on them as threat to him, and authority, where females we learned, he responded better to, with the one to one with the therapeutic approach. He would be very aggressive towards a male nurse. So in that case it wasn't really the male nurse's fault, but it certainly did make it worse situation. (Carroll 3)

The knowledge about some of the potential motivation for this young patient's behaviour is presented in the previous paragraph. It is significant that this understanding was identified as occurring later on in his admission, and was not part of the identified assessment at the time of the event of fighting with the male nurse. Carroll was very clear about what her priorities were in the immediate management stage of the situation;

> Supporting my colleague and stopping him from getting harmed. Because the young man wasn't hurting himself, he wasn't trying to hurt himself; he was trying to hurt my colleague. He was fighting my colleague, the whole scene; I wanted to help my colleague. (Carroll 3)

Environmentally, the area was fairly quiet apart from this incident, which occurred in an area somewhat isolated from the rest of the unit. It was the emergency alarm system which drew attention to what was occurring:

> Yes, the environment was fairly calm at that time. I had been with two other patients, sitting in the dining room, in the High Needs lounge area. This young man was in a room, room 5, one of the furthest rooms away from that area, so in fact there wasn't a lot going on in this area. The emergency beeper had been rung; my colleague [involved in the fight] had rung that, so there was a half a minute or whatever before we had at the staff there, by that time we had really got it under control. (Carroll 4)

In this particular event it appeared that the two staff members were able to regain control and prevent any further damage or harm. The initial response whilst physically restraining the young man was to calmly talk to him, which had positive effects. It appears that the later arrival of additional staff lead to a further exacerbation of the situation, with the end result being seclusion. Despite previously stating that the event was not the male nurse's fault, Carroll did see an alternative outcome as being possible, had another course of action been taken:

> Um, within half a minute, 2 minutes talking to this man, we actually calmed him down, the end result was that he did erupt again, and the end result was seclusion. I think, um, if the nurse and this man had entered into dialogue, quiet dialogue before they started throwing punches, seclusion wouldn't have been the end result and I didn't think it was a

> good idea. I didn't like the end result. Anybody who is secluded, to me is not a good result. (Carroll 3)

At this point in the event there was only two staff members involved. It appeared their intervention, although risky, had been quite successful. They were now physically safe and quietly communicating with the patient concerned, who appeared to be settling. As would be expected a further staff response occurred following the use of the duress alarm. The consequences of this response was regarded as less than positive from Carroll's perspective, and made the end result worse:

> We did press our alarm, and within seconds there were about 4 other staff, but I thought that exacerbated the situation, the guy 'nutted' off because all these people came towards him, where if they stood out the door, we had the young man on the floor, we were quietly talking to him; all these people rushing in just set him off again. I would say it was quite intimidating for him, because he wants to fight, to get out. (Carroll 3)

Unfortunately, despite assessing the situation, the response from the later arrivals on the scene appears to have been one which resulted in a worse outcome for the patient concerned, with him ending up in seclusion, having been further restrained. I asked Carroll what her assessment of the cause of the situation was, or the contributing factors. Her reply indicated a difficulty with the nurse/patient relationship:

> My colleague was male, and not aggressive, but quite confrontational sometimes. Because this young man and my colleague didn't really hit it off, he found it really difficult to actually nurse this young boy, where my approach was different, and his approach was different. So when I looked after him I had no problem, but unfortunately when they got together they just seemed to clash. (Carroll 3)

Key factors identified by Carroll in this scenario were:

> "I have got to help my colleagues,"
>
> "I can't walk out," and
>
> "all these people rushing in just set him off again" (Carroll 3).

Within this different situation there are some significant factors identified that may have contributed to the outcome;

- There was limited immediate knowledge of this young man's history, particularly in relation to his response to men.
- There was an immediate response strongly motivated by protecting a colleague, with little other consideration for the risks involved (which was however, successful in the short term).
- Staff responding to the duress alarm appeared to take a course of action that (in retrospect) exacerbated the whole situation.
- It appeared to be inevitable that, having assaulted a staff member, the patient would end up in seclusion.

Summary of restraint scenarios

With these two different restraint situations, it is clear that there has been a diverse set of approaches taken, with significantly different outcomes for the patients concerned. To assist in understanding the differences that appear between these two types of events a simple diagrammatic representation (Figure 4.1) was developed using some of the identified factors in each situation. Essentially this shows a greater level of planning and preparation when time is not so restricted, and physical risk is not immediately compromised. Clearly stated in the first situation was the ability to generate alternative strategies to those offered by other staff. In the second situation no alternative strategy other than entering the situation and becoming immediately involved in restraint was considered, and perhaps, no other effective strategy was available. In the first situation there was an assessment of the need for restraint, the purpose for using restraint, and options for outcomes following the use of restraint. This assessment was agreed upon by all staff involved. Within the second event the need for restraint was immediately identified, however no other assessment appears to have occurred at the point of initiation. In the following chapters, the considerations in these and similar events will be investigated. In doing so, the broad processes of assessment of need for a restraint intervention and assessment of risk will be further broken down and examined in greater detail.

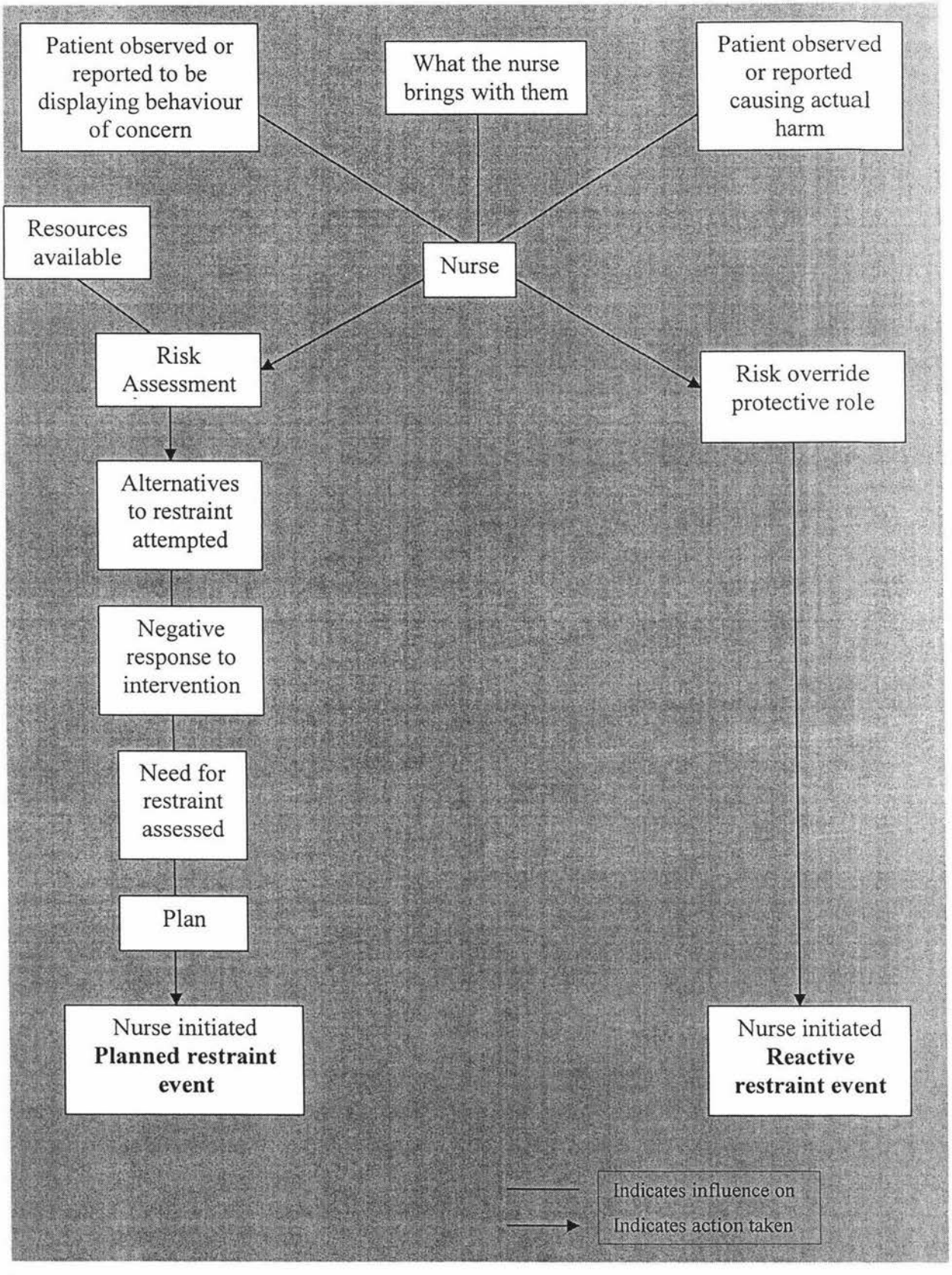


Figure 4.1: Factors in responding to situations where restraint is used.

Chapter V

Attitudes about patients, restraint, and risk

Introduction

In this chapter the data relating to nurses' beliefs about patient motivation and behavioural causes of aggressive or violent behaviour are presented, including their assessment of the patient's responsibility for their behaviour. Opinions about how that assessment may affect their response to the behaviour are investigated. Nurses' views regarding the therapeutic and controlling value of restraint are explored, particularly in relation to the benefits to individual patients and the need for maintaining control of a mental health unit. Risk assessment and its components relating to patient history are discussed, along with response differences towards patients with different presentations and perceived motivations for their behaviour.

Nurse's Perceptions of Patient behaviour

This section looks at the nurses' perceptions of the underlying causes of patient behaviour and violence and the relationship between that and the response to that violence. The influence of fear in response to violent behaviour is introduced and the views of nurses in relation to patients who are viewed as not belonging in mental health services are presented.

Assumptions about the causes of behaviour

From observation of clinical settings and as identified in the data, it is clear that mental health clients display behaviours that are risky in a variety of ways, and there are significant similarities in these behaviours. When questioning the nurses about this and their assessment of the intent behind these behaviours a theme emerged around different means of managing the behaviour, dependent on the assumed underlying causes. Specifically, several nurses raised questions around whether some of the assaultive clients were appropriately domiciled within a mental health unit or required mental health services. Associated with this question was the perception that clients who were not regarded as psychotic

to the point of losing control over their actions were a greater risk to staff and other patients:

> It meant that he could have quite easily [hurt me] and I wonder if that person should have been in that place any way. He subsequently went on into the justice system. I think that restraint happens more often with clients like that [those perceived as being in control of their actions], they are a bit more cunning and pick their times, rather than the randomness that seems to occur with people who are quite psychotic. (Sue 5)

And from another participant (Joan):

> No they [the police] left us to restrain. And they cuffed the client, put her in handcuffs, and we moved back and out and they took the client away.
> Interviewer: Okay, so she then didn't go through Mental Health process, she went through criminal [processes]?
> Joan: No it wasn't actually a mental health problem. She had been in there several times, and mentally healthy. (Joan 4)

The debate about how best to deal with violence that occurs outside the context of psychosis, or where a patient is deemed by staff to be responsible for their actions, is current and of considerable importance in health services. Brown (2001) states that "...determining the cause of violence is essential as it enables the most appropriate response to be identified" (p32). This suggests that different causes of violence will result in different response to it. With the process of deinstitutionalisation now well advanced, this debate appears to be gaining further momentum as options for managing people who prove 'problematic' within society are diminishing. Mental health services appear to be defining their role with greater assertiveness and identifying whom they can provide service for and whom they cannot. This was supported by contractual arrangements and national policy which continues to direct services to provide for the most acutely mentally unwell only; the three percent of New Zealanders who "are severely affected by mental disorders" (Moving Forward, 1997, p 11). This position raises questions about whether or not the assumption of intent or the influence of psychosis affects the decision making in choosing how to manage any given situation. This question was raised in the interviews with nurses where they were

asked if patients deemed to be in control of their behaviour were treated differently when presenting with challenging behaviour. The responses indicated a willingness to take a more restrictive approach if there was felt to be a conscious intent of harming others.

George puts it this way:

> Possibly, I would suggest that if they were disjointed [their behaviour] there wouldn't be the heavy-handed approach, whereas if they are testing from that situation you may be more inclined to say, "look, these are the boundaries, don't cross them, you are crossing them now" (George 8).

Bill's response was similar and also raised the question of how a patient perceived as acting with specific intent may be viewed in the future. This extract relates to a particular incident where he was physically attacked by a patient:

> I think potentially I would have taken a longer time in relaxing the hold, and guaranteeing that it wasn't going to happen again. I may have possibly sought out medication to relax the person more. I probably wouldn't have been as trusting of his word, or why the event occurred. I would have been a lot more cautious and wary of that person after that because you know, I would sort of see it as a logical thought out, determined attack sort of thing. (Bill 4)

In these pieces of data there is a common theme of not trusting patients who were deemed to have control over their actions and an element of apprehension at their abilities to inflict harm on others.

Fearfulness of patient groups

Additionally, an element of fear was identified by some participants. Fear is identified in the literature as having an influence on the way in which decisions are reached, whether that is in the context of fear of how actions will be viewed by others (Crozier & Raynard, 1997), or because of the high levels of risk faced (Schulman, 2002). Despite asserting that their responses remain professional, nurses are likely to be influenced by the element of fear, invoking some basic

biological responses. As Carroll identifies, particular groups of patients engender a stronger response than others:

> Yes, drug induced people who are psychotic, very much so I am very wary of them, because they just don't know what they are doing. People who have schizophrenia and bipolar, and who are incredibly acutely unwell, you can often manage, but people who are drug induced, [under the influence of] alcohol, they really scare me. They are so out of control, they haven't a clue what they are doing, and those are two people you often cannot talk to because they have got no insight at all. They are quite crazy some of them. In fact I find I'm getting more and more tired lately of having these drug and alcohol people on the ward. I don't think [the inpatient mental health ward] is really a facility for these people. I mean, it seems just lately that we are just a holding bay for these people that come in. They go on to detox [detoxify], and they are there for about four days, they [go out and] get all their drugs (and) bring them back and then they go out into the community. I don't find that I am doing a worthwhile job with these people, because I am a) not qualified, and b) I just don't think our ward is right. I think it is unsafe for other patients. This is like their holding bay. (Carroll 12)

Joan had a similar story relating to a particularly vivid incident in which she had awareness of a patient through previous (non mental health) professional contact. She was asked about her knowledge of the individual concerned and what opinion she had of her potential for violence:

> Interviewer: Were you aware of this person's background?
>
> Joan: No. Oh, sorry I did actually, not so much through mental health, in another capacity. Yes, aware of her violence and her drug seeking, and her criminal behaviour.
>
> Interviewer: Right, so there were some pretty clear indicators, and essentially this could be violent?
>
> Joan: Yes, she was a very dangerous person. (Joan 5)

The feeling that patients, who are deemed in control of their behaviour, or alternatively completely unable to control their behaviour because of drug or

alcohol use, do not belong in mental health services is emerging from these extracts of data. This results in some difficulties for staff working with these patients.

Staff attitudes to patients not regarded as mentally unwell

Asked about how staff viewed a particular patient that had required restraining George's comments were that staff were:

> Pretty peed off, they thought they shouldn't be really offering a baby-sitting service to look after somebody who was being a rat-bag.
>
> Interviewer: Okay, yes, so did he have a psychiatric diagnosis?
>
> George: Had been one. That a lot of it was drug abuse and personality stuff. He seemed to be "a client of convenience" and we were being used as a five-star hotel when he didn't want to be doing what we wanted him to do. (George 1)

This client had in place a formalised plan that responded to issues of being absent without leave and illicit drug use that included the use of the high needs unit for a set period. This plan did not include the use of personal restraint, however the time spent on attempting to achieve his compliance without recourse to personal restraint was minimal, from the description given.

Reflecting back to Bill's experience of being attacked he was asked if his assessment of a patient's motivation affects the way in which he chooses to intervene:

> Yes, I do actually. I think, personally to a degree, right or wrong, it comes down to the mad or bad type argument, and having worked with bad type people within that environment and seen them attack and assault people and the reactions to that. This guy was quite psychotic at the time, and it actually made, to me, the whole situation, not acceptable but I was able to understand where he was at, and what's more, that it wasn't just he didn't like me and wanted to attack me, it was his thought processes that was messed up the time, and he misconstrued the whole situation. (Bill 3)

From the interviews a repeated theme of frustration associated with managing patients with criminal, drug abusing, or non Axis 1 (i.e. non functional mental illness as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association, Version IV, {DSM IV}) conditions is identified. The implication from participants was that those with disorganised thought processes due to functional or organic (but non drug-related) causes would be treated differently to those identified as variously "criminal," or "drug induced," or "behavioural." Patients identified as being "psychotic" or "disorganised" appear to be treated with considerable compassion and patience given the behaviours they display. Opportunities for in-depth communication, acceptance of violent behaviour as part of an illness process, and least restrictive approaches seem to be more frequently offered by the nurses interviewed, however there is often a more regimented and strict approach for those not deemed to be unwell in the same way. Frequently the latter group's placement within the Mental Health system and services is questioned, and a concurrent feeling that dealing with them is "not my job" exists as evidenced by a number of the previous comments.

The importance of this determination of intent needs to be considered in the context of the place of previous history and knowledge of the patient's behaviour in the past, and raises questions about the way in which people may be treated differently if they have been identified as "aggressive." Knowledge of previous history and behaviour is significant in the process of risk assessment, and is a key component in the NZ Guidelines for Clinical Risk Assessment and Management in Mental Health Services (Ministry of Health, 1998).

Caring and Controlling in Mental Health

This section introduces the complex relationships that exist between caring and controlling in the context of mental health services. The need for some nurses to be seen to be maintaining control of the total situation is investigated. This is followed by presentation of the participants' thoughts on whether restraint is a therapeutic intervention and the conflicts this produces for them. The last part of this section looks at the justification of disempowering patients 'for their own good.'

Maintaining control of the unit

The need to be seen to maintain control was expressed, some more strongly indicating this than others. In particular this related to those defined as being 'behavioural' in their motivation as opposed to illness attributed actions. George related an incident where a client was unwilling to comply with a request relating to returning inside:

> I think it's, it's not quite a case of you do as I tell you because I wave the big stick. But, no, in here we do, you know, even though we try to give you quite a bit of slack, we do call the shots. Otherwise other clients see that and think "we can do what we bloody well like and you can't do a thing about that, so there." And so, I think the big thing that goes through the back of mind, I don't want go in sort of the heavy coercive you know, "get in here ya sod, we're gonna deal with you.."
> But at the same time I suppose the other issue that goes through my mind is, um, I don't particularly need other clients getting the message that they can do what they like, when they like and they can get away with it because the staff are powerless to do anything about it.
> (George 8)

Sarah speaks of her perception of some of the staff she has worked with in relation to this concept, when she describes the difficulties of being a lone voice of dissent in situations where restraint is used prematurely or inappropriately in her view. She portrays the dominant approach thus:

> And it is easier, and it is almost if you weigh up the greater good. The greater good, which is yourself, the ward, the other patients, your reputation as opposed to one single old mad person; who cares about them anyway? "They don't care about being restrained, they're not going to remember, because they're too mad." I mean that is a really blasé way to look at it but that is how a lot of people feel. They go "oh no, there's no point in arguing, this person's mad." (Sarah 7)

Sue expressed the opinion that the needs of staff to have a sense of control was influential in their decision to choose restraint as the intervention of choice

earlier than may have been ideal in a situation she was involved in early in her nursing career.

> I'd like to say it was to maintain the safety of the environment, and the people within it. But really it was about getting this person out of the open environment as fast as possible and getting things back under control. Staff were getting frustrated with her mouthing off and stirring things up
>
> Interviewer: Was there much time invested in trying other strategies?
>
> Sue: Not really, not when I see what can be done now, with the staff and that.
>
> Interviewer: You mentioned frustration there; do you think that carries over into the decisions made about how to move forward?
>
> Sue: It would be good to say no, but realistically that's a lot of what was going on. It doesn't sound very good does it? (Sue 2)

This is expressed in more general terms by George, following on from his previous comments about the need for boundaries for both personal reasons for the patient and to ensure that nurses are able to achieve what they feel is necessary, maintaining an environment that is conducive to recovery for others.

> My concern would be that if you don't show that there are boundaries on the unit, and around the unit, you just end up running, to use a crude expression, you could end up running around like a blue-arse fly and do nothing all day apart from chase folk, and you are achieving nothing. (George 3)

Whilst this approach to maintaining control appears very overt and focussed on control for the sake of an identified greater good as opposed to a single patient, the theme of control in one form or another runs through all of the participants' interviews. Initially my position was that 'caring' and 'controlling' were discreet and usually dichotomous concepts, however that position was significantly challenged by a number of responses when investigating the philosophical position of nurses, their understanding of what nursing is about and how, for them, restraint fits into that construct.

The difference between approaches that seem to indicate great need for control to ensure that chaos does not reign within a unit, due to patients being able to model non-cooperation, and the need to impose control on a patient due to personal risk was highlighted several times by participants. For the individual patient restrained, the use of force to ensure compliance with boundaries seems to hold little (subjective) benefit.

Restraint as a therapeutic action; nurses' internal conflicts

Restraint is described as being therapeutic by some participants, citing it as an option for maintaining individual safety and, once viewed as effective, likely to be more comfortably used in the future, with an assertion that it becomes clearer when people need to be restrained as one gains experience. Bill expressed it this way, having been asked if restraint was ever therapeutic:

> It can be, yes. Restraint is a way of stopping somebody from harming themselves. So in that sense I see it as therapeutic. But again, there are a lot of options I would try and use before I get into that situation, but again it is not unlike the medication type when forcing it on people. Once you have seen it used it in a successful manner and a therapeutic manner, I have less issues with every time it happens that I deem it needs to happen sort of thing. Again I sort of question what right do I have to physically restrain somebody, or what right do I have to make that choice to take away that right for that person to react in a certain way? But this becomes obvious when people need it. (Bill 14)

There is however, a contrary position expressed that strongly opposes the idea that restraint is ever therapeutic. This position expresses the dichotomous approach to categorising actions as being 'caring' or 'controlling,' and leads to some major challenges for the nurse concerned. Carroll's views on restraint's place within her caring philosophy were sought:

> I don't see restraint fitting in my philosophy. In fact, I've had to really come to terms with restraint since I've been here, and go home and reflect and think why am I nursing. This is not nursing for me. This is not why I wanted to nurse....the caring side, restraining somebody is not caring. This is absolutely against all my philosophy. If I restrain somebody I

> think of myself, and think "if it had been me and been restrained how would I react?" And I know how I would react. I would go nuts because it's my personal space invaded. I don't like restraint. I don't like having to do restraint. I don't initiate restraint, I never have. I've got involved in it and I've talked to my colleagues about this but, restraint is the last resort. I can't see it as a caring, it's not a caring thing, restraint. (Carroll 13)

Yet despite this stated position Carroll had been involved in a number of restraint incidents, including some involving serious assaults on colleagues, where the immediacy imperative seems to have overridden concerns about the place of restraint in nursing. An example of her reaction is seen in this extract previously discussed in Chapter IV:

> Oh, yuk, I can't walk out, I have got to help my colleagues, which I did. (Carroll 3)

The degree of conflict this raises within Carroll is evident in this further statement in which it is acknowledged that restraint is sometimes necessary for safety but doesn't fit with beliefs about what nursing is:

> I don't like restraining people. As I said in the last interview, it is just not me. If it comes to nursing to restraining people, I would be a police woman. It is against my principles, and my values. But in the same token if it is a safety issue, I have got to do it because if my colleagues are in trouble. (Carroll 5)

This position is identified in other nurses by Dave. He expresses his position on how it should be managed:

> I think what a lot of it comes down to is that there are staff that are not prepared to take part in restraint, do not believe that it is part of their job and don't want to. And I think if that is your attitude they shouldn't take part in restraint, and why traumatise them by putting them into that situation? (Dave 6)

Later, when exploring issues around resources and the personnel worked with, some of the reactions from participants to those people who do not restrain for one reason or another are considered.

Disempowering for the patient's long term good

In each of the interviews participants were asked about their philosophy or understanding of what mental health nursing was about. Following on from that question, the issue of where they see restraint fitting with that philosophy was addressed, with the specific question about whether or not restraint was, or could be, used therapeutically. The answers reveal a significant degree of conflict within individual nurses about the perception that restraint is necessary, but never the less unpleasant, and raised questions about the way in which restraint is used on occasions. Sarah had this to say:

> I struggle with that sometimes, and also with seclusion as well. There's a part of me that says that I don't see it as being therapeutic at all. And I think that's not about the use of restraint, I think it's about the manner in which it's put into practice. So that's about individuals rather than restraint itself, because I'm sure that there's lots of people out there that say they have used restraint in a therapeutic way. And they would probably have a good sound argument if they were a credible, solid clinician. I don't know, but it's the manner... but then on the other hand, to have a person put themselves in dangerous situations is disempowering as well because we also have a responsibility to care for people, to keep people safe. I mean, like you know how people sometimes disempower people in the process of calming, because it would be too awful for them to allow them to do worse things.
> (Sarah 14)

The theme of disempowering a patient because the option of allowing them to cause harm to themselves or others is worse than the option of removing control is echoed throughout the interviews. In an environment in which much is made of empowerment and recovery models, this apparently paternalistic response is strongly held by participants as being a necessary part of their practice. Dave expressed it this way:

> It's always a contentious issue isn't it, because a lot of mental health, if you consider the Mental Health Act, the environments we use to treat people's mental health, it's all about using our power to take control away from the client. I don't think we can avoid doing that, I think we need to manage it better. (Dave 10)

This concern for the ongoing implications of allowing a patient to escalate or continue to behave in an assaultive manner is seen in this comment from Norm who had been seriously assaulted by the person concerned. He was speaking of his focus during a debriefing following an incident, and possible alternative pathways that might have occurred if the patient had not been successfully restrained.

> One of the things that I tried to work out was the fact that restraint, the need for restraint wasn't in doubt at all; stop him, what he was doing to me, contain him. But if you let this guy escalate he goes from an assault (of a serious nature) for unknown reasons on a staff member, to assaults on many others. And he's going to end up in a forensic unit and the guy won't be able to shit or fart without 3 staff members present around him all the time. (Norm 7)

George's view of things incorporated the need for boundaries to be established, at times through the use of restraint, for the individual's wellbeing as well as for the maintenance of what he saw as a therapeutic milieu in which patients were aware of the limits of acceptable behaviour. He was asked if establishing boundaries had any importance in terms of sending a message to other clients about behavioural expectations.

> It can be very much, particularly with younger guys. Although the thing is that you also really needed to lay some boundaries down and help the person establish personal boundaries for themselves, which they are often either unwilling or don't have the insight or the desire to do. (George 2 - 3)

Overall Sue viewed restraint as being a complex mix of therapeutic and disempowering actions that can, at once, be frightening but supporting:

> Interviewer: Is restraint a therapeutic intervention, do you think?
> Sue: I think it can be, in a bizarre way. Some clients do thank you. They do thank you sometimes; "I would have done such and such."[indicating a harmful action] But it doesn't happen very often, it's seen as being very disempowering and it is. Very disempowering and quite frightening. In training, falling to the ground, you know, knowing my face could plant straight into the ground [during a move to place a person on the floor] if someone isn't there to make sure that it wouldn't. That was quite scary for me, let alone scary for someone who is psychotic. So, maybe from a Nursing perspective it could be therapeutic, but from the recipient's perspective I don't think it would. (Sue 12)

This extract also raises the difficult question of whose perspective holds the greatest sway – the nurses or the patients. If an action can be perceived by one group as necessary and therapeutic, but as frightening and disempowering by another, there is clearly a significant gulf between those perceptions. In New Zealand the Mental Health Commission is tasked with representing the interests of consumers of mental health services. Their recent review, Seclusion in New Zealand Mental Health Services (Mental Health Commission, 2004) identified the use of personal restraint in the process of effecting seclusion, and asserted;

> From a therapeutic standpoint, any form of coercive practice has the potential to damage the therapeutic relationship between clinical staff and service user, for the power differential is highlighted in these circumstances. The therapeutic mode of care is replaced by a custodial mode of care (p 8).

Additionally in the comment on the review, David Chaplow, New Zealand's Director of Mental Health raises the very important issue that Sue alludes to when addressing the issue of better outcomes related to seclusion use. The question is "better for whom?" (p vi). As shown in the excerpts presented, nurses have a perspective that restraint can be seen as protective of the patients, themselves, and the rights of others, however this may not be a universally shared view.

Risk Assessment: Minimising Harm

In this section the place of risk assessment prior to the decision to restrain is presented with the predominant theme of maintaining safety being evident. The concept that maintaining safety is representative of having done a good job as a mental health nurse is introduced. Finally, the assessment of the patient's previous history, using both clinical sources and other people known to the patient, and the influence that has on the management options chosen is discussed.

Safety first

High on the list of reasons given for the use of restraint was the seemingly obvious factor of physical safety of people in the environment, be they staff, patients or visitors. Every participant had a story of restraint that was fundamentally about maintaining safety, irrespective of other factors. At times these events were already in action when they became involved, leading them to a position where they believed there was no other alternative other than to restrain the patient concerned. Some examples are given below:

> Joan: I was working in the intensive psych unit, relieving on this particular day, and a woman there was very agitated and became aggressive, and became a danger to herself, to other clients, and to staff. She was throwing furniture around, she was a very big woman and, yes we restrained her. That was successful.
>
> Interviewer: And everyone agreed that the restrain was the intervention to go ahead. That any possibility of anything else that could have been tried?
>
> Joan: Well, it was too dangerous to try anything else at that time.
>
> Interviewer: Right, so it was one of those immediate situations?
>
> Joan: Really immediate, yes. (Joan 1 - 2)

And this from Norm relating to a patient with a current history of violence towards his partner:

> I'm thinking of one recently where we restrained a young gentleman at the front entrance as the door was about to be closed and a distraught partner was leaving with 3 or 4 family members, one of whom had signed the 8 [Section 8, Application for Assessment under the Mental Health Act]. It was at this point that he took a flying kick at the doors, which burst open as they weren't locked. He was restrained for his safety and for the safety of his family. (Norm 2)

In all of these events the overriding goal was the maintenance of safety, suggesting this is a highly valued outcome for the participants which influences the nature of interventions attempted.

Doing a good job means keeping safe

Notable in this is that these events were all related in response to the question about restraint events that had gone well, suggesting that a clear indication of safety as an indicator for the need for restraint gives nurses a sense of satisfaction with their response. Having a clearly perceived safety issue to respond to appears to be a powerful justification for the use of physical force, and often leads nurses to feel they have 'done a good job' by using restraint. Dave discussed this more when asked to consider the hypothetical justifications for restraint, which were identified in Chapter IV (p 50-51). He spoke of risk to himself, his team and to the patient, firstly in terms of physical risk, which he describes as "a big area to get past" (Dave 2). Dave further discussed the balance of risks between intervening with restraint and not intervening, and his belief that, at times, "there is a risk of over-restraining which does still happen to a lot of people [when staff] take that lowest common denominator approach to it." (Dave 2) The comment that the physical risk is a big area to "get past" is reflected in many of the stories from other participants who have variously stated that their involvement in restraint was "all for safety reasons" (Carroll 2) and that if the issues relate to safety, "then that comes first" (Sue 5). There is, however some dissention about whether or not this safety first justification may be used in situations where other approaches could be tried first. Dave commented that over-restraining occurs quite frequently when a "lowest common denominator" (Dave 2) approach is used. This arose in some more general discussion in which the notion of

challenging practice was discussed, and the question of whether there exists a culture of using restraint in response to many behavioural manifestations. Sarah had this to say:

> I don't think there is a culture, but I think there are individuals, [who] will always argue the safety of the staff is paramount, when in fact it might not have anything to do with the safety of other consumers or the safety of the staff.
>
> Like it becomes, instead of a therapeutic ward milieu, it becomes normal ward policy [to restrain]. (Sarah 6)

Similarly Carroll relates an incident where the immediate risk appears to be low but restraint is used. A female patient who had recently been in seclusion due to her volatility and violence had dragged a male staff member into a room. The staff member had managed to extract himself from the situation and sought assistance. On Carroll's arrival the patient was asleep on the floor, probably due to exertion and high doses of antipsychotic medication.

> She had to be restrained. In those circumstances looking back at it now I think probably I would have left her on the floor in that room and shut the door quietly and let her sleep it off. But because she had her own room and had been in seclusion we made the decision to take her back to that room. In the course of taking her back to that room there were five of us taking her back, One of my female colleagues who I was with quietly said to us, as we were walking this girl along the floor and she was getting quite violent, "would somebody move her teeth out of my shoulder?" And she got a very nasty bite. We had to keep this woman safe, and actually had to put her in seclusion as she was a danger to others, but probably in retrospect, if we had just left her in that room and just left her, it would have been the best solution. (Carroll 11)

In this situation the action of using restraint appears to be linked to the injury suffered by the staff member and Carroll seriously questions the need for this intervention "in retrospect" (Carroll 11). Knowing the outcome allows a much more critical eye to be cast over events as they move from being 'semi-factuals' with no established reality, into the realm of factual events that have occurred.

This however does not necessarily assist in making a decision at the time events are unfolding. Many participants are able to identify options other than restraint, however often these options remain untested as the 'safety first,' risk averse approach appears to override the decision making. The fact that the patient concerned had recently been in seclusion and was regarded as particularly volatile undoubtedly influenced the approach taken by the staff who implemented restraint and returned her to her room.

Patient's previous history

Risk assessment tools used in New Zealand mental health services encourage identification of factors such as previous history of violence as a potential marker for greater risk currently, this being regarded as one of the more reliable indicators of future behaviour. This was investigated during the interviews with specific questions relating to previous knowledge of the patient concerned. Joan commented on one patient's background of drug-seeking and violent behaviour, describing her as "a very dangerous person" (Joan 5). Dave developed this idea further when asked if he had prior knowledge of an individual patient and then in a more general sense, how he would make use of that knowledge. This was seen in the events described on page 49 and further explored through other participants' recollections. The effect of previous experience on likely future responses is highlighted in these comments from Sue:

> If something similar happened, I'd like to think that I've got a little more experience now to maybe see triggers a bit more clearly and maybe intervene sooner. (Sue11)

In this statement the knowledge of what occurred appears to be not only viewed as knowledge of how this patient responds in certain situations, but is integrated into the individual nurses (building of) experience. Certainly, nurses are often urged to 'intervene early' by colleagues and through the various trainings in management of aggression, however the nature of that intervention is often left up to the individual practitioner and considerable variance occurs. The negative side to having previous knowledge of a patient's presentation emerged from a number of participants including concerns from Norm.

> We are 'hanging' you; we are going to make an judgement on the old bulk file, the old box file that exists, that we found shows that in May, June and July, August and September you were restrained on average 5 times a week during that period in 1980!
>
> If you think about it, he was 22, 21 years old. But if we do have to restrain him, we have to get the [additional staff resources] over. So we are going to drop him, and there is no other option but to go straight into seclusion. He will know that. He will understand that. That is one way of looking at it. The other thing too is, if we have got to take an aggressive posture with you, an aggressive posture, whether that is in the tone of how we treat you or the approach we take to you, we should actually expect a bit of brickbat coming back at us.(Norm 8)

Norm's concern is that too much emphasis may be placed on distant historical behaviour (both the patients and staff behaviour) in deciding what an appropriate course of action is. In the last part of the statement there is an acknowledgement that taking an aggressive approach can draw out further aggressive responses from the person concerned, thereby creating a situation of self fulfilling prophesy, in which the need for restraint is again reinforced. Similarly, experience of a patient over the course of an admission can lead to staff taking more restrictive approaches as Sarah expresses when discussing how risk is assessed and managed when a patient has displayed aggressive behaviours towards staff:

> Well it sort of makes people more, well it makes me, because I don't know if you have faith in the people around you, would make the people even scareder. It is you almost become too scared to let them go because if you do, and they were actually in a more angry state than they were prior to restraint.
>
> Interviewer: So there are fewer options as you go.
>
> Sarah: Yes, and say like for this gentleman, the end result was always seclusion, and this was a guy who basically lived in seclusion and this is a guy who had for instance, been fairly well in society, and who was suddenly smearing faeces ... so the end result is like, we are restraining him a couple of times a week, and the next thing we are secluding him

and he is starting to live in seclusion, you know it is like they are more backed into a corner the more they come out fighting, when they were just unwell.

Interviewer: So the staff responding in a particular way, always in the same way, we've set him up for a whole set of behaviours?

Sarah: Yes, all it does is reconfirm that here's a person that needs to be restrained and in seclusion. (Sarah 6)

Here we see a continuation of a management approach which does not appear to be achieving positive change for anyone concerned, apparently because of staff fear that they will have to deal with a worse situation if they don't take the restrictive approach of restraint and seclusion. In this particular situation the outcome for the patient concerned was a transfer to a more secure environment for a prolonged period of hospitalisation, again reinforcing a belief that restraint was justified by his behaviour. The more complicated, and perhaps important, question raised by Sarah is whether the actions of the treatment team, by taking a restrictive approach caused the development of severely regressed behaviour, to the point where this previously functional person was smearing faeces, or was that a symptom of his illness, or a combination of the two? From this it is clear that, at times, a clear assessment of the history and the patient's response to treatment approaches does not always occur, and that information is not well utilised.

Making use of information from other sources

Risk assessment involves seeking information from a variety of available sources whenever possible. Often nurses are dealing with families, friends, and other staff who have a heightened sense of anxiety about the behaviours demonstrated by the patient because of their own experiences with them. How then, does the nurse undertaking an assessment of risk make sense of this information and respond to it if it appears to be in conflict with what they see presented to them at any given time? George had this perspective:

> Another client who comes in and a little bit of an unknown quantity, and initially reports I had from family and from other folk was "look be careful because he's inclined to…., there's some pretty nasty stuff where

he can focus on people and do some stuff that's pretty dangerous." But at the same time when I got to know the guy a little better I also found out that if you gave him a little bit of slack or leeway, he'd go out and wouldn't abuse that and he'd come back again. And initially there was a problem with the guy coming up and (saying) "nah, I've had a gutsful, I'm leaving." "No, sorry, you can't do that." But then with a change of focus slightly to, sort of what was happening, talk to him further..... as best as you can "we'd just get you out for a few minutes, and get some breathing space," and he was not a problem. But I think a lot of it there would have been due to limited information there from certain staff who said, "this is what's likely to happen, he's dangerous."

Interviewer: So I must take it that the source of information from other people, and what I would like to look at is how much weight do you give on that, given that these people have got, I guess, considerable history and background knowledge, compared to what you see in front of you and your own experience with this person?

George: Well, if you don't know the person you have got to listen to what other people say who have dealt with this guy. Having dealt with somebody once or twice, sometimes you develop - it is almost like a gut feeling and you are sort of uncomfortable; I can go here because I have had him here before and I am able to trust him at this point. Now you can't put gut feeling down in a text book, but it's still something sometimes you have to trust. (George 12)

Again, this indicates variation in approach and practice, from some team members taking an approach that gives some "leeway" to others who focus on historical evidence of dangerousness. In this situation the concept of "gut feeling" arises; a theme which is seen in a number of the other participants' interviews, but which is difficult to quantify and not regarded as a part of the formalised risk assessment process as used in Mental Health Services. Certainly, gut feeling is not considered an acceptable rationale when reviewing situations after the event, particularly if an outcome has been perceived as negative or flawed.

Summary of attitudes, risk assessment, and the place of restraint in care

From reviewing the data there is support for the idea that assessment of a patient's intent may well affect the response to their behaviour. Patients viewed as not being psychotic, and therefore deemed as being more in control of their behaviour are regarded as more problematic and potentially ill placed in mental health services. There was a theme of annoyance and frustration expressed regarding this. At the other end of the spectrum are those patients who are behaving violently as a result of drug or alcohol use, who are viewed with considerable trepidation by nurses. There is a suggestion that this leads to different levels of intervention in response to challenging behaviour, in that patients who are more disorganised may be viewed as deserving of care and treatment, whereas those identified as able to control and plan their behaviour are more in need of boundary setting with recourse to restraint being a part of that. Those who are affected by substances are treated with considerable caution, and regarded as being very high risk to themselves and others.

There was considerable diversity expressed about the place of restraint in care in mental health services. Male participants expressed a position that saw restraint as being a potentially therapeutic part of mental health nursing, in terms of preventing further harm to the patient, or preventing the patient from harming others and then carrying that history with them into the future, potentialy with negative consequences. A number of the female participants were less convinced of this position and saw restraint as being something that, whilst necessary at times, sat outside what they saw as their purpose as nurses; a necessary evil, that caused considerable intrapersonal conflict for them.

The determination of intent was seen as part of the risk assessment process with patients felt to be in control being seen as a greater risk, due to the perception that they are capable of causing greater harm to others. Whilst risk assessment was seen as an integral part of what should occur there was an element of concern that an emphasis on past behaviours and potentially negative outcomes can lead to overly restrictive approaches. Many participants identified that the formalised approach to risk assessment was of restricted value in the minute by

minute clinical environment, and that an element of gut instinct or intuition is used to guide their practice when in need of rapid decision making.

Chapter VI

Resources to restrain

Introduction

In this chapter the resources available to staff when confronted with behaviour that may lead to restraint are examined. Gender issues are presented from the perspective of expectations, by both female and some of the male participants, that men have a significant role to play in maintaining the safety of others and the existence or non-existence of enforcement or safety roles. Participant's views about the usefulness of C&R training are presented including the effect that has on their responses to challenging situations. The role of gut instinct is an emergency is explored along with its context in nursing. The impact of differing physical environments is considered, both from the perspective of providing a wider set of options to manage challenging behaviour and from the impact of those behaviours on others in the environment.

Gender Roles in Mental Health Services

As the interviews progressed it became clear that there were variations in how males and females perceived their roles and the roles of those of the other gender. Throughout this discussion the terms male and female are used as no assumptions have been made about individual participants' gender identity. Participants were asked to share their thoughts, firstly on whether they believed differences existed, and secondly on how this influenced staff responses.

The basis of gender role differences

In most cultures and throughout the passage of time men have been physically dominant and displayed higher levels of physical aggression, generally taking on warrior roles to the exclusion of women (Sanday, 1981). From the point of view of adaptive behaviour this has advantages in protecting oneself and those important to you, given males generally greater size and strength compared to females. Whilst we consider ourselves well advanced from more primitive states of humankind it is clear that our responses when stressed revert to some

fundamental behaviour, and that advanced thinking and decision making is often lost or impaired. Our bodily responses to fear and threat remain as in primitive humans, with changes in our circulatory, endocrine, muscular, respiratory and neurological systems preparing us for the classical "fight or flight" response (Valent, 1998). Given this physiological response to threat, do we still retain the traditional roles of protective or aggressive males even when the context is very different to the situations that encouraged the evolution of these responses? Nursing remains a female dominated (numerically) profession even within the specialty of mental health, which raises questions about whether or not male and female staff make different contributions to the delivery of care. Do males, for example, take a more authoritarian approach to the management of patients with challenging behaviour? If that is the case, what are the reasons for this? Who places gender role expectations on staff; the staff themselves or others? Would altering the gender mix in a service significantly influence the manner in which challenging behaviour is responded to? Does territorial behaviour play a role in this?

Clearly the expectations of a male staff member will be different to those of primitive man living in a physically hostile environment, with physical threats from wild animals or other humans, or the need to be adept at hunting to provide sustenance for oneself and one's family. An ability to fight off others and provide high levels of sustenance would allow the continuation of one's genetic line and improve the chances of success and survival. In a modern world, in the context of providing professional care to others, the ability to be a strong fighter, capable of overpowering opponents would appear, at first glance, to be of limited utility. Or is it, for this is what physical restraint essentially achieves – the overpowering of one individual by another (or group of others)?

Expectations of male nurses in mental health

Participants in this research were clear about one thing relating to gender of staff; if there were male staff available there was an expectation that they would take a significant role in restraint situations, often leading or initiating the restraint. George states:

> "It would be predominantly male; I think with one them [restraint event] we could have had one or two females about, but it was predominantly male staff that were calling the shots." (George 6)

Where this expectation arises from is less clear for some of the participants, and in particular the male staff did not overtly express that this was a role imposed on them by others. They do however seem to assume the role whether they perceive it to be imposed externally or innately assumed.

Female participants were much more forthright about how this situation comes about. They see it as an expectation imposed by female staff on males that males will take a role that is protective of them, and that situations requiring restraining are evidence of the need for male staff in mental health units. Sue talks of "complaints if there are no males on any given shift" (Sue 7). Carroll expresses similar thoughts:

> "The men have a harder time, because they are called all the time to help...I look at my male colleagues and think they have a lot of extra responsibility to look after female nurses..." (Carroll 12 - 13)

Sarah, an experienced and advanced practitioner, is critical of some of her fellow female staff members who impose this expectation on the male staff. She reflects on how this is seen in the acute ward;

> "I would say that we have a culture, and I can only talk about the culture on our ward, where we have had a number of unskilled, inexperienced women, and I mean not by years, but by knowledge, skills and attributes, who have expected that the men on the ward are to behave in a custodial manner, and so they have always sought to be protected by their colleagues. And so I believe that often men do respond in a way that is different, but it is also something that women actually expect. And it would be my belief that it takes a very skilled female to not take advantage of that, and I would say that in the ward that I don't see a helluva lot of skill actually, and knowledge. I think that it is improving hugely and it is has improved since I was last there, but I don't believe that, um, yeah, I don't believe that it was done that well actually.

"Often, I can think of certain *(female)* nurses , you know, my build, my age, went in, created chaos and stepped back and left it for the big boys to sort it out." (Sarah 3 - 4)

Norm identifies an expectation that males will take lead roles in restraint in the unit he works. For example, he cites a patient whom he had restrained the previous afternoon which he identified as being caused by a female staff member's unwillingness to engage in the situation and manage it to a conclusion he saw as inevitable (seclusion) earlier in the day:

> And we went out about 3 o'clock to see if he had calmed, and he had a go at us, so we dropped him and locked him up [secluded him]. I said "Why didn't you do this when you restrained him [this morning]?" Bruce, the PA (Psychiatric Assistant) said, "you know we can't initiate seclusion. Michelle doesn't like using seclusion." Which doesn't matter, she doesn't come in here. So I was a little bit pissed. But yes there is a strong expectation [to use restraint and seclusion]. Particularly in the acute units. (Norm 5)

The service in which Norm works has another Mental Health Unit nearby which is frequently called on to provide assistance in managing patients displaying aggressive behaviour. In this situation an alarm is sounded in one unit and male staff are sent to the other unit. Their purpose is clear from Norm's perspective:

> This is why the [other unit] boys, when they come over here, they are not coming over to negotiate, pacify or talk. They come over and drop someone [restrain them down to the floor]. (Norm 6)

This culture is reflected in Dave's words about these situations. Dave previously worked in the Acute Unit referred to, and described what he saw as "hero" type behaviour on the part of some male staff:

> I have seen people [staff] go "right!" and go in there and be extremely aggressive and end up being in restraint and giving an injection and they have come out viewing themselves as a hero. I have seen that happen and it still happens in [the Acute Unit] now. (Dave 6)

Norm further explains some of the rationale for what might be viewed as an aggressive approach in terms of the resource issues faced by the unit providing staff to deal with any restraint related incidents in other units:

> I will explain that to staff. I have worked there: if we get an urgent call over the intercom for two male staff to [the Acute Unit] back door immediately, if you are working there that night, you would know that two staff would leave immediately, and then we have got to call everyone in. Because we haven't got the staff then to cover the courtyard. So that incident here, impedes what is going on over there. (Norm 6)

The fact that these staff would invariably be male staff further reinforces a set of expectations that males take on these roles as the staff who deal with aggression and violence, and do so decisively with physical interventions.

Training in Calming and Restraint

Prior to the introduction of Calming and Restraint (C&R) training, nurses relied on skills they acquired from on the job experience and whatever else they brought with them from outside the job. Nurses with the physical skills and attributes to successfully contain aggressive patients were highly valued within mental health services; the calls out to male staff to attend incidents of violence were frequent and reinforced the culture of men taking on physically protective roles. The introduction of C&R training lead to the offer of the development of skills for all nurses engaged in the management of patients with the potential for violence, irrespective of gender or physical attributes (Wright, 1999). In my experience, this development has been generally well-received by staff concerned, in that it provides a broader tool-kit for staff involved in one to one work with clients, allowing them to work in areas of conflict that would previously have been left to "the boys."

In this section the participants share their thoughts on the value of training in calming and restraint in a variety of different circumstances. How safety is affected by being trained is discussed, and the role of 'gut instinct' in making decisions to restrain or not restrain is introduced.

The value of calming and restraint training

Norm was a participant who brought a significant degree of experience in a physically confrontational sport (boxing). He was certainly used to violence and responses to it which would fall outside of acceptable practice in a Mental Health setting. Prior to C&R training being available he would have likely been one of those strongly valued for their physical prowess and ability to contain others' behaviour. He acknowledges these abilities then tempers them with his knowledge of C&R techniques and appropriate responses in the mental health context. When asked about whether C&R training was useful in a situation where he was unexpectedly attacked he replied:

> Yes and no. Because what I should have done after I got on him, in the larynx, what I strictly should have done was followed up with a double blow to the face, spun him around and hit him with kidneys shots and short punches that I could have controlled my balance with. I could have spun him around like that, and knee lifted him; IF I was fighting him. It does take a great deal of semi automatic responses not to throw left hooks or whatever, instead of actually cutting the distance down, to get him locked off [apply wrist locks to the patients arm]. (Norm 3)

In this situation the training resulted in Norm having a set of responses outside of what might be described as his initial response to the attack. Clearly, he is operating in a different manner to the way one would respond to an unprovoked attack in other, non-clinical contexts. He describes what he *should* have done *if* he had been fighting the patient concerned, making a clear distinction between the context of restraining responses and what might happen in a fight outside of his nursing practice. Despite the nature of attack the element of professionalism remains clear in his concern for the patient's wellbeing, even when his own situation was precarious:

> I managed to pin him in a corner and get a lock on him, but I was losing consciousness – I was gushing blood, and , um there was a distinct lack of volunteers to come out, because I needed to, I could hold my lock on OK, but I was losing my legs. And in that 25, 30 second period I

> thought, "if I lose my balance I'll end up breaking this [patient's] wrist." (Norm 4)

Joan was positive about the usefulness of training in a situation she encountered where a patient was throwing furniture around in a dangerous manner. She described the restraint event as:

> actually played out to the book. Because interestingly enough, I had probably done the training the week before. And one of my instructors was with me, so we did the restraint together, and it went just as we'd practiced it; it went well. (Joan 1)

Throughout the interviews it was generally accepted that C&R training was a positive and helpful thing in managing aggression. There are however, some reservations that relate to the nature of incidents participants (in C&R training) are being prepared to manage. Bill summed it up this way:

> It is hard to train for restraint type situations but they are always so different in nature, and every one that I have ever been involved has been 100% different from the one before it and there is no preparation and in a sense there is only the ability to learn from it and reflect from it afterwards. (Bill 17)

Similarly Sue expressed her opinion that a situation she was involved in "didn't go as well planned as what it is taught, I don't think it ever really can – it would be nice if it could!" (Sue 1). The incident was however resolved without serious physical sequelae for any of the parties involved.

Dave was involved in the situation where another health professional's approach put others at risk, resulting in a patient threatening them with a knife. In this extract he contrasts the effectiveness of the approach from C&R training and the approach that lead to the escalation of the event. He was asked if the training made a difference:

> I believe that it did make a big difference because I think we are talking to different staff who have done different courses in the past. Even under

> your own personality it used to come into it I think. I think it did; what we were doing prior to the [other health professional's] intervention, was working well, which was basically a safety first point of view with minimum intervention. (Dave 4)

Dave's comments raised the issue of safety in these situations, and the value of knowing how to intervene initially and maintain safety was evident. The training allowed physical intervention to occur even after the other health professional compromised the safety of the situation and escalated the whole scenario to a point where intervention was needed immediately.

Training and safety

Further to the benefits Dave identified, he commented on the nature of training and identified benefits for the clients in reduced risk of injury. He had described the incident as being "a shit fight to the ground" (Dave 4), yet still saw the C&R training as benefiting those involved:

> It is interesting, because I think restraint training is difficult to do. You can't train people in realistic situations of how someone is going to defend themselves or you will get continuous injuries on every day of the five day programme. I think it does, but it doesn't teach you an ideal. But we are not teaching people how to do Tae Kwon Do or Kung Fu, or how to be superstars at wrestling. The technique of control of a limb to physically direct them to the ground worked in that case even though it was a shit fight basically. I do think they make a difference and I think they make a difference from an injury point of view to the client. We are not going in there with a mattress and leaping on top of them any more, whereas we are actually mechanically working them to the ground. (Dave 5)

Another participant, Joan, was also involved in the same incident. The level of physical threat was significant, and usually staff would be instructed to keep well out of the way and let the Police deal with the situation. In this case the actions of

another health professional left them with little choice but to respond. Asked if training was of use in such extreme situations she replied:

> Absolutely, yes. I wouldn't have even entered if I hadn't have had that training.
>
> Interviewer: So in that situation you are actually putting yourself into a considerable degree of risk...
>
> Joan: In that situation I had good back up (Joan 3)

The last comment may raise some concern about whether or not training encourages staff to intervene in situations which they would previously have avoided. The difficulty of course is that no training would doubtless have resulted in significant injury to one or other of the parties involved. Joan's further response indicated that without training she would have been less able to take a constructive role in the management of that situation, and would see herself as "just being an extra support. But I would have gone behind them" (Joan 3).

Personal experience informs me that, prior to the introduction of C&R, some nurses (particularly women) in mental health felt they had little to offer in managing situations of violence. This is reflected in Daffern, Mayer, and Martin's (2006) work investigating staff ratios in forensic psychiatric units, where staff balance is considered in their study setting in terms of having enough male staff on each shift, largely for the purpose of maintaining security. It seems that training provides services with a much larger pool of people willing and able to be involved in such situations. The counterpoint is whether or not we engender overconfidence in our abilities. Carroll related this story:

> I had two patients having a fight – verbal fight, and instead of restraining and pulling them back, I actually got in the middle of them, which is probably a stupid thing to do.
>
> Interviewer: I would like your thoughts on the risk there was with those two patients involved in that fight, altercation.
>
> Carroll: Risk-wise they were going to start hitting each other. Also risk-wise there were quite a few patients around that were actually starting to get involved and put their comments towards it. So it could have actually ended up in a full-blown fight. By getting between these two and telling

> everybody else to clear out, which I did and the patients did, I managed to diffuse the situation because it was scary. It was quieter, I went in between them. One of the patients really liked me, and he could see that, hey I was in the middle here; he didn't want to hurt me, so it really resolved the situation. (Carroll 7)

Whilst C&R training would strongly suggest that in such a situation you do not intervene on your own but send for help, the question still remains as to whether being trained and exposed to such critical incidents may lead to a degree of over-confidence in your own abilities to deal with things. Carroll clearly put her own safety at significant risk by intervening alone and was fortunate that the situation did not deteriorate to the point of actual physical violence. She was confronted with this possibility and how she thinks people would have reacted had the situation not been calmed. She responded:

> They would have probably said I should have got help straight away. That I shouldn't have gone in, and did what I had done, and I was a bloody fool to try and sort it out. (Carroll 8)

Despite this acknowledgement she did not see her actions as unreasonable and articulated a rationale for her risk assessment which revolved around one of the parties having a pathological attachment to her, describing him as a "sexual predator" who "had a bit of a shine for me" (Carroll 8). This resulted in the nurse believing that one of the parties would be very unlikely to hit her in that situation. Contrasting with that approach was the response from Joan who was asked about the necessity for intervention in any given situation. She replied:

> We were just standing by really in preparation and we would have followed the process that we are trained in. That you don't have to rush in, only if someone was in real danger. (Joan 6)

This response appears to identify real benefit from the training in providing a more considered set of responses to a potentially explosive situation, and in ensuring that safety was maintained as the most important factor. The training informed a more considered approach to the situation, with time to make an

evaluation of the most appropriate response. Some nurses however, felt that there were more intrinsic, less conscious mechanisms in play.

Gut instinct resurfaces

Participants generally acknowledged the value of training for themselves, however some voiced reservations about it's effectiveness for others. There remains considerable dissention about the role of "gut instinct" (however that may be defined or explained) and learned, considered responses. Dave was asked whether training gives people a wider range of possible options in challenging situations;

> I think the current training does definitely. I think the problem with that is the amount of staff who have been doing restraint in psychiatric nursing for a very long time, that are really comfortable with, "this is the way it has always been and this is what has worked for me." That's their comfort zone. They are happy to go and do the training, happy to nod and grin and say anything they're asked. Straight back onto the ward, straight back into their old habits, because that's what they're comfortable with. I think that's the current danger. And along with the fact there is a lot of new staff with no knowledge of interpersonal skills. The training can only teach people so much really. It's just like getting a degree; it only teaches you so much. (Dave 8)

The theme of "gut instinct" is further expressed in terms of having to respond to events immediately. This was strongly seen in responses from all of the participants; however this instinct seems to be informed by some quite advanced considerations of options and assessments of the situation, despite time limitations. When asked if he ever operated on gut instinct Bill acknowledged that he did, however then went to describe a quite complex process of consideration that he equated to gut instinct:

> I would say, yes, you are prepared for the unexpected I suppose - expect the unexpected to a degree. A lot of it does come down to the actual person's judgement, their interpretation of the situation and the way I

would interpret something would be entirely different from how you see it potentially, and we have to take that into account. With somebody seeing the need for something, and I might not see the need for it, but you have to weigh up these odds and sometimes you don't get the chance to put these thoughts forward or these ideas forward and end up having to react. (Bill 17)

The strong pull to protect colleagues from possible harm often seemed to precipitate immediate action from nursing staff, even in the face of considerable personal risk. It appears that training in Calming and Restraint provides the techniques to intervene with greater effect in such situations, but usually does not alter the decision to attempt restraint or not, in a circumstance where there is a perceived need for immediate response:

> Interviewer: What did you see your role as being in that particular circumstance?
>
> Carroll: Supporting my colleague and stopping him from getting harmed. (Carroll 3)

And similarly from Dave;

> There was no way I was going to stand there and let the lady kill somebody basically, which what she was intent on doing. He may have struggled the knife out of her hand, but I wasn't going to be spectator to that. (Dave 3)

It appears from the data that gut instinct is a mechanism largely at play when time is limited and risk is perceived to be immediate and substantial. From the literature on decision making, particularly as it relates to 'expert' decision makers (Schulman, 2002), it is clear that these responses exist in a variety of highly charged situations, where action is taken intuitively. In the nursing literature this is most clearly expounded by Benner (1984) where the expert is described as having the ability to link the whole of a situation to the appropriate response without *conscious* consideration of all the factors present. This allows for rapid response and actions which seem 'magical' in their speed and efficacy

to less experienced practitioners. From these explanations, gut instinct is conceived as a product of experience which is developed over time and exposure to similar situations. Despite being difficult to quantify, it clearly has a place in mental health nursing as a means of accessing expert decision making. It is, however a difficult construct to use when needing to justify a decision making process when retrospective analysis occurs, usually in the context of an adverse outcome.

Physical Environment

One of the study sites had recently had a significant change of environment, moving from an adapted, prefabricated building into a newly designed purpose built environment. This provided an additional opportunity to look at how participants regarded environment (in the physical sense) as affecting responses to challenging incidents and the ultimate use of restraint to manage these incidents. Francis (2004) cites a study conducted by the University of Sheffield which found some specific relationships between mental health outcomes and purpose built facilities. Treatment (admission) times were reduced by 14% when comparing older facilities with newer, purpose built facilities, patients were required to spend less time in secure facilities (i.e. seclusion rooms or locked sections of units) when housed in the newer buildings, and rates of serious verbal abuse and threatening behaviour were significantly reduced.

Environments influencing nursing actions

During the course of the interviews the effect of the environment was raised at various times. Participants were generally of the opinion that the environment had an effect on their ability to intervene constructively in situations of conflict, and provided them with different sets of options. George refers to the earlier environment and identifies some difficulties nursing people who were wishing to leave. Among the difficulties here was the lack of individual areas for patients who were not housed in the high needs area, a lack of ability to maintain adequate observation and an environment with multiple, unsecured exits:

> OK you had a number of difficulties over there [in the previous facility] in that it was a very difficult place to keep secure. (George 1)

And in relation to another patient:

> Now he had been in one of the four-bed wings down there, but he said "nope, I am going home, that's it". And he walked out. (George 5)

With both of these patients, circumstances lead to them being restrained. Whether a more suitable environment would have prevented this is impossible to predict, however another of the participants, Bill, was enthusiastic about the flexibility of the newer environment, the effects on the security of the high needs area, and the way in which the environment influences the clinical practice:

> I am making a comparison, and I am comparing (the previous high needs area) with the new high needs area. In our new unit we have the ability to lock off one side of the unit into a three-bedded unit and have the other three beds on another side which could be locked down or open at the time. And it just contains the clients within a smaller, safer, more easily observed environment, than what I found the (old high needs area) to be. The other thing I noticed too, is that in the new unit we don't have an office that we sit in, whereas in the old unit, you know, typically I suppose nurses tend to spend a good deal of their duty in the office for various reasons, whether it was doing nursing type work, making up medicines, reading magazines, or making cups of tea.. Now we are forced to interact a lot more with our clients and that is beneficial to them in my opinion, and we develop a much better rapport and therapeutic relationships through that, rather than isolating ourselves to a degree like we used to over there. (Bill 11)

Participants also expressed the view that there was less restraint occurring in the newer environment than previously. Sarah expressed her surprise at reaching that conclusion, having been so strongly focussed throughout her interviews on the value of the therapeutic relationship:

> I would like to say that it shouldn't make a difference at all, that you should be able to work therapeutically with somebody in a tent. But I would say that the shift has, that the environment has had an impact. I mean the confidence, there is a number of things that have occurred;

> some problematic stuff, has moved on, that the philosophy of care has changed, and people having a couple of really good role models. People having cleaner, nicer environment to work in, like if anything, it is actually a harder environment in a sense, because it's bigger. Because nurses actually have to make themselves available and actually be with patients. Philosophically I don't think the environment should [have any effect], but I know that it has. (Sarah 13).

These participants, all from one service setting, identified a difference between the previous environment and the new, purpose built facility, and an influence on the way in which challenging behaviour was managed. The environment or setting is not just restricted to the building structure within which service delivery occurs however, and must take into account the total milieu.

Others in the environment

Sue adds another dimension to this debate by highlighting the environment as a factor when other patients see people in distress and are either distressed themselves or actively become involved in the process. The setting was seen as not allowing a transitional arrangement from full containment and control when acutely unwell and disturbed, to the open environment which housed other, less unwell or disturbed patients. She was asked if the physical environment was significant factor in the situation;

> I think it was quite possible that it was, being the environment that it was at the time. Other clients there, well most of them were distressed by what they saw, and others that were sort of goading it on. I don't know what; maybe they got something out of the excitement as they perceived it. (Sue 2)

So, in essence the situation resulted in restraint not because of the needs of the patient but because the staff had difficulty maintaining control in an environment which was difficult to provide for the diverse needs of the patient group This reflects the use of the justification for restraint found within the Procedural Guidelines for Physical Restraint (Department of Health, 1993): When an individual seriously compromises the therapeutic environment (p 3). As Sue indicates here:

> I'd like to say it was to maintain the safety of the environment, and the people within it. But really it was about getting this person out of the open environment as fast as possible and getting things back under control. Staff were getting frustrated with her mouthing off and stirring things up (Sue 2)

Although the environment was not as dominant a theme for those who had not had recent changes, there still existed acknowledgement that physical environment plays a part in the way in which disturbed behaviour might be managed. Dave speaks of the environment in a more holistic way, only part of which is about the physical layout:

> I think that's always part of the assessment; the environment, the personnel resources, who's appropriate to the person, who's available to do it, who is winding the person up, who is around that winds them down, is the environment that they're in an OK environment for them to be wound up in, are they OK to be wound up with particular clientele around them? Those things are very important. (Dave 8)

Reflecting back to Sue's comments the idea that an environment can effect a person's behaviour, but also the response to that behaviour is identified; "an OK environment for them to be wound up in," (Dave 8) and the need to get "this person out of the open environment as fast as possible and getting things back under control." (Sue 2)

Joan was reflecting on an incident that went poorly in her judgement due to the intervention of another health professional. The team of people involved had identified a significant risk due to the patient having a weapon, and had made a decision to use the environment to contain them and seek Police assistance. Her comments reflect her belief about the environment in which the events occurred, and that without the unfortunate involvement of others, would have supported a safe outcome.

> And if this person panicked, and put himself at risk, we could have shut the person in the situation, in a safe environment and called the police, which it should've been handled by the police. (Joan 3)

Summary of resource issues

Despite both male and female staff being trained in the same restraint methodologies, there is a sense that males are more often involved in restraint, and in particular initiating restraint, and tend to respond in a more aggressive manner. In some circumstances this seems to be partly explained by the structure of the service and expected responses to aggressive patient behaviour, as outlined by Norm (Norm 6).The impact of pulling staff from one area to another to deal with aggression is significant and leads those staff to take an approach which quickly 'gets the job done,' assuming 'the job' is containment of behaviour. Within one of the sites for this research the service structure was such that access to other Mental Health staff was not an option and this role was fulfilled by security personnel should there be a requirement for additional people. It is not possible to ascertain which of these situations is preferable in the course of this research.

Male staff were less certain that they had a role of maintaining safety that was any greater than that of female staff, and did not appear to view that role as one that was imposed on them from their female colleagues. This reluctance did not seem to be shared by their female counterparts, who all identified males as having a role expectation of contributing to a safe environment, particularly in respect of the physical safety of their female colleagues.

The "hero" status emerged as an overt issue in Dave's comments, however was also perhaps reflected in some of Norm's remarks about the need to 'tidy up' after others who had chosen a less restrictive intervention approach. This theme must also take into account the perception of those who attend incidents outside their own work area. Clearly they would not be called unless there was an understanding that they had something to offer (even if only greater force) that the staff calling them did not. The hero theme also emerges to some degree in the discussion around the need for immediate responses when a colleague is in

physical danger, and as can be seen by Joan and Carroll's responses, is not entirely the domain of male staff. Both of these participants acted in a protective manner towards their colleagues, even when there was considerable risk to them. The risks to self appear to be largely ignored, and assessment is replaced by instant response, fortunately for the responder with an advanced set of physical skills in restraint at their command.

Participants were all able to identify benefits in C&R training in that it provided them with a set of skills that allows them to effectively intervene in situations of high risk and violence. Overall however, the training did not seem to alter their intention to intervene, especially in the context of a colleague being in significant danger. There are references to the impact of training on the nature of the restraint response, with acknowledgement from participants that C&R modifies their responses; in some cases it gives greater confidence to be able to intervene more actively, and in others it allows them to select less violent interventions that are safer for the patient and more contextually appropriate.

References to acting on gut instinct were identified; it appeared that despite identifying a reaction as instinctive there was a significant underlying process associated with identification of behaviour and presentation. Training is acknowledged as not being perfect, or able to simulate every possible situation, but as contributing to the safe resolution of potentially or actually dangerous situations.

Those who had worked in different environments with a similar staff and patient set identified positive value in the effect of the physical environment on the responses to disturbed behaviour. It must also be recognised however, that other changes in the philosophy and staffing structure were occurring at the same time. Other staff, without the experience of a direct comparison, were still able to identify influence of the environment on the choices available to them for managing disturbed behaviour, in that environments may support patients to vent their emotions safely, or prevent these things from happening.

Chapter VII

Working with others

Introduction

Restraint use and the management of challenging behaviour is a team effort for reasons of safety to both clinicians and patients. In this chapter the views of the research participants regarding team decisions to restrain are presented, including times when there has not been unanimous agreement that the path taken was the optimal one, and times when the team all agreed with the actions taken. A significant theme throughout the data was that of being let down by other staff. This is explored in the section entitled 'not working as a team.' The willingness of nurses to engage therapeutically or to use restraint earlier than some participants viewed as ideal is presented. Following this, the role of the nurse as negotiator is explored, highlighting the limited set of options patients generally receive.

Disagreeing with other team members

Not all participants in restraint events agree with the decisions made by other nurses involved. It appears that there is significant pressure to reach a consensus decision about a particular course of action, which reduces the opportunity for discussion. This is consistent with the findings of Pilette (2005) referred to in the literature section relating to Groupthink. Sue had this to say about such a situation;

> Interviewer: Whose decision was it not to continue with those strategies? Do you recall? Was it a team decision?
>
> Sue: I think probably it was more the individual clinician's decision and the team agreed.
>
> Interviewer: Was there much discussion about that?
>
> Sue: Probably not as much as what there could have been. (Sue 2)

Even when nurses disagree with a decision made to restrain a patient, they often find themselves going along with the actions of others, at times in deference to

greater experience, a sense of needing protection, or because of a belief that other perspectives may be as valid as their own. Carroll reflects on a situation where she felt other options (to restraint) were available:

> My colleague that made the decision is a really experienced nurse and really I respect her a lot, so maybe it wasn't the right decision but that was her decision and that is the end of it. I personally probably would have seen, and said "Oh, lets get a blanket and put it over her, put her down (there) and let her sleep it off." But then we are different and do make different decisions, we see things differently and we have got to take into consideration the situation. (Carroll 11)

Especially when situations are unexpected or more chaotic than the norm, some participants found themselves acting in a way that left them feeling particularly uncomfortable, but with a sense of very restricted options:

> Basically, the guy picked up the TV and then everything happened just very quickly. And I just happened to be in the lounge area at the time, and next thing you know the patient is actually fighting the (other) nurse, and then there is a whole pile of people on the ground, and I was holding the guy's head. And I think I might have even been sitting on him or something. And I have just remembered thinking, "this is appalling," or you just think, "this is wrong." (Sarah 5)

Asked about her thoughts about the whole of the situation, which resulted in the patient being removed to another area and secluded, Sarah was blunt:

> Yeah, I can remember it quite clearly, I remember thinking, "this is just a fucking mess, and I can't believe we're doing this." (Sarah 6)

The longer term outcome was even more deleterious for the patient concerned, with transfer to a higher security facility, extended periods of seclusion, medication against his will, often involving restraint, and a decline in functioning to the point of engaging in pica (eating of faeces and other non food substances). Whilst all of this is obviously not directly attributable to an unsatisfactory restraint event, the restraint reflected a system of management of this man's needs that was ineffective:

> I think like that it is something that really concerned me, the whole time this patient was in, I mean (the acute unit), at that time, was poorly managed. In fact they were so poorly managed by us that they went to [more secure facilities] for a long, long time. (Sarah 6)

Bill identifies the discomfort with some of the restraint events he has been involved with in more general terms, in situations where there may be more time for consideration, and introduces how this is managed:

> A lot of it does come down to the actual person's judgement, their interpretation of the situation and the way they would interpret something would be entirely different from how you see it potentially, and we have to take that into account. With somebody seeing the need for something, and I might not see the need for it, but you have to weigh up these odds and sometimes you don't get the chance to put these thoughts forward, or these ideas forward, and end up having to react, but that is where this debriefing time comes in handy. (Bill 17)

Additionally, there appears to be a threshold level of disagreement evident for some participants where they will not go along with a decision, but that other factors such as the need for immediate action may influence where that threshold lies. Carroll provides a succinct response to the question of backing up one's colleagues;

> Unless you really, really strongly think that "hey this is the wrong call," and because things happened so fast when restraining people, there is no time to get them to argue, you have got to rely on your colleagues judgement. Definitely real quick judgement and I guess the consequences.... well, then they could be ironed out and reflected on. (Carroll 10)

What is clear from these extracts is that the need for immediate action is often viewed as a limiting factor in full consideration of alternative strategies, and that sorting it out later is seen as valid way of dealing with disagreements. At times the situation is clearer and team members concur with each others' decisions.

Unanimous agreement within the team

Whilst there were stories of being in positions where nurses acted in a way that they were personally uncomfortable with, there were also stories of effective teamwork where the situation was assessed in advance, discussion occurred, and all team members appeared to be comfortable with the approach taken. The example previously used to highlight the divergent manner in which restraint events can unfold is a prime example of this: Dave relates how the planning prior influenced the approach taken. The patient concerned had been reported at staff handover as escalating through the day, with little apparent intervention having been attempted:

> We, as a team, talking about it earlier, felt quite confident that the training that we were going to use, that everyone brings together, would work and we went in there confident that we were going to achieve something, so there was a definite spirit within our team of: this is great, this is going to work, this is going to achieve a better outcome. I think that in itself does make a difference in approaching a person. Where we have got a good belief in what we are doing. (Dave 1)

As previously identified the outcome of this event was viewed as positive, with an emphasis on the least restrictive intervention being chosen as the preferred approach. In another scenario, staff members were concerned around the escalation of a patient undergoing compulsory admission processes and the involvement of his family. The report of this from Norm indicates how much thought went into the deployment of available resources, and their response when the patient concerned attempted to break down the unit doors:

> The other staff involved in it, we had preplanned it. We were a pm. shift; there were six staff on; only three were C&R trained. So Len and Charles, who are on tonight, and I took him down [restrained the patient to the floor]. One of our more experienced casuals was out there with us and she was the one who dealt with the family. So it was good.
>
> The staff member was saying (to the patient's partner), "hang on, just wait for people to come, please don't say anything," because he was screaming her name out. And we got him up and walked him through to [the high needs unit] and actually sat her outside in the ward area. His

> brother then came in and clarified to him what had happened, "You know you were kicking the doors in. Don't forget you recently assaulted S and were in court." And there was a snap of reality there, you know, (and the patient said) "Have I?" And we didn't need to restrain further to that, and we didn't need to initiate seclusion, or need to use intramuscular injection as initial medication. The partner had calmed down then, and she came in and said goodbye, a quick "goodbye, and please keep yourself safe.' (Norm 1)

In this instance, the team had some clearly defined roles around managing the total situation, including the role of being in the restraint team itself, and the role of working with family. This contributed to a successful resolution with outcomes that were more positive than may have otherwise been the case. The patient concerned was admitted to hospital as (legally) required, the use of restraint was short-lived, there was no escalation to seclusion, and intra-muscular medication was not used. This positive example was balanced by times when participants felt significantly unsupported by their colleagues.

Not working as a team: being let down

Throughout the interviews a theme that was frequently heard was when other staff did not support the participant either in a restraint situation or, more frequently, when a patient had assaulted the participant. These events brought with them high levels of emotional content and were described vividly by the participants. Every participant in this research related an incident where they felt placed at risk, or suffered actual harm, due to what they perceived to be the inappropriate actions or inaction of other staff.

Bill's experience was one of working with a staff member who did not usually work in Mental Health, however had been trained in Calming and Restraint techniques. He was working in a high dependency unit on night shift at the time:

> I knew this person well, had looked after them a few times and worked with them a few times, and had been [working with them] quite successfully throughout the night. I'd been dealing with this person and de-escalating them, um, come to about 6 o'clock in the morning when I

was in the same position with this person, who was doing something he shouldn't do, he'd been into another clients room and taking his section papers out, and I was in the process of trying to explain to him why he couldn't take the papers away and have them for himself. He all of a sudden, um, pushed me, and backed me into a corner and started taking swings at me, um, which he connected a couple of times. The nurse I was working with just stood there, um, looking like a goldfish with her mouth wide open, um, didn't activate any alarms, didn't come to my assistance, or anything like that. I had the position of the fight or flight option, I was cornered, and as a result of that, ended up fighting my way out of the corner. (Bill 11-12)

Exploring this incident further raised some of the concerns that Bill had as a result of these events, and his interpretation of why he didn't get support from his colleague. The incident had a significant effect on the way Bill viewed working with people who are volatile:

Interviewer: What do you think the problem was in terms of the person's inability to support you?

Bill: Lack of experience in the area. I think she was quite scared, you know he was quite a big guy. I didn't find him intimidating, but he tended to invade personal space just a little bit and I believe she probably did find that intimidating when she was out and about with him in the unit that night. But I think that the way it all happened when it went down, I think she was probably just scared more than anything, and froze like a 'possum in headlights' type reaction to what had happened which was no helpful support to me at the time. I was left on my own, sort of getting dealt with, or dealing with it.

Interviewer: So that's a critical incident in terms of the sort of support that you would expect from your colleagues, but didn't appear to get?

Bill: Yep

Interviewer: How did that leave you feeling?

Bill: Um, pretty shaken up to tell you the truth. I was a care assistant at the time, but about, in the process of doing my transition to practice, um, was about to become a registered nurse, and the whole way through it,

days, weeks, months afterwards, all I could think of was that I had a registration to protect, what would have happened then? How would I have gone about it?

Interviewer: Do you think that this incident changed the way in which you practised?

Bill: Yes, I am a lot more wary now after that. I suppose to a degree I have been a little bit cocky and sure of myself in that type of situation, and this is the most violent event I have ever come across or ever been involved in, and up until then being in a restraint type of position with potentially violent person, people are always, as a junior type member of a restraint team, somebody else taking the lead and calling the shots. Yes, it scared me a helluva lot thinking that shortly that I am going to be taking that leading role in making these judgement calls and leading these type of events. Yes, it was quite a worry at the time. (Bill 12 - 14)

Bill's concern about being involved in this incident does, however, have seemed to have some positive consequences in that he was now more reflective about how he would manage such situations in the future, in his own words, not being as 'cocky' and sure of himself. On the other hand, a degree of decisiveness and ability to act swiftly would also seem to be necessary in many of these situations, a somewhat contradictory set of imperatives as seen in the literature regarding decision making.

Sue had an experience of a situation that unexpectedly escalated into physical violence and, despite another staff member being present, there was no immediate support forthcoming:

A situation where a client went racing out of PICU. Quite a high profile client actually, and um, I was working in PICU that particular day with a casual RN. And, I know things are changed a bit now, a little bit with the open door policy, but back then it was quite different, and I went down the corridor to bring this person back. And the person came back ....willingly, you know I didn't need to use restraint, and I wouldn't do it alone anyway, but I didn't need to use any force or physically hold that person to get back .... But once we got through the door it turned to mud.

Um, and I really don't know what happened, but because I was still close to that person and able to maintain a hold, or attempt to maintain a hold, knowing that I had colleagues to back me up, ...but they didn't. That was an appalling situation to be in, where I was actually, the client's arm was around my neck, while my colleague sat there watching.

Interviewer: If you had thought that the colleague wasn't going to intervene, would you have seen any other options?

Sue: Like in letting the client leave the unit? That's an option that probably would have been a better option in that scenario.

Interviewer: Had the casual person been trained in C&R as far as you were aware?

Sue: That has been a sore point for me; I think everyone that works here should be trained with the [Employer's] C&R programme, but we had been told that if people had been trained elsewhere that was OK. But how long ago had they been trained and had they got refreshers, and were they doing it the same as us?

Interviewer: OK. And they didn't attempt to intervene?

Sue: No. In fact they were ... that person could have done an uppercut quite easily on me, but actually had control not to. I give him credit for that, but luckily the keyworker [staff member with primary responsibility for an individual patient's treatment plan] came in at that time and distracted him, and had a really good calming effect on that person. I wouldn't say calming effect actually; just reduced the level of agitation so I was able to be let go.

Interviewer: Right. So that person didn't physically intervene?

Sue: Not physically, no. (Sue 4)

In this situation a rare event occurred: another staff member (the patient's keyworker) intervened in a situation where a colleague was being assaulted without using physical restraint. This was not identified by any of the other participants but does raise the question, 'why not?' If this intervention can be shown to be effective, it would seem preferable to the more usual approach (as identified in the data) of attempting restraint in the first instance. This is certainly

an area that requires further investigation in future research as it may well inform training development and new approaches to similar situations.

Continuing with this event, the effect of this incident on Sue was explored, particularly how she approached the patient in the future and her thoughts about protecting herself:

> Interviewer: So, at that point your instincts would have been self preservation?
>
> Sue: Yeah it was, knowing that he could really have hurt me. Thinking when is it going to happen? Thinking, where is my back-up? Knowing it was standing there watching me, cos I couldn't move away from this person. So lots of thoughts were going through my mind at the time.
>
> Interviewer: Do you think that altered the way in which you approached that person in the future?
>
> Sue: Made me, I guess more cautious and more aware that ... of what the potential was. You know that before, you have risk assessments and things, but then in reality it's quite a different thing. Um, I had more respect for that person, if you could call it that. And a bit more respect for myself! And actually didn't work with that particular nurse again in there. (Sue 5)

Echoing earlier data relating to attitudes towards patients who are perceived as not having a mental illness, Sue had this to say about patients whom she perceived to be in control of their actions:

> I mentioned the fact that he had the control not to hit me? It meant that he could have quite easily have hit me..... and I wonder if that person should have been in that place any way. He subsequently went on into the justice system. I think that restraint happens more often with clients like that, they are a bit more cunning and pick their times, rather than the randomness that seems to occur with people who are quite psychotic. (Sue 5)

Sue's recollection of her experience brings a number of issues to the fore, including repeated concerns about whether or not people who appear to be able to control their actions but yet display violent behaviour should be managed

within a mental health setting or dealt with through the justice system. The incident related by Norm (p 86) involved a patient who was in the mental health service as a result of a court order for psychiatric assessment, and many nurses express their discomfort at having to assess and 'manage' patients who may colloquially be described (within mental health services) as 'bad not mad.' There is a notable current trend to laying charges against patients who assault others, on the basis that even those who are legally defined as mentally disordered (in terms of the Mental Health Act) still retain some of their capacity and therefore the level of culpability should be determined through the same processes as for any other person, that is through a legal determination of responsibility. Despite some resistance from Police to be involved in these situations due to a presumption that the patient will be found under disability and therefore not responsible, local experience has been that nurses find support for this from their management as particularly helpful in setting expectations for unit culture and a sense of valuing of staff (personal communication with senior clinical staff in local mental health services, 15 February, 2006). This also arises in the discussion of the need to maintain control, with the assumption of intent to disrupt the milieu being viewed by some as justification for restraint. The events also raised the issue of working with other staff in whom you do not have confidence, which will be investigated in more detail later.

Sarah's experience of being let down by others was possibly not as overt as the previous stories in terms of the failure of others to support her, however the impact on her personally appears just as great, and the potential for permanent harm was high. In this incident the harm occurred not through a failure to respond, but through the inattention of other staff, possibly due to a misreading of the level of arousal of the patient concerned. Sarah was asked about a time when restraint was not used and the outcome was unsatisfactory:

> I can think of one. Yeah, we had a woman who was incredibly unwell on the ward who was hugely deluded, um and she had all of the symptoms, like wearing lots of makeup that were actually indications that she was incredibly unwell, and she attacked me, and burnt me. And so, I believe that she could have been managed better, whether it would have got to

restraint, I don't know that but, I would say that she should've been engaged in a more, I suppose, enclosed area.

People walked down to the high dependency unit with her and I offered to make her a cup of coffee to, I think, you know, to calm her. I went in the little side room, and I didn't lock it, but I assumed that the nurses were with her and I was boiling the jug. And putting the milk in and I turned around just in time to see her pouring it over my head, and I hadn't even heard her come in the room and I couldn't believe that the other nurses weren't watching her.

Interviewer: That was a situation where your colleagues let you down?

Sarah: Yes hugely. And I ended up, I don't know how, but I ended up sitting on top of her, and with a jug in my hand which was like empty, but I don't know if I knew that, or if it was just a little bit of water in it, and then basically not wanting her to ....I remember also thinking, God, I hope she hasn't burnt herself. Which is pretty weird given that I'd just had my face burnt. (Sarah 10)

This piece of narrative describes an event where the incident could be seen to be caused not by unwillingness to intervene but by a lack of observation on the part of other staff, and an assumption on Sarah's part that observation was occurring, hence her leaving the door unlocked. Again there is evidence of concern for the patient expressed despite being in a precarious situation herself, similar to the concern expressed by Norm when dealing with being assaulted unexpectedly. (p 86)

Sarah was asked about how this event influenced her and her thoughts about the colleagues involved:

Sarah: They were clearly distressed and I felt really sorry, because I know that they felt really bad. There was a guy that was caring for her at the time, was a very confident nurse whom I really liked. I remember when he started at [the unit] I felt a sense of reassurance that here was finally someone that I could have a relationship with that was my own age. There were some good solid nurses but that next generation above me, there wasn't anyone that was good and solid around my age. I was really

very sure at that stage, and I do [still] think she was managed poorly, I remember, but by the team, not by him as an individual.

Interviewer: That experience, do you think, influenced the way in which you nursed?

Sarah: It did for about two weeks! Or even less than that. I had a week off, I was discharged from hospital and I went off to (university) to do a block course, and I went back to work on a Friday, so I didn't really have any time off and I didn't really have a proper de-briefing, and I just went back on the 14th to there, and I just went straight back down to the High Dependency Unit. The woman was down there, she paced the floor quite a bit, and she was still clearly unwell. I just felt this sense of incredible anxiety, almost waiting to be attacked, and I just started crying and left. ... and then I didn't come back to work for a couple of days, and then I went to clinical supervision and I got proper de-briefing as part of clinical supervision. But it wasn't about anything anybody in charge did for me, I did it for myself. (Sarah 11)

This episode demonstrates the value Sarah got from her clinical supervision, but also highlights what she perceived to be a lack of support for her from those in charge of the service. Judging by her response to returning to work it was unreasonable to expect her to return to nursing the same patient in the same setting so soon after a traumatic experience. Also notable was the lack of debriefing aside from the regular supervision she accesses, a lack which many participants highlighted, either stating that debriefing did not occur, or was done in a superficial or informal manner.

Notable in her recollection of this incident was that Sarah has analysed what occurred leading up to the incident, and does not ascribe blame to one individual. She sees the incident in terms of a period of time when the patient concerned was 'poorly managed' by the whole care team. Later, she talks in terms of the non-recognition of escalation and the failure to engage with disturbed patients, and how that can result in restraint becoming almost inevitable.

Being committed to action by others

When asked about situations where they were unhappy with the restraint situation participants often related events where others were involved in a decision to restrain that they considered unnecessary or where they encountered an event already underway with considerable risk to a colleague occurring. The sense of immediacy of action required was clear expressed throughout these events, with little time to plan, call for assistance, or consider any other options.

Carroll reflects on unexpectedly coming upon an incident where a patient and a staff member are fighting. There is an immediate response on her part:

> Yes, one incident where I walked into a room in (High Needs) and my colleague was um, he was fighting with this patient, and of course I went in to help my colleague because I didn't like to see what I was seeing.
>
> Interviewer: What were your thoughts at that moment when you walked in on this event?
>
> Carroll: Oh, yuk, I can't walk out, I have got to help my colleagues, and which I did, and then we took the young man out to the High Needs courtyard and I sat with him and talked him through certain things. (Carroll 3)

Bill finds himself in a different circumstance where he is committed to a course of action by the approach of another staff member, which results in a restraint, which he felt may not have been necessary:

> Rather than go into a proper restraint type situation – I was out there with 2 care assistants, myself as the RN, um, the way this person was returned to their room I found, um, given another few minutes could probably talked the person into it, or de-escalated them a little bit more, and made restraining them a more safer option rather than what became, what became was more of a full type incident, where one of the people I was working ended up having their hair grabbed and pulled quite hard, to the extent that he grabbed this client by the throat, um, which I found quite excessive, and um, I didn't feel it was necessary. (Bill 5 - 6)

Bill's recounting of this situation also introduces the idea that de-escalation (an approach used to lower the emotional tone of an individual) may be useful to allow restraint to occur more easily or in a less threatening manner. This raises the issue of whether a successful de-escalation technique is used to make the restrictive measure of restraining less difficult for staff. The question raised is why de-escalation would be terminated if it was apparently having a positive effect, and does this indicate a willingness to engage in a process of de-escalation and then use the (restraint) intervention which is supposed to lie at the far end of the intervention spectrum?

Dave's example of a situation of immediacy was one of greater personal threat, arguably as a result of over confidence on the part of medical staff, resulting in significant risk to others. This extract highlights the way in which staff can become engaged in situations not of their own making:

> [A client] was brought up here to the Community Mental Health foyer, waiting to see the doctor, while she was waiting to see the doctor she pulled a knife out; a kitchen knife with a very long blade on it, stating she was going to harm herself or other people if she was admitted to the inpatient unit. That was her statement. The crisis team backed off away from her gave her some space as you are supposed to do, and someone alerted the police to come and deal with the weapon, which is what our protocol is. Where that went wrong was, the patient actually knew the doctor and wanted to talk to the doctor who was going to assess her, so the doctor said "right oh," and came right out to talk to her and approached her and then she said "back off or I'm going to be poking a knife into you," basically. He stepped forward, um and she said "you back off now!" and she stood up, "or I'm going to poke the knife into you." At that point he took another step forward. She could have up and stabbed him, and I was asked to be present earlier to that, um.... Standing back, and we had nothing else to do but restrain the lady, in that she was threatening with a knife. It was a disaster; we were extremely lucky nobody got hurt. (Dave 3)

Despite knowing the decision to intervene meant considerable personal risk and having assessed his medical colleague's actions as unreasonable Dave felt strongly compelled to act, putting his own risk assessment on hold, and providing an immediate response:

> My first gut reaction was to leap in there anyway and if I had thought about it a little bit more, it would have been "I am putting myself at risk even though he is already at risk," but I couldn't not do anything. And that's a part of being a health professional anyway. I wasn't going to do a clunky "okay I'm doing a risk assessment now, I am not going to endanger another person, blah, blah, blah." But there was no way I was going to stand there and let the lady kill somebody basically, which what she was intent on doing. He may have struggled the knife out of her hand, but I wasn't going to be spectator to that. (Dave 4)

Whether this was Calming or Restraint or acting instinctively was posed to Dave who, in response, described it as:

> ..a shit fight to the ground, she was putting up maximum resistance right to the ground, and she was physically bruised. (Dave 4)

Joan was also involved in this same situation and expressed similar views about the need to support a colleague whose actions had put him at risk, despite considerable personal risk to her self. She presented a possible rationale for the doctor's actions and expressed confidence in the ability of other staff in the immediate environment and her abilities as a result of her training in calming and restraint;

> Interviewer: So you weren't aware of what his rationale was for getting into that situation?
>
> Joan: No, other than the fact that he knew the client from (another city), and I assume that he thought he might have been able to calm her without further intervention.
>
> Interviewer: Okay. Would he have been aware of the nurses' training in calming and restraint, do you think?
>
> Joan: I don't think he was aware of that, and he is relatively new to our staff, so he won't know how much training we have had in this area.

Interviewer: Right. Okay. So that was a situation where someone else's actions dragged you in?

Joan: Yes

Interviewer: OK, do you think that um, I mean your reflex I guess is to protect somebody else....

Joan: Colleague...yes.

Interviewer: Right, so you had a lot of confidence in the people that were around you?

Joan: I did, yes.

Interviewer: Otherwise you wouldn't go near her....

Joan: No. And if this person panicked, and being close by put himself at risk, we could have shut the person in the situation, in a safe environment and called the police, which it should've been handled by the police. (Joan 2 - 3)

Joan's assessment of the ability of her colleagues to contain the situation appears to be more positive than that of Dave, who was more concerned at the risk involved and their ability to contain the situation. Whilst both were critical of the doctor's actions, Joan was willing to proffer a possible explanation for them. She also talked of the value of Calming and Restraint training in this situation, stating that she would not have got involved had she not been trained. Non-involvement would likely have resulted in injury to other staff, or possibly the patient concerned (who had also threatened self-harm), but from a contrary perspective, one would have to ask whether equipping people with skills that result in them feeling able to enter situations of considerable personal risk is a positive outcome. Both Dave and Joan were aware of the correct procedure (according to their organisational guidelines) to deal with such a situation, and had initiated it. They both felt that the situation developed in such a way that the formal procedure needed to be overridden and another heuristic set applied – that of protecting one's colleagues.

As these examples show, nurses are often in the position of having to restrain clients as a result of the actions of others or the fact that events have already

progressed by the time they become involved. Their immediate responses are to protect their colleagues and the client concerned, leaving little time for considered decision making. Whether or not this represents an opportunity to display good judgement is hard to assess, the overriding drive being the protection of others and the quelling of a perceived threat. Within all of these examples it is also notable that there were descriptions of interventions that would fall outside accepted calming and restraint training practices. The chaotic nature of events and the involvement of staff with limited support are contradictory to the taught methodology, however there is a strong sense of need to intervene immediately when colleagues are at risk or the threat is perceived to be high.

Norm's experience (p 85) of being unexpectedly attacked highlights some of the difficulties of having to make decisions in extremely high stress situations, and also of not receiving support from his colleagues. Norm's comment that staff deactivated the alarm twice and later remarks that those in the immediate vicinity did not provide support are mirrored by the experience of Bill (pp 103 - 104) where he ended up having a one to one fight with a patient due to being cornered and not receiving support. This experience left Bill with significant concerns about working with violent clients in the future, as he was in the process of transitioning to practice as a Registered Nurse and was concerned about his ability to take the lead in restraint situations such as this. "Yes, it scared me a helluva lot thinking that shortly that I am going to be taking that leading role in making these judgement calls and leading these types of events." (Bill 13)

The descriptions of not working effectively as a team came with considerable emotional content and concern at being engaged in activities not of the participants' choosing. Further, there was concern expressed about what occurs after the restraint event.

Being unsupported by those in authority

George's story of being dissatisfied with the outcome of a restraint relates to the events following a restraint situation in which he felt a critical (in a negative sense) appraisal occurred of his actions. His rationale for using restraint related not only to his assessment of the patient's immediate needs, but also to a

perceived need to ensure a sense of control was maintained, and that a negative example to other patients was not presented;

George: There was a situation that came up, again going back to the old high needs unit.....can't think of the clients name....male guy who at times could be rather difficult, push things to the max; "No, I'm not doing this, no, I'm not doing that."

We had 2 or 3 staff available; "No, we're locking up, it's inside time." Because he was outside having a smoke. I'm saying "No, we are not staying here, we are inside." Questions were raised afterwards about, um, the need to have gone in and physically coerced the guy to come inside.

Interviewer: Right. What did you feel about that?

George: Difficulty I have - I don't want to be seen as going in and laying all the shots down; at the same time it's the old story "give somebody an inch and they think they're a ruler!" (laughs)

I think it's, it's not quite a case of you do as I tell you because I wave the big stick. But, no, in here we do it our way, you know, even though we try to give you quite a bit of slack, we do call the shots. Otherwise other clients see that and think "we can do what we bloody well like and you can't do a thing about that, so there." And so, I think the big thing that goes through the back of mind, I don't want go in sort of the heavy coercive you know, "get in here ya sod, we're gonna deal with you."

But at the same time I suppose the other issue that goes through my mind is, um, I don't particularly need other clients getting the message that they can do what they like, when they like, and they can get away with it because the staff are powerless to do anything about it.

Interviewer: Yeah.....OK. So, in that situation in terms of staff preparation, was there much around that? Were people aware that this was likely to happen?

George: I did speak to staff and that. The concern came more after an incident report was put in and "oh, it could have been handled differently." Yes, it could have been maybe. If the management had been in the position at the same time, what would they have done about the situation? It's um, almost like there's an un - level playing field where you know "call the shots, control the stuff, then oh, you could've let him

get away" and I'm thinking "hang on a minute there's a point of balance somewhere." (George 9)

In this situation George feels that there are strong expectations to maintain control of the ward, but then a lack of support when he attempts to do so using physical restraint. Further investigation discovers a rationale that is not just about George's sense of needing to maintain control for its own sake, but because of the influence loss of control may have on other patients and a loss of his own sense of being constructive:

> Interviewer: So what happens if you don't keep control, I guess is the fundamental question? You have got to work with people that haven't had that sense of keeping control.
>
> George: Yes, it can be a bit difficult because if you are not careful it will make you question your own sense of what you can do, or maybe there is somebody who feels we can do what we like and there is not a thing they can do about it. Now maybe that person has decided that they can't be bothered addressing their issues, the last thing I need is somebody who decides that, stopping somebody else who does want to do something, discouraging them from doing that, and so my concern - earlier I suppose I would have felt personally challenged by some of that stuff, but now not only the fact of being personally challenged, if you choose to go down that road, your choice, but down the road, these are things you are going to run into, and don't come screaming to me that you have got a headache when you run into some brick mortar. (George 10)

How this is dealt with following the event and how the nurses were left emotionally is an important factor in future reactions to similar situations, including the notion that some staff become "gun shy" and avoid involvement in situations where restraint may be absolutely indicated. As seen in some of the preceding events, there have been instances where support from others has not been forthcoming. During the course of this research an attempt to contact people who, for whatever reason, did not become involved in situations where restraint would generally be regarded as being necessary, however those able to be identified did not work within mental health services any longer, or were

unwilling to be involved in the research process. Clearly there exists some criticism of those unwilling to become involved with these situations as seen in the comments of some of the research participants. There is acceptance from participants that fear may play a part in the lack of response from others; however the situations resulting were dangerous and left participants with a degree of concern about the commitment of other team members they may work with. Up to now, the definition of 'team' has been limited to other staff; it can however be extended to include the other participants in the events related.

Patients as part of the team; nurses as negotiators

From interviewing staff it emerged that there was a variety of situations in which options to avoid restraint or minimise its use were considered. At times these were able to be presented to the patient for them to make a decision as to how to proceed. One of the justifications for the use of restraint is to administer "planned, prescribed, essential treatment [usually medication] to an individual who is resisting, and there is legal justification" (NZS8141:2001 p 14). In the majority of situations patients are offered alternative administration routes for the medication; however the alternative of not receiving that medication is not usually available. This from Sarah:

> I have gone into a situation, on numerous occasions actually, where I would often be the negotiator. Everyone knew that (we were) offering liquid and if the person didn't take the liquid then it would be given to them IM [by intramuscular injection] and it would be all drawn up and ready to go. That was the position.
>
> Interviewer: And along with IM, would there be the assumption of restraint?
>
> Sarah: Yes, because we would say in the end, that you would have to have this medicine and if you don't have these medicines then we will have to give you medicine. And I would give them the option where they would in effect ... it wasn't a choice at all. And you're right, it was either a good option or a bad option, and in fact it wasn't a good option because we were making them do something they didn't want to do, so they had a bad option and a badder option. (Sarah 9)

Bill reflected on his experience of similar situations and how he approached the issue of "non-compliance" in relation to medication. This was elicited when asking about situations that had gone well without restraint:

> I've walked in the door in the past and somebody has said, "You will have this medication or we will give it to you IM form and we will restrain you." I've found sitting down and giving the client the opportunity to explain why they don't want that medication and me to express why we think they need to, and the fact the doctors charted it, and we have to give it to them, and there's no reason not to, and then going away for a period of time, and then going back 10, 20 minutes later. Um, not always, but probably 80% of the time has met with being able to give it, even if reluctantly, to the person: they've taken the medication without being restrained. (Bill 8)

Sarah expressed a similar view and approach to that described in the previous excerpt, despite having acknowledged that the choice was limited by the nursing staff and not the choice the patient wanted to make at the time:

> I think that other people might having considered using restraint and I might have been the person, it would have been because of my position that I would say "hey, we're not gonna do that. We'll do this first." Because in my experience, that if you can negotiate, I believe that you can actually negotiate with the sickest person, like I mean using Phil Barker's [a psychiatric nursing theorist] words, "no-one is that sick that they can never ask to have a cigarette lit." And, I believe that it doesn't matter how unwell a person is, that there is tiny wee patches or tiny wee moments where you can catch them, where you can actually engage someone, and you can get them to do what it is that they need to do. It would be more about the fact that other people would say well, "this is what we're gonna do," and I would say "hang on, we're gonna try this first." And, generally it does work well, like if you offer options to people, if you say to them, "You're unwell, I know you don't want these meds, but you have to have these medicines, this is the choice, you can either have it IM or you can have it liquid." I reckon 9 times out of 10 they would choose liquid. (Sarah 8)

Similarly Sue related a situation where other staff had decided that restraint was going to be necessary for medication administration, however another approach was successful. This example involved considerable negotiation and a willingness to not let one's ego prevent alternatives being used:

> Working on the ward, and I wasn't this person's nurse. I had the nurse come up to me and say, "We need to restrain to walk this person down to (the High Needs Area) and give her a depot injection." And I said, "Well, let's go and see and have a chat to them about it." I'll go back to the client here. The client did not want her depot injection at all, but what became more apparent the more we spoke about it was that she didn't like that particular nurse, and she refused to have it given to her by that nurse, so she wasn't going to have it. So we said, "Well come down, we'll take you down to your room and talk about it there." As we were walking down there, the client decided that she would like to have this depot (injection), but for it to be administered by a male nurse. He happened to be an enrolled nurse. And I thought, "That's great, you know." I said "yes, that's fine. You don't mind if I stay in the room while he does it and make sure that you're comfortable and all that." We did that and she had the injection and there was no need for restraint, no need to go to the High Needs area and the situation was resolved. And it was all around a personality clash I think. That nurse got quite angry at us actually, for interfering. (Sue 8)

A further example, this time from Dave:

> This particular patient hasn't taken medication the night before and it's handed over to us in the morning. "He didn't take his medication, he hasn't slept all night, he's wandering around he's a 'loose unit' [mental health nursing vernacular for an uncontrolled person] and we're going to have to put him into seclusion and we're going to have to IM him, so we're waiting for you guys to come on today so that you can restrain him and do it." There're a lot of foregone conclusions in that, just in the handover before you even see the client. So we thought "yeah, yeah, we'll just try it one more time," So we went out there as a team of 3 guys

> and said to him, "we need to talk to you about the medication," In the end he didn't want to listen to us anyway, "it's not gonna happen basically, you're just going to be like jabbing me" so it's like, yep Cutting a long story short he did move to another area with us, still in an open area but away from other clientele, and he wanted to express that he wasn't being listened to. And he wasn't having his options put forward. Just giving him lots and lots of feedback over quite a long period of time, well over an hour, which is a long time when somebody's wound up to have 3 staff standing there thinking they should be doing other things. It did make a difference, he didn't get restrained, he did have an IM injection because we put forward the possibility of it working a lot quicker, and him getting some rest, and it went really well. (Dave 5)

In this example a willingness to invest a very significant amount of time, to the exclusion of other patients, to affect a more positive outcome is demonstrated. Three people spent over an hour talking with this patient and, as a result, there was no need for restraint. This event would result in a much more positive experience for the patient concerned than the proposed alternative of restraint and seclusion, indicating the need for frequent reviews of approaches and the situations faced. The previous excerpts do raise the issue that nursing approaches vary considerably, and that restraint events may happen more in response to who is making the decisions and their exposure to the patient and situation, rather than a more objective appraisal of what needs to occur. In both of the last two situations other staff members had a pre-determined course of action in mind which was not followed by the study participants. On both occasions the outcomes were positive. The benefit of hindsight allows us to challenge the thinking of the other staff involved, however the positive experience of being able to avoid the use of restraint is probably a more powerful learning experience. These study participants related these events as being very positive for themselves and the patients concerned, and they indicated their commitment to continue to practise in this manner.

In broader terms, the ability to engage people in meaningful dialogue about their situation was often raised. Putting the situation to the patient and asking for their

assistance to make things happen was viewed as a positive exercise in many situations, with a contextual background that also has some fairly tight boundaries about what can and cannot happen. This was how Dave explained the approach when asked about considering patient's viewpoints in relation to the need for treatment:

> I think that is something that is part of the assessment and part of their (nurses) communication with the person who you are communicating with. The patient gets an idea of what they think is going to happen and then to be very honest and truthful to them about what needs to happen and what is negotiable. I think that is about the whole thing of the late 1990s of trying to allow the patient to become empowered on that sort of thing, and having them involved in the decision process. All that still holds good ground, it makes a big difference if you can say to the patient "this needs to happen; how will you help it happen?" "How can you help us to get it to happen?" And find out from them what do they really think is going to happen, and then talk about whether or not that really does need to happen. And if it does, be honest I think, by letting them know why. (Dave 7)

There is an assumption here (which is generally present in all of medicine) that the health professional is the one who knows "what needs to happen" and why. Despite displaying a willingness to negotiate within parameters how things will occur, and attempting to engender cooperation from the patient, the setting of those parameters is seen as the prerogative of the nurse involved. As identified in the data, boundaries are deemed by nurses to be in existence, and the refusal to accept them can result in patients being restrained, or at the very least being identified as uncooperative. It is common parlance for mental health nurses to refer to patients as "pushing the boundaries," as has been referred to in a number of extracts from the data. This indicates that patient choice is in fact restricted to those choices other people in control allow them to make and that concepts of empowerment are restricted at best or completely illusory at worst. This position is inherent in the current environment of mental health services in New Zealand (and elsewhere) due to the underpinning of service delivery with a legislative framework that involves compulsion if patients refuse to comply. This brings

with it the responsibility for the outcomes; staff are empowered to use force if necessary and are therefore expected to deliver outcomes viewed as acceptable to the community, a huge responsibility that affects the courses of action taken. This leads staff to question the interventions of others when things do not turn out positively.

Working therapeutically or restraining early

At times, attempts at intervention appeared to make the situation worse or did not have the desired effect of de-escalating the patient. When an alarm is raised the usual response is for more staff to attend to the situation as a means of ensuring greater safety for those already engaged and to allow control to be restored by physical means if necessary. Carroll (p 55) spoke of a time when the arrival of extra staff was not a positive event and the situation turned from one of being under control through the intervention of therapeutic engagement, to one that engendered a fearful response from the patient restrained.

Other nurses acknowledged that on occasions their actions may be in some way responsible for escalating a situation, even if they are unaware of the causes of such escalation. As Joan puts it:

> "I don't think anything in particular had upset her, I am not sure if I wound her up or not." (Joan 1)

Sarah was quite overt about her beliefs regarding what she had observed at times in other staff and their reluctance to engage therapeutically. This was from a period earlier in her nursing career which she later qualified with a statement that there had been a "philosophical shift" in the service she was working in. However the statement raises an interesting point about how people perceive the nature of working with mental health patients:

> Because it's actually it's easier, it might be harder physically to restrain someone, but it's actually easier emotionally, mentally, to restrain someone, for you (the staff member). It's almost like a lazy option, like restraint is meant to be the last choice but it's probably, I don't think it's the first choice but it's the middle choice rather than the, the final choice. To actually therapeutically engage someone who's really unwell, that's

> bloody hard work. I don't believe that many nurses within our service actually have the skill or knowledge, because you're relying on yourself aren't you, as an individual to form a relationship and negotiate with the person, but a restraint, there's 4 or 5 of you, you can actually rely on your colleagues so it's real easy to say "well, if you don't we'll take you down." I think to me, often, restraint seems a bit like a lazy option. (Sarah 9)

Likewise Dave raised the issue of people using restraint too early:

> There is a risk of over-restraining which does still happen to a lot of people that take that lowest common denominator of it. It is not worth the chance that you do maximum and then worry about it later. (Dave 3)

So whilst some participants saw this situation as a failing of ability or willingness to engage therapeutically with patients, others saw it as a practical response to resources being drawn from other areas and a need to resolve situations quickly. Either way the patient concerned ends up being restrained perhaps precipitously, and with little attempt at negotiation.

Summary of working with others

There were many examples of teams working effectively to manage patient behaviour with a variety of approaches. What was clearly evident was that nurses were prepared to plan and look at alternatives to restraint if they were working with others they had confidence in. These times were described in the context of times when restraint interventions had gone well, by the participants' criteria. There does however appear to be a degree of Groupthink in existence, in that participants were willing to go along with courses of action if they perceived others in the team as being more experienced than themselves, even when they were uncomfortable with the chosen course. More senior practitioners appeared less likely to do this, however this would be expected as they would be more likely to take the lead decision making role. All participants expressed that there was a threshold at which they would challenge the actions of others; however this would more often than not occur after the event in the form of debriefing or review.

All participants had experienced events where they felt let down by their colleagues. During the course of the interviews it was clear that these carried significant affective (feeling) components that lasted well after the occurrence of the event. This often led to nurses feeling wary of working with the patients involved, and unhappy about working with the staff concerned. Their expectations of the staff involved in future situations were such that they may avoid working directly with them or suggest they be absent at the time restraint was likely.

Participants identified that the options put to patients in many situations did not include the option patients had indicated was their preferred one; that of not accepting treatment or being detained in a mental health setting. Nurses did, however, identify themselves as being in the role of 'negotiator' albeit with a limited set of possible options. Nursing staff set the boundaries and provided a limited set of ways in which compliance could occur, ranging from cooperation through to enforced compliance using physical restraint. Many participants also identified that even this limited engagement with the patient did not always occur, either through staff not feeling confident to do so, not wanting to do so, or because of pressures to get a situation under control and requiring additional resources drawn from other areas to achieve this. Overall the patient appears to have a limited role in the decision making, due to few options, and non–inclusion of the option to decline treatment.

Chapter VIII

Discussion

Introduction

In this chapter the identified themes are further examined in relation to the (limited) relevant literature available. Further development of a graphic representation of how the decisional factors interact is presented along with a model which includes time-bound processes which occur in restraint events described. Implications for nursing practice and service delivery configurations are discussed. The studies limitations and identified areas for further research are articulated with concluding thoughts.

The model of influences

Earlier, a model of restraint processes (Figure 4.1) was presented on the basis of two diverse types of events: those which were planned and those which occurred spontaneously and resulted in a quickly unfolding, reactive response on the part of the staff involved. As the data was explored in more detail it becomes clear that this model was too simplistic in its structure to identify the possible pathways and outcomes that may occur. Also, much of the detailed information used to make a decision on whether or not to restrain was not in evidence in this earlier model. In particular the areas of risk assessment and resources, whilst identified, were not presented in any level of detail. Similarly, the background influences on the nurse themselves were not overt when just looking at the two identified exemplar (or representative) events. Figure 8.1 represents a refined and expanded model which introduces those factors identified through analysis of the data. What needs to be recognised is that this model represents one nurses' involvement in a situation: it does not identify the decision making of others involved, or necessarily, the effect of that one nurse's decisions on others. It does, however reflect what can happen when confronted with a situation which appears to require an assertive response, which, as such, represents a response to something others have already set in motion, be they other staff or patients. This limitation on what the model can represent is consistent with the nature of the

research, given that the interviews were conducted with individuals who were giving their personal perspectives about what was occurring and how they made their decisions with regard to restraint. Given the complex dynamics that are in play during a restraint event this might be seen as a significant shortfall, however the purpose was to explore the decision making at the point of initiation, as this determines the majority of subsequent action.

Having constructed this model from the data it becomes apparent that much of what influences the decision about how to handle any given situation resides in the realm of the background. In other words the immediate presentation is not the predominant factor in decision making. What the patient is actually doing may be the trigger for action, but the choice of action is strongly influenced by the factors identified. Attitudes relates to the nurses' thoughts and feelings regarding the patients' motivation for aggression, and a value judgement about whether or not the patient is appropriately served by being in mental health services. This partly influences the assessment of the level of risk involved, risk largely being defined in terms of avoidance of bad outcomes. Knowledge of the patient from a variety of sources also informs the risk assessment and selection of responses by the nurse. Beliefs regarding what it is that constitutes 'doing a good job,' the need to maintain control and knowing what is for the patients' good are influential in the eventual decision as to how to respond to the patient. The role of teamwork and whether or not there is agreement or dissention within the team influences the assessment of resources available and the likely courses of action followed. Experience of working with other staff also influences how they are viewed, either as a useful resource or an encumbrance, in future events. The training of the individual nurse (in C&R) and that of others constitutes a component part of the assessment of resources available. Other resource issues include the environment of care, access to additional staff and the commitment of time to resolution of the situation. Finally the rather nebulous construct of gut instinct, in one form or another, is seen as an influential part of decision making. This construct appears to relate to a collection of experiential and knowledge components that are rapidly and (perhaps) subconsciously integrated into the nurses assessment of the situation and their choice of intervention.

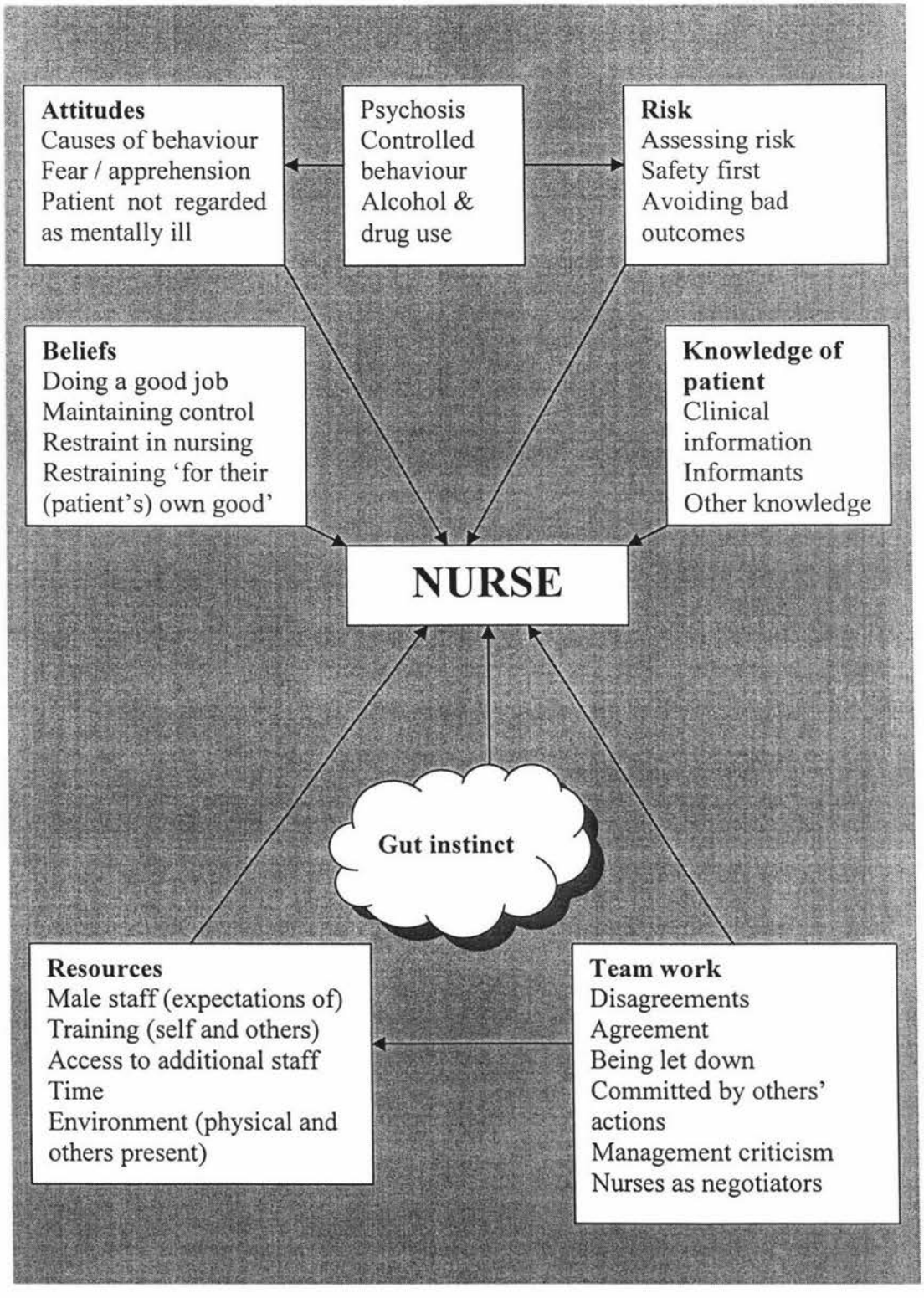


Figure 8.1: Influences identified as acting on nurses during challenging incidents

Attitudes and Beliefs.

Attitudes and beliefs of nurses includes their personal position about where restraint fits into nursing, the need for control, the perception of what it means to do a good job, and assumptions about what is motivating the patient's behaviour. The ascription of the ability to control their behaviour to patients who are not viewed by staff as having a psychotic illness or extreme mood disorder significantly influences how these patients are approached.

Attitudes towards patients

The factor of patient control seems to influence the approach taken in two main ways: there is an apparent sense of annoyance at patients who are perceived as not suffering from a 'real' mental illness such as schizophrenia or bi-polar disorder, and there is an element of apprehension in dealing with patients who are perceived as having a greater ability to plan their behaviour. This includes those patients with diagnosed personality disorders and those with primarily substance abuse related conditions. Participants spoke of being more cautious about discontinuing restraint with patients who they believed were able to control their behaviour, as opposed to patients who were viewed as displaying aggression or violence as a result of their mental illness. The same behaviour perceived as having different causations were variously regarded as intentional and malicious or understandable and forgivable. When regarded as intentional, the risk associated with the behaviour was assessed as greater than when the behaviour was considered as a result of a mental illness. Violence in the context of assumed mental illness was perceived as being more disorganised and less of a threat than violence perpetrated by patients not regarded as having a mental illness characterised by delusions or hallucinations, which was seen as being more organised and able to be controlled by the patient concerned. It was therefore regarded as being of higher risk and in need of a more assertive response to avoid the negative outcomes, a finding reflecting what is known about the nature of risk assessment (Matthewson, 2002). An example of this was seen in the recollection of Sue, who stated that the patient who attacked her and her perception of "knowing that he could really have hurt me" (Sue 5) but was in control of his actions. This then influences further contacts with the patient concerned and the degree of tolerance for disturbed or aggressive behaviour. It

can also result in pathways into the justice system when staff make an assessment of culpability and then seek to lay criminal charges against the patient, further reinforcing the position that 'they don't belong here,' or are less deserving of services in some way. Again Sue was clear that clients perceived as being able to control their behaviour were restrained more frequently than those who were disorganised (Sue 5). Participants used various language to describe patients who were perceived as not having a 'real' mental illness and also where they believed they should be dealt with. Terms such as "client of convenience" (George 1), "cunning" (Sue 5) and "mad or bad" (Bill 3) are used in describing these patients. Responses to them reflected the frustration of having to work with this group with staff being described as being "Pretty peed off, they thought they shouldn't be really offering a baby-sitting service to look after somebody who was being a rat-bag" (George 1) and "frustrated" (Sue 2) and questioned whether or not the mental health service was an appropriate place for these patients to be located. The use of such language could well meet with censure from those disposed to believe such terminology is unprofessional; however there is no question that these terms are fairly common place in psychiatric nursing. Hamilton and Manias (2006) in their analysis of language used in acute inpatient settings viewed such language as being laden with taken for granted knowledge and an important indicator of the ways in which patients were being perceived, and a likely indicator of how they will be responded to in their contact with mental health services.

Maintaining control

There was also a willingness on the part of some nurses to use restraint to impose control with this patient group (in particular). The benefits of this approach were not directly to the individual patient involved, but were centred on a need to maintain control of the environment and demonstrate to other patients that staff were in charge. There was a sense that patients who were regarded as being able to control their behaviour but were disruptive had a great ability to cause chaos, to the detriment of other patients and the staff. As George commented, "you can end up running around like a blue arse fly... and you achieve nothing" (George 2) when you fail to establish boundaries with this patient group. This resulted in responses to situations that were about enforcing boundaries, and is given official

sanction through the justification that the patient "seriously compromises the therapeutic environment" (NZS8141:2001, p 14) which is said to include damage to property, social milieu, or relationships with other patients or the service providers. The range of opinions expressed on this justification was quite broad ranging from those participants who saw it as being perfectly reasonable to those who viewed restraint as only being justifiable to maintain safety. Dave reflected on this as being a way in which staff were given license to use their judgement about restraint and described it as meaning "and any other situation in which you think you need to" (Dave 8). Sarah represented the other side of this debate succinctly when she was critical of the actions that seem to demean patients in the name of maintaining control which results in others saying. "OK well, we will restrain to keep the peace." (Sarah 6)

Examples of restraint were provided by participants that clearly indicated that, for some, restraint was a viable and justifiable approach to ensuring control of the ward, and that individual risk to self or others was sometimes not the justification for using restraint. Some participants saw this as indicating a shortfall in skills in other nurses who used such approaches or as representing a "custodial" approach to care which was unresponsive to individual patient needs or circumstances. Blom-Cooper et al., (1992), in their report on complaints regarding Ashworth Hospital (UK) criticised this approach to the use of restraint, describing it as oppressive.

Obviously the diverse opinions about the use of this justification lead to some inconsistency of practice which should be addressed through clear establishment of unit priorities and positions about the need for this control. Failure to address this can lead to patients being uncertain as to the expectations of them, contributing to difficulty functioning within the inpatient environment, essentially setting them up to fail and possibly leading them into situations where they are restrained.

All these considerations lead to the conclusion that how a patient's behaviour is viewed by the staff affects the response to it; if the patient is viewed as not having a 'real' mental illness it is likely that the threshold for restraint will be

lower, and the approaches taken more restrictive. The patient may be regarded as being of nuisance value, disruptive to the environment and potentially subversive of the aims of the service and staff working within it. If however, the patient is viewed as being mentally ill there is a greater understanding of why they behave aggressively or disruptively, a sense that they are deserving of their place in a mental health service, and a different level of tolerance of that behaviour.

The place of restraint in mental health nursing

Associated with this assessment of intention are the elements of caring, controlling and the place of restraint within nursing as perceived by individual nurses. For many of the participants this represented a significant ongoing tension which even advanced practitioners struggled with. Despite the tension there was a common understanding by all the nurses which was that at some point the need for restraint is unquestionable. All participants identified restraint as being justified if there was a significant safety risk for anyone. It is interesting to note that this understanding is not universally shared by consumer groups and is challenged by the recently published document; *'No – Force Advocacy by Users and Survivors of Psychiatry'* (Minkowitz, 2006) which was commissioned by the New Zealand Mental Health Commission (NZMHC). Minkowitz is a human rights lawyer and self described survivor of psychiatric assault. Her paper identifies restraint, seclusion, the forced use of electro-convulsive therapy, and forced "drugging or chemical poisoning" (p 12) as being infringements of the human rights of psychiatric patients, and aligns these practices with torture. Her view is that these practices have no place in services for people with psycho-social disabilities. The debate is by no means black and white however, as the NZMHC *'Recovery Competencies for New Zealand Health Workers'* (2001) addresses the issue of patient autonomy, describing it as "fundamental to the recovery of people with mental illness" (p 9) but also acknowledges the need for parameters to that autonomy (competency 1.2(b)). What is not clear is who sets the parameters and are they consistently applied. For the majority of participants there was recognition that mental health services are about controlling at some point or another, that this is legally mandated through the Mental Health Act and is an expectation of the community. Concepts such as empowerment appear to be viewed with a broad focus, in that they also take into account the

disempowerment than can occur as a result of allowing extreme behaviour to continue. An overt example of this view was related by Norm when speaking of the consequences for patients who assault others, staff in particular, and follow a course through legal and forensic psychiatric services which results in even greater restriction for the patient "and the guy won't be able to shit or fart without three staff members present." (Norm 7).

All this leads to an understanding that beliefs about some fundamental issues such as the need for control, the attribution of patient intent, and the place of restraint within mental health services will create a set of diverse responses on the part of nurses initiating restraint. Wright (1999) adds that restraint training should be considered for all disciplines in mental health as the predominant use of restraint by nurses makes it easier for them to be perceived as the agents of control, thereby diminishing their potential therapeutic value. From a patient perspective, divergent responses and confusion about roles must add to their confusion as to what is expected of them, how they must manage their behaviour, and, if observing the use of restraint on others, why it is used in some situations and not in others that appear similar. Presumably staff who are unfamiliar with those they work with will have the same dilemma around what is and isn't acceptable in their work areas unless there is clearly articulated guidance in such matters, which would appear to be the exception rather than the rule. Boddy (1992) states "the dominant belief system in a particular setting shapes the meanings attributed by nurses to patient behaviours, nurses' expectations of patient outcomes, and the kinds of interventions with patients which are viewed as possible or appropriate"(p 211). This finding is consistent with the findings of this research in the context of restraint use or non-use, however what appears to be missing in the services studied is a clear expression of a dominant belief system or philosophy of care, in particular the place of restraint in that philosophy. This lack leaves individual nurses to respond from their own belief system and attitudes, contributing to inconsistency of responses to patient behaviour.

Working with others

There was considerable content relating to working with others to manage challenging situations. Restraint is a team process which requires a degree of trust in the actions of colleagues: they are seen as an important resource to assist in the management of challenging behaviour. With a safety first approach in force the need for others to maximise safety where there is potential violence seems self evident, however there is little available in existing literature relating to this specific area of exploration, so much of this appears to be newly expressed knowledge and worthy of considerable consideration. That this emerged from the data so strongly was initially surprising given the research aimed to understand the individual nurses' decision making, however it appears to reflect the reliance on others in these situations, and the assessments individual nurses make of other staff.

Assessing the staff resources available

Within the data it was revealed that many nurses make an initial assessment of the other staff on duty with them, usually at the commencement of the shift. Factors assessed include the gender of the staff, an assessment of their training, access to additional staff if required, and an assessment of the other staff's abilities in managing difficult situations based on previous experience of them in restraint situations. As Sue put it:

> "It got to the point where I would come on duty and ask who was C&R trained, and people would look at me as if I was crazy, but um, I think that's actually a really worthwhile question to ask when you come on duty. Who's C&R trained you know, 'I am, no, I'm not," look at who you've got, gender and things like that, and try and work out who that team might be if you need to have a team" [to effect restraint]. (Sue 6)

The information appears to be carried with the nurse throughout the course of the duty and as such falls into the category of background information, however information which is more temporal than the training, attitudes and beliefs, past experience, and even knowledge of the patient. Its validity lasts only for the extent of the shift, but appears to be strongly influential factor in the decision making around choice of intervention. Staff will not attempt a planned restraint

with others that they do not have confidence in. The influence of this earlier assessment reappears close to the point of the actual restraint decision as part of the assessment of resources available. An important question this raises is whether or not having the resources readily available to undertake restraint means that this option is more frequently the chosen one. Searching through the data the opposite appears to be true; the occasions when planned restraint has occurred appear to be representative of more extensive consideration of options and a willingness to attempt less restrictive interventions, with the confidence of knowing that the fall back position of restraint was available if the other interventions failed to produce the desired results. This was also seen in the willingness to challenge others who have (perhaps precipitously) decided that restraint is the only intervention possible, with several participants reflecting similar stories of doing their own assessment, knowing who else they were working with, and attempting less intrusive approaches, often with success. This occurred when they felt the support of colleagues in whom they trusted and who they felt held similar values regarding restraint use. Often these stories appear to occur within the context of a shift changeover, where the lack of intervention on the part of previous staff was brought into question. It therefore appears that what usually happens is that situations remain unanswered when there is not confidence in others around us, possibly allowing events to escalate which may mean non-restraint becomes a more difficult option to implement. Intervening at an earlier stage because of confidence in colleagues' ability to support would be advantageous to all concerned, particularly the patient who may avoid prolonged distress and the possibility of being restrained.

Conversely, the perception of others as being not competent or capable in the area of physical restraint often led to the situation where other resources were drawn in to assist in the management of challenging situations. This was clearly identified as a situation in which the use of restraint was almost inevitable, as the called in staff had responsibilities elsewhere and were expected and perceived their role as getting the situation tidied up as rapidly and decisively as possible. In Norm's words, "when they come over here, they are not coming over to negotiate, pacify or talk; they come over and drop someone" (p 82).

As noted earlier in the data (pp 101-108) every participant had a story of being let down by their colleagues, resulting in them experiencing an assault, of a greater degree of injury than they would otherwise have sustained. Despite attempts to purposively interview staff that were identified by others or themselves as restraint avoidant there were no staff willing to participate or identify themselves as avoidant. This has limited the ability to understand what the mechanisms in play are for those people; is their response just fear related, or does it represent a more complex dynamic of not seeing restraint as something they should not be expected to do within a nursing role? Unfortunately this question remains unanswered by this research and we are left with the perceptions of the participants, which are generally critical of their colleagues who choose, for whatever reason, to absent themselves from restraint events, fail to respond at all, or respond in ways regarded as inappropriate. Bill's comment summed up the perception of participants that much unresponsiveness is as a result of fear. "I think she was probably just scared more than anything, and froze like a possum in headlights type reaction to what had happened." (Bill 12)

Analysing the data, it appears there are two distinct pathways that can occur when a patient is already engaging in dangerous behaviour: that of taking a role that is protective of others, or a role that is protective of self, which often results in people leaving the scene or otherwise avoiding involvement. These people then become seen as a liability or at the least of limited use in situations where confrontation is likely to occur. Norm had a blunt assessment of what these people should do in such situations:

> There are some here I won't even think about it (restraining with them). Tell them to go and make a cup of tea, or go and read the 'Kai Tiaki' [a NZ nursing journal] or something. (Norm 5)

The need to be able to trust other colleagues in these situations is paramount for personal safety and an integral part of C&R methods. Participants generally would prefer to know if their colleagues were not competent or confident in C&R and would rather they were kept away from involvement in restraint events rather than having them engage inappropriately or unexpectedly disappear when support is expected. The fact that every participant had a story to relate that

involved them being let down or abandoned by colleagues is significant, and was obviously a particularly notable event for those involved. These situations led to caution about engaging with the patients concerned in some cases and a loss of therapeutic relationship They also led to a breakdown in trust between staff as the participants variously described those who let them down as being a "tinkerbell" (Norm5), "frozen like a possum in headlights" (Bill 12), or that it was "was an appalling situation to be in, ...the client's arm was around my neck, while my colleague sat there watching" (Sue 4). The implications from these situations extend beyond what occurs for the nurse let down by their colleagues in that their confidence in working with patients is adversely affected and they become increasingly cautious of the patient concerned and others with similar presentations.

Staff Gender and expectations

Gender of other staff was identified as more of an issue for female staff than males, with the women identifying a protector role for the male staff; however the men did not seem to regard this as an uncomfortable imposition, for some they seemed unaware that this expectation existed. There was however acceptance that usually it is male staff who take the lead role in restraint situations (where males are present) in spite of males and females undergoing the same training. It was asserted by both male and female participants (pp 79-81) that despite a higher number of staff being female, males still initiated restraint more often and that they took a more authoritarian approach to situations.

Some female participants were critical of women expecting this of male staff, proposing that they would cause "chaos" through a lack of skills and then expect male staff to clean up the situation. Similarly, in recent discussions with advanced (male) practitioners this has been a subject of debate when staff members have expressed a sense of security when working with them (personal communication with K. Roffe, 25 November 2005). A perception exists that this then perpetuates the status quo and leads to stagnation of skill development as long as these staff continue to rely on others to maintain their security. Norm also expressed concern that this tends to typecast males into authoritarian roles, negating or diminishing what they have to offer therapeutically (Norm 6). This is

similar to the concerns expressed by Wright (1999) when he advocated wider training in C&R for other health professionals so that nurses do not become typecast as the enforcers of control.

Training in Calming and Restraint

All participants had positive comments about the role of training in managing challenging situations, irrespective of gender, age, or previous experience. Even those who expressed great reluctance to use restraint felt the training benefited them in being able to contribute to situations that were already in process, such as when they encounter an assault in progress. Training allowed staff to physically intervene more effectively in containing situations that represented immediate danger, but did not generally seem to alter the decision to intervene itself. Participants said they were happy to have had the training, but would likely have become involved in the situation in any case if they thought people were at significant risk. However of greater benefit was the ability to have a wider range of interventions available to them, when the danger was not so immediate. There was a clear message that having confidence in their abilities to effect restraint should things escalate to that point allowed them to intervene earlier and try less restrictive approaches to the situation than when if they were feeling unconfident, under pressure of time, and struggling to cope. This is consistent with the theoretical work of Schulman (2002) in his investigation of split second decision making among expert fire-fighters and police where high risk interventions (which it would seem reasonable to categorise restraint as) become the chosen intervention even if there has been a history of failure of that approach. Being able to provide a lower level of anxiety and pressure in any given situation by instilling confidence in staff's ability to manage will reduce the chance of them choosing the risky and restrictive lines of intervention, or of them failing to respond at all and allowing situations to further escalate and thereby restrict the options available when intervention becomes inevitable.

Training's relationship to actual restraint events

There was some concern expressed about how difficult it is to train people in C&R and to prepare people for the actual situations they will face in working with patients, and frequently incidents were related that involved less staff than

are recommended in the training programmes, and holds that were difficult to apply in reality; "The holds just weren't the right holds; it just didn't work out" (Sue 9). Despite these difficulties the situation was eventually resolved due to the persistence of staff in using the taught techniques, and nobody suffered any physical ill effects. The patient concerned was well known to the mental health service and had been restrained many times in the past, making her well aware of the techniques likely to be used, and adept at seeking ways to counter them. This patient also fell into the category of those identified as not having a 'real' (Axis1 on DSM IV, 1994) mental illness, and represented a considerable frustration for those working with her in her continued inability to benefit from treatments offered to her. Given these factors the likelihood of restrictive approaches being used appears high; however the C&R derived approaches allowed for less restriction than had been used by other agencies (Police and Ambulance services) in their encounters with this person, where detainment in cells and the use of handcuffs had resulted. Obviously there are other factors involved in this, however an approach to managing extreme behaviour that includes confidence in the ability to effectively restrain contributed to less restriction and more attempts at therapeutic intervention than might otherwise have been the case.

Training not always effective

Some participants also acknowledged that a small number of other staff may participate in C&R training but that it had little influence on what was then put into practice when they returned to their workplace. In particular this related to the aspects of calming and defusion as opposed to the physical techniques of restraint. Dave saw this as being a limitation (Dave 8) and acknowledged that training can "only teach people so much," and that personal attitude also contributes to how the person will respond in practice. Hopefully training will be a significant influence in how these attitudes are developed, however it is clear that other factors are also in play. This is consistent with what other aspects of this research indicated, and further reinforces the need for units to have clear positions on when restraint should be used and for what purposes. Again, without this being in place individual nurses are left to their own devices to decide, based on their preferences and priorities.

Many of these background factors combine to form the category of previous experience which in turn influences attitudes and beliefs about what can and should be done in any given situation. Questions such as do I trust the people I am working with to support me, why is this patient displaying this behaviour, what level of risk I perceive to be present, and what is the priority here, all influence the course of action taken.

Knowledge of the Patient and Risk Assessment

Knowledge of the patient's previous presentations, their likes and dislikes and the things they respond to, both positively and negatively was a factor in how challenging situations were managed. From a positive perspective attempts at calming using baths, quiet time, time to talk with staff, and offers of medication (not forced medicating) were in evidence in the stories related. Particularly when a patient was well known there was a willingness to engage in negotiation, from a basis of knowing what had worked previously and what was likely to be successful in averting restraint use in the current situation.

Possible negative implications of knowledge of patient history

There was some concern however, relating to nurses' knowledge of a patient's previous history in regard to violence. The premise of the New Zealand Ministry of Health Guidelines for Clinical Risk Assessment and Management tool (New Zealand Ministry of Health, 1998). is that previous behaviour is a strong predictor of future behaviour. The section "Risk of harm to others" (Appendix 1) highlights that the best predictor of offending is the same as for the general population; "such as their previous record of offending, or threats" (p14). Chien (1999, 2000) highlighted one of the imperatives that nurses operate under; that of preventing harm occurring to patients under their care, in the same way that risk is defined as the avoidance of harmful outcomes. She asserts that this can lead to an approach that can override the rights of patients to act freely. Both recent and distant histories of being violent or requiring restraint were identified as factors in how patients were approached and the options available to them. The concern about this was well expressed by Norm:

> We are hanging you; we are going to make a judgement on the old bulk file, the old box file that exists, that we found shows that in May, June

and July August and September you were restrained on average five times a week during that period in 1980! (Norm 8)

A number of other participants spoke of being "wary' or "more cautious" with patients they had recently been involved in restraining. It is clear that these histories follow patients and can become significant information when evaluating the risk they represent, and how nurses should respond.

Patient's knowledge of staff

Some events indicated that well known patients' knowledge of the nurses they were in contact with was also a factor in how events unfolded. Patients who had trusting relationships with staff could be defused from heightened states of arousal by relatively simple verbal interventions that obviated restraint. This was seen in events relating to admission processes where patients arrived agitated and distressed but quickly calmed with the presence of a previously known nurse, through to events where staff were in the middle of being assaulted and an authoritative word from a keyworker (clinician with primary responsibility for delivery of treatment) or other well known staff member would bring the assault to a halt without the need for physical intervention. This was most clearly demonstrated by Sue's recollection of being attacked, when the patient's keyworker intervened verbally and resolved the situation (p 106).

In summary, knowledge of the patient can be viewed as either leading to a greater commitment to attempting verbal interventions when these were previously known to be effective or alternatively leading to a more 'cautious' approach (which appears to equate to giving patients less leeway or opportunity to behave aggressively) which may involve earlier recourse to restraint where the patient had a known history of assaultive behaviour. What is particularly interesting about the latter approach is that the language used suggests a perception that restraint is a less risky intervention than negotiation, in that there is a sense that having assaulted previously, this is the most likely end result of contact with this highly aroused individual. It can result in a position of nurses "getting in first" so that the patient is in a position of physical disadvantage and unable to effect as much harm. The likely response to such an approach is that

the patient will retaliate or resist out of a need to defend themselves, thus perpetuating the belief that this patient is 'dangerous' and further providing evidence to be used in later risk assessment. Examining other factors identified in the NZMOH risk assessment guidelines it is evident that active, untreated psychiatric symptoms are regarded as significant factors in patient's violence. One of the issues identified here is non-compliance with medication. Again the language (compliance and non-compliance) used indicates that power and an assumption of 'knowing what is best' rests with the service providers, and that patients must passively be obedient. This position covertly gives strength to the mandate to use restraint to effect treatment in those individuals who are resisting it. Doing so is seen to be beneficial to the patient concerned, but also shows responsiveness to the perceived risk; thereby protecting services from criticism should events occur which warrant further investigation.

Gut Instinct

A theme emerged which was not seen in the literature examined; that of gut instinct or intuitive responses. Perhaps it is not surprising that this was not seen in the literature, given the design of most research examined was based on indicators for restraint (i.e. patient and environmental factors) and artificial scenarios which did not have the same time and resource constraints, or the emotional state attachments as real life restraint events. This research looked at restraint decision making from the perspective of the nurse initiating restraint (or choosing not to) which draws on the multiple factors and pressures associated with restraint situations. The use of gut instinct has long been a hallmark of mental health nursing, and one of the factors that makes definition of what mental health nursing entails difficult. Referring back to the literature on decision making, (Garling, Karlsson, & Romanus, 1988) gut instinct could be aligned with the use of heuristics which allow us to shortcut the decision making process by using processes which have been successful in the past and fit with personal approaches. Heuristics or 'rules of thumb' are particularly useful in situations of extreme pressure, where outcomes are likely to be catastrophic, time is limited, and there is a strong desire to act decisively. Inherent in developing these heuristics is the need for experience so that rapid assessments can be made of what is and what is not important to consider, allowing rapid decision making to

occur under pressure. This was demonstrated in many of the stories related where training and quick-fire assessment allowed staff to act quickly and decisively. This is the hallmark of the 'expert nurse' as described by Benner (1984). Heuristics do have some drawbacks however; there is a tendency to continue with whatever has been used in the past even if the situation may indicate an alternative strategy may be of greater utility (Garling et al, 1988). One participant, Dave, referred to seeing this in nurses attending C&R training and then returning to their work place and doing the same things they had always done, with little modification of their practice (p 81). Their personal gut instinct has not appeared to have changed as a result of training, possibly due to other factors in their environment reinforcing the maintenance of the status quo. It would appear that gut instinct is a construct worthy of further research in this and other subject areas where expert decision making occurs in situations of extreme pressure. This would allow better understanding of this mechanism and the possibility of enhancing its development in newer practitioners.

Further development of the restraint model

The model which presented an expanded view of the factors influencing restraint decision (Figure 8.1) made use of the data specific to that area of investigation. The influences are seen; however because of the structure of the interviews, much more information was captured than just the decisional influences. Rich descriptions of events yielded information about outcomes and processes that occurred. These suggested common pathways of events occurring around behaviours displayed by patients that were perceived as dangerous or challenging. It also identified some of the actions taken in attempts to avoid restraint such as using alternative strategies involving verbal communication, offering alternative responses, medication, or calming activities. This information allowed for the synthesis of a model which captures not only decisional factors but also some of the procedural components of the events described (Figure 8.2).

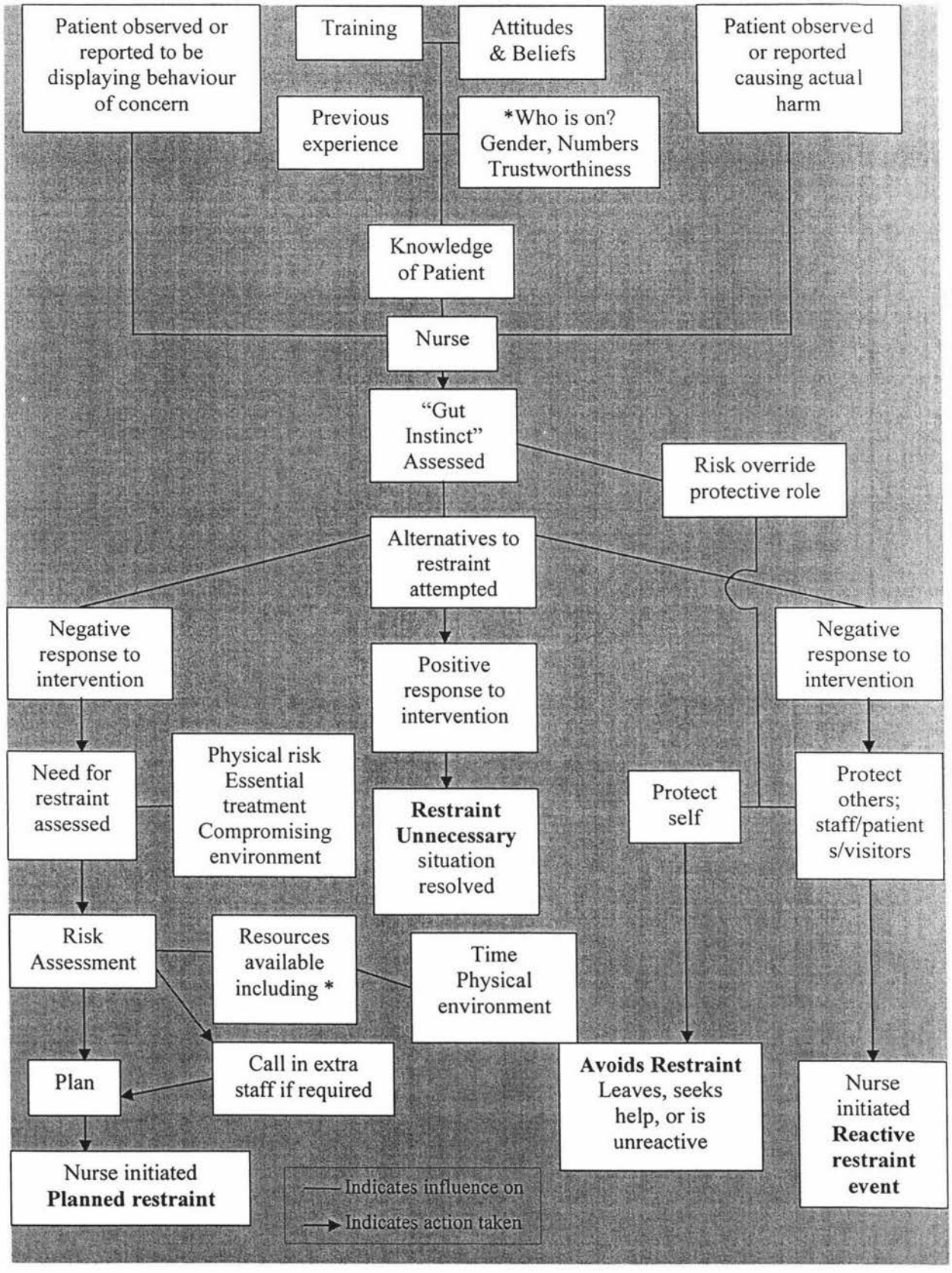


Figure 8.2: Processes involved in various restraint situations

This model presents all the situations described in the participant interviews. Significantly, none of the participants described themselves as avoiding restraint or being unable to react. This component of the model is generated from the participants descriptions of what others had done in response to them (the participants) being assaulted. As is demonstrated there is a pathway whereby restraint is used without recourse to alternative strategies; when others are being assaulted. There was however an instance where a successful intervention occurred in this situation without restraint being used (see p 139), however this was not generally the case.

Summary

Attitudes towards the basis of patient behaviour appear to be strongly influential of the responses to that behaviour. Patients identified as having 'real' mental illness tend to be treated with greater leniency and understanding, with a less restrictive approach being demonstrated. Those otherwise identified are at greater risk of more prolonged restraint, and are more likely to be restrained for purposes of maintaining order within the therapeutic milieu. Language used to describe such patients was largely negative and reflected degrees of frustration at having to manage them in mental health services. Many participants queried the appropriateness of such people being in the mental health services.

Overall there was agreement that who else is available affects the decision making about what occurs in managing challenging behaviour. A lack of skilled colleagues (in relation to C&R skill), as perceived by the study participants, can lead to situations not being addressed and allowed to escalate. The need to seek external resources signals the near inevitability of restraint occurring due to expectations that things will be quickly resolved, or that those drawn in will have duties elsewhere. However, having particularly skilled colleagues can lead to an over reliance on their skills and some participants saw a lack of willingness in others to therapeutically engage, or a lack of skills to do so. The obvious recommendation is that staff working in these areas should all be well prepared to manage challenging behaviour, including having recourse to restraint in extreme situations, as this is likely to result in more attempts to calm and defuse, or use lesser levels of restraint, than when there is a scarcity of these skills, and

they are sought from elsewhere at short notice, when the situation has escalated or failed to resolve. Gender roles were clearly identified by all the female participants who saw males as having traditional protective function. This led to some assertion that males had more authoritarian styles, a position that did not sit comfortably with many of the male participants who saw this as demeaning the therapeutic value they had to offer.

Training was viewed by all participants positively, even though it was acknowledged that the situations were artificial, and that no two restraint events are ever the same. The ability to physically manage events should they deteriorate to that point was rated as highly valuable and contributed to a willingness to try other non-physical interventions earlier. In emergency situations training was not identified as significantly influential in the decision to intervene but was regarded as protective in taking that course of action. There was some acknowledgement of the limited effect of training on people's attitudes in some cases.

Knowledge of patients from previous experience was either a positive factor in reducing restraint, or a significant factor in increasing the use of restraint. When patients were well known to staff, rapport established, and there was knowledge of the effectiveness of various interventions, this information led to less use of restraint. Conversely, a recent history of aggression, a perception of responsibility for behaviour, or a determination that the patient was 'pushing boundaries' led to greater use of restraint in the first instance without attempts to use other means of resolution. The perspective of the risk assessment tools used in these services that risk is all about adverse outcomes tends to objectify the patient as a problem that needs to be managed.

Implications for nursing practice and service development

The findings of this study lead to suggestions about how services should be structured and the resources required to maintain an effective, safe and therapeutic environment. It is clear that attitudes towards patients affect the decision making around the use of restraint. There needs to be clear service expectations about what they are there to provide in the way of mental health

services and who these services are provided for. Without this the individual clinician is left to determine who is deserving of their care and who is not, irrespective of their status as a patient. With the evolution of mental health services from large institutions to smaller inpatient units the function of services has, at times been poorly articulated, and many working in the field identify large service gaps which they fill because there are no other services available.

Individual services should also clearly articulate the place of restraint in their service. Included in this should be the use of restraint in the context of effecting compliance with treatment, or service norms. Restraint events that are perceived as being out of step with the position on restraint should be examined in detail and viewed as opportunities for education and development, rather than censure and disagreement. This approach will reduce individual variation in practice and provide clearer expectations for patients.

Training in Calming and Restraint for all staff working in acute mental health services should continue to be mandatory and actively supported. Staff who feel confident in their own skills and those of their colleagues identify more attempts at calming and defusing approaches, intervened earlier, and felt the outcomes were more positive. Where services had to resort to using staff resources from other parts of the service or elsewhere, there was greater recourse to restraint use without attempts at other interventions.

Further development of debriefing or critiquing processes needs to occur. Participants all had stories to tell of inappropriate, poor, or non-performance of other staff which led to poor outcomes for themselves or the patients concerned. What was glaringly absent was the critiquing of their own practice in an effective way. Despite asking about times when events did not go well, no-one was prepared to relate times when their decision making was less than optimal. To ensure thorough critiquing can occur services need to develop a culture that does not blame or censure, except in extreme circumstances, and views learning from less than ideal outcomes as being a positive attribute. Practitioners with advanced skills in C&R should also be further developed in this area to facilitate this.

Risk Assessment methods need to be revised to provide more emphasis on patient strengths. This would be more consistent with recovery approaches to treatment, in that it would allow patients to identify what they can do to avoid negative outcomes. Earlier engagement in the risk management process could empower patients to see themselves as active agents in the process rather than objects to be acted on to prevent harm. This could positively influence the perception of patients by nurses, leading to an attitudinal shift that would be beneficial to both parties by influencing the decision making process in restraint use.

Limitations of the study and areas for further research

My role as an instructor in C&R provides several complications to this research. First, and most importantly, it brings an assumption that I believe in the necessity of restraint in mental health services. This belief is not universally held, particularly by those in the consumer movement. It is also likely that I was perceived as being comfortable with the use of restraint due to my greater familiarity with it. This may have led to participants making assumptions that would modify their responses to the questions asked; if the underlying belief had been that restraint was quite unacceptable, both the content and the manner in which stories were related may have altered through a natural social desire to develop rapport with the interviewer. Whilst this needs to be borne in mind, the obverse is that participants appeared relaxed about the topic, willing to engage freely, and easily developed rapport.

As analysis progressed it was clear that there was a limitation to this investigation. All participants had identified events where they felt unsupported by their colleagues and expressed opinions about those actions and the subsequent effect on their own future behaviours. Despite attempts to do so, through the means previously used (direct approaches at nursing meetings) and by talking with nurse leaders, it was not possible to interview staff members who had been unable or unwilling to respond. Where these people were identifiable, they had moved to other areas of work, outside of mental health nursing. This limitation is significant, in that it represents a gap in understanding the processes that lead people to not restraining. As will be shown there is a considerable sense

of abandonment associated with poor support from colleagues, which often leads to severe criticism of those who fail to 'back up' others. In this area, we operate on assumptions made by others, often with very significant affective (feeling) factors associated with the outcome of not being supported in the way the participants would expect. Findings of the study relate to nurses who, by self selection, appeared to have successfully been engaged in restraint events. Those who chose not to or could not respond when violence was occurring were notable in their absence. We can only surmise as to the reasons for their reactions, and much of this surmising occurs within a significant affective context; that of being let down by one's colleague. Given the finding that a sense of having competent staff around you, capable of contributing to the management of aggression and violence, was indicative of greater commitment to non-physical, non-coercive interventions, it would be useful to know what is happening for those whom others perceive to be 'useless' in such circumstances. Greater understanding of each others positions may lead to greater confidence in the team as a whole.

The study is limited in that the investigation has been from the perspective of nurses that initiate or engaged in restraint. Clearly the decision making that occurs for the patient is lacking in this picture; as a result of this research we still are unaware of what motivates a particular response on their part. What interventions are found to be helpful in them selecting to behave in a non or less aggressive manner would be extremely useful in determining how best to help skilfully. This would be a useful avenue for further research to expand on what is already known about patients' perceptions regarding the use of restraint and seclusion.

Time constraints exist for all researchers, and this thesis is no exception. This has led to a selective presentation of themes which appeared dominant in the data. The exclusion of some themes due to their low representation (e.g. debriefing) is a limitation of this research. The role of debriefing in future decision making, emotional resolution or distress, and for wider process improvement is worthy of more investigation.

The number of participants in this study is small. They were recruited from two adjacent District Health Boards. Clearly a greater number of participants would have yielded a greater pool of data and themes would have been able to be identified with greater strength than this research allowed. All participants were New Zealand trained nurses who had worked predominantly in the New Zealand health sector. Undoubtedly there is diversity in the approach to restraint use among different countries, which may well have yielded a greater variation of decision making processes, however this research was intended to focus primarily on the New Zealand situation, so that its conclusions could be used to inform process and training development.

The construct of 'gut instinct' is worthy of further investigation, given the rapid decision making in evidence and the multiple factors in play in reaching those decisions. Given the need to deconstruct this somewhat ill defined and complex concept, methodologies such as Sense – Making (Dervin, 1983) may be beneficial in any such investigation. Gut instinct is certainly a commonly used term in psychiatric/mental health nursing in relation to restraint and other types of intervention, making its investigation seemingly essential if a better understanding of the processes nurses used is to be developed and shared with newer practitioners.

Other methods of investigating the subject may have yielded different types of data. Operationally it would be difficult (and very time consuming) to adopt an approach of observing restraint events, however the opportunity to immediately interview all staff involved at a time close to the event seems compelling. Issues around the ethics of being a researcher observing such distasteful and potentially distressing events would be complex, with the possibility of intensifying the distress of both the patient and staff members. It would seem unlikely that an appropriate informed consent to discuss the restraint event with the patient would be possible, at least not close to the time it occurred.

Final thoughts

The need for investigation of the 'front end' of restraint decision making has appeared self evident to me ever since I began to be involved in training other staff in its use. This research has further reinforced that need and identified a number of areas that could beneficially be investigated in our mission to better understand what goes on when restraint is resorted to. Strongly evident in this study is the understanding that much of what influences nurses' decisions to restrain has little to do with the immediate presentation of the patient, unless they are actually in the midst of assaulting others. Attitudes towards the patient's motivation, their degree of control over their behaviour, and whether or not they are rightly served by mental health services are highly influential. Core beliefs about the nature of mental health nursing and its relationship to restraint also affect the decisions, but are often overridden by the imperative to maintain safety. Evident in the relating of events about this overriding is the internal conflict this causes many nurses, to the extent that some leave the profession.

The need to have services develop clearly articulated values around how patients are to be treated emerged from the discussion around attitudes and beliefs. These values need to form a shared understanding for both staff and patients such that expectations are more clearly articulated, removing some of the uncertainty evident in the participants, particularly when there is a perceived conflict between acting therapeutically and meeting the organisational and societal expectations of managing risk.

Research of this nature brings a particular set of challenges to the researcher. In particular the findings that much of what influences decision making is bigger and more intrinsic to the individual than what is able to be taught in limited four or five day courses in calming and restraint is a significant point of contemplation. From this research the challenge is now to determine how best this knowledge can be used to influence the use of restraint in mental health services.

Appendix 1

Risk of harm to others

Violence and mental illness

In summary, the current state of knowledge about the risk of violence from those with mental illness is as follows.

- The great majority of mentally ill people present no greater danger to others than the general population

- The best predictor of offending among mentally disordered people are the same as those for the rest of the population, such as their previous record of offending, or threats.

- The risk posed by people with a severe mental illness, such as schizophrenia or manic depressive disorder, is increased when they are experiencing active psychotic symptoms.

- The risk of violence is further increased for those with severe mental illness who have active symptoms, and also misuse drugs or alcohol.

- The relative risk posed by people with mental illness is of the same order as that posed by the general population aged between 18 and 24 years. It is lower than the risk presented by young males from lower socio-economic backgrounds, and is lower than the risk presented by people who misuse alcohol or other drugs.

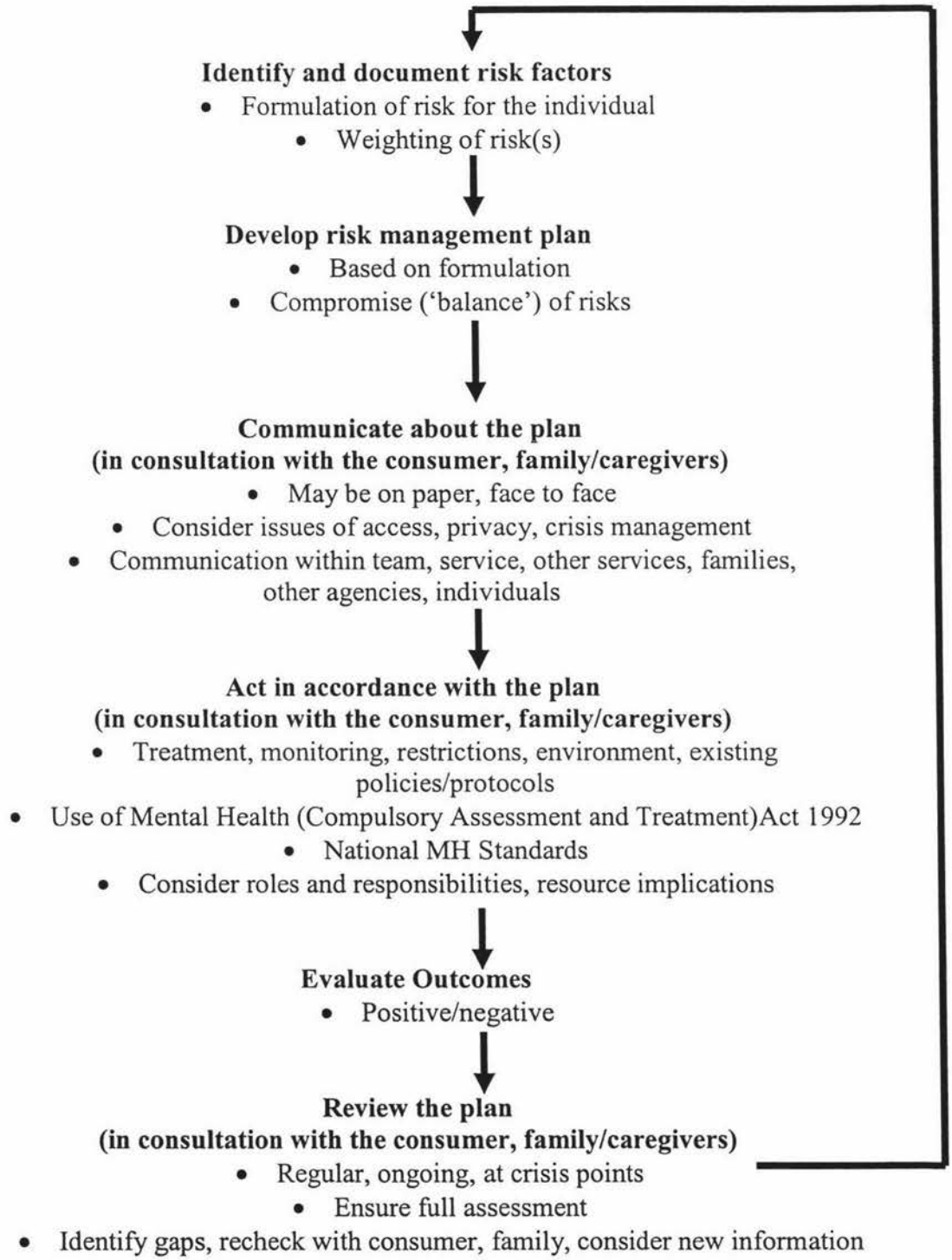
Overall there is a moderately increased risk of violent or fear-inducing behaviour among those who have mental illness.

The increased risk appears almost entirely due to active, untreated symptoms of illness, including non-compliance with medication. The best way to control the risk is to ensure that there are effective monitoring systems that can detect early signs of relapse, and ensure ready access to services that will deal with these promptly.

From: Guidelines for Clinical Risk Assessment and Management.

Appendix 2

The process of risk management planning



From: Guidelines for Clinical Risk Assessment and Management

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Request for Volunteers

Physical Restraint – How do you decide?

Kia Ora, greetings. My name is Murray Edgar and I am a registered Psychiatric Nurse with over 20 years experience. Currently I am the Clinical Nurse Specialist in Psychogeriatrics at MidCentral Health. My research, which is going towards my Master's degree, is an investigation of the factors nurses consider when deciding to use physical restraint. I believe nurses working in Mental Health are expected to make very difficult decisions that involve the restriction of patient's liberty to maintain their safety and the safety of others. I am interested to learn the varied ways in which nurses make decisions to restrain, and hope this research will assist in the development and refinement of training courses in this field.

I am seeking eight to twelve participants to take part in this study. As it is usually the Registered Nurse who takes the lead in deciding to restrain I am most interested to speak with nurses who are Registered Comprehensive or Psychiatric nurses. It would be useful to have a variety of people to speak with, so whether you are more experienced in restraint use or have not applied it often I would like to hear from you. It is essential that you have had training in a Calming and Restraint programme or similar. Your input would involve two or three taped interviews with me, each lasting no more than one hour, at times suitable to you, held between June and September 2002. The venue would be wherever is suitable for you. Anonymity would be maintained throughout the study and subsequent release of the report.

My research supervisor is Dr Julie Boddy, School of Health Sciences, Massey University, Palmerston North. If you are considering taking part in this research, or would like to know more about it, please do not hesitate to contact me at:

STAR Outpatients
ElderHealth
Palmerston North Hospital
PO Box 2056
Palmerston North
Ph. (06) 350 8020
Home Ph. (06) 323 6300

You may also contact my supervisor, during office hours, concerning this research:

Dr Julie Boddy
School of Health Sciences
Massey University
Ph. (06) 350 5700 ext. 2541

Thank you for reading this explanation sheet, and I hope I will hear from you regarding this research.

Murray Edgar

This study has been approved by the Manawatu Whanganui Ethics Committee.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/75. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Regional Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz

Appendix 4

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Physical Restraint – How do you decide?

INFORMATION SHEET FOR PARTICIPANTS

Thank you for seeking additional information and considering being a participant in this study. This research focuses on how Registered Nurses make decisions to restrain or not restrain patients in Mental Health settings.

Despite significant research into the use of physical restraint, especially in long term settings and the elderly, there is still a lack of knowledge around the real influences on decisions to use physical restraint (including seclusion). Many researchers have found consistency in the factors staff identify as being key indicators for the need for restraint, however studies that looked at the actual application of restraint did not support this consistency. Holzworth and Wills(1999) study identified this disparity as did Chien (2000). What I wish to study further are these other factors that influence your decisions to restrain. Your part would be to relate various situations in which you initiated physical restraint, how you made those decisions, and your reflections on those events. It would also involve reflecting on situations where you thought of using restraint but took another course. We would then meet again and discuss particular areas in greater depth. This information would be the data for my masterate thesis on this topic.

Your commitment would be to participate in 2 or 3 interviews of not more than 60 minutes each. We will negotiate times and places to suit you. These interviews will be audio taped and transcribed. At any time, you will have the right to have the audio tape turned off. Pseudonyms will be used to protect your anonymity, the transcriber and researcher will be bound to confidentiality, and all data will be secured. At the completion of the study you will have the choice of having your tapes and transcripts given to you, or I will make arrangements for their destruction.

Participation in this study is entirely voluntary, and written informed consent from participants will be sought before any interviews take place. No identifiable information will be handed on to any third party, including your employer, to protect you from adverse consequences to your employment or career development. It is important that you feel entirely free to speak on these matters, and I recognise that restraint is at times a contentious and difficult area of practice. For this reason, and so that you give me your personal experiences, I would recommend that you keep your participation in this research confidential. Interview data (transcripts and tapes) will be kept securely for 10 years for the purpose of academic audit, then destroyed. Notwithstanding the above, you must be fully aware that there are minimum professional standards which I am obliged to uphold.

Please read the consent form enclosed with this information sheet.

As a participant, you will have the right to:

- Decline to participate
- Refuse to answer any particular question or to withdraw from the study at any time without having to give a reason
- Ask further questions about the study at any time
- Have your anonymity maintained
- View and edit the transcripts prior to their inclusion in the research data
- Request the tapes and transcripts of your interviews be given to you
- Have access to the studies findings when it is concluded
- Agree to participate under the conditions laid out on this sheet

Please contact me if you have any further questions or wish to participate in this study.

Murray Edgar
Ph. (06) 350 8020

You may also contact my supervisor, during office hours, concerning this research:

Dr Julie Boddy
School of Health Sciences
Massey University
Ph. (06) 350 5700 ext. 2541

This study has been approved by the Manawatu Whanganui Ethics Committee.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/75.
If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Regional Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz.

Version 4
4 July 2002.

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Physical Restraint – How do you decide?

Consent Form

I, _____, have read the Information Sheet (version 4, dated 4 July 2002) and have had details of the above study explained to me by the researcher. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time during the study.

I am participating in this study voluntarily and I am aware that I may withdraw from the study at any time, or refuse to answer any particular questions, without having to give a reason.

In particular, I agree to participate in the interviews and provide information to the researcher on the understanding that my anonymity will be protected and that no information that is likely to result in my identification will be released without my prior written consent.

Notwithstanding the above, I understand that there are minimum professional standards which the researcher is obliged to uphold.

The information gathered will be used for this research and publications (including seminars or workshops) that may arise from the research project. The knowledge gained will be used to assist in the further refinement of training programmes in Calming and Restraint.

I agree to the interviews being audio taped, and these tapes being transcribed into written format.

I understand that I may choose to view and edit the transcripts prior to their inclusion in the data set.

I understand that I may ask for the tape to be temporarily stopped at any time during the interview.

I **wish** to have copies of my interview tapes and transcripts returned to me at the conclusion of this research

OR

I **do not wish** to receive copies of my interview tapes and transcripts following the conclusion of the research.
(delete as appropriate)

All interview tapes and transcripts will be destroyed 10 years after the conclusion of the research. Until such time it will be stored securely by the researcher.

I agree to participate in this study under the above conditions and those set out in the Information Sheet (version 4, dated 4 July 2002).

Signed: _____

Name: _____

Date: _____

This study has been approved by the Manawatu Whanganui Ethics Committee.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/75. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Regional Human Ethics Committee: Palmerston North, telephone 06 350 5249, email S.V.Rumball@massey.ac.nz.

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