

**A Hermeneutic Phenomenological Exploration of 'Last
Resort' in the Use of Restraint**

By

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**A thesis submitted in partial fulfilment for the requirements for the degree of
Doctor of Philosophy at the University of Central Lancashire**

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STUDENT DECLARATION FORM

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

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(Refer to Appendix H)**

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Abstract

Restraining patients (i.e. physically confining their movement or using devices to restrict their movement) is a practice that dates back at least three centuries. In more recent years, there has been a mandate and advocacy in countries such as Canada, USA and UK, for organisations to shift towards the minimisation of restraint, whereby its use is only as a 'last resort' when all other alternative interventions have been exhausted. There is growing evidence internationally indicating the negative impact of the use of restraint. However, to date there is no research describing the concept of 'last resort'. Further insights to explore how this concept is enacted within practice amongst mental health nurses are therefore warranted.

I undertook an integrative review to synthesise existing knowledge of mental health nurses decision-making into the use of restraint. The empirical research comprised a hermeneutic phenomenological study. By recruiting and interviewing mental health nurses who had experiences of restraint use, the research aimed to generate a deeper understanding of the meanings and lived experiences of the concept of 'last resort'. A total of thirteen mental health nurses were recruited from various provinces in Canada. Data was collected through fifteen in-depth interviews. Data analysis was undertaken through a hermeneutic phenomenological framework based on van Manen's approach and Heideggerian hermeneutics. Five Heideggerian concepts were used to illuminate 'last resort' in restraint use by mental health nurses - temporality, inauthenticity, thrownness, leaping in and leaping ahead and fear. Key highlights emerging from these concepts are that nurses past experiences influence when they use restraint as a 'last resort'. Moreover, nurses demonstrated a collective view in relation to their lived experience, the patients and the care provided. Lastly, there appears to be a dependency on the knowledge and skills of others that impact nurses determining restraint to be used as a 'last resort'.

Theorisation of the findings from within the broader literature also revealed a number of concepts that further offer an understanding of 'last resort'. The concepts are

dehumanisation, collective identity, groupthink, fear-based approach, and trauma. With this initial insight into 'last resort', a number of practice recommendations, such as debriefing, recovery-oriented care, de-escalation techniques and mitigation of groupthink, have been discussed in support of restraint minimisation.

In conclusion, the lived experience of 'last resort' is comprised of many elements. This study provides insights and an initial understanding, which is hoped to pave the way in the advancement of our knowledge in the field of restraint minimisation.

1.0 Introduction

In this introductory chapter, I provide the purpose and reasons for undertaking this hermeneutic phenomenological study and the opportunity to uncover the relationship of my pre-understandings to the research. I then provide an outline of the structure of the thesis.

1.2 Purpose of this research

The aim of this study is to gather the perspectives and lived experiences of Canadian mental health nurses on the use of restraint with a particular focus upon the notion of 'last resort'. The research question is 'how do mental health nurses perceive the notion of 'last resort' when using restraint?' It is hoped that the findings from this study will contribute to bridging the gap in understanding why this practice continues to be used and what underpins mental health nurses decisions of 'last resort'. It is also hoped that the findings will help to inform strategies in restraint minimisation and to ultimately prevent restraint use in mental health care.

1.3 Why this research?

Reflection and reflexivity are essential activities in qualitative research and the evolution of any doctoral candidate. Reflection is an in-depth consideration of events or situations outside of oneself and it involves reviewing and reliving the experience to bring it into focus (Mortari, 2015). This would include reflecting on such points as who said and did what, how, when, where, and why, which may lead to insight about something not noticed in time. Reflexivity refers to finding strategies to question our own attitudes, thought processes, values, assumptions, prejudices and habitual actions, in order to strive to understand our complex roles in relation to others (Enosh & Ben-Ari, 2016; Steier, 1995). Altheide and Johnson (1994) state '*how knowledge is acquired, organised, and interpreted is relevant to what the claims are*' (p. 486). This

process is referred to as '*researcher positionality*' (Cousins, 2009, p. 18). Thus, I believe it is important to begin by reflecting on my own place in this study, how this has influenced the focus of my study and the design, collection and interpretation of the data – my biases and pre-understandings. These practices reflect Heidegger's fore-structures of understanding (refer to section 4.4 for details) and are key within a hermeneutic phenomenological study, as he believes interpretation is pre-determined by the fore-structures of the researcher/interpreter. Therefore, I start by sharing my academic, professional, and personal motivations.

1.3.1 Academic rationale for the study

The use of restraint falls within the challenges seen in the overly coercive cultures in mental health being experienced internationally. Often coercive practices are used in response to the aggressive behaviours displayed by individuals with mental health problems. There is evidence suggesting the causes of aggressive behaviours by mental health patients may be seen as part of an interrelated triad of factors generally seen to be of internal, external or situational origin (Duxbury, 2015b). Duxbury (2015b) further elaborates on these origins of causes, stating:

'A person may be aggressive because of personal influences such as substance abuse, individual personality traits or illness-related factors; as a result of aspects of the environment whether that be physical or atmospheric; or as a result of alien situations, relationships and encounters that are experienced when an individual is unwell or in an environment such as the clinical setting' (p. 89).

Hence, clinicians may have reactive responses and rely on coercion to manage aggression, especially if the contributory factors are not identified and addressed through a preventative approach. There are many guidelines, such as the UK's National Institute for Clinical Excellence (NICE) on the prevention and management of imminent violence (2015), and the Department of Health's Positive and Proactive Care guidelines (2014), that promote the need for violence prevention and the minimisation of coercive practices.

Focussing specifically on restraint use, over the past two decades, there has been a significant movement towards the minimisation of restraint in mental health care (Huckshorn, 2008; LeBel et al., 2014). This has been the result of growing evidence emphasising the negative impact that restraint use has on patients, staff, and healthcare organisations (Ashcraft & Anthony, 2008; Moran et al., 2009; Muralidharan & Fenton, 2012; Sailas & Fenton, 2012). Restraint minimisation specifically indicates that all other alternative interventions should be exhausted, and restraint should only ever be used as a 'last resort'. However, to date, there is no literature exploring what 'last resort' actually means in relation to restraint use. Furthermore, despite existing knowledge and awareness of the negative effects of restraint use, this practice continues, suggesting that 'last resort' may be inconsistently defined and understood.

Given the upsurge of interest, debate, research and policy in the area of coercion, including the use of restraint, internationally in mental health, it is critical to continue to question and review these practices. I passionately believe that there is a need to continue to promote person-centred and compassionate approaches in care and to evaluate the poorly evidenced practices in mental health. From this perspective, I am motivated to understand the concept of 'last resort', which I believe is a key driver in restraint minimisation. I believe this could enable greater insight towards reduction efforts in the prevalence of restraint use.

1.3.2 Personal and professional motivation for the study

My personal motivation for undertaking this study is closely linked to my professional experience. I decided to become a nurse after my high school vocational placement experience working as a nursing student. I stumbled into this experience, rather than it being an active choice, and initially was uncertain as to whether I would enjoy it. However, I learned very quickly that I had a passion for helping and caring for others. Graduating and entering into the field of nursing continued to foster my passion, leaving me with the desire to want to somehow make a difference in people's lives. Although I felt I was achieving this in my day-to-day nursing role, I wanted to make a

difference at a higher leadership level and therefore, pursued my Master's degree to continue my professional growth. The achievement of my Master's enabled me to become a clinical educator with greater opportunities to influence training, education and policies. My journey as a Registered Nurse (RN) has spanned some fifteen years during which time I have specialised in mental health for the past nine years.

Professionally I became passionate about restraint minimisation with the start of my role as a clinical educator at a stand-alone mental health hospital in Canada in 2009. This was the first time in my professional life where I worked at a hospital dedicated only to serving the mental health population. I was quite shocked when I first started my role at the hospital, as I had never seen such a significant use of restraint among patients in my career. It was frustrating to be part of situations where I felt restraint use was unnecessary, but witnessed its continuation nonetheless. I felt helpless in protecting the patients and simultaneously upset with staff.

I am aware that I come to this study with my own unique attitudes, assumptions, prejudices and values in relation to restraint use. I was interviewed at the start of my study by one of my supervisors to elicit my pre-understandings, beliefs and biases towards the topic area, which formed the start of my reflexive diary that I continued throughout. I believe it is important to share these perspectives as part of my personal and professional motivation. Below I share part of my reflexive diary entry at the start of the study that demonstrates my early experiences in my educator role, I wrote:

'My initial experiences at the hospital watching staff place patients in restraint, felt as though I had been placed in a time machine and was working 30 to 40 years earlier. I couldn't believe patients were being treated in the manner they were. My typical experience would include an emergency code being called overhead in the entire hospital stating the location of the code. As a clinical educator, I, along with a mass of clinicians, rushed in the hospital hallways towards the unit with the code. I can still remember my heart pounding and being very anxious about what I was going to observe. Often there were 20 or more clinicians surrounding one patient. There would be brief attempts to talk to the

patient and most often the patient would get 'rushed' [dashed towards in an attempt to contain them] by many of the staff and taken to the floor. One nurse would then administer an injection to the patient. After what felt like a lifetime, but probably 10 minutes in reality, the patient was applied walking restraint and taken – sometimes carried by staff - to the isolation room where they were placed on the bed and mechanical restraint applied. Most often I would feel the patient was invisible in the entire process. No one talked to them or acknowledged them in any way. All the staff would then leave the room as soon as the restraint was placed on the patient, the door to the room locked and the patient would then be monitored via a camera. I went through observing these types of incidents over and over and couldn't believe or understand how this was okay. I kept having more and more questions and left with little answers.'

Witnessing restraint practices contravened both my professional and personal values and principles on many levels. Specifically my values and principles of respecting everyone, providing a person-centred caring environment for patients, and being compassionate with people, especially those who are unwell, were disregarded. Hence, my personal desires influencing this study were to make a difference in the lives of those needing care and valuing human rights of all people. My experiences are part of a journey and as such I have to acknowledge and work with them and recognise their influence in my view of the world. My experiences related to restraint use in the hospital setting have improved over time. I have observed staff spending more time to verbally de-escalate patients and minimise the use of restraint. However, I continue to feel disturbed by the lack of focus on prevention. Professionally, the catalyst and motivation for this study has been the result of my ongoing frustration and curiosity about 'last resort' and how it tends to be understood by nurses, as well as my hope to change and eliminate restraint practices. These influences have significantly contributed to shaping the focus of my study.

1.4 A guide to the chapters

In chapter two I present the background to the Canadian mental health care system to assist in framing the study. I then discuss the history of coercive practices overall prior to focusing on restraint - its definition, historical context, current practice and evidence. This leads to a discussion on the current activities related to the restraint minimisation movement. A number of evidence-based models are reviewed such as, Six Core Strategies to Reduce the Use of Seclusion and Restraint©, REsTRAIN YOURSELF, Safewards, and No Force First. The chapter is then concluded with a description of restraint use in Canada, to demonstrate the continued practice and the need for this study.

Chapter three provides a detailed integrative review exploring the decision-making factors that influence mental health nurses in the use of restraint. This section provides a background to the study through a comprehensive overview of the extant literature related to decision-making and restraint use. Moreover, it identifies the gap in knowledge relating to 'last resort'. The thematic findings of the integrative review are presented.

Chapter four outlines the theoretical positioning of the study. I first present the epistemological and ontological perspective for this study. I then describe the theoretical approach selected, namely hermeneutic phenomenology. I provide a background of the phenomenology movement and my rationale for choosing hermeneutic phenomenology. The philosophers chosen to guide this research are then introduced which include Heidegger, Gadamer and van Manen. Lastly, I introduce and describe key philosophical concepts in order to provide context for the interpretations of the findings.

In the fifth chapter, the study design and method are described. I provide details of the approach taken in engaging the participants, the ethical considerations, gathering the lived experiences of the nurses, and the analysis of the experiences. In this chapter I

demonstrate how the hermeneutic phenomenological approach was adopted, as well as how rigour was achieved.

Chapter six represents the first of the findings chapters. In this chapter my pre-understandings related to the use of restraint are presented as part of building credibility of my research. This is then followed by the themes that emerged from the interviews. Seven themes are presented and discussed.

The second part of the findings is provided in chapter seven. This chapter draws on Heideggerian concepts for an in-depth analysis of the insights presented in chapter six. Five Heideggerian philosophical concepts are used as a lens to develop a deeper understanding and meaning of 'last resort' in practice. The selected concepts are temporality, inauthenticity, thrownness, leaping in and leaping ahead, and fear.

Chapter eight is the discussion section of the thesis. Here I bring together the findings and contextualise them further by drawing on wider literature. I first provide an overview of the findings from the integrative review and my study. I then further theorise the results and link them to wider theoretical concepts of dehumanisation, collective approach, groupthink, fear-based approach, and trauma. The second half of this chapter discusses practice recommendations in the form of antidotes that support restraint minimisation. These include debriefing, recovery-oriented care, trauma-informed care, mitigation of groupthink, and de-escalation techniques. Lastly, I review the strengths and limitations of the study prior to making suggestions for future research in this area.

Chapter nine provides a conclusion to the study. Unique contributions made to evidence from this study are detailed. Finally, in chapter ten, I write about my own experiences whilst conducting this study, representing the end of my journey.

2.0 Introduction

I begin this chapter by situating the study within the Canadian mental health care context. I believe this will aid in understanding the larger context in which the study takes place, given its focus on restraint use in Canada. I then provide a comprehensive background on the use of coercive practices in mental health, followed by a focus on defining restraint. Since restraint is a form of coercive practice, it is important to appreciate the history and use of these practices in mental health prior to concentrating on restraint use today. In order to describe the importance of exploring the concept of 'last resort', I also provide a history about restraint use and its current practice and evidence. I then present the rise of the restraint minimisation movement globally and restraint utilisation within the Canadian context.

2.1 Framing the research: Mental health care in Canada

Early 1900s asylums were being increasingly accepted in Canada as a necessity to protect society from the 'mad' and therefore becoming a warehouse for those deemed unfit. With this rising population of people with mental illnesses in asylums, superintendents became dictators running institutions on marginal funds, with poorly trained and minimal amount of staff who increasingly relied on force to keep patients under their control (Scull, 1977; Whitaker, 2002). In the 1960s and 1970s the deinstitutionalisation movement began. Deinstitutionalisation refers to the release of the people who were segregated in asylums from the institution setting to being placed into community settings (Niles, 2013). The literature identifies various reasons for this movement in North America. Some researchers suggest the increasing cost of maintaining mental hospitals, combined with the advancement of society into capitalist, urbanised place where large sums of money was required for urban development to continue (Lamb & Bachrach, 2001; Scull, 1977) created an appealing case for deinstitutionalisation. Additionally, there were rising numbers of class action suits against mental hospitals during the sixties and seventies on behalf of patients

regarding mistreatment (Scull, 1977; Whitaker, 2002). Another rationale for deinstitutionalisation was economically based. It was believed that discharging patients out of asylums into the community was enabling the government to save a substantial amount of money and present society with the belief that this was being done under the guise of humanitarian care. The challenge was that there were no detailed community services put into place to assist patients with integration and provide support (Niles, 2013).

Therefore, five decades ago, deinstitutionalisation turned the Canadian mental health system inside out. Nearly 50,000 beds were closed in aging provincial asylums, and a new patient regime of short hospital stays, psychiatric drugs, and community services was set in place. The repercussions of the deinstitutionalisation movement included isolation of patients who had limited to no support in the community, increased emotional burden and social costs, and strained relationships among family and friends of those attempting to support patients greatly in need of care (Niles, 2013). A psychiatrist working in Canada during this movement provides his description of the experience, stating:

'Deinstitutionalisation was an incredible thing...all you had to do was to load them with neuroleptic drugs and send them into the community. We began reading Erving Goffman and Ernest Gruenberg from New York State and how hospitals screw people up. So we took tens of thousands of patients and threw them out of the hospital without any support system. We said there was going to be follow-up, but the fact of the matter is that nobody really understood, so the bureaucrats were delighted to get them out of hospitals...and only...later did we say. "Hey, this is crazy, what about housing, what about recreation?"' (Simmons, 1990, p. 160)

In the latter half of the twentieth century it was identified that many of the patients that were moved into the community ended up homeless, while others were being incarcerated in mental health hospitals and jails (Dear & Wolch, 1987). Dear and Wolch (1987) attribute the lack of benefits realised by deinstitutionalisation to *'the*

lack of adequate community supports...[which]...led to...[their]...incarceration....within the criminal justice system for crimes more indicative of their mental health disabilities than criminal intent' (p.174). Additionally, their incarceration may have been due to the insufficient amount of quality of community based residential and psychiatric facilities available.

Presently, Canada Health Act governs the Canadian healthcare. The purpose of this Act is to protect, promote and restore the mental and physical well-being of Canadians and to ensure reasonable access to health services irrespective of personal factors such as income, education or cultural differences. Provinces and territories are required to provide coverage for health services that are deemed 'medically necessary' with funding from the federal government. This typically covers all inpatient treatments such as those received in a hospital or physician's office. The majority of mental health services however, under the current health regime, do not meet the eligibility requirements of 'medically necessary', unless received in a hospital. This is despite the recognition that health, including mental health, is a fundamental right for all Canadians. As well, as identified by deinstitutionalisation much of mental health care today is pushed to the community where much of the services is not covered (Canadian Civil Liberties Association, 2017).

The Canadian reality is that one in five people will be affected by mental illness in their lifetime. The cost to the country's economy is staggering - \$50-billion a year in health care and social services, lost productivity and decreased quality of life (Mental Health Commission of Canada, 2014). Canadians seeking help for mental illness often are prescribed medication, even though research illustrates that psychotherapy works just as well, if not better, for the most common illnesses (depression and anxiety) and does a better job at preventing relapse (Mental Health Commission of Canada, 2014). A 2012 Canada Statistics study showed that while 91% of Canadians were prescribed the medication they sought, only 65% received the therapy they felt they needed (Mental Health Commission of Canada, 2017). This raises the biggest barrier in mental health care – access. Receiving evidence-based psychotherapy (first line of treatment identified by experts) is limited and wait times are long (Mental Health Commission of

Canada, 2017). Additionally, no province in Canada covers therapy delivered in private practice, creating a two-tiered system where families without coverage through work – those most likely to be low-income – often pay out of pocket or just go without the treatment. Even Canadians with coverage, seldom have enough for care that meets the treatment guidelines.

The government has taken some steps to address calls for Canadian health care reform led by health care providers, researchers, and policy experts. The Mental Health Commission of Canada was created as an independent agency acting under the federal government with a mandate to draft the first mental health strategy for Canada (Canadian Civil Liberties Association, 2017). Their 2012 Strategy 'Changing Lives, Changing Directions' brings mental health to the forefront of Canadian policy and takes a holistic approach, where it acknowledges that to reduce the impact of mental health problems action needs to be taken beyond just treatment. Attention needs to be given to the promotion and prevention of mental health where possible, and there needs to be an increase in open conversations and advocacy around mental health. There have been six Strategic Directions made by the Mental Health Commission of Canada (2012) that includes the following:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit, and Metis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilise leadership, improve knowledge, and foster collaboration at all levels.

(p.11)

Overall, as depicted above, the evolution of the Canadian mental health care system has gone through significant changes that have led to the mismanagement and limited support of those with mental health problems. Today, there is increased awareness of this in Canada and strategies are being developed to provide better supports and treatment throughout the continuum of care. With deinstitutionalisation changing the locus of treatment for most people with mental illness from the hospital to community, inpatient settings have increasingly been called upon to treat individuals with highly acute and severe symptoms that cannot be managed with the available support and resources in the community. I believe it is important to appreciate the changes to the Canadian mental health care system and its impact to the mental health inpatient settings as preamble to my study.

The next section will transition the focus to specifically review coercive practices in mental health, as an introduction to the topic of restraint use.

2.2 Coercive practices in mental health care

In order to define restraint, it becomes important to begin by providing context about coercion, what it means and how it has been used in mental health. Restraint is considered a coercive practice in mental health care. Coercion is defined as involving *'the use of authority to restrain another's autonomy'* (O'Brien & Golding, 2003, p. 167). As a result of acting against an individual's autonomy, these practices have been identified as ethically problematic (O'Brien & Golding, 2003). The coercive treatment of patients with a mental illness has a long history and has been relatively common in the care and treatment of people who are mentally ill (Molodynski et al., 2016; O'Brien & Golding, 2003).

As far back as the ancient civilisations, mental illness was thought to be caused by magic or affliction by an evil spirit that had entered affected people's bodies (Shorter, 1997). Approximately 190 years AC, insanity was explained as an imbalance of bodily substances (such as blood, yellow bile, black bile, phlegm) and a variety of treatments were given to restore this balance. These included: herbs, laxatives, hallucinogens,

prayer, moral or emotional suasion, bleeding or shock (Shorter, 1997). In the middle ages, as the Catholic Church emerged, those with a mental illness were viewed as being possessed by supernatural forces of the devil and formulas and rituals were used to drive the evil spirits from the body (Porter, 2006). With the creation of the first institution for the mentally ill in Europe in the 13th century (Porter, 2006), the purpose was less about treatment and more focused on protecting society by locking up the mentally ill. From the 13th century to 18th century many coercive measures were being used with those with a mental illness such as chaining them to the walls if they displayed restless behaviours, placed in unsanitary conditions, ridiculed and treated as less than human (Porter, 2006; Shorter, 1997). From the 18th century onwards, coercive practices in mental health institutions came into question, further described in section 2.3.

When examining the extant knowledge about coercive practices in mental health care, it is acknowledged that its use is understudied and under-researched (Luciano et al., 2014). Current literature identifies several factors as possible predictors for coercive practices including patients' socio-demographic and clinical characteristics. These include male gender (Dumais et al., 2011; Hendryx et al., 2010; Knutzen et al., 2011; Lay et al., 2011; Taylor et al., 2012), younger age (Dumais et al., 2011; Hendryx et al., 2010; Knutzen et al., 2011; Lay et al., 2011; Migon et al., 2008; Taylor et al., 2012), diagnosis of psychotic disorder (Dumais et al., 2011; Hendryx et al., 2010; Hunt et al., 2012; Hustoft et al., 2013; Husum et al., 2010; Knutzen et al., 2011; Lay et al., 2011; Raboch et al., 2010; Taylor et al., 2012) or of substance abuse (Migon et al., 2008), belonging to an ethnic minority group (Hendryx et al., 2010; Knutzen et al., 2011; Lawlor et al., 2010; Norredam et al., 2010; Priebe et al., 2009; Tarsitani et al., 2013), being cognitively impaired or having no insight of their mental illness (Hustoft et al., 2013; Taylor et al., 2012), history of trauma in their lifetime (Steinert, Bergbauer, et al., 2007), and low satisfaction with previous treatment (Priebe et al., 2009). To further elaborate on the latter factor related to patient satisfaction, Priebe et al. (2009) conducted a prospective cohort study examining 1570 patients and found that lower level of initial treatment satisfaction and being African and or Caribbean were associated with higher involuntary readmission rates.

Mental health staff related characteristics have also been identified as possible predictors for the use of coercion. One study found that coercive measures were more frequently adopted when staff perceived great expressions of anger and aggression in other team members and when safety measures in the workplace were insufficient (De Benedictis et al., 2011). Other studies highlighted factors related to staff composition where lower incidences of coercion existed among psychiatric wards with lower number of nurses and higher number of junior doctors (Bowers et al., 2007; Bowers et al., 2012). Among environmental factors, studies found higher rates of seclusion and restraint in psychiatric wards located in urban areas and in locked-door wards (Bowers et al., 2012; Husum et al., 2010).

The impact of coercion on outcomes of patients with mental illness has also been studied and has demonstrated inconsistent findings. Some authors (Georgieva et al., 2012; Kallert et al., 2011) found positive associations between the use of coercion and symptom reduction. For example, in Georgieva et al.'s (2012) study, when seclusion or restraint were not part of the coercive intervention, patients who received involuntary medication alone experienced less isolation. As well, the involuntary medication emerged as significantly associated with lower psychological and physical burden (Georgieva et al., 2012). Other research (Iversen et al., 2007; Kjellin & Wallsten, 2010; O'Donoghue et al., 2011; Opjordsmoen et al., 2010; Priebe et al., 2011; Sheehan & Burns, 2011; Strauss et al., 2013; Theodoridou et al., 2012) found that the use of coercive measures had a negative impact on the therapeutic relationship between staff and patients (Sheehan & Burns, 2011; Theodoridou et al., 2012), led to negative feelings of patients toward clinicians (Theodoridou et al., 2012), and reduced satisfaction with treatment (Iversen et al., 2007; Priebe et al., 2011; Strauss et al., 2013), resulting in reduction of patients' overall engagement with the service (O'Donoghue et al., 2011). Even though there are some studies that do demonstrate positive results in relation to several coercive practices, the overall negative impact recognised by many other studies seem to overshadow them. Based on the current body of knowledge it can be surmised that coercive practices need to be prevented as

a result of their negative effects. However, further research is also needed to build on this work and our knowledge.

There are also a number of limitations identified in the extant research when exploring the relationship between coercion and outcomes, which impacts the generalisability of the findings (Luciano et al., 2014). These limitations include: the absence of a standardised definition of coercion in mental health care (Sheehan & Burns, 2011); the various types of coercive measures used in different institutions and countries – therefore a comparison of studies using different coercive measures may be biased (Janssen et al., 2011; Lepping et al., 2009; Martin, Kuster, et al., 2007; Raboch et al., 2010; Sailas & Fenton, 2009; Steinert, Lepping, Bernhardsgrutter, & al., 2010); the procedural, legal and ethical differences which makes it difficult to conduct comparisons among institutions (Jacobsen, 2012); and the heterogeneity of considered outcomes among various studies (Kisely et al., 2011). Further research is needed in this area to expand the body of knowledge.

2.3 What is restraint

The purpose of this section is to discuss the various types of restraint and their definitions, prior to stating how it has been defined for my study (refer to section 2.3.1). Restraint is considered a coercive measure in mental health care. The term ‘restraint’, although lacking standardisation in definition, has been defined by Sailas and Fenton (2012) in a Cochrane systematic review on seclusion and restraint for people with serious mental illness as: *‘[it] involves measures designed to confine a patient’s bodily movements’* (Sailas & Fenton, 2009, P.2). It is important to note that the regulations and clinical practice on restraint in mental health vary considerably internationally (Negroni, 2017; Salize et al., 2002; Steinert & Lepping, 2009). Overall, the term ‘restraint’ can be defined as something that limits a person’s freedom of movement (Negroni, 2017). Restraint is used in non-medical fields (e.g. law enforcement) and in the medical field, including various specialties such as emergency medicine, geriatrics, orthopaedics and psychiatry.

According to the Academie Suisse des Sciences Medicales, it may be said that all activities that are carried out against a person's stated will (or presumed will, if they are unable to communicate) or cause the person to resist must be considered 'coercive acts' (Negroni, 2017). The Mental Capacity Act (2005) in England provides a definition of restraint that encompasses both coercion and limitation of freedom of movement: '*[A person] D restrains [another person] P if he (a) uses, or threatens to use, force to secure the doing of an act which P resists, or (b) restricts P's liberty of movement, whether or not P resists*' (p. 4). Another notable definition which acknowledges the various types of restraint is provided by the US Joint Commission of Accreditation of Healthcare Organisation (JCAHO) (2002), stating: '*any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body*' (p. 2). The Italian National Bioethics Committee (NBC) (2006) defines restraint as '*mechanical or pharmacological limitation of an individual's possibility of autonomous movement*' (p. 7). The U.S Code of Federal Regulations (2013) defines physical restraint as '*any manual method, physical or mechanical device, material, or equipment that immobilises or reduces the ability of a patient to move his or her arms, legs, body, or head freely*' (p. 10). Essentially physical restraint can be implemented by two different means, with a common goal such as to limit a person's possibilities of autonomous and spontaneous movement. The first method requires a number of staff (usually two or more) who physically grab a patient in such a way as to control their ability to move freely – referred to as manual restraint or physical restraint. The second means of physical restraint is carried out by mechanical devices that are either directly applied to the patient's body or adjacent to them, and not easily removable, preventing, limiting or controlling the patient's body movement – referred to as mechanical restraint (Negroni, 2017). A considerable difference between manual and mechanical restraint is in its time-span, where manual restraint is intrinsically limited to a short period of time. Mechanical restraint on the other hand may last for a few hours to days.

Another form of restraint is chemical restraint, also referred to as 'pharmaceutical restraint', 'acute control medication' or 'rapid tranquilisation'. The US Federal Agency Centers for Medicare and Medicaid Services (CMS) (2013) has provided the following

definition: *'a drug or medication, when used as a restriction to manage the patient's behaviour or restrict the patient's freedom of movement, and is not a standard treatment or dosage for the patient's condition'* (p. 10). Moreover, CMS (2011) goes to further describe chemical restraint, stating:

'Chemical restraint is defined as any drug that is used for discipline or convenience, and not required to treat medical symptoms. "Discipline" is defined as any action taken by the facility for the purpose of punishing or penalising residents. "Convenience" is defined as any action taken by the facility to control a resident's behaviour or manage a resident's behaviour with a lesser amount of effort by the facility and not in the resident's best interest. "Medical symptom" is defined as an indication or characteristic of a physical or psychological condition' (p. 56).

Negrone (2017) highlights that while chemical restraint and 'forced therapy' (treatment undertaken without consent) are related concepts, they are not synonymous and have a clear distinction. Negrone (2017) indicates that chemical restraint does not aim to cure the patient's psychiatric disorder, whereas forced therapy is intended to treat such disease. He further defends this stating that antipsychotic medications that are used in chemical restraint *'require days to weeks to exhibit effects on the positive symptoms of psychosis, clinicians in essence make use of the extensive side-effect profiles of these agents to achieve rapid sedation without immediately affecting the underlying pathology'* (Currier, 2003, p. 60).

The above definitions clearly describe how restraint may be performed by various means, physical, mechanical or chemical. However, it also shows the differences in how restraint is being described internationally, further illustrating the lack of standardisation. In the following section, I provide a description on how restraint is being defined for this study.

2.3.1 Defining restraint in this study

The focus of this study is on both mechanical and manual restraint. For the purposes of this research, mechanical restraint refers to the use of *'straps, belts or other equipment to restrict movement'* (Stewart et al., 2009, p. 2). Whereas manual restraint relates to *'any occasion on which staff physically hold the patient, preventing movement, typically in order to prevent imminent harm to others or self, or to give treatment, or to initiate other methods of containment'* (Bowers et al., 2012, p. 31; Canadian Institute for Health Information, 2011). I have chosen to focus on both mechanical and manual restraint for a number of reasons. One rationale is that many studies refer to both mechanical and manual forms of restraint interchangeably. There are also variances in the use of mechanical and manual restraint among countries. For example, some countries only use manual restraint (such as United Kingdom), whilst others may use both (such as Canada). Lastly, both mechanical and manual restraint serve to immobilise movement of a person against their will, while other forms of restraint such as chemical restraint and seclusion do not do this. Therefore, in this study the overarching term of 'restraint' used will refer to both mechanical and manual forms of restraint.

With the descriptions of the various types of restraint and its definition for the purposes of this study, it then becomes important to have an understanding of the history of restraint use. In sharing the historical perspective I aim to provide a better understanding of why this practice began in the first place and how deeply rooted it is in mental health.

2.4 Historical context of restraint

Restraining patients is a practice that dates back at least three centuries (Masters, 2017). Controversy has surrounded the use of restraint in the care of mental health patients since the beginning of psychiatric medicine (Colaizzi, 2005). In the 1740s a legal precedent for the use of restraint was established with the vagrancy laws in English towns (Masters, 2017). The laws allowed public authorities the right to

restrain unruly people based on the assumption that it would be of benefit to them and that the restraint would lead to an improvement or cessation in their unruly behaviour (Masters, 2017).

As mentioned earlier, the first institutions for the mentally ill were created in the 13th century in Europe and by the first half of the 19th century these institutions or asylums had grown internationally. One of the primary flaws identified soon after their establishment was that the demand exceeded the available resources (Colaizzi, 2005; Porter, 2006). As a result, the asylums became overcrowded and behaviour control became a key concern (Colaizzi, 2005). Early writings on psychiatric asylums depict restraint use as a way to control behaviour and as an accepted part of the treatment (Beck, 1811; Colaizzi, 2005; Eddy, 1815). Brigham (1994) provides a summary of the conditions found in a well-known asylum, Bedlam, most notorious for subjecting the patients to inhumane treatment:

'They were confined in badly ventilated apartments where they were never discharged but by death. The quiet, the noisy and the violent were all congregated together, and a majority were chained to beds by their wrists and ankles. No contemplation of human misery ever affected us so much: the howling, execrations and clanking of chains gave to the place the appearance of the infernal regions' (p. 13).

As early as the 1840s there is evidence of controversy related to the use of restraint. This was first seen at the inaugural meeting of the Association of Medical Superintendents of American Institutions for the Insane (AMSAIL) in 1844, where a number of psychiatrists for the AMSAIL took a position on minimising the use of restraint (Colaizzi, 2005). For example, an American psychiatrist, Channing (1880), made the following remarks:

'Hand restraint means the use of force. To allow the ordinary attendant to use personal force to restrain the patient in an outburst of excitement and violence seems to me in most cases highly undesirable. One attendant cannot control the

patient; it must take two or three, a scuffle must frequently ensue, sometimes continue until the patient is exhausted, and often to be again renewed. Such hand-to-hand fights are demoralising, both to the patients and attendants' (p. 174).

However, this proposal was declined by the majority of the members who believed psychiatrists should have the right to use all available methods for the treatment and management of mental illness (Colaizzi, 2005). Overall, there was disparity among psychiatrists internationally in how they viewed restraint. Masters (2017) reports on the differences of opinion, stating:

'The American physicians saw restraint as a procedure ordered by a physician in his or her role as a caretaker of the patient. The English psychiatrists, however, saw themselves as part of a team that included mental health staff, who required governance in the application of restraint' (p. 53).

In the 1870s, an English psychiatrist, John Charles Bucknill, commented on the American asylums stating: *'the reliance on restraint was an internal barrier to the care of the mentally ill patients'* (Masters, 2017, p. 53). During this time there were a number of different types of restraint used on mentally ill patients within the asylums. This was largely mechanical including: metal manacles; leather wristlets; cloth restraints; a composing chair (also known as a 'coercion chair' which was firmly attached to the floor, where patients were confined for most of the day); straitjackets; protection beds (a narrow bed with a lid that could be fastened to confine the patient); and hydrotherapy, where patients were restrained to a chair and lowered into a tub of cold water several times (Colaizzi, 2005).

Debates with respect to the use of restraint continued to the end of the 20th century. It was not until the 1960s where concerns with respect to restraint use had been raised through the consumer movement in mental health (Masters, 2017). Contemporary practices continue today with the utilisation of restraint, although some of the above-mentioned methods have become obsolete, such as composing chairs, protection beds

and hydrotherapy. This is further described in the following section as I discuss the current practices and related evidence in the use of restraint in mental health.

2.5 Current practice and evidence of restraint use

Control and containment measures, such as restraint, are frequently used as first line interventions within health care settings (Cowin et al., 2003; Foster et al., 2007; Kynoch et al., 2011). These measures are commonly used in the treatment and management of disruptive and aggressive behaviours (Sailas & Fenton, 2012). While restraint as an institutional method of control may be perceived as warranted at times, there is growing literature indicating the potential counter-therapeutic (non-beneficial) effects of this practice (Borckardt et al., 2011). As a result, in more recent years, there has been a mandate and advocacy through various legislations, guidelines and papers in countries, such as Canada, USA and UK, for organisations to shift towards the minimisation of restraint, whereby its use is only as a 'last resort'. This means that restraint is used when all other alternative interventions have been exhausted (American Psychiatric Nurses Association, 2014a, 2014b; College of Nurses of Ontario, 2009; MIND for better mental health, 2013; National Institute for Health and Care Excellence, 2015; National Offenders Management Services, 2013; Registered Nurses Association of Ontario, 2012; Royal College of Nursing, 2008). This movement supports health care organisations in placing greater emphasis and investment on proactive and preventative approaches, such as sensory modulation (helping patients regulate sensory inputs), staff mix review (ensuring the right staff with skill and competencies are available to care for the unique needs of the patient), training, and education, bolstering the prevention and management of violence and aggression.

A Cochrane review was undertaken to assess the effectiveness of the use of restraint and seclusion compared to alternatives, such as educational and behavioural strategies, policy changes, and medication, for those with serious mental illnesses (Sailas & Fenton, 2009). The review concluded that '*no controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness*' (Sailas &

Fenton, 2009, p. 2). Moreover, other reviews report similar findings (Muralidharan & Fenton, 2012; Nelstrop et al., 2006; Sailas & Fenton, 2012). Evidence has also linked the use of restraint to a number of adverse outcomes, such as further exacerbation of aggression, injury to staff or patients, increased organisational costs, psychological impact including traumatisation, and rupture of the therapeutic alliances amongst staff and patients (Ashcraft & Anthony, 2008; Bonner et al., 2002; Fisher, 2003; Foster et al., 2007; Mildred, 2002; Moran et al., 2009; Sequeira & Halstead, 2004). Some of the physical injuries identified in the studies on restraint practices include coma, fractured bones, bruises, and abrasions, as well as deaths due to asphyxiation, strangulation, cardiac arrest, blunt trauma, drug overdose or interaction, choking, and neglect secondary to the use of restraint and seclusion (Mildred, 2002). Many argue that continuation of restraint use must be questioned from within well-designed and reported randomised trials that are generalisable to routine practices (Aiken et al., 2011; Duxbury, 2015b, 2015c; Paterson & Duxbury, 2007; Paterson et al., 2013; Sailas & Fenton, 2009).

Conversely to the above outcomes, a recent integrative review examining the physical and psychological impact of restraint use on people admitted to mental health care in inpatient settings did find that for a minority of patients, restraint was reported as a positive intervention (Cusack et al., 2018). Three studies found that patients viewed restraint as a way to calm them, letting others take control of their behaviour (Haw et al., 2011; Sequeira & Halstead, 2004; Wynn, 2004).

Studies exploring the use of restraint have identified that the most common circumstances where restraint is utilised are in response to violent patient behaviour, abscondment, staff denial of a request, patient agitation, refusal of medication, self-harm, verbal aggression and property damage (Bowers et al., 2012; Gudjonsson et al., 2004; Ryan & Bowers, 2006; Southcott & Howard, 2007). Other qualitative studies illustrate that nurses view restraint as a necessary intervention which is distressing, and view the organisational culture, staff experience and composition, conflict, ethical considerations, and patient characteristics as contributing factors (Bigwood & Crowe, 2008; Bowers et al., 2012; Happell & Harrow, 2010; Sequeira & Halstead, 2004).

Though there is a paucity of literature that explores patients' perspectives and experiences in the use of restraint, those that do exist reveal that patients do not view this practice as needed or effective. Soininen et al. (2013) for example, explored patients' perceptions of their hospital treatment following seclusion or restraint. The findings revealed that patients were unsatisfied with their overall treatment, felt that seclusion and restraint were *'hardly'* necessary, and that perceptions varied by age. The older the patient, the less they perceived seclusion and restraint to be necessary. Patients' believed that their opinions were not included in treatment planning, and patients' perceptions did not differ when they were mechanically restrained or secluded (Soininen et al., 2013). With respect to the last point, although at times clinicians may feel seclusion is a lesser form of coercion than mechanical restraint, from the patients' perspective there is no difference among the two. Another study that provided further insight into patients' perception was the Psychiatric Patient Advocate Office (PPAO) that reviewed seclusion and restraint practices in Ontario (Canada) psychiatric hospitals and the former Queen Street Mental Health Centre (PPAO, 2000). They found that more than 50% of the patients considered that they had not posed a threat to themselves or others at the time they were restrained or secluded. Additionally, once in seclusion or restraint, almost 50% said they did not know what was required of them in order to be released (PPAO, 2000). Other studies indicate that when patients are restrained this can lead to feelings of anger, fear, panic, and a sense of feeling dismissed (Bonner et al., 2002; Bowers et al., 2012; Sequeira & Halstead, 2004).

In trying to better understand the scope of the problem, where restraint use continues despite the evidence of negative outcomes, it becomes relevant to see how often it is being used. Literature related to this is very limited due to variability in definition, collection, reporting and availability of data across countries. However, a study by Steinert et al. (2010) included data from 12 countries, although it was difficult to identify specifically how many publications were included in their review. Still, all of the data were from very limited studies with small samples. One indicator the study reported on was the percentage of mental health patient admissions who were

exposed to restraint, revealing the following: Austria 35.6%, England 7.3%, Finland 5.0% (Keski-Valkama et al., 2007), Germany 9.1% (Steinert, Martin, et al., 2007), Iceland 0% (Snorrason, 2007), Japan 4.1% (Hatta et al., 2003), The Netherlands 1.2% (Abma et al., 2005), New Zealand 9.1% (El-Badri & Mellsop, 2002), Norway 2.6% (Steinert, Lepping, Bernhardsgrutter, Conca, et al., 2010), Spain 13.5%, Switzerland 3.1% (Martin, Bernhardsgrutter, et al., 2007), and Wales 5.7% (Steinert, Lepping, Bernhardsgrutter, Conca, et al., 2010). A more recent study (Steinert et al., 2014) compared coercive practices in mental health among two neighbouring countries, Germany and the Netherlands. Although the two countries have comparable social structure and standards, as well as, similar politics, the findings showed wide variation in the way coercive measures were captured and published, as well as, in its prevalence and length of use (Steinert et al., 2014). The findings of the study were based on data from 18 studies but most samples were below 1000 patients and few had data from more than one hospital or region. Similarly, Lepping et al.'s (2016) study reviewed the available data and indicated that there continues to be considerable differences among countries with respect to when, how, how often and how long patients were restrained (Lepping et al., 2016) and identified that the best evidence is available from Europe (Kalisova et al., 2014; Steinert & Lepping, 2009). Lepping et al.'s (2016) study reviewed data from four countries, Wales, Ireland, the Netherlands, and Southwest Germany, where electronic data were being collected enabling a comparison of restraint utilisation . When they compared patients affected by restraint per 100 admissions per month and the average number of restraints per affected patient, the study concludes that there are significantly higher restraint numbers per admission, per patient and per capita in the Netherlands compared to the other countries. Additionally, the incidents of restraint per admission were higher in Germany than in the other countries (Lepping et al., 2016). Cowman et al. (2017) explored violence management practices and related research and education priorities across 17 European countries. Findings identified physical restraint, seclusion and medications as commonly used interventions in the management of violent patients (Cowman et al., 2017). As it is evident in the limited data, there is wide variation in the use of restraint internationally, indicating there is a requirement to continue efforts towards restraint minimisation. The following section builds on the

current practices and evidence of restraint use focusing on the restraint minimisation movement.

2.6 Restraint minimisation movement

The growing consumer movement in the 1960s, raised concerns about the use of restraint, and was the catalyst for the restraint minimisation movement that continues today. This international shift towards restraint minimisation has also been a driver for the development of a number of evidence-based models to assist health care organisations in planning and implementing strategies to reduce the use of restraint and seclusion. In this section a number of these models will be discussed and the various methods some organisations are using to shift practice. The models have been selected based on their visibility through publications and recognition in the mental health field.

The *Six Core Strategies* to Reduce the Use of Seclusion and Restraint © (Six Core Strategies) is one model adopted by some organisations to address the multidimensional approach required to minimise such practice (Huckshorn, 2004). The model identifies six overarching strategies which include: 1) leadership toward organisational change; 2) using data to inform practice; 3) workforce development; 4) use of preventive/proactive tools; 5) patient roles in the organisation; and 6) debriefing techniques (Huckshorn, 2004, 2008; LeBel et al., 2014).

Leadership toward organisational change identifies the need for an organisational plan for restraint minimisation that clearly outlines the roles of all management and staff. It is also recommended that this plan include 'witnessing' of events by executive management as a core activity. The second strategy, using data to inform practice, signifies the importance of data utilisation to inform practices, without being used punitively. Therefore, the use of data is seen as providing insight into the use of restraint practice while not having negative repercussions for staff. The next strategy of workforce development focuses on ensuring that the staff are supported through education and training to develop and practice necessary skills. The fourth strategy

stresses the significance of implementing and using tools (such as assessment scales) to prevent behaviours that often result in restraint and seclusion. Strategy five emphasises the need to allow patients and their families to have meaningful roles in the organisation and decision-making in their care. These meaningful roles include actively participating in the treatment plans. Lastly, the debriefing strategy identifies the importance of debriefing patients and staff following a restraint or seclusion event with the aim to mitigate adverse effects and to use the learning to inform future events (Huckshorn, 2004).

Internationally, evidence has demonstrated that the incorporation of the Six Core Strategies© into practice has resulted in: decreased incidents and hours of restraint and seclusion; decrease in staff injury, absenteeism, and turnover; decrease in patient injury, length of stay, medication use, and incidents of rehospitalisation; and increase in staff satisfaction (LeBel et al., 2014). To date, this is one of the few published models that exhibit evidence of improved outcomes in relation to restraint.

A recent study undertaken in the United Kingdom - *REsTRAIN YOURSELF* program was designed to avoid unnecessary harm caused by the use of physical restraint and to enhance patient safety through the use of evidence-based restraint reduction approaches. This study was undertaken in seven Mental Health Trusts acute inpatient settings in North West of England. The program was based on the Six Core Strategies© and provides a toolkit for organisations to guide them in the implementation of each strategy drawing on complex adaptive theory and human factors theory (Duxbury, 2017). The recent study that implemented this program across seven mental health wards in seven Trusts in the North West of England demonstrated an overall 21% reduction of restraint use for all the wards (Duxbury, 2018). There was also a 40% restraint reduction for four of the seven Trusts. Moreover, the study's findings demonstrated observable improvements in staff's reaction to violence by being more reflective, de-escalation focused and less on restraining the person, across all wards. Lastly, the participants of the study noted that the implementation of the program had made them think prior to using restraint and sought to use restraint reduction methods (Duxbury, 2018).

Another model that focuses more broadly on conflict and containment in psychiatric settings is the *Safewards* Model (Bowers, 2014). This model includes ten interventions that aim to modify patient and staff interactions, experiences, and perceptions and essentially develop better relationships between patients and staff. The interventions focus on engagement as opposed to containment. The ten interventions include: 1) mutually agreed and publicised standards of behaviour by and for patients and staff; 2) short advisory statements ('soft words' – such as being respectful and polite) on handling flashpoints, hung in the nursing office and changed every few days; 3) a de-escalation model used by the best staff de-escalator to expand the skills of the remaining ward staff – this champion essentially reviews de-escalation skills with their colleagues; 4) a requirement to say something good about each patient at nursing shift handover; 5) scanning for the potential bad news a patient might receive from friends, relatives or staff, and intervening promptly to talk it through; 6) structured, shared, innocuous, personal information between staff and patients via 'know each other' folder kept in the patients day room; 7) a regular patient meetings to bolster, formalise and intensify inter-patient support; 8) a cart/box of distraction and sensory modulation tools to use with agitated patients; 9) reassuring explanations to all patients following potentially frightening incidents; and 10) a display of positive messages about the ward from discharged patients (Bowers et al., 2015, p. 1414). The Safewards model has been demonstrated to decrease conflict incidents by 14.6% and containment by 23.6% in psychiatric units (Bowers et al., 2015). This is related to the identification of clinical scenarios and situations reaching 'flashpoints' – points in time that can lead to conflict and containment (Bowers, 2014; Bowers et al., 2015). These interventions are meant to shift the culture of care from one that entails coercive practices towards one of focusing on partnering with patients and supporting recovery.

No Force First is another program with similar foci of eliminating coercion and enhancing recovery. It was developed to fundamentally change how challenging behaviours were managed in mental health services in the United States. This initiative, which has spread internationally, aims to shift inpatient culture from one of

containment to one of recovery and essentially set the ultimate goal to eliminate force (Anthony, 2006; Ashcraft et al., 2012). Mental Health organisations that embrace the No Force First approach follow these guidelines:

1. *Make public a No Force First policy.*
 2. *Define the use of force and coercion as a treatment failure.*
 3. *Have an active program to eliminate and avoid the use of force through:*
 - a. *Staff training in de-escalation*
 - b. *Debriefing*
 - c. *Critical incident review*
 - d. *Performance improvement program that includes tracking and reporting of all types of coercive interventions*
 4. *Use of advanced directives, active outreach, and peer support.*
 5. *Use involuntary inpatient treatment only for those who present a real danger to self or others.*
 6. *Adopt programs that encourage risk-sharing partnerships as opposed to risk management control.*
 7. *Promote patient driven and self-directed education and advocacy programs.*
 8. *Train others in No Force First, including police, security, families, and carers.*
- (Ashcraft et al., 2012, p. 416)

The above initiatives have all provided mental health organisations with clear directions towards restraint minimisation. As evident, there are overlapping principles among the various approaches and all attempt to provide guidance and support to prevent coercive practices, including restraint use in mental health care. The overall methodology identified in addressing restraint reduction includes having a plan that is multifactorial in its approach, ambitious, and is based upon the knowledge of the environment, individuals involved, context, assessment, and other relevant information (Duxbury, 2015a). Six Core Strategies©, REsTRAIN YOURSELF and No Force First include strategies aiming to reduce coercion at various levels of the organisation – suggesting that restraint minimisation requires an overhaul of practices and procedures at the micro, meso and macro level, such as changing

policies, enhancing training of staff, and tracking and use of data to inform practice. Moreover, all models promote the concept of partnering with patients in their care and in revising practices, which encompasses the recovery philosophy. Safewards uniquely focuses on the clinical setting and more so on the interaction between the patient and staff. Although this model highlights critical strategies needed towards restraint minimisation, a gap remains in not addressing overall policies and practices at the organisational level. Therefore, an opportunity to use these models in parallel, i.e. implementing Safewards at the clinical wards, while following the strategies of such models as Six Core Strategies©, REsTRAIN YOURSELF or No Force First at the organisational level could prove advantageous. All three models provide tools and guides for organisations interested in pursuing restraint minimisation.

As more organisations adopt these approaches, it becomes critical to better understand why restraint use continues and what 'last resort' means in relation this practice. 'Last resort' is a key term that has surfaced in approximately the last two decades in relation to restraint use. As referenced earlier in section 2.5, the term is cited in policy and research to promote the use of restraint only when all other less intrusive alternatives have been exhausted and deemed ineffective (Bonner et al., 2002; Moran et al., 2009). The Care Quality Commission in the United Kingdom referred to the use of restraint as a 'last resort' intervention in their recent review of the use of the Mental Health Act (Care Quality Commission, 2011). However, as will be further described in chapter three, currently there are no publications or studies, which clearly describe this term or identify what this means when operationalised into day-to-day practice. Additionally, even with the evidence-based models focusing on restraint minimisation, as described above, it has not provided clarity into this term that drives efforts towards prevention. This inadvertently creates the opportunity for variances in understanding and application of restraint use as a 'last resort'. Essentially, the purpose of this term is to promote clinicians to deviate from the traditional practices to commonly use restraint as part of care and instead manage these situations through the use of other alternative interventions, and to refrain from the use of restraint unless absolutely necessary. Deveau and McDonnell (2009) suggest a limitation to the term 'last resort' and argue that the *'reliance upon the 'last*

resort' principle has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge' (p.175). Therefore, they suggest possible shortcomings of this term.

As discussed, there is growing evidence internationally indicating that the use of restraint is counter-therapeutic, coercive, punishing, traumatic and unnecessary (Curran, 2007; Soininen et al., 2013). Restraint is also considered to be over-used under false assumptions that it is an effective means to manage violence and aggression and can protect and assure the safety of patients and staff (Cutcliffe & Santos, 2012). As it is mental health nurses who generally employ restraint in mental health settings, further research to explore how 'last resort' is enacted within their practice is therefore warranted.

Throughout this chapter I have provided details related to restraint use. However, given that focus of this study falls within the Canadian mental health setting, it is important to also better understand restraint use in Canada. In the following section I provide details of current practice and its use in order to illustrate why this study is important in the Canadian context.

2.7 Restraint use from the Canadian context

As this study took place in Canada, it is important to provide the context in relation to restraint use in this country. There have been a number of efforts to develop best practices and guidelines to support the minimisation of restraint and promote least restrictive practices in Canadian health care. Many of these initiatives have been influenced by a number of legislations. In the province of Ontario this includes the Patient Restraint Minimisation Act (Government of Ontario, 2001b), the Mental Health Act (Government of Ontario, 2001a), and the Health Care Consent Act (Government of Ontario, 1996). Moreover, a 2008 coroner's inquest as a result of a patient's death while in restraint (Office of the Chief Coroner of Ontario, 2008), made recommendations that facilities strive to provide restraint-free care and to ensure

greater involvement of patients and their advocates in managing risks that may ultimately lead to restraint (Canadian Institute for Health Information, 2011).

The most recent publication reviewing statistics on coercive practices is by the Canadian Institute for Health Information (2011). In this report an analysis of adults hospitalised for mental illness who, during their hospital stay, experienced the use of at least one of the three types of control interventions - acute control medication, mechanical or physical restraint, or seclusion - is provided. This report focused on data from the Ontario Mental Health Reporting System (OMHRS) from 2006 to 2010. The findings demonstrated that close to one in four of all individuals admitted to a designated mental health bed in Ontario experienced at least one type of controlled intervention, such as chemical restraint, mechanical or physical restraint, and seclusion, during their hospitalisation (Canadian Institute for Health Information, 2011). Ontario is the only province that has mandatory assessments and reporting requirements for patients being admitted to any inpatient mental health bed, as it has implemented a mandatory Resident Assessment Instrument that measures incidents of restraint use that are completed on a standard frequency and submitted to the Canadian Institute for Health Information. This mandatory assessment is not consistently completed in other provinces in Canada. Hence, most of the reports and initiatives related to restraint have come from Ontario.

A study by Dumais et al. (2010) found that 23.2% of 2,721 mental health patients in Canadian mental health care facilities were placed in seclusion and 17.5% of them had been restrained. Additionally, a 2009 report compared the rates of physical restraint in Ontario nursing homes to other countries and found that rates of restraint in Ontario (31.4% on average) were higher than rates in Finland, Hong Kong, Switzerland and the United States (Feng et al., 2009).

Overall, whilst there is limited data related to restraint utilisation in Canada, the extant literature demonstrates that it continues to be a problem in Canadian health care. Despite the various changes in the health care system mandating restraint minimisation (such as the Patient Restraint Minimisation Act, 2001), restraint

practices continue to be high. Hospitals across Canada are beginning to adopt such models as described above in their efforts to minimise restraint use, however, there are no formal strategies provincially or nationally and this is dependent upon each hospital's efforts and priorities.

2.8 Conclusion

This chapter has provided context about the mental health care system in Canada and identified the gaps that have been created as a result of deinstitutionalisation. Deinstitutionalisation has transformed the mental health populations being served in inpatient settings, where patients present with more complex behaviours and acuity levels. This in turn may be managed by clinicians through the use of coercive interventions to help contain challenges in behaviour and symptom management. This chapter also outlined the historical perspective of coercive practices, including restraint use and its evolution in relation to policy and practice. In thinking about the evolution of this practice, although the principles of containing a person against their will continues today, one may argue that over the decades the methods of containment have evolved to be less extreme, where people are not lowered into tubs of cold water or placed in narrow beds with lids (Colaizzi, 2005). Alternatively, it can also be argued that very little progress has been made and many of the principles of coercion continue today. However, a key difference when comparing restraint use practices today to that of previous centuries is that currently there is an international momentum to minimise restraint use and eliminate restraint practices that did not exist then. Whilst this restraint minimisation movement has increased awareness that the literature continues to demonstrate a lack of evidence in the effectiveness of restraint use, the practice continues. Moreover, many organisations continue with their efforts towards restraint minimisation and prevention, with inconsistent progress. Given the lack of understanding related to 'last resort' in the use of restraint, it is imperative to explore this issue and to begin to have insight into what 'last resort' means in practice to help advance minimisation efforts. In an effort to do this, the next chapter presents an integrative review exploring decision-making factors for restraint use by mental health nurses, within the context of 'last resort'.

CHAPTER 3: INTEGRATIVE REVIEW
Exploration of Decision-Making Factors Influencing Mental Health Nurses in the Use of Restraint

3.0 Introduction

In the previous chapter the background to this study was presented, utilising a wide range of literature pertaining to restraint. In this chapter the integrative review undertaken to establish the foundation of this study in terms of what is known is presented. Holloway and Walker (2000) identify the importance of conducting a literature review and recommend that for qualitative studies it is completed at the beginning of the research to ensure that the planned research has not been done in similar way and to establish and define the topic and concepts on which to focus.

The original aim of this integrative review was to explore mental health nurses' decision-making processes that influence when and how restraint should be used as a 'last resort'. As an initial scoping review was unable to locate any primary research explicitly focused on this phenomenon, a more inclusive approach was adopted to explore factors that influence nurses' decision-making in the use of restraint. It is considered that these in-depth insights would help to illuminate the situational, environmental and personal factors that have impact on decision-making and would help inform future research on 'last resort' within practice.

The literature attempts to describe decision-making in nursing, where is it distinguished from judgement. I believe as context for this integrative review it is initially important to highlight an overview of how decision-making is defined and differentiated from judgment in nursing. Some nursing literature uses the term decision-making and judgement interchangeably. For example, Tanner (2006) remarks that the terms 'clinical judgment', 'problem solving', 'decision making', and 'critical thinking' tend to be used synonymously. In her research exploring clinical judgment for nursing, the term 'clinical judgement' is used 'to mean an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response' (Tanner, 2006, p.204). This

perspective has led to some confusion amongst the terms decision-making and judgement. In contrast, Dowding and Thompson (2004) distinguish between the two terms. They defined judgement in nursing as the process that involves 'integrating different aspects of information (which may be about a person, object or situation) to arrive at an overall evaluation' (p.42). Judgements then feed into decision-making where the evaluations a person makes can be used as the basis of choices between alternatives (Dowding & Thompson, 2004). Thompson et al. (2004) further builds on the concept of decision-making by describing it as a process that involves 'choosing from a discrete range of options, which may include doing nothing or a 'wait and see' strategy' (p.68). Thompson et al. (2004) also describe that decision-making is informed by an evaluation of available information – the process of using clinical judgment.

In the following sections I present the purpose, methodology and results of the integrative review.

3.1 The importance of the literature review

Rowley and Slack (2004) highlight that all research needs to be informed by the existing knowledge in the area being studied. Overall, reviewing the literature in the area of research enables the opportunity to distil the extant literature in the subject field, summarise the knowledge, and identify gaps in which further research would be beneficial (Rowley & Slack, 2004). Although there is consensus that literature review should be conducted for research studies, there is debate as to when it should be completed (Dunne, 2011; McGhee et al., 2007). In quantitative research, the review is undertaken prior to data collection to guide the development of the research question and the methods used and to provide the rationale for future research by considering previous gaps and inconsistencies (Giles et al., 2013). Essentially, it is believed that a detailed literature review is an essential foundation upon which to build a study (Dunne, 2011).

However, this guideline on literature review differs for qualitative research. Glaser and Strauss (1967) explicitly advised against conducting a literature review in the area of research in the early stage of the research process. The rationale for this is that it was believed this would allow categories to emerge naturally from the empirical data during analysis, uninhibited by the extant theoretical frameworks and associated hypothesis. According to Dey (2007) the target of this contentious maxim '*was undoubtedly the researcher inclined to plough ahead along an established theoretical furrow regardless of the diversity and richness of the data, thereby diminishing its potential for a wider repertoire of the theoretical innovation*' (p.176). Not everyone agrees with this perspective where the literature should be reviewed near the end of the study. Kamler and Thomson (2011) propose that the review of the literature is an on-going process. Boote and Beile (2005) for example, hold the view that a substantive literature review is a pre-requisite for conducting a substantive, thorough, sophisticated research.

Holloway and Wheeler (2010) argue that researchers often enter the study with prior knowledge, thus preconceptions will always exist. Smythe and Spence (2012) hold similar perspective and add that when conducting a literature review in a hermeneutic study, the reviewer stands '*at the crossroads of all their fore-understanding*' (p.16). From a hermeneutic perspective, Gadamer (2007) states that understanding text '*does not primarily mean to reason one's way back into the past, but to have a present involvement in what is said*' (p. 42). Hence it is acknowledging that it is impossible to read a text and examine it from a neutral and objective stance. As a reader, we are always interpreting, which involves bringing our past understanding and experiences to this (Smythe & Spence, 2012). Smythe and Spence (2012) believe that '*our own experience of engaging with the literature in a hermeneutic manner was one where text, were it a research report, a scholarly opinion, or a piece of poetry, became a partner in our journey of thinking*' (p. 14).

For this integrative review, I acknowledge that I'm coming to this with my own understanding and knowledge of the topic. Heidegger (1996) describes our ready-made understanding in three ways, which I will use to explain my knowledge and

awareness of the topic entering the review process. First, Heidegger (1996) describes the concept of fore-having, which is the understanding we have in advance that enables us to begin to make sense of that which we encounter. Due to my professional role and the restraint minimisation activities I have been involved in (described in details in section 6.1, pre-understanding), I already had the opportunity to read extensively on the topic. This is one reason I was drawn to this study. Second, is Heidegger's (1996) concept of fore-sight which brings understanding that sees in advance. Seeing ahead guides the process and pre-shapes reading decisions (Smythe & Spence, 2012). My fore-sight provided me with a sense of which journals to prioritise, which authors to search for, and which countries produced greater knowledge about the topic. Given the dangers of such pre-judgements, I developed a rigorous search protocol to ensure I was reviewing and open to all relevant text. Lastly, Heidegger (1996) refers to fore-conception as having in advance an idea already shaped of what will be encountered. Smythe and Spence (2012) see this '*as the most dangerous aspect of understanding*' and that '*it is not wrong....it can be no other way*' (p. 16). In possessing fore-conception I already have an idea about what I will meet and the direction of the findings of the review. However, given that this literature review is not specifically about the concept of 'last resort' in restraint use because of no current publications, I believe it may be less influential on my research.

I chose to engage in a substantive review of the literature at the beginning of my research to have the foundational knowledge in which I could build my research on. This has also enabled me to better understand the gap with respect to 'last resort' in restraint use. I have also reviewed the literature continuously to remain alert to emerging work and have revisited my review at the end of the study to ensure that no relevant literature had been overlooked.

3.2 The focus of the literature review

The purpose of this literature review is to explore what influences mental health nurses' decision-making in the use of mechanical and manual restraint (referred to as restraint).

3.3 Consideration in selecting the method for literature review

There are many types of literature reviews, each with its own approach, analysis and purpose (Grant & Booth, 2009). In order to determine the method I was going to use to review the literature for this research I considered a number of approaches. I specifically explored systematic review, scoping review, and integrative review methods. The following sections will provide a brief description of each approach, as well as a rationale as to why I did not select a certain approach. Furthermore, I will provide an explanation as to why an integrative review method has been adopted for this study.

3.3.1 Systematic review

Systematic reviews are defined by Cochrane Collaboration (2014) as *'a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review'*. Moreover, statistical methods (meta-analysis) may or may not be used in order to analyse and summarise the findings of the included studies. Systematic reviews may use both quantitative and or qualitative evidence in order to generate a robust, empirically derived answer to the focused question (Mallett et al., 2012).

A significant advantage to systematic reviews is that the results can be generalised and extrapolated into the general population more broadly in comparison to individual studies (Grant & Booth, 2009). This is related to the rigorous protocol and exhaustive review of the current literature and other sources. However, some disadvantages include that depending on the studies being included in the review, it may not be easy to combine them (Grant & Booth, 2009). Cochrane Collaboration (2014) also indicates that in order to conduct a robust systematic review, it requires significant time and effort. Specifically, they estimate a timeline of approximately 18 to 24 months, with a minimum of four team members to contribute to the completion of the systematic review. One reason for not pursuing a systematic review was the

foreseen challenges in combining the results of the various quantitative and qualitative studies related to the topic. In other words, I felt that the design, methodological quality, specific interventions used, and types of clinician studies of the primary studies related to this topic were so significantly diverse that it would not allow for appropriate pooling of the studies. Lastly, the timeline and resources required to proceed with the review did not align with that of my PhD study program.

3.3.2 Scoping review

Mays, Roberts and Popay (2001) were one of the first authors to define scoping review. They stated that scoping reviews *'aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before'* (p.194). Alternative terms may be used for scoping reviews, such as scoping study, scoping project, scoping exercise, scoping report, scoping method, scoping exercise method, literature mapping, mapping of research, evidence mapping, systematic mapping, literature review, and rapid review (Colquhoun et al., 2014; Pham et al., 2014). Scoping reviews tend to address broader topics where various study designs may be applicable. Furthermore, scoping reviews are less likely to seek to address very specific research questions or assess the quality of the included studies (Arksey & O'Malley, 2005). As a result, scoping reviews are limited in their rigour.

Although this method created a greater suitability to the diversity of the potential study designs and aligned with my boarder approach to the aim of my literature review, I could not select this approach due to its limitations in rigour. Assessing the quality of the studies being included in the review was important to ensure rigour and reliability to the findings.

3.3.3 Integrative review

An integrative review aids in maintaining a current knowledge base in a particular research area (Russell, 2005). This literature review method summarises past research by drawing overall conclusions from many studies (Broome, 1985). I selected this approach for my literature review for a number of reasons. This narrative descriptive method enables the inclusion of diverse methodologies allowing for a greater depth and breadth of the research topic. Additionally, integrative review summarises previous empirical or theoretical literature in order to provide a greater comprehensive understanding of a particular phenomenon (Whittemore & Knafl, 2005). *'Well-done integrative reviews present the state of science, contribute to theory development, and have direct applicability to practice and policy'* (Whittemore & Knafl, 2005, p. 546). Cooper's (1989) framework was adopted to undertake the integrative review. This framework includes five stages: 1) problem identification stage; 2) literature search stage; 3) data evaluation; 4) data analysis stage; and 5) presentation (Whittemore & Knafl, 2005). The following sections describe each stage and the details involved for this integrative review.

3.3.3.1 Problem Identification Stage

This stage involves the development of conceptual and operational definitions of variables to be examined (Russell, 2005). As described in the introduction of this chapter, the initial phenomenon I wanted to focus on for this integrative review was related to the various factors influencing mental health nurses decisions in using restraint as a 'last resort'. However, no published papers were identified. Therefore, I took a broader approach to the integrative literature review focus and aimed at examining factors influencing mental health nurses' decision-making in the use of restraint. Therefore, as part of this first stage of the integrative review I defined the term restraint, as shared in section 2.3.

Through my initial scoping of the literature I found that there was only one published literature review that explored mental health nurses' overall decision-making related to restraint use (Laiho et al., 2013). This further validated the gap in the body of

knowledge for me. Additionally, I believe a greater in-depth understanding of the factors influencing decision-making will provide important foundational knowledge for my study, as decision-making with regards to the use of restraint plays an integral part in the concept of 'last resort'. Moreover, the findings from this review will add to the literature, given the paucity of publications and may positively influence overall restraint minimisation strategies in the practice, policy and research domains.

3.3.3.2 Literature Search Stage

When formulating a search strategy, often a search tool is used as an organising framework to list terms by the main concepts in the search question (Methley et al., 2014). There are a number of tools that have been used for this purpose including PICO and SPIDER, which were the two tools I explored for this review. SPIDER (sample, phenomenon of interest, design, evaluation, research type) is designed to specifically identify relevant qualitative and mixed method studies (Methley et al., 2014). While the PICO tool focuses on Population, Intervention, Comparison, and Outcomes of an article (Methley et al., 2014). PICO is also commonly used in quantitative research (Caldwell et al., 2012). The key difference between PICO and SPIDER, which both seemed suitable for this integrative review at first glance, is that the SPIDER tool is intended to increase the ability to identify qualitative articles (Cook et al., 2012). Methley et al. (2014) compared the SPIDER and PICO search tools and found that SPIDER demonstrated a substantially lower number of hits generated than PICO. However, Methley et al. (2014) also report that the PICO tool does not accommodate terms relating to qualitative research or designs. Given the findings of the comparison study, as well as wanting greater inclusivity of publications that include qualitative, quantitative and mixed methods, I chose the PICO tool for the integrative review research question. However, for the purposes of my search strategy I have modified the tool to accommodate for the use of both quantitative and qualitative studies. The PICO format that I used to translate the research question into an effective search strategy focused on Population, Intervention, Context (rather than Comparison) and Outcomes. The Comparison component of PICO concentrates on the alternatives to the intervention, such as placebo, different drug, surgery, while Context

component explores the setting or distinct characteristic. I believe substituting the component of Comparison for Context enabled me to focus my search within the mental health speciality. The databases searched for this integrative review were Medline, Cochrane, CINAHL (Ebsco), Psychinfo, and EMBASE. *Table 1* details the search terms used within each database and *Table 2* describes the search strategy used. Additionally, a literature search log was maintained to capture every step of the search strategy (Appendix G).

Table 1: Search Terms

| Population | AND | Intervention | AND | Context | AND | Outcome |
|-------------------|------------|-----------------------|------------|----------------|------------|-------------------|
| mental health | | restraint | | inpatient | | experience |
| OR | | OR | | OR | | OR |
| psychiatry | | physical intervention | | mental health | | attitude |
| OR | | OR | | services | | OR |
| mental disorder | | physical restraint | | OR | | perception |
| OR | | OR | | psychiatric | | OR |
| violence | | coercive practice | | hospitals | | decision-making |
| OR | | OR | | OR | | OR |
| aggression | | manual restraint | | psychiatric | | nursing care |
| OR | | OR | | department | | OR |
| self-injurious | | clinical holding | | | | safety management |
| behaviour | | OR | | | | |
| OR | | restrictive practice | | | | |
| suicide | | OR | | | | |
| OR | | restraint hold | | | | |
| suicide-attempt | | OR | | | | |
| OR | | physical control | | | | |
| mentally ill | | OR | | | | |
| persons | | last resort | | | | |
| OR | | OR | | | | |
| nursing | | behaviour control | | | | |
| OR | | OR | | | | |
| psychiatric | | coercion | | | | |
| nursing | | OR | | | | |
| OR | | immobilisation | | | | |
| nurs* | | OR | | | | |
| | | nursing care | | | | |
| | | OR | | | | |
| | | safety-management | | | | |

Table 2: Search Strategy

| |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| S1: Mental health; S2: Psychiatry; S3: mental disorder; S4: Inpatient; S5: Violence; S6: Aggression; S7: self-injurious behaviour; S8: Suicide; S9: suicide-attempt; S10: mental health services; S11: psychiatric hospitals; S12: psychiatric department; S13: mentally ill persons; S14: Nursing; S15: nurs*; S16: Psychiatric nursing; S17: Restraint; S18: physical intervention; S19: physical restraint; S20: coercive practice; S21: manual restraint; S22: clinical holding; S23: restrictive practice; S24: restraint hold; S25: physical control; S26: last resort; S27: behaviour control; S28: Coercion; S29: Immobilisation; S30: nursing care; S31: safety management; S32: Experience; S33: Attitude; S34: Perception S35: decision-making |
| S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 = S39 |
| S14 OR S15 OR S16 = S38 |
| S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 = S37 |
| S32 OR S33 OR S34 OR S35 = S36 |
| S36 AND S37 AND S38 AND S39 |

The inclusion and exclusion criteria for identified literature in the review are detailed in *Table 3*. As part of the inclusion criteria, studies published up to March 2014 were included in this review. Due to the paucity of literature related to mental health nurses' decision-making and restraint use, it was decided with my supervisory team that studies which explicitly included manual and or mechanical and seclusion as interventions would be included in this review. For example, experts in the field who have developed approaches such as the Six Core Strategies© in the minimisation of restraint use have tackled restraint and seclusion together (Huckshorn, 2004; LeBel et al., 2014; Putkonen et al., 2013). Additionally, all qualitative, quantitative and mixed method designs were included in the review. As per the exclusion criteria, studies that only explored seclusion and or chemical restraint were not included, in order to maintain rigour related to restraint use practices. Studies focusing on subspecialties, such as geriatrics, dual diagnosis, and forensics were also excluded to maintain the focus of the review to overall decision-making and restraint use. It is acknowledged that specialised skills and knowledge are required for subspecialty populations, which I believe, require their own unique focus. Also, studies which focused on staff training were excluded, as this is not relevant to the aim of this thesis and research study. Lastly, since the focus of this research and the literature review is mental health

nurses, studies exploring patient and or family perceptions related to restraint use were also excluded.

Table 3: Integrative Review Inclusion & Exclusion Criteria

| Inclusion Criteria | Exclusion Criteria |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Studies with a focus on mental health setting, psychiatric nursing, and adult psychiatry • Includes the application of and or witnessing of the application of manual and or mechanical restraint • Qualitative and or quantitative studies • Full text articles • Studies reported in English • Published papers up to March 2014 | <ul style="list-style-type: none"> • Studies with a focus on non-mental health population and setting, non-nursing professionals, specialised populations (geriatrics, adolescent, intellectual disability, forensic), nursing students • Studies focused on staff training • Studies reporting patient perception and or family perception of restraint use • Studies which only focused on use of seclusion practices and or chemical restraint • Studies where full text is not available • Papers no published in English |

In addition to the database searches, Bates' (1989) 'berry-picking' approach was adopted. The berry-picking model of information retrieval reflects the natural interaction of the researcher whose information needs to constantly change in the examination of the results of search sets. This approach was used in the initial steps of scoping the research question and defining the concepts of 'last resort' and 'restraint', as well as, during the data evaluation stage. The berry-picking strategies included in this review were: 1) footnote chasing; 2) citation searching; 3) journal run; 4) area scanning; 5) subject searches in bibliographies and abstracting and indexing; and 6) author searching. A total of 22 articles in addition to the database search were identified and reviewed as a result of these approaches.

A follow up to the literature search stage was completed in April 2018 given that the original search took place in 2014. This update has been completed to see whether new evidence is available that needs to be included in the integrative review. All search strategies described above were replicated and limited the search to publications between 2014 to April 2018. A total of 34 articles were identified, duplicates were then removed (n=12) resulting in 22 articles to be reviewed. Titles and abstracts were then reviewed against the inclusion and exclusion criteria, which resulted in one publication meeting the integrative review criteria. A paper by Mahmoud (2017) on attitudes towards restraint provided four key findings that are very much aligned with the existing findings of this review and did not add any new information. Therefore, I am confident that this integrative review represents findings relevant to April 2018.

3.3.3.3 Data Evaluation

The next step in Cooper's (1989) integrative review framework is data evaluation. During this stage the reviewer critically evaluates whether the data elements are worthy of remaining in the study data set (Russell, 2005). Standard critical appraisal tools are frequently used to evaluate the quality and utility of published research reports (National Health and Medical Research Council, 2000a). These tools provide analytical evaluations of the quality of the study, specifically looking at the methods applied to minimise biases in a research project (National Health and Medical Research Council, 2000b). These factors have potential to influence study results, as well as, the interpretation of the findings (Katrak et al., 2004). Essentially the tool is to assist the consumers of research to ascertain whether the results of the study can be believed, and transferred appropriately into other environments. Therefore, identifying an appropriate critical appraisal tool is an important component of the data evaluation stage (Clarke & Oxman, 2003; Crombie, 1996; National Health and Medical Research Council, 2000a). However, there is no consensus regarding the 'gold standard' tool for any medical evidence among the large number of critical appraisal tools available (Katrak et al., 2004).

Critical appraisal tools are broadly classified into two categories, those that are research design-specific and those that are generic (Katrak et al., 2004). Design-specific tools consist of items that address methodological issues that are unique to the research design (Crombie, 1996; Elwood, 1998). This precludes comparison however of the quality of different study designs (Bialocerkowski et al., 2004). To overcome this limitation, generic appraisal tools have been developed to enhance the ability of the research consumers to synthesise evidence from a range of quantitative and or qualitative study designs (Katrak et al., 2004). It is also important to note that there remains to be very little consensus regarding the most appropriate items that should be contained within any critical appraisal tools.

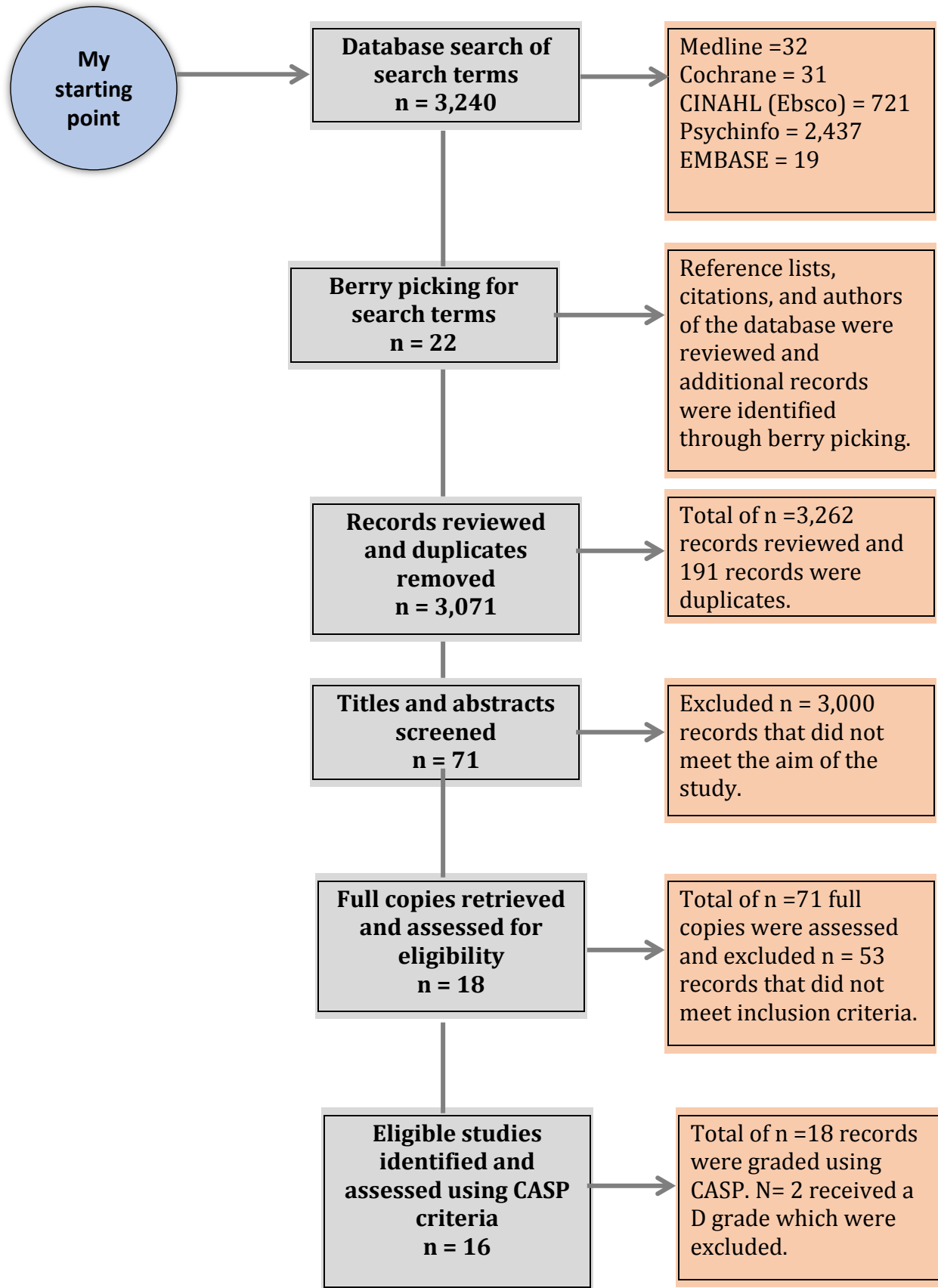
I chose to use the Critical Appraisal Skills Program (CASP) tools (Appendix A) to evaluate the literature, as it is a commonly used tool. Modifications were made to the CASP tools to appraise quantitative and mixed method studies as these broad categories are not available in the existing CASP suite. The process to appraise the literature consisted of having myself and my two PhD supervisors using the CASP tools to evaluate each of the papers. Each article was reviewed and appraised by two reviewers and graded using the system described in *Table 4* (Walsh & Downe, 2006). Key domains appraised included: appropriate research design, sampling, data collection, reflexivity, ethics, data analysis, findings, and value of research as per the CASP criteria. The grading was then compared for significant discrepancies, of which there were none. Due to the small sample size of articles, only those receiving a grade D, indicating significant flaws in the quality of the study likely to affect its validity, reliability and generalisability, were removed (i.e. lack of methodological detail). This decision to reject papers was also made if they did not add to the body of knowledge relative to the findings from others deemed to be of high methodological quality. This led to one study being removed, leaving 16 articles as the final number to be included in the integrative review.

Table 4: Appraisal Grading

| Grade | Description |
|--------------|---------------------------------------------------------------------------------------------------------------|
| Grade A | No, or few flaws. The study validity, reliability and generalisability are high. |
| Grade B | Some flaws, unlikely to affect the validity, reliability and generalisability of the study. |
| Grade C | Some flaws that may affect the validity, reliability and generalisability of the study. |
| Grade D | Significant flaws that are very likely to affect the validity, reliability and generalisability of the study. |

Figure 1: Flow Diagram of Integrative Review summarises the literature search, data evaluation and analysis stages details.

Figure 1: Flow Diagram of Integrative Review



3.3.3.4 Data Analysis

Data analysis is the fourth stage in Cooper's (1989) framework. Cooper (1989) defines this stage as '*reducing the separate data points collected by the inquirer into a unified statement about the research problem*' (p. 104). This stage of data analysis and strategies used is one of the least developed aspects of the integrative review process. Cronin et al. (2008) suggest using a PQRS (preview, question, read, summarise) method for a summary system of publications being used in the literature review. They suggest this serves to maintain good record keeping throughout your literature review. Although I did not specifically use the PQRS system, I did adopt the overall strategy and created a table (refer to Table 5) where I identified the reference of each article, its aim, participants, method, key findings, key themes, and added the appraisal grading.

A constant comparison method is a recommended method, which is an overarching approach in the development of the results in this integrative review (Whittemore & Knafl, 2005). I chose this method to analyse the data from the studies, as there were no other strategies identified in the literature specifically for integrative reviews. This involved the analysis of studies where the data were extracted into systematic categories, identifying distinct patterns, themes and relationships within and across the studies. Overall, eight key themes were identified in relation to factors influencing mental health nurses' decision-making in the use of restraint which will be discussed in details in the following section.

Table 5 provides a summary of the studies together with the key themes and quality rating within each individual paper.

Table 5: Summary of Studies

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Lindsey (2009) | To examine the association of nurses' work empowerment, as well as, individual characteristics of the patient and of the nurses with nurses' decision to restrain. The study also examined the decision patterns used by psychiatric nurses in response to patient situations in which restrain might be considered. | Thirty nurses | Correlational descriptive design Quantitative questionnaires | Nurses with more experience were more likely to use restrain as their initial intervention in response to the vignettes. A significant negative correlation between the total empowerment scores and psychiatric nurses' decision to restrain. Patient's age, diagnosis and nurse's familiarity with the patient were common themes identified by nurse respondents as influencing their decision to retrain. Patient cues noted by respondents with the greatest frequency were potential danger to self or others, injury to self, and injury to others. Most frequently endorsed initial interventions were the least restrictive methods. Nurses chose as-needed medication with high frequency in all of the vignettes. Nurses were inconsistent in their decision-making about restraint use and pattern of intervention choices. | <i>'Restraint as a Last Resort'</i> <i>'Maintaining Control'</i> <i>'Nurses' Knowledge and Perception of the Patient'</i> <i>'Staff Composition'</i> | Grade A |
| Bigwood & Crowe (2008) | To understand the mental health nurses' experiences of physical restraint. | Seven nurses | Descriptive phenomenological | Themes which emerged within the study were: 'It's part of the job', Control, Conflicted nurse and Scared nurse. | <i>'Safety for all'</i> <i>'Restraint as a Necessary Intervention'</i> <i>'Role Conflict'</i> <i>'Maintaining Control'</i> | Grade A |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Bonner et al. (2002) | To establish the feasibility of using semi structured interviews with patients and staff in the aftermath of untoward incidents involving physical restraint. To gather information on the factors patients and staff groups found helpful and unhelpful, during and in the aftermath of restraint. To explore the lived subjective experience of restraint. | Six incidents were analysed and twelve staff and six patients were interviewed. | Qualitative semi structured interviews | The staff related themes which emerged from the study were: 'Antecedents', 'In the midst of conflict', 'last resort' and 'planning, containment and support'. During the 'aftermath' of the untoward incident of restraint the themes of 'distress in the aftermath' and 'resolution: debriefing' emerged. Additional staff-related themes included 'ethical issues' and 're-traumatisation'. | <i>'Restraint as a Last Resort'</i> <i>'Role Conflict'</i> <i>'Psychological Impact'</i> | Grade B |
| Perkins et al. (2012) | To explore the attitudes of staff towards restraint and understand some of the influences on their decision-making and behaviour. | Thirty nurses | Retrospective analysis – interviews and focus groups | Four groups of factors were identified by staff to have influenced the use of restraint: contextual demands; lack of alternatives; the escalatory effect of restraint itself; and perceptions of risk. | <i>'Restraint as a Necessary Intervention'</i> <i>'Maintaining Control'</i> <i>'Nurses' Knowledge and Perception of the Patient'</i> | Grade B |
| Terpstra et al. | To explore the attitudes | 144 nurses | Quantitative surveys | Length of time nurses worked on the unit has a | <i>'Safety for all'</i> | Grade C |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------|
| (2001) | and opinions of nurses toward seclusion and restraint use. | | | positive correlation with the mean number of restraint episodes in which they were involved in. Most frequent responses given for use of restraint or seclusion was that they were more likely to result in immediate control of violent behaviours, greater safety for staff and other patients, and medication sometimes could worsen a patient's condition. 40% felt restraint would be more successful than seclusion. Rationale for the use of restraints included: reduced physical injury to all involved, allows staff greater control over violent behaviour, provides physically reassuring contact by staff, and provides immediate feedback about the dangerousness of their behaviour. 51% indicated that staff mix on the ward influenced decisions to place a patient in restraint or seclusion. 48% felt the number of staff present was another factor influencing treatment choices. Where fewer staff increased staff fear when approaching difficult patients. | <i>'Maintaining Control'</i> <i>'Nurses' Knowledge and Perception of the Patient'</i> <i>'Staff Composition'</i> | |
| Holzworth & Wills (1999) | To investigate the clinical judgment of psychiatric nurses using judgment analysis within the framework of social judgment theory. | Nine nurses | Quantitative questionnaire | Nursing interventions that involved use of physical restraint were made infrequently. There were general similarities among nurses, reflecting appropriate reluctance to recommend restraint as an initial action, and a consensus that problematic behaviours typically would warrant close observation or observation and seclusion. Nurses with least professional experience made nearly three times as many recommendations for the most restrictive type. Most impact for clinical status cues included: agitation, harming self, assaultive to others, and destructive to property. | <i>'Restraint as a Last Resort'</i> <i>'Nurses' Knowledge and Perception of the Patient'</i> <i>'Staff Composition'</i> | Grade B |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|----------------------------|--------------------------------------------------------------------------------|------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------|
| Sequeira & Halstead (2004) | To explore the psychological responses of nursing staff to restraint. | Seventeen nurses | Qualitative semi structured interviews | The following themes emerged related to staff responses as a result of restraint events: Anxiety; reduction in anxiety through familiarity with restraint; anger; anger and abuse of interventions; boredom, frustration and low morale; conflict with role as nurse; distress and crying; coping with strong emotional reactions through inhibition of emotional distress or laughing and joking to release feelings; automatic responding/'no feelings'; ambivalence about support. Overall, nursing staff reported discomfort with and dislike of the use of restraint and seclusion. | <i>'Psychological Impact'</i> | Grade A |
| Moylan & Cullinan (2011) | To examine assault and injury in relation to the nurse's decision to restrain. | 110 nurses | Mixed method | Nurses with a history of being injured made the decision to restrain a patient at a later time in the progression of aggression. Four themes emerged in the interviews: <ul style="list-style-type: none"> - Belief that aggressive behaviours were routine and to be expected as part of the nursing role and they felt pressured to avoid restraint use. - Nurses refrained from making official reports of injury because administrative responses to official reports of injury were negative. - In the nurses' experience, nurses were blamed for their assaults and injuries by administrative nurses and sometimes by their peers. - Psychological and emotional trauma of assault and injury is routinely ignored and is often more long lasting than the physical effects | <i>'Role Conflict'</i> <i>'Psychological Impact'</i> | Grade B |
| Moran et al. | To explore the | 23 nurses | Qualitative - focus | Three themes emerged from the focus groups: the | <i>'Restraint as a Last</i> | Grade A |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------|
| (2009) | emotions and feelings experienced by nurses in response to restraint and seclusion interventions. | | groups | last resort; emotional distress; suppressing unpleasant emotions. | <i>Resort'</i> <i>'Psychological Impact'</i> | |
| McCain & Kornegay (2005) | Explore the lived experiences of psychiatric nurses' use of physical restraints as perceived by Registered Nurses with 5 years or more of psychiatric nursing experience. | Nine nurses | Qualitative - Phenomenological method | Participants in the study believed that restraint is necessary to prevent harm, should be used only as a last resort after less restrictive measures had been tried, should not be used judiciously to ensure safety and prevent harm by carefully following procedures and monitoring restrained patients. | <i>'Restraint as a Necessary Intervention'</i> <i>'Restraint as a Last Resort'</i> | Grade B |
| Marangos-Frost & wells (2000) | To explore the possible influence of nurses' thoughts and feelings on the decision to restrain. | Six nurses | Qualitative - Ethnographic design | The decision dilemma during restraint situations was supported by 4 themes: the framing of the situation as a potential for imminent harm; the unsuccessful search for alternatives to physical restraints; the conflicted nurse; and the conditions of restraint. | <i>'Restraint as a Last Resort'</i> <i>'Role Conflict'</i> | Grade B |
| Lemonidou et al. (2002) | To: a) investigate the type of restriction used | 190 nurses working across | Quantitative - survey | 69% of nurses prefer room isolation to physical restraint. 51% of nurses reported, restraints are | <i>'Safety for all'</i> <i>'Maintaining Control'</i> | Grade B |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------|
| | to suppress violent behaviour of psychiatric patients, b) explore nurse's attitudes toward seclusion and restraints, and c) determine if there is a difference in nurse's attitudes due to their level of education and years of experience. | 12 psychiatric wards | | used more frequently during evening shift. Nurses believe that patient assessment (53.7%) and frequent communication (32.6%) are the most important practices in preventing violent behaviour. Staffing was recognised as the most important environmental factor (56.3%) that influences the use of restraint or seclusion. Restraint or seclusion are most often used for patient safety (70.5%), behaviour control (23.2%), and for staff convenience (0.5%). | <i>'Nurses' Knowledge and Perception of the Patient'</i> <i>'Staff Composition'</i> | |
| Lee et al. (2003) | To explore nurses' views related to their last experience of implementing physical restraint. | 269 nurses | Quantitative - survey | 96.3% of respondents felt that there was a positive outcome in the incidents in which they were last involved in. These views were associated with perception that the incident was brought under control, regardless of the aftereffects. Nurse participants reported negative outcomes of restraint use, reason for the use of physical restraint, organisational issues impacting restraint use and suggestions regarding alternative strategies. | <i>'Maintaining Control'</i> <i>'Nurses' Knowledge and Perception of the Patient'</i> <i>'Staff Composition'</i> | Grade C |
| Kontio et al. (2010) | To explore the ethical aspects of nurses' and physicians' perceptions of: 1) what actually happens when an | 22 nurses and 5 physicians | Qualitative – focus groups | Participants described the management of patients' aggressive behaviour as a decision-making process occurring: before, during, and after restraint and seclusion. Measures before restraint and seclusion included | <i>'Role Conflict'</i> | Grade B |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------|
| | aggressive behaviour episode occurs on a ward; and 2) what alternatives to seclusion and restraint are in use as normal standard practice in acute psychiatric care. | | | <p>patient's versus other's best interests as an ethical dilemma.</p> <p>Measures during restraint and seclusion included patient's versus other's best interests as the time- and labour-division dilemma.</p> <p>Measures after restraint and seclusion included psychological consequences and needs of patients and staff.</p> <p>Both nurses and physicians considered alternatives to restraint and seclusion. These perceptions fell into 3 categories: 1)nursing interventions (as first step alternative to restraint and seclusion); 2) multiprofessional agreements involving the patient; 3) the use of authority and power.</p> | | |
| Gelkopf et al. (2009) | To examine the nurses' attitudes regarding the goals of restraint, the environmental conditions influencing restraint, the emotional aspects of restraint, and their beliefs about whether other staff members should participate in restraint procedures. | 111 nurses | Quantitative - surveys | <p>Reasons indicated by nurses for restraining patients:</p> <ul style="list-style-type: none"> - Endangerment of the patient's self and surroundings; patient's bothersome actions; patients fought with each other <p>More men than women considered restraint if:</p> <ul style="list-style-type: none"> - Patient refused medication; patient kept others from sleeping; patient bothered other patients; fought with other patients; created a brawl in the ward; continuously banged on the nurses' windows <p>Goals and meaning of patient restraint:</p> <ul style="list-style-type: none"> - Means to prevent self-harm and harm to others; method for calming patients; smaller but substantial percentage of staff use restraints as a method to end commotion in the ward; male | <i>'Nurses' Knowledge and Perception of the Patient'</i> <i>'Staff Composition'</i> | Grade A |

| Author (year) | Aim | Participants | Methods | Key Findings | Key Themes | Appraisal Grading |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------|
| | | | | <p>nurses more frequently considered restraint as a way to 'show a patient that he/she behaved badly'</p> <p>Environmental conditions and intervention affecting restraints:</p> <ul style="list-style-type: none"> - Factors most frequently noted to reduce restraints include: administration of appropriate pharmacotherapy (96.4%), early identification of potential violence (92.7%); most prominent environmental factor believed to contribute to the use of restraints is inexperienced nursing staff (49.5%) <p>The nurses' emotions while restraining a patient:</p> <ul style="list-style-type: none"> - 75% have pity on restrained patient; about half feel frustration and helplessness; licensed nurses express more negative emotions than non-licensed nurses; women expressed more negative emotions than men <p>80% of nurses believe other professionals should participate in the restraining process.</p> | | |
| Bowers et al. (2012) | To assess the relationship of show of force and manual restraint to other conflict behaviours, the use of containment methods, service environment, physical environment, patient routines, staff characteristics, and staff group variables. | 136 acute mental health wards | A multivariate, cross-sectional study | <p>Both show of force and restraint were a regular feature of life on all the study wards. The patient feature most associated with show of force and restraint was the proportion detained under the mental health legislation.</p> <p>Numbers of qualified staff were associated at the ward level, indicating that better and more richly-staffed wards used greater amounts of coercive measures.</p> <p>Provision of security guards associated with increased use of restraint. Constant observation, especially when accompanied by engagement was positively associated with show of force and restraint.</p> | 'Staff Composition' | Grade A |

3.4 Results

The results represent the findings from the '*data analysis*' and '*presentation*' stages of Cooper's (1989) integrative review process, where key insights are identified, reported and visually represented. A total of 16 articles were included in the review, eight qualitative research articles, seven quantitative research articles, and one mixed method research article. Key areas of focus for the articles were nurses' decision-making for the use of restraint (n=3), nurses' perceived experience of restraint (n=8), nurses' attitudes towards restraint (n=4), and relationships of show of force [*a number of staff are assembled within view of the patient, with the implicit or explicit threat that the patient will be manually restrained or forced to undergo treatment, unless they comply voluntarily*](Bowers et al., 2012, p. 31) and manual restraint compared to other factors (n=1). The articles were published in the United Kingdom (n=5), United States (n=5), Finland (n=1), New Zealand (n=1), Canada (n=1), Ireland (n=1), Greece (n=1) and Israel (n=1).

Prior to discussing the results of the data analysis in more detail and introducing the themes identified, I will provide a brief discussion of each paper. I believe this will allow for an in-depth understanding of the various studies that contribute to the results of this integrative review.

3.4.1 Overview of the studies included in the review

As stated above there are 16 published papers that met the eligibility criteria related to mental health nurses' decision-making in the use of restraint that will be discussed briefly.

The first paper reflects a descriptive phenomenological study with an aim to explore how mental health nurses perceived the experience of physically restraining patients in an acute mental health service (Bigwood & Crowe, 2008). The study recruited seven nurses (four male and three female) and conducted semi-structured interviews to further explore their perspectives. Four themes emerged from the data: 'it's part of the job', control, conflicted nurse, and scared nurse. The theme 'it's part of the job' referred to the mental health nurses' perspective that physical restraint of patients was an essential part of acute mental

health nursing practice. The concept of control was a subtheme that was identified within this theme. This subtheme reflected that maintaining control in the acute setting was critical to the job. Maintaining control involved maintaining a structured and safe environment. Bigwood and Crowe (2008) also reported the theme of conflicted nurse that highlighted nurses feeling a clash between their therapeutic role and the culture of control. Lastly, the findings also acknowledged the scared nurse and the anxiety related with physical restraint use. Overall, this study suggests that although nurses are accepting of the use of physical restraint, they remained uncomfortable with it.

Lindsey's (2009) study used a correlational descriptive design with a purposive sample of psychiatric nurses at four hospitals with low restraint use located in the Midwestern United States. The study specifically examined the significance of individual characteristics of nurses and patients, the concept of empowerment, patient cues, and nurses' decision patterns. Findings indicate that nurses with greater years of experience were more likely to use restraint as their initial intervention choice. Additionally, the results suggest that there are some association between increased sense of empowerment and reduced use of restraint. With respect to patient characteristics, the findings report that the nurses' decision to restrain is influenced by their level of tolerance of the patient behaviour. A key outcome of the study is that *'nurses were inconsistent in decision making about restraint use, both in cue use and pattern of intervention choices'* (p.47). This paper illustrates the complexities in nurses' decision-making related to restraint use.

This next paper is a pilot study conducting semi-structured interviews with patients and staff who were a part of six incidents of restraint use (Bonner et al., 2002). The interviews which occurred closely after the incidents, asked patients and staff to identify and discuss the factors that they found helpful and unhelpful during and in the immediate aftermath of the incidents. The staff-related findings, based on the responses of 12 clinicians, found that staff acknowledged the effect of disturbed environment on the patients, acting as an antecedent to the restraint incident. Moreover, a few nurses in the study expressed their distress and discomfort in implementing restraint. While other staff found good teamwork and

policies to support and guide decision-making to be important for incident management. Overall, this study highlights that patients and staff experiences of incidents of restraint use are grim, although the factors were different for the patient and staff cohorts.

Perkins and colleagues (2012) conducted a study examining mental health nurses decision-making process during restraint episodes. Thirty nurses from acute care setting were interviewed either individually or in a focus group to elicit their perspective on using restraint and their experience in specific incidents. Four factors were identified to influence the decision to restrain. First factor was contextual demands, which referred to the common view that organisational demands and ward factors created a climate where difficult behaviours developed and escalated. Second factor was the lack of alternatives, where participants didn't feel other interventions were being tried before the use of restraint. The next factor identified was the escalatory effects of restraint. Meaning, once restraint was implemented it appeared that the end goal was simply an attempt to reduce the undesirable behaviour. Perceptions of risk were the fourth factor identified and one that emerged as a crucial driver of decision-making. This study depicted the complex and sometimes contradictory interaction of variables, which were perceived by staff to impact their decision to restrain.

Another study included in the review is by Terpstra and colleagues (2001) who used a descriptive correlational design to examine the attitudes and opinions of 144 nurses towards restraint use in a psychiatric setting. Survey findings from the study revealed that the length of time nurses worked on a unit had a positive correlation with the mean number of restraint episodes in which they were involved. Nurses shared that the most likely reasons they used restraint was related to gaining immediate control of violent behaviours, and achieving safety for staff and other patients. Forty percent of the nurse participants in this study also felt that restraint was more effective than seclusion as it was believed that it reduced physical injury to all involved, enabled staff greater control over violent behaviour, provided physically reassuring contacts by staff, and provided immediate feedback to patients about the dangerousness of their behaviour. The study reported 51% of respondents to believe staff mix on the ward influenced

decisions to use restraint. Moreover, 48% of the nurses felt that staffing influenced their decision to restraint, whereby less staff increased staff sense of fear when approaching challenging patients. Although the study sample was from one hospital in Midwestern United States, limiting its generalisability, nonetheless, it provides good insight into the perception of nurses in relation to restraint use and some factors that impact its use.

Holzworth and Wills (1999) examined the clinical judgment of nurses using judgment analysis based on the framework of social judgment theory. This study included nine mental health nurses and reported that generally all the nurses reflected appropriate reluctance to recommend restraint as an initial intervention. Furthermore, there was consensus among the participants that problematic behaviours would typically warrant close observation or observation and seclusion. Interestingly, the nurses with the least professional experience made recommendation for the most restrictive interventions such as restraint, three times more than the nurses with greater experience. This study used a unique method of assessing nurses' clinical judgment related to restraint use and highlighted interesting findings impacting their decisions.

A study conducted by Sequeira and Halstead (2004) exploring the psychological responses of nursing staff to restraint was also included in this integrative review. Through semi-structured interviews the researchers examined the nurses' experiences before, during and after restraint events. The results identified a number of themes to represent the nurses' perspectives. These included: anxiety; reduction in anxiety through familiarity with restraint; anger; anger and abuse of interventions (the thought of being able to hurt a patient and the guilt associated with this); boredom, frustration, and low morale felt by staff; conflict with role as nurse; distress and crying; coping with strong emotional reactions through inhibition of emotional distress or laughing and joking to release feelings; automatic responding/'no feeling'; and ambivalence about support. Overall the nurse participants in the study reported discomfort and dislike of using restraint. This paper offers some similar findings to the other studies that also reported on the concepts of distress and anxiety in the use of restraint and role conflict for nurses. A strength in the design of the study is the interviews conducted with the

nurses at various intervals in relation to a restraint event, as it explores the nurses' experiences at varying points, before, during and after, providing a different perspective and depth to the body of knowledge.

Moylan and Cullinan (2011) assessed assault and injury in relation to the nurse's decision to restraint. This study consisted of having 110 nurses undergo testing and interview. This entailed the nurse to watch a brief video and identify on the Moylan Assessment of Progressive Aggression Tool (MAPAT) the time, in seconds, at which they believed restraint was the only safe option in the progression of aggression. Additionally, they would complete a survey. Results demonstrated that nurses with a history of being injured made the decision to restrain at a later time in the progression of aggression. The findings from the survey identified four themes overall. First theme indicated that nurses believe aggressive behaviour is a routine part of their role and that there was a pressure to avoid the use of restraint. Second theme was nurses' avoidance of formally reporting injuries as a result of a negative perception of administrative responses to them. The third theme highlighted the nurses' perception of being blamed for their assaults and injuries by administrative nurses and some peers. Lastly, nurses felt that psychological and emotional trauma of assault and injury was routinely ignored. This paper mainly focuses on the assault and injury management related to restraint use. However, the theme of aggression being seen as part of the job by the nurses is similar to the results from Bigwood and Crowe's (2008) study.

To explore the emotions and feelings experienced with the use of restraint by mental health nurses, Moran et al. (2009) interviewed 23 nurses within three focus groups. Their findings identified three themes. The first theme emphasised that the nurses used restraint as a 'last resort' when all other alternatives had failed. The distressing emotions of anxiety, fear and guilt emerged from the experiences of restraint use described by the nurses. The final theme indicated that nurses suppressed their unpleasant emotions in order to get through the restraint interventions. This study aligns with many of the findings from the papers shared so far and builds on the evidence, which will be discussed in the next section where all the papers are analysed.

A phenomenological study exploring nine mental health nurses' lived experiences of using restraint was conducted by McCain and Kornegay (2005), which identified seven emergent themes. Main findings included restraint as a necessary intervention, although it was felt that it was used as a 'last resort' method of treatment and not used punitively. Nurses' experience of using restraint was described to be painful and that early intervention helped to mitigate using restraint. Moreover, if restraint was used, proper procedure and monitoring was important to maintain safety. Lastly, the nurses in the study had identified that the use of restraint had reduced as a result of increase in education, crisis prevention and intervention training, increased involvement of physicians and nurse managers, and recent policy changes.

Similar to the above study, Marangos-Frost and Wells (2000) set out to explore the thoughts and feelings of mental health nurses who had experienced participating in the decision to restrain a patient. They also tried to better understand how their thoughts and feelings influenced the nurses' decisions to use restraint. An ethnographic design was undertaken with six nurses participants. Overall theme that emerged was that the restraint situation represented a decision dilemma for them. This dilemma entailed making a choice between risking harm to a patient, to co-patients, and staff or restraining the patients. The researchers identified four subthemes within the overarching decision dilemma. The first subtheme was related to framing the situation where a determination for imminent harm was a key element to the nurses' decision dilemma and was based on the patients' behaviours being observed, as well as their past behaviours. The next subtheme emerged from the nurses describing the unsuccessful search for alternatives to restraint. The nurses also felt conflicted in their role as a result of using restraint. Lastly, the contextual factors to their decision dilemma included: 1) the composition of the inpatient population at the time; 2) the facility policy of having all restrained patients on constant care; and 3) the attitude of management and physicians at the facility. This study has demonstrated some insights regarding the on-going use of restraint by uncovering the complexities in the nurses' decisions to use them.

Similar to a number of the studies in this integrative review, Lemonidou and colleagues (2002) further explored the mental health nurses' perceptions towards seclusion and restraint in Greece. The study included 190 nurses from 12 mental health wards to a) investigate the types of restrictions used to manage violent behaviours, b) explore attitudes towards restraint and seclusion, and c) determine if there were differences in nurse's attitudes in relation to their level of education and experience. Results from the questionnaire demonstrated most nurses (69%) preferred seclusion to restraint use to manage violent behaviours. More than half of the nurses (56.3%) identified staffing as the most important environmental factor to impact the use of restraint or seclusion, as well as 51% reported that restraints were frequently used during evening shifts with less staffing. Nurses believed the reasons for restraint or seclusion use to be related to safety (70.5%), behaviour control (23.2%), and staff convenience (0.5%). From a proactive perspective, the nurse participants recognised patient assessment (53.7%) and frequent communication (32.6%) to be key in mitigating violent behaviour. The nurses' overall attitude toward restraint was that the intervention is clearly necessary but not desirable.

Lee et al. (2003) conducted a survey with 269 mental health nurses in England and Wales to investigate their views related to their last experience of using physical restraint. Almost all the respondents (96.3%) held a belief that there was a positive outcome in the incident in which they were last involved in. Positive outcome was perceived as maintaining control of the situation regardless of the aftereffects. Some of the respondents also shared concerns and ambivalence in the use of physical restraint. Some of the concerns were related to the use of the procedure, specific aspects of the techniques for physical restraint and its impact on staff and patients. Some respondents also expressed worrying opinions about their colleagues' negative attitudes towards the use of physical restraint.

In another study by Kontio et al. (2010), focus groups were held with 22 nurses and 5 physicians to better understand what happens when an aggressive behaviour episode occurs on the ward and the types of alternatives to restraint and seclusion used as part of standard practice in mental health care. The participants described the management of aggressive behaviour as a decision-

making process that occurred before, during and after restraint and seclusion. Overall the participants declared aggressive patients' best interest to be their first priority, however, when participants encountered the ethical conflict of choosing between a patient's and another person's best interests, the latter was often preferred. Participants reported ethical conflicts related to decision-making about restraint and seclusion. Nurses in particular further expanded on their ethical conflict by sharing their experience of frustration and feelings of guilt and dread as a result of their inability to always find alternatives to the use of restraint or seclusion, as well as, the amount of time spent with those in seclusion and restraint which inevitably reduced their time with others. The findings from this paper add to our understanding of the ethical dilemma faced by nurses in the use of restraint.

Gelkopf and colleagues (2009) surveyed 111 mental health nurses in Israel to examine their attitudes regarding the goals of restraint, the environmental conditions influencing restraint, the emotional aspects of restraint, and their beliefs about whether other staff members should participate in restraint procedures. Most common reasons nurses in this study used restraint were due to patient demonstrating high risk of self-harm or injury to the staff and or environment. Occasionally, nurses also declared that they would use restraint on patients to keep the ward calm. In this study more men than women considered restraint if patients refused medication, kept others from sleeping, bothered other patients, fought with other patients, and continuously banged on the nurses' window. Women demonstrated a negative feeling towards the use of restraint and believed restraints reflects the inability of the staff to cope with violence. A large number of nurses noted that acquisition of tools for coping with violence would help reduce the number of restraint. A key finding in this study was that nurses who experienced large number of restraint considered restraint a therapeutic tool. Additionally, these nurses felt more negative emotions, experienced more symptoms of burnout, and tended to restrain more easily. In contrast, nurses with limited experience in restraint, viewed restraint as punishment, avoided restraining, and placed responsibility for restraint on the physicians. These nurses felt less negative emotions, believe that the increase in the use of restraint is a result of unskilled staff, and value increasing personal sessions with patients as a means to reduce restraint use.

The last paper in this integrative review is that of Bowers et al. (2012). This study assessed the relationship of manual restraint and show of force to conflict behaviours, the use of containment methods, service environment, physical environment, patient routines, staff characteristics, and staff group variables. Data from 136 mental health wards in England were analysed. Bowers et al. (2012) describe show of force as *'a number of staff are assembled within view of the patient, with the implicit or explicit threat that the patient will be manually restrained or forced to undergo treatment, unless they comply voluntarily'* (p.31). Results of the study illustrate that both show of force and manual restraint were part of the routine practice of all study wards. Interestingly, findings indicated that more richly staffed wards used greater amount of coercive measures, including restraint. Lastly, the use of security guards increased the incidents of restraint.

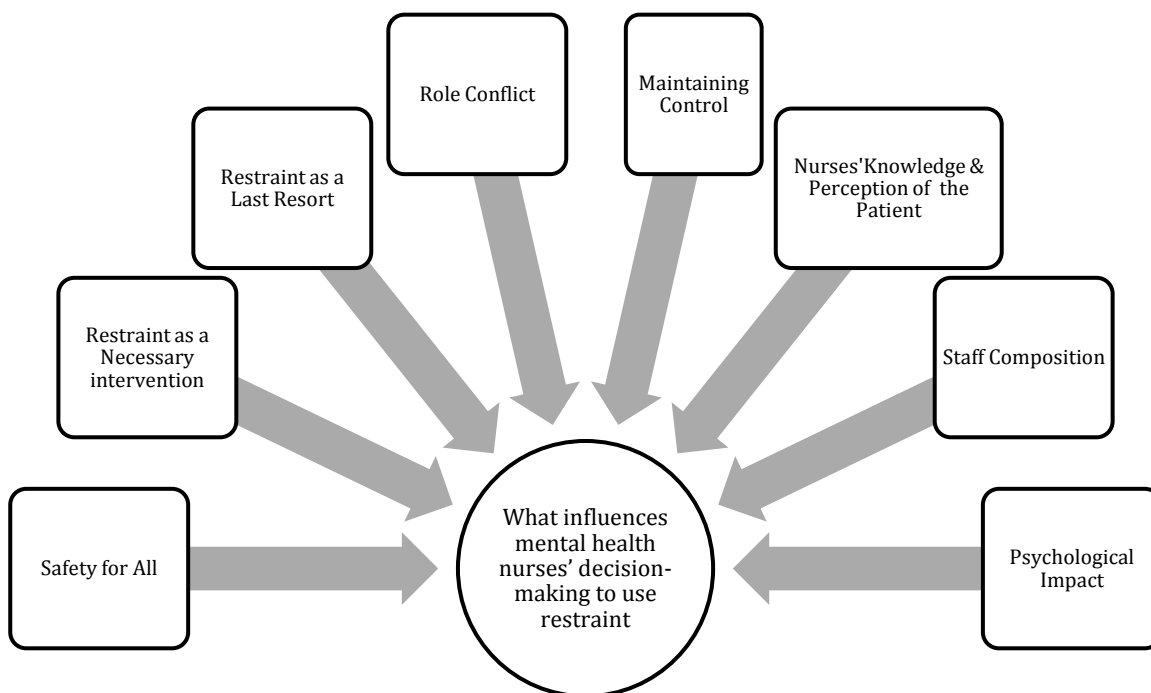
Having considered each of papers included in this integrative review individually, I now have engaged in the data analysis process and provide my results in the following section.

3.4.2 Thematic findings

Overall, eight themes were identified in the analysis of the papers included in this integrative review. A constant comparison method was adopted to analyse the papers, as described in section 3.3.3.4. As a result of this analysis, the emerging themes include 'safety for all', 'restraint as a necessary intervention', 'restraint as a last resort', 'role conflict', 'maintaining control', 'staff composition', 'nurses' knowledge and perception of the patient', and 'psychological impact'. While an array of factors have been identified to influence mental health nurses' decision-making in the use of restraint, it is also important to identify their inter-relational nature. For example, the themes of 'safety for all' and 'restraint as a necessary intervention' are significantly interrelated. Nurses perceived restraint as a necessary intervention primarily to maintain safety for both patients and staff. Similarly, maintaining control of the situation was highly influenced by safety for all, which again was associated with viewing restraint as a necessary intervention.

A visual representation of the data has been developed to display findings in Figure 2: Visual Presentation of Findings.

Figure 2: Visual Presentation of Findings



In the following sections I will describe each theme and highlight the key findings from each paper that contributed to each theme.

3.4.2.1 Safety for All

The concept of safety was a prominent theme to emerge (Bigwood & Crowe, 2008; Lemonidou et al., 2002; Terpstra, 2001). This concept of safety for all refers to how nurses believe that the use of restraint maintains safety for patients, co-patients, colleagues and themselves. Terpstra (2001) for example, in exploring staff's attitudes and opinions of seclusion and restraint, found that 40% of respondents felt restraint was a more effective approach in helping a patient '*calm down*'. Their reason for choosing this method was that '*restraint reduced physical injury to all involved*' (Terpstra, 2001). Additionally, this study reported that one of the most frequent reasons that nurses used restraint was due to a perception that greater safety was achieved both for staff and other patients (Terpstra, 2001). Similarly,

exploring nurses' attitudes towards seclusion and restraint, Lemonidou et al. (2002) reported that 70.5% of the nurses used restraint most often for the safety of patients and others. Nurses in one study reported feeling scared at a personal level because of the risk of actual harm, where the fear of this impending danger activated some *'self-preservative'* responses (Bigwood & Crowe, 2008). These papers highlight the value nurses perceive in restraint use related to safety. In mental health setting, maintaining safety of the environment, patients and themselves (including their team) is often a key priority for nurses. Therefore, if restraint is perceived as an intervention to achieve this priority, it may provide insight into why this practice continues despite counter-therapeutic evidence.

3.4.2.2 Restraint as a Necessary Intervention

While closely related to the theme of 'safety', 'restraint as a necessary intervention' is another key area that surfaced in the data analysis. In a number of studies this was inherently linked to nurses' professional responsibility and accountability in providing a safe environment for all involved parties (Bigwood & Crowe, 2008; McCain & Kornegay, 2005; Perkins et al., 2012). Similarly, Bigwood and Crowe (2008) reported restraint to be *'part of the job'* to prevent harm or injury to patients or others and considered this to be *'an integral, essential, and unavoidable part of acute mental health nursing practice'* (Bigwood & Crowe, 2008, p. 218). Furthermore, in exploring the attitudes of staff towards restraint and factors influencing decision-making, Perkins et al. (2012) reported that although the use of restraint as a 'last resort' was recognised, it was also viewed as a *'necessary evil'*. One participant stated:

'You need it because it's for your safety and other people's safety. Because, you just need it there because if you didn't have it, people could get hurt. I mean I know it's not the nicest thing, and it is uncomfortable, but you have got to look at it, at the safety aspects of what could happen if we don't use restraints' (Perkins et al., 2012, p. 46).

The nurse participants in Moylan and Cullinan's (2011) study also expressed that they felt the management of aggressive behaviours, including the use of restraint, was part of their routine practice, however, they did state that they felt pressured to avoid the use of restraint. One nurse participant illustrates this perspective by stating: *'physical restraint are necessary at some point, but they are really to prevent harm to self or others'* (McCain & Kornegay, 2005, p. 239). This theme suggests that in many cases nurses may view restraint as the only effective intervention to maintain safety and therefore necessary in their practice.

3.4.2.3 Restraint as a 'Last Resort'

While there is some evidence reporting nurses' beliefs for restraint to be a necessary and needed intervention, studies also identified how nurses were strongly committed to use restraint only as a 'last resort' and displayed dislike in its use (Bonner et al., 2002; Holzworth & Wills, 1999; Lindsey, 2009). For example, in Bonner et al.'s (2002) research, one nurse stated:

'It's one of those things that personally I don't like and any other way of dealing with it would be better. It's the last resort' (p. 468).

Similarly, within a number of studies nurses expressed adopting a least restrictive approach where other alternatives such as, therapeutic communication with the patient, creating a calmer environment and administration of medications, were attempted prior to the use of restraint (Holzworth & Wills, 1999; Lindsey, 2009; Marangos-Frost & Wells, 2000; McCain & Kornegay, 2005; Moran et al., 2009). For example, one nurse in McCain and Kornegay's (2005) research commented: *'there are certainly times when physical restraint is an appropriate intervention to use, but it should be used as a last resort'* (p. 239). Most commonly in these studies, because the nurses interpreted the use of restraint as the 'last resort' in managing aggression, they experienced emotional distress when they had to use the intervention (Holzworth & Wills, 1999; McCain & Kornegay, 2005; Moran et al., 2009). Although no study described what 'last resort' means to mental health nurses, this theme does transpire from the data identifying the nurses' perception of when restraint may be used.

3.4.2.4 Role Conflict

An emerging theme in the literature is the interface between ethics and safety. Several studies have illustrated instances when nurses experienced a conflict in their role. These experiences happened as nurses were endeavouring to preserve safety, and feeling the need to participate in an intervention they disliked while attempting to use restraint as a 'last resort'. Bigwood and Crowe (2008) and Marangos-Frost and Wells (2000) refer to this as the 'conflicted nurse' where essentially there is not a balance of ethical and safety values. One participant from Bigwood and Crowe's (2008) research described this conflicted sense of self, stating:

'I felt instantly like a bully. I felt instantly like, I am awful, you know, look what I have done to this man. It is very easy to push my button and I feel like a bully and that is what I felt like. You know, that I had bullied him and I had been controlling and I had, you know all the things I hate' (p. 220).

Kontio et al. (2010) identified nurses' decision-making about restraint application as an ethical dilemma, in terms of nurses' need to consider patients' versus other's best interests. A nurse participant depicts the conflict they experienced in their role as a result of using restraint by stating:

'I would like to know that the most important stuff is what we handle. And keeping the place safe for others is important....I think there is sometimes a feeling of failure, although I know that it is impossible to be with them the whole time. It's just how could I have prevented it? Why didn't I prevent it? And maybe I should have gone more with my gut feeling....I know that there is still the feeling of maybe a little bit of guilt that maybe I hadn't done enough' (Marangos-Frost & Wells, 2000, p. 366).

This demonstrates the struggle experienced by nurses in attempting to care for their patients and simultaneously enacting an intervention that breaches this perspective. Similarly, Bonner et al. (2002) explored the lived experience of restraint from nurses where 'ethical issues' were an emerging theme. One nurse for this study highlights this by stating:

'The use of restraint is unpleasant and undignified. The dilemma that it causes add a lot of friction for the staff' (Bonner et al., 2002, p. 470).

Sequeira and Halstead's (2004) research in examining the psychological effects on nursing staff when using restraint also referred to the concept of role conflict. A female nurse in their study described her frustration with the lack of other effective management techniques and reported on this conflict by stating:

'I know there is no other management technique we could have used, but...this goes against my conscience and that really frustrates me and I think what am I doing here? What is my role? We are trying to help these patients' (p. 8).

This theme has commonly been described throughout the literature as evident in this integrative review. This sense of role conflict can result in distress for nurses and impact their quality of work life and approach to care. Frequently nurses experience this conflict as a result of feeling as though they had no other option than to use restraint. This highlights the importance of supporting nurses to find other therapeutic alternatives to manage aggressive behaviours than resorting to restraint.

3.4.2.5 Maintaining Control

Nurses being in control and taking control of the situation was another common theme amongst the studies. As an example, Perkins et al. (2012) reported 'taking control' to be a central feature in nurses rationalisations of the use of restraint and included two conceptualisations: 1) *'restraint as a technique to directly suppress aggressive and violent behaviour'*; 2) *'restraint as a management strategy to maintain order and stability within the organisational setting'*. In the same study the participants viewed the physical intervention as a *'battleground for control'* among staff and patients (Perkins et al., 2012). One nurse articulates this experience by stating:

'The minute you lay hands on, the incident that originally got you to that point, is lost, it then becomes a situation of well you know, get off me, I will calm down when you get off me, and then the retort from the staff side is well no, when you have calmed down, and the service user then says well I will calm down when you get off me, and it then becomes a stalemate...a service-user, might calm down quicker if the restraint wasn't so long, instead of being forced, as it were, into submission, sort of like we will take hands-off when we feel you have calmed down' (Perkins et al., 2012, p. 46).

Lee et al. (2003) explored nurses' views relating to their last experience of implementing restraint and 96.3% of respondents perceived that there had been a positive outcome in their last incident. This positive perception was associated with the view that the incident was brought under control, regardless of the aftermath. Terpstra et al. (2001) found that the most frequent reason provided by nurses for the use of restraint and seclusion was the higher probability of interventions resulting in immediate control of violent behaviour.

Similarly, *'behaviour control'* was the second highest reason (23.2%) nurses cited as needing to use restraint in Lemonidou et al.'s (2002) study. Bigwood and Crowe (2008) found that nurses upheld an expectation that maintaining control was integral to the job, with some considering this practice to be therapeutic:

'I view restraint as a necessary therapeutic tool. Yes it is unavoidable in certain circumstances. Definitely it is a therapeutic intervention that is necessary at that point of time of crisis, to either reinstate control, to create safe outcome, to impose a treatment plan, to keep everyone safe basically and to just re-establish control' (Bigwood & Crowe, 2008, p. 219).

Lindsey's (2009) study reported a significant negative correlation between mental health nurses sense of empowerment and decision to restrain. Empowerment in this study entailed the following domains: opportunity, information, support,

resources, formal power, and informal power (Lindsey, 2009). Respondents in Lee et al.'s (2003) study revealed negative staff attitudes when restraint were initiated, such as '*deck them first*', a '*bouncer mentality*', and a tendency to use restraint '*too quickly*', all of which are aligned with a sense of maintaining control.

I believe this theme is very much interconnected with the safety for all theme, where maintaining control and safety go hand-in-hand. Meaning, when nurses strive to maintain safety, it is then creating a need to maintain control to achieve safety. Moreover, the sense of control itself creates a sense of safety. In addition, nurses view restraint as the means to achieve safety and control in violent and aggressive situations.

3.4.2.6 Nurses' Knowledge and Perception of the Patient

Familiarity with the patient, in terms of knowing their behavioural patterns and triggers as well as knowledge of patient's past behaviour was found to help inform nurses' expectations of an individual's behaviour and essentially influence their decision to restrain (Perkins et al., 2012). Lindsey (2009), for example, found nurses' perceptions of the patient's familiarity with the unit rules and norms influenced their decision to restrain. Nurses were therefore less inclined to use restraint if the patient was 'new' to the unit and unfamiliar with the rules. Factors contributing to nurses' knowledge and perception of the patients which influenced whether restraint methods were applied included: danger, injury or harm to self or others (Gelkopf et al., 2009; Holzworth & Wills, 1999; Lee et al., 2003; Lindsey, 2009; Terpstra, 2001), agitation, destruction of property (Holzworth & Wills, 1999; Lee et al., 2003), aggressiveness, anger, stress (Lemonidou et al., 2002), age, and diagnosis (Lindsey, 2009). These factors were viewed as information for the nurses about the patient, which influenced nurses' perception of the patient and inadvertently shaped decision-making related to restraint use. In Lemonidou et al.'s (2002) study, 53.7% of nurses believed that patient assessment and frequent communication (32.6%) were important practices to prevent violent behaviour and restraint use. Therefore, nurses' knowledge about the patient was seen to be critical by more than half of the participants.

3.4.2.7 Staff Composition

Staff composition is another emerging theme. In Terpstra et al.'s study (2001) for example, 51% (n=33) of the nurse respondents indicated that staff mix on the ward influenced their decision to place a patient in restraint. The study did not define the term staff mix, although staff mix commonly refers to the combination of different categories of health-care personnel employed for the provision of direct patient care (McGillis Hall, 2005). This study also reported that 48% (n=31) of respondents considered that the number of staff present was influential in their decision to restrain. This means that a fewer number of staff contributed to a sense of fear in approaching difficult patient-related situations and further influenced the likelihood to use restraint (Terpstra, 2001). Evening shifts were reported to increase the frequency of restraint use by 51% in one study (Lemonidou et al., 2002). This study also indicated 'staffing' to be the most important environmental factor (56.3%) influencing nurses' decisions to use restraint. Similar results were reported by Lee et al. (2003) who identified understaffing, inexperienced staff in the management of violence, and regular use of agency staff as important organisational factors impacting upon decision-making. Interestingly, Bowers et al. (2012) reported the 'better' and 'more richly-staffed' the wards were, the greater the amount of coercive measures, including restraint, were used.

There are some inconsistencies within the literature regarding the impact of professional experience and the decision to restrain by mental health nurses. Lindsey (2009) reported nurses with greater experience in both nursing and psychiatric nursing were more likely to use restraint as their initial intervention. Similarly, another study reported a positive correlation among the length of time nurses worked on a unit and the mean number of restraint episodes they were involved in (Terpstra, 2001). However, Holzworth and Wills (1999) found nurses with the least professional experience made nearly three times as many recommendations for the most restrictive type of intervention. Similarly, one study reported that 49.5% of nurses considered that the most important environmental factor to influence the use of restraint was inexperienced nursing staff (Gelkopf et al., 2009).

Gender was another staff composition factor identified in the literature. Gelkopf et al. (2009) found more male nurses in comparison to female nurses, considered the use of restraint if patients refused medication, kept others from sleeping, 'bothered' other patients, fought with other patients, and continuously banged on the nurses' windows. Bowers et al. (2012) explored staff variables in the use of restraint and found an increase in its use when security guards were present as part of the staff composition.

Although staff composition emerged commonly amongst a number of the studies, consistently there are inconclusive findings in the various aspects of staff composition (staffing numbers, experience and gender). Further research needs to be conducted to better understand the unique attributes of this theme.

3.4.2.8 Psychological Impact

The studies included did not directly address the psychological effects of the aftermath of restraint use on future decision-making. However, the psychological impact of the after-effects of restraint use among nurses was a key theme in a number of the selected studies (Bonner et al., 2002; Moran et al., 2009; Sequeira & Halstead, 2004). As an example, 're-traumatisation' of violent incidents was reported by nurses in Bonner et al.'s (2002) study, where one nurse stated, *'even smaller incidents like this can trigger thoughts of previous incidents'* (p. 471). Another study emphasises the emotional distress experienced by nurses, as seen by one participant's statement:

'It's [restraint/seclusion] bad for the whole unit, because other people pick up on it as well. It just leaves a bad atmosphere all around, just a very uneasy feeling. I really don't like it' (Moran et al., 2009, p. 601).

Sequeira and Halstead (2004) further report on the emotional distress and describe the intense reactions of several female nurses following the restraint of patients:

'It's always helplessness and despair and anger, so I know why I'm crying and what I'm feeling is hers...it's not mine....but I've been left with it' (p. 8).

This study reviewed the psychological responses of nurses to restraint and reported a number of findings. Anxiety was the most prevalent emotion nurses experienced when using restraint, with a noted reduction in anxiety when restraint usage was familiar to the nurse (Sequeira & Halstead, 2004). Interestingly, one study reported that nurses who had a history of being injured in the past would influence their decision to restrain a patient at a later time in the progression of aggression (Moyle & Cullinan, 2011).

Overall, this theme indicates that even though nurses may feel that restraint is a necessary intervention, it has significant impact on nurses psychologically. The psychological distress occurs at various times in relation to restraint use, such as while applying restraint, to the aftermath reflections of the incidents, as well as, the overall role conflict experienced.

3.5 Discussion

A literature review to explore nurses' decision-making in the use of restraint in mental health settings was undertaken by Laiho and colleagues (2013). This review identified a number of domains that impact nurses' decision-making in the use of restraint: 'patient-related cues', 'personnel-related cues', 'previous experience of the use of seclusion or restraint', and 'organisational-related cues'. While the current study confirms the findings from the previous review, two additional, previously unreported themes emerged: 'restraint as a last resort' and 'staff composition'. Additionally, the similarities from this existing review are further confirming the initial findings from Laiho et al (2013) and essentially expanding the small body of knowledge in relation to this topic.

The staff composition theme highlights inconsistencies in terms of how staffing numbers (high or low) and level of experience (inexperienced or well experienced) can influence restraint use, as well as how restraint use is influenced by gender issues and the presence of security personnel. These findings therefore emphasise

the need for further consideration of staff related factors in a mental health environment.

The concept of 'last resort' is mentioned in many policies and guidelines (National Institute for Clinical Excellence, 2005; Royal College of Nursing, 2008; College of Nurses of Ontario, 2009; Registered Nurses Association of Ontario, 2012; National Offenders Management Services, 2013; MIND, 2013; American Psychiatric Nurses Association, 2014a; American Psychiatric Nurses Association, 2014b) around the world and can be viewed as a key driver for nurses in making decisions related to the application of restraint. As this review has identified that no existing studies focus on, nor clearly consider what 'last resort' actually means, further exploration into how this concept is perceived and enacted upon in practice appears critical. This could potentially provide insights into strategies that support and prevent the use of restraint in mental health settings.

A key strength of an integrative review is the combination of diverse methodologies, which provides an opportunity for an in-depth review of the evidence, providing a depth and breadth of the evidence without over-emphasising and over-valuing hierarchies of evidence. However, this may also be viewed as a limitation as the combining of diverse methodologies may be argued to contribute to a lack of rigor, inaccuracies and bias. Recognising the paucity of literature related to nurses' decision-making and restraint in mental health, an integrative review appeared to be an appropriate strategy to permit the inclusion of a greater number and range of publications, increasing the extensiveness of the review. While only published research studies were included, a broad and inclusive search strategy was adopted to ensure that all key studies were included. My supervisory team and I also undertook the analysis and identification of themes until consensual validation had been obtained. A further strength of the review is the similarities of findings with the one other published review, demonstrating a robust methodology, as well as, validity to the key influences on mental health nurses decision-making in restraint use. Furthermore, as new and previously unreported issues were identified, this review provides new and unique contributions to knowledge in this area of practice.

A limitation of this review is the generalisability of the findings to institutions in countries where decisions related to restraint tend to involve other health care professionals. Furthermore, although many countries are moving towards restraint minimisation, practices and definitions vary. Consequently, these variations create difficulties in drawing comparisons about restraint use across different study contexts.

The topic of restraint use in mental health is controversial. There are some who question whether restraint could ever be therapeutic (Huckshorn, 2004; Paterson & Duxbury, 2007), while others believe restraint use is necessary, but only in extreme situations (Fisher, 1994; Mohr et al., 1998). In addition, while research from clinicians' perspectives report how restraint maintains safety (Bigwood & Crowe, 2008; Lemonidou et al., 2002; Stubbs et al., 2009; Terpstra, 2001), there is evidence that reductions in restraint increase safety for staff (Goetz, 2012; LeBel et al., 2014; Lebel & Goldstein, 2005). As restraint use has negative physical and psychological consequences (Fish & Culshaw, 2005; Sequeira & Halstead, 2004; Soininen et al., 2013; Strout, 2010), there is a need to further understand the intricacies involved in decision-making to use restraint as a 'last resort' in mental health settings.

3.6 Conclusion

This chapter provides a comprehensive integrative review on the factors influencing mental health nurses' decision-making in relation to restraint. This review has demonstrated the gap in literature on the concept of 'last resort' further emphasising the need for this research study. Moreover, the emerging themes from this integrative review suggest a paradoxical situation for mental health nurses, where they use restraint to maintain safety for all (Bigwood & Crowe, 2008; Lemonidou et al., 2002; Terpstra, 2001), with safety viewed as an integral part of their role (Bigwood & Crowe, 2008; McCain & Kornegay, 2005; Perkins et al., 2012). These views exist despite the evidence that demonstrates that restraint poses safety risks for both patients and staff (Ashcraft & Anthony, 2008; Fish & Culshaw, 2005; Foster et al., 2007; Mildred, 2002; Sequeira & Halstead,

2004; Soininen et al., 2013; Strout, 2010). The following chapter will elaborate on the theoretical positioning of the study.

4.0 Introduction

In this chapter I describe the ontological, epistemological and theoretical approach for this research. This chapter provides a rationale for the selection of a hermeneutic phenomenological approach in human sciences research and describes the exploration into the various qualitative methodological approaches that were considered during the process. I will also present the approaches of the major contributors to phenomenology and hermeneutics that guide my research. Finally, I describe various philosophical concepts that help to frame and interpret the findings.

4.1 Positioning the theoretical approach

Crotty (1998) identifies four elements in developing a research proposal that aim to ensure the reliability of a research study. The four elements are epistemology, theoretical perspective, methodology and methods. Crotty (1998) states that identifying these elements in the research process enables the researcher to justify the methodologies and methods employed. This in turn creates greater opportunities to make the outcomes of the study more convincing. The definitions of the terms for the four elements are provided in Table 6 (Crotty, 1998, p. 3).

Table 6: Four elements of research process

| Element | Definition |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Epistemology | The theory of knowledge embedded in the theoretical perspective and thereby in the methodology. |
| Theoretical Perspective | The philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria. |
| Methodology | The strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes. |
| Method | The techniques or procedures used to gather and analyse data related to some research question or hypothesis. |

Crotty’s (1998) writings have guided my own explorations of the elements of the research process. Table 7 is adapted from Crotty (1998, p. 5) and illustrates the relationship among the various elements of this study which will be further discussed in the following sections of this chapter.

Table 7: Relationship among the various elements of this study

| Epistemology | Theoretical Perspective | Methodology | Methods |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------|
| <i>Constructionism</i> | <i>Interpretivism</i> <ul style="list-style-type: none"> ▪ <i>Phenomenology</i> ▪ <i>Hermeneutics</i> | <i>Phenomenological research</i> | <i>Interview</i> |

4.1.1 Aim of the research

As highlighted in chapter one, the aim of this study is to gather the Canadian mental health nurses perspectives and experiences about the use of restraint as a 'last resort'. The research question posed is 'how do mental health nurses in Canada perceive and experience 'last resort' when using restraint?'

4.1.2 Epistemological and ontological perspective

Social constructionism is the epistemological and ontological perspective I embrace. My perspective and interpretation have been guided by Crotty (1998). According to Crotty (1998) constructionism relates to how our understandings and meanings of what we encounter and experience are not discovered but constructed through our engagement with the world, stating '*what constructionism claims is that meanings are constructed by human being as they engage with the world they are interpreting*' (Crotty, 1998, p. 43). Therefore, the world and the objects within it are our partners in generating meaning (Galbin, 2014; Liebrucks, 2001). The process by which meaning is created, sustained, and modified is the focus of constructionists (Walker, 2015). Crotty's (1998) definition of constructionism aligns with my own perspective in that:

'...all knowledge, and therefore all meaning as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context'
(p.42).

Our pre-understandings of phenomena are socially constructed, and determined through a process of enculturation. Social constructionists believe that society is actively and creatively developed by human beings, where all meaningful realities are socially constructed (Crotty, 1998; Walker, 2015). This view adopts the notion that knowledge is constructed as opposed to created. An explicit account of social constructionism is offered by Greenwood (1994):

'Physical and social phenomena...differ in one essential respect. Chairs may exist independently of our knowing that they do; our knowledge of the existence of chairs is not constitutive of their existence. In contrast, social phenomena do not exist independently of our knowledge of them...Social realities, therefore, are constructed and sustained by the observation of the social rules which obtain in any social situation by all the social interactors involved...Social reality is, therefore, a function of shared meanings; it is constructed, sustained and reproduced through social life' (p. 85).

I believe that there is interdependency between researchers and participants. The question I want to ask is best answered using social constructionist approach. This allows the participants the opportunity to provide deep, rich and complex answers, where these insights would not be available when using a quantitative approach. I believe that by adopting a social constructionist approach I am able to construct meaning through the narrated experiences of the nurses.

An epistemology of social constructionism subsumes an interpretive theoretical approach in relation to research. Therefore in the next section I provide a rationale as to why an interpretive approach is appropriate for this study as opposed to a positivist approach.

4.1.3 Interpretive versus positivist

There continues to be varying definitions of the term 'positivism', however, in general, positivism elevates scientific knowledge above all else (Mackenzie, 2011; Ryan, 2015). The term has been extensively used to describe approaches to research that have made use of large data sets, quantitative measurements and statistical methods of analysis (Hasan, 2016). Hasan (2016) describes the positivist approach as enabling researchers to portray their disciplines as *'sufficiently and rigorously as the scientific experts'* providing them with the opportunity to *'make strong claims about the reliability, objectivity and usefulness of the knowledge they have to offer'* (p. 320). It has been argued that positivism has

provided analytical tools and aided in developing intervention and evaluation methods that were more effective compared to those previously used in social research (Hasan, 2016; Mackenzie, 2011). Therefore, in the positivist paradigm phenomena are both observable and measurable, and science is viewed as the way of reaching the truth.

However, there are also anti-positivists who identify significant flaws with the approach (Hasan, 2016; Rodwell, 1987). They argue that positivistic, quantitative based methods are not suitable to probe and understand the complexity and variability of the socio-behavioural phenomena (Rodwell, 1987). They also believe that the positivist approach excludes empathic understanding of the social phenomena from individual points of view, reducing complex actions to simple behaviours, as if each action has the same meaning irrespective of the context (Hasan, 2016; Ryan, 2015).

In contrast to positivism is the interpretive approach. Crotty (1998) describes interpretivists as those looking *'for culturally derived and historically situated interpretations of the social life-world'* (p. 67). Interpretive based research is situated within a post-positivist perspective which claims that there is no objective truth out there to be studied and that the world shows up through human engagement (Sandelowski, 2004). This approach generates knowledge that is grounded in human experience and is valued due to its capacity to provide deep and rich interpretations of phenomena (Mantzoukas, 2004; Sandelowski, 2004). Therefore, at the core of the interpretive research approach is the philosophical belief that experience is the source of our knowledge of the world (Mantzoukas, 2004). Interpretivists consider the positivist beliefs of truth, reality and knowledge to be flawed. For instance, Annells (1996) argues that it is beyond human capacity to comprehensively understand reality and absolute truth, even if it exists, because understanding is attained through individualistic viewpoints, as well as the context-dependent nature of phenomena.

It is evident based on the descriptions provided that it is highly problematic to understand phenomena and uncover meanings that humans attribute to life experiences using a positivist, quantitative based approach. Whilst the benefits of

this approach are not disputed across the research domains, statistical inferences are viewed as unsuitable to unearth real-world human experiences.

In relation to the aim of this research study, a deeper understanding of the phenomenon 'last resort' is necessary. Given the context-dependent and person-centred basis of 'last resort', interpretivism provides an opportunity to appreciate both these perspectives and explore the lived experiences of nurses to help reveal a greater understanding of the phenomena. In the following sections I will provide the considerations and justification for the methodological approaches being adopted in this study.

4.1.4 Consideration of methodological approaches

Qualitative research is a broad overarching term for research methodologies that describe and explain persons' experiences, behaviours, interactions and social contexts (Fossey et al., 2002; Green, 2007; Ryan et al., 2009). Qualitative methods aim to answer questions about the 'what', 'how' or 'why' of a phenomenon (Green, 2007; Ryan et al., 2009). In order to determine which qualitative method to adopt for this research, a number of approaches were considered, specifically ethnography, case study, grounded theory and phenomenology. These approaches were specifically considered as I felt they had the most appropriate opportunity to explore a topic that had not been formally studied in the past. A brief description of ethnography, case study and grounded theory approach is presented, as well as an explanation as to why these approaches are incompatible with the aim of my research. Additionally, a rationale as to why hermeneutic phenomenological approach has been adopted for this study is offered.

4.1.4.1 Ethnography

Ethnography is described as a social research method which occurs in natural settings characterised by learning the culture of the group under study and experiencing their way of life prior to attempting to derive explanations of their attitudes or behaviours (Goodson & Vassar, 2011). LeCompte and Schensul (2010) suggest that ethnography should be used to :

- *Define a problem when the problem is not yet clear.*
- *Define a problem when it is complex and embedded in multiple systems or sectors.*
- *Identify participants when the participants, population sectors, stakeholders, or the boundaries of the study population are not yet known or identified.*
- *Clarify the range of settings where a problem or situation currently occurs when not all of the possible settings are fully identified, known or understood.*
- *Explore the factors associated with a problem in order to identify, understand, and address them either through research or intervention studies, when they are not known.*
- *Document a process.*
- *Identify and describe unexpected or unanticipated outcomes.*
- *Design measures that match the characteristics of the target population, clients, or community participants when existing measures are not a good fit or need to be adapted.*
- *Answer questions that cannot be addressed with other methods or approaches.*
- *Ease the access of clients to the research process and its products.*

(p. 356)

In general, ethnographies are conducted in a single setting and data collection is dependent on participant observation and interviews. This is a research method based entirely on fieldwork. Ethnographic researchers strive to observe phenomena as it is occurring, thereby creating the opportunity to capture the worldview of their observed participants. Ethnographic accounts are descriptive, explanatory and interpretive; descriptive and explanatory as detail is crucial, and interpretive, because the ethnographer must determine the significance of what is observed (Dykes, 2004).

As this study aims to explore the lived experience of 'last resort' in the use of restraint, these perceptions and experiences can only be encapsulated

retrospectively. Given the sporadic nature of restraint use on inpatient mental health settings, as well as, the aim of the research, to explore mental health nurses' perspectives across Canada, observations of the practice would not be feasible. Furthermore, it could not be guaranteed that perception of 'last resort' could be witnessed, given the paucity of knowledge related to the topic. A further criticism of ethnographic research is that the observer's presence may in itself contribute to the participant's behaviour, who may act in a manner that is different had the observer not been present. This bias is referred to as the Hawthorn Effect (McCambridge et al., 2014).

4.1.4.2 Case Study

A case study approach is often used to generate an in-depth, multi-faceted understanding of a complex issue in its real-life context (Crowe et al., 2011). This is an established research design with its central tenet being the need to explore an event or phenomenon in depth and in its natural context. There are three types of case study designs, intrinsic, instrumental and collective (Stake, 1995). Intrinsic case study is often exploratory in nature, and the researcher is guided by their interest in the case itself as opposed to extending theory or generalising across cases. Instrumental case study uses a particular case to gain a broader understanding or appreciation of an issue or phenomenon. The difference between an instrumental and intrinsic case study design is the purpose of the study. In instrumental case study research the focus of the study is more likely to be known in advance and designed around established theory or methods (Brown, 2008). Lastly, the collective case study involves studying multiple cases simultaneously or sequentially in an attempt to generate a broader appreciation of a particular issue. Data collection involves the collection of multiple sources of evidence, ranging from quantitative (e.g. questionnaires, audits, routinely collected data) to qualitative (e.g. interviews, focus groups and observations) techniques to develop a thorough understanding of the case. Integral to data analysis is the repeated reviewing and sorting of voluminous and detail-rich data (Crowe et al., 2011).

Case study design was not considered suitable for this research given the minimal data available related to the topic area. Although mental health nurses have

accountabilities related to documentation of restraint events, the focus of this information is often limited to the facts of the event and not necessarily about the meaning of 'last resort' and how this was determined. Additionally, researchers often undertake intrinsic case studies not because the case represents other cases but rather there is an intrinsic interest in the particulars of the specific case (Stake, 1995). For the aim of this research there is an interest to represent what 'last resort' means to mental health nurses, thereby it is beyond learning about one nurse's perception. It also acknowledged that when the purpose of a research is to provide *'explanation, propositional knowledge, and law...the case study will often be at a disadvantage...when the aims are understanding, extension of experience, and increase in conviction in that which is known, the disadvantage disappears'* (Stake, 1995, p. 21). Given that there is currently no formal understanding of 'last resort' in the use of restraint, the aim of this study is to find understandings and meanings of this concept, therefore, as identified by Stake's (1995) in the above statement, this method is not suitable. Additionally, a case study method is particularly useful for theory development and testing which is not aligned with this study (Brown, 2008). For these reasons, I have not selected this approach for my study.

4.1.4.3 Grounded theory

Grounded theory is another method that I considered for this study. It is a research method concerned with the generation of theory (Glaser, B. G. & Strauss, A. L., 1967), that is 'grounded' in data that has been systematically collected and analysed (Strauss & Corbin, 1994). Through the use of an inductive technique, the researcher collects information and draws conclusions from what is observed (Miller, 2015). Grounded theory is used to discover such things as social relationships and behaviours of groups, known as social processes (Crooks, 2001). According to Shank (2006), complex settings are best understood by starting at 'ground zero' and allowing the data to guide the theory development process.

Grounded theory research emphasises for the researcher to start with as few preconceptions as possible. To achieve this, Glaser and Strauss (1967) directed researchers to write the literature review only after completing analysis so as not to contaminate research findings. If the researcher is already familiar with the setting under investigation, they must set aside what is already known and allow

the situation to speak to the researcher (Shank, 2006). However, within the field of Grounded theory there are debates on whether this is the best approach. Charmaz (2006) argues that the literature review conducted at the initial onset of the research provides an opportunity for researchers to summarise and evaluate the literature as well as situate themselves in relation to current discourse. She also highlights the importance of sensitising concepts, '*ways of seeing, organising, and understanding experience that are embedded in our disciplinary lenses*' (Charmaz, 2000, p. 515). Using this position as a starting point, researchers can incorporate sensitising concepts into inquiry without forcing preconceived notions on emergent theory (Charmaz, 2006). This controversy related to literature review has continued for over three decades among grounded theorists, creating confusion in the field.

Essentially, grounded theory seeks not to simply understand how individuals make sense of their lives and experiences, but to build a theory that explains the phenomenon of interest. This method consists of the researcher analysing the individual stories of each participant, taking them apart and putting them back together in such a way that tells the story of all the participants collectively (Merriam & Associates, 2002).

Paley (2017) argues that Glaser and Strauss demonstrate no interest in 'experience', and their grounded theory approach focuses on fieldwork studies based on extensive observation as well as interviews. Paley (2017) believes that through evolution of the approach due to selective pressures such as the academic environment, inductive, descriptive, interview-based studies of experience are often inaccurately classified as grounded theory. Miller (2015) believes this approach is best suited to explore problems for which little theory has been developed. I did not select this methodology, as the purpose of this study is not to develop a theory related to 'last resort', rather to understand the lived experience of nurses – a research focus which is better suited to hermeneutic phenomenology. In the following section I provide a rationale of the methodological approach I have selected for this study.

4.1.4.4 Justification for a hermeneutic phenomenological approach

From the above descriptions, neither ethnography, case study nor grounded theory were appropriate approaches for this research. In contrast, a hermeneutic phenomenological approach offers a methodology through which lived experiences of a particular phenomenon can be generated. This approach incorporates the perspective of the individual, as well as the socio-cultural context on how events are interpreted. Additionally, this approach recognises that research cannot operate through a value-free objective standpoint and thus hermeneutic phenomenology values the perspective of the interpreter within the construction of meanings.

Furthermore, as described in chapter three, currently there is no published literature describing how nurses when using restraint perceive 'last resort'. Given that current evidence in the form of guidelines, legislation, white papers, and so forth, insist that all other alternatives must be exhausted prior to the use of restraint as a 'last resort', it becomes essential to understand mental health nurses' experience and understanding of 'last resort'. I believe hermeneutic phenomenology to be the most suitable approach given the aim, to describe, understand and interpret participants' experiences (Tuohy et al., 2013), and to focus upon the phenomenon of 'last resort'.

In the following sections I will present the phenomenological approach undertaken for this study.

4.2 Phenomenological Approach

4.2.1 Phenomenology

'Back to the things themselves' is the phrase that marks the launch of the phenomenological movement. The 'things themselves' exemplify the phenomena that present themselves immediately to us as conscious human beings (Crotty, 1998). Crotty (1998) describes phenomenology to suggest that:

'If we lay aside, as best we can, the prevailing understandings of those phenomena and revisit our immediate experience of them, possibilities for new meaning emerge for us or we witness at least an authentication and enhancement of former meaning' (p.78).

Phenomenology aims to describe an experience as it is lived by the subject and interpreted by the researcher (Burns & Grove, 2001). Finlay (2008) describes phenomenology as the study of phenomena – their nature and meanings. It places focus on the way things appear to us through experience or in our consciousness where the phenomenological researcher aspires to provide a rich textured description of lived experience (Koch, 1995). Anderson (1993) further elaborates on the definition and explains the purpose of phenomenological research is to uncover, understand, and illuminate the experiences of everyday life. Edmund Husserl (1859-1938), often referred to as the father of phenomenology, described this methodology as essentially the study of lived experience or the lifeworld (Lavery, 2003). Husserl describes 'lifeworld' as what we experience pre-reflectively, without resorting to categorisation or conceptualisation, and often includes what is taken for granted or those things that are common sense (Husserl, 1970; Lavery, 2003). Studying these phenomena intends to return and re-examine these taken for granted experiences and perhaps uncover new and or forgotten meaning (Lavery, 2003). It aims to fill gaps in understanding that are left by rational-empirical science approaches and offers to illuminate the type of knowing that occurs when involved in a particular world and social situation rather than the understanding gained as an onlooker standing outside of it (Chan et al., 2010).

Phenomenology requires us to place aside our usual understandings and have a fresh look at a phenomenon (Crotty, 1998). There are two main approaches that guide the majority of phenomenological explorations – descriptive and hermeneutic (interpretive). Edmund Husserl, a German philosopher and mathematician, is considered to be the founder of phenomenology and the descriptive approach to inquiry (Wojnar & Swanson, 2007). Descriptive phenomenology is concerned with *'how objects are constituted in pure consciousness, setting aside questions of any relationship of the phenomenon to the*

world in which one lives' (Wojnar & Swanson, 2007, p. 173). In his work, Husserl (1970) explained how to overcome personal biases in order to achieve the state of pure consciousness. He defines phenomenology as the '*science of essence of consciousness*', which calls for the exploration of the phenomenon through direct interaction between the individual and the object being studied (Husserl, 1970). Husserl believed that by successfully abandoning one's own lived reality, the individual is then able to describe the phenomenon in its pure and universal sense. This was referred to as employing the process of bracketing (referred to as *epoche*) (Husserl, 1970; Wojnar & Swanson, 2007). His concept of bracketing was derived from his mathematical ideas. By bracketing the individual is tasked with setting aside all assumptions, perceptions, experiences, knowledge, biases and beliefs, and pre-judgments (Husserl, 1970). From a research perspective bracketing would then be necessary as assumptions, perceptions, experiences, knowledge, biases and beliefs, and pre-judgments may influence data collection and the way of understanding and working with the data (Beech, 1999; Crotty, 1996; Dowling, 2007; LeVasseur, 2003). Husserl's descriptive philosophy believed that the 'lifeworld' was about an individual's pre-reflective experience (Crotty, 1996).

Husserl's concept of bracketing has been widely debated amongst researchers. It is argued that by bracketing the researcher can take an *etic* view (a perspective of an observer) hence unearth the participants' own reality, rather than a Heideggerian *emic* approach (from the perspective of the subject) that fuses the world of the researcher with that of the participant where the final research is a co-construction (Hamill & Sinclair, 2010). Furthermore, a key aspect to Husserl's philosophy was the concept of intentionality, which was highly influenced by Brentano's (1838-1917) work. 'Intentionality' refers to the concept that every mental act is related to an object and this suggests that all perceptions have meaning. Accordingly van Manen (1990) translates this to all thinking is about something.

For the purposes of this study I have adopted the second approach in phenomenological exploration, referred to as *hermeneutic* (interpretive)

phenomenology. The following sections will expand on this approach and the philosophers who influenced my research.

4.2.2 Hermeneutic Phenomenology

The theoretical perspective I have adopted for this study is hermeneutic phenomenology and will be drawing on philosophers such as Heidegger (1889-1976) and Gadamer (1900-2002). The term hermeneutics originated from the Greek word *hermeneuein*, which means 'to interpret' or 'to understand' (Crotty, 1998). Hermeneutics came into modern use in the seventeenth century within the context of biblical studies. It was the science of biblical interpretation, providing scholars with guidelines in engaging in the task of interpreting Scripture (Crotty, 1998). More currently, hermeneutics has been integrated into many areas of scholarship in an attempt to bring understanding through text and unwritten sources (Crotty, 1998).

Hermeneutic principles where emphasis is on the *'phenomenological explication of human existing itself'* (Palmer, 1969) have guided the exploration of this study and in particular the phenomenon of 'last resort'. Hermeneutic phenomenology is known as a contemporary philosophy that emphasises the human experiences of understanding and interpretation (Thompson, 1990). Therefore, hermeneutic phenomenology is not designed to explain the world, rather it strives to enhance and understand experiences and practices of being human (Thompson, 1990). Crotty (1998) describes Heidegger's hermeneutic phenomenology as a *'phenomenological return to our being, which presents itself to us initially in a nebulous and undeveloped fashion, and then seeks to unfold that pre-understanding, make explicit what is implicit, and grasp the meaning of Being itself'* (p.97). Hermeneutic phenomenology is founded on the constructs of 'interpretation', 'textual meaning', 'dialogue', 'pre-understanding', and 'tradition' (van Manen, 2014). Hermeneutic phenomenology embraces the belief that there is a fusion of the social world of the participant with that of the researcher with an attempt to co-construct reality. Gadamer (1996) states that:

'Hermeneutics has to do with theoretical attitude toward the practice of interpretation, the interpretation of texts, but also to

the relation to the experiences interpreted in them and in our communicatively unfolded orientations to the world' (p. 112).

Gadamer believed that hermeneutic phenomenology is not a method for understanding, rather it seeks to explain the conditions in which understanding takes place (Gadamer, 1975). Heidegger's 'historicality of understanding', highlights that an individual's 'fore-conceptions' or 'pre-understandings' about the world stem from past experience (Koch, 1995). From Heidegger's perspective, 'inter-subjective' understanding among individuals occurs through 'lived human relation' with others in a 'hermeneutic circle' (further described in section 5.4.2.4) of interpretation, therefore reinforcing or revising 'fore-conceptions' when encountering new situations (van Manen, 1990).

A hermeneutic phenomenological exploration thus attempts to reveal, enhance and further extend understandings of the human situation as it is lived (van Manen, 1990). This method aligns well with my research as it will enable a greater understanding of how mental health nurses experience 'last resort' when using restraint from a person-centred and value-laden perspective. This approach thereby allows me to start to understand what 'last resort' actually means to nurses. In the following section I will highlight the works of Heidegger and Gadamer and their influences on hermeneutic phenomenology.

4.3 The phenomenologists who have influenced this research study

There are a number of philosophers who have contributed to the broad movement of hermeneutic phenomenology. For this research I have selected the philosophical perspectives of Martin Heidegger and Hans-Georg Gadamer to influence and guide this study. The following section will provide details of some of the philosophical offerings of each to hermeneutic phenomenology.

4.3.1 Martin Heidegger (1889 – 1976)

The work of Martin Heidegger is considered as the prime instigator of modern hermeneutic phenomenology (Annells, 1996). Martin Heidegger was born in

Germany and began his career outside of the field of philosophy (in theology) (Lavery, 2003) but became known for his phenomenological explorations of the *'question of Being'* (refer to section 4.4 for details)(Heidegger, 1996). Heidegger taught at Freiberg and worked with Edmund Husserl as his student. Heidegger initially committed himself to the Husserlian phenomenology, as he was trained by Husserl in the processes of phenomenological intentionality and reduction (Lavery, 2003). Later on Heidegger dissociated himself from Husserl's work as he developed hermeneutic phenomenology. Heidegger's perspectives differed from that of Husserl in the way their exploration of lived experience proceeds (Lavery, 2003). Heidegger's creation of a second branch in phenomenology led him on a *'path of the question of the Being, illuminated by the phenomenological attitude'* (Annells, 1996, p. 706). The phenomenological attitude refers to Husserlian's approach where our habitual, taken for granted understandings are bracketed. Heidegger transitioned from Husserl's epistemological emphasis to one that focused on the ontological foundations of understanding that is achieved through *'being-in-the-world'* (refer to section 4.4 for details) (Annells, 1996). This led to him postulating the notion of *'Dasein'* – human everyday existence (Annells, 1996). Heidegger's main focus was to answer the question of *'Being'*. His reference to Being, relates to our fundamental capacity to make sense of our lifeworld (refer to section 4.4 for details). This central concept, Being, signifies an inseparable connection between the mind and world, lived experience and historical or social context (Heidegger, 1996). In his seminal text, *Being and Time* (1962), he distinguishes his philosophical approach from that of Husserl's, asserting that it is impossible to separate oneself from our previous knowledge or experiences in order to establish an independent standpoint, thus rejecting Husserl's process of *'bracketing'*.

4.3.2 Hans-Georg Gadamer (1900 – 2002)

Hans-Georg Gadamer was a German philosopher and a student of Heidegger. He further evolved *'philosophical hermeneutics'* through his primary commitment to practical hermeneutics (Annells, 1996). This was an area that was initiated by Heidegger, however, left unfinished. Gadamer's core tenet is the notion that *'understanding and interpretation are indissolubly bound up with each other'*

(Gadamer, 2004, p. 399). His perspective remained that interpretation is always evolving and hence it is not possible to achieve definitive and final interpretations (Gadamer, 2004). For him, it is our 'belongingness' to the world, which enables us to experience things as meaningful to us. Gadamer argues that this is realised through our mastery of language and this allows the world to become unlocked for us. Therefore, we must accept that we exist within a language-mediated culture in order to begin to understand ourselves (Gadamer, 1977)

Moreover, Gadamer refers to 'horizon' as a way to conceptualise understanding. He believed that your horizon is as far as you can see or understand. Gadamer states that:

'The concept of horizon suggests itself because it expresses the superior breadth of vision that the person who is trying to understand must have. To acquire a horizon means that one learns to look beyond what is close at hand – not in order to look away from it but to see it better' (Gadamer, 2004, p. 305).

Understanding is believed to happen when our present understanding or horizon is moved to a new understanding or horizon by an encounter (Gadamer, 2004). Therefore, the process of understanding is a 'fusion of horizons', where the old and the new horizon combining into something of living value. Gadamer (2004) further elaborates on this concept, stating:

'Every finite present has its limitation. We define the concept of 'situation' by saying that it represents a standpoint that limits the possibility of vision. Hence essential part of the concept of situation is the concept of 'horizon'. The horizon is the range of vision that includes everything that can be seen from a particular vantage point... A person who has no horizon is a man who does not see far enough and hence overvalues what is nearest to him. On the other hand, 'to have an horizon' means not being limited to what is nearby, but to being able to see beyond it... Working out of the hermeneutical situation means the achievement of the right horizon of inquiry for the questions evoked by the encounter with tradition' (p. 302).

This supports Heidegger's perspective where entering the world of the person and interpreting the meanings they assign to their lived experiences begins with the understanding that each Dasein, as a being-in-the-world (discussed in section 4.4), presents with one's own prejudices or horizon (Miles et al., 2013). Gadamer believed the fusion of horizons occurs in everyday conversations where language is used as a mediator in understanding (Miles et al., 2013).

Gadamer further developed Heidegger's concept of hermeneutic circle of understanding and brought it to the forefront of philosophical hermeneutics. The hermeneutic circle represents the art of understanding, where the circle is a metaphor to explain the dynamic movement between the parts and the whole of a text within seeking understanding (Annells, 1996). Essentially Gadamer viewed it as an iterative process that enables the interpreter to reach a new understanding of reality established through the exploration of the details of existence found in text (Gadamer, 2004). Gadamer explains:

'every encounter with tradition that takes place within historical consciousness involves the experience of a tension between the text and the present. The hermeneutic task consists in not covering up this tension by attempting a naïve assimilation of the two but in consciously bringing it out' (Gadamer, 2004, p. 317).

Above I have described the perspectives of the phenomenologists influencing the theoretical perspectives of this study. In the following sections I will elaborate on various philosophical concepts of hermeneutic phenomenology, which have later been used to interpret the findings of this study (chapter six).

4.4 Heidegger's 'Being' as 'Dasein'

In *Being and Time*, Heidegger (1996) discusses that to understand Being, one must first understand the human kind of Being referred to as 'Dasein', which literally means 'Being-there' (Sheehan, 2005). Heidegger's focus on 'Dasein' – the human entity - embodies what it is to be human (Heidegger, 1996). It emphasises that our

experiences are based on our context of the world and as humans, we cannot be separate from that (Miles et al., 2013). Heidegger argues that as entities or beings, we are fundamentally 'being-in-the-world'. He purposefully hyphenated the link between these terms to emphasise the inseparableness of who we are as human beings and our life-worlds – the world and Dasein are one and the same (Miles et al., 2013). In other words, Dasein's being-in-the-world relates to how self and our lifeworld are fundamentally co-constituted (Heidegger, 1996).

Heidegger describes the fundamental ontological basis of Dasein's Being to consist of three elements thrownness, projection and falling – with these forming what he refers to as the care structure of temporality (further discussed in section 4.4.1) (Heidegger, 1996). Each of these three elements are grounded in an aspect of time – the past (thrownness), present (falling) and future (projection). In relation to thrownness, Heidegger proposes that every human being (Dasein) is shaped by the culture into which they are thrown (further discussed in section 7.2.3). He believed that our understanding of the world is associated with the 'facticity of life'; the actual concrete realities of our existence into which we are thrown (Heidegger, 1996). Our skills, practices and ways of being-in-the-world derive through our culture and society in which we inhabit – referred to by Heidegger as our 'tradition' (Heidegger, 1996). Thrownness represents the past aspect of time – it is the background context of how we come to understand and make sense of our life world. Projection (the futural aspect of temporality) relates to how Dasein understands itself by projecting itself, or 'pressing ahead' into some way of life, or as Heidegger describes, our possibility of being. Projection is grounded in and originates from the thrownness of our existence (Heidegger, 1996). Finally, the third element – our present - is falling. Blattner (2005) discusses the terminological ambiguity regarding the concept of falling in *Being and Time*. He states:

'on one hand, falling refers to Dasein's tendency to fall away from authenticity and onto the world of its mundane concerns in fleeing from the anxiety of a confrontation with death. On the other hand, it names Dasein's essential encounter with and absorption in non-human things in the course of pursuing its possibilities. Equipment, paraphernalia, gear (das Zeug) are available (zuhanden) to Dasein as it goes about its daily business. The latter define the

former by giving them their place in a cultural matrix of human concerns, projects, possibilities, places and time' (p. 313).

Falling generally concerns how in our normal everyday ways of being-in-the-world we are absorbed and immersed in the tradition and cultural practices of our society – where the standards, beliefs and prejudices of our life-worlds are embraced and unchallenged. This element is grounded in the present aspect of time (Heidegger, 1996).

For Heidegger and Gadamer, all understanding is ultimately self-understanding, where our pre-understandings are a product of our situatedness in the world (McManus Holroyd, 2007). In applying this perspective to research, this makes it essential for researchers to reflect on their pre-understandings and the meanings that exist within them in an effort to determine their legitimacy and to manage their influence on new understanding. When understanding takes this form, it transcends the subjectivist and objectivist stance, and is more of a movement between tradition and interpretation (McManus Holroyd, 2007). Similar to Heidegger, Gadamer describes the concept of tradition as how we as human beings are always immersed in particular ways of coping with our world (Gadamer, 2004). Thereby, it is possessing certain forms of practical knowledge and doing things in certain ways that in turn provide us with the basis through which interpretation takes place (Warnke, 2012).

Heidegger and Gadamer also both refer to the disclosure of the fore-structure at great length in the understanding of the hermeneutic experience (McManus Holroyd, 2007). Fore-structure is described by Heidegger as our innate capacity to intuit meanings and understandings (Heidegger, 1996). Therefore, every encounter that we have is grounded and guided by something that exists in advance – *'an already decided way of conceiving that which we are interested in'* (McManus Holroyd, 2007, p. 3). Within the fore-structure of understanding, the interpretation is founded upon what Heidegger describes our fore-having ('vore-habe') something had in advance, fore-sight ('vore-sicht') something seen in advance, and fore-conception ('vore-griff') something grasped in advance (Heidegger, 1996). For Heidegger, there can never be a presuppositionless stance

in any act of interpretation and rather interpretation is pre-determined by the fore-structures of the interpreter (Koch, 1995; McManus Holroyd, 2007).

As mentioned earlier, the elements of the care-structure are grounded in and relate to temporality. In the following sections I will describe the concept of temporality and authenticity, as they are both closely related to Dasein in terms of what we come to know, engage in, and understand our lifeworld.

4.4.1 Temporality

Heidegger proclaims an intimate connection between time and Dasein, which he refers to as our fundamental care structure (Blattner, 2005):

'Temporality will be shown to be the sense of being of that very entity whom we call Dasein. This account must prove itself in recapitulating the structures of Dasein that were presented preliminarily and interpreting them as modes of temporality' (Heidegger, 1996, p. 17).

Heidegger (1996) further elaborates on this relationship between temporality and Dasein by stating:

'By keeping an eye on this connection [between Dasein and temporality] it should be shown that the time is that on the basis of which Dasein understands and interprets something like being. Time must be brought to light and genuinely conceived as the horizon of all understanding of being and every interpretation of being. In order to make this transparent [einsichtig], we require an originary explication of time as the horizon of the understanding of being in terms of temporality as the being of Dasein who understands being' (p. 17).

To Heidegger, we are time. The concept of temporality refers to lived time from a subjective perspective and lived time is our temporal way of being in the world

(van Manen, 1997). For Heidegger the concept of time refers to temporality, where it is beyond the ordinary conceived 'clock time' and rather a basic structure of Dasein's being (Blattner, 2005). He describes the notion of temporality to consist of three dimensions – what he calls 'ecstases' - of past, future and present forming a unity (Heidegger, 1996). The concept portrays the notion that when I project towards the future (the ahead-of-itself), what comes out of the future is my past, what Heidegger refers to as 'having-been-ness' (Gewesenheit), which releases itself in the present moment (staying-with) of action (Heidegger, 1996; Scott, 2006). Heidegger believes that the human is not confined to the present, rather is always projecting towards the future (Scott, 2006). He also believes that a person is not condemned to the past but can make decisions to take over the fact of who they are in a free action, which he refers to as 'resoluteness' (Scott, 2006).

Scott (2006) highlights the constant friction that Heidegger's philosophy of temporality has with modernism, where temporality could be viewed as 'clock time'. Heidegger describes 'clock time' as a deficient form of temporality. He indicates that looking at the clock and orienting oneself towards time diminishes time to the 'now', our always awaiting something in the present (Scott, 2006). Heidegger rejects the notion of clock-time as he refuses to reduce Dasein to 'now-time' – the idea of time as a uniform, linear and infinite series of 'now-points' (Blattner, 2005). He therefore establishes a phenomenological shift of orientation towards the concept of time by approaching it in the 'taking care' of the human Dasein:

'Whereby, time is publicised through the practical concerns prevailing for human lives...Dasein reads time off the face of a clock...the being of the clock is determined by the 'how' of Dasein's existing...while, time is that only in 'how' it shows itself...consequently, the making public of time call for orienting oneself 'towards it, so that it must somehow be available to everyone'' (Scott, 2006, p. 193).

To continue to expand on Heidegger's philosophical perspectives, the following section will describe the concept of authenticity, which is closely related to concept of Dasein.

4.4.2 Authenticity

As described above, there is a close connection between Dasein and temporality. Similarly, a link also exists among Dasein and authenticity. Heidegger proposes that we can exist in the world authentically, in an inauthentic way, or in an undifferentiated way (Heidegger, 1996). 'Authenticity' is a translation of the German term 'Eigentlichkeit' which more precisely is translated to the term 'ownedness', in the sense of possessing what is truly one's own, what truly belongs to one (Carman, 2005). For Heidegger, authenticity consists of a shift in attention and engagement, a 'reclaiming of oneself' from the typical everyday ways of being (Heidegger, 1996). This sense of authenticity *'merely marks a distinction between one's immediate relation to oneself and one's mediate relations to others, or to oneself as another'* (Carmen, 2005, p. 285). Authenticity is about our approach in the world in our day-to-day activities and the challenge of bringing ourselves back from lostness in *'the They'* (Sherman, 2005). Heidegger believes that it is an inevitable tendency for Dasein to fall into an everyday (inauthentic) mode of existence, an immersion into the common world of experience that is ready at-hand (the being of tools, and things available to us to be used), which is what he refers to as *'the They' (das Mann)* (Carman, 2005; Sherman, 2005). Essentially, 'the They' is everyone and no one in particular, where in our day-to-day existence we have lost our true selves – our authentic selves (Heidegger, 1996). While Heidegger refers to this mode as *inauthentic*, this was not intended to be critical but rather as a description of an existential fact (Sherman, 2005). The inauthentic person is disengaged and lacks the internal consistency between thinking and acting (Conroy, 2003). This undifferentiated way in inauthenticity is seen in those who do things by habit, by rote, or under orders; *'those who 'do' but do not 'think' but acquire a way of (non)thinking and (non)acting that does not set them out as different from others: the anonymous self'* (Conroy, 2003, p. 8).

From Heidegger's perspective, authentic existence can only be realised when individuals arrive at the awareness of who they are and understand the fact that every human being is a unique entity (Heidegger, 1996). Once people realise that they have their own individualised destiny to fulfil, then their concern with the world will no longer be the concern to do as the masses do, but can become an 'authentic' concern to fulfil their real potentiality in the world (Carman, 2005).

4.5 Use of Language

Heidegger and Gadamer both identify language as integral to hermeneutic understanding (Gadamer, 2004; Heidegger, 1996). Hermeneutic experience is believed to occur in and through language, where it is language that discloses the world in which we live and how we perceive it. Annells (1996) viewed hermeneutics as an interpretive process that seeks to bring understanding and disclosure of phenomenon through language. According to Heidegger, to express meaning through language is not just the act of assigning a value-laden term to an object - it is something deeper than the logical system of language. He believed it is based on the cultural, historical basis of how language is used and expressed to achieve understanding (Palmer, 1988). Gadamer also perceived that understanding is always linguistically mediated (Gadamer, 2004).

Both Heidegger and Gadamer view language and understanding to be inseparable structural aspects of human 'being-in-the-world' (Lavery, 2003). Gadamer states *'language is the universal medium in which understanding occurs...understanding occurs in interpreting'* (Gadamer, 2004, p. 389). Gadamer deemed the linguistic nature of understanding as critical, given his belief that language was not merely some instrument by means of which we are able to engage in the world, but as the very medium for such engagement. He believed we are 'in' the world through being 'in' language (Gadamer, 2004).

In summary, I have selected a hermeneutic phenomenological methodology for this study, as I believe it best suits the aim to describe, understand and interpret mental health nurses' experiences of the phenomenon of 'last resort' in restraint use. Hermeneutic phenomenology approach was selected through its situated,

exploratory and value based ontology. Heidegger and Gadamer's philosophical perspectives have influenced and guided this study. I have described the philosophical perspectives of Dasein, temporality, authenticity and the use of language to provide context of some of the key pillars that will guide this research. Further consideration of these concepts are made in the interpretation of the findings (refer to chapter six).

4.6 Conclusion

This chapter has provided in-depth insights and justification for the ontological, epistemological and theoretical perspective adopted for the research. Through consideration of the specific aim of the research study and through deliberation of a number of approaches, namely ethnography, case study and grounded theory, a hermeneutic phenomenology was considered the most appropriate approach. Aspects of key philosophers that have influenced the hermeneutic phenomenological approach of the research have been highlighted and various underpinnings of this approach that have been influential to the research have been described.

CHAPTER 5: METHODOLOGY AND METHODS

A Hermeneutic Phenomenological Approach

5.0 Introduction

In this chapter I describe the framework and research methodology directing the design of the study. The methodological decisions are contextualised by the hermeneutic phenomenological philosophies of Martin Heidegger and Hans-Georg Gadamer discussed in the previous chapter. This chapter is presented in six sections. First, I describe the various terms existing in the literature for the hermeneutic phenomenological approach and identify why this term was adopted for this study. This is followed by a description of the strategies used to engage the study participants. The next section provides details of ethical considerations, describing the approaches used to ensure ethical principles guided and were adhered to in the design and implementation of the study. Details regarding how understanding of the lived experiences was gained, followed by a discussion on the data analysis approach adopted is then provided. Lastly, strategies to achieve rigour in this study are outlined.

5.1 Phenomenological Approach

Hermeneutic phenomenology was adopted to guide the theoretical and methodological approach for this study. In reviewing the literature, there are various terms used interchangeably to reflect hermeneutic phenomenology. These terms include Heideggerian phenomenology (Benner, 1985, 2001; Leonard, 1989), hermeneutic(al) phenomenology (Annells, 1996; Fredriksson, 1998; Linseth & Norberg, 2004; van der Zalm & Bergum, 2000; Walters, 1995), philosophical hermeneutics (Geanellos, 1998a, 1998b; Koch, 1995, 1996), hermeneutic interpretive phenomenology (Crist & Tanner, 2003), and interpretive phenomenology (Benner, 2001; Lopez & Willis, 2004). For the purposes of this study the term hermeneutic phenomenology has been adopted to align with the works of Heidegger and Gadamer. I also chose this term to align with the data analysis approach of van Manen (1997) used for this study. van Manen (1997) believes *'hermeneutic phenomenological human science is interested in the human*

world as we find it in all its variegated aspects' (p.573). The rationale for selecting van Manen's approach to data analysis is further discussed in section 5.4.4.

5.2 Engaging the Participants

The following section describes how the participants were recruited and the actual methods of engagement employed in the research.

5.2.1 Participants and Setting

5.2.1.1 Sampling Method

A purposive sampling method was adopted to identify participants to take part in the research. This is a non-probability sampling method where recruitment is based on identifying participants who meet certain criteria, such as knowledge of a particular phenomenon (Palinkas et al., 2015). This sampling aligns well with hermeneutic phenomenological approach, which acquires new understanding about lived experience of a particular phenomenon. In the context of this study this relates to mental health nurses who had personal lived experiences of restraint use in an inpatient mental health setting.

5.2.1.2 Sample

To reduce biases, which may arise as a result of focusing recruitment of subjects from one setting (i.e. culture) and my interest in the Canadian perspective related to the use of restraint, I chose to recruit mental health nurses from across Canada. The goal was to recruit a purposive sample of 10-15 mental health nurses through the Canadian Federation of Mental Health Nurses (CFMHN) association (refer to section 6.2 for further details related to sample). The sample size for this study was guided by two principles, one of time and the other of data saturation. Smythe (2011) maintains that the researcher should base the number of participants on the time available to pursue the study; thereby ensuring there is time to value each story and time for the researcher to work intensively with each participant's lived experience. Additionally, the sample size was also guided by data saturation, while recognising that current literature provides very limited guidelines related to qualitative research sample size (Guest et al., 2006).

5.2.1.3 Recruitment Process

As referred to above, all participants were recruited through CFMHN, which is a national voice for mental health nursing in Canada. It is an associate group of the Canadian Nurses' Association (CNA) and provides expertise in matters relating to mental health nursing. CFMHN's membership is currently over 1000 nurses who work in a variety of settings that provide mental health nursing intervention to individuals, families, and communities.

The timeline for recruitment of participants and completion of in-depth interviews was from 1st January, 2015 to 1st June, 2015. An email that included a detailed information sheet and consent sheet (Appendix B) was issued to all mental health nurses who were members of CFMHN. The email distribution took place monthly from January 2015 to June 2015. The administrator of CFMHN distributed the email on a monthly basis. Additionally, a poster was posted on the main CFMHN website as another recruitment strategy for voluntary participation. The instructions within the information and consent sheet indicated that any interested participant should contact me as a first step. Following contact, a pre telephone interview meeting of approximately 10-15 minutes was held to provide further details about the study. During this meeting I reviewed the information and consent sheet for the study; the approximate length of time for the interview (i.e. one hour); the purpose of the interview (to explore their experience of 'last resort' in the use of restraint); the process of the interview being audio-recorded; that de-identified data would be published in a dissertation and other publications, presentations, etc.; and their ability to withdraw their data from the study up until the final analysis was undertaken. Additionally I also reviewed the risks of participation, including privacy risks related to confidentiality, and potential psychological risks such as anxiety, stress and re-traumatisation when recalling particular of experiences of restraint. The participant was also advised that if there was any disclosure of professional misconduct, incapacity and incompetence that presented a cause for concern that I would have a professional duty to disclose this to the appropriate Regulatory College. Lastly, the benefits of the study were also outlined in terms of the potential for further understanding of their experience

about 'last resort' in the use of restraint and to inform future service delivery and practice.

In order to allow a cooling off period, participants were advised to contact me after 48 hours if they were still interested in participating, and at which point a time and date was set up for the in-depth interview. Overall, one interested individual selected to not participate in the study post this cooling off period.

5.2.2 Ethical Considerations

Ethical approval for the research was received from the University of Central Lancashire (UCLan) (Appendix C) on 5th November, 2014 (STEMH 267) and Ontario Shores Centre for Mental Health Sciences (hospital) (Appendix D) located in Ontario, Canada on 17th October, 2014 (#14-009-D). Due to the differing locations of UCLan (host university where my Ph.D. is being completed) and where research was being conducted, in consultation with my supervisors, it was decided to seek approval both in UK and Canada to ensure the research met all ethical requirements in both countries.

This research and my practices are informed by the *Tri-Council Statement: Ethical Conduct for Research Involving Humans (TCPS)* (2010), jointly developed by the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. The TCPS promotes the ethical conduct of research involving humans. It is critical for research studies to ensure adherence to ethical principles and guidelines, as historically there have been unfortunate examples including research participants needlessly, and at times, being harmed (sometimes even dying) as a result of research (Canadian Institutes of Health Research et al., 2010). In order to prevent such occurrences, ethical principles and guidelines play an important role in advancing the pursuit of knowledge while protecting and respecting research participants (Canadian Institutes of Health Research et al., 2010). I will first highlight the TCPS core principles, which have been adopted for this study. I then describe the four key elements that universally underpin ethical research and provide examples of how I have adhered to these.

The guidelines in the TCPS are based on the three core principles: respect for persons, concerns for welfare, and justice (Canadian Institutes of Health Research et al., 2010). Respect for persons acknowledges the intrinsic value of human beings and the respect and consideration that they are due. This involves dual moral obligations to respect autonomy and to protect those with developing, impaired or diminished autonomy (Canadian Institutes of Health Research et al., 2010). Concerns for welfare includes researchers and research ethic boards to aim to protect the welfare of research participants, and in some circumstances, to promote that welfare in light of any foreseeable risks related with the research. Welfare of a person refers to the quality of that person's experience of life in all its aspects. Welfare consists of a number of factors that may be impacted, such as a person's physical, mental and spiritual health, as well as, their physical, economic and social circumstances (Canadian Institutes of Health Research et al., 2010). TCPS (2010) describes the principle of justice as the obligation to treat people fairly and equitably. Fairness involves treating all people with equal respect and concern. TCPS (2010) defines equity as requiring *'distributing the benefits and burden of research participation in such a way that no segment of the population is unduly burdened by the harms of the research or denied the benefits of the knowledge generated from it'* (Canadian Institutes of Health Research et al., 2010, p. 10).

Aside from the above guideline and its core principles, there are various guidelines from organisations highlighting ethical considerations for research, such as the World Health Organisation (WHO) and Council for International Organisations of Medical Sciences (CIOMS). Four key elements underpinning ethical research have been identified, which include: beneficence, non-maleficence, justice, and respect for autonomy (Manning, 2004). Some of these overlap with the TCPS guidelines, however, I will now describe them briefly and describe how these have been achieved in this study.

Beneficence emphasises the notion of 'do good and avoid evil' (Manning, 2004). The second principle of non-maleficence requires research to refrain from doing harm. Ethical research is viewed as a balance among beneficence and non-

maleficence - if these principles were literally applied it would make any action impossible, given that even the best intentions may result in harmful consequences. Therefore, the aim is to attain the best possible balance of benefits over harms related to a particular circumstance (Manning, 2004). The third principle is 'justice' and as described above it concerns the assurance that the benefits and costs of the research are fairly distributed among those affected by the study and or the findings. Lastly, the principle of 'respect for autonomy' emphasises the notion of informed consent, acknowledging the capacity of participants to make meaningful choices.

A participant information and consent sheet (Appendix E) was developed outlining the purpose and nature of the study. Participant's respect for autonomy was achieved through the information and consent sheet where it addressed the ethical issues of informed consent, as well as the participant's right to withdraw from the study without any negative repercussions. Participants were asked to sign two copies of the information and consent sheet (one for the study and one to keep for their records) prior to the initiation of the interview. Some strategies to achieve non-maleficence included separating the consent form from the transcripts and audio recordings in order to preserve confidentiality and to safeguard the data. Paper based documents (i.e. consent forms) were also stored in locked cabinets in my office at Ontario Shores Centre for Mental Health Sciences, to ensure confidentiality. Each audio recording was stored on a password protected audio device, where I was the only person with the password. A participant code was assigned to link the documents. Additionally, all patient and staff names mentioned in the interviews were anonymised on the transcripts and all findings used pseudonyms to anonymise participants' identity.

Considerations in relation to 'justice' were addressed through creating a balance among 'beneficence' and 'non-maleficence'. One consideration was to provide appropriate referrals and or contact details for participants in the event where they experienced distress. The availability of these resources was indicated on the information sheet, as well as, through my conversation with the participant in collecting informed consent. Another deliberation was the duty to disclose concerns related to professional misconduct, incapacity and incompetence to the

appropriate Regulatory College. As described in the recruitment process section, this was discussed with each participant prior to initiating the interviews and obtaining informed consent. Attempts to minimise burden on the participants were made through multiple methods through organising interviews at times where it was most convenient for the participants and ensuring both written and verbal detailed information were provided to them about the study. In addition, multiple opportunities were provided to ask questions and participants were given time to consider their participation after receiving the information.

5.3 Gaining Understanding

As described in the previous chapter, according to Heidegger, understanding arises out of being-in-the-world. Furthermore, both Heidegger and Gadamer perceived that the world and our existence within creates a shared understanding between people, and the medium which makes this possible, is language (refer to section 4.5 for details) (McManus Holroyd, 2007). Through language, participants shared their lived experience to help me gain a better understanding of the notion of 'last resort' in the use of restraint. The following section discusses the approach and processes involved towards gaining participant's understanding in this study.

5.3.1 The interview

Interviews are commonly used as a data collection tool in qualitative research (Ryan et al., 2009). They are typically used as a research strategy to collect information about participants' experiences, views and beliefs concerning a specific research question or phenomenon (Lambert & Loiselle, 2007). Semi-structured interviews were conducted for this study. This type of interview offers a more flexible approach to the interview process and allows for unanticipated responses and issues to emerge through the use of open-ended questioning, which will be elaborated on further in this section (Ryan et al., 2009; Tod, 2006).

As described in the recruitment process an overview of the aim of the research and all ethical considerations were reviewed with each participant. This occurred during the pre-telephone meetings and at the beginning of each interview. Each

nurse was openly invited to ask questions during both occasions. The interview occurred either in-person face-to-face or via videoconference face-to-face dependent on the geographical location and participant's preference. Once all queries were addressed, the participants signed the consent form either in person or videoconference. For participants who completed their interview via videoconference, they signed two copies of the consent that was emailed to them prior to the interview, one of which was postal mailed back to my office location at Ontario Shores. Basic demographic information was collected at the beginning of each interview. These included gender, the participant's current professional role, and years of experience and level of education.

Understanding was gained through in-depth interviews. Sorrell and Redmond (1995) describe the purpose of the hermeneutic phenomenological interview to focus on understanding shared meanings through the vivid description of the lived experience of each participant. Prior to the start of each formal interview I prompted an informal dialogue with each participant, which included an exchange about general topics such as location, weather and time of day. During this time I self-disclosed my professional and personal background, sharing with the participants that I was a nurse and my current job location and explained my PhD study focus. The purpose of this mutual exchange was to increase comfort between both parties and to start the interview from a more conversation based position rather than a professional encounter. Developing open and trusting relationships with interviewees is critical (Sorrell & Redmond, 1995) and time should be planned during the interview to establish rapport, as interviews are often accompanied by strong emotions (Sorrell & Redmond, 1995).

Smythe et al. (2008) describe the 'phenomenological conversation' as one which shifts away from a textbook definition of a semi-structured interview towards a conversation that is unique itself in each interview. They express every interview/conversation to be an event that simply 'is' (Smythe et al., 2008). Gadamer (2004) depicts this when he stated:

'We say that we 'conduct' a conversation, but the more fundamental a conversation is, the less its conduct lies within the will of either partner. Thus

a fundamental conversation is never one that we want to conduct. Rather, it is generally more correct to say that we fall into conversation, or even that we become involved in it. The way in which one word follows another, with the conversation taking its own turning and reaching its own conclusion, may well be conducted in some way, but the people conversing are far less the leaders of it than the led. No one knows what will 'come out' in a conversation. Understanding or its failure is like a process that happens to us. Thus we can say that something was a good conversation or that it was a poor one. All this shows that conversation has a spirit of its own, and that language used in it bears its own truth within it, i.e. that it reveals something which henceforth exists' (p. 345).

In my attempts to adopt this approach, in each interview/conversation I was open to listening to the unique experiences of each nurse and essentially open to the 'play of the conversation' (Gadamer, 2004). At the start of the interview each nurse was asked a broad open-ended question. *'Would you please describe in as much detail as possible a situation where you experienced applying restraint to a patient as a 'last resort'?'* This question aimed to encourage the participants to recount their lived experience. However, post the first three interviews, I had noticed that some nurses were having difficulty describing personal experiences in detail and rather were sharing general group perspectives. Even with various strategies to probe for further descriptions, elaborations or clarification, this did not seem successful. Consequently, in consultation with my supervisory team and reflecting on the responses from the first three interviews, I revised the first question to: *'Can you recall a situation where you had to place someone in restraint and tell me everything you remember about that situation?'* A second question was also asked from each participant to create a greater focus on 'last resort' in the use of restraint. Nurses were asked *'How do you determine when restraint is used as a 'last resort'?'*

Linseth and Norberg (2004) identify the potential risk of misunderstanding, which could occur during interviews, given the interviewees can only understand and narrate their lived experience in relation to their pre-understanding and the interviewer can only understand the lived experience in relation to their own pre-suppositions. It therefore becomes important for interviewers to check their

understanding of the lived experience with the interviewees during the interview, which can be done through probing questions such as 'what do you mean' (Linseth & Norberg, 2004). Throughout the interviews I used prompts to advance the exploration of the lived experience. The prompts I used included: How did that make you feel? Can you tell me more about 'X'? Can you give me a further example about what you mean when you stated 'X'? What happened next?

Gaining understanding was a highly iterative process where the information obtained during the initial interviews informed and re-framed subsequent interviews, as well as subsequent re-analysis of the findings. Although I made attempts to revise the interview questions with the intent to capture greater individual perspectives from the nurses about their lived experience, nurses continued to frequently speak in a collective manner (through the pronoun of 'we') and rarely expressed their individualised experience (through the pronoun of 'I') (refer to section 6.3.3.3 for details). Given these findings, two follow up interviews were conducted with two participants to further explore this phenomenon. The participants selected were those whose lived experiences strongly demonstrated this collective view. The two follow up interviews were much more of a hermeneutic focus, where I explained the collective, 'we' based responses provided from the participants and my interest in further exploring and understanding this. Questions that were explored with these participants included: when you talk about restraint there was a lot of reference to 'we' versus 'I', can you tell me a little bit more about that? Why do you think this happens? What influences this? Why do you think it's important to have a shared experience of restraint or do you think there is an individual perspective? Responses from both participants further confirmed the collective response to be the lived experience of nurses when using restraint. See section 7.1.2 for in-depth analysis of these insights.

5.3.2 Transcribing

I transcribed all interviews as close to the completion of the interview as possible. Transcribed interviews were then sent to my supervisory team for review and any feedback throughout the process. Any feedback received was incorporated in the following interviews conducted. For example, as discussed above, changes were

made to the interview questions post the first three interviews given the collective responses received from the nurses.

5.4 Analysis of the Experiences

I adopted Max van Manen's (van Manen, 1997) approach to hermeneutic phenomenological data analysis to guide my analysis of the experiences and later in this chapter, I will provide the rationale for this decision. The literature depicts a number of hermeneutic phenomenological frameworks, which have been constructed to support analysis of the text (Benner, 2001; Conroy, 2003; Fleming et al., 2003; Linseth & Norberg, 2004). Heidegger and Gadamer have argued against the use of method to understand lived experiences of phenomenon (Ironside, 2005) and rather believe the process of understanding and interpretation is not rule-bound but one which is viewed as dialogical, practical and situated activity (Gadamer, 2004). van Manen (1997) highlights Gadamer (1975) and Rorty's (1979) perspectives that there is no method in phenomenology and hermeneutics. He further elaborates on this by stating:

'While it is true that the method of phenomenology is that there is no method, yet there is tradition, a body of knowledge and insights, a history of lives of thinkers and authors, which taken as an example, constitutes both a source and a methodological ground for present human science research practices' (van Manen, 1997, p. 791).

In this section of the chapter, I will highlight Max van Manen's contributions to hermeneutic phenomenology and some of his philosophical offerings, as well as, describe details of the data analysis approach.

5.4.1 Max van Manen (1942 - present)

Max van Manen is a Professor Emeritus at the University of Alberta, Canada and has been exploring and evolving phenomenology and pedagogy through his on-going research involvements. His interest in the human sciences and

phenomenology through his studies into pedagogy began in the Netherlands prior to immigrating to Canada and becoming a citizen in 1973.

According to van Manen (1997), phenomenology differs from almost every other science as it tries to gain insightful descriptions of our pre-reflective experience of the world, without taxonomising, classifying, or abstracting it. van Manen (1997) views phenomenology as the opportunity to explore plausible insights that *'bring us in more direct contact with the world'* (p. 397), where we can explicate meanings as we live them in our everyday existence, our lifeworld. van Manen (1997) states:

'To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal...the phenomenological reduction teaches us that complete reduction is impossible, that full or final descriptions are unattainable' (p.18).

He identifies the strengths of hermeneutic phenomenology to be an interpretive approach that intends to understand lived experience by uncovering our assumptions underpinning what we know, or our way of knowing (van Manen, 1997). van Manen emphasises that the phenomenological text is interpretive in that it effectively *mediates*. Once these intentions and meanings are apparent, they can be viewed alongside with what is already known and the interpretation that is derived from the data (van Manen, 1997).

van Manen drew upon a number of phenomenologists in his work, such as, Heidegger, Merleau-Ponty and Gadamer. The work of these individuals has influenced van Manen's development of his hermeneutic phenomenological research method. He proposed a model of human science inquiry which he first described in the book *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* (1997). van Manen (1997) identified a *'dynamic interplay among six research activities'* (p. 30) as a means to convey the elemental methodical structure of how hermeneutic phenomenology can be undertaken. These stages are:

- 1) *Turning to a phenomenon which seriously interests us and commits us to the world;*
 - 2) *Investigating experience as we live it rather than as we conceptualise it;*
 - 3) *Reflecting on the essential themes which characterise the phenomenon;*
 - 4) *Describing the phenomenon through the art of writing and rewriting;*
 - 5) *Maintaining a strong and oriented pedagogical relation to the phenomenon;*
and
 - 6) *Balancing the research context by considering parts and whole.*
- (van Manen, 1997, pp. 31-34)

These six activities are not necessarily sequential and van Manen insists that a systematic or procedural approach cannot be followed. He holds the belief that *'critical moments of inquiry are ultimately elusive to systematic explication'* (van Manen, 1997, p. 34).

5.4.2 Description of the dynamic interplay of activities

In this section I will briefly explain how this framework has been considered throughout the study and the activities that I have engaged in.

5.4.2.1 Turning to a phenomenon which seriously interests us and commits us to the world

Van Manen (1997) believes that every project of a hermeneutic phenomenological inquiry is driven by a commitment of turning to an abiding concern. From his perspective hermeneutic phenomenological research is a *'being-given-over'* to some quest or deep questioning of something. In chapter one I have provided an extensive discussion in terms of my background, experiences and stated interest in this topic, which led me towards the focus of this study. I also considered the available literature related to the topic currently available in chapter three.

5.4.2.2 Investigating experience as we live it rather than as we conceptualise it

This component of the framework aims to establish a *'renewed contact with the original experience'* (van Manen, 1997, p. 31). Van Manen (1997) describes

Merleau-Ponty's view of turning to the phenomena of lived experience as relearning to view the world by '*reawakening*' the basic experience of the world. The experience one comes with is considered wisdom as a result of the practice of living, and in doing phenomenological research, this '*practical wisdom is sought in understanding of the nature of lived experience itself*' (van Manen, 1997, p. 32). This element essentially refers to attempting to understand the nature of the lived experience itself and refers to the data collection strategy. As described above, I chose to investigate the phenomena ('last resort') by conducting in-depth semi-structured interviews with mental health nurses. The fact that I transcribed all the interviews myself also provided an in-depth immersion into the phenomenon. I also participated in a pre-understanding interview to capture my lived experiences and perspectives (refer to section 6.1 for details).

5.4.2.3 Reflecting on the essential themes which characterise the phenomenon

Van Manen (1997) describes this element as the process of reflecting and '*bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitudes of everyday life*' (p. 32). Below, in section 5.4.3 details of the data analysis process that I engaged in is described.

5.4.2.4 Describing the phenomenon through the art of writing and rewriting

van Manen (1997) believes that in order to do justice to the 'fullness' and 'ambiguity' of lifeworld, writing will need to take form of a complex process of writing and rewriting which includes re-thinking, re-reflecting, and re-cognising. The aim is to create depth and this '*depthful*' writing cannot be accomplished in one session, rather the process is '*more reminiscent of the artistic activity of creating an art object*' (p. 131) and it needs to be approached again and again, going back and forth between the parts and the whole (van Manen, 1997). This process is the hermeneutic circle, in which both the individual parts and the whole text are understood with reference to each other (Heidegger, 1996). Heidegger used the hermeneutic circle when exploring '*The Origin of the Work of Art*' (1935-1936). He proposes that art works and artists can only be understood with reference to each other, and both of them cannot be understood away from 'art' which in itself cannot be understood apart from the former two (Heidegger, 1971). Gadamer

further developed the concept and viewed it as an iterative process that enabled the interpreter to reach a new understanding of reality based on the exploration of the detail of existence found in text (Gadamer, 2004).

I initially identified preliminary themes illuminating meaning to the notion of 'last resort'. These themes were then further analysed and explored through writing and rewriting. This process enabled me, as described by van Manen, to continue to explore in-depth the characteristics of the phenomenon and bringing them into nearness. This interpretive journey spanned over time with multiple edits, revisions, and discussions with my supervisory team.

5.4.2.5 Maintaining a strong and oriented pedagogical relation to the phenomenon

van Manen (1997) notes that to be oriented to an object '*means that we are animated by the object in a full and human sense*' (p. 33). Furthermore, in order to attain a strong orientation to our fundamental question, it means that we will not settle for '*superficialities*' and '*falsities*'. van Manen discusses that for researchers engaging in phenomenological studies, it is possible to have many temptations to get side-tracked from their fundamental notion of interest unless they maintain a strong orientation.

During many phases of the study, I used strategies to maintain a strong orientation to my research question and phenomenon. The semi-structured interview schedule (Appendix F) was developed to specifically focus on the notion of 'last resort'. To seek feedback about the interviews I was conducting, I shared the interview transcripts with my supervisory team. Furthermore, my supervisory team assisted in ensuring I was maintaining focus. Additional feedback was also sought from the supervisory team during the data analysis phase where I held many discussions and shared my reflections related to the interpretations generated.

5.4.2.6 Balancing the research context by considering parts and whole

As part of this last component of the framework, van Manen (1997) explains the importance of constantly measuring the overall design of the study against the

'significance that the parts much play in the total textual structure' (p. 37). He notes that it is very easy for the researcher to get too buried in writing that one finds themselves lost, not knowing where to go or what to do next. He points out that it is essential that at several points the researcher steps back and looks at the 'whole' and how each part (the individual meaning units) contributes towards the whole (van Manen, 1997). This element was present in my data analysis approach as described in section 5.4.3, and, my reflexivity strategies described in this chapter (section 5.5.1.1). This enabled me to step back and review how the parts combined and merged to form the 'whole' of the phenomenon.

5.4.3 Data analysis

I used MaxQDA software to support data analysis (www.maxqda.com). This software was chosen, as it is a technical solution that provides a simple and flexible approach in managing large sets of textual data. This software was used to organise the textual data and support the coding process. Additionally, it also provided me with greater visual opportunities to review the texts during the ongoing manual hermeneutic phenomenological analysis.

Some argue that there are methodological risks that accompany the use of computers in qualitative research (Ritchie & Lewis, 2003; Sinkovics & Alfoldi, 2012). These include the potential short cuts within the analysis and the possibility of their use to make qualitative research rigid and mechanistic (Ritchie & Lewis, 2003; Sinkovics & Alfoldi, 2012). In light of these arguments, it is essential to note that MaxQDA cannot perform any actual analysis of the data. Those in agreement of using such software as MaxQDA, view it as a powerful tool for data management (Salmona & Kaczynski, 2016), where the researcher's focus can be placed more on the analysis of the data. Thus, a significant advantage of utilising such software is the efficiency created in working with large volumes of data, leaving more time for the researcher to explore interpretive decisions (Sinkovics & Alfoldi, 2012).

5.4.4 Selection of data analysis approach

Philosophers such as Heidegger and Gadamer do not posit a methodological framework for hermeneutic phenomenology as the basis of explanation and interpretation (Ironside, 2005). More specifically, Heidegger and Gadamer particularly argue against the use of method to understand lived experiences of phenomenon and believe that the process of understanding and interpretation is seen as dialogical, practical and situated activity (Gadamer, 2004), rather than a rule-bound operation. van Manen (1997) distinguishes hermeneutic phenomenology as *'interpretation of experience via some "text" or via some symbolic form'* (p. 704). Thematic understanding of the text is not viewed as a rule-bound process, rather an open act of uncovering or 'seeing' meaning (van Manen, 1990). Moreover, this process lays focus on recovering structures of meaning represented in the human experiences as characterised in the text. (van Manen, 1990). The preliminary analysis is reflective of exploring the text at the level of the *'whole story', 'separate paragraph', 'sentence, phrase, expression, or single word'* (van Manen, 2014, p. 319) to explore themes and insights.

Thematic analysis can often be understood as an unambiguous and mechanical application, whereby the researcher conducts some frequency count or coding of selected terms in transcripts or texts and at times uses computer software to complete this (van Manen, 2014). van Manen (1997) describes thematic analysis in hermeneutic phenomenology to differ from this understanding as this approach consists of *'making something of a text or of a lived experience'* (p.79) through interpreting its meaning which is more reflective of a process of *'insightful invention, discovery or disclosure'* (p.79) – a free act of 'seeing' meaning. Ultimately, the theme itself is irrelevant as its purpose is to reveal meaning and the structures of experience (van Manen, 1997).

I chose to use van Manen's thematic analysis approach to inform the analysis of the lived experiences from this study. This approach was believed to best fit the study and helped guide my analysis to grasp the essential meaning of the lived experiences of 'last resort'. van Manen provides a number ways data analysis can be accomplished. Given my novice stance in hermeneutic phenomenological

inquiry, the approaches van Manen provides (described below), towards revealing thematic aspects of phenomenon in text, were appealing and helpful. It is also important to emphasise that while he identified specific strategies, these do not limit the researcher and are not prescriptive in nature, therefore, holding true to the essence of phenomenological data analysis.

van Manen (1997) describes three approaches that can be undertaken towards uncovering or isolating thematic aspects of a phenomenon in text. These include: 1) the holistic or sententious approach; 2) the selective or highlighting approach; or 3) the detailed or line-by-line approach. I chose to follow the selective or highlighting approach to be the best fit for the interpretation of the experiences. These approaches were selected as right from the start of reading the transcripts, statements and phrases revealed themselves as themes. This approach requires reading the text several times and asking *'what statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?'* (van Manen, 1997, p. 93). These statements were then highlighted for further analysis. I initially began by reading and listening to the transcripts multiple times. I then reflected on each paragraph and highlighted any themes that surfaced or revealed itself from each experience. Furthermore, I analysed the experiences through exploring sentences, phrases or words and noted any specific themes. Once I felt I had reached a place where I had revealed all the themes surfacing, I reviewed each theme and reflectively attempted to uncover something telling by unearthing meaning within the themes. This was an iterative process, which required multiple consultation sessions with my supervisory team to ensure rigour (refer to the following section for details).

It is noteworthy to highlight criticisms of the data analysis approaches in hermeneutic phenomenology recently published by John Paley (2017). He specifically argues that there is an overall vagueness in phenomenological qualitative research in how data analysis has been undertaken. Paley (2017) believes that phenomenological qualitative research (PQR) is differentiated from other qualitative approaches by the fact that it aims to illustrate meaning attributions. He defines meaning attributions as:

'...something that is not in any sense statistical, and they are not predicated on categories. Instead of reporting on sample frequencies or suggesting a causal hypothesis, the researcher makes a statement about the meaning of the phenomenon being studied' (Paley, 2017, p. 17).

He then criticises various phenomenologists, including van Manen's claim that PQR aims to distil meaning of a phenomenon from text. The criticism is specifically related to van Manen's inability to explain 'meaning' and how it can be identified (Paley, 2017). Paley critiques Giorgi (a PQR methodologist, who uses a Husserlian descriptive phenomenology approach) and van Manen, stating:

'They [Giorgi and van Manen] say only that meaning must be elucidated from the text and nothing but the text. Their examples suggest that, in practice, meaning is whatever Giorgi and van Manen say it is. There are no well-specified and non-arbitrary procedures for achieving the 'transformations in meaning' and 'thematic formulations' that a phenomenological qualitative research [PQR] analysis is said to involve; and at no point does either author provide a theory of meaning, or criteria by which meaning attribution can be tested, checked, or evaluated' (Paley, 2017, p. 87).

Overall, in Paley's recent publication *Phenomenology as a Qualitative Research: A Critical Analysis of Meaning Attribution* (Paley, 2017), he scrutinises various examples of meaning attribution in the work of PQR methodologists in order to identify a clearer answer to the question of how meaning attributions is undertaken. van Manen (2017) provided a response to these criticisms and argues that meaning attribution is an inappropriate tool to be used with the phenomenological method. He further expands on this through describing phenomenology, stating:

'Husserl has pointed out, that the phenomenological gesture is to lift up and bring into focus, with language, any such raw moment of lived experience and orient to the living meanings that are embedded in the experience. Any and every possible human experience (even, happening, incident, occurrence, object, relation, situation, thought, feeling and so on) may become a topic for

phenomenological inquiry. Indeed, what makes phenomenology so fascinating is that any ordinary lived through experience tends to become quite extraordinary when we lift it up from our daily existence and hold it with our phenomenological gaze. Wondering about the meaning of a certain moment of our lived life may turn into the basic phenomenological question: “what is this experience like?” (van Manen, 2017, p. 6).

van Manen also points out that review of attribution theories indicates that ‘*the lived world is always ambiguous, open to more than one interpretation*’ (Langdridge & Butt, 2004, p. 357). Thus, Paley’s aim to remove the ambiguity contradicts attribution theories, as they are not intended to remove ambiguity. Moreover, van Manen responds to Paley’s criticism of having a lack of clarity in how meaning is distilled from a text, stating that:

‘phenomenology is not the study of how or why people attribute their meanings to texts...the focus of phenomenology is on how phenomena are given to us in consciousness and pre-reflective experience. The problem of phenomenology is not how to get from text to meaning, but how to get from meaning to text’ (van Manen, 2017, p. 2).

Many (Vincent Deary, Ian Deary, Hugh McKenna, Tanya McCance, Roger Watson and Amandah Hoogbruin) in the field of phenomenology disagree with Paley’s critiques (van Manen, 2017). Nonetheless, no matter the varying perspectives, it is important for qualitative research to be recognised as credible and authentic and in order to do so there are specific criteria that need to be addressed (Lincoln & Guba, 1985; Sandelowski & Jones, 1986). The next section describes the strategies undertaken in this study to ensure credibility and rigour.

5.5 Addressing Rigour

A critical aspect of qualitative research is to establish confidence and trust in the findings through rigour (van Manen, 2014). Lincoln and Guba’s (1985) model of trustworthiness of qualitative research proposes four components to establishing this rigour. The components to enhance the rigour or ‘trustworthiness’ of

qualitative research include: 'credibility', 'dependability', 'confirmability' and 'transferability' (Lincoln & Guba, 1985; Thomas & Magilvy, 2011). The activities used to accomplish rigour in this study are described below.

5.5.1 Credibility

Credibility is an evaluation of whether the findings from the study represent a reliable conceptual interpretation of the experiences collected from the participants (Lincoln & Guba, 1985; Rolfe, 2006). A qualitative study is determined credible *'when it presents an accurate description or interpretation of human experience that others having that experience would immediately recognise'* (Lincoln & Guba, 1985). In this study, I have used quotations and anecdotes from the nurse participants in order to be true to their words and their description of their experience lived. Lincoln and Guba (1985) suggest 'peer debriefing' as a strategy to improve credibility. This is supported by van Manen's (1997) perspective that collaborative analyses are believed to be helpful in the generation of deeper insights and understanding. For this study regular consultations were held within the supervision team to discuss all decisions taken and analytical interpretations generated. Reflexivity is another strategy adopted to achieve credibility. This is further elaborated on in the following section.

5.5.1.1 Reflexivity

In order to establish credibility in this study I have incorporated reflexivity. This concerns awareness of how researcher's prejudices and biases may influence the research process. Sandelowski and Barroso (2002) explain that:

'Reflexivity is a hallmark of excellent qualitative research it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquired; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share' (p. 222).

Lincoln and Guba (1985) highlight how it is important for researchers to identify their pre-understandings of the topic being studied. As a researcher, underpinning my work with the philosophies of Heidegger and Gadamer, it was essential to acknowledge my pre-understandings related to restraint use as a 'last resort'. It is believed that this reflecting process provides an opportunity to move beyond these pre-understandings to understand the phenomenon and essentially transcend their horizon (Fleming et al., 2003).

In this study, I have incorporated a number of methods and techniques to attempt to reduce opportunities for my biases to dominate or 'conceal' the participants' voices. I have participated in a 'pre-understandings interview' conducted by a member of my supervisory team at the start of this study to capture my views and opinions on the use of restraint. This also served to identify to my supervisory team my pre-understandings, in order for them to recognise if and when my biases were becoming a barrier to data analysis. Some of my pre-understandings included struggling with why restraints continued to occur at the practice level when there is substantial evidence identifying its adverse effects. I believed that there was a lack of knowledge and skills among the nurses related to the use of alternatives towards restraint prevention. I also believed there was a lack of interest to stop this practice, as the use of restraint was viewed as a strategy to keep nurses safe and its minimisation was perceived as compromising their safety.

A reflexive diary has also been maintained throughout the study to record ongoing thoughts, issues and analytical issues. The interviews and interpretations of such have also been regularly shared and discussed with my supervisory team. An additional strategy has been to present the study findings at various conferences and educational forums throughout the analysis. This has provided an opportunity to receive feedback and comments from nurses and other health professionals, which have either validated the emerging themes and or provided perspectives to further expand on understanding and meaning. Additionally, when I re-examine my written reflections during this study, I do so with the recognition of the part I played in bringing it to fruition, and with this appreciation I recognise how someone else may have decided to approach the topic very differently.

5.5.2 Dependability

Another key component of the model is dependability, which occurs when the researcher can account for the ever-changing context of the research. In other words, another researcher can follow the decision trail used within the study (Fleming et al., 2003; Lincoln & Guba, 1985). The strategies to establish dependability in this study include a reflexive journal, as mentioned earlier. I documented thoughts, feelings and perceptions throughout the study, including after each interview, to examine and consider the emerging themes and issues in a reflexive journal. Additionally, significant changes and decisions related to the study have been documented.

5.5.3 Confirmability

Confirmability is another element within Lincoln and Guba's (1985) model. This refers to the extent to which the findings from the study are the product of the inquiry of the participants' experiences and not the biases of the researcher. This can be achieved through the degree to which the findings can be confirmed or validated by others (Lincoln & Guba, 1985; Thomas & Magilvy, 2011). This study incorporated confirmability through various strategies such as the inclusion of textual data within the findings, thereby allowing the reader to clarify and verify the interpretations produced. Feedback was sought from my supervisors through interpretation meetings to check that the themes were grounded and reflective of the interview narratives. Throughout the completion of the interviews my supervision team reviewed the interview questions and transcripts to identify leading questions or questions that reflected my understanding of the phenomena rather than being open to new understandings. Furthermore, my pre-understanding interview was reviewed throughout the study to bring forth my pre-understandings with the ethos to reduce bias during interpretation of the texts. As part of this study, I have shared my perceptions at the start of my research through my pre-understanding interview (refer to section 6.1), as well as my perceptions post the completion of interviews and analysis of the texts (refer to chapter nine). This enabled confirmability and highlights how throughout my

study attempts were made to gain awareness of my ideas, values and culture and its influence on my research.

5.5.4 Transferability

Transferability is the final component of the model, described by Lincoln and Guba (1985) as *'how one determines the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects/participants'* (p. 290). In this research, the broad approach to recruitment of nurses from across Canada enabled a wide contextual basis for how 'last resort' is experienced. Additionally, the comments about the findings received from nurses at the various oral presentations I have conducted at international conferences and forums have demonstrated applicability. Feedback from audiences in Ontario, Belgium and United Kingdom where the presentations took place indicated their agreement and or verification of the findings that resonated. For example, many audience members agreed with the findings and provided their own similar experiences, such as the collective view and know-how (discussed in chapter six).

5.6 Conclusion

This chapter described the methodological framework for this study, contextualised by the hermeneutic phenomenological approach adopted. Additionally, the study protocol, including an explanation of the recruitment and engagement strategies and ethical considerations has been provided. Furthermore, this chapter outlines the thematic analysis method and the influences of van Manen's approach in the study. Lastly, a framework for addressing the various aspects of rigour has been explained. This chapter provides a foundation towards engaging in hermeneutic inquiry to uncover the findings in the following chapter.

6.0 Introduction

The findings of my study are presented in two parts in order to demonstrate my interpretations of the data. I believe this approach of illustrating my findings provides the opportunity to clearly describe the interpretive journey and outcomes. In this chapter I begin by discussing my personal pre-understandings of restraint use as a 'last resort' in light of my professional role. I then discuss the overall impressions of the findings and provide two case studies from the participants in the study to demonstrate the overall impressions. This is followed by a description of the themes uncovered from the nurses' lived experiences. Its purpose is to begin to uncover the phenomenon of 'last resort' as lived and reported by participants, while chapter seven presents the in-depth interpretations of the themes drawing on the philosophies of Heidegger.

6.1 Pre-understandings

Guided by hermeneutic phenomenology, as well as, Lincoln and Guba's (1985) principles related to building the credibility of a research study, in this section I share my pre-understandings related to the use of restraint as a 'last resort'. Additional details can be found in chapter five, describing the importance of the researcher engaging in a reflective process of sharing their pre-understandings of the phenomenon being studied. While some of my pre-suppositions have changed through undertaking this research, these will be shared later in my reflective chapter (chapter ten). I believe it is important to provide my professional background and experiences, all of which are related to my perspectives and passion for the study. As described in chapter five my views were shared in a 'pre-understanding interview' conducted with one of my supervisors (GT) with a twofold purpose: first to uncover my pre-suppositions, and second to use this knowledge to prevent biases from uncovering new meanings throughout my research. Below I share highlights from the pre-understanding interview to provide an in-depth view of my perspectives.

As a nurse I have worked in a number of settings including an acute care medical and surgical inpatient unit and outpatient clinic. Over the past eight years (prior to the initiation of my PhD study) I have worked in a mental health hospital. For the last five years, I have been employed as Director of Professional Practice where a large part of my role has focussed on restraint minimisation and essentially prevention. I entered this research with a number of pre-understandings generated from my own lived experiences of using restraint with patients, as an educator, teaching violence prevention and intervention courses, and as an observer to incidents in my role as a Director. My in-depth review of the literature related to this topic had also influenced my thinking.

When reflecting on my own experiences where I had to use restraint, I harbour feelings of shame and regret at some level. Through my current knowledge and understandings related to practice and restraint use, I realise that the majority of the incidents where I did use restraint, they were not always necessary and could have been prevented. During the interview, some of the factors influencing my decisions to restrain patients were identified. These included being new to the profession and that in practice, hands on physical restraint was what you did to manage a situation where a patient was aggressive and/or violent. I listened to the advice of many of the more experienced nurses whom I sought mentorship in developing my skills and competencies as a nurse. Additionally, I did not know any other way of managing situations, and recalled some occasions when I did not agree with the use of restraint but felt unable to verbalise my disagreements with the team of nurses I was working with. This was largely due to a lack of confidence and a fear of vocalising my opinions to more experienced staff. Lastly, while I was in a direct care role as a nurse, I did not have any awareness of the negative outcomes related to restraint use for all involved – this was a knowledge gap for me.

Professionally, as I transitioned from a direct care nursing role to a management position, my perspective and experiences changed significantly. When I commenced working at the mental health hospital in 2009 I had the opportunity to place a significant amount of focus on restraint minimisation. By reading the literature on this topic and enhancing my knowledge, I began to view restraint use

from a very different lens - one that questioned its use and promoted the use of alternatives. Over the years of actively participating in and leading initiatives focusing on restraint minimisation and prevention, I developed certain views on why I believe restraint use continues to happen despite the current knowledge of its adverse effects.

Prior to the initiation of this study, one view I held was that restraint use was a result of traditional nursing practices. It happened because that is just what usually happened in particular circumstances. Another belief was the lack of nursing skills related to the management of violence due to limited training – where nurses learned on the job from others rather than using evidence-based practices. I also appreciated that there is often an element of fear and/or past trauma, which can influence the use of restraint by nurses who may stigmatise some mental health patients. For example, it is common to hear nurses describe a patient by their diagnosis, such as ‘the schizophrenic’, and this stigma can carry presuppositions about the patient that may be false but contribute to decisions to use restraint. Additionally, over the years I perceived there to be an expectation by some nurses that if they attended an emergency situation to manage an aggressive patient, that there must be some action taken, such as the use of restraint – there is not always as much value and time given to verbal de-escalation. Further there are environmental factors that can contribute to the use of restraint such as small unit designs and policies, and patients being kept in restraints for a specific period of time.

Nurses have similarly shared with me on a number of occasions, that restraining patients is not the ‘right thing’ to do and how they believed that incidents they were involved in could have been prevented. In further exploring these situations in my role as the Director of Professional Practice, nurses reported that when they have attempted to advocate for not using restraint they felt isolated by the clinical team they were working with, and at times felt bullied.

With regards to the notion of ‘last resort’, I do believe that this can easily become the ‘first resort’, where there may be little incentive to try other interventions prior to the use of restrictive practices. Given that the use of restraint has been a

common traditional practice in mental health settings for many years, continuing to permit its use makes it difficult for nurses to deviate from their traditional practice and employ other alternatives. Under stressful and or acute situations it may be easier to go directly to the use of restraint. Finally, I do believe that restraint use can be prevented in mental health care.

Above, I have shared some of my pre-understandings related to restraint use as a 'last resort', which are based on my own lived experiences. The purpose of this is to identify my personal pre-suppositions and prejudices as I entered into and engaged in the fusion of horizon (defined in section 4.3.2) while hearing, listening and interpreting the stories of the participants. I will now introduce the nurse participants in my study.

6.2 Introduction to the participants

Overall, thirteen phenomenological interviews were completed between 1st January, 2015 to 1st June, 2015 from four provinces (Ontario, British Columbia, Alberta, Manitoba) across Canada. In this section I will share a summary of the participant demographics, and pseudonyms that have been used to ensure anonymity.

From Table 8, demonstrating the participants' demographics, it can be seen that the majority of the participants were female (3 males), which is a close representation of the Canadian nursing workforce. In 2016, it was reported that the nursing workforce in Canada consisted of 90% being female (Porter & Bourgeault, 2017). Most of the participants (11 nurses) had over ten years of mental health nursing experience. Nine of the nurse participants were from the province of Ontario – which is the most populist province in Canada. From an education perspective, most of the nurses either had their Bachelor degree or Masters in nursing, with the exception of three who had completed their diploma.

Table 8: Participant Demographics

| Pseudonym | Years of Experience as MH nurses | Level of Education | Location |
|------------------|-----------------------------------------|---------------------------|------------------|
| Rebecca | 17 | Diploma | Ontario |
| Tom | 10 | Bachelor Degree | British Columbia |
| Sarah | 13 | Diploma | Ontario |
| Jayne | 17 | Bachelor Degree | Ontario |
| John | 15 | Diploma | Ontario |
| Molly | 18 | Bachelor Degree | Alberta |
| Melinda | 1 | Bachelor Degree | Ontario |
| Caitlin | 5 | Bachelor Degree | Ontario |
| Natalie | 39 | Masters | Manitoba |
| Aidan | 18 | Bachelor Degree | Ontario |
| Dana | 41 | Masters | Manitoba |
| Kelly | 30 | Bachelor Degree | Ontario |
| Amanda | 22 | Masters | Ontario |

6.3 Introducing the findings

This section presents the themes identified in this study. However, prior to sharing this, I believe it is important to address the overall impression that the findings may be perceived as restricted. I believe the reason for this restricted

findings are two-fold, first there was a lack of specificity in the nurses' lived experiences of restraint use, and second the commonalities in the accounts shared. Through listening to the experiences of the 13 nurses I constantly heard very similar narratives with respect to the use of restraint as a 'last resort'. Moreover, as I continued to engage with the data analysis process, I persistently recognised a commonality in understanding and experiences. This resulted in recurrent issues emerging as central tenets of what 'last resort' has come to mean in varied contexts. I will demonstrate this through sharing two case studies before introducing the key themes that surfaced.

6.3.1 Case study examples

Tom's experience:

[silence] a specific example, I mean I've done it a fair bit. When I worked on the units I worked primarily in maximum security in the forensic setting. So we were doing restraint fairly regularly, even still as a last resort though. So specific examples, patients that were escalating, getting verbally agitated, um with each other, with staff, and the de-escalation opportunity to kind of self-depress wasn't working and they lashed out on staff. I'm trying to think of a good example.

We had a patient who's got brain injury and because of the brain injury, very impulsive, sudden unexpected violence. So, for a period of time I was involved in restraining him probably about 13 times in a 6-month period. So each time he escalated we would try to talk him down, because it was usually something innocuous that provoked him. Like patient offered him a cigarette and he'd lose it for some reason or someone started talking with the police and he'd get upset. So, you know each time we'd talk to him and the last time it happened he was on the phone and someone else was waiting to use the phone and we asked him to get off and he hung up and then started kind of escalating. So we talked to him to calm down and offer him a prn to help him, time away from everyone like in our separate dining room and he just kept escalating. So it got to the point where because I had been involved in so many restraints, he

blamed me. So he came up to me and got into my personal space and said 'I'm gonna f!#ing get you', luckily there were a couple of other staff around and they had to go hands on and once they had hands on and sort of out of my space I was able to go hands on as well. It was just a matter of physically sort of holding his arms back and walking him over to restraint room.'*

Molly's experience:

'Oh my God, like I can't remember one. Let me think because now I have a whole bunch going through my head, just hold on. [long silence] ok, I can think of one where we had a female patient that was extremely violent and a whole group of us had to go in and we tried to convince the patient to settle down, you give them medication to try to diffuse the situation and we couldn't. So we had to as a group go in and physically grab her and restrain her and we put her in restraints. I can't remember exactly what her diagnosis was but we have a psychiatric ICU area where I work and so typically when patients come in and if their threatening or aggressive or anything like that we'll put them in the ICU area and that's where our restraint beds are. So typically we'll put people back there and I think she just escalated so nothing happened in particular but she was just getting violent – she didn't want to be in the hospital – she didn't want to be in the back area and she was just escalating and I don't think we were able to get medications into her if I remember correctly, and she wouldn't calm down and was threatening and so then we had to put her in restraints.'

As mentioned earlier, I have shared the above two case studies to depict the similarities in the lived experiences of the nurses. From my perspective these recurring commonalities contribute to the themes described in the following sections.

6.3.2 Introducing the themes

In my analysis of the data seven themes related to 'last resort' were uncovered. These include: 'it depends', 'collective view', 'know-how', 'justifying best interest',

'the past and the present', 'point of no return: the roadmap', and 'just in case of any risk'. A description of the themes, and exemplars from the participant narratives are detailed below.

6.3.3 Key codes/terms

A number of symbols have been used in the presentation of quotes in the remainder of this thesis. Table 9 provides an overview of these codes.

Table 9: Symbols used within text narratives

| Symbol | Meaning |
|---------------|------------------------------|
| Int-1 | Interview 1 |
| Int-2 | Interview 2 |
| Par | Paragraph number |
| [...] | Contextualised meaning added |

6.3.3.1 It depends

This theme emerged as a result of nurse participants sharing the perspective that coming to the decision of using restraint as a 'last resort' is multifactorial in nature. In other words, they believed that reaching this point was not based on one factor but many elements unique to the patient and the situation. When the nurses were asked if they could further elaborate on what these factors were, some could not name them, whereas others identified the situation, policies, safety and professional liability as some overarching influential elements. Tom shared this perspective of restraint practice being contingent on multiple issues, stating:

'it tends to be a little fluid...[determining restraint as a 'last resort'] depends on the situation you are in with the patient' (Int-1, Par. 65).

This theme highlights the ambiguity surrounding the use of restraint as 'last resort'. It reveals the uniqueness to each event and the broad spectrum of situations leading to the use of restraint, as well as, the variations in how nurses manage the situation.

6.3.3.2 Know-how of nurses

Commonly amongst the nurse participants it was felt that the overall level of experience and knowledge of nursing staff that they worked with impacted restraint use as a 'last resort'. In particular, the participants demonstrated a dependency on this know-how in managing situations that may lead to restraint use. For example, this was seen when Tom considered the team's familiarity with the unit and patients, as well as, the level of knowledge and experience that he felt were key components when needing to manage escalating situations. He shared:

'If it was a staff I was not sure of, like if it was a bunch of new hires or a bunch of on-calls that don't work very often, I might be more reactive only to make sure that we're at a point where I have the support as opposed to it being late and then realise people don't know how to handle the situation' (Int-1, Par 59).

Tom admitted that he might react more quickly to using restraint when he is working with those who he knows have less experience. This could be interpreted as him believing that a lack of 'know-how' was more likely to result in negative outcomes, such as, the inability to manage an escalating situation safely, or triggering patients to escalate as a result of their interactions, and where restraint use was a way to mitigate unsafe possibilities. Similarly, Sarah emphasised how 'last resort' was directly associated with the experience of the nursing staff and stated:

'There tends to be more incidents on days where there are staff that maybe aren't quite as experienced' (Int-1, Par 33).

This reliance on the other nurses' know-how may be based on the reality that nurses do not commonly manage escalating situations by themselves and that it requires a team approach. As identified in the integrative review (section 3.4.2.1), restraint is viewed to keep nurses safe, therefore, if nurses feel their team lacks the know-how required to manage an escalating situation, it may diminish their sense of safety and in return more quickly escalate the use of restrictive practices.

6.3.3.3 Collective view

The majority of nurse participants, when describing their lived experience, rather than using the pronoun 'I', used 'we' to describe the restraint event taken place and the decisions made. During the interviews many attempts were made through the use of probing questions to encourage the participant to describe a situation from their own experience/perspective. However, it appeared that a 'collective identity', where the nurses presented a group-based responsibility for their decision-making was far more common. This was evident when Kelly described her experience through the use of 'we' statements:

'We always did this in a large group focus, we didn't all take single decisions, we just all decided together what the best course would be' (Int-1, Par 11).

Amanda's experience also highlights this collective perspective, when she stated:

'Generally you prepare ahead of time who is going to be involved, generally they don't want to be in restraints of course so we usually have security involved as well, and we bring people in, talk to them first and try to get them to lay down last attempt, inform them that we'll be putting them in restraints for their safety and for ours, and what's going to happen and then basically all go together and hold because usually it's not a good situation unfortunately' (Int-1, Par 11).

Further exploring the concept of 'collective view' with Caitlin in a follow-up interview, she specifically highlighted her reliance on the team, stating:

'I'm very much cognisant of I need them [the team], as well as, I need to involve them in the decision-making [about 'last resort']' (Int-2, Par 8).

This suggests that the act of placing someone in restraint is collective in nature and requires joint decision-making and therefore, this collective view is a reflection of this. Tom also participated in a follow-up interview in exploring this concept and

explained that he felt this collective approach is necessary in order to ensure safety for all by stating:

'The basis for maintaining the safest environment for both staff and patients is doing things as a team and not working in isolation. I've found that, some of the most dangerous situations I've been involved in or heard about, have involved staff working as lone rangers' (Int-2, Par 5).

Aidan's experience provided a different view to this theme. He highlighted the difficulties of not agreeing with a team decision and sometimes this collective view may be as a result of avoiding being an outlier within the team. He stated:

'They'd [the nurses] rather go with the more powerful voices, whether reasonable or not. The louder the voice, they'd rather go with it. Not everybody's comfortable, competent or confident, or especially comfortable, I would say, to challenge something even if they are not sure, especially a newcomer. They go with the flow. Eventually they may be confident enough to challenge some things, but by and large it would upset the applecart here, you know. At the end of the day I come back and I work with these people' (Int-1, Par 103-105).

Aidan's experience indicates that at times decisions towards restraint being a 'last resort' may be made in order to fit in with the rest of the team they are working with.

Apart from the nurses' collective perspective described above, there was also a collective view about the patients and the incidents of restraint use. Nurses often struggled to remember one specific experience of restraint use during the interviews. Even when nurses started to describe one incident, they very easily went on to generalise their experience and to generalise the patients. During the interview with Rebecca, she specifically made remarks about this, stating:

'it's hard to pick one incident because they are so common, there is such a commonality to them [incidents of restraint use]' (Int-1, Par 31).

Moreover, Rebecca reflected on the generalisability of restraint situations, stating:

'This is the way it all ways goes' (Int-1, Par 29).

She elaborated about her challenges of trying to remember one specific restraint incident, again illustrating the 'collective view' approach, stating:

'But it would be really hard to differentiate a specific incident because what I gave you as a commonality it seems to be always the way it goes' (Int-1, Par 49).

One rationale for nurses having difficulties in remembering specific incidents and generalising their experience may be due to depersonalising the situation. This could be related to nurses being traumatised over time as a result of escalating situations and having to place patients in restraint, which in turn creates a sense of detachment from the incident. Or it could be a defence mechanism due to the nurses not wanting to associate themselves with the use of restraint. Nevertheless, it was very clear that majority of the participants generalised their own experience, the patients and the incidents, which will be further analysed in the following chapter.

6.3.3.4 Justifying best interest

It was commonly noted among the participants that there was a perspective of getting to a point of needing to use restraint as a 'last resort' was believed to be in the best interest for the patient, themselves and/or the team. This seemed to surface in the form of a need to attain power and control over the situation in the spirit of achieving best interest rather than for domination or coercion. For example, Molly shared:

'We do it because it's what is best for the patient at the time' (Int-1, Par 49).

John conveyed:

'You're not just erring on the side of caution, you're going to make sure that this is going to go the way you need it to go...' (Int-1, Par 148).

This quote demonstrates John taking over the situation to ensure safety (*'the way you need it to go'*) for all. Overall, this theme aligns with current literature on nurses needing to attain power and control (section 3.4.2.5) and achieving safety (section 3.4.2.1) highlighted in the integrative review. However, these findings also reveal that this is driven from a perspective believed to achieve best interest. This will be further discussed in the following chapter.

6.3.3.5 The past and the present

Another theme that emerged amongst the nurse participants was the influence of past experiences impacting decision-making related to restraint use as a 'last resort' in the present. This was reflected when John shared his past experience of being assaulted by a patient and its influence on his other clinical encounters. He expressed:

'They do [the assaults influence my decisions on 'last resort']. I would have to say it makes people a lot more cautious around patients. I have become hyper vigilant' (Int-1, Par 126).

This highlights how John's previous history and experiences of managing aggressive incidents influenced his willingness to use alternative interventions. Similarly, Natalie expressed how she believed health professionals' personal and professional experiences impacted on their decisions to enact 'last resort'. She stated:

'I think these kinds of incidents will stir up past baggage and past history and how you feel and if you've had bad experiences in your life with being out of control, then you'll often want to move in a controlling way because it creates such anxiety' (Int-1, Par 31).

The notion of how our past experiences affect our perspectives and interactions in the use of restraint is further discussed in section 7.1.1 in relation to Heidegger's concept of temporality. This theme also suggests the importance of nurses addressing their past negative experiences in order to prevent its limitations on their daily clinical interactions, which will be further discussed in chapter eight.

6.3.3.6 Point of no return: The roadmap

As nurses shared their lived experiences it was commonly acknowledged that they reached situations that they felt they had no other options but to use restraint – feeling as though they reached a point of no return. For example, this was evident when Tom reported:

'You very quickly in a lot of cases can reach a point where it's like a breaking point. The escalation will lead to either a fizzle or an explosion' (Int-1, Par 49).

This view of reaching a point of no return reflects nurses believing that restraint use is a 'last resort', having no other choice left. It may also suggest that the situation has reached a point where it cannot continue and requires them to intervene perhaps due to safety concerns.

Moreover, as nurses were describing reaching this point, they would also describe the interventions they would attempt prior to using restraint. The list of interventions revealed a generic roadmap or an algorithm that guided the nurse through a sequence of set interventions unique for each nurse (based on their knowledge and experience) that they would proceed through with all their patients. This would include such activities as medication administration, verbal de-escalation and using seclusion prior to the use of restraint. This was seen when Caitlin expressed:

'It's essentially a stepwise process, ideally we try verbal de-escalation, then try to offer PRNs, then we'll go to seclusion, and then, as a last resort, an absolute last resort, restraint' (Int-1, Par 42-46).

Given the variability in each situation, as discussed in the theme 'it depends' earlier in this chapter, a roadmap appeared to be a helpful tool for nurses to determine 'last resort'. Although this roadmap or algorithm was described differently by each nurse, meaning, the sequence of their interventions varied, it seemed to provide a sense of direction for unpredictable situations. A more formulaic set of steps appeared to lead nurses to a place where they felt they had attempted all alternatives and where the only option remaining is restraint.

6.3.3.7 Just in case of any risk

Another theme that was present in many nurses' experiences was the perception of risk. Risk seemed to drive many of the decisions related to restraint use as a 'last resort'. This perception was unique, as it did not reflect actual risk but rather the view of 'just in case' or 'what if' a risk was to occur. Molly illustrated her perceptions of potential risk when she shared:

'If the patient is potentially going to lash out and injure somebody then we use restraint' (Int-1, Par 21).

Molly's statement resonated in other nurses' experiences as well, suggesting that this potential risk influenced nurses' interventions in managing clinical situations. It seems that nurses' perceptions (rather than actual) of risk created safety concerns and fear, which they then felt obligated to act upon, i.e. place an individual in restraint. This perceived risk might also emerge as a result of past experiences of the nurse, as discussed earlier in section 6.3.3.5, impacting on the individual's perspectives of the event and the extent to which clinical interventions were warranted. This will be further explored in the following chapter.

6.4 Conclusion

Overall, this chapter presents seven emerging themes from the lived experiences of the nurses. These themes are descriptive in nature and highlight a number of elements that emerged from nurses' perspectives in relation to 'last resort'.

Overall, nurses believed that 'last resort' depended on a number of variables – not one factor determined this; but they could not always identify the factors. Many of the nurses also had a difficult time recalling one experience of using restraint and generalised their recollections of the incident and the patient. Moreover, nurses took on a collective identity in determining 'last resort'. Their lived experiences showed that their past impacted their perspectives of 'last resort' in the present. There was also a dependency on the knowledge and experience of other staff in order to mitigate the use of restraint. Nurses resorted to informal generic algorithm-like approach to manage escalating situations rather than individualising care to the unique patient. There was also a desire to maintain safety and control of the situation, which was believed to be in the best interest of the team, themselves and the patients. Finally, 'Last resort' may be determined as a result of perceived risk by nurses rather than actual risk.

In the following chapter I have re-interpreted these findings drawing on a number of Heidegger's philosophical concepts. From my perspective, these themes represent the building blocks in forming the foundation of the findings as I continue in the analysis of constructing the findings.

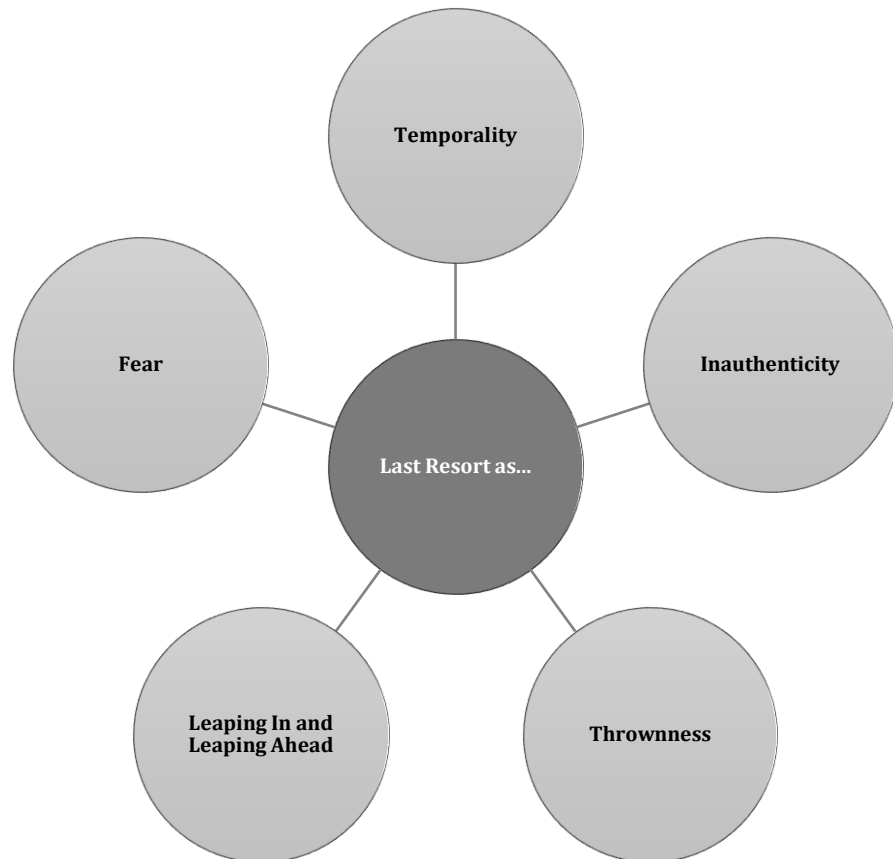
7.0 Introduction

This chapter presents the second part of the findings of the study. Here I present a re-interpretation of the findings detailed in chapter 6. The in-depth interpretations draw on a number of Heidegger's philosophical notions to illuminate and reveal nurses experiences of last resort. Below I will present each concept and discuss my analysis in relation to the themes.

7.1 Introducing the concepts

Engaging with the data led to the identification of five Heideggerian phenomenological concepts that represent the experiences of the nurses related to 'last resort' – these are depicted in Figure 3 below. This analytical phase entailed following van Manen's approach (refer to section 5.4.4) of exploring the text at various levels and interpreting meaning through an iterative reflective process. The five Heideggerian concepts that resonated within participant accounts are: temporality, inauthenticity, thrownness, leaping in and leaping ahead, and fear, which are each discussed in the following sections.

Figure 3: Visual depiction of the Heideggerian concepts



7.1.1 Temporality

From Heidegger's perspective '*we are time*' and lived time is our temporal way of being in the world (Heidegger, 1996). Time refers to temporality, a basic structure of Dasein's being which consists of three dimensions – the past, future and present – which together form a unity (Heidegger, 1996). Heidegger (1962) states:

'We must show that time is that from which Dasein tacitly understands and interprets something like being at all. Time must be brought to light and genuinely grasped as the horizon of every understanding and interpretation of being. For this to become clear we need an original explication of time as the horizon of the understanding of being, in terms of temporality as the being of Dasein which understands being' (p. 17).

The concept of temporality has been further described in detail in chapter four (refer to section 4.4.1). The data from the study clearly illustrated Heidegger's

notion of temporality in relation to how the nurses' past experiences influenced the practice of 'last resort' (as described in the theme the past and present - section 6.3.3.5). Some of the participants' experiences signified the interconnectedness of their prior experiences on their current practices and decision-making. For example, John depicts this unity where his past experience of being assaulted by a patient influenced his actions and decision-making related to 'last resort' in the present time.

[My experiences of being assaulted] I think tends to colour the way you respond to the next person that comes in. Even if their level of aggression or agitation isn't as severe, it tends to be seen as more severe than it is because you're expecting the worst...I think that instead of talking them to death you tend to talk to them for a couple of minutes and then it's 'okay, let's go'...' (Int-1, Par 134).

These insights suggest that as a result of his past, John could overemphasise the potential for violence, which in turn impacts on his efforts to engage in alternative interventions. This aligns with Heidegger's (1962) view where he stated:

'It its factual being Dasein always is how and "what" it already was. Whether explicitly or not, it is its past. It is its own past not only in such a way that its past, as it were, pushes itself along "behind" it, and that it possesses what is past as a property that is still objectively present and at times has an effect on it. Dasein "is" its past in the manner of its being which, roughly expressed, on each occasion "occurs" out of its future' (p. 19).

As described earlier (section 6.3.3.5 – theme the past and the present), Natalie shared how her past experience of growing up in a difficult family situation had created a need for her to gain control in her life in order to reduce her anxiety. She reflected that she could easily see how encountering situations to restrain a patient could 'stir up' past feelings for her influencing her decision towards 'last resort'. Heidegger's posits that within the concept of temporality, *'the future does not here mean a Now, which not yet having become 'actual', sometime will be, but rather the coming in which Dasein comes toward itself in its ownmost ability-to-be'*

(Heidegger, 1979, p. 325). In the nurses' experiences it is evident that the impact of events from their past is influencing them as individuals and their abilities in caring for patients.

In contrast to many of the participants, Jayne highlighted how her past experiences of using restraint were helpful to her current decision-making related to 'last resort'. She stated:

'I think you have to have a bad exposure and that knowledge ... to actually have those experiences like I had ... you have to be able to learn, be in those situations and learn from them and grow' (Int-1, Par 29).

Jayne's believed that having a lived experience of using restraint enabled learnings, which aided her to have more insight and understanding in future events and felt she made better decisions as a result. These lived experiences clearly highlight the role of temporality with 'last resort'. The following sub-section expands on the notion of time and identifies its impact on nurses' attitudes and behaviours.

7.1.1.1 Clock time

Heidegger distinguishes two kinds of everyday time, world-time and time as ordinarily conceived (Blattner, 2005). Time as we ordinarily conceive it (*der vulgare Zeitbegriff*) is time as a pure container of events (Heidegger, 1962). Blattner (2005) further elaborates on Heidegger's perspective of everyday time, stating:

'He [Heidegger] wants to emphasise that when we disengage from our ordinary experience and talk about and contemplate time as such, we typically interpret time as such a pure container, as the continuous medium of natural change. When we are pre-theoretically engaged with time, however, we experience it as world-time. World-time is the sequence of meaningfully articulated, everyday times: dinner time, bed time, rush hour, the Great Depression, the Cold War Era, the '60's, and the like' (p. 10).

The two definitions of time differ from one another in that world-time is overtly defined in terms of its relation to human interests. Whereas ordinary time is conceptualised as independent of human interest. This existence of the ordinary conceived time, which often Heidegger (1996) refers to as 'clock time', is also described as a deficient form of temporality, where it diminishes time to 'now time' (Scott, 2006). The concept of clock time was disclosed within the nurses' accounts. A number of the nurses expressed '*being busy*' and/or not having enough time to complete all their tasks during their shift. Participants believed that being busy negatively impacted on their capacity for early interventions to prevent escalation of violence/aggression and potential restraint use. Some nurses reported that other nurses' sense of being busy meant that the needs of the patients were compromised. In turn, this could result in a crisis situation and a decision to restrain. For example, Caitlin shared:

'Sometimes people do get a little bit busy and so they can't—they don't have the time for all those de-escalation techniques' (Int-1, Par 121).

Caitlin further elaborated on this referring to how 'busyness' in the present 'now' time created greater risks for patients. She stated:

'Busyness influences my decision because the busier the unit is, the more at risk they are to other people, just by sheer numbers. You know, someone's acting out and there are 10 people on the unit, then that's nine potential other people that he could hurt' (Int-1, Par 119).

This notion of 'busyness' or 'lack of time' can lead to expectations of what needs to be accomplished by nurses outside of their interactions with patients, and drive 'clock time' behaviours (such as documentation, administrative duties). These 'clock time' behaviours, which are essentially future orientated, directly impact on interactions (or lack thereof) with patients in the 'now' time and ultimately influence nurses in their decisions related to 'last resort'. Jayne's experience clearly highlights this when she stated:

'I think, you can never have enough time. That's one of the weird situation for nursing now is we're so understaffed and overworked and you're just tired and people don't take the time to do simple things. You know, like to communicate with your client, to ask them 'how are you doing today?' 'What are you thinking about?' 'How's it going?' You're just so caught up in do, do, and do. I have this task to do, I have that task to do and it's going take me from you know 30 minutes to do this and that's how we work. We don't fundamentally think about, ok I need to form a relationship with this person and we need to address not just the thing they are in for, they're admitted for in the hospital setting, but all these other things' (Int-1, Par 35).

Caldas and Bertero (2012) argue that when nursing interactions are influenced by 'clock time', there is no understanding of human life in nursing care. Similarly, Heidegger rejects the notion of reducing Dasein to chronological 'clock time' or 'now-time', indicating that Dasein is not linear and is beyond just the now. The nurses when sharing their lived experiences of 'last resort' seldom shared any details about the patient aside from demographic details and diagnosis. It was extremely difficult to view the patients as individual human beings with their own characteristics and needs based on the experiences provided by the nurses. This may be as a result of the busyness nurses experienced in the now, creating a barrier for them to have the time to understand the patient beyond their diagnosis and thereby impacting upon their interactions with them.

A contributor to busyness identified by some of the participants was being understaffed. Some nurses shared how being understaffed led to a greater number of 'tasks' being taken on, which in turn meant they did not have sufficient time to spend with the person who was eventually restrained. The restricted time spent with patients often meant that warning signs were missed and that proactive strategies to defuse a situation were less likely to be used. Melinda one of the participants who shared this perspective, stated:

'We're very often short-staffed and a lot of staff members are working overtime and they're not getting enough breaks and where those situations [use of restraint as 'last resort'] do happen, decision-making may alter

because of that as well because we do tend to get really frustrated at work'
(Int-1, Par 45).

John shared a similar perspective:

'We don't have adequate staff to do all the daily chores that they've got outlined for us, and they've added a few things to this, such as 15 minute corridor checks and room checks...We don't have adequate staff, especially when we have, say, three admissions coming in and they sometimes all end up at once, there's nobody to do therapy with the patient. They end up sitting there for hours on end with nobody actually dealing with their issues because you don't have time to actually do that, and so you see an increase in their frustration levels' (Int-1, Par 69).

Thus, as evident in the data, temporality played a key role in 'last resort' in two main perspectives. One relates to how past negative experiences influence nurses' behaviours and action in the present and future; secondly due to the nurses being consumed in their busy tasks that restricted their interactions with patients. A lack of staff-patient contact had obvious implications on staff-patient relationships, nurses' capacity to deliver needs-based care, and was a key precursor for restraint use. According to Heidegger (1962) ordinary time, is the *'pure flow of clock-time, meaningless, empty, and potentially precise. It is a "pure succession"'* (p. 422). Although Heidegger (1962), perceived clock-time to be less meaningful than his notion of temporality - *'the sense of the being of that very entity whom we call Dasein'* (p. 17) - it had significantly impacted on the potential for 'last resort' for the nurse participants. The next section further explores nurses' engrossment in their busy days and provides some further clarity in relation to 'last resort'.

7.1.2 Inauthenticity

Heidegger believed we may exist in one of two modes; authentic and inauthentic existence (also refer to section 4.4.2). Inauthentic existence describes operating in the everyday of existence as 'the They'. The 'They' refers to how individuals come to exist not on their own terms, but rather embrace the standards, beliefs and

prejudices of society. The inauthentic Dasein therefore does not live as itself but as 'they live', thereby becoming absorbed and lost in the anonymous public self (Polt, 2005). While Heidegger did not view inauthenticity in negative terms, as it is the fundamental basis of our socialisation, he did consider that an inauthentic existence could lead to a state of passivity, an alienated self, where one is disburdened of moral autonomy and responsibility (Heidegger, 1996). Authentic existence on the other hand is where we do not definitively accept what is handed down to us but seek our 'own-most potential to being'. Heidegger refers to authenticity as *'being one's self'* and speaks to honesty and veracity to be essential components whereby *'Dasein is in the truth'* (Heidegger, 1962, p. 263). Heidegger describes authenticity to require a shift in attention and engagement – a reclaiming of oneself.

Heidegger viewed inauthenticity as an existential fact of our being (Heidegger, 1996; Sherman, 2005). Heidegger explains, being lost in the They where it:

'Dissolves one's own Dasein completely into the kind of being of 'the Others', in such a way, indeed, that the Others, as distinguishable and explicit, vanish more and more' (Heidegger, 1996, p. 164).

Furthermore, Heidegger (1962) refers to the inauthentic state as 'fallenness', saying:

'Being-lost in the publicness of the "they" and in this situation we have declined our potential to be authentic and have fallen into the world' (p. 220).

Inauthenticity appears to be relevant in influencing 'last resort' within this study. Within all the nurses' accounts, inauthenticity was evident in their expressions of being busy and getting immersed in the daily activities of the ward. In addition, nurses in the study rarely explicitly shared an experience of restraint from their own perspective (also highlighted in sections 5.3.1/6.3.3.3). The theme of collective view described in section 6.3.3.3 reflects the nurses' ability to embrace the standards, beliefs and prejudices of the others – the 'They' – among the team – thereby illustrating an inauthentic state of being. Kelly suggested that adopting a

team approach was the normal part of the team's everyday daily practice. This view was also discussed by John, who said:

'It isn't just the fact that we don't want to physically restrain them, but we also have to consider the other patients' (Int-1, Par 93).

In John's quote above, his beliefs and practices are in reference to 'we', the others in the team when considering restraint use. Heidegger (1962) further describes 'the They' stating *'the self of everyday Dasein is the they-self, which we distinguish from the authentic self, that is, the self which has explicitly grasped itself'* (p. 125). He goes on to further state:

'If Dasein is familiar with itself as the 'they-self', this also means that the 'They' prescribes the nearest interpretation of the world and of being-in-the-world. The they itself, for the sake of which Dasein is every day, articulates the referential context of significance' (Heidegger, 1962, p. 125).

In line with Heidegger's view, John describes a situation where the referential context of significance is a collective approach. Further analysis of the theme collective view in relation to inauthenticity may also suggest that the nurses who are immersed within the teams they work with, turn to the collective view to interpret the situation with the patient, as well as to determine the interventions and decisions to manage the situation. Inauthenticity is related to our everyday 'absorption in' our activities of life where we do not become fully engaged with our responsibilities (Healy, 2011, p. 222). In my study, an inauthentic state among the nurses highlighted their inability to take responsibility for their own individual decisions related to the care of their patients. Healy (2011) elaborates on inauthenticity stating:

'Being 'fallen into the world' is a state in which we act in a programmed way with each other by conforming and not trying to obtain a unique perspective' (p. 222).

As discussed in the theme of 'collective view' (section 6.3.3.3), the nurses demonstrated having a general view about the patients and the incidents of restraint use. Nurses were challenged to recall one specific experience of 'last resort' throughout their interviews, which reflects the inauthentic state of fallenness. In my conversation with Molly, I asked her if she could tell me about one experience where she had to place a patient in restraint as a 'last resort' and if she could tell me everything that happened. Her immediate response was:

'Oh my God! One in particular you want? (Silence) oh my God, like I can't remember one' (Int-1, Par 8-13).

After thinking for a few minutes, she was able to recall one incident. However, it was quite evident how difficult it was for her to do so. Amanda also demonstrated this when she was describing getting to 'last resort'. Her perspective generalised all her encounters into what appears to be the typical experience all patients go through. She stated:

'Generally they [the patient] don't want to be in restraint of course, so we usually have security involved as well, and we bring people in, talk to them [the patient] first and try to get them to lay down as last attempt, inform them that we'll be putting them in restraint for their safety and for ours' (Int-1, Par 11).

Given that inauthentic existence in deferring to the pronoun of 'we' appeared frequently in the experiences of the nurses interviewed, it felt important to revisit this issue with two of the participants – Caitlin and Tom (also discussed in section 5.3.1). There were significant commonalities in Tom and Caitlin's responses, which provided legitimacy in relating these accounts to Heidegger's notion of inauthentic existence. Both Caitlin and Tom expressed that there is a strong dependency on the team during the use of restraint – thereby supporting the notion of a collective 'inauthentic' identity. The specific examples of the kinds of support necessary included: the actual application of restraint which involves multiple people; requiring other nurses to take on the care of their patient assignment (all the patients assigned to them for the shift) while they managed the situation that may

end in restraint use; and the dependency on the skill set or 'know-how' of other team members during the management of the situation. Tom and Caitlin's comments below further illustrate these points. Tom shared that when restraining a patient:

'You want to have a trust in your colleagues to be able to support you in that way' (Int-1, Par 8).

Tom's insights suggested that while there was a dependency on the knowledge and skills of the team members, there was also an element on implicit trust that the team members would help to achieve safety. In further exploration with Caitlin as to why she frequently referenced 'we' when describing her experiences of restraint use, she indicated:

'[deciding to use] restraint, it really needs to be a team discussion and how I also transfer care of my other clients to them, so there's that one aspect of why I consider it the WE' (Int-1, Par 4).

Caitlin felt it is not only about the restraint situation but also a need to manage the rest of the patients in parallel. Her perspective highlights the multipronged situation restraint use can create and how this cannot just be managed by one person. Managing this situation instead, requires a team approach. In turn, this requirement may make it more likely to function in an inauthentic state. She further explained the dependency on the team, stating:

'Relying upon the skill sets of your team members...so although you might be their primary clinician, and you might have developed some rapport, you can also recognise that if the client continues to escalate and your interventions are not working to help de-escalate them, that someone else's approach might be what's needed to help reduce that tension a little bit' (Int-1, Par 16).

In the quote above, Heidegger's concept of inauthenticity is apparent as Caitlin describes the reliance on the team, where the nurse requires the team to help

manage the situation, as well as, the interdependence on the 'know-how' or skills of other team members, especially if they could help de-escalate the situation.

In the follow-up discussions with Tom, he also raised the concept of collective, inauthentic decision-making when he said:

'Whenever I was involved in restraint of patients, I was working with strong teams and sort of embracing collective decision making...no one person was saying I'm going to put that person in restraint and that's the end of it. There's possible room for debate and room for basic checking each other to make sure we're doing the right thing' (Int-2, Par 10).

These insights highlight an expectation that 'last resort' is determined as a team decision. Thus, embracing the beliefs and practices of the team is an accepted norm, reflecting 'the They'. This may be as a result of such reasons as wanting to preserve safety, relying on the support of other team members during management of situations, as well as, the desire to make the '*right decision*'. He further explains his perspective on team decision-making, stating:

'Because they [the nurses] want to make sure that they're making the right decision' (Int-2, Par 16).

Overall, there is a sense of safety that accompanies collective inauthentic decision-making, where nurses do not have to take on sole responsibility for the outcomes of the situation. This aligns with Heidegger's (1996) explanation that in an inauthentic state one feels absolved of moral autonomy and accountability. This collective inauthentic approach may decrease nurses' fear of liability, which surfaced in further explorations with both Tom and Caitlin. For example, Tom stated:

'I think that there's a fear among health care providers to do that [restrain patients], if they're making the wrong decision in isolation, that there's a risk of liability' (Int-2, Par 14).

Moreover, Caitlin specifically raised the issue that if a nurse was acting alone it may be difficult to defend the decisions made, without other team members as witnesses. Given the multitude of negative outcomes that may occur as a result of using restraint, such as physical injuries and psychological trauma, it appears that nurses may want other team members present to ensure their support in defending their decision. Therefore, this inauthentic state appears as though to be the preferred state for the nurses. Caitlin further portrayed this in her statement:

'Honestly I think there is also a liability issue. You want to make sure that the client gets into restraint safely but also recognising it becomes a 'us' against 'them' situation, there could be issues of liability' (Int-2, Par 22).

The above perspectives illustrate the desire nurses have to make the right decisions and mitigate any potentially wrong decisions, partially fuelled by the fear of liability. Caitlin and Tom both also believed that safety was a contributing factor towards a collective inauthentic approach to restraint practices. Tom and Caitlin's perspectives continue to support this belief where having multiple clinicians participate in the decision-making process ensured a greater sense of safety. Tom stated:

'The basis for maintaining the safest environment for both staff and patients is doing things as a team and not working in isolation' (Int-2, Par 5).

Caitlin similarly shared:

'The sheer idea that you have to put someone in restraint means that they're in such distress that you actually do need a team approach to make sure that the client is in the restraint in a safe way and to also maintain the safety of the nursing staff as well as the client themselves' (Int-2, Par 10).

More specifically, it also seems that multiple team members created a greater sense of physical safety. Tom believed:

'Everyone's safety is dependent on a cohesive sort of thinking' (Int-2, Par 29).

The above perspectives continue to illustrate Heidegger's inauthenticity. Heidegger specifically explains:

'If a given Dasein's thoughts and deeds are (determined by) what 'they' think and do, its answerability for its life has been not so much displaced (on to others) as misplaced....everyone is the other and no one is himself. The 'they' which supplies the answer to the question of the 'who' of everyday Dasein is the 'nobody' to whom every Dasein has already surrendered itself in Being-among-one-another' (Heidegger, 1962, p. 165).

Thus, according to Heidegger (1962), if Dasein typically loses itself in the They, as seen among the nurse participants, he/she will then understand both its world and itself in terms of the They. This was seen among the nurses collective 'inauthentic' identity whereby there was dependency on their team, needing to make decisions collectively, and gaining comfort and security from the approach.

The reality of applying restraint in mental health setting remains that it is conducted as a team, which may easily translate into the collective perspective from each nurse's lived experience. Additionally, this collective approach reflects the state of inauthenticity and perhaps suggests that this state of existence is one that may be providing a significant sense of comfort and confidence in the day-to-day management of these situations for the nurses. Therefore, suggesting, as reflected by Heidegger, that this state of inauthenticity provides a sense of disburdenment, a lack of individual accountability among the nurses.

7.1.3 Thrownness

Heidegger also perceives fallenness to be the fundamental basis of thrownness; the primordial nature of our Being-in-the-world (Healy, 2011). Thrownness is a basic characteristic of Dasein and relates to how we are thrown into a world of understanding (our tradition) that is culturally and historically significant (Thomson, 2011). Richardson (1963) describes thrownness by stating:

'Awareness and acknowledgement of the arbitrariness of Dasein is characterised as a state of "thrown-ness" in the present with all its attendant frustrations, sufferings, and demands that one does not choose, such as social conventions or ties of kinship and duty. The very fact of one's own existence is a manifestation of thrown-ness. The idea of the past as a matrix not chosen, but at the same time not utterly binding or deterministic, results in the notion of Geworfenheit [thrownness] – a kind of alienation that human beings struggle against' (p. 37).

Many aspects of mental health practice have been grounded in tradition and culture, resulting in variances in care. It has only been over the recent years that further evidence-based care is being integrated into practice. Therefore, historically and currently, nurses in Canada acquire their mental health knowledge and skills whilst on the job where they are 'thrown' into their environment, as their academic training in mental health speciality is insufficient. The inadequacy is based on the fact that many nursing programs have removed their mental health courses/practicum placements. Thus, this limited knowledge nurses enter into mental health practice influences their abilities to mitigate restraint practices. This was evidenced in the lived experiences of the nurse participants who expressed the importance and impact of the levels of experience and knowledge of nursing staff upon 'last resort'. As reflected in the theme 'know-how' (section 6.3.3.2), nurses consistently viewed that when they were thrown into escalating situations, the level of knowledge and experience available to them (most often amongst the team they were working with) influenced their management strategies. The level of experience and knowledge are seen as interrelated and represent the expertise and abilities of a nurse – their 'know-how'. As mentioned earlier, the nurse participants heavily relied on others' know-how and experienced this to be significantly influential in 'last resort'.

Caitlin, a nurse participant, felt that nurses who were newly qualified less often use restraint, so therefore only used it as a 'last resort', than those who had years of experience. She believed that nurses with more experience based their practice on historical knowledge. Caitlin explained how the understanding and meaning of 'last resort' depended on years of experience nurses had, specifically stating:

'Not to discriminate against some of the older school nursing, but, I find the nurses who've been working for over 20 to 25 years, tend to have an old school model of 'let's restrain them'. Whereas some the nurses who have graduated in the last five years tend to buy into the work of restraint and seclusion reduction philosophy' (Int-1, Par 106-107).

In contrast, the majority of the participants expressed that nurses with greater years of experience and confidence would use restraint at a later point than 'newer' nurses. Jayne shared this view and said:

'I mean it comes with experience too and just your level of comfort in what you know how to do, I think that is a lot of it too. If you're confident in your skills and how to manage or treat or communicate with your patients, I think you see a level of comfort and safety that I don't sometimes see with younger nurses' (Int-1, Par 27).

From her perspective 'know-how' translated into a sense of comfort and confidence that resulted in more positive interactions with patients. Currently when nurses are 'thrown' into their nursing positions in mental health, they learn from other nurses, who have their own tradition reflective of history and culture. This reliance of others' know-how may be a reflection of thrownness, where nurses' understanding of the mental health world is from other nurses.

From Heidegger's (1996) perspective our thrownness affects our being, creating a sense of struggle, as a person does not choose their tradition that is influenced by history and culture. As indicated by the theme 'it depends' (section 6.3.3.1), nurses commonly said that every time they used restraint as a 'last resort' this depended upon a number of elements and was not always related to one factor. This highlighted a sense that they were being 'thrown' into unpredictable and uncontrollable situations. Rebecca specifically shared this in discussing how she determined restraint was used as a 'last resort' and stated:

'There is so many different variables' (Int-1, Par. 23).

Jayne articulated similar views:

'I would probably say it depends on a lot of things. It depends on the situation, I mean, what situation are you in with the patient? Is the patient at a point where you've tried pharmacological management of the patient and is it not working? Are you dealing with a situation where they're violent and could hurt themselves or could they hurt other people? Are they making threats?'
(Int-1, Par 26-27).

Jayne's description and the questions she raises highlight some of the various contributing factors that, for her, would determine 'last resort'. These include the effect of alternative interventions (e.g. pharmaceutical) and level of safety for self and others. This also illustrates the sense of ambiguity and the uncertainty that she has to encounter each time she is thrown into a potential restraint situation.

The perception that 'last resort' can be dependent on a variety of factors, reveals the complexities and variability nurses encounter in practice, however, it also reduces the ability to have a clear understanding of how 'last resort' may be perceived. Hence, given this variability, nurses are defining 'last resort' in the moment based on the situation, their knowledge, and skills of others who are present in the situation – their tradition. Variability in the perception of 'last resort' may be a reflection of the lack of definition and understanding of 'last resort' in practice.

Thrownness was further revealed among the data as some nurses expressed a generalised algorithm-like order of interventions that they attempted in order to mitigate 'last resort'. The development of this informal algorithm-like approach seems to be the nurses' attempts to deal with being thrown into escalating situations where minimal directions and training are provided. The interventions often included initial attempts to administer medications, talking to the person and using seclusion. However, once these had been exhausted they felt there was no choice but to restrain the person. This order of interventions did not appear to be individualised for each patient, rather a routine driven approach. This was evident in Sarah's experiences when she stated:

'In all the other situations we would try as a first line to use seclusion and then we would only escalate it to 4-points [restraint] if they weren't able to just kind of rest' (Int-1, Par 29).

This algorithm-type application of interventions as an approach to a complex and variable situations, illustrates the way nurses adopt generalised approaches in managing unique situations. They conform to the routine practices and culture of their environment, where care is generalised as a result and not necessarily tailored to the patient and the situation. This may be a consequence of thrownness experienced by the nurses in the study.

7.1.4 Leaping-in and leaping-ahead

Heidegger describes *'being-with'* as an existential characteristic of Dasein, we are thrown into the world, where we are always *'being-with'* others. Solitude is the concern that Dasein displays towards other human beings (Heidegger, 1996). Heidegger (1996) introduces two extreme positive modes of solicitude, stating:

'With regard to its positive modes, solicitude has two extreme possibilities. It can, as it were, take 'care' away from the other and put itself in his position in concern: it can leap in for him. In contrast to this, there is also the possibility of a kind of solicitude which does not so much leap in for others as leap ahead of him in his existential potentiality-for-Being, not in order to take away his 'care' but rather to give it back to him appropriately as such for the first time' (p. 122).

Heidegger identifies these modes of solicitude as *'leaping in'* and *'leaping ahead'*. *'Leaping in'* is an inauthentic mode of solicitude where we are taking over from the other, *'in such solicitude the other can become one who is dominated and dependent, even if this dominating is a tacit one and remains hidden'* (Heidegger, 1996, p. 158). In contrast, *'leaping ahead'* is more authentic, although it is important to reflect that it is not a direct helping act. *'Leaping ahead'* relates to opening up the potential for others (Heidegger, 1962).

Further analyses of the experiences of the nurses highlighted how 'leaping-in' surfaced in all the participants' experiences. This was revealed through the nurses actions being based on the need to be safe and/or in control to contain the situation - where the nurses felt the need to leap in with their own decision of what needed to happen - 'last resort'. Reaching the place of needing to 'leap in', and take over the care of the other (Heidegger, 1996) through restraint practice is best articulated through the theme of point of no return, as described in the previous chapter (section 6.3.3.6). Nurses shared how they were faced with situations where they reached a point of no return, leaving them no alternative but to use restraint procedures. Nurses either distinctly expressed that they felt that they '*tried everything*' prior to deciding to restrain and/or they felt they had no other option.

Tom described his experience of getting to this point of no return to be based on '*warning signs of physical violence*', which subsequently resulted in him 'leaping in' to take over the patient's behaviours. Similarly, Aidan felt that 'last resort' was a situation where he had tried other interventions that were not successful and where restraint was the only option available. He stated:

'So this was truly a 'last resort' situation having exhausted all options' (Int-1, Par 14).

Reaching a point of no return may be a reflection of the knowledge and skills related to the use of alternative interventions for nurses. It may also reflect the issues of time and staffing impacting upon the nurse's ability to explore other alternatives.

As Heidegger (1962) suggests, we engage in '*leaping in*', the notion of taking up the other person's burden and therefore helping them by relieving them of their trouble. In other words, leaping in is taking away care from the other, taking over for the other (Heidegger, 1962). As stated above, where it seemed that nurses were 'leaping-in' to enact 'last resort' as influenced by a need to attain power and control, it appeared that rather than the decision being based on domination or

coercion, it was based on a desire to achieve what they believed was in the best interest for themselves, the team and/or the patients. For example, Melinda stated:

'If patients cannot be controlled then we have no choice but then we have to get orders for restraint' (Int-1, Par 15).

Melinda's quote highlights the need to leap in and obtain control of what was deemed to be an unsafe situation. Similarly, Tom's perspective reflected this as he indicated:

'When you reach the point where it's not safe, it's negatively affecting staff or negatively affecting the other patients, then that's where we choose the point to intervene' (Int-1, Par 49).

A similar justification was presented by Molly who said:

'I think it's important for people [general public] to know that when we do restrain people there are a lot of good reasons and it's after we've tried many other things' (Int-1, Par 45).

Molly stressed her frustrations with what she believed as stigma towards mental health nurses in using restraint. In her tone, there was a sense of unfairness in the judgments she felt from others and felt the need to justify the reasons restraint occurred. This emphasises her genuine belief that these decisions are made for the patients for caring reasons. Overall, the active taking over the patient by the nurse does not represent a harmful act on behalf of the nurses, rather one that is perceived to illustrate 'care' or concern for others.

Molly goes on to further explain her perspective of how restraint may be helpful to a patient and it should not always be viewed negatively. Her perspective illustrates leaping-ahead, stating:

'I think that there's a stigma to that [the use of restraint] and I think there are preconceived ideas about it. I don't think that being in physical restraints

is necessarily a bad thing. People think it's a bad thing – but I have never felt bad about putting somebody in restraints, I've never felt that I've done it unnecessarily and every time that we do it I think it's for the benefit of the patient and it's for the benefit of the staff. And if it's done correctly it's not a bad thing and it's amazing really how fast you can put somebody in restraints and just being immobilised like that and getting some medications into them and getting them calmed down, it can make a huge difference [for the patient]' (Int-1, Par 45).

Although in mental health care there has been significant movement towards empowering patients through the promotion of choice and shared decision-making, there continues to be practices reflecting a paternalistic approach to care. Paternalism can be defined '*as an action which restricts a person's liberty justified exclusively by consideration for that person's own good or welfare and carried out either against his present will or his prior commitment'* (Breeze, 1998, p. 260). This dichotomy between the varying approaches, paternalism and empowerment, may create dilemmas for clinicians and patients during day-to-day care. 'Last resort' may be a reflection of the paternalistic approach where the nurses are 'leaping in' and taking over, and in that moment determining what is best (in their view) for the patient and situation. A paternalistic approach towards care is one that is entrenched in traditional mental health care and weaved into daily practices. Therefore, the nurse participants' actions of leaping-in to help the patient and situation are most often meant to indicate a 'leaping ahead' caring approach from their perspective, even though its impact may have negative results.

Leaping ahead also emerged among some of the nurses' experiences. Heidegger (1962) describes leaping ahead as assisting the other to see themselves in their care and become 'free for it' (p. 159). He believed that '*this kind of solicitude pertains essentially ... to the existence of the other, not to a 'what' with which he is concerned; it helps the Other to become transparent to himself in his care'* (Heidegger, 1962, p. 122). Natalie's remarks raised this concept where there was a need for the nurses to connect with themselves during these acute situations in order to ensure they are making right decisions. Therefore, Natalie's practice of

grounding herself enabled her to assist the patients to take over their own care and support themselves. She stated:

'Some of the mantra for me would be things like asking myself am I at immediate risk of harm? Is this person at immediate risk of harm? Is someone right immediately going to get very seriously hurt unless we restrain this person right now? And if the answer to that is no – then it's like okay how can we remove the audience, how can we give time, and then how can we make sure that we're not in that person's physical space so that we give them more distance... So part of it is I think giving the patient time to express what they want, but giving yourself time to sort of reflect on what's going on almost to slow the process down inside you so that you can think. If you take away that 'I immediately have to jump on this person', then you can sort of say okay let's really assess and get in touch with your own emotions around whether you personally are and then if you can ground yourself then you're in a position to really listen to the other person. But if you're always scared and anxious that it immediately has to happen, then you're not giving your own self time and space to get grounded and to make better decisions' (Int-1, Par 33).

Natalie described the opportunity to ground oneself as a nurse in these situations in order to not take away their care but to give it back to the patients. Leaping ahead certainly aligns with the patient empowerment approach in mental health care and enables the opportunity for nurses to further partner with patients in their care. This concept resonates with Heidegger's accounts in that Dasein must attend to relations with others in order to attend to its own authentic projects. Heidegger's claim, *'Dasein is always 'beyond itself', not as a way of behaving towards other entities which is not, but as Being toward the potentiality-for-Being which it is itself'* (Heidegger, 1962, p. 192). The inauthenticity related findings in the earlier section 7.1.2, demonstrated how nurses were referring to patients as a diagnosis and/or their behaviours. They were also having difficulty recalling specific patients and their experience of placing them in restraint. If behaviours and routines do not involve engagement with patients in order to understand them beyond their diagnosis, as human beings, it can have impact on therapeutic

relationships and establishment of rapport with patients, which then can influence 'last resort'. Therefore, it becomes essential to leap-ahead rather than leap-in in order to create a therapeutic environment that counters 'last resort'.

7.1.5 Fear

Often in philosophical accounts, moods are dismissed and conceptualised as merely subjective colourings of our experience of the world. However, Heidegger disputes this and claims that moods reveal something important about the fundamental structure of the world and our way of being in it (Dreyfus & Wrathall, 2005). Heidegger (1996) notes that 'moods assail us', disclosing that we are 'thrown' into a world not of our making. In addition, he indicates that mood is something shared, not simply inner and private. Moods are neither merely objective or subjective properties of entities (Dreyfus & Wrathall, 2005; Naimo, 2013). Dreyfus and Wrathall (2005) further elaborate on this, stating:

'So, being-in-the-world means that we always find ourselves in the world in a particular way – we have a 'there', that is, a meaningfully structured situation in which to act and exist – and we are always disposed to things in a particular way, they always matter to us somehow or other. Our disposed-ness is revealed to us in the way our moods govern and structure our comportment by disposing us differentially to things in the world. So disposed-ness is an 'attunement', a way of being tuned in to things in the world' (p. 5).

For Heidegger, moods influence how we perceive or interpret situations as well as people (Heidegger, 1996). Although Heidegger provides limited discussion on the mood of fear, he viewed fear to be an inauthentic state of being that arises when we encounter something in our lifeworld that threatens our potentiality-for-being (Heidegger, 1996). He articulates fear to exist in relation to being fearful of something which is considered to pose a danger to oneself (Magid, 2016). Fear is a state through which rational thought becomes compromised (Heidegger, 1996). Heidegger also considered that fear has an object and when that object is removed, we are no longer fearful (Heidegger, 1996). Heidegger (1996) believed a number of points needed to be considered related to fear:

1. *What is encountered has the relevant nature of harmfulness. It shows itself in a context of relevance.*
2. *Thus harmfulness aims at a definite range of what can be affected by it. So determined, it comes from a definite region.*
3. *The region itself and what comes from it is known as something which is “unnerving” [“geheuer”].*
4. *As something threatening, what is harmful is not yet near enough to be dealt with, but is coming near. As it approaches, harmfulness radiates and thus has the character of threatening.*
5. *This approaching occurs within nearness. Something may be harmful in the highest degree and may even be constantly coming nearer, but if it is still far off it remains veiled in its fearsome nature. As something approaches in nearness, however, what is harmful is threatening, it can get us, and yet perhaps not. In approaching, this “it can and yet in the end it may not” gets worse. It is fearsome, we say.*
6. *This means that what is harmful, approaching near, bears the revealed possibility of not happening and passing us by. This does not lessen or extinguish fearing, but enhances it (p. 137).*

In further analysis of the nurses’ experiences, fear was sometimes explicitly reported. For instance, some nurses highlighted a perception of risk of harm to self or others to be an object of fear. At times, it was often the ‘*just in case*’ or ‘*what if*’ perception rather than actual risk of harm that determined restraint use. Although in the narratives there was at times no actual apparent risk, the consequent actions may be related to fear. Similar to Heidegger’s characteristics of fear, as described above, there may have been a sense of threat that felt near and approaching for the nurses but there were possibilities of the threat to pass by and not happen. For example, the nurses’ fear may be underpinned by concerns for personal safety, or the safety of, colleagues and/or co-patients. Sarah shared her perception on how fear influenced decision-making and ‘last resort’, stating:

‘Fear unfortunately plays a role in some situations. If the staff are afraid and they feel that they can’t manage a situation, they may jump to putting

somebody into restraints prematurely and it's something we certainly try to work on. But I get what it felt like to be [in a situation with] three female nurses on a night shift and you have somebody that is threatening you and security is out ploughing snow in the parking lot. You know you're alone and that the police are going to be 20 minutes away, there is an element of fear. That sometimes may drive decisions, not in all cases but it certainly I think it would be naïve to not think that it's out there and that it is a factor sometime' (Int-1, Par 35).

From Heidegger's perspective, *'inauthentic existence exists in a state of fear'* (Thomson, 2011, p. 148). Fear is always *'fear of something and for the sake of something'* (Heidegger, 1962, p. 179). In this study, it is this concept of potential possibilities that at times drives the determination for 'last resort', even without the actual risk or danger being present. A number of factors such as past experience, knowledge of the patient, and know-how of the nurse and team influence these perceptions of risk. For example, some nurses perceived a risk if they had encountered negative situations in the past. Additionally, some nurses perceived a level of risk if the patient has had a history of violence or if they as nurses were not familiar with the patient. Also, the knowledge and skills of the nurse and the team they are working with influence the perception of potential possibilities that may be a risk. Heidegger suggests that being in a state of fear means that rational thought becomes compromised and one hangs onto safety and defensiveness (Thomson, 2011). One may question whether nurses view the use of restraint as a safety net to defend themselves, therefore, when these 'what if' perspectives arise, they may be quick to act to mitigate potential risk and ensure safety without always having strong rationale. This is reflected in Rebecca's experience when she stated:

'You know it's really hard sometimes to work around that situation [using restraint] because you do sometimes need that 'just in case'' (Int-1, Par 17).

Heidegger (1962) suggested that fear *'bewilders us and makes us "lose our heads"'* (p.137). For the nurses in this study, fear may have led to a need to gain control over the situation resulting in the use of restraint. Additionally, nurses also shared

that given their past experiences, their level of patience may be minimised in the present moment with patients. Therefore, fear may be impacting upon the threshold for nurses in opting for 'last resort'. In alignment with Heidegger's depiction of fear, the nurses may view the patient as the object of fear and therefore placing the patient in restraint may help to minimise this negative emotion.

7.2 Conclusion

In this chapter I presented an in-depth interpretation of the findings through the lens of Heidegger. The analysis unearthed how the nurse participants of this study experienced 'last resort' in relation to restraint use through five key philosophical concepts of temporality, inauthenticity, thrownness, leaping in and leaping ahead, and fear. The mental health nurse participants were able to articulate the complexities and realities they encountered when determining 'last resort'. The experiences of the participants had many similarities even though their geographical locations varied. The following chapter will focus on further bringing to light an understanding of 'last resort' through discussing and theorising the findings drawing on the greater body of literature outside of hermeneutic phenomenology.

8.0 Introduction

The impetus for my study, to better understand the experience of 'last resort' by mental health nurses in the use of restraint, has driven this work. The philosophical perspectives and approaches of Heidegger, Gadamer, and van Manen provided structure and guidance to the hermeneutic phenomenological inquiry into the lived experiences of the participants. Taking a hermeneutic phenomenological approach has helped unearth new understandings and insight into this phenomenon which has not been formally studied before.

In the previous chapter, an in-depth data analysis through a Heideggerian lens was provided highlighting the findings that describe nurses lived experience of 'last resort' in restraint use. This research aims to bridge the gap in the literature identified through the integrative review (chapter three) and uncover how mental health nurses perceive 'last resort' in using restraint.

This chapter presents the discussion of the research. It has been written over five sections. In the first section, an overview of the findings of the study is presented to summarise the work. In the second section, the key insights generated through the study are discussed through drawing on the wider literature. The third section makes recommendations in the form of antidotes related to the findings of using restraint as a 'last resort'. I then discuss the limitations and strengths of the study and lastly, offer suggestions for future research.

8.1 Overview of the findings

8.1.1 Integrative review findings

My study commenced with the examination of the literature through an integrative review. This review highlighted the gaps in knowledge related to restraint use and the notion of 'last resort', identifying a dearth of research that has focused on this phenomenon. As a result, the integrative review took a broader focus, exploring

the decision-making factors that influence mental health nurses in the use of restraint. Overall, eight themes were identified as factors that influence nurses decision-making. These include: safety for all, restraint as a necessary intervention, restraint as a 'last resort', role conflict, maintaining control, nurses' knowledge and perception of the patient, staff composition, and psychological impact (refer to chapter three for details). This work exposed how mental health nurses' decisions are influenced by interrelated issues of ethical and safety responsibilities, as well as, interpersonal and staff related factors. The findings from the integrative review suggest a paradoxical situation for mental health nurses, where restraint occurs to maintain safety for all (Bigwood & Crowe, 2008; Lemonidou et al., 2002; Terpstra, 2001), as safety is an integral part of their role (Bigwood & Crowe, 2008; McCain & Kornegay, 2005; Perkins et al., 2012), while evidence demonstrates the risks for both patients and staff as a result of restraint practices (Ashcraft & Anthony, 2008; Fish & Culshaw, 2005; Foster et al., 2007; Mildred, 2002; Sequeira & Halstead, 2004; Soininen et al., 2013; Strout, 2010). Restraint use thereby creates a conflicting situation for mental health nurses, as while upholding safety is an integral part of their role, the practices they use have potential harm for both patients and staff. The results of the integrative review also uncovered two unexplored areas in previous studies on restraint, 'restraint as a last resort' (although this is identified in policy) and 'staff composition' (see details in chapter three), adding to the body of knowledge.

8.1.2 Hermeneutic phenomenological approach overview

To explore the concept of 'last resort' in relation to the use of restraint, I undertook 15 interviews with thirteen mental health nurses from various provinces in Canada. An in-depth analysis of the data was then conducted guided by van Manen's method to uncover the findings. Analysis of the data was undertaken in two phases. In the first phase core recurrent issues that emerged from the interviews were highlighted. Seven themes are reported in regard to: 'it depends', 'collective view', 'know-how', 'justifying best interest', 'the past and the present', 'point of no return: the roadmap', and 'just in case of any risk'. This was followed by an in-depth analysis that drew on Heideggerian philosophy and identified five Heideggerian phenomenological concepts that contribute to our understanding of

lived experiences of 'last resort', namely: temporality, inauthenticity, thrownness, leaping in and leaping ahead, and fear (see chapter seven).

The next section presents an interpretation and discussion of the findings described in chapter six and seven (summarised above) drawing on the wider literature.

8.2 In-depth discussion of the findings

Further analysis and theorisation of the findings from within the broader literature revealed a number of theoretical concepts that can further lend an understanding to 'last resort'. The next sections discuss the concepts of dehumanisation, collective identity, groupthink, fear-based approach, and trauma from extant literature.

8.2.1 The utility of dehumanisation

When considering the wider literature, the Heideggerian interpretation of the findings in relation to inauthenticity, leaping-in, and thrownness align well with the concept of dehumanisation. In particular, during the interviews, nurses frequently described factors associated with dehumanisation in terms of rationalisation of restraint use, generalisation of patients, de-individuation of care and labelling of patients with their illness and/or behaviours. First, I provide details of current literature regarding dehumanisation, followed by explaining how this concept was evident in nurses' experiences of 'last resort' as supported by Heidegger's concepts of inauthenticity, leaping-in and thrownness.

Haque and Waytz (2012) define dehumanisation as '*the denial of a distinctively human mind to another person*' (Haque & Waytz, 2012, p. 177). The mind is described as consisting of two dimensions, one of experience (the capacity to feel pleasure and pain) and one of agency (the capacity to plan, intend, and exert choice); dehumanisation involves denying a person either or both of these dimensions (Haque & Waytz, 2012; Kelman, 1976). Haslam's (2006) integrative review on dehumanisation reports on how this concept appears prominently in writings on modern medicine, where patients are dehumanised in various

manners such as, lack of personal care and emotional support, and reliance on technology. The concept of dehumanisation has also been raised in psychiatric practice; Szasz (1973) for example, argues that psychiatry's coercive treatments relieve individuals of their autonomy and moral agency. Szasz (1973) also criticises the psychiatric classification system as dehumanising, believing it involves a '*mechanomorphic*' style of thinking that '*thingifies*' persons and '*treats them as defective machines*' (p. 200).

In the literature, the concept of infra-humanisation also appears as a form of dehumanisation. Infra-humanisation involves the denial of secondary emotions (e.g. humiliation, nostalgia) to others (Haque & Waytz, 2012; Lammers & Diederik, 2011). This concept is used to describe a lesser or more subtle form of dehumanisation (Haslam, 2006). In recent years, dehumanisation has increasingly been used to describe more moderate forms of dehumanisation that were formerly indicated as infra-humanisation (Lammers & Diederik, 2011). For the purposes of this thesis, I do not delve into the distinction between the two terms. I use the word dehumanisation to indicate both to align with more recent literature and contemporary use of the term (Haque & Waytz, 2012; Haslam, 2006; Lammers & Diederik, 2011; Livingston Smith, 2016).

Haque and Waytz (2012) note that dehumanisation in medicine is not intended to be malicious on the part of the health care professional. Rather, '*unconscious, unintentional dehumanisation of patients can occur as a by-product of the way humans' evolved minds interact with present widespread social practices and functional requirements in hospitals*' (Haque & Waytz, 2012, p. 177). Moreover, research has demonstrated that dehumanisation enables people to experience less moral concerns for their actions toward dehumanised others, and can justify acts that would otherwise be considered harmful (Haque & Waytz, 2012, p. 177). Overall, in my study, it is evident that restraint use was not perceived to be a malicious act, which aligns with extant literature of nurses using restraint for the purposes of safety (Bigwood & Crowe, 2008; Lemonidou et al., 2002; Terpstra, 2001), where they see it as a necessary intervention (Bigwood & Crowe, 2008; McCain & Kornegay, 2005; Perkins et al., 2012). As described in the findings by Heidegger's concept of leaping-in (section 7.1.4), nurses often justified the use of

restraint as a method to achieve the best interest for patients and/or staff. Although the majority of the nurses were aware of the risk of adverse effects of restraint use, they often rationalised its use. The use of restraint in mental health is historical and traditional in nature (refer to chapter two for details). As previously mentioned, the practice of restraining patients with a mental illness dates back at least three centuries (Masters, 2017), and although the methods and approaches to restraint use may have evolved, its realities of containing a person against their will continues today. Furthermore, over the decades most clinicians would be socialised to perceive this practice to be a functional requirement to support clinicians and patients. Thus, while this practice may not be overtly viewed as dehumanisation, it carries many of the characteristics described in the literature.

Dehumanisation is further understood through its causes, which are categorised as functional and non-functional. The non-functional causes of dehumanisation include de-individuating practices, impaired patient agency, and dissimilarity. De-individuation refers to people becoming immersed in a group or otherwise anonymised. De-individuation causes dehumanisation in two ways: through de-individuation of the person being perceived (the dehumanised), or through de-individuation of the perceiver (the dehumaniser) (Haque & Waytz, 2012). For example, mental health patients can become subsumed into a homogenised group of patients on the wards rather than individual agents with unique needs. This emerged in the interpretation of the findings using the notions of inauthenticity and thrownness where nurses generalised patients and their care approaches (sections 7.1.2 and 7.1.3). Likewise, clinicians can become anonymised in the hospital setting among the rest of their peers, which subtly diffuses their individual accountability toward patients; a notion similar to Heidegger's concept of inauthenticity (discussed in section 7.1.2). An interesting concept that may lead to de-individuation is power which is associated with increased dehumanisation (Lammers & Diederik, 2011). Lammers and Stapel (2011) suggest that as powerful people often have to make difficult decisions on behalf of other people dehumanisation justifies those decisions through minimising the suffering that comes with them. Moreover, the experience of power, such as that possessed by clinicians in the power imbalances that exist among clinicians and patients, is linked to reduced 'perspective-taking' (perceiving a situation or understanding a

concept from an alternate point-of-view), making people more closed to others, and increase de-individuation – which are the psychological processes associated with increased dehumanisation (Lammers & Diederik, 2011).

The other two non-functional causes of dehumanisation are closely related. One is the perception of patients as impaired in agency and the other is dissimilarity (Haque & Waytz, 2012). Dissimilarity is described as the physician-patient differences that manifest in three ways. First, the distinction created through the patient being ill. Second is the labelling of the patient as an illness rather than as a person with a particular illness. Lastly, through power imbalance that naturally exists between the physician and patient. This is also linked to Lammers and Stapel's (2011) perspectives related to power, discussed above. There is also a large body of literature that illustrates there is greater likelihood for people to dehumanise others if they appear different from them (Haque & Waytz, 2012; Haslam, 2006; Simpson, 2015). Both, impaired agency and dissimilarity isolate the patient as they signify them as lesser to 'others' (i.e. health professionals). Stigma towards patients is common in mental health care and is claimed to dehumanise people who are experiencing mental disorders (Haslam, 2006). Having a mental illness has, throughout history, carried a perception of having impaired agency. For example, as mentioned in chapter two (section 2.4), as early as the 1740s the vagrancy laws in English towns allowed public authorities the right to restrain unruly individuals based on the assumption that it would be beneficial to them (Masters, 2017). This highlights the longstanding perception that people who demonstrate disorderly behaviours have impaired agency.

All of the non-functional causes of dehumanisation were observed throughout this study, where the nurses' experiences consistently raised practices of de-individuation, dissimilarity and impaired patient agency. As described in the concept of inauthenticity (p. 111), de-individuation reflects how mental health patients were identified more generally in relation to their behaviour, diagnosis or other demographics, rather than as an individual person with unique characteristics. Moreover, the collective view of the incidents presented by the nurses where that they had difficulty remembering one specific experience aligns with these non-functional causes. Rather their experiences were very much

dominated by an objective perspective of the situation such as, the patient's diagnosis, the potential risks and other justifications rationalising the use of restraint (as discussed in the concept of thrownness, section 7.1.3 and collective view theme, section 6.3.3.3).

The presence of these non-functional causes may have resulted in the inability of the nurses to identify specific accounts of restraint use and instead generalised their experiences. This raises an important question as to whether disconnection from the patient and incident makes it easier for nurses to use restraint. Smith and Hart's (1994) study exploring the nurses' responses to patient anger indicated that the research participants most often used disconnection as common initial reaction to being the recipient of a patient's anger. Moreover, all of the nurses in the study revealed going through a disconnecting process at some point in their nursing career (Smith & Hart, 1994). They describe disconnecting as *'the lack of ability to associate mentally, emotionally and physically with the angry patient'* (p. 645). Evidence of disconnection was also apparent among the nurse participants in my study through the generalisation of care approaches, patients and incidents. Research also illustrates that dehumanisation can act as a justification for making tough decisions (Lammers & Diederik, 2011). The nurses' experiences highlighted that using restraint as a 'last resort' was a difficult decision but perhaps one that was made easier through the process of dehumanisation.

In contrast to the non-functional causes of dehumanisation, there is a limited body of literature that highlights the functional causes of dehumanisation in health care (Haque & Waytz, 2012; Lammers & Diederik, 2011; Vaes & Muratore, 2013). The functional causes include mechanisation, empathy reduction and moral disengagement (Haque & Waytz, 2012; Vaes & Muratore, 2013). Mechanisation refers to how medicine views the diagnosis and treatment of a patient to be a mechanical system consisting of interacting parts, resulting in dehumanisation through 'objectification' (Haque & Waytz, 2012). To a large extent, the algorithm-like order of interventions described by many of the nurses in the concept of thrownness illustrates the mechanisation of patient treatment. This approach dismisses the uniqueness of the patient and their individualised needs and

highlights the systematic approach towards behaviour modifications and essentially management of the situation.

Another functional cause of dehumanisation is reduction in empathy. This has been highlighted in research as a strategy that supports clinicians to engage in a higher level of medical problem solving (Haque & Waytz, 2012), as well as reduce the risk of emotional exhaustion, and burnout for clinicians (Vaes & Muratore, 2013). Evidence demonstrates that physicians down-regulate their empathy response when they encounter visual pain stimuli (Vaes & Muratore, 2013). Neuroscientific studies also demonstrate that by dampening pain empathy, it reduces feelings of unpleasantness that appear from perceiving others' pain, which in turn frees up cognitive resources for clinical problem solving (Haque & Waytz, 2012). Dehumanisation also enables people to suppress emotions that they normally would have towards human beings (Lammers & Diederik, 2011). Based on this evidence, Haque and Waytz (2012), report:

'The problem-solving benefit of dehumanisation may be especially important when the pressure to deliver efficient care is high. Humanising patients can increase stress, and medical caregivers use dehumanisation spontaneously as a method to cope with stress' (p. 179).

In this study, the nurses rarely revealed empathy towards the patients in their interviews. Often, as interpreted through Heidegger's concept of leaping-in, nurses justified the use of restraint as a 'last resort' to support the patient's best interest (section 7.1.4). The limited occasions where empathy was expressed (n=3), were related to the notion of *'failing the patient'*. It may be that limited empathy was a purposeful reaction to support the nurses' decision-making and problem solving during the stressful time of using restraint. However, inadvertently this reduction in empathy as a coping strategy may contribute to the continuation of the use of restraint and/or when it is determined as a last resort.

Moral disengagement is another functional cause of dehumanisation and it serves to justify past or prospective harm (Haque & Waytz, 2012; Haslam, 2006). The literature highlights how physicians often find themselves in both contexts, where

there is a need to inflict pain necessary for treatment and moral disengagement helps to minimise the guilt and thereby increasing dehumanisation (Haque & Waytz, 2012). Moral disengagement was present among the nurses in my study as described through Heidegger's concept of leaping-in (section 7.1.4). It was evident that nurses were aware of the negative impact of using restraint but felt it was necessary to do so for multiple reasons, consequently rationalising its positive impact for patients and/or staff. This moral disengagement may also be another explanation for the limited expressed feelings from the nurses about their accountabilities for the use of restraint and its impact on patients. This functional cause of dehumanisation also emerged in the literature as nurses experienced role conflict, where the decision-making about restraint application highlights the interface among ethics and safety for nurses (Bigwood & Crowe, 2008; Kontio, Välimäki, et al., 2010; Marangos-Frost & Wells, 2000).

Overall, the concept of dehumanisation and restraint use has not been formally linked, aside from a small number of qualitative research studies expressing patients' perspective of feeling dehumanised when restrained (Brophy et al., 2016). However, insights from this study strongly suggest that all facets of dehumanisation are present for nurses when determining 'last resort'. Although the nurses did not overtly express and or recognise dehumanisation per se, many aspects of the functional and non-functional causes of dehumanisation surfaced associated with Heidegger's concepts of inauthenticity, leaping-in and thrownness described in the interpretations (chapter seven). Overall these insights raise questions as to whether dehumanisation helps nurses to cope with the tensions of placing someone in restraint or if it is further enabling this practice to continue. There is a wealth of research illustrating the benefits of therapeutic relationships and therapeutic alliance on the wellness of mental health patients and reduction of violence and aggression (Auerbach et al., 2008; Beauford et al., 1997). These benefits of therapeutic relationships and alliance which require an increase in empathy, raise the question of whether dehumanisation has a role in mental health and specifically with the use of restraint or not, although there is some results demonstrating its functional aspects. Moreover, all the characteristics of dehumanisation described above are often entrenched practices in health care that clinicians would most likely adopt simply by conforming to a hospital setting.

Therefore, the dehumanisation uncovered in the nurses' experiences might be inadvertently as a result of their work environment and culture, underlining wider and pervasive systemic issues.

8.2.2 Relying on the collective approach

The collective approach among the nurses was a key finding contributing to Heidegger's concept of inauthenticity as described in the previous chapter. This section aims to provide further in-depth analysis into the collective identity drawing on a broader body of knowledge.

The concept of clinicians working in teams, collectively, has been promoted in health care with research highlighting how efficient, safe and patient-centred outcomes can be achieved through teamwork (Finn et al., 2010). Therefore, policy-makers, practitioners, and academics have increasingly emphasised team-based practices (Finn et al., 2010). Given many health care organisations are adopting this and promoting teamwork in the day-to-day operations of care, it may provide an explanation for the experiences of the nurses working collectively in my study.

As discussed in chapter six, there are varying reasons why nurses adopt a collective approach in the use of 'last resort'. Aside from what has appeared in the experiences shared by the nurses highlighted within the concept of inauthenticity in this study (section 7.1.4), there may also be some innate reasons why individual nurses are drawn towards this collective approach. From the research and theoretical perspective on collective identity, Brewer and Gardner (1996) explain that *'individuals seek to define themselves in terms of their immersion in relationships with others and with larger collective and derive much of their self-evaluation from such social identities'* (p. 83). Similarly, Baumeister and Leary (1995) propose that individuals are driven to form positive, lasting, and stable relationships as a result of a *'need to belong'* that they believe is a basic and fundamental innate feature of human nature. Likewise, in Maslow's hierarchy of needs, which is a motivational theory in psychology comprising of five tier model of human needs, a sense of belongingness is identified as a deficiency need, which when unmet can motivate people (Maslow, 1970). Given the multiple factors that

influence mental health nurses' decision-making to use restraint (chapter three), one can argue that this is a difficult decision to make. Moreover, disagreements related to this decision may cause rupture in the relationships among team members. Therefore it could be argued that nurses comply with restraint practices in order to meet an innate need of preserving their relationship with their team members, as described by Brewer and Gardner. Although nurse participants in this study did not explicitly discuss innate needs, some alluded to this by describing their reliance on the team, recognising that they needed their team's support in decision-making.

Brewer and Gardner (1996) also explain that at the collective level, the group's wellbeing becomes an end in itself. Experimental research has illustrated the powerful impact of collective identification on individuals' willingness to restrict individual gain to preserve a collective good (Brewer & Gardner, 1996). Translating this concept to the work environment of the nurses, where the ward, including the staff and patients, can represent the group, the nurses have a sense of belonging to the group and strive to achieve its wellbeing. Perhaps from the nurse's perspective when they reach the decision to use restraint as a 'last resort', it is viewed as restricting one for the greater good of the group– other staff and patients.

Social Identity Theory aims to describe a person's sense of who they are based on their group membership (Tajfel, 1981). According to this theory, the experience of being a member of a group provides participants with '*an instant and meaningful collective identity that is experienced as emotionally significant*' (Ashmore et al., 2004, p. 84). We need to consider whether this collective approach by nurses during what is considered a highly stressful situation of determining restraint use, creates an experience that is meaningful and emotionally significant. The sense of being part of a group and having a collective approach may alleviate the stress experienced in applying restraint.

However, it is also important to acknowledge that processes related to restraint use occur in the form of a team approach. In practice nurses often adopt a team or collective approach to safely use restraint and would not do this individually as it

poses many safety risks. Additionally, nurses are trained in crisis prevention and intervention types of education in the format of teams/groups. This raises the question of whether the collective identity and approach is a reflection of the broader practice and training in nursing or specifically towards practices that are only conducted in a team approach. Hence, these findings may simply be reflecting the method of restraint application itself. The collective approach also aligns with the theme of maintaining control from the integrative review (section 3.4.2.5), where nurses used restraint as a strategy to suppress aggressive behaviours of patients and achieve order, stability and safety on the ward (Lee et al., 2003; Perkins et al., 2012). It may suggest that the collective approach enables maintaining control for nurses.

The next section builds on the concept of a collective approach and looks to further expand on it through the concept of groupthink, which closely links to the Heideggerian informed interpretations of restraint practices through thrownness and inauthenticity.

8.2.3 Groupthink

Heidegger's concepts of thrownness and inauthenticity provided a useful lens to the interpretations of nurses' accounts. These concepts reflect how nurses depended on the know-how of their peers (refer to sections 6.3.3.2 and 7.1.3), as well as, the collective decision-making (refer to sections 6.3.3.3 and 7.1.2), which aligns closely with the notion of 'groupthink'. Groupthink is a term coined by the social psychologist, Irving Janis, from Yale University (Janis, 1997). Janis (1997) defines groupthink as:

'a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action' (p. 237).

There are other researchers who assert that groupthink can also occur in groups via a false sense of cohesion (Shirey, 2012). According to Janis (1997), even though group members may view like-minded thinking as an asset, this '*superglue of*

solidarity that bonds people together often causes their mental process to get stuck' (p. 237) . The collective identity and the dependency on the others' knowledge and experience unearthed in the concept of thrownness in my study (section 7.1.3) can be further explained by this concept of groupthink. Nurses expressed a reliance on the 'groupthink' – the knowledge and experience of their team members – to determine 'last resort' in the use of restraint.

Nurses in my study repeatedly reflected on the actions and decisions of other nurses rather than their own when enacting 'last resort'. Even if they disagreed with others' actions or decisions, they did not reveal their disagreement to the team. Rather, their experiences mainly demonstrated conformity. Shirey (2012) highlights that in the presence of groupthink, *'groups examine few alternatives, are not highly selective in gathering data for analysis, fail to challenge assumptions, and do not look beyond the immediate environment for answers or expert direction'* (p. 69). Therefore, it may be a result of groupthink that nurses continue to use restraint, even as a 'last resort', even when they are aware of its negative impact. This could mean that nurses may be using restraint to comply with team expectations and decisions to ensure harmony among the team instead of exploring other alternatives. Essentially, the teams' mental processes may be stuck in the traditional restraint practices as a result of maintaining solidarity among the team members, thereby limiting opportunities to challenge these practices.

Kaba and colleagues (2016) in their study of teamwork in health care, highlight the direct evidence of group conformity bias. In particular, they describe the preference for consistency among humans when they interact, which may lead individuals to change their decision in order to avoid inconsistency (Kaba et al., 2016). The data from my study also revealed this concept (refer to inauthenticity, section 7.1.2). For example, Aidan explained how nurses often do not like to be considered an 'outsider' and rather have a desire to be part of the team. From his perspective this influenced nurses making collective, the 'They' based decisions. Furthermore, Aidan's experiences suggest that a lack of confidence and the desire to be accepted overpowers any clinical judgment or disagreements related to 'last resort'.

Moreover, Kaba and colleagues' (2016) study explored group conformity bias with nursing and medical students and identified that both groups of students were susceptible. They found that group conformity resulted in incorrect interpretation of important physical findings, thereby inferring an increased risk of adverse outcomes (Kaba et al., 2016). This was reflected through the interpreted findings using Heidegger's concept of thrownness (section 7.1.3) that evidence-based practices may be subconsciously dismissed in order to naturally conform to consistent practices among the team – restraint use.

When the participants in the experiments conducted by Kaba and colleagues (2016) were interviewed, three-quarter of those who demonstrated conformity bias denied conforming, suggesting that preference for consistency and pressure to conform occur on a subconscious level (Kaba et al., 2016). This finding may explain why the experiences of the nurse participants in my study did not explicitly reveal groupthink or conformity bias, as these acts most often would be unconsciously occurring.

The next section shifts to examine Heideggerian informed interpretation of the concept of fear uncovered from the lived experiences of nurses. It will review the findings of this study in relation to the wider literature with the aim to better understand the phenomenon of 'last resort' in the use of restraint.

8.2.4 Fear-based approach

Heidegger's concept of fear was used to illuminate why nurses apply restraint (refer to section 7.1.5). The lived experiences of the nurses suggested that the perceived risk in relation to dealing with aggressive patients created a mood of fear. With regards to the larger health care literature, the concept of 'risk' has become increasingly prevalent, however, the underlying and influencing factors in determining risk, such as fear, have been relatively unexplored and under-theorised (Furedi, 2006; Jacob & Holmes, 2011). Literature has illustrated that nurses working under threat are compelled to redefine their interactions and choice of interventions with patients (Arnetz & Arnetz, 2001; Duxbury &

Whittington, 2005; Foster et al., 2007; Jacob & Holmes, 2011; Kindy et al., 2005; Morrison, 1990; Needham, 2006). Jacob and Holmes (2011) crystallise this stating:

'Because of the perceived risk of violence that patients embody, the need for self-preservation on the part of nurses becomes a perceptible variable that influences nurse-patient interactions. The negative effects of fear (one of the most reported effects of violence) on patient care have been described by various authors. The apprehension about being victimised may lead fearful health care staff to adopt more controlling and less responsive services, to dissociate themselves from patients and to become passive carers' (p. 107).

This perspectives aligns with Heidegger's concept of fear, suggesting that this mood arises when individuals encounter something within their world that is threatening to their potentiality-for-being (Heidegger, 1996). Similarly, the literature also suggests that mental health nurses have instituted rituals of protection, such as removing personal articles from patients and conducting searches, as a response to the fear of violence. This supports Heidegger's (1996) belief that fear has an object and when that object is removed, the fear no longer exists. Therefore, the findings of my study imply that nurses felt threatened at any perceived risk in a situation (section 6.3.3.7) and the use of restraint may reflect the removal of the object causing fear – the patient.

Literature also indicates that nurses limit their chance of violence by acting on situations that have not yet happened (Jacob & Holmes, 2011). Lazarus and Folkman (1984) suggest that in managing situations, nurses evaluate the consequences of using certain strategies over others, which will vary based on the relationship between the individual, the context and the available resources. This further supports Heidegger's concept of temporality highlighted in this study, where the nurses past experience impacts the present relationship and context between the nurse and patient, influencing whether restraint is needed as a 'last resort'. Jacob and Holmes' (2011) study also indicated that the escalation of a patient increased the nurses need to control the disruptive object (patient) with the aim of neutralising the risk or threat. This is done on a continuum of restrictive interventions, ranging from de-escalation to physical force. However, the level of

danger and fear associated with some patients drive nurses towards precautionary coercive measures to ensure overall safety of the ward (including their own safety) (Jacob & Holmes, 2011). This is similar to findings from my study where nurse participants referred to acting on their 'just in case' perceptions (section 6.3.3.7) to ensure overall safety, and thereby leading to their 'last resort' intervention of restraint.

The above evidence from the wider literature supports the findings from this study related to Heidegger's concept of fear. It essentially suggests that perceived risk drives reactive responses by nurses, such as the use of restraint. These perceived risks identified by nurses are most likely producing fear that the nurses want to remove in order to attain control and safety, through the use of restraint. Additionally, these perceived risks might also be present as a result of the nurses' past experiences and encounters with patients (refer to section 7.1.1 on temporality). Therefore, the findings indicate that fear and temporality contribute to nurses attempting to control the environment and minimise their fear of risks through coercive actions, such as the use of restraint. If the perceived risks did not produce fear for the nurses, one may question whether restraint would be used at all.

The next section further expands on temporality and discusses the findings in relation to the concept of trauma, where both fear and trauma are viewed as possible outcomes related to temporality.

8.2.5 The impact of trauma

Building on the concept of temporality (section 7.1.1) used to interpret the findings of this study it becomes integral to then examine the concept of trauma, specifically, where the past experiences of restraint use impacts upon the nurses' future responses in similar situations. Some authors suggest that the repeated exposure of staff to aggression and violence (including involvement in restraint) may result in trauma for those directly involved or vicariously exposed (Bonner et al., 2002; Paterson et al., 2013). The exposure to, or involvement in coercive events (including restraint) can often generate very strong feelings usually characterised

by fear, anger and frustration (Maier, 1999; Paterson et al., 2013). Bloom (2000) indicates *'the negative effects associated with exposure to violence are so noxious that the individual cannot contain them without resorting to protective defences that are often destructive'* (p. 13). It is also acknowledged that such feelings will be a continued source of stress for the individuals involved, as well as, the team and eventually the organization and its culture (Bloom, 2010).

Moreover, there is a small number of studies that identify that psychiatric staff who have been assaulted by patients, experience post-traumatic stress, and that the rate of post-traumatic stress disorder (PTSD) appears to be between 9% and 10% for these staff (Chen et al., 2008; Richter & Berger, 2006). Studies have also indicated that the trauma and PTSD experienced appears to affect the psychiatric nursing staff workplace performance, including decision-making (Mealer et al., 2009).

Aside from the evidence reporting the psychological impact (Bonner et al., 2002; Moran et al., 2009; Sequeira & Halstead, 2004), literature has also identified physiological effects of trauma that influence responses. From a physiological perspective, research has demonstrated that people who are traumatised have deficits in their ability to regulate their emotions (Breslau, 2002; Cook et al., 2009; NETI, 2005). In looking at the brain to further understand response and emotional regulation, the amygdala and the hippocampus play key roles. The amygdala is responsible for fight or flight and the hippocampus above the amygdala applies context to situation and aids to regulate the amygdala and other function of the brain (De Bellis et al., 1999; NETI, 2005). When there is a stimulus, it is transmitted very quickly to the amygdala and in split seconds the same stimulus is relayed to the cortex and the hippocampus. This is where the memory and context come into play. For people with traumatic stress, when they experience a particular stimulus that reminds them of that trauma, their immediate response is altered. When their amygdala is activated, their capacity to wait for the 'context' is diminished and therefore they respond rapidly to a perceived threat or emergency and shift into an 'emergency state of behaviour' (LeDoux, 1996; NETI, 2005). As described in the findings of temporality (section 7.1.1), when John shared that his past experience of being assaulted by a patient 'coloured' the way he responded to the next patient

who was demonstrating aggression, no matter their level of severity, the impact of trauma was emphasised. He described that because of his past experience he would not spend too much time talking/de-escalating the patient and would be more ready to use restraint. This depicts the changes to John's response given his past traumatic experience of assault. Overall, research demonstrates that the experience of trauma can compromise the individual's functioning. Processing of information in the present time is impaired and slower (LeDoux, 1996). There are several studies that have repeatedly illustrated the damage to the hippocampus and the cortex, where context and understanding of stimulus are sacrificed for speed and survival, as a result of traumatic exposure (Kilpatrick et al., 2001; LeDoux, 1996, 2002; NETI, 2005; Smith & Hart, 1994; Solomon & Davidson, 1997).

The above evidence links to the interpreted finding of temporality from my study by demonstrating the possible impact of trauma from past experiences and the influence it can have on nurses' responses. What the findings may be suggesting is that the trauma some nurses experience is influencing their behaviours and interactions with patients, leading to restraint as a 'first resort'. Trauma may influence the nurses' management of escalating patients and their perspective of when restraint is used as a 'last resort'. This poses the question of whether nurses' perspective when restraint is used as a 'last resort' would alter if the experience of trauma were either mitigated in the first place or addressed/dealt with through debriefing, further discussed in section 8.3.1.

An additional perspective to acknowledge is the impact of trauma on organizational culture. As mentioned earlier in this section, the individual psychological impact of trauma has potential to permeate through to the organizational culture. Furthermore, in section 2.5 the variation in restraint incidents among mental health services was discussed which can suggest the possibility that organizational culture may be influencing restraint utilization.

The above sections have provided a discussion of the findings of this study through further theorisation with the wider literature. Although this is a small study, the findings have made contributions to knowledge in the field of restraint utilisation largely due to the absence of any previous similar studies. Whilst some studies

have focused on various aspects of restraint use such as decision-making, impact, or minimisation, this study has provided insight into how its use as a 'last resort' as experienced by mental health nurses. The following section will identify various practice recommendations framed as antidotes to restraint use. Antidote is defined as something that relieves, prevents or counteracts. Therefore for the purposes of this thesis, these antidotes have emerged as a result of the findings with the aim to advance restraint minimisation.

8.3 Practice recommendations: Antidotes to the attributing factors in using restraint as a 'last resort'

As a result of the findings from this study, a number of practice recommendations have been identified in the form of antidotes. The purpose of the antidotes is to counter the key findings, which I believe contribute to the continued use of restraint and are seen as attributes to what is perceived by nurses as 'last resort'. These antidotes are opportunities for mental health nurses, organisations, and the mental health system to mitigate restraint utilisation and include: debriefing, recovery-oriented care in mental health, trauma-informed care, mitigating groupthink, and de-escalation techniques.

8.3.1 Debriefing

Debriefing may be a helpful antidote in relation to the nurses accounts that illustrated how temporality and fear contribute to their perception of 'last resort' when using restraint. Unaddressed negative experiences influence people's approaches over time and therefore, it is imperative that timely support and interventions are provided. Debriefing is a key practice that can address the impact of negative experiences (Bonner & Wellman, 2010; Goulet & Larue, 2015; Larue et al., 2010; Secker et al., 2004; Te Pou o Te Whakaaro Nui, 2014). Although there are other treatments and interventions that aid in the treatment of trauma, such as pharmacotherapy (Sullivan & Neria, 2009), cognitive behaviour therapy (Keen et al., 2017), and eye movement desensitisation and reprocessing (Seidler & Wagner, 2006), I have selected debriefing techniques as a key antidote given the

evidence that exists directly in relation to the experience of restraint use and the prevention and management of violence specifically in inpatient settings.

The literature focusing on debriefing related to restraint use categorises this into three types: patient debriefing, staff debriefing and psychological debriefing (Goulet & Larue, 2015; Te Pou o Te Whakaaro Nui, 2014). Specifically in relation to my study, staff debriefing and psychological debriefing may be supportive interventions to reduce the possibility of adverse influences in the nurses' future approach and care. Staff debriefing is defined as a rigorous event analysis of each incident to address practice issues, identify system problems and prevent recurrences (Caldwell, 2005; Huckshorn, 2008; Te Pou o Te Whakaaro Nui, 2014). Although within the extant literature there are methodological limitations of research studies, outcomes have consistently demonstrated the contribution of formal debriefing in successful seclusion and restraint reduction initiatives (Huckshorn, 2008; Te Pou o Te Whakaaro Nui, 2014). Psychological debriefing is identified as an equally important process of providing post-incident emotional support in literature (Te Pou o Te Whakaaro Nui, 2014). Despite the increased recognition of the negative psychological effect linked with coercive practices, there is limited research or guidance on psychological debriefing or other forms of post-incident support in mental health settings (Grubaugh et al., 2011; Jacobowitz, 2013). Staff reported the impact of restraint use including feeling traumatised, fearful, guilty and powerless (Jacobowitz, 2013; Sequeira & Halstead, 2004) and therefore studies exploring restrictive practices have emphasised an urgent need for improved post-incident support (Larue et al., 2010; Meehan et al., 2000; Ryan & Happell, 2009). This evidence further supports this practice recommendation for this study given the indications of fear and trauma among the nurse participants, as well as, the signs of guilt and powerlessness. In relation to my study, the intention of debriefing would be to support the nurses in their negative experiences such as their feelings of failing the patient or reaching a point of no return, where nothing else could be done except to implement restraint, leaving them feeling powerless.

A recent publication by the National Centre for Mental Health Research, Information and Workforce Development (2014) reviewing the literature on

debriefing following seclusion and restraint, identified two functions to debriefing – *‘to reduce distress and support a return to individual and ward ‘equilibrium’ in the acute phase and then to provide a feedback loop through more formal review processes’* (p. 20). The National Association of State Mental Health Program Directors also recommends that the formal debriefing post a restraint incident follow the steps in a root cause analysis to ensure a rigorous problem solving procedure is followed (Huckshorn, 2008). This is believed to aid in identifying what went wrong, what knowledge was unknown or missed, what could have been done differently, and how this may be avoided in the future (Huckshorn, 2008).

Implementing debriefing technique will require organisations to create policies and procedures to ensure nurses are provided with an opportunity to participate in debriefing post a restraint incident and also have oversight in ensuring that this is occurring. This antidote is recommended in order to address the reported consequence of restraint use related to negative experiences identified in the findings of temporality and fear. Moreover, mental health nurses need to also recognise the importance of participating in such events and partake in them.

8.3.2 Advancing recovery-oriented care

The findings of my study interpreted using Heidegger’s notions of inauthenticity, leaping-in, and thrownness, also have been linked closely to the concept of dehumanisation when further analysed. As indicated in the findings and in section 8.2.1 on dehumanisation, key characteristics seen among the nurses were rationalisation of restraint use for the best interest of the patient, de-individuation of care, generalisation of patients and labelling of patients with their illness and/or behaviours. I believe the antidote towards these practices is the adoption of recovery-oriented care in mental health. The concept of recovery in mental health refers to *‘living a satisfying, hopeful, and contributing life, even when a person may be experiencing ongoing symptoms of a mental health problem or illness’* (Mental Health Commission of Canada, 2015, p. 8). The Mental Health Commission of Canada (2015) recently published Guidelines for Recovery-Oriented Practices where a number of dimensions have been articulated to support this transition towards incorporating recovery in mental health care. Recovery is described as

being personal, unique to each individual. To embrace a recovery orientation in practice it requires an essential shift that embraces seeing each individual not as a *'patient who is fundamentally different or damaged, but as a person striving to live the most fulfilling life possible'* (p. 25). This approach avoids placing labels on patients or defining them by a diagnosis, where:

'Each person brings their own special skills, qualities, values and experience and holds multiple roles and identities that fuel their sense of personal agency and can be drawn upon to support recovery...focusing on the inherent and diverse strengths and abilities of each person, rather than on their deficits or limitations, motivates people to feel good about themselves and builds confidence and resilience while helping people take action towards achieving their goals' (Mental Health Commission of Canada, 2015, p. 25).

Adopting a recovery-oriented practice also involves incorporating empathy in care. Empathy is often suggested as a requirement for overcoming dehumanisation (Halpern & Weinstein, 2004; Haslam, 2006). Although some literature report benefits gained by sacrificing empathy in order to further increase cognitive objectivity, especially in solving complex clinical problems (Cheng et al., 2007; Decety et al., 2010), there is empirical evidence that empathy benefits patients (Halpern & Weinstein, 2004; Haslam, 2006; Spiro et al., 1996). Specifically in mental health, evidence points out that nurses with greater empathy endorse more positive attitudes towards caring for those with mental illness (Hsiao et al., 2015). Moreover, literature suggests that empathy, 'as a backbone of therapeutic relationships', assists in accurately eliciting and identifying patient preferences and values in response to health problems, and therefore, improves patient health outcomes (Gateshill et al., 2011; Hojat, 2007). Several studies have also proposed that empathy can assist in creating an interpersonal climate that is free of defensiveness and that enables individuals to talk about their perceptions of need (Mercer & Reynolds, 2002; Reynolds, 2000). A study by Yang et al. (2014) explored the association between empathy of nursing staff and the reduction of seclusion and restraint in inpatient mental health setting and reported empathy to impact minimisation of these coercive practices. In their study a key recommendation

included that recruiting and retaining empathic nursing staff member is a strategy that can reduce restraint and seclusion incidents (Yang et al., 2014).

Often the question remains as to how to operationalise recovery into practice, which is what the Mental Health Commission of Canada has attempted to accomplish through their publication of the Guidelines for Recovery-Oriented Practice. Specifically related to implications to practice, the guidelines have articulated a series of elements in the domains of values and attitudes, knowledge, and skills and behaviours gathered from literature to aid in this transformation. Below depicts key highlights from each domain in relation to mental health practitioners and providers:

Values and Attitudes:

- *Are open to changing, developing and embracing new work practices.*
- *Commit to learning and continuous improvement.*
- *Welcome the contribution of experiential knowledge to strengthening compassionate, person-centred ways of working.*
- *Respect the dignity of risk and approach positive risk-taking as an opportunity for success.*

Knowledge:

- *Know how the core elements of a recovery orientation can be practiced in any mental health setting and how this orientation can be applied with diverse populations.*
- *Are knowledgeable about psychosocial rehabilitation practices, values and competencies and their role in promoting personal recovery.*
- *Know the relevant legislation and requirements regarding safety and the rationale for when coercive interventions may be required.*
- *Are knowledgeable about the range of options for treatment, therapy and other supports and how best to help manage symptoms.*

Skills and Behaviours:

- *Collaborate with people with lived experience when formulating plans for training and development.*
- *Encourage and equip teams to strengthen the application of a recovery orientation across different settings and with various and diverse populations.*

- *Engage regularly in reflective practice to continually increase knowledge, examine their own work, mind sets and habits, and make progress in supporting recovery.*

(Mental Health Commission of Canada, 2015, p. 90)

Clinicians and organisations should work towards implementing recovery-oriented practices that would ultimately support individualised care where patients are seen as unique human beings, while building collaborative, mutually respectful, partnership-based relationships with patients.

8.3.3 Trauma-informed care

As a result of the link between the prevalence of childhood exposure to trauma and long-term adverse mental health outcomes, there is a strong evidence base for the need for inpatient mental health setting to become trauma informed (Muskett, 2014). As mentioned earlier (section 8.2.5), the advancements in neuroscience have illustrated that the structure and function of a developing brain is altered following exposure to significant childhood trauma (Bremner, 2002; Heim & Nemeroff, 2002). Additionally, becoming more evident is the phenomenon of neuroplasticity and the brain's ability to compensate for deficits, such as those emerging from childhood abuse, and reverse neural pathway discrepancies between the limbic system and cortex, assuming sustained exposure to positive experiences at any age (Citri & Malenka, 2008). Studies demonstrate that up to 90% of people seeking treatment for serious mental illness and substance abuse were exposed to significant emotional, physical and or sexual abuse in childhood (Felitti, 2004; Hennessey et al., 2004; Morrison et al., 2003; Scaer, 2005; Stein & Kendall, 2006; Talbot et al., 2011; Wheeler et al., 2005). Among the literature, a key outcome of trauma-informed care is the reduction of the use of restraint and seclusion in mental health care (Ashcraft & Anthony, 2008; Azeem et al., 2011; Barton, 2009; Borckardt, 2011). Therefore, trauma-informed care has emerged as a key paradigm in order to meet the needs of persons accessing mental health services. Trauma-informed organisations are those that are aware that their services can traumatise and re-traumatise patients through indiscriminate application of coercive practices (Hodas, 2006).

Muskett (2014) describes the key principles of trauma-informed care to include:

- i) Patients need to feel connected, valued, informed, and hopeful of recovery;*
- ii) The connection between childhood trauma and adult psychopathology is known and understood by all staff; and*
- iii) Staff work in mindful and empowering ways with individuals, family and friends, and other social services to promote and protect the autonomy of that individual' (p. 52).*

Trauma-informed care is closely linked with recovery philosophies of care described in the above section, where nurses adopt specific principles and philosophies in their care provision. Jennings (2004) suggests that an effective trauma-informed service is not just designed to treat symptoms or syndromes related to significant sexual, physical, or emotional abuse; rather the staff are aware of and sensitive to doing no further harm to survivors. It is therefore best practice for organisations to apply 'universal trauma precautions' to all they serve; where nurses routinely incorporate practices that are growth promoting and recovery focused and less likely to re-traumatise those already exposed to significant interpersonal trauma (Muskett, 2014).

A method of operationalising this approach into care practices is the implementation of restraint minimisation models; all of which embrace the core principles of trauma-informed care. As discussed in detail in chapter two, there are a number of models for organisations to implement with the purpose to minimise the utilisation of restraint and seclusion and enhance trauma-informed care practices. The models described earlier were the Six Core Strategies©, REsTRAIN YOURSELF, Safewards, and No Force First. All of these promote a multidimensional approach towards minimising coercive practice – including the use of restraint (Ashcraft et al., 2012; Bowers, 2014; Duxbury, 2017; Huckshorn, 2008). A recent publication by Lebel et al (2014) demonstrated the effectiveness of reducing restraint and seclusion use, as well as, the prevention of conflict, violence and overall coercion in care, when a multidimensional evidence-based model has been implemented.

Overall, this recommendation directly challenges nurses to review many of their practices and procedures in mental health settings, such as ward rules, search procedures, locked doors, and the use of restraint and seclusion, as they are re-traumatising and are experienced by patients as emotionally unsafe and disempowering (Borge & Fagermoen, 2008; Clark et al., 2008; Cleary, 2003; Walsh & Boyle, 2009). Therefore, this recommendation is seen as an antidote to increase awareness for clinicians' about their patients and how they perceive their patients - in a less dehumanising manner. In better understanding their patients it can positively impact the care provided and their responses, potentially mitigating restraint use.

8.3.4 Mitigation of groupthink

Nurses' interdependency on the team's knowledge and expertise captured in Heidegger's concept of thrownness, as well as, groupthink specified in the concept of inauthenticity, were key findings in my study. There are a number of antidotes to improve teams practices and to prevent the negative impacts of the dependency on know-how of others and groupthink. These antidotes are detailed as follows:

One antidote includes reflexivity. A recent study by Boumans et al. (2012) exploring nurses' decision on seclusion reported a negative correlation between the degree of reflexivity of a team and the team's tendency to seclude. Therefore, the reflexivity of teams may be an important antidote to groupthink that endorses coercive practices. It has been noted that teams often do not engage in reflexive behaviour spontaneously (Schippers & Homan, 2009). The literature identifies several factors to enhance reflexive processes amongst teams that should be considered (Widmer et al., 2009). From a team perspective the characteristics that influence team reflexivity include trust, psychological safety, shared vision, and diversity (Widmer et al., 2009). Moreover, the patterns and styles of leadership have been identified as an important factor to enhance reflexivity. For example, a team's leader has to react in an adequate way to incidents that evoke teams to step back from their original task to discuss the impact. In one study, Hirst and colleagues (2004) demonstrated that facilitative leader behaviour – promoting

respect and positive relationship between team members, productive conflict resolution, and open expression of ideas and opinions – was positively associated with team reflexivity.

Janis (1997) proposed another antidote to reduce the risk of groupthink that relates to critical evaluation of an individual's performance and getting explicit feedback from patients on whether the interventions were effective (similar to the concept of debrief mentioned earlier). Shirey (2012) proposes a number of strategies to prevent groupthink such as, addressing group member composition and ensuring diversity among them. Shirey (2012) also believes group members who are willing and able to act independently are most desired as it allows for individual critical evaluation to surface. Another recommendation is for groups to be centralised such that their affiliation is not exclusively aligned with one team perspective. This relates to where a nurse is not associated to one ward and team, and rather works with different people and contexts to prevent conforming to unique cultural perspectives that may endorse coercive practices. This may be accomplished through changing operational practices in relation to staffing and scheduling. A limitation of this approach is that there will be less familiarity with patients and team members if nurses are scheduled onto different wards. Lastly, there is also opportunity to incorporate some of the strategies early on in training and curriculum of clinicians, where reflexivity and teaching to receive feedback from patients is built in within their activities.

8.3.5 De-escalation techniques

The nurses' experiences in this study depicted that there is often dependency on other staff members who are perceived to have the skills to support and manage escalating situations. An antidote for practice is an enhanced understanding of de-escalation techniques and how to further integrate these into practice.

De-escalation techniques are composed of a variety of psychosocial techniques aimed at reducing violent and/or disruptive behaviour (National Institute for Health and Care Excellence, 2015). Though there is a paucity of research in this area, Cowin et al. (2003) provided guidance in their examination of the concept of

de-escalation through the following definition: *'a gradual resolution of potentially violent and/or aggressive situation through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit setting that is based on respect'* (p. 65). However, there continues to be a lack of consensus in understanding the elements of de-escalation techniques (Cowin et al., 2003; Duxbury, 2002; Johnson & Hauser, 2001; Price & Baker, 2012). Elements of effective de-escalation interventions identified in the literature for the management of aggression include preserving patients' autonomy and dignity, self-awareness, intervening proactively, offering patients choices and options and evading physical confrontation (Cowin et al., 2003; Price & Baker, 2012). Studies have illustrated least restrictive and least intrusive clinical practices, including de-escalation, support nurses in further developing relationships with patients, resulting in a potential increase in the nurses' self-esteem and job satisfaction (Cowin et al., 2003; Price & Baker, 2012).

Price and Baker (2012) through a thematic synthesis of the literature on de-escalation techniques have identified key components of this practice. The authors reported on seven themes, which fell within two core categories of 'staff skills' and 'intervening'. Among the category of staff skills the emerging themes included: characteristics of effective de-escalator, maintaining personal control, and verbal and non-verbal skills. In the process of intervening four themes were identified which included: engaging the patient, when to intervene, ensuring safe conditions for de-escalation, and strategies for de-escalation (included two sub-themes, autonomy confirming interventions, and limit-setting and authoritative interventions) (Price & Baker, 2012). In addition, their findings highlighted the lack of trials conducted within rigorous experimental conditions. More robust research is suggested to be critically needed, especially in light of research continuing to depict negative staff-patient interactions as common antecedents to assaults on psychiatric settings (Duxbury, 2002; Duxbury & Whittington, 2005; Price & Baker, 2012). The key elements in the process of de-escalation are *'establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression'* (Price & Baker, 2012, p. 318). Though de-escalation

is the first line intervention recommended in policy governing the management of violence and aggression (National Institute for Health and Care Excellence, 2015), it is also important to acknowledge a key criticism of it being used as a reactive approach, rather than one which is proactive in managing aggression (Duxbury, 2002; Price & Baker, 2012).

A key recommendation from my study is to build skills and competencies of nurses in de-escalation techniques and ensure these practices are proactively and consistently integrated in the clinical settings.

8.4 Strengths and limitations of the study

This study is the first to date that explores the concept of 'last resort' in the use of restraint. It contributes to our initial understanding of this phenomenon through the lived experiences of thirteen mental health nurses throughout Canada. This study uses an in-depth analytical approach guided by van Manen that supported the interpretations of the lived experiences of the nurse participants. The use of Heideggerian concepts enabled unique perspectives of 'last resort' to be identified. The mental health nurses were from a range of mental health inpatient services from various provinces in Canada, thereby increasing the transferability of the findings. The in-depth interviews with each participant enabled the opportunity to focus on understanding the meanings of the phenomenon through descriptions of lived experience of each nurse.

A limitation of this research is the small sample size of the study. The sample size was guided by the principles of time and data saturation (Smythe, 2011). Whilst the participants were from various provinces across Canada and not localised to one geographical location and it was felt that data saturation was reached, the findings may not represent the general mental health nursing population in Canada. There is the possibility that there are mental health nurses in practice who had different experiences.

It is important to note that this research reflects a position in time, denoting the temporal nature of our being. From a hermeneutic phenomenological perspective,

once we understand, this changes our perceptions of how we view our lifeworld, which in turn alters our understanding (Gadamer, 2004). Therefore, the interpretation is circular, and never ending. Future research about this phenomenon will assist in substantiating the interpretations generated. It is also inevitable, despite all attempts and strategies implemented (such as reflexive diary and regular supervision) to avoid biases and prejudices entering into the interpretive analysis. Thus, I am aware that my own prejudices were a critical part of this research process and findings developed and acknowledge that my preconceptions are enmeshed in the interpretations of the data. Further research is needed to corroborate or refute findings. Additionally, the Canadian mental health care culture may pose unique experiences and perspectives that differ from other cultures and countries, posing a limitation in transferring the findings outside of Canada.

Another limitation includes the inherent bias of social-desirability in social science research, where the nurse participants may have reported what they believed to be expected of them. In this study the nurses understood the purpose of the research, which naturally pointed towards restraint minimisation/reduction by the essence of trying to understand 'last resort'. The participants may therefore have felt obligated to construct a story that met the expectations of the research, rather than reality. Carolan (2004) and Miller (2000) explain that participants hold public and private narratives. The private narrative consists of inner, personal experiences, whereas a public narrative represents a construction that conforms to societal expectations. Additional qualitative insights such as observational analysis to authenticate the nurses' accounts are warranted.

Lastly, although in the literature review within the theme of staff composition, a study by Gelkopf et al. (2009) identified male nurses to consider restraint more often upon specific patient behaviours, my study did not identify any gender variances among the participants.

8.5 Suggestions for future research

There are a number of recommendations for future research as a result of this study. First, further research examining 'last resort' is needed given that this is the first formal study of its kind. The examinations could include similar approaches to see if further findings can be uncovered. Additionally, 'last resort' in restraint use can be explored in different cultures and settings and with different methodological approaches such as ethnography to expand our understanding. Moreover, there could be comparative studies to understand whether there are any differences in perspectives related to 'last resort' in organisations that have formally implemented restraint minimisation practices compared to those that have not.

Greater understanding of the significance and impact of the collective identity on care and clinical decision-making of nurses would also be beneficial. Further exploration of the functional and non-functional aspects of dehumanisation with respect to restraint use is also warranted. Given the emergence of this concept with no formal studies associated with restraint use in mental health, it would be beneficial to examine whether there is a role for dehumanisation in this practice. A qualitative study analysing the generalisation of patients and better understanding what this represents amongst nurses, such as depersonalisation, and its function would make a significant contribution to the knowledge base related to nursing and mental health care. Another suggestion would be to examine the impact and management of fear among mental health nurses.

Lastly, I believe there are opportunities to further evaluate the various antidote recommendations made in this study. It would be helpful to further research team reflexivity and its impact on restraint use. Similarly, in better understanding how receiving patient feedback can impact nursing practice in relation to restraint use. Examining debriefing techniques, how they are operationalised and its effect on restraint use will advance the area of understanding. In addition, exploring whether the centralisation of nursing staff scheduling would influence restraint use and mitigate groupthink, would make important contributions to the body of knowledge and practice. Finally, studying the patients' perspective on all the issues

stated above will add very meaningful insights and understanding regarding this area.

9.0 Introduction

In this chapter I draw together all of the previous chapters to present my final conclusion – an explanation for my findings overall. This chapter is organised into two sections. After briefly re-iterating the basis for the study in the first section, in section two, I then highlight the unique contributions I believe the findings make to the body of knowledge.

9.1 The basis for the study

At the start of my study I set out to explore the concept of ‘last resort’ in the use of restraint among mental health nurses. I have explained that restraint use in mental health has been practiced for centuries and that over the past number of decades there has been a greater recognition and understanding that the use of restraint in mental health is a counter-therapeutic measure to care and is experienced by patients as coercive and punishing. Despite the growing body of literature indicating the negative effects of restraint practice on patients, staff and organisations, the practice continues in mental health care. However, this knowledge has created an international movement towards restraint minimisation that essentially advocates to only use restraint as a ‘last resort’ when all other alternative interventions have been exhausted. Therefore, the notion of ‘last resort’ can be viewed as a key driver for nurses when making decisions related to the application of restraint. The integrative review presented in chapter three illustrates that to date there have been no studies that have explored this notion of ‘last resort’.

In order to address this gap, I chose a hermeneutic phenomenological approach guided by the work of Martin Heidegger and Hans-Georg Gadamer. My epistemological and ontological viewpoint was, and remains, to be of social constructionism, believing that meaning is constructed through our engagement with the world. We are immersed and fundamentally interconnected to our lifeworld of objects and others to generate meaning. I explored the lived experiences of thirteen mental health nurses across Canada and used the data to

develop a deeper understanding of the meanings and perspectives of 'last resort' in restraint use. As this is the first study of its nature, it offers some new and unreported insights, thereby contributing to the evidence base.

9.2 Unique contributions to evidence

Although this is a small study, a number of contributions to knowledge have been made. Mainly this is because of the absence of any previous similar study focusing on the phenomenon of 'last resort' and drawing on Heideggerian concepts to illuminate the findings. As a result, the overall findings of this study using Heidegger's philosophical perspectives are unique. There are five main areas that appear to be new knowledge in relation to the overall restraint literature that could provide a greater understanding for mental health nurses about restraint use as a 'last resort'. The following sections discuss the various aspects.

9.2.1 Negative experiences over time

The study has revealed that the mental health nurses' past negative experiences influence what 'last resort' means to them in the present time in the use of restraint. It was also evident from the nurses' stories that past negative experiences also influence 'last resort' for future decisions related to restraint practices. This is a unique finding highlighting the impact of nurses' experiences with respect to determining 'last resort' in restraint use.

9.2.2 Embracing a collective perspective

Some of the unexpected findings from the mental health nurses' stories were that a collective identity to enact restraint use was evident – which from a Heideggerian perspective would reflect an inauthentic practice. When the nurses were sharing their experience of restraint use from their own perspective, they used 'we' statements rather than using the pronoun 'I'. The findings demonstrated that the nurses embraced the standards, beliefs and prejudices of the collective team in their decision-making related to using restraint as a 'last resort'. When this was further explored with nurses, they shared that this collective identity was as a result of a dependency on their team, needing to make decisions collectively, and a

gained sense of comfort and security from this approach. The application of restraint is also done in a team approach, which may have further influenced these findings. Moreover, within the concept of inauthenticity I also showed that nurses consistently held a generalised view of the patient and the incidents of restraint use. This was explicitly seen in the interviews where some of the nurses had difficulty recalling an incident or they very easily went on to generalise their experience and the patients.

Furthermore, the concepts of collective approach and groupthink have emerged and provided a greater understanding to 'last resort'. The concepts demonstrate the impact of teams and cultures in decision-making. Although there is existing research related to collective approach and groupthink (refer to section 8.2.2 and 8.2.3) that have not been formally linked to restraint use in the past.

9.2.3 The existence of thrownness affecting restraint use as a 'last resort'

The concept of thrownness transpired from the data and highlighted how mental health nurses perspective of 'last resort' depended on the knowledge and experience (know-how) of the other nurses. Aligned with extant literature (Gelkopf et al., 2009; Holzworth & Wills, 1999; Lindsey, 2009; Perkins et al., 2012; Terpstra, 2001), the majority of the nurses believed that the greater the knowledge, experience and familiarity of the patients the nursing team had, the lesser the chance of having to use restraint as a 'last resort'. In the concept of thrownness, nurses commonly said that every time they used restraint as a 'last resort' it was influenced by a number of elements and that it was not always related to one factor. However, they could not consistently identify the factors, as they believed they were unique to each situation.

9.2.4 Preserving control of the situation

Unsurprisingly, a finding that is well acknowledged in literature (Bigwood & Crowe, 2008; Lee et al., 2003; Lemonidou et al., 2002; Lindsey, 2009; Perkins et al., 2012; Terpstra, 2001) with respect to restraint use in general, has been the concept of nurses maintaining control and safety to contain the escalating situation. In order to accomplish this the nurses displayed the concept of leaping in

and needing to use restraint as a 'last resort'. Their experiences provided a sense of reaching a point of no return where restraint was their last option. Additionally, the need to attain power and control that was commonly seen amongst the nurses, which seemed to be based on the desire to achieve what they believed was in the best interest for themselves, the team and/or the patients. Lastly, maintaining control emerged from the findings, where nurses described being thrown into a situation without feeling much control over it. This lack of control also revealed that some of the nurses had inadvertently developed an informal algorithm-like approach to manage escalating situations and attempt to mitigate using restraint as a 'last resort'. The algorithm-like approach consisted of the nurse having predetermined set of interventions, such as administering medications, de-escalating, and using seclusion that they would follow for each person. Individualisation of care for each patient was absent in their approach to manage escalating situations, however, this may have been adopted by nurses to maintain control through predetermined interventions. This unique finding of a generic approach to care to maintain control will need further exploration in future studies, as it has not surfaced in the current evidence base.

9.2.5 The existence of dehumanisation in restraint situations

In further theorising the findings with the wider literature I demonstrated the existence of many elements of dehumanisation in the lived experiences of the nurses. All the nurses in this study displayed at least one of the functional or non-functional causes of dehumanisation. This relates to how nurses demonstrated aspects of mechanisation, empathy reduction, moral disengagement, de-individualising practices, impaired agency, or dissimilarity to some degree. Given the negative effects of dehumanisation as described in the literature, it is imperative to better understand this concept in relation to restraint use, which has not been formally explored as of yet. This is therefore a unique perspective that this study contributes to the wider body of knowledge.

9.3 Conclusion

Through a hermeneutic phenomenological approach, a deeper understanding of the meanings and lived experiences of 'last resort' related to the use of restraint

has been achieved. This research was particularly focused on the concept of 'last resort' as it has not been formally explored in the past. These findings have revealed that 'last resort' is composed of many elements, where it is a complex and multidimensional phenomenon.

A number of themes have been identified based on the lived experiences of the nurses to describe 'last resort'. Moreover, Heideggerian philosophical concepts were drawn upon for further interpretation and in-depth analysis of the findings. While this study had a unique focus further research in this area would help to confirm and/or expand our knowledge. Key practice recommendations to support restraint minimisation have been highlighted. .

We are now in a time where there is a greater acknowledgment that restraint practices are not an effective form of managing behaviours in mental health. However, the practice still continues. Mental health organisations have depended on the various publications internationally that advocate for restraint use only as a 'last resort' to guide their restraint minimisation efforts. Therefore, understanding 'last resort' appears to be critical in this shift in practice and culture. The findings from this study are hoped to pave the way in this next level of understanding within the field of restraint minimisation.

The following final chapter describes the completion of my journey of this study and provides my personal reflections.

10.0 Introduction

The following sections represent the end of my journey and will share my experience of the study through highlighting a number of my reflections that have surfaced along the way. This includes reflecting on my shared experience with the participants, my gained new lens through the lived experience of the study, my sense of sadness, and my experience in engaging with philosophy. My final thoughts are offered in the concluding section.

10.1 My experience of the study

10.1.1 Realising my shared experience with the participants

During this study, as I was interviewing the nurses, I entered the experience with the notion that I did not know any of the participants and felt nervous in how I could connect with them to help them feel comfortable to share their lived experience. However, I soon realised that the commonality of experiencing the use of restraint with patients offered a connection between the participants and myself. Sharing the experience of restraint use with the participants was helpful, as it positioned me in the role of the 'insider' and as such offered some advantages as discussed by Padgett (2008) and Kacen and Chaitin (2006). The advantages included an easier introduction, a head start in knowing about the topic, and understanding nuanced reactions of participants. I found this did help develop a relationship and rapport with the nurse participants. Additionally, this shared experience positioned me to be better equipped with insights and the ability to understand implied content and was more sensitised to certain dimensions of data – such as the language used for day-to-day care.

Further in my reflections I continued to identify more shared experiences with the nurse participants that were also unexpected. Earlier I provided my pre-understandings of 'last resort' in the use of restraint (section 6.1) where I shared my sense of shame and regret when reflecting on my own past practices related to restraint use. This was mainly as a result of knowing that many of the restraint

incidents I was involved in my practice could have been prevented and were not always necessary. However, I shared that I tended to follow the guidance of the experienced nurses I worked with and followed their lead related to this practice, similar to how I learned many of my other skills – hands on, in the moment. It was not until during the data analysis phase I realised the similarities of my lived experiences with that of the nurse participants. In reviewing all the lived experiences multiple times, I recognised my shared experience with the nurses of being thrown into situations and influenced by team expectations and culture around restraint use. This insight and reflection created a new sense of empathy towards the nurse participants for me, as I felt I had a deeper understanding of their perspectives by virtue of the shared experience.

Overall, what was surprising and interesting was the sense of relatedness I gained through this journey. This was extremely unexpected because I thought given my advocacy for restraint minimisation that my perspectives would be very different from the nurses who were continuing to use restraint in their practice. I soon realised that the only difference between myself and the nurses was that I had the opportunity to step outside of direct care and observe practice from a different lens – one which is not stuck in the daily complexities and realities of patient care.

10.1.2 Gaining a new lens

As a result of my lived experience of this study, I believe I have gained a new lens. Listening to the participants describe their experiences was quite different than reading academic papers related to restraint use or as a Director of Professional Practice at work, listening to a nurse describe information about a restraint incident. Having the opportunity to have the nurses openly share their stories enabled me to develop a level of empathy that was quite unexpected. Often in my professional role I discuss clinical situations with nurses and need to be objective of the facts. However, as a researcher I was able to be with the participants in their narratives and empathetically experience their emotions and journey. Throughout my journey in my reflections I recognised that in my interviews and data analysis I was not appraising or judging the lived experiences against what ‘should be’ rather I was just open to understanding their experience as it was. This was a significant

shift in my own being. This openness enabled me to develop a deeper level of understanding of the participants' experiences that perhaps in the past was not there. Reflecting on my experience and identifying this empathy early on was helpful in keeping me open to the stories of the nurses and limited my judgement – as my role was not to determine whether these nurses met standards of practice as it would be in my professional role. In this journey I have recognised that staying in my researcher role brought a lens to nursing practice and restraint use that I had not had before. Over the years in my role in the professional practice department, I have often been stuck in a lens where I needed to assess and evaluate practice and ensuring clinicians (including nurses) adhere to their standards of practice. I have realised that this lens has limited me in my understanding of the person and the situation. This realisation has created a new layer of awareness for me, which I want to incorporate into my professional life, as I believe it is essential.

10.1.3 Experiencing a sense of sadness

Through my experience of analysing and theorising the data I recognised that I have gained a sense of sadness. The sadness relates to my perceived loss of humanity in practice. Encountering the lived experiences that clearly identified the patient being lost as a person felt disappointing for me. In my journey I had to reflect a lot on my own judgements on this while reviewing the data. There were many times I would review the data and think 'but what about the patient – who were they and what did they need?'. Given how much advocacy is occurring in mental health care to advance recovery, this realisation was a painful reality that there continues to be lots of opportunities to shift practice.

10.1.4 Engaging with philosophy

This study was my first encounter to extensively engage in philosophy. When I initially started to engage with philosophical texts, I found it very difficult to understand and at times confusing and meaningless. I found the style of writing frustrating and impossible to connect with. Getting validation from my supervisors that this is a normal experience when one first begins to engage in philosophical

texts provided a sense of validation, which helped me to continue my efforts. As I continued with extensive and iterative reading, I began to connect with the texts and found myself gaining comfort and understanding. There were two distinct moments that I recognised I had made some strides in my knowledge and understanding of hermeneutic phenomenology. The first was attending a course on Heideggerian Hermeneutical Methodology where I was able to follow and participate in the discussions. The second distinct moment was during one of my supervision meetings, my supervisor (GT) inquired of my rationale for not using one of Heidegger's philosophical perspectives related to technology in my findings and I was able to in the moment provide a response. Recognition of my knowledge and understanding in the use of Heideggerian philosophy, which mostly has been self-taught is highly rewarding for me. To grapple with, overcome my frustration and challenges, and start to enjoy philosophical underpinnings has been one of the most self-gratifying parts of my research.

10.2 Final thoughts

It has been such a privilege to experience this journey. I have had a variety of opportunities and learning as a consequence. There are, inevitably, findings to every research study; these are my introspective findings that have evolved personally, professionally and academically. I have learnt significantly about qualitative research and hermeneutic phenomenology in particular. This has been my first formal qualitative research study and I am proud to have successfully gone through the journey.

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Appendix A-Critical Appraisal Skills Programme (CASP): Systematic Review Template

| Screening questions (A) Are the results of the review valid? | Consider | Yes | No | Can't tell | Comments |
|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|-------------------|-----------------|
| 1. Did the review address a clearly focused issue? | <i>An issue can be focused in terms of:</i> <ul style="list-style-type: none"> - <i>The population studied</i> - <i>The intervention given</i> - <i>The outcome considered</i> | | | | |
| 2. Did the authors look for the appropriate sort of papers? | <i>The 'best sort of studies' would</i> <ul style="list-style-type: none"> - <i>Address the review's question</i> - <i>Have an appropriate study design (usually RCTs for papers evaluating interventions)</i> | | | | |
| Is it worth continuing? | | | | | |
| Detailed questions | Consider | Yes | No | Can't tell | Comments |
| 3. Do you think the important, relevant studies were included? | <i>Look for:</i> <ul style="list-style-type: none"> - <i>which bibliographic databases were used</i> - <i>follow up from reference lists</i> - <i>personal contact with experts</i> - <i>search for unpublished as well as published studies</i> - <i>search for non-English language studies</i> | | | | |
| 4. Did the review's authors do enough to assess the quality of the included studies? | - <i>The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the studies' results</i> | | | | |
| 5. If the results of the review have been combined, was it reasonable to do so? | <i>Whether:</i> <ul style="list-style-type: none"> - <i>the results were similar from study to study</i> - <i>the results of all the included studies are clearly displayed</i> - <i>the results of the different studies are similar</i> - <i>the reasons for any variations in results are discussed</i> | | | | |
| (B) What are the results? | Consider | Yes | No | Can't tell | Comments |
| 6. What are the overall results of the review? | <ul style="list-style-type: none"> - <i>if you are clear about the review's 'bottom line' results</i> - <i>what these are (numerically if appropriate)</i> - <i>How the results were expressed (NNT, odds ratio, etc.)</i> | | | | |
| 7. How precise are the results? | - <i>look at the confidence intervals, if given</i> | | | | |

| (C) Will the results help locally? | Consider | Yes | No | Can't tell | Comments |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|-------------------|-----------------|
| 8. Can the results be applied to the local population? | <i>Whether:</i> <ul style="list-style-type: none"> - <i>the patients covered by the review could be sufficiently different to your population to cause concern</i> - <i>your local setting is likely to differ much from that of the review</i> | | | | |
| 9. Were all important outcomes considered? | | | | | |
| 10. Are the benefits worth the harms and costs? | <ul style="list-style-type: none"> - <i>Even if this is not addressed by the review, what do you think?</i> | | | | |

Appendix B- Email notification seeking voluntary participation for study



Are you interested in sharing your lived experience of using restraint as a last resort in a mental health setting?

Below are further details of how you could participate in a research project.

What?

This project is exploring the mental health nurses' experience and perception of using restraint as a last resort.

Who?

As part of this exploration we would like to talk to mental health nurses who have experienced or been involved in the use of restraint within an inpatient mental health setting across Canada. This research project is part of the PhD study of the student investigator at the University of Central Lancashire, located in Preston, Lancashire, United Kingdom.

How?

If you are interested please contact student investigator (Sanaz Riahi) who will send you further details to support your consideration in participation.

Student Investigator: Ms. Sanaz Riahi riahi.sanaz@gmail.com

Appendix C- STEMH Ethics Committee Approval



5 November 2014

Joy Duxbury / Sanaz Riahi
School of Health
University of Central Lancashire

Dear Joy / Sanaz

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 267

The STEMH ethics committee has granted approval of your proposal application 'A Phenomenological Exploration of 'Last Resort' in the Use of Restraint in Mental Health Settings'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use [e-Ethics Closure Report Proforma](#)).

Yours sincerely

A handwritten signature in black ink, appearing to be 'Paola Dey', written in a cursive style.

Paola Dey
Deputy Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

Appendix D- Ontario Shores Research Ethics Board Approval



Ontario Shores Centre for Mental Health Sciences

Ontario Shores Centre for Mental Health Sciences
Research Ethics Board
700 Gordon Street Whitby, Ontario L1N 5S9
REBSubmissions@ontarioshores.ca
905-668-5881 ext. 6996

October 17, 2014

Documents Approved:

- Revised Protocol ver. 2, October 14, 2014
- Revised & Combined Participation Information Sheet & Consent Form ver. 2, October 14, 2014
- Semi-structured Interview Schedule (In-person & Video Conference) ver. 1, September 28, 2014
- Revised Last Resort Restraint Study Poster ver. 2, October 14, 2014

Documents Acknowledged:

- Application Cover Letter dated September 28, 2014
- General Checklist for Submission of New Studies dated September 28, 2014
- Informed Consent Process and Checklists received September 29, 2014
- Draft Protocol ver. 1, September 28, 2014
- Draft TAHSN Form ver. 1, September 28, 2014
- Revised TAHSN Form ver. 2, October 15, 2014
- Draft Participant Information Sheet ver. 1, September 26, 2014
- Draft Consent Form (Face to Face Interview) ver.1, September 28, 2014
- Draft Consent Form (Video Conference Interview) ver. 1, September 28, 2014
- Draft Last Resort Restraint Study Poster ver. 1, September 28, 2014
- CFMHN Letter of Support dated July 28, 2014
- Uclan Research Student Progression Monitoring Letter dated July 09, 2014
- Uclan Ethics Committee Application Form submitted September 29, 2014
- Uclan Data Protection Checklist ver.1, September 2012
- Uclan Risk Assessment Form submitted September 29, 2014
- Uclan STEMH Ethics Committee Review Letter dated September 23, 2014
- REB Initial Review Letter dated October 14, 2014
- PI Response dated October 14, 2014
- Ms. Sanaz Riahi's CV submitted September 29, 2014

The Ontario Shores Centre for Mental Health Sciences Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations.

10 Initial Approval Letter ER

Page 1 of 2

RE: Ontario Shores' REB # 14-009-D

Study Title: A Phenomenological Exploration of 'Last Resort' in the Use of Restraint in Mental Health Settings

PRINCIPAL INVESTIGATOR:

Ms. Sanaz Riahi
Director, Professional Practice & Clinical Information
Ontario Shores Centre for Mental Health Sciences
700 Gordon St. Whitby, Ontario L1N 5S9

Dear Ms. Sanaz Riahi:

The above named submission received an expedited review by the Ontario Shores Centre for Mental Health Sciences Research Ethics Board. The above mentioned documents have been approved and/or acknowledged by the Research Ethics Board (REB) until October 14, 2015. If the study is expected to continue beyond the expiry date, you are responsible for ensuring the study receives re-approval. The REB must also be notified of the completion or termination of this study and a final report provided.

If, during the course of the research, there are any serious adverse events, changes in the approved protocol or consent form, or any new information that must be considered with respect to the study, these should be brought to the immediate attention of the Board. As the Principal Investigator, you are responsible for the ethical conduct of this study.

The signature below confirms our attestation to all information noted in the footer of this document.

Sincerely,



Dr. Ron Heslegrave, PhD
Chair, Ontario Shores Centre for Mental Health Sciences Research Ethics Board

Date of Initial REB Approval:

October 15, 2014

Expiry Date of REB Approval:

October 14, 2015

The Ontario Shores Centre for Mental Health Sciences Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations.
10 Initial Approval Letter ER

Appendix E- Participant Information Sheet and Consent



A Phenomenological Exploration of 'Last Resort' in the Use of Restraint in Mental Health Settings

This project is exploring the mental health nurses' experience and perception of using restraint as a last resort. As part of this study we would like to talk to mental health nurses who have experienced or been involved in the use of restraint within an inpatient mental health setting. Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take` time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information please contact the student investigator using the details provided at the end of the information sheet.

Why is this study being done?

The aim of this research project will be to explore the concept of 'last resort' on the use of restraint by mental health nurses in Canada. As part of this we want to hear the views of mental health nurses who have experienced or been involved in restraint use in an inpatient Canadian mental health setting.

Who is doing this study?

This study is being undertaken as part of the PhD study at the University of Central Lancashire, located in Preston, Lancashire, United Kingdom.

Why have I been invited to participate?

We want to explore the perception and experience of Canadian mental health nurses related to the concept of 'last resort' in restraint use with the aim to bridge the gap that currently exists in literature.

What will I be asked to do?

If you are interested in participating please contact the student investigator (details below) for a pre telephone interview meeting of approximately 10-15 minutes to provide you with further details about the research and answer any questions you may have. If you continue to be interested, we will set up an interview at a time and date, which is convenient for you.

The interview may be either in-person or by videoconference, and will take approximately 1 hour. At the start of the interview, we would like you to read the consent form (attached to this form) and you will be asked to complete the consent form. For participants in which the interview will occur via videoconference, you will be asked to mail your consent to the student investigator's address stated at the bottom of this information sheet. You will be provided with a signed copy of the consent for your records. The interview will ask you about your experience and perception as a mental health nurse using restraint as a last resort in an inpatient mental health setting. With your permission we would like to audio record this interview.

Following the interview and the analysis of the data, we would like to send you a copy of the summary key findings and invite you to take part in an interpretation meeting. This meeting will provide an opportunity to discuss the findings to make sure that they reflect your experiences. The student investigator will contact you to set up a telephone interview.

Please note, if more participants come forward to take part than the study intends to recruit, you may not be selected to take part and this will be communicated to you after your initial contact.

Who has approved the study?

In order to make sure that the project is being conducted in a professional manner, the project has been approved by one of the University of Central Lancashire's ethics sub-committees, STEMH (the ethics committee for Science, Technology, Engineering, Medicine and Health) and Ontario Shores Centre for Mental Health Sciences Research Ethics Board.

What will happen to the data?

All data will be kept secure in a lockable filing cabinet, and/or password protected/encrypted computer files. All personal data will be destroyed at the end of the student investigator's PhD study, and the anonymized data will be kept for five years from the end of the project and then destroyed. The results of this study will be presented at conferences and written up for publication purposes.

Will the data be kept confidential?

All patient and participant information will be kept strictly confidential in locked filing cabinets and in password protected/encrypted computer files. No personal data such as your name or contact information will be shared with anyone outside of the research team. Whilst anonymized data and quotes will be used in the final report or publications produced, these will not be directly attributable to any individual.

Do I have to take part?

No – it is entirely up to you to decide whether or not to take part. Even if you agree to take part, you are still free to not answer any questions, to end the interview at any time, and you may withdraw all the interview data prior to the undertaking of the final analysis.

Are there any benefits or risks to taking part?

Whilst there are no direct benefits to taking part in this study, it is hoped that it will give you an opportunity to reflect on your views and experiences, and to help uncover important insights into the use of restraint as a last resort by mental health nurses. There are no anticipated risks to this study however for a small number of people recollections of experiences while participating in the interview could cause some degree of anxiety. If this occurs, we will provide you with information related to institutional supports and local counselling, which you may choose to use. An additional risk may be if you disclose professional misconduct, incapacity and incompetence, the student investigator may be required to disclose the information to the appropriate regulatory college as part of the professional duty.

What do I do if I have any concerns or issues about this study?

If you have any complaints, concerns or issues about this study, please contact the University Officer for Ethics at OfficerForEthics@uclan.ac.uk or Dr. Ron Heslegrave, Chair, Ontario Shores Centre for Mental health Sciences Research Ethics Board at (905) 668-5881 x 6996. Information provided should include the study name or description (to help identify the study), the principle investigator or student investigator or researcher, and the substance of the complaint.

Thank you for reading this information sheet and considering taking part in this study.

For further information on the study

Contact the research team:

Student investigator: Ms. Sanaz Riahi (416) 919-6494 riahi.sanaz@gmail.com
[700 Gordon Street, Whibty, Ontario, L1N 5S9](#)

Professor Joy Duxbury JDuxbury@uclan.ca.uk

Dr. Gill Thomson gthomson@uclan.ac.uk

Phenomenological Exploration of 'Last Resort' in the Use of Restraint in Mental Health Settings

Consent Form: Interview (Face to Face)

Please read each statement and initial the boxes to indicate your agreement.

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| I have read and understood the information sheet (version 2, October 14, 2014) and had the opportunity to ask questions | <input type="checkbox"/> |
| I understand that I am free to not answer any questions during the interview and may stop the interview at any point | <input type="checkbox"/> |
| I understand that I will be able to withdraw my data from the study up until final analysis has been undertaken. | <input type="checkbox"/> |
| I understand that participation will be anonymous and any details that might identify me will not be included in reports, presentations or other publications produced from the study. | <input type="checkbox"/> |
| I agree to anonymized quotes being used within reports, presentations or other publications produced from the study | <input type="checkbox"/> |
| I agree to the interview being audio recorded. | <input type="checkbox"/> |
| I agree to take part in a follow-up interpretation meeting to review key points from my interview | <input type="checkbox"/> |
| I agree to take part in the interview | <input type="checkbox"/> |

| | |
|-------------------------------------|-------|
| Participant Name (PRINT): | Date: |
| Participant Signature: | |
| Position/Job Role (if appropriate): | |
| Province: | |
| Name of researcher taking consent: | |
| Signature: | Date: |

Phenomenological Exploration of 'Last Resort' in the Use of Restraint in Mental Health Settings

Consent Form: Videoconference Interview

Consent form is to be completed by the researcher on behalf of the participant at the start of the interview

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| I have read and understood the information sheet (version 2, October 14, 2014) and had the opportunity to ask questions | <input type="checkbox"/> |
| I understand that I am free to not answer any questions during the interview and may stop the interview at any point | <input type="checkbox"/> |
| I understand that I will be able to withdraw my data from the study up until final analysis has been undertaken. | <input type="checkbox"/> |
| I understand that participation will be anonymous and any details that might identify me will not be included in reports, presentations or other publications produced from the study. | <input type="checkbox"/> |
| I agree to anonymized quotes being used within reports, presentations or other publications produced from the study | <input type="checkbox"/> |
| I agree to the interview being audio recorded. | <input type="checkbox"/> |
| I agree to take part in a follow-up interpretation meeting to review key points from my interview | <input type="checkbox"/> |
| I agree to take part in the interview. | <input type="checkbox"/> |

| | |
|-------------------------------------|-------|
| Participant Name (PRINT): | Date: |
| Participant Signature: | |
| Position/Job Role (if appropriate): | |
| Province: | |
| Name of researcher taking consent: | |
| Signature: | Date: |

Appendix F: Semi-Structured Interview Schedule (in-person & video conference)

1. Introduction:

As mentioned during our brief telephone conversation, I am currently a PhD student at the School of Health at the University of Central Lancashire. Thank you for being willing to take part in an interview for this research project. My interest is in exploring the mental health nurses' experience and perception of using restraint as a last resort in an inpatient mental health setting.

2. Patient Information Sheet:

We reviewed the Patient Information Sheet during our brief telephone conversation earlier but I wanted to take a moment to see if you may have any further questions or concerns you would like to discuss prior to moving forward.

3. Consent:

I would like to review the consent form with you and answer any further questions or concerns.

4. Demographic Information:

To begin with, I will ask you some demographic questions.

Gender:

Current role:

Years of experience:

Level of education:

5. Exploratory questions:

Before we begin with the questions, I would like to review the definition of restraint to ensure there is clarity in our interview. Restraining a person involves measures designed to confine a patient's bodily movements, more commonly known as mechanical restraints in Canada.

- Would you please describe as detailed as possible a situation where you experienced applying restraint to a patient as a last resort.
- What helps you determine when restraint is used as a last resort?

(Prompts will be used to advance exploration of the above two questions if necessary. These will include such statements as: how did that make you feel? Can you tell me more about xx? Help me understand what you meant when you stated xx. Why did that happen? What happened next?)

6. Closure:

You have kindly provided detailed information in relation to the questions, thank you very much.

From your perspective, is there anything further you would like to add which you feel may have been missed?

Do you have any other comments about what we have discussed, or about the research as a whole?

With your permission, I will contact you to set up a follow-up interpretation meeting to review key points from our interview today and seek your feedback for accuracy.

In the meantime, if you have any questions or concerns about our interview, please do not hesitate to contact me. My information is on the Participant Information Sheet.

Appendix G: Literature Search Document

| Database Searched | Date & Person Searching | Keywords | Downloaded File Saved as | Hits/Results | Limiter | Action |
|--------------------------|------------------------------------|-----------------|---------------------------------|---------------------|----------------|---------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Appendix H: Publication: An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint

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An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint

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Keywords: containment, decision-making, integrative review, mental health, psychiatric nursing, restraint

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Accessible Summary

What is known on the subject?

- There is emerging evidence highlighting the counter therapeutic impact of the use of restraint and promoting the minimization of this practice in mental health care.
- Mental health nurses are often the professional group using restraint and understanding factors influencing their decision-making becomes critical.
- To date, there are no other published papers that have undertaken a similar broad search to review this topic.

What this paper adds to existing knowledge?

- Eight emerging themes are identified as factors influencing mental health nurses decisions-making in the use of restraint.
- The themes are: 'safety for all', 'restraint as a necessary intervention', 'restraint as a last resort', 'role conflict', 'maintaining control', 'staff composition', 'knowledge and perception of patient behaviours', and 'psychological impact'.
- 'Last resort' appears to be the mantra of acceptable restraint use, although, to date, there are no studies that specifically consider what this concept actually is.

What are the implications for practice?

- These findings should be considered in the evaluation of the use of restraint in mental health settings and appropriate strategies placed to support shifting towards restraint minimization.
- As the concept of 'last resort' is mentioned in many policies and guidelines internationally with no published understanding of what this means, research should prioritize this as a critical next step in restraint minimization efforts.

Abstract

Introduction: While mechanical and manual restraint as an institutional method of control within mental health settings may be perceived to seem necessary at times, there is emergent literature highlighting the potential counter-therapeutic impact of this practice for patients as well as staff. Nurses are the professional group who are most likely to use mechanical and manual restraint methods within mental health settings. In-depth insights to understand what factors influence nurses' decision-making related to restraint use are therefore warranted. **Aim:** To explore what influences mental health nurses' decision-making in the use of restraint. **Method:** An integrative review using Cooper's framework was undertaken. **Results:** Eight emerging themes were identified: 'safety for all', 'restraint as a necessary intervention', 'restraint as a last resort', 'role conflict', 'maintaining control', 'staff composition', 'knowledge and perception of patient behaviours', and 'psychological impact'. These themes highlight how mental health nurses' decision-making is influenced by

ethical and safety responsibilities, as well as, interpersonal and staff-related factors. **Conclusion:** Research to further understand the experience and actualization of 'last resort' in the use of restraint and to provide strategies to prevent restraint use in mental health settings are needed.

Introduction

Control and containment measures, such as restraint, are often used as first-line interventions within health care settings (Cowin *et al.* 2003, Foster *et al.* 2007, Kynoch *et al.* 2011) and frequently used in the treatment and management of disruptive and aggressive behaviours (Goetz 2012). The term 'restraint', although lacking standardization in definition, has been most recently defined by Sailas & Fenton (2012) in a Cochrane systematic review on 'seclusion and restraint for people with serious mental illness' as: *[it] involves measures designed to confine a patient's bodily movements* (Sailas & Fenton 2009, p. 2). The focus of this paper is on mechanical and manual restraint, whereby it involves the use of *straps, belts or other equipment to restrict movement* (Stewart *et al.* 2009, p. 2) or by *any occasion on which staff physically hold the patient, preventing movement, typically in order to prevent imminent harm to others or self, or to give treatment, or to initiate other methods of containment* (CIHI, 2011, Bowers *et al.* 2012, p. 31). The term 'restraint' in this paper will refer to mechanical and manual restraint.

Background

While restraint as an institutional method of control, may be perceived as warranted at times, there is growing literature indicating the potential counter-therapeutic (non-beneficial) effects of this practice (Borckardt *et al.* 2011). As a result, in more recent years, there has been a mandate through various legislations, guidelines and papers in countries, such as Canada, USA and UK, for organizations to shift towards the minimization of restraint, whereby its use is only as a 'last resort' when all other alternative interventions have been exhausted (Royal College of Nursing, 2008; College of Nurses of Ontario, 2009; Registered Nurses Association of Ontario, 2012; MIND for Better Mental Health, 2013; National Offenders Management Services, 2013; American Psychiatric Nurses Association, 2014a,b; Department of Health, 2014; Riahi *et al.* 2014, National Institute for Health and Care Excellence, 2015). This movement supports health care organizations in placing greater emphasis and investment on proactive, preventative approaches, such as sensory modulation, staff mix

review and training and education, in the prevention and management of violence and aggression.

A Cochrane review in 2009 was undertaken to assess the effectiveness of the use of restraint and seclusion compared to alternatives, such as educational and behavioural strategies, policy changes, and medication, for those with serious mental illnesses. The review concluded that *no controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness* (Sailas & Fenton 2009, p. 2). Other reviews report similar findings (Nelstrop *et al.* 2006, Muralidharan & Fenton 2012, Sailas & Fenton 2012). Furthermore, evidence has linked the use of restraint to a number of adverse outcomes, such as further exacerbation of aggression, injury to staff or patients, increased organizational costs, re-traumatization, and rupture of the therapeutic alliances amongst staff and patients (Bonner *et al.* 2002, Mildred 2002, Fisher 2003, Sequeira & Halstead 2004, Foster *et al.* 2007, Ashcraft & Anthony 2008, Moran *et al.* 2009). Some of the physical injuries identified in studies include coma, abrasions, bruises, and fractured bones, as well as, deaths due to asphyxiation, cardiac arrest, strangulation, drug overdose or interaction, blunt trauma, choking and neglect secondary to the use of restraint and seclusion (Mildred 2002). Sailas & Fenton (2009) argue that continuing the use of restraint must be questioned from within well-designed and reported randomized trials that are generalizable to routine practice (Duxbury 2015).

Studies exploring the use of restraint have identified that the most common circumstances where restraint is utilized are in response to violent patient behaviour, abscondment, staff denial of a request, patient agitation, refusal of medication, self-harm, verbal aggression and property damage (Gudjonsson *et al.* 2004, Ryan & Bowers 2006, Southcott & Howard 2007, Bowers *et al.* 2012). Other qualitative studies illustrate that nurses view restraint as a necessary intervention which is distressing, and view the organizational culture, staff experience and composition, conflict, ethical considerations, and patient characteristics as contributing factors (Sequeira & Halstead 2004, Bigwood & Crowe 2008, Happell & Harrow 2010, Bowers *et al.* 2012).

Though there is a paucity of literature that explores patients' perspectives and experiences in the use of restraint, those that do exist reveal that patients do not

view this practice as needed or effective (Riahi *et al.* 2014). Soininen *et al.* (2013) for example, explored patients' perceptions of their hospital treatment following seclusion or restraint and found that patients were unsatisfied with their overall treatment, felt that seclusion and restraint were *hardly* necessary, and that perceptions varied by age. The older the patient, the less they perceived seclusion and restraint to be necessary. Patients believed that their opinions were not included in treatment planning and patients' perceptions did not differ when they were mechanically restrained or secluded (Soininen *et al.* 2013). The Psychiatric Patient Advocate Office (PPAO) reviewed seclusion and restraint practices in Ontario (Canada) psychiatric hospitals and found that more than 50% of the patients considered that they had not posed a threat to themselves or others at the time they were restrained or secluded (Riahi *et al.* 2014). Additionally, once in seclusion or restraint, almost 50% said they did not know what was required of them in order to be released (PPAO, 2000). Other studies indicate that when patients are restrained this can lead to feelings of anger, fear, panic, and a sense of feeling dismissed (Bonner *et al.* 2002, Sequeira & Halstead 2004, Bowers *et al.* 2012).

The term 'last resort' is cited in policy and research to promote the use of restraint only when all other less intrusive alternatives have been exhausted and deemed ineffective (Bonner *et al.* 2002, Moran *et al.* 2009). However, Deveau & McDonnell (2009) argue that the *reliance upon the 'last resort' principle has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge* (p. 175). There is growing evidence internationally indicating that the use of restraint is counter-therapeutic, coercive, punishing, traumatic and unnecessary (Curran 2007, Soininen *et al.* 2013). Restraint is also considered to be over-used under false assumptions that it is an effective means to manage violence and aggression and can protect and assure the safety of patients and staff (Cutcliffe & Santos 2012). As mental health nurses are generally the ones who implement restraint in mental health settings, further research to explore how 'last resort' is enacted within their practice is therefore warranted.

The original aim of this integrative review was to explore mental health nurses' decision-making processes that influence when and how mechanical and manual restraint should be used as a 'last resort'. As an initial scoping review was unable to locate any primary research that explicitly focused on this phenomenon, a more inclusive approach to explore factors that influenced nurses' decision-making in the use of restraint was adopted. It was considered that these in-depth insights would help to

illuminate the range of situational, environmental and personal factors that impact on decision-making and would help inform future research on the concept of restraint as a 'last resort' within practice.

Aim

To explore what influences mental health nurses' decision-making in the use of mechanical and manual restraint.

Method

An integrative review of the literature was undertaken, using Cooper's (1989) framework. This narrative descriptive method enables the inclusion of diverse methodologies allowing for a greater depth and breadth of the research topic. Integrative review summarizes previous empirical or theoretical literature to provide greater insight in understanding a specific phenomenon (Whittemore & Knaf 2005). Additionally, *well-done integrative reviews present the state of science, contribute to theory development, and have direct applicability to practice and policy* (Whittemore & Knaf 2005, p. 546). Cooper's framework includes five stages: (1) problem identification stage; (2) literature search stage; (3) data evaluation; (4) data analysis stage; and (5) presentation (Whittemore & Knaf 2005).

Problem identification stage

Currently there is a gap in the body of literature related to the various factors influencing mental health nurses' decisions in using restraint as a 'last resort'. In addition, there is very limited published literature that explores mental health nurses' overall decision-making related to restraint use (Goethals *et al.* 2012, Laiho *et al.* 2013). A greater in-depth understanding of the factors influencing decision-making may aid in undertaking future research to explore 'last resort', to enhance knowledge and influence overall strategies at both the clinician and organizational levels, as well as help to advance restraint minimization.

Literature search stage

The databases searched were Medline, Cochrane, CINAHL (Ebsco), Psychinfo, and EMBASE. The PICO (population/intervention/context/outcome) format was used to translate the research question into an effective search strategy. The key terms searched are included in Table 1. The inclusion and exclusion criteria for identified literature in the review are detailed in Table 2. Studies

Table 1
Search terms

| Population AND | Intervention AND | Context AND | Outcome |
|-----------------|----------------------|-------------|--------------|
| mental health | restraint | inpatient | experience |
| OR | OR | OR | OR |
| psychiatry | physical | mental | attitude |
| OR | intervention | health | OR |
| mental | OR | services | perception |
| disorder | physical restraint | OR | OR |
| OR | OR | psychiatric | decision- |
| violence | coercive practice | hospitals | making |
| OR | OR | OR | OR |
| aggression | manual restraint | psychiatric | nursing care |
| OR | OR | department | OR |
| self-injurious | clinical holding | | safety |
| behaviour | OR | | management |
| OR | restrictive practice | | |
| suicide | OR | | |
| OR | restraint hold | | |
| suicide-attempt | OR | | |
| OR | physical control | | |
| mentally ill | OR | | |
| persons | last resort | | |
| OR | OR | | |
| nursing | behaviour control | | |
| OR | OR | | |
| psychiatric | coercion | | |
| nursing | OR | | |
| OR | immobilization | | |
| nurs* | OR | | |
| | nursing care | | |
| | OR | | |
| | safety-management | | |

published up to March 2014 were included in this review. Due to the paucity of literature it was decided among the authors that studies which explicitly included manual and or mechanical and seclusion as interventions would be included in this review. As per the exclusion criteria, studies that only explored seclusion were not included. The rationale for this was to ensure inclusivity of the limited yet important studies exploring restraint use among mental health nurses. Restraint and seclusion have commonly been included in a number of key studies and to exclude them would be a mistake. For example, experts in the field who have developed approaches such as the Six Core Strategies in the minimization of restraint use have tackled restraint and seclusion together (Huckshorn 2004, Putkonen *et al.* 2013, LeBel *et al.* 2014). In addition to the database searches, Bates's (1989) 'berry-picking' approach was adopted. This approach was used in the initial steps of scoping the research question and defining the concepts of 'last resort' and 'restraint', as well as, during the data evaluation stage. The berry-picking strategies included in this review were: (1) footnote chasing; (2) citation searching; (3) journal run; (4) area scanning; (5) subject searches in bibliographies and abstracting and indexing; and (6) author searching (Bates, 1989). A total of 22 articles in

Table 2
Integrative review inclusion and exclusion criteria

| | Inclusion criteria | Exclusion criteria |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Population | Mental health; psychiatric nursing; adult psychiatry | Non-mental health population and setting; non-nursing professionals; family perception of restraint use; specialized populations (geriatrics, adolescent, intellectual disability, forensic); nursing students, patient perception, staff training |
| Intervention | Application of and or witnessing of the application of manual and or mechanical restraint (studies which included mechanical and or manual and seclusion were included) | Seclusion practices; chemical restraint |
| Type of study | Qualitative and quantitative | Thesis, policy documents, book chapter, commentaries, editorials, literature reviews |
| Language | English | Other languages |

addition to the database search were identified and reviewed as a result of these approaches.

Data evaluation

The next step in Cooper's (1989) integrative review framework is data evaluation. The Critical Appraisal Skills Program (CASP) tools were utilized to appraise the articles. Modifications were made to the CASP tools to appraise quantitative and mixed method studies as these broad categories are not available in the existing CASP suite. Each article was reviewed and appraised by two reviewers and graded using the system described in Table 3 (Walsh & Downe 2006). Key domains appraised included: appropriate research design, sampling, data collection, reflexivity, ethics, data analysis, findings, and value of research as per the CASP criteria. The grading was then compared for significant discrepancies, of which there were none. Due to the small sample size of article, only those receiving a grade D, indicating significant flaws in the study likely to affect its validity, reliability and generalizability, were removed (i.e. lack of methodological detail). The decision to reject papers was also made if they did not add to the body of knowledge relative to the findings from others deemed to be of high methodological

Table 3
Appraisal grading

| Grade | Description |
|---------|--------------------------------------------------------------------------------------------------------------|
| Grade A | No, or few flaws. The study validity, reliability and generalizability are high |
| Grade B | Some flaws, unlikely to affect the validity, reliability and generalizability of the study |
| Grade C | Some flaws that may affect the validity, reliability and generalizability of the study |
| Grade D | Significant flaws that are very likely to affect the validity, reliability and generalizability of the study |

quality. This led to three studies being removed, leaving 16 articles as the final number to be included in the integrative review.

Data analysis

One of the least developed aspects of the integrative review process is the strategy for data analysis. A constant comparison method is a recommended method, which is an overarching approach in the development of the results in this integrative review (Whittemore & Knafl 2005). This method was deployed and involved the analysis of studies where the data were extracted into systematic categories, identifying distinct patterns, themes and relationships within and across the studies. Overall, eight key themes were identified in relation to factors influencing

mental health nurses' decision-making in the use of restraint.

The flow diagram in Fig. 1 summarizes the literature search, data evaluation and analysis stages. Table 4 provides a summary of the studies and the key themes identified within each individual paper.

Results

The results represent the findings from the *data analysis* and *presentation* stages of the integrative review process where key insights are identified, reported and visually represented. A total of 16 articles were included in the review, eight qualitative research articles, seven quantitative research articles and one mixed method research article. Key areas of focus for the articles were nurses' decision-making for the use of restraint ($n = 3$), nurses' perceived experience of restraint ($n = 8$), nurses' attitudes towards restraint ($n = 4$), and relationships of show of force and manual restraint compared to other factors ($n = 1$). The articles were published in the United Kingdom ($n = 5$), United States ($n = 5$), Finland ($n = 1$), New Zealand ($n = 1$), Canada ($n = 1$), Ireland ($n = 1$), Greece ($n = 1$) and Israel ($n = 1$).

While an array of factors have been identified to influence mental health nurses' decision-making in the use of

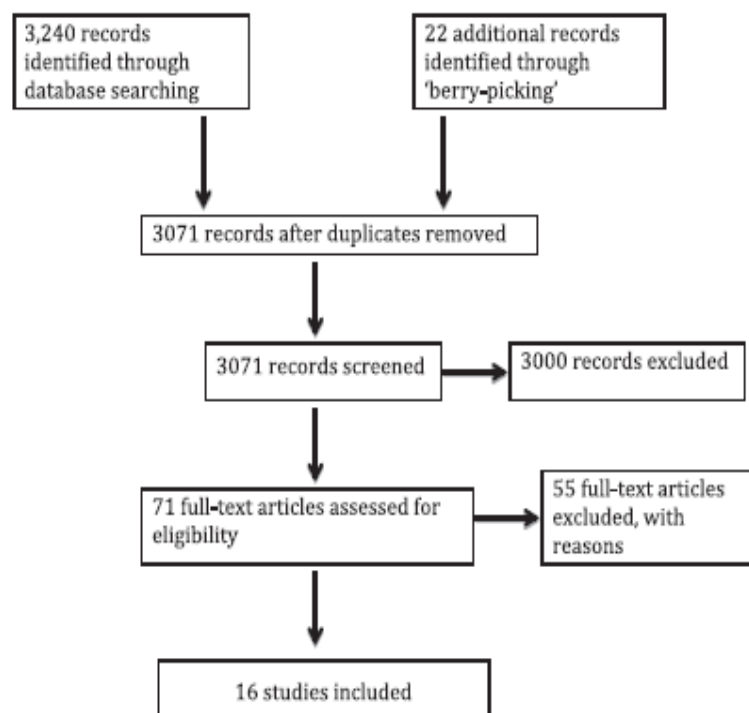


Figure 1
Flow diagram of integrative review

Table 4
Summary of studies

| Author (year) | Aim | Setting & participants | Methods | Key themes | Appraisal grading |
|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------|
| Bigwood & Crowe (2008) | To understand the mental health nurses' experiences of physical restraint | Acute adult inpatient psychiatry (UK) Seven nurses | Descriptive phenomenological | 'Safety for all' 'Restraint as a Necessary Intervention' 'Role Conflict' 'Maintaining Control' | Grade A |
| Bonner <i>et al.</i> (2002) | To establish the feasibility of using semi structured interviews with patients and staff in the aftermath of untoward incidents involving physical restraint. To gather information on the factors patients and staff groups found helpful and unhelpful, during and in the aftermath of restraint. To explore the lived subjective experience of restraint | Mental health ward (UK) Six incidents were analyzed and twelve staff and six patients were interviewed. | Qualitative semi structured interviews | 'Restraint as a Last Resort' 'Role Conflict' 'Psychological Impact' | Grade B |
| Bowers <i>et al.</i> (2012) | To assess the relationship of show of force and manual restraint to other conflict behaviours, the use of containment methods, service environment, physical environment, patient routines, staff characteristics, and staff group variables | 136 acute mental health wards (UK) | A multivariate, cross-sectional study | 'Staff Composition' | Grade A |
| Gelkopf <i>et al.</i> (2009) | To examine nurses' attitudes regarding the goals of restraint, the environmental conditions influencing restraint, the emotional aspects of restraint, and their beliefs about whether other staff members should participate in restraint procedures | 350-bed Mental Health Centre (Israel) 111 nurses | Quantitative – surveys | 'Nurses' Knowledge and Perception of the Patient' 'Staff Composition' | Grade A |
| Holzworth & Wills (1999) | To investigate the clinical judgment of psychiatric nurses using judgment analysis within the framework of social judgment theory | Short-term psychiatric care facility (USA) Nine nurses | Quantitative questionnaire | 'Restraint as a Last Resort' 'Nurses' Knowledge and Perception of the Patient' 'Staff Composition' | Grade B |
| Kontio <i>et al.</i> (2010) | To explore the ethical aspects of nurses' and physicians' perceptions of: (1) what actually happens when an aggressive behaviour episode occurs on a ward; and (2) what alternatives to seclusion and restraint are in use as normal standard practice in acute psychiatric care | Two psychiatric hospitals (Finland) 22 nurses and five physicians | Qualitative – focus groups | 'Role Conflict' | Grade B |
| Lee <i>et al.</i> (2003) | To explore nurses' views related to their last experience of implementing physical restraint | 63 randomly selected secure and psychiatric intensive care units (UK) 269 nurses | Quantitative – survey | 'Maintaining Control' 'Nurses' Knowledge and Perception of the Patient' 'Staff Composition' | Grade C |
| Lemonidou <i>et al.</i> (2002) | To: (1) investigate the type of restriction used to suppress violent behaviour of psychiatric patients, (2) explore nurse's attitudes towards seclusion and restraints, and (3) determine if there is a difference in nurse's attitudes due to their level of education and years of experience | 12 psychiatric wards (Greece) 190 nurses | Quantitative – survey | 'Safety for all' 'Maintaining Control' 'Nurses' Knowledge and Perception of the Patient' 'Staff Composition' | Grade B |

Table 4
Continued

| Author (year) | Aim | Setting & participants | Methods | Key themes | Appraisal grading |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------|
| Lindsey (2009) | To examine the association of nurses' work empowerment, as well as, individual characteristics of the patient and of the nurses with nurses' decision to restrain. The study also examined the decision patterns used by psychiatric nurses in response to patient situations in which restrain might be considered | Four hospitals (USA) Thirty psychiatric nurses | Correlational descriptive design Quantitative questionnaires | 'Restraint as a Last Resort' 'Maintaining Control' 'Nurses' Knowledge and Perception of the Patient' 'Staff Composition' | Grade A |
| Marangos-Frost & Wells (2000) | To explore the possible influence of nurses' thoughts and feelings on the decision to restrain | Psychiatric inpatient unit (Canada) Six nurses | Qualitative – ethnographic design | 'Restraint as a Last Resort' 'Role Conflict' | Grade B |
| McCain & Komegay (2005) | Explore the lived experiences of psychiatric nurses' use of physical restraints as perceived by Registered Nurses with 5 years or more of psychiatric nursing experience | Inpatient psychiatric unit (USA) Nine nurses | Qualitative – phenomenological method | 'Restraint as a Necessary Intervention' 'Restraint as a Last Resort' | Grade B |
| Moran et al. (2009) | To explore the emotions and feelings experienced by nurses in response to restraint and seclusion interventions | Psychiatric hospital (Ireland) 23 nurses | Qualitative – focus groups | 'Restraint as a Last Resort' 'Psychological Impact' | Grade A |
| Moylan & Cullinan (2011) | To examine assault and injury in relation to the nurse's decision to restrain | Five institutions – two psychiatric hospital, three with psychiatric units (USA) 110 nurses | Mixed method | 'Role Conflict' 'Psychological Impact' | Grade B |
| Perkins et al. (2012) | To explore the attitudes of staff towards restraint and understand some of the influences on their decision-making and behaviour | Acute adult mental health setting (UK) Thirty nurses | Retrospective analysis – interviews and focus groups | 'Restraint as a Necessary Intervention' 'Maintaining Control' 'Nurses' Knowledge and Perception of the Patient' | Grade B |
| Sequeira & Halstead (2004) | To explore the psychological responses of nursing staff to restraint | Specialized mental health care hospital (UK) Seventeen nurses | Qualitative semi structured interviews | 'Psychological Impact' | Grade A |
| Terpstra et al. (2001) | To explore the attitudes and opinions of nurses towards seclusion and restraint use | 376-bed psychiatric hospital (USA) 144 nurses | Quantitative surveys | 'Safety for all' 'Maintaining Control' 'Nurses' Knowledge and Perception of the Patient' 'Staff Composition' | Grade C |

restraint, it is also important to identify their inter-relational nature. For example, the themes of 'safety for all' and 'restraint as a necessary intervention' are significantly interrelated. Nurses perceived restraint as a necessary intervention primarily to maintain safety for both patients and staff. Similarly, maintaining control of the situation was highly influenced by safety for all, which again was

associated with viewing restraint as a necessary intervention. The eight emergent themes are 'safety for all', 'restraint as a necessary intervention', 'restraint as a last resort', 'role conflict', 'maintaining control', 'staff composition', 'nurses' knowledge and perception of the patient', and 'psychological impact'. A visual representation of the data has been developed to display findings in Fig. 2.

Safety for all

The concept of safety was a prominent theme to emerge (Bigwood & Crowe 2008, Lemonidou *et al.* 2002, Terpstra *et al.* 2001). Terpstra *et al.* (2001) for example, in exploring staff's attitudes and opinions of seclusion and restraint, found that 40% of respondents felt restraint was a more effective approach in helping a patient *calm down*. Their reason for choosing this method was that *restraint reduced physical injury to all involved* (Terpstra, 2001). Additionally, this study reported that one of the most frequent reasons that nurses used restraint was due to a perception that greater safety was achieved both for staff and other patients (Terpstra, 2001). Similarly, Lemonidou *et al.* (2002) when exploring nurses' attitudes towards seclusion and restraint reported that 70.5% of the nurses used restraint most often for the safety of patients and others. Nurses in one study reported feeling scared at a personal level because of the risk of actual harm, where the fear of this impending danger activated some *self-preserved* responses (Bigwood & Crowe 2008).

Restraint as a necessary intervention

While very closely related to the theme of 'safety' a further key issue highlighted nurses' perceptions of restraint

as a necessary intervention. In a number of studies this was inherently linked to nurses' professional responsibility and accountability to provide a safe environment for all concerned (McCain & Komegay 2005, Bigwood & Crowe 2008, Perkins *et al.* 2012). Similarly, Bigwood & Crowe (2008) reported restraint to be *part of the job* to prevent harm or injury to patients or others and considered this to be '*an integral, essential, and unavoidable part of acute mental health nursing practice*' (Bigwood & Crowe 2008, p. 218). Similarly, in exploring the attitudes of staff towards restraint and factors influencing decision-making, Perkins *et al.* (2012) reported that although the use of restraint as a last resort was recognized, it was also viewed as a '*necessary evil*'. One participant stated:

You need it because it's for your safety and other people's safety. Because, you just need it there because if you didn't have it, people could get hurt. I mean I know it's not the nicest thing, and it is uncomfortable, but you have got to look at it, at the safety aspects of what could happen if we don't use restraints (Perkins *et al.* 2012, p. 46).

Restraint as a last resort

While there is some evidence reporting nurses' views for restraint to be a necessary intervention, studies also identi-

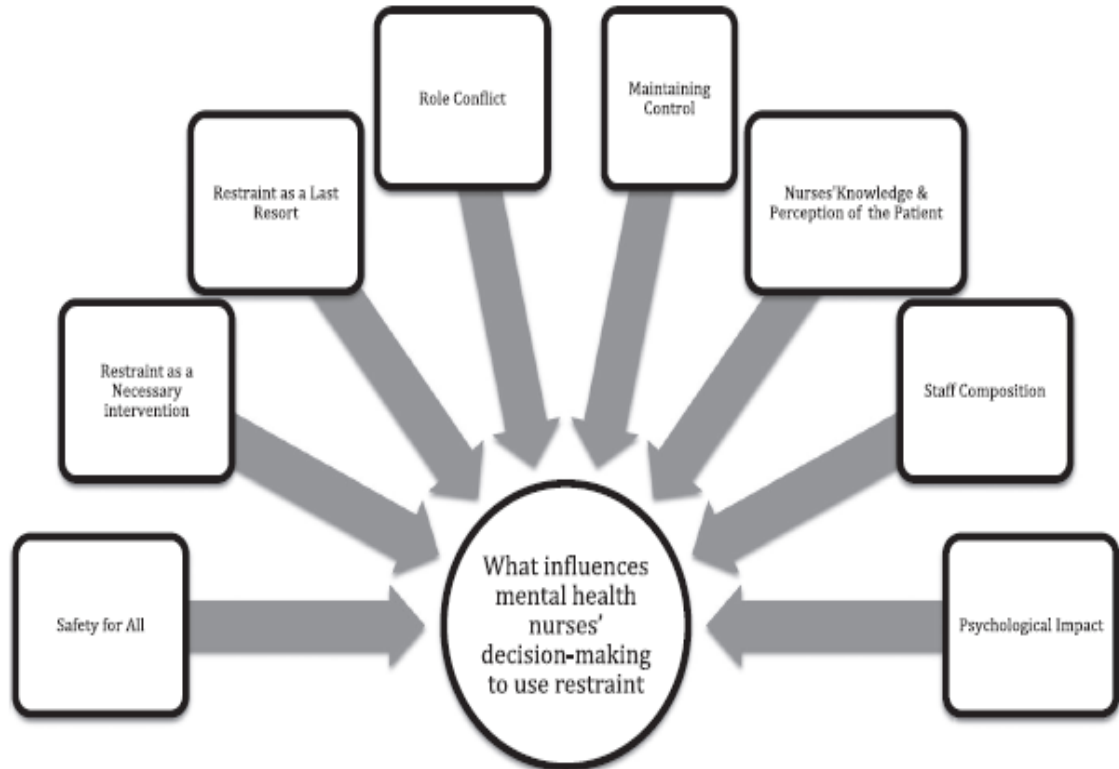


Figure 2
Visual presentation of findings

fied how nurses were strongly committed to use restraint only as a last resort and displayed dislike in its use (Holzworth & Wills 1999, Bonner *et al.* 2002, Lindsey 2009). Similarly, within a number of studies nurses expressed adopting a least restrictive approach where other alternatives such as, creating a calmer environment, therapeutic communication with the patient and administration of medications, were attempted prior to the use of restraint (Holzworth & Wills 1999, Marangos-Frost & Wells 2000, McCain & Komegay 2005, Lindsey 2009, Moran *et al.* 2009).

Role conflict

An emerging theme in the literature was the interface between ethics and safety. Several studies illustrated how nurses experienced a conflict in their role, while endeavouring to preserve safety, and feeling the need to participate in an intervention that they disliked while attempting to use restraint as a last resort. Bigwood & Crowe (2008) and Marangos-Frost & Wells (2000) frame this as the 'conflicted nurse' where ethical and safety values need to be balanced. Kontio *et al.* (2010) identified nurses' decision-making about restraint application as an ethical dilemma, in terms of nurses' needing to consider patients vs. others' best interests. Similarly, Bonner *et al.* (2002) explored the lived subjective experience of restraint from nurses where 'ethical issues' were an emerging theme. Moylan & Cullinan (2011) reported nurses' beliefs that aggressive behaviours by patients were an expected part of the mental health nurses' role and that nurses felt pressure to avoid restraint use.

Maintaining control

Nurses being in control and taking control of the situation was another common theme. Perkins *et al.*'s (2012) study, for example, reported 'taking control' to be a central feature in nurses rationalizations of the use of restraint and which included two conceptualizations: (1) *restraint as a technique to directly suppress aggressive and violent behaviour*; (2) *restraint as a management strategy to maintain order and stability within the organizational setting*. The study revealed that the participants considered physical intervention as a *battleground for control* among staff and patients (Perkins *et al.* 2012). One nurse articulates this experience by stating:

The minute you lay hands on, the incident that originally got you to that point, is lost, it then becomes a situation of well you know, get off me, I will calm down when you get off me, and then the retort from the staff side is well no, when you have calmed down, and the service user then says well I will calm down

when you get off me, and it then becomes a stalemate... a service-user, might calm down quicker if the restraint wasn't so long, instead of being forced, as it were, into submission, sort of like we will take hands-off when we feel you have calmed down (Perkins *et al.* 2012, p. 46).

Lee *et al.* (2003) explored nurses' views relating to their last experience of implementing restraint and 96.3% of respondents perceived that there had been a positive outcome in their last incident. This positive perception was correlated with the perspective that the incident was controlled, regardless of the aftermath. Terpstra *et al.* (2001) found the most frequent reason provided by nurses for the use of restraint and seclusion was that the interventions were more likely to result in immediate control of violent behaviour. Similarly, *behaviour control* was the second highest reason (23.2%) nurses cited as needing to use restraint in Lemonidou *et al.*'s (2002) study. Bigwood & Crowe (2008) found that nurses upheld an expectation that maintaining control was integral to the job, with some considering this practice to be therapeutic:

I view restraint as a necessary therapeutic tool. Yes it is unavoidable in certain circumstances. Definitely it is a therapeutic intervention that is necessary at that point of time of crisis, to either reinstate control, to create safe outcome, to impose a treatment plan, to keep everyone safe basically and to just re-establish control (Bigwood & Crowe 2008, p. 219).

Lindsey's (2009) study reported a significant negative correlation between mental health nurses sense of empowerment and decision to restrain. Empowerment in this study entailed the following domains: opportunity, information, support, resources, formal power, and informal power (Lindsey 2009). Respondents in Lee *et al.*'s (2003) study revealed negative staff attitudes when restraint were initiated, such as a *bouncer mentality*, *deck them first* and a tendency to use restraint *too quickly*, all of which are aligned with a sense of maintaining control.

Nurses' Knowledge and Perception of the Patient

Familiarity with the patient, in terms of knowing their behavioural patterns and triggers as well as knowledge of patient's past behaviour seemed to help inform nurses' expectations of an individual's behaviour and essentially influence their decision-making to restrain (Perkins *et al.* 2012). Lindsey (2009) for example, found nurses' perceptions of the patient's familiarity with the unit rules and norms influenced their decision to restrain. Nurses were therefore less inclined to use restraint if the patient was 'new' to the unit and unfamiliar with the rules. Factors contributing to nurses' knowledge and perception of the

patients which influenced whether restraint methods were applied included: injury, danger or harm to self or others (Gelkopf *et al.* 2009, Holzworth & Wills 1999, Lee *et al.* 2003, Lindsey 2009, Terpstra, 2001), agitation, destruction of property (Holzworth & Wills 1999, Lee *et al.* 2003), stress, anger, aggressiveness (Lemonidou *et al.* 2002), age, and diagnosis (Lindsey 2009). These factors were viewed as information for the nurses about the patient, which influenced nurses' perception of the patient and inadvertently shaped decision-making related to restraint use.

Staff composition

Staff composition was another emerging theme. In Terpstra *et al.*'s study (2001) for example, 51% ($n = 33$) of the nurse participants specified that staff mix on their ward swayed their decision-making related to restraining a patient. The study did not define the term staff mix, although commonly staff mix refers to the blend of various categories of health care personnel employed for providing direct patient care (McGillis Hall 2005). This study also reported that 48% ($n = 31$) of respondents considered that the number of staff present was influential in their decision to restrain, whereby a fewer number of staff contributed to a sense of fear in approaching difficult patient-related situations and further influenced the likelihood to use restraint (Terpstra, 2001). Evening shifts were reported to increase the frequency of restraint use by 51% in one study (Lemonidou *et al.* 2002). Lemonidou *et al.* also found that 'staffing' was the most important environmental factor (56.3%) impacting nurses' decision-making in the use of restraint. Similar results were reported by Lee *et al.* (2003) who identified understaffing, regular use of agency staff, and inexperienced staff in the management of violence as important organizational factors impacting upon decision-making. Interestingly, Bowers *et al.* (2012) reported the 'better' and 'more richly-staffed' the wards were, the higher the use of coercive measures, including restraint, were used.

There are some inconsistencies within the literature regarding the impact of professional experience and the decision to restrain by mental health nurses. Lindsey (2009) reported nurses with greater experience in both nursing and psychiatric nursing were more likely to use restraint as their initial intervention. Similarly, another study reported a positive correlation among the length of time nurses worked on a unit and the mean number of restraint episodes they were involved in (Terpstra, 2001). However, Holzworth & Wills (1999) found the most restrictive type of interventions were made by nurses with the least amount of experience professionally. They made

nearly three times as many recommendations in comparison to those with greater professional experience. Similarly, one study reported that 49.5% of nurses considered that the most important environmental factor to influence the use of restraint was inexperienced nursing staff (Gelkopf *et al.* 2009).

Gender was another staff composition factor identified in the literature. Gelkopf *et al.* (2009) found more male nurses in comparison to female nurses, considered the use of restraint if patients refused medication, kept others from sleeping, 'bothered' other patients, fought with other patients, and continuously banged on the nurses' windows. Bowers *et al.* (2012) explored staff variables in using restraint and found an increase in use when security guards were present as part of the staff composition.

Psychological impact

The studies included did not directly address the psychological effects of the aftermath of restraint use on future decision-making. However, the psychological impact of the after-effects of restraint use among nurses was a key theme in a number of the selected studies (Bonner *et al.* 2002, Sequeira & Halstead 2004, Moran *et al.* 2009). 'Re-traumatization' of violent incidents for example was reported by nurses in Bonner *et al.*'s (2002) study, where one nurse stated, *even smaller incidents like this can trigger thoughts of previous incidents* (p. 471). One study reported that nurses who had a history of being injured in the past would influence their decision to restrain a patient at a later time in the progression of aggression (Moylan & Cullinan 2011). Sequeira & Halstead (2004) reviewed the psychological responses of nurses to restraint and reported a number of findings. Anxiety was the most prevalent emotion nurses experienced when using restraint, with a noted reduction in anxiety when restraint usage was familiar to the nurse (Sequeira & Halstead 2004).

Discussion

Overall, the emerging themes from this review suggest a paradoxical situation for mental health nurses, where they use restraint to maintain safety for all (Bigwood & Crowe 2008, Lemonidou *et al.* 2002, Terpstra, 2001), with safety viewed as an integral part of their role (McCain & Kornegay 2005, Bigwood & Crowe 2008, Perkins *et al.* 2012), despite the fact that there is existing evidence that demonstrates that restraint poses safety risks for both patients and staff (Mildred 2002, Sequeira & Halstead 2004, Fish & Culshaw 2005, Foster *et al.* 2007, Ashcraft & Anthony 2008, Strout 2010, Soininen *et al.* 2013).

A literature review to explore nurses' decision-making in the use of restraint in mental health settings was undertaken by Laiho *et al.* (2013). Key findings identified a number of domains, which impact on nurses' decision-making in the use of restraint: 'patient-related cues', 'personnel-related cues', 'previous experience of the use of seclusion or restraint', and 'organizational-related cues' (Laiho *et al.* 2013). While the current study confirms the findings from this previous review, two additional, previously unreported issues emerged in relation to 'restraint as a last resort' and 'staff composition'. Additionally, the current study undertook a broader search with the use of PICO search strategy.

The staff composition theme highlights inconsistencies in terms of how staffing numbers (high or low) and level of experience (inexperienced or well experienced) can influence restraint use, as well as how restraint use is influenced by gender issues and the presence of security personnel. These findings therefore emphasize the need for further consideration of staff-related factors in a mental health environment.

The concept of 'last resort' is mentioned in many policies and guidelines (Royal College of Nursing, 2008; College of Nurses of Ontario, 2009; Registered Nurses Association of Ontario, 2012; MIND for Better Mental Health, 2013; National Offenders Management Services, 2013; American Psychiatric Nurses Association, 2014a,b; Department of Health, 2014; National Institute for Health and Care Excellence, 2015) around the world and can be viewed as a key driver for nurses in making decisions related to the application of restraint. As this review has identified that no existing studies focus on, nor clearly consider what 'last resort' actually means, further exploration into how this concept is perceived and enacted upon in practice appears critical. This could potentially provide insights into strategies that support and prevent the use of restraint in mental health settings.

A key strength of an integrative review is the combination of diverse methodologies, which provides an opportunity for an in-depth review of the evidence, providing a depth and breadth of the evidence without over-emphasizing and over-valuing hierarchies of evidence. However, this may also be viewed as a limitation as the combining of diverse methodologies may be argued to contribute to a lack of rigor, inaccuracies and bias. While only published research studies were included, a broad and inclusive search strategy was adopted to ensure that all key studies were included. All the authors also undertook the analysis and identification of themes until consensual validation had been obtained. A further strength of the review is the similarities of findings with other reviews, demonstrating a

robust methodology, as well as, validity to the key influences on mental health nurses decision-making in restraint use. Furthermore, as new and previously unreported issues were identified, this review provided new and unique contributions to knowledge in this area of practice. A limitation of this review concerns the generalizability of the findings to institutions in countries where decisions related to restraints tend to involve other health care professionals. Furthermore, although many countries are moving towards restraint minimization, practices and definitions vary. This therefore creates difficulties in drawing comparisons about restraint use across different study contexts.

The topic of restraint use in mental health is controversial. There are some who question whether restraint could ever be therapeutic (Huckshorn 2004, Paterson & Duxbury 2007), while others believe restraint is necessary, but only in extreme situations (Fisher 1994, Mohr *et al.* 1998). In addition, while research from clinicians' perspectives report how restraint maintains safety (Bigwood & Crowe 2008, Lemonidou *et al.* 2002, Stubbs *et al.* 2009, Terpstra, 2001), there is evidence that reductions in restraint can increase safety for staff (Lebel & Goldstein 2005, Goetz 2012, LeBel *et al.* 2014). As restraint use has negative physical and psychological consequences (Sequeira & Halstead 2004, Fish & Culshaw 2005, Strout 2010, Soininen *et al.* 2013), there is a need to further understand the intricacies involved in decision-making to use restraint as a 'last resort' in mental health settings.

Implications for practice

Mental health nurses' decision-making is influenced by interrelated issues of ethical and safety responsibilities, as well as, interpersonal and staff-related factors. Although nurses reported restraint as a necessary intervention, they also reported their dislike of this intervention and at times viewed it as a last resort, leaving them conflicted in their role. Additionally, it draws attention to the importance of understanding and taking into consideration these situational, environmental and personnel-related factors that influence restraint use by hospital leaders in shifting towards restraint minimization practices.

'Last resort' appears to be the mantra of acceptable restraint use. However to date, there are no studies that specifically consider what this concept actually is. Further studies are needed to understand how 'last resort' is experienced and actualized by mental health nurses in restraint use. This would enable greater understanding of how restraint minimization can be achieved and the supports required for mental health nurses.

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