Nursing staff's experiences of using manual physical restraint within inpatient adolescent mental health care: A descriptive phenomenological study

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ABSTRACT

Background: Manual restraint is a 'hands on' type of physical restraint used by staff in inpatient mental health care and beyond to maintain patient and staff safety. However, its use has been linked to adverse physical and psychological patient and staff outcomes, and a recognised need to minimise manual restraint use globally has arisen. Despite the high reported rates of manual restraint use within inpatient child and/or adolescent mental health care, little research has been undertaken exploring the manual restraint experiences and perspectives of staff and young people in this setting.

Objective: The purpose of this qualitative study was to explore nursing staff's experiences of using manual restraint within inpatient adolescent mental health care.

Methods: Individual in-depth videoconference interviews were conducted with 12 nursing staff recruited from four inpatient adolescent mental health hospitals across three National Health Service Trusts in England. Interviews were transcribed verbatim and data analysis was undertaken through a descriptive phenomenological methodology using reflexive thematic analysis.

Results: Four themes were generated from the analysis which captured the essences of participants' experiences: It needs to be done . . . sometimes; It's not a nice thing to do; It doesn't really damage the therapeutic relationship; and Importance of team support. Whilst reporting that it was sometimes necessary to manually restrain young people for substantial safety reasons, participants spoke with dislike about its use, and described consequential

aversive experiences of emotional distress, patient aggression, pain and injury, and exhaustion. Participants reported relying on each other for emotional and practical support.

Conclusion: The findings provide unique insights into the manual restraint experiences of nursing staff working within inpatient adolescent mental health care. Implications for practice and research are discussed in relation to the inclusion of temporary nursing staff and young people, and recommendations for manual restraint minimisation programmes are made.

CHAPTER ONE: INTRODUCTION

Chapter Overview

This chapter serves to orientate the reader to the research topic presented in this thesis. For ease of reading, this chapter has been divided into three parts. In part one (Background), I define what manual restraint is and discuss its uses, its United Kingdom (UK) history, the concerns associated with its use, psychological ways of understanding its use, and the efforts that have been undertaken to minimise its use. In part two (Integrative Review and Meta-Synthesis of the Literature), I present an integrative review and meta-synthesis of studies reporting on healthcare staff's experiences of manual restraint to identify a gap in the literature. Finally, in part three (Rationale and Aim of the Study), I discuss the rationale for the present study and provide a clear statement of the research question and aim of this study.

Part One: Background

What is Manual Restraint?

In order to define manual restraint, it becomes necessary to define physical restraint. Physical restraint refers to "any action or procedure that prevent a person's free body movement to a position of choice and/or normal access to his/her body by the use of any method" (Bleijlevens et al., 2016, p. 2307). Manual restraint, as it has been termed in the literature (e.g., Ryan, 2010; Stewart et al., 2009), is a skilled 'hands-on' type of physical restraint whereby one or more persons restrict the movement of another by manually holding and/or moving them (National Institute for Health and Care Excellence [NICE], 2015; Royal

College of Nursing [RCN], 2008; Stubbs & Paterson, 2011). This type of physical restraint differs from the mechanical type of physical restraint which refers to the use of equipment (e.g., cuffs, belts) to restrict movement (Care Quality Commission, 2018). In practice, manual restraint typically involves a team of two or more trained persons immobilising an individual face-up (supine position) or face-down (prone position) on the floor, or less restrictively, in standing or seated positions (Whittington et al., 2006). Manual restraint is the most common type of physical restraint used within inpatient mental health care in the UK, with mechanical restraint rarely being used (NHS Digital, 2021a; Wilson et al., 2017).

The commonality of manual restraint practice, particularly within inpatient mental health care, is evidenced by research that has suggested that its use is a routine part of the inpatient mental health nurse's job (Bigwood & Crowe, 2008; Wilson et al., 2017). Alarmingly, within England alone, there were over 105,000 recorded incidents of manual restraint in National Health Service (NHS) funded secondary mental health, learning disability and autism services between the years 2020 and 2021 (NHS Digital, 2021a). This reflects a substantial rising increase compared to the 63,000, 73,000 and 97,000 recorded incidents of manual restraint for the years of 2017, 2018 and 2019 respectively (NHS Digital, 2018, 2019, 2021b). Concerningly, this increase has been reported in the context of national falling inpatient mental health care bed numbers (Campbell, 2021).

Restrictive Interventions: Situating Manual Restraint

In order to situate manual restraint practice, it becomes necessary to define restrictive interventions. Restrictive interventions refer to "deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently" (Department of Health, 2014, p. 14). Manual restraint, like mechanical restraint, chemical restraint (restricting movement by medication means [RCN, 2008]) and seclusion

(confining a person alone into a room/area in which they are prevented from leaving [Knox & Holloman, 2012]), is considered to be a restrictive intervention in mental health care and beyond, and is used internationally (Brenner et al., 2014; Chapman et al., 2016; Dijkhuizen et al., 2020; Duxbury et al., 2019b; Riahi et al., 2020; Scheuermann et al., 2016).

Given the oppressive hallmark of restrictive interventions and their susceptibility to be used abusively, it is thus not surprising that their use is regulated by laws and policies globally (e.g., Department of Health, 2014; Mental Health Units [Use of Force] Act, 2018; National Disability Insurance Scheme Quality and Safeguards Commission, 2020; United States Department of Education, 2010). For instance, within the UK, the Department of Health (2014) states that restrictive interventions, such as manual restraint, should only be used as a "last resort" to prevent significant harm to the individual and/or others, and that the use of restrictive interventions should be proportionate to the risk, be imposed for no longer than necessary, and represent the least restrictive option. However, despite such policies and/or laws, there is evidence to indicate that restrictive interventions, including manual restraint, are not always used as a last resort in the UK and beyond (Knowles et al., 2015; Riahi et al., 2020; Wilson et al., 2017).

Use of Manual Restraint within Inpatient Mental Health Care

Within inpatient mental health care, nursing staff commonly use manual restraint to prevent harm to patients and staff, and to provide compulsory treatments. For instance, the literature has illustrated the application of manual restraint in response to patient aggressive behaviour (Bowers et al., 2015), patient attempted absconding behaviour (Ryan & Bowers, 2006), patient deliberate self-harm behaviour (James et al., 2012), patient medication refusal (Owiti & Bowers, 2011), and in the provision of compulsory nasogastric feeding

interventions for food and/or fluid refusing patients with severe eating disorders (Fuller et al., 2019; Kodua et al., 2020).

Within inpatient mental health care, manual restraint is commonly used as a precursor in the application of other restrictive interventions such as chemical restraint and seclusion because patients may need to be physically held and/or moved in order to be medicated or secluded (Ryan, 2010; Whittington et al., 2006). However, the literature has also evidenced the standalone use of manual restraint in the absence of other restrictive interventions such as in the prevention of patient deliberate self-harm behaviour, and in the provision of compulsory nasogastric feeding interventions (James et al., 2012; Kodua et al., 2020). For instance, in a nationwide study of UK inpatient adult mental health care, James et al (2012), found that, of the 129 cases in which the intervention used following patient deliberate self-harm was specified, manual restraint was used in 31 cases, whereas chemical restraint and seclusion were used in just seven and five cases respectively. Although, it was not clear from this study whether the interventions were independent of each other, the study nonetheless highlights that not all incidents of manual restraint lead to chemical restraint or seclusion.

Literature and documentation on the duration of manual restraint within inpatient mental health care has been variable, with time lengths ranging from less than five minutes to over 30 minutes (Kodua et al., 2020; Walker, 2019; Whittington et al., 2006), but with an average time of around 10 minutes (Stewart et al., 2009). This is congruent with the NICE (2015) guidelines which has highlighted that staff “should not routinely use manual restraint for more than 10 minutes” (p. 34).

Aside from its use within inpatient mental health care, manual restraint is also used by staff within physical health care, residential care, the criminal justice system, and educational institutions to manage disruptive behaviour and to prevent harm to self and/or others

(Brenner et al., 2014; Chapman et al., 2016; Dijkhuizen et al., 2020; Scheuermann et al., 2016; Steckley & Kendrick, 2008).

Use of Manual Restraint within Inpatient Child and Adolescent Mental Health Care

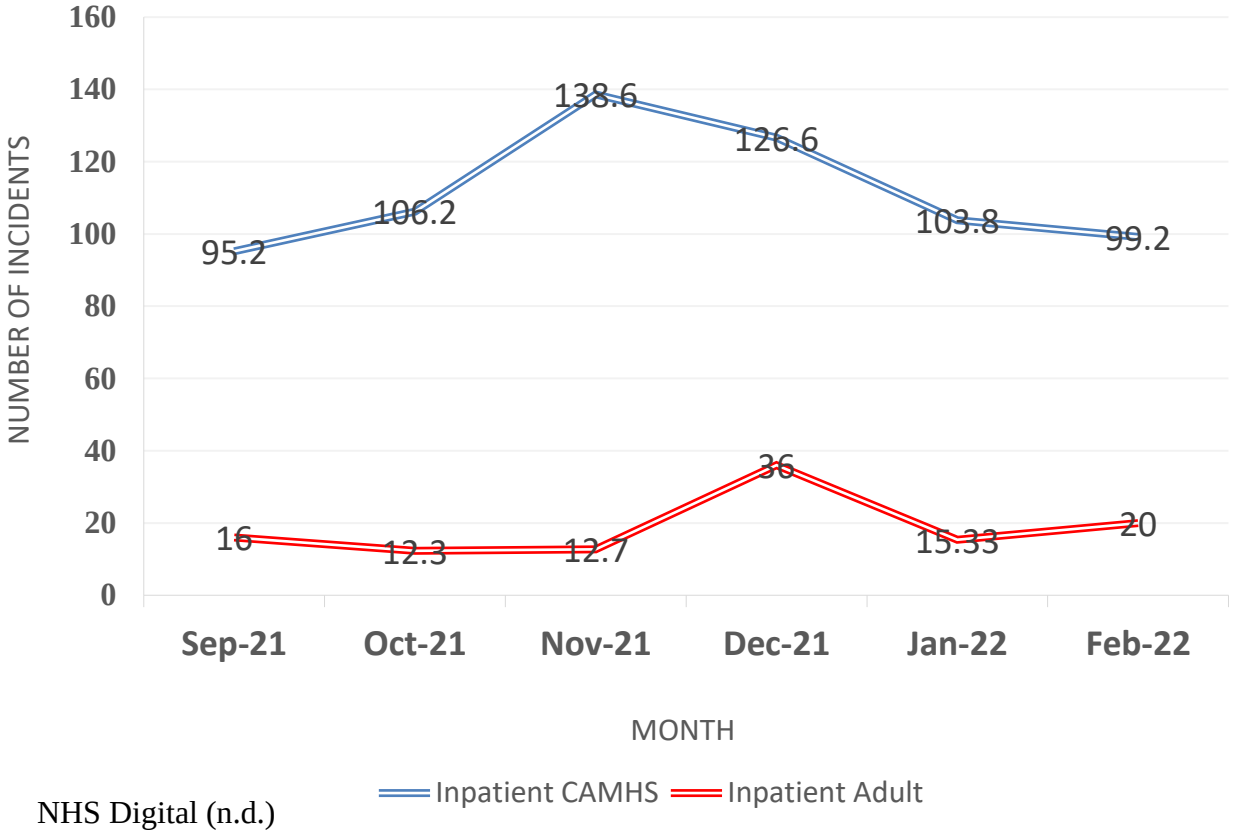
Like its use within inpatient adult mental health care, manual restraint is used within inpatient child and adolescent mental health care to prevent harm to young people and staff, and to administer compulsory treatments, with deliberate self-harm, aggression, and refusal of foods and/or fluids being commonly cited antecedents (Blikshavn et al., 2020; Furre et at., 2016; Muir-Cochrane et al., 2014). Overall, compared to the literature available on inpatient adult mental health care, research on inpatient child and adolescent mental health care is lacking. This lack of research is even greater reflected in the inpatient child and adolescent mental health care manual and mechanical restraint literature, with there, to my knowledge, being just two published reviews of the literature in this area (De Hert et al., 2011; Nielson et al., 2021). Notwithstanding, studies have identified that young people younger in age, and with longer hospital stays are more likely to be manually restrained (Pogge et al., 2013; Sourander et al., 2002); this trend however has not been reported in other studies (Furre et al., 2016).

Rates of manual restraint use appear to be substantially higher within inpatient child and adolescent mental health settings (LeBel et al., 2004; NHS Digital, n.d.). For instance, within the UK, for the 2021/2022 months of September, October, November, December, January and February, there were 95, 106, 139, 127, 104 and 99 respective recorded incidents of restrictive interventions per 1,000 occupied beds (inclusive of manual restraint) in NHS funded inpatient child and adolescent mental health services (CAMHS). These figures reflect a substantial elevation compared to the 16, 12, 13, 36, 15, and 20 recorded incidents of restrictive interventions per 1,000 occupied beds for the same months within inpatient adult

mental health services (NHS Digital, n.d.); a graph of these figures is presented in Figure 1, page 12. The Restraint Reduction Network (2022) argues that the high rates of restraint use in child and adolescent inpatient mental health care suggests that "restraint is currently not being used as a 'last resort'" in these settings (p. 4).

Figure 1

Number of Restrictive Interventions per 1,000 Occupied NHS Funded Beds Between September 2021 and February 2022 Across Inpatient CAMHS and Inpatient Adult Settings



NHS Digital (n.d.)

History of Manual Restraint Practice in the UK

Manual restraint practice in the UK dates back to at least the Victorian era when manual restraint guidelines were published in the 1885 text: *Handbook for the Instruction of Attendants on the Insane* (Winship, 2006). These guidelines, like the present UK guidelines, highlighted that manual restraint should only be used as a last resort, and recommended

particular methods of holding to safeguard the patient (Clark & Campbell, 1885/2008). The development of these guidelines occurred at a time when the 'non-restraint' movement was well under way within psychiatry in England. This movement, pioneered by Quaker William Tuke in 1796, and considerably forwarded by the work of psychiatrist John Conolly at the Middlesex Hanwell Asylum from 1839, attempted to treat the mentally ill humanely, and worked towards the abolishment of mechanical restraint (Haw, 1989). Mechanical restraint previously had been in routine use in mental asylums and 'madhouses' in England, with patients being shackled and chained in iron (El-Badawi, 2021; Winship, 2006). One such patient at the London Bethlem Asylum, James Norris, had been chained to an iron bar with a ring on his neck and a cage on his body for 10 years (Scull, 2013). Advances in psychiatric medicine by the 1900s led to a revolution in the use of medication as an alternative method of restraint. As a result, the remaining remnants of mechanical restraint were slowly discontinued (e.g., straight-jackets), and manual restraint was increasingly practiced within mental asylums in England (Winship, 2006).

Up until the 1980s, there had been little advancement in UK manual restraint practice, with Winship (2006) commenting that the 1885 guidelines were "barely modified over the next century" (p. 58). Prior to the 1980s, manual restraint practice within UK prisons and inpatient mental health care settings were ad-hoc, disorganised, involved high staff numbers, and were likened to "an undignified rugby scrum" (Ryan, 2011, p. 38); there was also an increased risk of injury (Wright, 1999). It was not until 1981 when the first systematic widespread training course in manual restraint, titled "control and restraint" (C&R), was designed (Paterson & Leadbetter, 1999; Wright, 1999). Based on elements of Japanese martial arts, C&R was originally developed by the Home Office to enable prison staff to respond to violent and disruptive prisoners (Gooch, 2014; Ryan, 2011). However, due to the death of a mental health patient and longstanding concerns about the quality of manual

restraint practice in inpatient mental health settings, C&R was later adapted and cascaded into NHS inpatient mental health care in the mid-1980s, beginning with the high security forensic psychiatric hospitals of Broadmoor, Ashworth and Rampton (Ryan, 2011; Wright, 1999). With the induction of C&R into inpatient mental health care, a spectrum of independent training providers emerged from the 1990s, many of whom claimed to offer their own unique adapted-for-healthcare versions of C&R; examples of such courses included: "Care and Responsibility" (C&R), "Prevention and Management of Violence and Aggression" (PMVA), Crisis and Aggression Limitation Management" (CALM) and "Therapeutic Holding" (Ryan, 2011). These courses arguably formed the precursors for contemporary manual restraint practice in the UK today.

Concerns of Manual Restraint Use

Despite the discussed safety maintaining functions of manual restraint, its use has, and continues to raise ethical concerns globally (e.g., Australian Human Rights and Equal Opportunities Commission, 1993; Mind, 2013). This is not surprising considering that manual restraint has been linked to service user death (Duxbury et al., 2011), service user and staff distress (e.g., Bigwood & Crowe, 2008; Cusack et al., 2018), staff misuse (e.g., Brophy et al., 2015; Lee et al., 2003) and staff and service user injury (Lee et al., 2003; Wilson et al., 2017). In the following sections, I discuss each of these adverse manual restraint outcomes.

Service User Death

Deaths of individuals in healthcare and custody from the use of manual restraint are arguably some of the most controversial (Duxbury et al., 2011). The death of George Floyd two years ago in the United States is no exception. George was manually restrained in the

prone position by the police and died within nine minutes of being restrained; one of the officers had knelt on his neck for the duration of the restraint (Freeman, 2021).

Within the UK, there were 38 identified manual restraint-related deaths between 1999 and 2010, equating to a death every three or four months (Duxbury et al., 2011). The majority of those who died were men aged 30-50 years and had been restrained in the prone position. Positional asphyxia, a complication arising when an individual's position prevents them from breathing adequately, was implicated in at least 26 of the 38 deaths (Chmieliauskas et al., 2018; Duxbury et al., 2011). Moreover, in the Netherlands, there were at least 38 restraint-related deaths involving the police between January 2005 and December 2016, accounting for a such death at least every four months. Similarly, the majority of those who died were men aged 30-40 years and had been restrained in the prone position; the deceased also had Body Mass Indexes of over 30 (Dijkhuizen et al., 2020). Furthermore, a recent study on manual restraint-related deaths in children and adolescents in the United States identified 63 such deaths over a 26-year period between 1993 and 2018, equating to a death every five months. Unsurprisingly, the majority of deaths occurred in the prone position, with asphyxia being the single greatest cause of death accounting for approximately 50% of all fatalities (Nunno et al., 2022).

The link between sudden death and the manual restraint prone position has led to the implementation of policies restricting or prohibiting its use within the UK and beyond (NICE, 2015; Queensland Health, 2021). However, some healthcare staff report strong justifications for its continued use such as the prone position being reportedly safer for them, being reportedly easier to administer intramuscular medication, and posing less of a risk of being bitten or spat at by service users compared to other restraint positions (Meehan et al., 2022).

Service User and Staff Distress

Service users have reported numerous adverse psychological consequences as a result of being manually restrained. A 2018 integrative review of patients' manual restraint experiences within inpatient mental health care alarmingly indicated the psychological harm inherent in manual restraint practice (Cusack et al., 2018). This review, involving 10 studies and over 250 patients generated the following four patient distress related themes: trauma/re-traumatization, distress, fear, and dehumanization. Within the included studies in the review, patients described experiences where manual restraint had prompted trauma symptoms (e.g., intrusive thoughts and vivid dreams) and trauma memories of past abuse, including childhood and sexual abuse (Bonner et al., 2002; Brophy et al., 2015; Knowles et al., 2015; Wynn, 2004). Patients in some studies also reported feeling humiliated, ashamed, frightened, 'subhuman', and angry as a result of being manually restrained (Bonner et al., 2002; Brophy et al., 2015; Haw et al., 2011; Wilson et al., 2017; Wynn, 2004), further highlighting the adverse psychological consequences to patients/service users of being manually restrained.

Staff have equally reported a number of adverse psychological consequences as a result of using manual restraint. First-hand experiences of anxiety, guilt, anger, distress, and re-traumatisation have all been reported within the staff experiences of manual restraint literature (Bigwood & Crowe 2008; Bonner et al., 2002; Kodua et al., 2020; Wilson et al., 2017).

Staff Misuse

The literature has evidenced accounts of staff misuse of manual restraint as reported through service users' first-hand experiences. Service users have reported being subjected to excessive force in restraint (Brophy et al., 2016; Haw et al., 2011), being restrained unfairly and unnecessarily (Knowles, et al., 2015), and believing that restraint had been used to punish

them (Haw et al., 2011; Sequeira & Halstead, 2002). These concerning findings have been mirrored in staff accounts of manual restraint, with some staff reporting being a witness to such practices (Lee et al., 2003; Wilson et al., 2017). In a survey study of 269 nurses' views on manual restraint, some staff respondents reported worrying manual restraint practices of their colleagues including a "bouncer mentality" attitude and a tendency to use restraint too quickly (Lee et al., 2003, p. 427). Alarmingly, in this same study, manual restraint was referred to as "a legal way of hurting patients" in one instance (Lee et al., 2003, p. 427).

Staff and Service User Injury

Staff have reported sustaining a range of physical injuries because of manually restraining service users, such as back pains, bruises, grazes, scratches, and physical pain (Kodua et al., 2020; Lee et al., 2003; Wilson et al., 2017). More severe physical injuries have also been reported including head injuries, black eyes, and dislocated arms and shoulders (Chapman et al., 2016; Kodua et al., 2020; Lee et al., 2003). In one study, 22% of 269 nurses reported sustaining an injury as a result of applying manual restraint (Lee et al., 2003). It appears from Kodua et al's (2020) study that manual restraint-related injuries are sustained by staff both through the execution of the restraint and the aggressive behaviour of service users during the process.

Service user injuries have also been reported as a consequence of manual restraint. Thirteen percent of the 269 nurses in Lee et al's (2003) study reported injuries sustained to patients during restraint. However, the injuries were described to be minor, and were reported less commonly in comparison to staff injuries. In another study, two out of 13 patient participants described first-hand experiences of occasional injuries they sustained during manual restraint (Wilson et al., 2017), providing further evidence of the patient injury risk consequent to manual restraint use.

Manual Restraint Minimisation Efforts

Given the concerns about manual restraint practice, it is not surprising that numerous policies, guidelines and programmes have emerged globally advocating for its reduction and/or elimination (e.g., Bowers, 2014; Department of Health, 2014; Duxbury et al., 2019a; Mental Health Commission, 2014; O'Hagan et al., 2008; Royal Australian and New Zealand College of Psychiatrists, 2021). Within the UK, manual restraint garnered increasing attention following a 2011 report on restraint-related deaths (Aiken et al., 2011), and the Winterbourne View Hospital abuse scandal also in the same year (Department of Health, 2012; Duxbury, 2019b). Since then, various UK guidelines have emerged calling for the reduction of manual restraint (e.g., Department of Health, 2014; Department of Health and Department of Education, 2019; Care Quality Commission, 2017), and several manual restraint minimisation programmes have consequently been developed. In the following sections, I will discuss three manual restraint minimisation programmes that have been implemented in UK inpatient mental health care: 'REsTRAIN YOURSELF' (Duxbury et al., 2019a), 'No Force First' (Ashcraft & Anthony, 2008) and 'Safewards' (Bowers, 2014).

REsTRAIN YOURSELF

This programme was developed by Professor Joy Duxbury and her colleagues in the Northwest of England. They adapted the evidenced-based United States' 'Six Core Strategies' programme for minimising seclusion and restraint and applied it to UK inpatient mental health care contexts (Duxbury et al., 2019a; Huckshorn, 2004). Titled 'REsTRAIN YOURSELF', this multilevel manual restraint minimisation programme targets both organisational and individual factors through six clusters of interventions as per the 'Six Core Strategies'. A summary of these interventions is presented in Table 1, page 19.

Table 1

REsTRAIN YOURSELF Interventions Aligned to Each of the Six Core Strategies

Six Core Strategies	REsTRAIN YOURSELF Interventions
Leadership	Identified and agreed targets and philosophy Use of ward champions Executive walk arounds (management presence on ward)
Data Informed Practice	Reporting, analysing and visually presenting restraint incidents over time to foster reflection
Workforce Development	Trauma and prevention focused staff training
Restraint Reduction Tools	My safety plan (e.g., patient early warning signs knowledge) Sensory spaces and tools Visible nurse approach
Service User Involvement	Community meetings, advocacy and peer support Making physical and procedural changes to the environment
Debriefing	Post-restraint debriefing with involved staff and patients

A non-randomised controlled trial study of the 'REsTRAIN YOURSELF' programme involving 14 UK inpatient adult acute mental health wards found that manual restraint rates decreased by an average of 22% on the seven wards that had implemented 'REsTRAIN YOURSELF' (Duxbury et al., 2019a). Although Professor Joy Duxbury and her colleagues highlighted several methodological limitations (e.g., non-randomised design; significant differences in baseline restraint rates between intervention and control wards) and did not achieve the 40% reduction in manual restraint rates that they had hypothesised, the study still demonstrated the effectiveness of the 'REsTRAIN YOURSELF' programme. It is possible that greater restraint reduction rates might have been achieved from the programme with improved staff engagement, improved leadership from the hospital management teams, and improved staffing levels. This is in light of the negative staff attitudes, the lack of clear management and the inadequate staffing levels that were reported by some staff involved in

the study (Duxbury et al., 2019b; McKeown et al., 2019). For instance, some staff perceived the learning process of the programme as an "unfounded criticism of their professionalism" (Duxbury et al., 2019b, p. 848).

No Force First

More comparable to a model, this programme was developed in the United States by Recovery Innovations Incorporated in 2006, a non-profit organisation operating a range of mental health recovery-oriented programmes (Ashcraft & Anthony, 2008). Believing the use of force to be incongruent with recovery principles, the 'No Force First' model seeks to improve the experience of service users by minimising, and eventually eliminating the use of restrictive interventions such as manual restraint (Ashcraft et al., 2012). The 'No Force First' model has been implemented into UK inpatient care settings with promising results. A recent study involving 44 UK inpatient mental health, psychiatric intensive care unit (PICU), forensic mental health, learning disabilities, and older adult wards, found that manual restraint rates decreased by an average of 19% following the implementation of a 'No Force First' model (Haines-Delmont et al., 2022). Haines-Delmont and her colleagues operationalised the philosophy of 'No First Force' using six bespoke interventions. A summary of these interventions is presented in Table 2, pages 20-21.

Table 2

Haines-Delmont and Colleagues Six Intervention Operationalisation of 'No Force First'

'No Force First' Informed Intervention	Description
'No Force First' engagement sessions	Healthcare teams are introduced to 'No Force First' and hear accounts of patients' experiences of manual restraint

Continued

Table 2 Continued

'No Force First' Informed Intervention	Description
'No Force First' ward criteria and reviewing restrictive interventions	Clinical staff are encouraged to listen to patients, and remove or reduce restrictions and "blanket rules" that can cause frustration or conflict
Positive handovers	Objective nursing handovers focused on recovery and on understanding patients' past traumas in relation to their triggers and behaviours that challenge
Healthy communities	Patients are given the opportunity to be involved in the decision-making of the functioning of the ward
Individualised meaningful day	Patients are offered activities that meet their individual needs, interests and aspirations
Debriefing for service users and staff	Patients and staff are given the opportunity to reflect on adverse events (e.g., manual restraint) and identify areas of improvement and learning

Despite Haines-Delmont and her colleagues' promising findings, the main limitation of their study can be attributed to the repeated measures design that they implemented and the subsequent lack of a control group. Such a design limits any causal conclusions from being drawn with regards to the implementation of 'No Force First' being the cause of the 19% reduction in manual restraint rates.

Safewards

Unlike the 'REsTRAIN YOURSELF' programme and 'No Force First' informed programmes which focus predominantly on reducing restraint and/or seclusion, 'Safewards'

is a theoretical model which attempts to explain the variable rates of patient conflict incidents (e.g., aggression, deliberate self-harm, absconding) and staff containment incidents (e.g., manual restraint, chemical restraint, seclusion) observed on different inpatient mental health wards, and the bidirectional relationship between the former and the latter (Bowers, 2014). Developed in the UK by Professor Len Bowers in 2014, the 'Safewards' model suggests that various aspects of mental health wards known as 'originating domains' (e.g., physical environment, patient characteristics, nature of the staff team, etc) have the potential to cause 'flashpoints'. Flashpoints are situations (e.g., staff telling patients to wait), that have the potential to prompt patient conflict incidents (e.g., physical aggression), which in turn have the potential to prompt staff containment incidents (e.g., manual restraint) as a method of managing patient behaviour.

With respect to practice implications, the 'Safewards' model proposes that staff can reduce the rates of conflict and containment incidents on their wards at every level of the model: by reducing or eliminating originating domains (e.g., modifying the physical environment); by preventing flashpoints from arising out of the originating domains (e.g., responding to patients requests as soon as possible); by cutting the link between flashpoints and patient conflict incidents (e.g., adopting a compassionate approach when telling patients to wait); by opting not to use containment when it would be counterproductive (e.g., allowing patients time on their own to self-regulate if possible and effective); and by ensuring that any containment use does not lead to further conflict when used (Bowers, 2014; Bowers et al., 2015; e.g., refraining from using excessive force when restraining patients).

A seminal randomised controlled trial study by Professor Len Bowers and his colleagues involving 31 UK inpatient mental health wards found that staff containment incidents, which included manual restraint, reduced on average by 26% on the 16 wards that had implemented 10 safewards-informed interventions (Bowers et al., 2015). Although this

reduction was not attributed to the reduction in manual restraint alone, the findings highlight the effectiveness of the 'safewards' model in reducing restrictive interventions as a whole. A summary of the 10 'safewards' informed interventions is presented in Table 3, pages 23-24.

Table 3

Ten Safewards Interventions

Safewards Intervention	Description
Clear mutual expectations	Clients and staff agree on behaviour that is expected from both parties when on the inpatient ward (e.g., during admission), with visual reminders of these expectations displayed on the ward.
Soft words	Short statements, changed every few days, are displayed on the ward outlining potential strategies that staff can use to handle flashpoints (e.g., respectful sensitive communication).
Talk down	One staff skilled at verbal de-escalation is allocated as the 'talk down champion' and spends time coaching other members of the team in verbal de-escalation techniques, with the help of posters displayed in staff areas of the ward (e.g., nursing station).
Positive words	During nursing handover meetings, staff say something positive about each patient and offer potential psychological explanations for patient challenging behaviour.
Bad news mitigation	Staff understand, proactively plan for, and mitigate the effects of bad news received by patients (e.g., sympathetically communicating bad news and/or supporting patients after receiving such news).
Know each other	Staff give information about themselves that they are happy to share with patients (e.g., favourite TV shows) and encourage patients to do the same.

Continued

Table 3 Continued

Safewards Intervention	Description
Mutual help meeting	Regular meetings on the ward where staff and patients are encouraged to identify ways of helping and supporting each other.
Calm down methods	A box of sensory, distraction and relaxation tools is made available on the ward (e.g., weighted blankets) that staff can offer to patients when they are distressed before offering *pro re nata* medication or containment.
Reassurance	Staff debrief with and offer reassurance to patients either in a group or one-to-one context following incidents (e.g., manual restraint).
Discharge messages	Positive messages are displayed on the ward from discharged patients, covering what they liked about the ward and a helpful piece of advice for new patients.

Psychological and Explanatory Models of Why Staff Manually Restrain Patients

Psychological models attempt to explain human behaviour and why particular behaviours occur. Clinical explanatory models attempt to explain the causes of staff and patient behaviour in clinical contexts. In the following sections, I discuss two psychological models to explain the staff behaviour of manually restraining patients: Skinner's (1974) behaviourist model of operant conditioning and the social systems theory. I also discuss Nijman et al's (1999) clinical explanatory model of patient aggressive behaviour on inpatient mental health wards, and consider its contribution for explaining staff manual restraint use.

Skinner's Behaviourist Operant Conditioning Model

This psychological model of learning proposes that any behaviour that occurs (e.g., manual restraint) is occurring because it is being reinforced in some way or another (Vargas, 2020). In other words, the staff behaviour of manually restraining patients would not be

occurring and would cease to exist if it was not being reinforced. Reinforcement, from a behaviourist standpoint, refers to consequences that increase the likelihood of a behaviour occurring again, either through the addition of something perceived to be rewarding (positive reinforcement) and/or through the removal of something perceived to be aversive (Skinner, 1974; negative reinforcement). Conversely, punishment, from a behaviourist standpoint, refers to consequences that decrease the likelihood of a behaviour occurring again, either through the addition of something perceived to be aversive (positive punishment) and/or through the removal of something perceived to be rewarding (Skinner, 1974; negative punishment). According to the operant conditioning model, it is positive and negative reinforcement, and positive and negative punishment that drive human behaviour, with reinforcement and more immediate consequences having a stronger influence on behaviour than punishment and less immediate consequences (Miltenberger, 2015).

In explaining the staff behaviour of manually restraining patients on a mental health ward, the operant conditioning model would argue that the reason why this behaviour is occurring and persisting is because it is being followed by immediate positive and/or negative reinforcing consequences to the staff who are applying it. For instance, this might include, as demonstrated in the research literature, the positive reinforcement of staff gaining: an immediate sense of control over the situation (Bigwood & Crowe, 2008; Hawkins et al., 2005), a feeling of "bravado" (Sequeira & Halstead, 2004, p. 6), a sense of power (Sequeira & Halstead, 2004), and an immediate rush of adrenalin (Hawkins et al., 2005; Perkins et al., 2012; Sequeira & Halstead, 2004). Equally, negative reinforcing consequences of the staff behaviour of manually restraining patients might include, as demonstrated by the research literature, an immediate reduction in staff anxiety (Hawkins et al., 2005), and the suppression of patient risk behaviour such as aggression and deliberate self-harm (Hawkins et al., 2005; Perkins et al., 2012). Thus, in any one incident of manual restraint, the operant conditioning

model would argue that there are several immediate positive and negative reinforcing consequences that increase the likelihood of staff using manual restraint again. This means that, even in light of the co-occurring positive and/or negative punishing consequences of manual restraint such as the experience of staff anger and staff physical injury (positive punishment; Kodua et al., 2020), which tend be less immediate than the aforementioned reinforcing consequences (and therefore less influential in driving manual restraint behaviour), the staff behaviour of manually restraining patients would be a tough behaviour to eliminate.

According to the operant conditioning model, in order to reduce manual restraint, staff would need to find a clever way of reducing and/or removing the aforementioned positive and negative reinforcers of the behaviour of manually restraining patients, find an effective way of making the punishing consequences of manual restraint more immediate than the reinforcing consequences of it (e.g., conditioning themselves, at the point of their deciding to use manual restraint, to immediately think very graphically of the physical injuries they could sustain from using manual restraint), or be introduced to an alternative containment behaviour (e.g., breakaway techniques[1]). However, in order for this alternative behaviour to be effective in reducing manual restraint, it would need to produce the same reinforcing consequences and serve the same function as manual restraint as effectively (Miltenberger, 2015). Given that an alternative behaviour like breakaway techniques would not meet all these requisites, this is clearly no easy feat to achieve.

Social Systems Theory

This psychological model proposes that social systems (e.g., inpatient mental health wards) are fundamentally predisposed to resist change and maintain a state of balance or

[1] Breakaway techniques are a set of physical skills to help separate or break away from an aggressor in a safe manner that do not involve the use of restraint (NICE, 2015).

‘homeostasis’ through negative feedback self-regulatory mechanisms (Kirst-Ashman & Hull, 2018). This means that any change to one part of a social system (e.g., increased patient risk behaviour) will influence change in the other parts of the system (e.g., increased staff use of manual restraint) in an effort to maintain homeostasis (Bateson, 1972; Kirst-Ashman & Hull, 2018). From this standpoint, the social systems theory would argue that the ‘symptom’ or ‘problem’ that a social system presents with (e.g., frequent staff use of manual restraint), rather than being dysfunctional, actually reflects a stabilising influence of the system in its efforts to maintain homeostasis (Scott, 2018).

Thus, according to the social systems theory, in order to reduce manual restraint in a ward system with high restraint rates, a condition would need to be created where the staff use of manual restraint was no longer needed to stabilise the system. This ideally would require other parts of the ward system to change to account for this (e.g., improved staff therapeutic communication skills; admission of less risky patients; increased staffing levels; improved staff-patient relationships, etc). Simply adopting an isolated approach to reducing manual restraint in such a ward system would destabilise the system and prompt the system to revert back to its original structure, the social systems theory would argue (Becvar & Becvar, 2017; Scott, 2018). For example, adopting an isolated approach to reducing manual restraint might lead to an elevation of unmanaged patient aggression and deliberate self-harm incidents which in turn may lead to the return of the pre-reduction restraint levels. Interestingly, the social systems theory also argues that a destabilised social system can also prompt the reorganisation of the system into a new more effective homeostatic stability structure through ‘positive feedback’ in the less common circumstance (Becvar & Becvar, 2017). This would be the case if a reduction in manual restraint on a ward then led to a reduction in patient risk behaviour, and in turn, sustained lowered manual restraint rates.

Nijman's Explanatory Model of Patient Aggression on Inpatient Mental Health Wards

Nijman et al's (1999) clinical explanatory model is a model of patient aggressive behaviour on inpatient mental health wards, and therefore does not directly explain why staff manually restraint patients. However, because manual restraint is commonly cited as a containment response to patient aggressive behaviour (Bowers et al., 2015), understanding the causes of patient aggressive behaviour and how to reduce it has direct implications for understanding and minimising staff manual restraint use. Nijman et al's (1999) clinical explanatory model argues that patient aggressive behaviour on inpatient mental health wards can be explained as being caused by an interaction between various internal factors (e.g., patient's psychopathology and distorted beliefs), environmental stressors (e.g., ward restrictions, lack of privacy, under-stimulation) and interpersonal stressors (e.g., staff inconsistencies in limit setting, problematic staff-patient communication). The model posits that environmental and interpersonal stressors characteristic of inpatient mental health wards exacerbate patients' pre-existing psychopathology and distorted beliefs, and prompt patient aggressive behaviour (e.g., hitting and shouting at staff, damaging property), and subsequent restrictive intervention use by staff (e.g., manual restraint) as a management strategy (Nijman et al., 1999). However, the model argues that such interventions inadvertently reinforce patients' distorted beliefs, and place further environmental and interpersonal stress on patients, leading to a vicious cycle of patient aggression and subsequent staff restrictive intervention use (Duxbury & Whittington, 2005; Nijman et al., 1999).

Thus, according to Nijman et al's (1999) clinical explanatory model of patient aggression, in order to reduce manual restraint, staff would need to work towards reducing the patient-aggressive-behaviour-prompting environmental and interpersonal stressors originating from their inpatient mental health wards as far as is effectively possible. This might involve the provision of stimulating ward-based activities that meet patients' individual

needs (reducing under-stimulation-induced environmental stressors) and the provision of staff training in effective therapeutic communication (reducing problematic communication-induced interpersonal stressors), to name a few. The adoption of such approaches could help disprove some of patients' distorted beliefs (e.g., about staff and the ward), and reduce the number of patient aggressive behaviour incidents and subsequent staff manual restraint use on inpatient mental health wards. This, in turn, could have the effect of breaking the vicious patient aggression and staff subsequent restrictive intervention use cycle.

Part Two: Integrative Review and Meta-Synthesis of the Literature

Overview

In this part of the introduction, I integratively review and meta-synthesize the qualitative literature on healthcare staff's experiences of using manual restraint to situate the current study and to identify a gap in the literature. Although three qualitative reviews and/or meta-syntheses have been conducted in the past decade or so exploring service users' experiences of manual restraint (Cusack et al., 2018; Douglas et al., 2022), and service users' experiences of manual and mechanical restraint (Strout, 2010), only one review and/or meta-synthesis has been conducted exploring staff's experiences, representing a gap in the literature. This review however indiscriminately explored manual and mechanical restraint within inpatient mental health settings only (Riahi et al., 2016). Arguably, in order to reduce manual restraint practice effectively, it is important to understand both service users' and staff's experiences of manual restraint within mental health and non-mental health settings.

Aim of Review

The aim of this section is to integratively review and meta-synthesize the qualitative literature pertaining to healthcare staff's experiences of using manual restraint. The question guiding this review is: "How do healthcare staff experience the practice of manually restraining service users?"

Method

This integrative review was partly guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher et al., 2009). A pre-registered protocol of this review is accessible on the International Prospective Register for Systematic Reviews (PROSPERO) website (registration no: CRD42019160621).

Search Strategy

Three electronic databases (CINAHL Complete, MEDLINE and PsycINFO) relevant to healthcare and nursing, and accessed via the EBSCOhost platform through the University of Essex were individually searched on 12 November 2019 (updated 14 May 2022) to identify studies exploring healthcare staff's experiences of using manual restraint. No limits were applied to the search, and results were imported into the reference management software Zotero 5.0. Additional forward and backward citation searches of the final included studies in this review were performed using the "Cited by" and "References" feature of a further electronic database (SCOPUS) to identify additional studies. This was to ensure a thorough search strategy. Database and citation searching was conducted by I alone.

The search terms consisted of keywords related to, and including: staff ("staff" OR "nurs*" OR "worker*"), experience ("experience*" OR "perspective*" OR "perception*" OR "view*" OR "phenomen*") and manual restraint ("manual restrain*" OR "restrain*" OR

"physical restrain*" OR "physical intervention*" OR "restrictive intervention*" OR "seclu*" OR "PMVA" OR "MAPA"). Searches of these three keyword blocks were individually performed and subsequently combined using the "Search with AND" operator within the EBSCOhost platform. Seclusion was included within the manual restraint block of keywords because it is sometimes grouped with manual restraint in the literature (e.g., Chieze et al., 2019). PMVA (Prevention and Management of Violence and Aggression) and MAPA (Management of Actual or Potential Aggression) are commonly used models of manual restraint practice (Griffin, 2015; Obi-Udeaja et al., 2016). Hence, the inclusion of these terms.

Inclusion and Exclusion Criteria

Studies included in this review were required to meet the following inclusion criteria: (a) original qualitative or mixed method studies; (b) reporting on staff's experiences of manual restraint within a healthcare or residential care setting; (c) published in peer reviewed journals; and (d) written in English. The decision to only include studies published in peer reviewed journals was made to ensure that only studies of adequate quality were included in this review (e.g., peer reviewed studies). Single case studies were excluded to ensure that only studies that incorporated some forms of intersubjective analysis were included. Additionally, studies were excluded if they focused indiscriminately on manual restraint and seclusion (e.g., Moran et al., 2009) and/or if they did not distinguish manual restraint from other types of restraint (e.g., Riahi et al., 2020). This was to ensure that only studies that sufficiently focused on staff's experiences of manual restraint were included.

Study Selection

A total of 3,276 records were identified through electronic database searching. Following the removal of 1,135 duplicates using Zotero, I screened the remaining 2,141

records by title and abstract against the inclusion and exclusion criteria stipulated. If a title and/or abstract appeared relevant, or a title and/or abstract provided insufficient information, then the full text of the record was retrieved and assessed for eligibility. A second reviewer (JT) independently screened titles and abstracts for a random 25% of all records (535 records) to check for agreement, with any discrepancies being resolved through discussion. A sum of 2,076 records were excluded following title and abstract screening, leaving 65 articles eligible for full text retrieval and assessment. Full text articles were requested from authors on ResearchGate in circumstances where they could not be sourced. Of the 65 eligible articles, I excluded 51 articles following full text assessment against the inclusion and exclusion criteria; the reasons for exclusion are presented in Figure 2, page 33. Again, a second reviewer (JT) independently screened a random 25% of eligible full text articles (16 articles) to check for agreement, with any discrepancies being resolved through discussion. Fourteen studies thus met criteria for inclusion in this review (Bailey et al., 2021; Bigwood & Crowe, 2008; Bonner et al., 2002; Brenner et al., 2014; Chapman et al., 2016; Fish & Culshaw, 2005; Hawkins et al., 2005; Kodua et al., 2020; Lombart et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Svendsen et al., 2017; Wilson et al., 2017). No further studies were identified through forward and backward citation searches of these included studies.

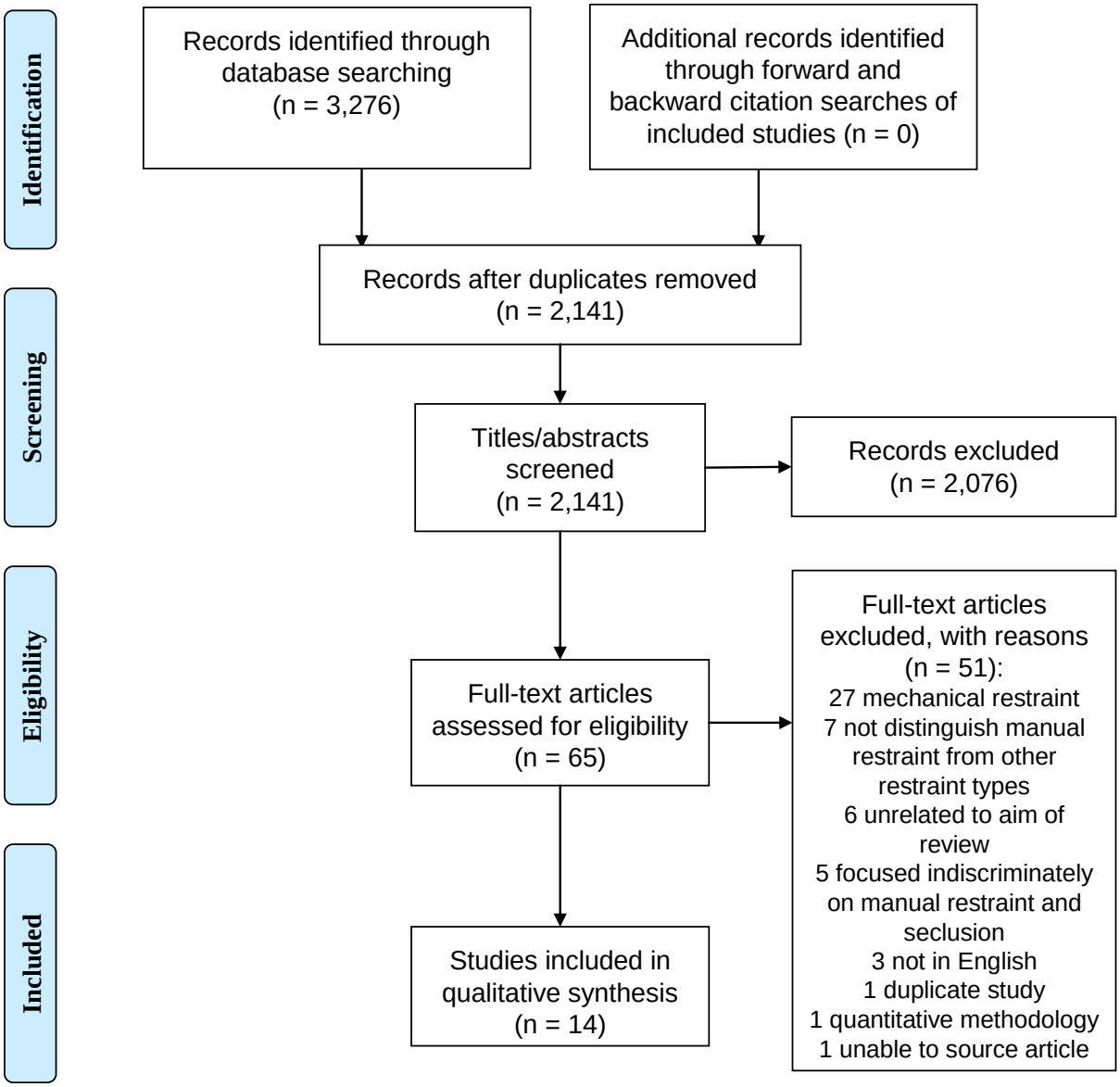
Quality Appraisal

Despite the lack of agreement about whether quality criteria should be applied to qualitative research (Lachal et al., 2017), a decision was made to quality appraise each included study using the Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research. This decision was informed by the increasing number of researchers who are choosing to quality assess studies for meta-synthesis (Hannes & Macaitis, 2012), and the argument put forward by some authors that a good meta-synthesis can no longer bypass a

quality appraisal (Ring et al., 2011). The CASP checklist, which is recommended by the Cochrane Collaboration (Noyes et al., 2019) and reportedly addresses key principles and assumptions of qualitative research (Tong et al., 2012), includes 10 questions: two for screening out inappropriate studies, and eight for assessing research design, recruitment, data collection and analysis, reflexivity, ethical considerations, and implications of qualitative studies.

Figure 2

PRISMA Flow Diagram of Study Selection Process



As recommended by the Cochrane Collaboration, an overall quality rating was not assigned to each study (Noyes et al., 2019). It was also felt that a narrative appraisal of the quality of studies would be more informative to the reader than assigning individual quality ratings. Given that there is no consensus or globally accepted method for excluding qualitative studies for meta-synthesis based on quality criteria (Majid & Vanstone, 2018), there were no plans to exclude studies in this review on the grounds of quality. I quality appraised all 14 studies and a second reviewer (JT) independently quality appraised a random 25% of studies (four studies). Discrepancies in appraisal were resolved through discussion.

Synthesis

The meta-synthesis of this review was guided by Thomas and Harden's (2008) thematic synthesis method and was performed using the qualitative data analysis software NVivo version 12. Thematic synthesis is well suited for qualitative integrative reviews that address questions concerning people's perspectives and experiences (Thomas & Harden, 2008), hence the choice of this method.

Initially, following my reading and re-reading of each study to facilitate immersion in the data, I inductively coded all author narrative text (excluding participant extracts, unless author narratives were ambiguous) within the "Findings" or "Results" sections of study articles, meaningful unit-by-meaningful unit with respect to meaning and content. A meaningful unit was any author narrative text that was relevant to the review question; this could range from a sentence to a paragraph. Codes applied to one study were applied to others, and if no prior codes were applicable, a new code was applied and added to the code bank. Irrelevant author narratives such as text exclusively addressing service users' experiences were not coded. In the next phase of the meta-synthesis, I grouped codes into descriptive themes and subthemes based on the differences and similarities between codes.

The final phase of the meta-synthesis involved the development of an analytical theme from the descriptive themes which went beyond the findings of the original studies. The codes and themes that I generated in the synthesis process were independently reviewed by a second reviewer (LA) at the level of the coded collated author narratives and at the level of the entire dataset, in relation to the review question. Discrepancies were resolved through discussion and modification of themes.

Reflexivity

As I will further discuss on pages 63-64 within the Methods Chapter of this thesis, I have four years' lived experience of using manual restraint within a previous nursing job role. Consequently, to improve the credibility of the meta-synthesis, I kept a reflexive log throughout the integrative literature review process in which I detailed my presuppositions and their potential influence on the meta-synthesis process. The independent reviewer JT is a mental health nurse with previous experience of using manual restraint. The independent reviewer LA is a doctorate in clinical psychology student without any experience of using manual restraint.

Results

Study Characteristics

Overall, the 14 included studies constituted a diverse participant population; sample sizes ranged from 7 to 41 with a total of 255 healthcare staff participants across studies (at least 136 females). Healthcare staff were mainly nursing and care staff, and worked in a variety of settings including the emergency department (Chapman et al., 2016), paediatric general hospital (Brenner et al., 2014; Lombart et al,, 2020; Svendsen et al., 2017), inpatient adult mental health (Bailey et al., 2021; Bigwood & Crowe, 2008; Bonner et al., 2002;

Perkins et al., 2012; Sequeira & Halstead, 2004; Wilson et al., 2017), inpatient child and adolescent mental health - eating disorders (Kodua et al., 2020), residential childcare (Steckley & Kendrick, 2008), and residential and inpatient learning disability services (Fish & Culshaw, 2005; Hawkins et al., 2005).

Across studies, healthcare staff participants' ages ranged from at least 18 to at least 62 years, and their experience of working within their specialities ranged from at least two weeks to 40 years. The majority of studies were conducted in the UK (Bailey et al., 2021; Bonner et al., 2002; Fish & Culshaw, 2005; Hawkins et al., 2005; Kodua et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Wilson et al., 2017). Five studies were conducted in Australia (Chapman et al., 2016), France (Lombart et al., 2020), Ireland (Brenner et al., 2014), New Zealand (Bigwood & Crowe, 2008) and Norway (Svendsen et al., 2017) respectively.

The terms used to describe manual restraint varied across studies with just two studies referring to the practice as such (Chapman et al., 2016; Kodua et al., 2020). Eight studies referred to manual restraint as "physical restraint" (Bailey et al., 2021; Bigwood & Crowe, 2008; Bonner et al., 2002; Lombart et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Wilson et al., 2017), two studies referred to manual restraint as "physical intervention" (Fish & Culshaw, 2005; Hawkins et al., 2005), one study referred to manual restraint as "restraint" (Svendsen et al., 2017), and one study referred to manual restraint as "restricting" (Brenner et al., 2014).

Six studies jointly explored staff's and service users' experiences of manual restraint (Bonner et al., 2002; Fish & Culshaw, 2005; Hawkins et al., 2005; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Wilson et al., 2017). However, staff and service users' experiences were deemed to be adequately distinctly reported in these studies, hence their inclusion in this review. A summary of the 14 included studies is shown in Table 4, page 37.

Table 4

Summary of Included Studies

Study (Country)	Main Aims	Sample	Setting	Data Collection	Data Analysis	Key Themes/Findings
Bailey et al., 2021 (UK)	To explore nurses' experiences of forcible touch during PR	14 nurses (9 females) Age: 28 - 59yrs Exp: 1 - 30yrs	Inpatient adult MH	Semi-structured interviews	Cohen's Hermeneutic PA	• Needing to justify • Inconsistent knowing • Compassionate whilst careworn
Bigwood & Crowe, 2008 (New Zealand)	To understand nurses' experiences of PR	7 nurses (3 females) Age: Not reported Exp: <5 - >5yrs	Inpatient adult MH	Semi-structured interviews	Van Manen's Hermeneutic PA	• It's part of the job (overarching theme) • Control (subtheme) • Conflicted nurse (facet) • Scared nurse (facet)
Bonner et al., 2002 (UK)	Pilot study to explore nurses and SUs' experiences of PR	12 nurses and 6 SUs Gender, age and exp duration not reported	Inpatient adult MH	Semi-structured interviews	Thematic Analysis	• Antecedents (ward atmosphere, failed communication) • During restraint (fear & embarrassment, last resort) • Aftermath (distress, resolution) • Re-traumatization
Brenner et al., 2014 (Ireland)	To describe nurses' experiences of restricting a child's movement for a clinical procedure	20 nurses Age: 24 - 60yrs Exp: 10 - 40yrs Gender not reported	Paediatric GH	Focus groups	Thematic Network Analysis	• Tensions in care (overarching theme) • Acknowledging restriction (subtheme) • The only way to manage them (subtheme)

Continued

Table 4 Continued

Study (Country)	Main Aims	Sample	Setting	Data Collection	Data Analysis	Key Themes/Findings
Chapman et al., 2016 (Australia)	To explore nurses' perceptions of MR use	15 nurses (12 female) Age: 24 - 46yrs Mean exp: 9yrs	Emergency department	Semi-structured interviews	Thematic Analysis	• Part of the job • Reasons for MR (aggression, leaving against medical advice, medical procedures) • Restraint techniques • Consequences (physical, psychological, organisational) • Lack of documentation
Fish & Culshaw, 2005 (UK)	To explore staff's and SUs' experiences of aggression and PI incidents	16 care staff (9 female) and 9 SUs Gender, age and exp duration not reported	Medium-secure inpatient LD	Unstructured interviews	Hycner's PA	• Staff responses to aggression (distress) • Reasons for PI (injury risk, control) • Re-traumatization • Last resort
Hawkins et al., 2005 (UK)	To explore staff's and SUs' views and experiences of PI	8 nursing staff (3 females) and SU pairs Staff age: 26 - 53yrs Staff exp: 1 - 17yrs	LD residential community care	Semi-structured interviews	Grounded Theory	• Before PI (negative emotions, rise in adrenaline) • During PI (emotional rollercoaster, physical exhaustion, getting it right) • After PI (walking on eggshells, physical & emotional aftermath)

Continued

Table 4 Continued

Study (Country)	Main Aims	Sample	Setting	Data Collection	Data Analysis	Key Themes/Findings
Kodua et al., 2020 (UK)	To explore nursing assistants' experiences of MR for compulsory nasogastric feeding of young people with anorexia nervosa	8 nursing assistants (4 females) Age: 23 - 36yrs Exp: 5 months - 3yrs	Inpatient child and adolescent MH (eating disorders)	Semi-structured interviews	Thematic Analysis	• An unpleasant practice • Importance of coping • Becoming desensitised and sensitised
Lombart et al., 2020 (France)	To explore healthcare professionals' perspectives of forceful PR in paediatric care	30 female healthcare professionals Age: 23 - 63yrs Exp duration not reported	Paediatric GH	Focus groups	Thematic Analysis	• A regrettable paradox that is rarely contested • From a taboo term to a feeling of unease • Constraints that allow for the use of force • A laborious practice that results in the child being forgotten
Perkins et al., 2012 (UK)	To examine nurses' decision-making process involved in a series of PR episodes	30 nurses (including 9 females and 8 males) Age: 25 - 56yrs Exp: 18 months - 25yrs	Inpatient adult MH	Interviews and focus groups Interview type not reported	Thematic Analysis	• Contextual demands (ward factors, organisational demands) • Lack of alternatives • The escalatory effects of PR • Perceptions of risk

Continued

Table 4 Continued

Study (Country)	Main Aims	Sample	Setting	Data Collection	Data Analysis	Key Themes/Findings
Sequeira & Halstead, 2004 (UK)	To explore nursing staff's experiences of PR with a focus on their psychological responses	17 nursing staff (8 females) and 19 SUs Staff age: 18 - 50yrs Staff exp: <1 - 15yrs	Inpatient adult MH	Semi-structured interviews	Grounded Theory	• Anxiety & anger • Conflict with nursing role • Boredom, frustration & low morale • Laughing/joking to release feelings & inhibition of emotional distress • Automatic responding/'no feelings'
Steckley & Kendrick, 2008 (UK)	To explore care staff's and SUs' views and experiences of PR	41 care staff (24 females) and 37 SUs Age and exp duration not reported	Residential childcare	Semi-structured interviews	Probable Thematic Analysis	• Necessity of PR • Dilemmas & complexities • Negative emotions & experiences • Concerns about PR (inadequate reasons, worrying for the YP) • Relationships & PR

Continued

Table 4 Continued

Study	Main Aims	Sample	Setting	Data Collection	Data Analysis	Key Themes/Findings
Svendsen et al., 2017 (Norway)	To explore staff's perspectives and reasoning about restraint use during medical procedures on pre-schoolers	15 nursing and physician staff (14 females) Age: 26 - 44yrs Exp: 2 weeks - 8yrs	Paediatric GH (somatic care)	Semi-structured interviews	Thematic Analysis	• Disparate views on the concept of restraint and restraint use • Ways to limit the use of PR and its negative consequences • Experience with the role of parents and their influence on restraint
Wilson et al., 2017 (UK)	To explore staff's and SUs' experiences of PR	22 healthcare staff (15 females) and 13 SUs Staff age: 20s - 50s Staff exp: 4 months - 20yrs	Inpatient adult MH	Semi-structured interviews	Thematic Analysis	• Is restraint a necessary evil? (overarching theme) • 'It never is very nice' (subtheme) • 'It's got to be done' (subtheme)

Note. GH = general hospital; LD = learning disability; MH = mental health; MR = manual restraint; NR = not reported; PA = phenomenological analysis; PI = physical intervention; PR = physical restraint; SU = service user; YP = young person; Yrs = years

Quality Appraisal

The CASP qualitative research quality assessment revealed that all but two studies (Bailey et al., 2021; Kodua et al., 2020) had at least one methodological and/or reporting limitation in respect to the CASP checklist items. These limitations included an absence of author reflexivity (Bigwood & Crowe, 2008; Bonner et al., 2002; Brenner et al., 2014; Chapman et al., 2016; Fish & Culshaw, 2005; Hawkins et al., 2005; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Svendsen et al., 2017; Wilson et al., 2017), a lack of information regarding ethical considerations (Chapman et al., 2016) and ethical approval (Hawkins et al., 2005; Sequeira & Halstead, 2004), a deficit of information regarding the participant sample (Bonner et al., 2002; Brenner et al., 2014; Fish & Culshaw, 2005; Lombart et al., 2020; Steckley & Kendrick, 2008), and a lack of information regarding the participant recruitment strategy (Hawkins, et al., 2005; Perkins et al., 2012; Svendsen et al., 2017), although the use of a purposeful sample was evident and appropriate in all studies.

While all studies used appropriate data collection methods such as interviews and focus groups, four studies provided insufficient justification for the selected participant sample size (Brenner et al., 2014; Perkins et al., 2012; Steckley & Kendrick, 2008; Wilson et al., 2017), and one study failed to provide any details of the interview/focus group topic guide that was used (Perkins et al., 2012). Six studies commented on whether “data saturation” or “saturation” had been achieved (Bailey et al., 2021; Chapman et al., 2016; Fish & Culshaw, 2005; Kodua et al., 2020; Lombart et al., 2020; Sequeira & Halstead, 2004), and it could be inferred from the grounded theory methodology of a further study that “data saturation” principles had been adopted (Hawkins et al., 2005).

All studies presented verbatim participant quotes to evidence the analysis, and used appropriate data analysis methods and/or methodologies including grounded theory (Hawkins et al., 2005; Sequeira & Halstead, 2004), types of phenomenological analysis (Bailey et al.,

2021; Bigwood & Crowe, 2008; Fish & Culshaw, 2005) and types of thematic analysis (Bonner et al., 2002; Brenner et al., 2014; Chapman et al., 2016; Kodua et al., 2020; Lombart et al., 2020; Perkins et al., 2012; Steckley & Kendrick, 2008; Svendsen et al., 2017; Wilson et al., 2017). However, one study provided insufficient information of the analysis process (Steckley & Kendrick, 2008), and seven studies featured a rather descriptive analysis, evidenced by the domain summary hallmark of generated themes (Bonner et al., 2002; Chapman et al., 2016; Fish & Culshaw, 2005; Hawkins, et al., 2005; Perkins et al., 2012; Steckley & Kendrick, 2008; Svendsen et al., 2017). Domain summary themes are representative of the *range of meanings* within a theme (e.g., "reasons for physical intervention"; Fish & Culshaw, 2005), rather than the *shared meanings* within a theme (e.g., "compassionate whilst careworn"; Bailey et al., 2021); such themes are argued to reflect "under-developed themes" (Braun & Clarke, 2019, p. 593).

Thematic Synthesis

One overarching interpretive theme and four subthemes were generated from the meta-synthesis: Unpleasant but necessary (overarching theme); Emotional distress (subtheme); Feeling conflicted (subtheme); Depletion (subtheme); and Maintaining safety triumphs all (subtheme). A summary of the generated overarching theme and subthemes of the thematic meta-synthesis is presented in Table 5, page 43.

Table 5

Summary of Generated Theme and Subthemes from Thematic Meta-Synthesis

Overarching Theme	Subthemes
Unpleasant but necessary	Emotional distress
	Feeling conflicted
	Depletion
	Maintaining safety triumphs all

Unpleasant But Necessary. This single overarching interpretive theme was latently inferred across all 14 studies, and explicitly evidenced within five studies (Bailey et al., 2021; Chapman et al., 2016; Kodua et al., 2020; Perkins et al., 2012; Wilson et al., 2017). "Unpleasant but necessary" describes an implicit and explicit narrative that was central to healthcare staff's experiences of manual restraint: that whilst manually restraining service users is unpleasant, it is nevertheless sometimes necessary to keep service users and staff safe from harm. This inference is captured by the author narratives of Perkins et al (2012) and Kodua et al (2020):

> Throughout the interviews, staff, while recognising the notion of restraint as a means of last resort, viewed it as a 'necessary evil', that is a necessary strategy in controlling behaviour and reducing the risk of violence and harm even though the majority of staff talked with dislike about its application (Perkins et al., 2012, p. 46).

> Despite recognizing the necessity of compulsory nasogastric feeding under manual restraint for young persons with anorexia nervosa who were refusing all foods and/or fluids, seven of the eight nursing assistants described the emotional distress they experienced as a result of administering manual restraint (Kodua et al., 2020, p. 1184-1185).

This overarching theme constitutes four subthemes. The subthemes of "emotional distress", "feeling conflicted", and "depletion" reflect the inference across the 14 studies that manual restraint is an unpleasant practice for healthcare staff. The remaining subtheme of "maintaining safety triumphs all" reflect the inference across the 14 studies that manual restraint is a sometimes-necessary practice for healthcare staff. Thus, the four reported subthemes collectively constitute the interpretation that manual restraint is "unpleasant but necessary". Hence, the selected title of this overarching theme.

Emotional Distress. All studies described the emotional distress associated with using manual restraint which included the experience of anxiety and fear (Bailey et al., 2021; Bigwood & Crowe, 2008; Chapman et al., 2016; Hawkins et al., 2005; Kodua et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Wilson et al., 2017), anger and frustration (Bonner et al., 2002; Hawkins et al., 2005; Kodua et al., 2020; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008), guilt (Bailey et al., 2021; Brenner et al., 2014; Kodua et al., 2020; Lombart et al., 2020; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008), sadness (Hawkins et al., 2005), embarrassment (Bailey et al., 2021), disgust – in relation to some service users' body odour (Bailey et al., 2021), and feelings of distress (Bailey et al., 2021; Bigwood & Crowe, 2008; Bonner et al., 2002; Brenner et al., 2014; Chapman et al., 2016; Fish & Culshaw, 2004; Hawkins et al., 2005; Kodua et al., 2020; Sequeira & Halstead, 2004; Svendsen et al., 2017; Wilson et al., 2017). Healthcare staff distress was inferred from study authors' use of terms such as "traumatising", "upsetting", "terrible" and "distressing" when narrating healthcare staff's experiences of manual restraint:

> The most dominant theme was that restraint was distressing for both patients and staff . . . Eleven staff members reported feeling distress and upset for themselves as a result of restraining patients (Wilson et al., 2017, p. 503).

> Many nurses and physicians said they felt terrible when a child was held . . . Two inexperienced nurses were quite affected when talking about how difficult and demanding it could be to use restraint (Svendsen et al., 2017, p. 6).

Healthcare staff anxiety and fear were the most prevailing emotions as evidenced by their descriptions in nine of the 14 studies. For instance, Bigwood and Crowe (2008) reported: "the participants all acknowledged the anxiety associated with physical restraint" (p. 220). Similarly, Sequeira and Halstead (2004) reported: "The most prevailing theme in the staff interviews was of anxiety" (p. 6). Across the nine studies, healthcare staff's experiences

of anxiety and/or fear were attributed to a range of reasons, such as the fear of being hurt or hurting the service user in restraint (Bailey et al., 2021; Bigwood & Crowe, 2008; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008), the unpredictability of manual restraint incidents (Hawkins et al., 2005; Kodua et al., 2020), and the worry about one's own performance when applying manual restraint (Bigwood & Crowe, 2008; Hawkins et al., 2005; Kodua et al., 2020; Perkins et al., 2012; Steckley & Kendrick, 2008):

> The most prominent aspects of the experience with which staff associated anxiety were being hurt themselves, other staff getting hurt or hurting the patient during restraint (Sequeira & Halstead, 2004, p. 6).

> The majority of the staff (n = 7) spoke of an overwhelming feeling of dread before the physical intervention, associated with thoughts about what lay ahead of them (Hawkins et al., 2005, p. 27).

> The participants also identified different expectations for male and female nurses as part of the nursing team in a physical restraint. One male participant described the performance anxiety he had experienced (Bigwood & Crowe 2008, p. 219).

Although two studies reported that anxiety and/or fear were highest in the moments leading up to a manual restraint (Hawkins et al, 2005; Sequeira & Halstead, 2004), an overall reduction in anxiety and distress was reported over time for the healthcare staff in three studies (Kodua et al., 2020; Sequeira & Halstead, 2004; Wilson et al., 2017). For example, Wilson et al (2017) reported that "restraint was seen to become less frightening with experience" (p. 504).

Of the six studies reporting on healthcare staff guilt, the experience of this emotion was most frequently linked to the coerciveness of applying manual restraint and the service user's distressing reaction to the practice (Bailey et al., 2021; Kodua et al., 2020; Lombart et al., 2020). The inability to find ways of avoiding restraint was also reported to prompt guilt

for the healthcare staff in one study: “a theme emerging from staff interviews is a sense of guilt or defeat related to their inability to find a way to avoid having to restrain the young person” (Steckley & Kendrick, 2008, p. 562).

Of the five studies reporting on healthcare staff anger and frustration, the experience of these emotions were associated with: being hurt by the service user in restraint (Kodua et al., 2020; Sequeira & Halstead, 2004); the service user hurting colleagues in restraint (Sequeira & Halstead, 2004); failing to meet the service user’s needs (Bonner et al., 2002); failing to execute one’s own restraint position (Kodua et al., 2020); and less restrictive alternatives proving to be ineffective (Hawkins et al., 2005; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008). The below author narratives provide examples of some of these reasons for healthcare staff anger and frustration:

> Fifty per cent said that they normally felt frustrated. This frustration appeared to be mainly because of the fact that less restrictive strategies were proving ineffective in calming a service user, resulting in the realization that a physical intervention was probably going to have to be used (Hawkins et al., 2005, p. 27).

> Many staff referred to the response of anger during the restraint process. Some associated this with the patient’s hurting them or their colleagues and to frustration with patients not responding to less restrictive interventions (Sequeira & Halstead, 2004, p. 7).

Four studies described conscious actions of healthcare staff inhibiting their emotions during manual restraint incidents through “switching off feelings” (Sequeira & Halstead, 2004, p. 9), “actively detaching themselves” (Kodua et al., 2020, p. 1186), “emotional detachment” (Bailey et al., 2021, p. 406), and temporarily suspending their ability to empathise (Lombart et al, 2020). These processes were reported to reflect healthcare staff’s methods of coping with restraint related distress:

> Five of the eight nursing assistants reported actively detaching themselves from the process when they were administering manual restraint for compulsory nasogastric feeding . . . Detaching the self appeared to be a conscious response used by participants to cope with the adverse psychological outcomes of manual restraint use (Kodua et al., 2020, p. 1186).

Support from colleagues in the aftermath of a manual restraint incident through talking (Bonner et al., 2002; Kodua et al., 2020), humour (Bigwood & Crowe, 2008; Kodua et al., 2020; Sequeira & Halstead, 2004), and formal and informal debriefings (Bonner et al., 2002) were also reported to reflect healthcare staff's coping behaviours for distress in four studies. However, one study reported that one healthcare staff "saw no need for debriefing" (Bonner et al., 2002, p. 470), while another study reported that healthcare staff "felt the commitment to debriefing was generally poor" (Bailey et al., 2021, p. 409). The possible harm that could arise from poorly managed formal debriefing meetings was highlighted in one of the only two studies reporting on formal debriefing meetings:

> While debriefing was generally viewed positively, there were also issues of concern around possible harm that might arise from poorly managed debriefing. Two nurses described unhelpful experiences relating to a serious incident which occurred some months before, where debriefing had been set up some 6 weeks after a particularly disturbing incident (Bonner et al., 2002, p. 470).

Contrary to this subtheme, two studies reported that manual restraint elicited "a degree of bravado" (Sequeira & Halstead, 2004, p. 6), "no negative emotional impact" (Wilson et al., 2017, p. 504) and "no emotional reactions" (Sequeira & Halstead, 2004, p. 6) for a small minority of healthcare staff, highlighting that manual restraint may not be overtly distressing for some healthcare staff. Additionally, one healthcare staff in one study highlighted that the staff experience of manual restraint entailed some positive as opposed to only negative feelings: "And then there are other feelings. I mean you're asserting control

and preventing danger or preventing harm. So there are positive feelings as well as negative feelings. It's a mixture of things" (participant; Hawkins et al., 2005, p. 28).

Feeling Conflicted. Twelve of the fourteen studies highlighted the relational conflict (Chapman et al., 2016; Kodua et al., 2020; Steckley & Kendrick, 2008; Wilson et al., 2017) and the internal conflict (Bailey et al., 2021; Bigwood & Crowe, 2008; Brenner et al., 2014; Chapman et al., 2016; Hawkins et al., 2005; Lombart et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Svendsen et al., 2017; Wilson et al., 2017) that healthcare staff experienced in relation to using manual restraint. The latter feelings of conflict were most commonly attributed to the inferred view that manual restraint was incongruent with the caring values of a healthcare worker (Bailey et al., 2021; Bigwood & Crowe, 2008; Chapman et al., 2016; Lombart et al., 2019; Sequeira & Halstead, 2004; Wilson et al., 2017):

> Their discomfort with having to manually restrain patients was articulated clearly by one nurse who viewed her role as patient advocate being compromised and felt restraint should not be part of her work as a nurse (Chapman et al., 2016, p. 1277).

> The first sub-theme, 'Only if I have to' revealed the nurses' negative feelings and reluctance about using physical restraint . . . Their moral discomfort about being a nurse and using force was expressed through apparent contradictions (Bailey et al., 2021, p. 405).

One study described how several staff members had to work through debates in their minds prior to using manual restraint which "appeared to be both distracting and distressing for the individual" (Hawkins et al., 2005, p. 28). The content of these debates appeared to reflect a degree of internal conflict: "I just want to walk away from this situation vs. I can't walk away, this is my job" (Hawkins et al., 2005, p. 28).

The use of manual restraint to maintain safety of the healthcare environment in the

absence of effective less restrictive alternatives was inferred from five studies as an antecedent that could prompt feelings of staff internal conflict. These studies highlighted that the use of manual restraint in such circumstances could be perceived by healthcare staff as being dissonant with the best interests of the service user (Perkins et al., 2012; Steckley & Kendrick, 2008) and the desire to avoid using manual restraint (Hawkins et al., 2005; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Svendsen et al., 2017):

> While the overall safety of the ward environment may be at the heart of such rationalisations, there is an evident tension between maintaining the therapeutic environment and the best interests of the individual service user (Perkins et al., 2012, p. 46)

> The following illustrates the dilemma between a desire to avoid creating a situation that, given the young person's difficulties and patterns of behaviour, might lead to him being physically restrained, and the necessity of setting boundaries (Steckley & Kendrick, 2008, p. 559)

It appeared from one study that the stipulated feelings of internal conflict could be somewhat relieved if staff members felt that attempts had been made to utilise other options prior to implementing restraint, and if staff members felt that they were able to maintain a therapeutic relationship with the service user following restraint:

> This sense of conflict could be ameliorated if they knew attempts had been made to try other options . . . The feelings of conflict could be suspended if the nurse was able to maintain a therapeutic relationship with the patient (Bigwood & Crowe, 2008, p. 220).

The relational conflict associated with using manual restraint was evidenced by the damage to the staff-service user therapeutic relationship from restraint in three studies (Chapman et al., 2016; Steckley & Kendrick, 2008; Wilson et al., 2017), as well as the conflict within the staff-staff relationship consequent to poor restraint performance in one study (Kodua et al., 2020):

> Seventeen participants reported a negative impact [of restraint] on patient–staff relationships, including patients feeling distrustful, feeling unable to approach or talk to staff, seeing staff members as the 'bad guys', and disliking and hating them (Wilson et al., 2017, p. 505).

> Five of the eight nursing assistants reported experiencing conflict with their colleagues as a result of administering manual restraint . . . Conflict typically occurred when participants had failed to execute their restraint positions effectively . . . some described incidents where their colleagues had made them feel incompetent (Kodua et al., 2020, p. 1186).

Of particular significance, one study highlighted that damage to the therapeutic relationship from manual restraint was only temporary for a small minority of healthcare staff: "one patient and three staff members reported that this negative impact on relationships was only short lived" (Wilson et al., 2017, p. 506). Additionally, a further study highlighted that good practice after a manual restraint through, for example, debriefing with the service user, could minimise damage to the therapeutic relationship (Steckley & Kendrick, 2008):

> I firmly believe that the aftermath of a restraint is probably the most significant time for a young person and also for the member of staff involved. If they manage themselves and manage that situation sensitively, clearly, concisely and the young person understands and the staff member understands and there is a joint understanding of how that situation came about and of how that situation could avoid happening again, I think there is minimum impact in terms of the relationship (participant; Steckley & Kendrick, 2008, p. 564).

In contrast to the inference of manual restraint as a cause of relational conflict, two studies highlighted improved staff-service user therapeutic relationships following manual restraint incidents (Bigwood & Crowe, 2008; Steckley & Kendrick, 2008): "Conversely, both staff and young people described situations where there was an improvement in their relationships after a restraint" (Steckley & Kendrick, 2008, p. 564).

Depletion. A theme that was inferred from at least five studies was that manual restraint was a laborious practice that could deplete staff numbers (Chapman et al., 2016; Perkins et al., 2012) and result in physical exhaustion to staff (Hawkins et al., 2005; Kodua et al., 2020; Lombart et al., 2020). The laborious hallmark of manual restraint at the service level could be inferred from Chapman et al's (2016) study that highlighted that, on many occasions, three to seven staff members were required to manually restrain one service user. Similarly, Perkin's et al (2012) reported: "restraint episodes were also labour intensive, often requiring higher staffing levels and drawing staff from other wards" (p. 44), again reflecting the staff-number-depleting consequences of manual restraint.

Although just three studies explicitly highlighted the physical exhaustion associated with using manual restraint (Hawkins et al., 2005; Kodua et al., 2020; Lombart et al., 2020), a further three studies implied a level of staff physical exhaustion. For instance, Bigwood and Crowe (2008) reported that manual restraint required "physical preparation" (p. 220), Perkins et al (2012) referred to manual restraint as a "physical struggle" (p. 47), and Bailey et al (2021) highlighted that manual restraint could be a "wrestling match" (p. 407). Of the three studies explicitly reporting on physical exhaustion, two provided vivid author narratives of healthcare staff's experiences:

> All nursing assistants described the physical exhaustion they felt in relation to applying manual restraint for compulsory nasogastric feeding, especially in circumstance where the young person was highly resistive. There were multiple manual restraints to perform per shift, and reports of sweating during restraints were not uncommon (Kodua et al., 2020, p. 1185).

> Six staff described experiencing physical exhaustion during the physical intervention . . . the physical exhaustion was attributed to: the continuous rise in adrenaline, the physical nature of the restraint techniques requiring muscle tension and long durations of physical interventions (Hawkins et al., 2005, p. 29).

In contrast to this subtheme, one study highlighted that manual restraint was not always physically demanding for staff members; this was the case when service users were compliant with the intervention: "the restraint of some young persons involved minimal physical exertion because of their increased compliance and preference to be fed under restraint" (Kodua et al. 2020, p. 1185).

Maintaining Safety Triumphs All. A central theme that was apparent across all 14 studies was that the use of manual restraint was sometimes necessary to keep healthcare staff and/or service users safe from harm, and that this maintenance of safety was of the upmost priority for healthcare staff. For instance, Bailey et al (2021) reported: "although they [nurses] spoke of not wanting to restrain, they defended their actions on safety grounds for service users and staff" (p. 405). Similarly, four studies described manual restraint as a "necessary evil" to protect staff and/or service users (Bailey et al., 2021; Perkins et al., 2012; Svendsen et al., 2017; Wilson et al., 2017), further highlighting the inferred view that maintaining safety is of the highest priority when staff use manual restraint:

> Despite the mainly negative image/descriptions of restraint and its emotional and relational impacts, a common theme from both staff and patients was that, at times (to keep patients and staff safe . . .), restraint is needed: 'it's a necessary evil' (Wilson et al., 2017, p. 506).

As evidenced by description in seven of the 14 studies, manual restraint was used most prevailingly in response to service user aggressive behaviour to prevent harm to staff and service users (Bailey et al., 2021; Chapman et al., 2016; Fish & Culshaw, 2005; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Wilson et al., 2017):

> The decision to manually restrain a patient was made to stop or reduce violent and aggressive behaviours to protect the safety of the patient, staff, other patients or relatives (Chapman et al., 2016, p. 1276).

However, nine studies also highlighted the staff use of manual restraint to: prevent service users from deliberately harming themselves (Kodua et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008); prevent service users from absconding and leaving the ward against medical advice (Chapman et al., 2016; Perkins et al., 2012; Steckley & Kendrick, 2008); administer necessary medications (Bonner et al., 2002; Perkins et al., 2012); administer necessary dietary intake to food and/or fluid refusing service users with eating disorders (Kodua et al., 2020); and perform necessary medical procedures including the collection of pathology, and the insertion of cannulas, catheters and nasogastric tubes (Brenner et al., 2014; Chapman et al., 2016; Lombart et al, 2020; Svendsen et al., 2017). These nine studies highlight the service user safety maintaining application of manual restraint:

> At times, the manual restraint continued even after nasogastric feeding had been completed because the young person was either trying to self-harm or purge the liquid supplement they had just been given (Kodua et al., 2020, p. 1185).

> Staff identified aggression or violence, self-harm, absconding and the planned administration of medication as the antecedents leading to restraint (Perkins et al., 2012, p. 44).

> Many participants gave examples of their own experiences of restricting a child for procedures such as lumbar punctures, insertion of nasogastric tubes, and insertion of intravenous cannulae . . . There was consensus in all groups that safety and expediency of care were absolutely necessary (Brenner et al., 2014, p. 1084).

Although the use of manual restraint to maintain staff and service user safety was inferred as being of the upmost priority for healthcare staff in all studies, ten studies highlighted that manual restraint was used only as a last resort, such as when less restrictive alternatives for managing the service user's behaviour were ineffective or not possible (Bailey et al., 2021; Bigwood & Crowe, 2008; Chapman et al., 2016; Fish & Culshaw, 2005;

Hawkins et al., 2005; Lombart et al., 2020; Perkins et al., 2012; Steckley & Kendrick, 2008; Svendsen et al., 2017; Wilson et al., 2017):

> All staff reported that physical intervention was used to control a situation when all other means had failed and there was risk of injury . . . all the staff interviewed stressed that the use of physical intervention would be their last resort (Fish & Culshaw, 2005, p. 100, 104).

> Some interviewees expressed with a degree of certainty that if they . . . assessed that the young person was likely to put him- or herself at significant risk by absconding, then they considered it appropriate and necessary to physically restrain the young person if there was no other way to prevent him or her from going (Steckley & Kendrick, 2009, p. 558).

However, six studies implied that differences in staff members' emotional reactions (Hawkins et al., 2005), tolerance of risk (Perkins et al., 2012), tiredness (Lombart et al., 2020), and needs to maintain safety and control (Bigwood & Crowe, 2008; Steckley & Kendrick, 2008; Wilson et al., 2017) could result in the premature, pre-emptive, and unnecessary use of manual restraint:

> It was suggested by four participants that experiencing strong emotions, being in an unpredictable situation and feeling the urge to respond automatically, could result in staff responding with a physical intervention too early (Hawkins et al., 2005, p. 28).

> The participants identified that their colleagues had different needs in relation to control and could act quicker than others in commencing a physical restraint . . . when the decision of another nurse to proceed with the physical restraint felt pre-emptive, then some participants described feeling uneasy (Bigwood & Crowe, 2008, p. 219-220).

> It was also emphasized that, while restraint was viewed to be necessary on some occasions, in certain situations it was also thought to have been unnecessary . . . A staff member gave an example of when he had witnessed the beginning of an unnecessary restraint that he was then able to prevent (Wilson et al., 2017, p. 507).

Contrary to this subtheme, three studies highlighted that manual restraint could cause physical harm to staff (Chapman et al., 2016; Kodua et al., 2020; Wilson et al., 2017) and service users (Wilson et al., 2017). Specifically, Wilson et al (2017) described manual restraint incidents which resulted in "pain" and/or "injury" (p. 507) to service users and staff. Additionally, Kodua et al (2020) highlighted that manual restraint incidents "frequently" resulted in injuries to staff ranging from "back pains to bruises" (p. 1185). Two studies highlighted the negative impact of manual restraint on the safety of the healthcare environment by illustrating how manual restraint incidents often took away staff, leaving fewer staff to care for other service users (Chapman et al., 2016; Perkins et al., 2012).

Discussion

This integrative review and meta-synthesis of 14 qualitative studies is the first to integratively review and meta-synthesize the literature pertaining to healthcare staff's experiences of using manual restraint, and consequently, provides valuable insight into this phenomenon. Overall, the findings suggest that healthcare staff experience manual restraint as an "unpleasant but necessary" practice that is sometimes required to keep service users, themselves, and their colleagues safe from significant harm. The findings also suggest that healthcare staff, through their use of manual restraint, appear to prioritise the aforementioned need to maintain safety above their own physical safety (in the context of restraint-related physical injury and pain) and psychological safety.

Alarmingly, the findings showed that manual restraint was associated with emotional distress (all 14 studies), internal and relational conflict (12 studies), and the experience of physical exhaustion and injury (at least five studies) amongst healthcare staff. Healthcare staff across the studies experienced unpleasant emotions such as anxiety/fear, anger/frustration and guilt, and felt conflicted in the capacity of their therapeutic role

consequent to their manual restraint use. Given these aversive psychological and physical outcomes, it is thus not surprising that nearly half of the reviewed studies highlighted the coping behaviours that healthcare staff used to manage their restraint related distress (e.g., inhibiting emotions, humour, talking with colleagues). This is congruent with the coping literature which has indicated that individuals develop coping responses when confronted with distressing experiences (Blum et al., 2012).

The meta-synthesis showed that manual restraint could damage the staff-service user therapeutic relationship (three studies). This finding is not surprising given the coercive hallmark of manual restraint practice. However, a small minority of the healthcare staff in one study highlighted that the damage was only temporary (Wilson et al., 2017), and another study highlighted how good practice in the post-restraint period (e.g., debriefing with the service user) could minimise damage to the therapeutic relationship (Steckley & Kendrick, 2008). These findings are reassuring, and the latter finding shed light on the significant role that post-restraint practices such as debriefing with the service user play in minimising restraint-related damage to the staff-service user therapeutic relationship. Reducing the potential damage to the relationship is important given that improved staff-service user relationships can reduce the overall need for restrictive interventions such as manual restraint (Restraint Reduction Network, 2022).

Although it was apparent from the reviewed studies that healthcare staff profoundly used manual restraint as a last resort intervention when effective less restrictive alternatives were lacking, six studies alarmingly highlighted the premature, pre-emptive, and unnecessary use of manual restraint, shedding light on the possibility for restraint to be used abusively (Care Quality Commission, 2022; Lee et al., 2003), even if this is not the intention of staff (e.g., responding with restraint too early due to differences in staff tolerance of risk [Perkins et al., 2012]). These findings reflect what service users have reported in the literature, with

some describing experiences of: being restrained unfairly, pre-emptively, and unnecessarily (Knowles et al., 2015), being subjected to excessive force in restraint (Brophy et al., 2016; Haw et al., 2011), and believing that restraint had been used to punish them (Haw et al., 2011; Sequeira & Halstead, 2002). These findings together with the findings of the present review challenge the notion of whether manual restraint is truly always used as a "last resort" intervention.

The findings of this meta-synthesis paradoxically mirror that of previous reviews of service users' experiences of manual restraint, which have highlighted the adverse physical and psychological outcomes to service users (e.g., distress, fear, pain, physical injury) consequent to manual restraint (Cusack et al., 2018; Douglas et al., 2022; Strout, 2010). These findings, combined with the findings of the present review, reflect poorly on manual restraint practice, and suggest that manual restraint is a predominately negative practice for both healthcare staff and service users, despite its protective functions. To this regard, manual restraint minimisation programmes such as 'Safewards' (Bowers, 2014), 'No Force First' (Ashcraft & Anthony, 2008; Haines-Delmont et al., 2022) and 'REsTRAIN YOURSELF' (Duxbury et al., 2019a) are important initiatives and would be assumed to be welcomed by healthcare staff and service users alike. Notwithstanding, it is important that such minimisation programmes clearly acknowledge and validate healthcare staff's experiences of restraint, as opposed to solely presenting benefits and being too changed focused, so that healthcare staff do not interpret these programmes as a "criticism of their professionalism" (Duxbury et al., 2019b, p. 848). Indeed, people are far more likely to be willing to change when they feel heard and validated (Bertolino, 2018; Day, 2008).

The themes generated within this meta-synthesis were consistent across studies from different countries, healthcare settings, and service user populations suggesting some universality to the experience of applying manual restraint within healthcare settings.

Limitations

This review needs to be considered in the light of several limitations. Firstly, the great majority of included studies were conducted in the UK; caution is therefore needed when transferring the findings of this review to other countries. Notwithstanding, it is acknowledged that this review might appeal more to UK settings, where manual restraint, when compared to mechanical restraint, is the most frequently used form of physical restraint practice (Wilson et al., 2017). Secondly, this review was limited to peer-reviewed studies published in English. Therefore, eligible non-English and doctoral thesis studies may have been missed; such studies may have influenced the themes generated within the meta-synthesis. Thirdly, this review is subject to the limitations of the reviewed studies, many of which were found to have several methodological and/or reporting limitations from the CASP quality appraisal. This needs to be considered when interpreting the findings of this review.

Part Three: Rationale and Aim of the Study

Problem Statement

The fact that just 14 studies were eligible for inclusion in the presented integrative review indicates the lack of research that exists exploring healthcare staff's experiences of manual restraint. This is unfortunate given the lived experience insights that such qualitative research can provide about the barriers to manual restraint reduction and the needs of such staff. Arguably, the implementation of staff's lived experience insights into manual restraint minimisation programmes could help staff to feel well validated, well heard, and less prone to feel criticised when these programmes are championed. Such an approach could increase staff's willingness and receptiveness towards manual restraint minimisation programmes and

translate into improved manual restraint reduction outcomes. In reference to all the above, I would thus argue that there is a need for further qualitative research exploring healthcare staff's experiences of manual restraint.

Of the 14 studies identified from the integrative review, just five were conducted in child and/or adolescent settings (Brenner et al., 2014; Kodua et al., 2020; Lombart et al., 2020; Steckley & Kendrick, 2008; Svendsen et al., 2017), and just one study from this subset was conducted within a child and adolescent mental health setting, albeit within a specialist eating disorder setting (Kodua et al., 2020). These findings reflect a key gap in the literature, given the substantially high restrictive intervention rates (including manual restraint) that have been reported within inpatient child and adolescent mental health services (LeBel et al., 2004; NHS Digital, n.d.). With recent NHS Digital (n.d.) figures highlighting a five-fold and beyond increase in such incidents for the 2021/2022 months of September, October, November, December, January and February, when compared to inpatient adult mental health services, I argue that research exploring staff's experiences of restrictive interventions, particularly manual restraint, within inpatient child and/or adolescent mental health care is greatly needed. Such research could provide valuable lived experience insights to increase understandings of the high restrictive intervention rates, and in turn contribute towards manual restraint minimisation efforts. In reference to the above, I would thus argue that there is a need for further manual restraint research within child and/or adolescent mental health contexts.

Overall, there is a substantial lack of manual restraint research in child and adolescent mental health care, despite the Restraint Reduction Network highlighting that "eliminating inappropriate use of restraint is particularly vital in relation to children, who are still developing both physically and emotionally" (Ridley & Leitch, 2020, p.13). Only a handful of such research has been conducted within the past two decades, with this literature largely

being limited to prevalence and incidence rates (e.g., Furre et al., 2016, 2017; Muir-Cochrane et al., 2014; Pogge et al., 2013; Sourander et al., 2002), and with the UK literature largely being limited to child and adolescent eating disorder settings (e.g., Fuller et al., 2019, 2022; Kodua et al., 2020). Only one qualitative study could be located that explored healthcare staff's experiences of manual restraint within a general child and adolescent mental health setting (Rippon et al., 2018). However, this briefly reported study, indiscriminately grouped manual restraint, chemical restraint, and seclusion under the umbrella term of "restrictive practices". Hence, it was excluded from the integrative review. In reference to all the above, I would thus argue that there is a need for further manual restraint research within child and/or adolescent mental health contexts.

Aim of the Study

In light of the aforementioned gaps in the literature, this study aims to explore nursing staff's experiences of using manual restraint within inpatient adolescent mental health care. The research question guiding this study is "How do nursing staff experience the practice of manually restraining adolescent patients within inpatient adolescent mental health care?".

CHAPTER TWO: METHODS

Chapter Overview

This chapter discusses the methodology and methods of the present study to detail how the research question was answered. This chapter is divided into three parts. In part one (Foundations of the Study), I discuss my positionality in relation to the research, detail my philosophical assumptions, and justify why a qualitative descriptive phenomenology methodology was selected. In part two (Method), I discuss the procedures used in this study, including those used to (attempt to) bracket my presuppositions, recruit participants, collect data and analyse data; I discuss these procedures through the lens of a descriptive phenomenology methodology. Finally, in part three (Quality of the Study), I discuss the processes undertaken to ensure the quality and rigor of this study. Here, I also detail the processes undertaken to ensure that this study was adherent to ethical standards. This chapter concludes with a discussion of the planned dissemination of the study. I report the methods of this study in accordance with the Consolidated Criteria for Reporting Qualitative Studies (COREQ) guidelines (Tong et al., 2007).

Part One: Foundations of the Study

Researcher Positionality

Even before the conception of a research question, a researcher's decision to pursue a given topic of study is often influenced by their personal interest in the topic (Altenmüller et al., 2021). For this reason, it is important that researchers explicitly consider what they bring to the research with regard to, for example, their personal history and their positionality in

relation to the research (Creswell & Poth, 2018; Dodgson, 2019). This practice, termed "reflexivity" in qualitative research, is recognised as a vehicle through which a researcher can acknowledge their contributions to the construction of knowledge (Willig, 2013). From the explicit reporting of reflexivity, the reader can judge for themselves how the researcher's relationship to the research may have influenced the research conduct and findings (Dodgson, 2019). To set the scene for this chapter, I have chosen to detail my personal history and positionality in relation to the research first.

Position Statement

I am a 31-year-old Black British male in my final year of doctoral training to become a clinical psychologist. I currently work in the NHS as a trainee clinical psychologist within an adult community mental health team. Several of the adults that I have supported in this role have experienced manual restraint during inpatient mental health hospital admissions. During the data collection phase of this study, I worked as a trainee clinical psychologist within an NHS inpatient adolescent mental health hospital; here, I witnessed young people being manually restrained by nursing staff. I recruited some of my research participants from this hospital.

For the most part of my 10-year career in mental health practice, I have held an interest in manual restraint use within child and/or adolescent mental health settings. This interest stemmed from my time working as a healthcare assistant (HCA) on a private inpatient mental health hospital for children and adolescents with eating disorders (from 2013 to 2017). As part of my role in this job, I frequently restrained food and/or fluid refusing young people to prevent their deliberate self-harm behaviour (e.g., tying neck ligatures) and to facilitate the administration of compulsory nasogastric feeding interventions. I regularly observed the emotional distress that manual restraint prompted for me, my colleagues, and

young people; anxiety and sadness were emotions that I frequently experienced. However, over time, I noticed that I was becoming somewhat emotionally desensitised to restraint. I also noticed that my relationships with young people grew stronger, rather than weaker in the context of my manual restraint use. These observations intrigued me. I wondered how it could be that a practice that was so clearly distressing for young people could be associated with an enhanced therapeutic relationship. I also wondered how I had become somewhat desensitised to a practice that I had found profoundly distressing. These questions motivated me to conduct research exploring nursing assistants' experiences of manual restraint for compulsory nasogastric feeding of young people with anorexia, as part of my master's degree in psychology in 2015; this research has since been published in a peer-reviewed journal (see Kodua et al., 2020). My decision to conduct the present study has also been influenced by these very same questions, and additionally, by the lack of research in the area of manual restraint within inpatient child and/or adolescent mental health settings.

I acknowledge my position as both an insider researcher (due to my lived experience of manually restraining young people) and an outsider researcher (due to my current role as a trainee clinical psychologist and researcher) in the present study (Dwyer & Buckle, 2009). Having witnessed several serious incidents, I believe that the use of manual restraint within inpatient child and/or adolescent mental health settings is sometimes necessary when it is used as a last resort to protect young people and staff from significant harm (including death). At the same time, I also believe that there are certain situations where manual restraint can be avoided, such as when the risks of restraining a young person outweigh the risks of refraining from restraint. For instance, I would not support the use of manual restraint to prevent a young person from superficial forms of deliberate self-harm such as scratching with fingernails.

Philosophical Framework

All researchers make certain philosophical assumptions about their research, whether they are aware of it or not, and such assumptions are typically the starting point for any research project (Creswell & Poth, 2018). These philosophical assumptions include the researcher's ontological beliefs about the nature of reality, and their epistemological beliefs about the nature of knowledge production (Grix, 2019); this influences the type of research questions being generated (Berryman, 2019). It is important that researchers identify and make explicit their ontological and epistemological assumptions to ensure that their choice of research methodology and methods are consistent with these assumptions (Willig, 2013); this helps strengthen the rigour of the research (Holden & Lynch, 2004). Additionally, by reporting their ontological and epistemological assumptions, researchers can ensure that readers take these assumptions into account when evaluating their research (Grix, 2019). In the following sections, I provide further definition of the terms ontology and epistemology, and then detail my ontological and epistemological assumptions.

Researcher Ontology

Ontology is a branch of philosophy that focuses on the nature of reality, and is concerned with the question "what is *there* to know?" (Grix, 2019; Willig, 2013). A researcher's ontological assumptions can be positioned on a continuum from realism to relativism (Braun & Clarke, 2013). A realist ontology assumes that there is an external reality that exists independently of our consciousness of it (Ormston et al., 2014). In contrast, a relativist ontology rejects the assumption of an external reality and assumes that the world is merely a construction of our minds (Levers, 2013). In between the realist and relativist continuum, sits the critical realist ontological position (Braun & Clarke, 2013). This ontology assumes that an external reality exists independently of our consciousness of it. However, it

posits that our experience of this reality is merely a subjective representation in the context of our personal histories and culture (Braun & Clarke, 2013). Thus, a critical realist ontology distinguishes between the external world (what exists) and the observable world (what is seen).

My assumptions about the nature of reality are represented by a critical realist ontology. Consequently, I assume that the act of manually restraining a young person within an inpatient adolescent mental health setting is an objective reality, rather than a mere construction of nursing staff's minds. At the same time, I also assume that when nursing staff manually restrain a young person, what they experience is a subjective representation of this act rather than a direct representation of it. To this end, I acknowledge that different nursing staff members can have different experiences of manual restraint in the context of their personal histories and cultures.

Researcher Epistemology

Epistemology is a branch of philosophy that focuses on the nature of knowledge and is concerned with the question "what *can* we know and how can we acquire knowledge of it"? (Grix, 2019; Ormston et al., 2014). Although it has been described in a number of ways, a researcher's epistemological assumptions can be broadly positioned on a continuum from positivism to interpretivism (Grix, 2019). A positivist epistemology assumes that an external reality exists that we can objectively know about through the use of rigorous objective methods, such as those used in the natural sciences (Charlesworth & Föex, 2016; Gray, 2014). From this epistemological position, the researcher is assumed to be independent from the phenomenon being researched (Grix, 2019). Conversely, an interpretivist epistemology assumes that objectivity is not possible; such an epistemology posits that knowledge is produced by exploring and understanding the subjective descriptions of those being studied

(Ormston et al., 2014). From this epistemological position, it is not possible to study the social world using the methods of the natural sciences, and the researcher is not assumed to be independent from the phenomenon they are studying (Charlesworth & Föex, 2016; Ormston et al., 2014). The post-positivist epistemological position lies between the positivist and interpretivist continuum (Grix, 2019). This epistemology assumes that there is an objective reality that can be known about. However, it posits that, because all observation is fallible, this reality can only be known about imperfectly (Gray, 2014). Consequently, the post-positivist epistemology would assume that knowledge is most effectively produced through the use of inferential statistics, whereby probabilities are assigned to denote the likelihood that observed findings are not due to chance (Gray, 2014).

My assumptions about the nature of knowledge are represented by an interpretivist epistemology. Consequently, I believe that it is through the exploration of the subjective descriptions of nursing staff that knowledge about their lived experiences of using manual restraint within inpatient adolescent mental health settings can be acquired. At the same time, I do not assume that this knowledge will be an objective reflection of the external reality of the act of manually restraining a young person within the aforementioned setting. Moreover, I assume that, although I can implement steps to strengthen the rigor of the research, my personal history and my relationship to the research phenomenon will inevitably have some influence on the research and the knowledge that is being produced in this study.

Selection of Methodology

The selection of an appropriate research methodology is informed by the ontological and epistemological assumptions of the researcher (Braun & Clarke, 2013). The research methodology provides a framework for how a research project should be undertaken, and the types of research methods that are to be used (e.g., sampling method, data collection method,

etc) to answer the research question (Braun & Clarke, 2013; Grix, 2019). Although the distinction is argued to be unclear (Allwood, 2012), research methodology can be categorised into two broad approaches: quantitative and qualitative (Smith & Zajda, 2018). In the following sections, I define these two methodologies and describe my rationale for selecting a descriptive phenomenology methodology, which is a type of qualitative methodology.

Quantitative Methodology

Stemming from (but not always) a realist and positivist/post-positivist ontology and epistemology respectively, a quantitative methodology typically employs the statistical analysis of numerical data to test a theory or hypothesis (Huff, 2009; Slevitch, 2011). This methodology seeks to discover relationships between variables to predict and explain, with the aim to generalise the research findings to the wider population (Braun & Clarke, 2013). Examples of research employing a quantitative methodology include those that have evaluated the effectiveness of manual restraint reduction programmes using statistical analyses (e.g., Duxbury et al, 2019a; Haines-Delmont et al., 2022).

A quantitative methodology was not deemed appropriate for the current study. This is because the aim of this study was to explore nursing staff's subjective experiences of a phenomenon (manual restraint), rather than to test a hypothesis or theory, or to make future predictions from the findings of the study. Additionally, my critical realist and interpretivist ontological and epistemological assumptions respectively are not aligned with the realist and positivist/post-positivist assumptions typically underpinning a quantitative research methodology.

Qualitative Methodology

Traditionally stemming from (but not always) a relativist and interpretivist ontology and epistemology respectively, a qualitative methodology uses words as data, and typically seeks to understand how people make sense of the world and experience events (Willig, 2013). Such a methodology aims to richly describe (and sometimes explain) events and experience, rather than to discover cause and effect relationships and make predictions (Braun & Clarke, 2013; Willig, 2013). A qualitative methodology also acknowledges the researcher's role in the construction of knowledge (Willig, 2013). Many different types of qualitative methodologies have been developed, with differing ontological and epistemological assumptions; these include but are not limited to grounded theory, types of discourse analysis, and the interpretive and descriptive variants of phenomenology (Langdridge, 2007; Willig, 2013).

A phenomenology methodology was deemed most appropriate for this study because of its profound focus on exploring people's subjective lived experiences of phenomena (Beck, 2021). This methodology is consistent with my critical realist and interpretivist ontology and epistemology respectively and is congruent with the aim of this study: to explore nursing staff's experiences of using manual restraint within inpatient adolescent mental health care. I did not consider adopting a grounded theory methodology because I was not interested in building an explanatory theory about the research phenomenon (Willig, 2013). Additionally, I did not consider adopting a discourse analysis methodology because I was not interested in exploring how nursing staff talk about their use of manual restraint (Gray, 2014).

Phenomenology Methodology

Both descriptive and interpretive variants of phenomenology are profoundly concerned with exploring how individuals experience a given phenomenon (Beck, 2021). However, the former is based on the original ideas of Husserl (the founding father of phenomenology), while the latter is a hermeneutic development of his ideas (Beck, 2021; Langdridge, 2007). Consequently, interpretive phenomenology places an emphasis on achieving a deeper understanding of experience, through the deliberate interpretation of the participant's experience on the part of the researcher (Langdridge, 2007; Matua & Van Der Wal, 2015). This is in contrast to the descriptive variant of phenomenology, where the emphasis is on the researcher (attempting to) "bracket" their presuppositions and describing the lived experience of the participant precisely without adding or subtracting from it (Giorgi, 1985; Langdridge, 2007). These processes are said to enable the "essences" of the studied experience to be identified (but more so generated) by the researcher; a central aim of descriptive phenomenology research (Gearing, 2008). Essences refer to those aspects of any experience that are invariant across perception and intersubjectively common to all those that have had that experience (Lopez & Willis, 2004). Researchers adopting a descriptive phenomenology methodology aim to achieve a state of "transcendental subjectivity". This means that the impact of the researcher on the research is continuously evaluated, and presuppositions neutralised (but not completely), so that they do not *profoundly* influence the experience being studied (Lopez & Willis, 2004). I have added and/or italicised the word "profoundly" and the phrase "but not completely" and will continue to do so throughout the rest of this chapter. This is to reflect my belief that even in a so-called state of "transcendental subjectivity" or through the so-called process of "bracketing", a researcher's presuppositions will inevitably influence the knowledge being produced. At the same time, I also believe that an attempt to implement the above approaches can still be valuable in reducing the

disproportionate (another word that I will italicise) influence of the researcher's subjectivity at the expense of participants' descriptions and experiences. Additionally, I have chosen to use the word "generate" instead of "identified" in the context of the process of gaining knowledge about the essences of experience. In doing so, I depart from more naïve approaches to descriptive phenomenology and adopt somewhat of a more critical approach. I will continue to use the former word in place of the latter where appropriate throughout the rest of this thesis.

Rationale for Descriptive Phenomenology Methodology

A descriptive, as opposed to, an interpretive phenomenology methodology was deemed most appropriate for this study. Whilst I acknowledged that a descriptive phenomenology methodology would not free me from interpretation or the lens of my own subjectivity (I believe this to be impossible), I nevertheless felt that the *focus* of this methodology on deliberately describing rather than deliberately interpreting would help me remain close to participants' experiences as far as possible during data collection and analysis, and limit the *disproportionate* influence of my presuppositions on the research process and the knowledge being produced. I believed that this was important to the credibility of the study, given my substantial lived experience of using manual restraint within the research context. Additionally, a descriptive, as opposed to, an interpretive phenomenology methodology has been argued to be more suited for exploring under-researched phenomena, such as the phenomenon being researched in the current study (Matua & Van Der Wal, 2015).

Rationale for Rejecting Structured Descriptive Phenomenology Methodologies

Several structured descriptive phenomenology methodologies exist such as Giorgi's (2009) seven-step methodology and Colaizzi's (1973, 1978) seven-step methodology. These 'off the shelf' methodologies have been used in healthcare research and provide step-by-step guidance for how a descriptive phenomenology study should be undertaken (Beck, 2021). A decision was made not to adopt one of these methodologies. This was due to the various restrictions and requisites that each of these methodologies incorporated that were not deemed appropriate for this study. For instance, Giorgi's (2009) descriptive phenomenological methodology does not allow for research participants to verify the findings of the research (Beck, 2021); I felt that adopting member checking was important for improving the credibility of this study in the context of my lived experience of the research phenomenon. Moreover, Colaizzi's (1973, 1978) methodology requires the researcher during analysis to take a "precarious leap" from what participants say to what they mean (Beck, 2021). While Colaizzi (1978) argued that this should never cut all connection with the original description, I still deemed such an approach to analysis to pose a significant risk of *disproportionally* reflecting my own lived experience of the research phenomenon rather than that of participants.

To the above ends, in undertaking this study, I instead chose to adopt the use of individual qualitative methods (e.g., semi-structured interviews, reflexive thematic analysis), through the lens of a descriptive phenomenology methodology, selectively drawing from elements of Giorgi's (2009) and Colaizzi's (1973; 1978) descriptive phenomenology methodologies where appropriate. Such a blended descriptive phenomenology methodology is in line with Langdridge's (2007) guidelines for conducting phenomenological research, who states that "it is perfectly possible to add or to amend existing methods and/or combine them in any single research project" (p. 165).

Summary

Drawing from a critical realist and interpretivist ontology and epistemology respectively, this qualitative study is underpinned by a descriptive phenomenology methodology. This is appropriate for the aim of this study. I felt that a descriptive phenomenology methodology would reduce the *disproportionate* influence of my lived experience of the research phenomenon on the study.

Part Two: Method

Approach to Bracketing

A central objective of any descriptive phenomenology study is for the researcher to (attempt to) "bracket" or suspend their presuppositions of the research topic in order to generate the essences of the experience being studied (Beck, 2021; Gearing, 2007; Langdridge, 2007). Although I did not believe it was possible to suspend myself from my assumptions, beliefs, and past experiences relative to this study, I felt that an attempt to partially do so would nevertheless reduce the *profound* and *disproportionate* influence of my presuppositions on the research and thus help me to generate the essences of participants' experiences. Notwithstanding, it was neither my end goal nor my wish to completely suspend or 'strip' away my presuppositions. This is because I consider my experience of the research phenomenon, in the appropriate 'doses', to be a resource to this study. The processes by which bracketing is practiced is often poorly described within phenomenological research (Chan et al., 2013). Consequently, I begin this part of the chapter by detailing some of the strategies that I used in an attempt to partially bracket my presuppositions. I also detail such strategies in later sections of this chapter.

Reflective Interview

As part of the bracketing process, I was interviewed (via videoconference) two months before the recruitment of participants using the participant interview schedule questions (see Appendix A, page 185 for interview schedule). The purpose of the interview was to uncover and bring into awareness my preconceptions, presuppositions and lived experience of the phenomenon under study. The interview lasted 45 minutes and was conducted by an outside source who did not have any manual restraint experience. I audio-recorded and transcribed the interview verbatim, and repeatedly re-read the resulting transcript. The interview and transcribing process helped me to uncover numerous dormant presuppositions about the research phenomenon; this enabled me to better (attempt to) suspend these presuppositions (but not completely as this is impossible) during the data collection and data analysis phases of the research, to a degree that I believe likely reduced their *disproportionate* influence on the research process. Below is an extract from my interview transcript which details one of my initially dormant presuppositions:

> I felt really sad about it [the restraint], so even when I was restraining her, I wasn't really holding, I wasn't really holding tightly and yeah . . . that same young person, that young person reported me actually, she reported me apparently to one of the nurses, so one of the nurses called me and she said, you know, "this young person said that when you restrain her, your grip is too loose", you know, "she doesn't feel secure when you're restraining her" . . . and I said "she doesn't feel secure?", and she said "yeah she said that she was feeling a bit unsafe when you were restraining her because your grip was quite loose" . . . to think that a young person will report you for not restraining them hard enough . . . at the beginning, I didn't really understand it.

Analysis of Reflective Interview

As part of the bracketing process, I also analysed my reflective interview transcript using an inductive approach to Braun and Clarke's (2006, 2019, 2022) method of reflexive

thematic analysis. My analysis led to the generation of five descriptive themes, which captured my lived experience of manually restraining children and adolescents: an emotional rollercoaster, it's not always used as a last resort, it weakens and strengthens the therapeutic relationship at the same time, becoming desensitised, and physical aggression from the patient is common. Collectively, these themes and the analysis process greatly increased my awareness of my presuppositions. This in turn helped me to remain self-aware during data collection and analysis, so that I could engage more precisely with participants' descriptions.

Mindfulness Practice

Mindfulness has been described as a method through which bracketing can be implemented in a phenomenological study (Lemon, 2017; Nicholls, 2019). Through the mindfulness practice of focused attention, a researcher can better notice when and where their mind is wandering (e.g., to presuppositions, predictions, past experiences, etc.), and continually non-judgmentally refocus their attention back to participants' descriptions (Nicholls, 2019). This can help the researcher (attempt to) bracket their presuppositions, for example, during a participant interview and/or during the data analysis phases of a study (Lemon, 2017; Nicholls, 2019). I have practised and taught mindfulness for the past several years and have developed the aforementioned mindfulness focused attention skills as a consequence. I consciously drew upon these mindfulness skills throughout the research process, which I believe enabled me to better (attempt to) bracket my presuppositions to a degree that likely reduced the *disproportionate* influence of them on the knowledge being produced.

Hospitals of Participant Recruitment

Participants were recruited from five 10-15 bedded adolescent mental health wards across four Tier 4 inpatient adolescent mental health hospitals spanning three NHS Trusts in England. Collectively, the four hospitals provide assessment and treatment for young people aged between 11 and 18 years with complex mental health needs who cannot be managed safely within the community. Young people admitted to the four hospitals experience difficulties such as depression, self-harm, suicidal ideation, eating disorders, psychosis, and severe anxiety disorders, and are deemed to pose a significant risk of harm to themselves and/or others. The four hospitals provide multi-disciplinary treatment to young people from a range of professionals including psychiatrists, psychologists, nursing staff, occupational therapists, dieticians, and family therapists. At the time of recruitment, all four hospitals had implemented COVID-19 safety precautions which included the wearing of face masks by all members of staff (including during the use of manual restraint), and regular COVID-19 testing of young people and staff.

In line with a descriptive phenomenology methodology, I made the decision to recruit participants from several hospitals across several NHS Trusts in an attempt to achieve maximum variation within the participant sample with respect to hospital cultures and environments. The rationale for this was that, with greater variation within the sample, it would be more possible to identify *and* generate those aspects of participants' experiences of using manual restraint that were invariant across perception: the "essences" of the experience (Langdridge, 2007). I had originally desired to recruit participants from a greater number of hospitals and NHS Trusts. However, this was not possible due to the time limitations placed upon this study. The resultant four hospitals were specifically selected due to their ease of access at the time of the study. I provide a brief description of each of the four hospitals below. The descriptions provided are brief to protect the anonymity of the hospitals.

Hospital 1

This hospital houses one locked mixed-gender general adolescent mental health ward that admits both informal patients and formal patients detained under Section 2 and Section 3 of the Mental Health Act 1983 (Department of Health, 2015). The young people on this ward are typically experiencing acute and severe mental health difficulties. The ward does not contain a seclusion room but does have a de-escalation room/sensory room. At the time of recruitment, I was working as a trainee clinical psychologist at this hospital.

Hospital 2

This hospital contains one locked mixed-gender general adolescent mental health ward that admits both informal patients and formal patients detained under Section 2 and Section 3 of the Mental Health Act 1983 (Department of Health, 2015). The young people on this ward are typically experiencing severe mental health difficulties. The ward does not contain a seclusion room but does have a de-escalation room. I had no affiliation with this hospital.

Hospital 3

This hospital houses one locked mixed-gender general adolescent mental health ward that admits both informal patients and formal patients detained under Section 2 and Section 3 of the Mental Health Act 1983 (Department of Health, 2015). The young people on this ward are typically experiencing acute mental health difficulties. The ward does not contain a seclusion room but does have a de-escalation room/sensory room. I had no affiliation with this hospital.

Hospital 4

This hospital contains two locked mixed-gender wards; one general adolescent mental health ward, and one adolescent PICU ward. The former ward admits both informal patients and formal patients detained under Section 2 and Section 3 of the Mental Health Act 1983 (Department of Health, 2015). However, the latter ward admits detained patients only. The young people on the general ward are typically experiencing acute mental health difficulties. The young people on the PICU ward are typically experiencing more severe mental health difficulties to the extent that they cannot be safely managed within a general adolescent mental health ward. The PICU ward has one seclusion room and one de-escalation room/sensory room. The general ward has one de-escalation room/sensory room only. I had no affiliation with this hospital.

Participants

Participants were a purposeful sample of 12 nursing staff. Purposeful sampling is a method of non-probability sampling whereby participants are selected based on their experience or knowledge of the research phenomenon (Creswell & Plano Clark, 2017). This method of sampling is congruent with a descriptive phenomenology methodology (Colaizzi, 1978). With the exception of my decision to recruit both qualified and unqualified nursing staff from several hospitals and NHS Trusts, no further efforts to achieve maximum variation within the participant sample were made. Notwithstanding, my hope was to achieve a significant degree of such variation within the sample with respect to participants' gender, age, ethnicity, experience, nursing job title, hospital of recruitment, manual restraint training and level of education. The rationale for this, as already reported, was that with greater variation within the sample, it would be more possible to generate the invariant intersubjective "essences" of nursing staff's experiences of manual restraint (Langdridge,

2007). The demographic details of the 12 recruited nursing staff participants are reported in full in Table 7, pages 101-102 within the Results Chapter of this thesis.

Inclusion and Exclusion Criteria

Participants were eligible to participate in this study if they met the following inclusion criteria. Firstly, participants were required to have lived experience of using manual restraint within any of the four hospitals of recruitment. Secondly, participants needed to be qualified or unqualified permanent members of nursing staff (e.g., registered mental health nurse [RMN], healthcare assistant [HCA], senior healthcare assistant [SHCA]). Thirdly, participants were required to have a minimum of six months' work experience in any of the four hospitals of recruitment. Participants were excluded from the study if they were agency or bank members of nursing staff, or if they held non-nursing roles or job titles (e.g., psychologists, psychiatrists, etc). The above inclusion and exclusion criteria were developed to ensure that only participants that had sufficient experience of using manual restraint within inpatient adolescent mental health settings were recruited.

Sample Size Considerations

Within their descriptive phenomenology methodologies, Giorgi (2009) and Colaizzi (1978) both highlight that the number of participants required for a descriptive phenomenological study is contingent on the richness of data that each participant provides. Thus, the richer the data that participants share about their experiences, the smaller the sample size that will be needed (Beck, 2021). This is congruent with Malterud et al's (2016) concept of information power which highlights that the more information a sample holds relative to the research question, the fewer participants that are required. Giorgi and Colaizzi have provided more concrete guidance on sample sizes for phenomenological research.

Giorgi (2009) reports that at least three participants are necessary for a phenomenological study. Moreover, Colaizzi (1978) has given a suggested sample size of 12 participants as an average number. In consideration of all the above, I thus planned to recruit at least 12 nursing staff participants in this study.

I made the decision to cease data collection after the twelfth participant due to the rich and intricate details that participants were sharing about their manual restraint experiences. I felt that this level of detail, in combination with the rather narrow aim of this study, and the homogeneity of the sample in respect to the phenomenon under study, suggested that this study had a high information power (Malterud et al., 2016). Even though the concept of "data saturation" is included as a quality criterion in the COREQ guidelines (Tong et al., 2007), I have deliberately chosen to use Malterud et al's (2016) concept of information power instead. Like other authors, I believe that the data saturation notion of 'no new information' is unachievable at worst and misleading and ambiguous at best (Braun & Clarke, 2021; Dey, 1999; Nelson, 2017).

Recruitment Procedure

Participants were recruited by means of email advertisements (see Appendix B, page 187), and poster advertisements (see Appendix C, page 188) displayed on staff room notice boards within the four hospitals. The email advertisements were sent to all nursing staff by the clinical psychologists of the four hospitals in March 2021 and again, as a "final call", in May 2021. A total of 14 participants responded to the email and poster advertisements and contacted me via email expressing their wish to participate in the study. However, two of these fourteen participants failed to respond to my follow-up email. A participant information sheet (see Appendix D, page 189) providing further participation details was sent to the 12 participants that responded to my follow-up email. Given that all 12 participants were happy

to participate following the receipt of this information, a suitable time and date was arranged via email for them to participate in the study. Participants were then shortly emailed a zoom videoconferencing invite and an electronic consent form (see Appendix E, page 192) to complete and return to me (via email) prior to the date and/or time of their planed participation.

Data Collection

All data collection for this study took place between March 2021 and July 2021 in the context of a number of COVID-19 restrictions. In the following sections, I describe the methods that I used to collect data for this study, and my rationale for selecting them.

Semi-Structured Interviews

Data was collected using individual in-depth semi-structured interviews. Although I had desired to conduct interviews in a face-to-face capacity, this was not possible due to the COVID-19 face-to-face research restrictions that the University of Essex had put in place at the time of the study. Consequently, all interviews were conducted over videoconference using the zoom videoconferencing platform.

Individual semi-structured interviews are a frequently used method of data collection in phenomenological research (Langdridge, 2007). This method of data collection, like other types of qualitative interviews, favours the use of open-ended questions, and allows for the generation of rich and detailed data about participants' experiences and perspectives (Braun & Clarke, 2013). At the same time, the semi-structured interview, through the use of a flexible interview schedule or topic guide, also allows the interviewer to cover particular aspects of the phenomenon being studied to elicit the maximum amount of relevant information possible (Langdridge, 2007). This is in contrast to an unstructured interview

where the interviewer has very little to help guide the interview, and where there is a greater risk of collecting data that fails to meet the aims of the study (Langdridge, 2007).

To the above ends, individual semi-structured interviews were deemed to be the most appropriate data collection method to meet the aims of this study. I did not consider using focus groups, given that the group format of such a data collection method does not lend itself well to the in-depth and detailed exploration of people's lived experiences (Braun & Clarke, 2013). I also did not consider the use of self-written descriptive accounts, given that the non-interactive nature of this textual data collection method does not allow the researcher to ask follow-up questions or probe participants (Braun & Clarke, 2013).

Interview Schedule. The semi-structured interview schedule for this study (see Appendix A, page 185) was developed and adapted from a previous interview schedule that I had constructed for a former similar research project involving a similar participant group. That project aimed to explore nursing assistants' experiences of manual restraint for compulsory nasogastric feeding of young people with anorexia (Kodua et al., 2020). I made the decision to adapt the stipulated interview schedule because it had already been piloted in the above research project and had been found to generate rich data. The piloting of an interview schedule is regarded as an important step in the development of an effective interview schedule (Dejonckheere & Vaughn, 2019; Majid et al., 2017). In developing the interview schedule, I consulted with my research supervisors and drew upon my mindfulness practice skills. These processes were part of the bracketing procedure and ensured that I did not develop any leading questions.

The interview schedule developed for this study included prompts to gain insight into the mental and physical experience of manual restraint, and consisted of seven open-ended questions covering the following topic areas: the process of using manual restraint within

inpatient adolescent mental health settings ("Can you describe to me, in as much detail as you can, what [manually] physically restraining a young person involves?"); the experience of using manual restraint within inpatient adolescent mental health settings (e.g., "Can you tell me about a typical time where you were involved in [manually] physically restraining a young person?"); the experience of the therapeutic relationship in the context of manual restraint ("Can you tell me what your therapeutic relationship is like with the young people who you have [manually] physically restrained?"); and participants' perceptions of the use of manual restraint within inpatient adolescent mental health care ("Can you tell me about your views towards the use of [manual] physical restraint within inpatient adolescent mental health settings?"). Questions were constructed in the above reported order. However, there was flexibility to depart from this order in response to participants' descriptions in interviews.

Interview Process. Interviews lasted between 45 and 96 minutes in duration (mean = 71 minutes). I conducted the interviews using an NHS laptop from a private confidential room within my home. Five participants also attended the interviews from a private confidential room within their homes. The remaining seven participants attended the interviews from a private confidential room within the inpatient adolescent mental health hospitals (but off the wards) in which they worked, during their break times or prior to the start of their shifts.

For the sake of being transparent and building rapport, I explicitly disclosed my insider status (my lived experience of using manual restraint within inpatient child and adolescent mental health settings) and my outsider status (my position as a trainee clinical psychologist and researcher) to all participants at the start of the interview. At the same time, I also told participants to share their manual restraint experiences as if I were someone with

no or little knowledge of the research phenomenon; this was to ensure that participants provided rich descriptions of their experiences.

Despite the virtual format of interviews, rapport was easily established and maintained throughout the interviews. This was evidenced by the rich and intricate details that participants provided about their experiences, and the personal examples that they shared within their accounts. As part of the bracketing process, I drew upon my mindfulness practice skills throughout the interviews; this helped me to notice the assumptions and associations that my mind was making in response to participants' stories and continually nonjudgmentally refocus my attention back to participants' descriptions. I believe that this back-and-forth process helped me to refrain as far as possible from asking leading follow-up questions in the context of my own lived experience of manual restraint. At the end of the interview, I verbally debriefed participants and emailed them a debrief sheet (See Appendix F, page 193). No participants appeared distressed or burdened by the interview, and some reported that the interview had helped them reflect on their experiences. All interviews were audio-recorded using a secure password protected Dictaphone placed next to the loudspeaker of my NHS laptop in preparation for verbatim transcribing.

Demographic Questionnaire

A demographic questionnaire was developed for this study (see Appendix G, page 195) to collect information with respect to participants' gender, age, ethnicity, experience, nursing job title, manual restraint training and level of education. The questionnaire ensured that a rich description of the sample could be provided, and was administered verbally to participants at the start of interviews. Participants were informed that they did not have to provide any information that they did not wish to.

Data Analysis

Inclusive of the transcribing of interviews and data familiarisation processes, data analysis for this study took place between October 2021 and April 2022. In the following section, I discuss the method used to analyse data for this study, and the rationale for selecting the chosen method.

Reflexive Thematic Analysis

Data was analysed using Braun and Clarke's (2006, 2019, 2022) cyclical six-phase reflexive approach to thematic analysis. Reflexive thematic analysis, like the post-positivist influenced coding reliability and codebook approaches to thematic analysis, is a theoretically flexible method (within paradigm limits) concerned with identifying, analysing and reporting patterns of meaning across cases within a dataset (Braun & Clarke, 2006, 2022). However, unlike the aforementioned approaches which focus on achieving 'accurate and reliable' coding through the agreement of multiple coders (coding reliability thematic analysis), and which make use of a finite number of pre-determined codes (codebook thematic analysis), reflexive thematic analysis fully embraces qualitative research values and practices, and conceptualises data analysis as an inherently and inescapably subjective practice (Braun & Clarke, 2019, 2022). Such an approach to thematic analysis views researcher subjectivity as a resource, and conceptualises theme generation as reflecting an intersection between the data, the researcher's subjectivity, and the analytical process (Braun & Clarke, 2019, 2022). The theoretical flexibility of reflexive thematic analysis means that, within a qualitative paradigm, it is compatible with a range of ontological and epistemological positions including the critical realist and interpretivist assumptions underpinning the current study respectively (Braun & Clarke, 2022). Additionally, the flexibility of reflexive thematic analysis also means that it is compatible with a range of orientations including the experiential,

predominantly inductive and predominantly semantic orientations characteristic of a descriptive phenomenology methodology (Sundler et al., 2019). The focus of reflexive thematic analysis on identifying patterns of meanings across cases within a dataset is congruent with a descriptive phenomenology methodology, where there is an emphasis on identifying (but more so generating) intersubjective commonalities across participants' experiences: the "essences" of their experiences (Gearing, 2008; Lopez & Willis, 2004).

Collectively, to the above ends, reflexive thematic analysis was deemed to be a suitable data analysis method for this study, accounting for my critical realist and interpretivist ontology and epistemology respectively, the experiential and phenomenological aims of this study, and my somewhat critical approach to descriptive phenomenology and to the use of bracketing.

Analysis Process. I adopted an iterative cyclical approach to analysis, guided by Braun and Clarke's (2006, 2019) six-phase method: familiarisation with the data; generating initial codes; generating themes; reviewing themes; defining and naming themes; and producing the report. I conducted the analysis with the assistance of the qualitative data analysis software NVivo (2020 release). This provided a medium to contain interview transcripts, record memo notes, code interviews and generate themes.

Phase One: Familiarisation with the Data. In the early stages of the analysis, I immersed myself in the dataset by transcribing each interview and repeatedly reading and re-reading the resulting transcripts; this helped me to develop a good grasp of, and familiarisation of the data. During this process, I drew upon my mindfulness practice skills of noticing and made memo notes of my initial assumptions, associations, predictions, and feelings in response to each participant's interview. This was part of the bracketing process

and helped me to become more aware of my initial presuppositions. In the below extract, I provide a snapshot of my memo notes for one of the participant interview transcripts. A pseudonym has been used to protect the participant's anonymity:

> I feel quite sad and sorry for Greg reading his experiences. It is quite evident that he has been subjected to a lot of physical aggression by young people during restraint and I wonder if his gender of being a male has also contributed to this. I notice myself thinking back to my own experience of restraint where this was the case for me.

Phase Two: Generating Initial Codes. In line with a descriptive phenomenology methodology, I adopted a predominantly semantic approach to coding. This involved analysing each interview transcript separately in a random order and assigning a descriptive code to each meaningful unit of text, but with latent codes being occasionally assigned where the interpretation was particularly salient. A meaningful unit of text ranged from a fraction of a sentence to a paragraph in length, and was any part of the transcript that was relevant to the research question. Codes were reused within and across interview transcripts if relevant, and some meaningful units of text were coded more than once with different codes. Each interview transcript was coded twice to ensure that my coding was comprehensive; this process led to the generation of 574 codes. As part of the bracketing procedure, I drew upon my mindfulness practice skills throughout the entire coding process, noticing my presuppositions and continually nonjudgmentally refocusing my attention back to participants' descriptions. I believe that this mindfulness practice process helped me to generate codes that were descriptive and grounded within the data as far as possible. An example of the coding process is presented in Table 6 on page 88. Pseudonyms have been used in this table to protect participants' anonymity.

Table 6

Example Coding Process

Meaningful Unit of Participant Transcript	Generated Assigned Codes
"Obviously when the patients gets really upset or angry, they've got a lot of power and energy to expend from those emotions and they're determined about something, and they're pushing themselves as hard as they can to do what they want to do, so restraining the patients and keeping a safe position and hold can be physically achy" (Alice).	Patient distressed in restraint Patient angry when restrained Patient resistive in restraint Restraint can be physically painful
"She was quite a big girl and she was quite strong and I feel like because she was actively trying to get up at that moment, it was quite a tiring restraint" (Naomi).	Some patients are strong Patient resistive in restraint Restraint is physically draining

Phase Three: Generating Themes. This phase involved arranging the different codes generated from phase two into themes, based on the differences and similarities between codes. To assist with this process, I printed out the 574 codes onto separate strips of paper; this allowed me to adopt a visual, comprehensive and manual approach to the assembling of codes into themes (see Figure 3, page 89 for picture of manual code assembling process). In congruence with a descriptive phenomenology methodology, each strip of paper indicated the number of participants that the said code had been assigned to; this helped me to generate themes that were reflective of the intersubjective commonalities or "essences" of participants' experiences of manual restraint. In the final stages of this phase, I transferred the manually generated themes back to NVivo by arranging the virtual form of the codes to reflect the paper strip arrangement. As part of the bracketing process, I drew upon my mindfulness practice skills throughout this phase of the analysis. This was in an attempt to

reduce the *disproportionate* influence of my presuppositions on the analysis, and to help me to generate themes that were predominantly grounded in the data.

Figure 3

Manual Code Assembling Process

Phase Four: Reviewing Themes. Drawing upon my mindfulness practice skills, I reviewed the themes generated in phase three at two levels. At the first level, I thoroughly reviewed the coded collated data extracts within each theme to assess whether they formed a coherent pattern and were reflective of the said theme. At the second level, I re-read the entire dataset to assess the extent to which the generated themes accurately reflected participants' descriptions of their manual restraint experiences as a whole. This iterative process resulted in the generation of some new themes, and the dissolution of some pre-existing themes.

Phase Five: Defining and Naming Themes. In this phase, through a process of deep reflection and reviewing themes, I started to identify the "story" that each theme told, and the extent to which this fitted with the overall story of participants' experiences of manual restraint. This process led me to collapse a number of themes into subthemes, and consequently generate a number of overarching themes. In the final stages of this phase, I named and defined each theme and subtheme. Here, I consulted with my thesis supervisor to ensure that the given names were a concise and punchy reflection of each theme and subtheme. Overall, at the end of this phase, I considered the final collection of overarching themes to represent the "essences" of participants' experiences of using manual restraint within inpatient adolescent mental health care.

Phase Six: Producing the Report. This phase involved writing-up the analysis to provide a coherent, concise, and interesting account of the story of participants' experiences of using manual restraint. In evidencing the generated themes in the analysis, I have included authentic participant extracts within the write-up, making sure to present a range of participant quotes across the four hospitals. The write-up is presented in the Results Chapter of this thesis on pages 103-126.

Summary

This qualitative study adopted the use of a purposeful sample, semi-structured interviews, and reflexive thematic analysis through the lens of a critical approach to a descriptive phenomenology methodology. This was congruent with the aims of the study, my personal orientation, and my ontological and epistemological assumptions.

Part Three: Quality of the Study

Quality Assurance

To ensure the quality and rigour of the research, I conducted this study in accordance with Lincoln and Guba's (1985) four-standard trustworthiness criteria for assessing quality in qualitative research: credibility, transferability, dependability and confirmability. I also consulted Braun and Clarke's (2006) 15-point checklist for assessing the quality of thematic analysis. In the following sections, I discuss the aforementioned quality processes in the context of a descriptive phenomenology methodology where appropriate.

Credibility

This quality criterion refers to the extent to which the analysis and findings of a qualitative study reflect the subjective realities of the research participants (Lincoln & Guba, 1985). In a descriptive phenomenological study, credibility thus refers to the degree to which the researcher's descriptions of the participants' experiences of a phenomenon, reflect their experiences of that phenomenon. In other words, it asks the question "to what extent are the 'essences', themes and subthemes generated in the analysis credible to the subjective experiences of the participants in which they have been drawn from?" I adopted a number of procedures to improve the credibility of this study. Firstly, I included a range of participant extracts to evidence the themes that I had generated from the analysis (see Results Chapter, pages 105-126). Secondly, I worked in one of the hospitals of participant recruitment over the four-month period of participant recruitment for this study. This, in addition to my lived experience of manual restraint, helped me to become more orientated to the context of the research phenomenon. I believe that such prolonged engagement in the research phenomenon helped me to understand the language and terminology of the participants, and in turn,

increased the likelihood that the themes and subthemes that I generated were reflective of participants' experiences. Thirdly, as a final procedure to improve the credibility of this study, and as recommended by Lincoln and Guba (1985), I adopted member checking into the analytical process. This involved emailing a summary of the themes and subthemes of the analysis to all participants for their verification. Eight out of 12 participants across three out of four hospitals responded to the member checking request. All eight of these participants reported that the themes had accurately captured their experiences. For example, one participant reported: "it appears to be a fair reflection". Additionally, another participant reported: "this looks about right for how I was/am feeling about physical restraint of adolescents".

Transferability

This quality criterion refers to the extent to which the analysis and findings of a qualitative study can be *transferred* to other groups of people and contexts (Lincoln & Guba, 1985). This criterion differs from the quantitative research criterion of generalisability which relies on the use of representative participant samples to make any such claims about the applicability of research findings (Russell & Purcell, 2009). Within qualitative research, transferability is enhanced by the researcher's thick and detailed reporting of the context, setting, circumstances and participants of a study; this then allows the reader to judge for themselves whether they can transfer the findings of the study to different contexts, settings or groups of people (Braun & Clarke, 2013). I enhanced the transferability of this study by providing a rich and detailed description of the participants (see Results Chapter, pages 101-102 for participant demographic information), the four hospitals of recruitment (see pages 77-78), the COVID-19 context of the hospitals (see page 76), and the dates at which data collection took place to situate the study in time (see page 81).

Dependability

This quality criterion refers to the extent to which the research process and adopted methods are logical, consistent, traceable, and palpably documented (Tobin & Begley, 2004). This allows the reader to better examine the research process, and in turn, better assess the dependability of the study (Lincoln & Guba, 1985). I enhanced the dependability of this study by clearly, consistently, and logically documenting my research decisions and my rationale for such decisions. For instance, I have clearly reported my rationale for the selected methodology (see pages 69-71), participant sample size (see pages 79-80), data collection method (see pages 81-82) and data analysis method (see pages 85-86). Additionally, in an attempt to make the research process as traceable as possible, I have provided a rich description of, for example, the reflexive thematic analysis process, with tangible references to memo notes, examples of assigned codes, and photo evidence of the manual code assembling process (see pages 86-90).

Confirmability

This quality criterion refers to the degree to which the analysis and findings of a qualitative study are derived from the data rather than the researcher's own preconceptions (Tobin & Begley, 2004). The following procedures were adopted to improve the confirmability of this study. Firstly, as I have illustrated throughout this chapter, and in line with a descriptive phenomenology methodology, I adopted a number of processes to partially "bracket" my presuppositions of the research phenomenon. This included my participation in a reflective interview prior to the recruitment of participants, and my drawing upon my mindfulness practice skills throughout the conduct of the research. I felt that these processes reduced the *disproportionate* influence of my lived experience of manual restraint, and helped me to generate themes and subthemes that were predominantly grounded in the data

rather than profoundly in my own presuppositions. Secondly, I thoroughly reviewed the themes that I generated against the raw data at the level of the coded collated data extracts, and again at the level of the entire data set of participants' interviews. This helped to ensure that the themes were predominantly grounded within the data. Thirdly, I kept a reflexive diary throughout the entire research process where I collated my memo notes and documented my assumptions, associations, and predictions throughout the research process. This also helped to ensure that the themes I generated were predominantly grounded within the data (Lincoln & Guba, 1985).

Braun and Clarke's (2006) 15-Point Thematic Analysis Checklist

I assessed the quality of the reflexive thematic analysis that I conducted using Braun and Clarke's (2006) 15-point checklist of criteria for good thematic analysis (see Appendix H, pages 196-197). This assessment was cross-checked by my thesis supervisor and revealed that I had adhered to all 15 items, reflecting a high-quality thematic analysis.

Ethical Considerations

This study was conducted in accordance with the British Psychological Society (BPS) Code of Human Research Ethics (BPS, 2021a). Additionally, the BPS's ethics best practice guidance on conducting research with human participants during COVID-19 was also followed (BPS, 2021b).

Ethical Approval

Ethical approval to conduct this study was granted by the Health Research Authority (HRA) and Health and Care Research Wales (HCRW) on 10th December 2020 (see Appendix I, pages 198-202). Subsequent ethical approval to conduct this study was obtained from the

University of Essex Research Ethics Committee on 18th January 2021 (see Appendix J, page 203).

Valid Consent

All participants gave their informed consent to participate in this study by signing electronic consent forms (see Appendix E, page 192) prior to their participation. Participants were provided sufficient information about the study via a participant information sheet (see Appendix D, page 189), including the possible advantages and disadvantages of their participation, to ensure that they were able to make an informed decision prior to giving their consent. Participants were also given the opportunity to ask further questions about the study via email or telephone contact prior to their giving of consent. This was to further ensure that they could make an informed decision to participate. The above procedures were adopted in congruence with the BPS (2021a) guidance on valid consent which highlights that "Researchers should ensure that every person from whom data are gathered for the purposes of research consents freely and voluntarily to participation, having been given sufficient information to enable them to make an informed choice" (p.12).

Right to Withdraw

Participants were informed of their right to withdraw their participation and their data from the present study at any time without giving a reason. This was communicated to participants prior to their participation (via participant information sheet [see Appendix D, page 189]) and during their participation (via verbally) in the study.

Confidentiality and Anonymity

To ensure the confidentiality and anonymity of participants and all implicated parties (e.g., hospitals of recruitment), the following processes were adhered to. Firstly, all interviews were conducted in private confidential spaces/rooms where no other party could overhear (e.g., private room in my home). Interviews did not proceed until participants could confirm that they were in a private confidential space. Secondly, all potentially identifiable information was removed from transcripts, and each participant was assigned a pseudonym. To this end, quotes were carefully selected to ensure that participants could not be identified. Thirdly, all identifiable information collected during this study were stored securely and only accessible by the research team. For example, participant consent forms were stored as password protected PDF files in a folder separate to that of interview transcripts. Moreover, participant demographic forms, although anonymous, were also stored in this same way as a safety precaution. Fourthly, all data use and storage within this study complied with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Finally, in accordance with the BPS (2021a) guidelines, participants were informed in advance of their participation, of the conditions that could lead to the overriding of confidentiality. To this end, participants were informed that confidentiality would not be guaranteed if they disclosed information that put themselves or others at significant risk of harm (e.g., abusive restraint practices).

Protection from Harm

The BPS highlights that researchers should identify the risks of physical and psychological harm to participants in relation to their participation in research, and develop protocols for risk management (BPS, 2021a). This study required participants to talk about their lived experience of manual restraint, a practice associated with adverse emotional and

physical consequences to staff (e.g., Bigwood & Crowe, 2008; Kodua et al., 2020; Wilson et al., 2017). As such, the possibility for participants to become distressed during their interviews was anticipated. Consequently, the following procedures were put in place. Firstly, participants were informed prior to and during their participation in the study that they did not have to answer any questions that they did not wish to. Secondly, drawing upon my clinical skills, I monitored participants for any signs of distress during interviews. In the event that participants were to become distressed, my plan was that I would then offer them the choice of postponing or ending the interview. This plan did not materialise in the study because no participants presented with visible signs of distress during the interview.

This research took place during the COVID-19 pandemic. There was thus a risk of physical harm to participants in the form of their probable COVID-19 contraction in the context of their face-to-face participation in the research. To manage this risk, interviews were instead conducted remotely via the zoom videoconferencing platform.

Debriefing

In accordance with the BPS guidelines (BPS, 2021a), all participants were verbally debriefed at the end of the study and provided with written debriefing information (see Appendix F, page 193). A minimum of 10 minutes was allocated for the debriefing process to allow for any reflections that participants had. Here, participants were also provided with information about accessing support should they wish.

Dissemination

This research will be disseminated to the senior management of the four hospitals of recruitment via a summary report. This research will also be disseminated via the University of Essex Research Repository. Finally, I plan to submit this research for publication in a

suitable peer-reviewed academic journal after it has been assessed, and suggested corrections implemented.

Summary

This qualitative study was conducted in accordance with Lincoln and Guba's (1985) trustworthiness criteria, and Braun and Clarke's 15-item thematic analysis checklist. This ensured the methodological quality of this study. This study followed the BPS guidelines for research with human participants, the GDPR and the Data Protection Act 2018. This ensured the ethical quality of this study.

CHAPTER THREE: RESULTS

Chapter Overview

This chapter discusses the results of the present study to answer the research question: "how do nursing staff experience the practice of manually restraining adolescent patients within inpatient adolescent mental health care?". This chapter is divided into two parts. In part one (Participant Demographic Information), I report the demographic and manual restraint training details of the participants to position the results within the sample in which they were generated from. In part two (Generated Themes and Subthemes), I discuss the resultant themes and subthemes generated from the reflexive thematic analysis. In congruence with a descriptive phenomenology methodology, I present verbatim extracts from participants to illustrate the analysis and to describe the phenomenon under study as the participants themselves have perceived it. All participants have been referred to using pseudonyms, and any identifiable information has been removed from their extracts to protect their anonymity.

Part One: Participant Demographic Information

Participant Characteristics

As I have reported in the Methods Chapter of this thesis on page 78, 12 nursing staff participants were recruited to take part in the study. A significant degree of maximum variation was achieved within the sample with respect to gender, age, experience, job title, hospital of recruitment, manual restraint training and level of education. However, little variation was achieved within the sample for ethnicity, with all but two participants

describing themselves as “White British”. Overall, seven participants identified as “female”, and the remaining five identified as “male”. The participants’ ages ranged from 22 to 47 years (mean = 30.1 years), and their length of experience working within inpatient adolescent mental health care ranged from eight months to nearly 12 years (mean = 3.6 years). Of the 12 participants, five were RMNs, four were HCAs, and three were SHCAs. Five and three participants were recruited from Hospital 1 and Hospital 2 respectively, and two participants each were recruited from Hospital 3 and Hospital 4. Eight participants held undergraduate degrees (mental health nursing degree = five participants; other degree = three participants), and the remaining four were educated to college level. One RMN participant also held a postgraduate diploma. A summary of the demographic information of the 12 participants is presented in Table 7, pages 101-102.

Table 7

Summary of Participant Demographic Information

Pseudonym (gender)	Job Title	Age	Ethnicity	Inpatient Adolesc Mental Health Exp	Hospital of Recruitment	Highest Education Level	Manual Restraint Training
Alice (F)	HCA	24	White British	Three years	Hospital 2	Undergraduate degree	Initial five-day course + one-day yearly refresher
Sarah (F)	RMN	33	White British	18 months	Hospital 2	Post graduate diploma	Initial five-day course
Jane (F)	SHCA	27	White British	Eight months	Hospital 4	Undergraduate degree	Initial five-day course
Emily (F)	HCA	34	White British	Five years	Hospital 1	Undergraduate degree	Initial five-day course + two-day yearly refresher
Naomi (F)	RMN	22	White British	11 months	Hospital 3	Undergraduate degree	Initial five-day course
Eric (M)	HCA	22	White British	13 months	Hospital 1	College	Initial five-day course
Daniel (M)	HCA	29	White British	Two years	Hospital 2	College	Initial five-day course + one-day yearly refresher

Continued

Table 7 Continued

Pseudonym (gender)	Job Title	Age	Ethnicity	Inpatient Adolesc Mental Health Exp	Hospital of Recruitment	Highest Education Level	Manual Restraint Training
Belinda (F)	SHCA	29	White British	Two years, three months	Hospital 4	College	Initial five-day course + two-day yearly refresher
Paul (M)	SHCA	47	White British	Seven years	Hospital 1	College	Initial five-day course + two-day yearly refresher
Wayne (M)	RMN	38	White British	11 years, seven months	Hospital 1	Undergraduate degree	Initial five-day course + two-day yearly refresher
Laura (F)	RMN	34	Mixed-Race British	Seven years, 6 months	Hospital 1	Undergraduate degree	Initial five-day course + two-day yearly refresher
Greg (M)	RMN	22	Black British	13 months	Hospital 3	Undergraduate degree	Initial five-day course + two-day yearly refresher

Note. adolesc = adolescent; exp = experience; F = female; HCA = healthcare assistant; M = male; RMN = registered mental health nurse; SHCA = senior healthcare assistant

Participant Training in Manual Restraint

All participants reported receiving a minimum of five consecutive days of manual restraint training at the start of their employment. The majority of participants that had been in post for more than 12 months additionally reported receiving a minimum of one day per year of manual restraint refresher training. The names and models of the manual restraint training that the participants received varied across the three NHS Trusts of the four hospitals. However, all participants reported that their manual restraint training consisted of practical and theoretical elements, including training in verbal de-escalation skills. The titles and models of the participants' manual restraint training have not been reported to ensure the anonymity of the hospitals and the corresponding NHS Trusts. A summary description of participants' manual restraint training is presented in Table 7, pages 101-102.

Part Two: Generated Themes and Subthemes

Overview: Themes and Subthemes

A total of four intersubjective themes, each with subthemes, were generated from the reflexive thematic analysis (Braun & Clarke, 2006, 2019, 2022) of participants' verbatim interview transcripts: It needs to be done…sometimes; It's not a nice thing to do; It doesn't really damage the therapeutic relationship; and Importance of team support. The four intersubjective themes were expressed across all 12 participants and are considered to represent the "essences" of participants' experiences of using manual restraint within inpatient adolescent mental health care. An overview of the generated themes and subthemes of the analysis is presented in Table 8, page 104.

Table 8

Overview of Generated Themes and Subthemes from Reflexive Thematic Analysis

Theme	Subtheme
Theme one: It needs to be done . . . sometimes	A last resort to protect young people
	A last resort to protect staff?
	The fantasy of eliminating restraint
Theme two: It's not a nice thing to do	It's distressing for the young person
	It's distressing for us
	Aggression from the young person
	Physical pain and injury
	It's physically exhausting . . . sometimes
Theme three: It doesn't really damage the therapeutic relationship	Damage to the relationship from restraint is only temporary
	Restraint strengthens my relationships with young people
	Long-term damage to the relationship from restraint is rare
Theme four: Importance of team support	Working together as a staff team
	Looking out for each other

Theme One: It Needs to be Done . . . Sometimes

Despite trying to avoid manual restraint where possible, all participants described situations where they had judged their manual restraint of a young person to be necessary. Participants reported that using manual restraint in such situations was a "last resort" to keep young people, themselves and their colleagues safe; this was particularly the case when other less restrictive alternatives were unavailable or ineffective. Overall, this theme provides a descriptive account of the protective functions of the manual restraint of young people as the participants themselves have described. In doing so, this theme highlights a central narrative that prevailed participants' experiences: that restraining young people is sometimes necessary. This theme constitutes three subthemes: A last resort to protect young people; A last resort to protect staff?; and The fantasy of eliminating restraint.

A Last Resort to Protect Young People

All participants described using manual restraint as a "last resort" intervention to protect young people from significant harm. Self-inflicted harm through deliberate self-harm behaviour such as head-banging, ligature-tying, cutting and approaching life-threatening danger while on community leave were the most commonly cited antecedents leading to the possible manual restraint of a young person to protect them. Although participants described several examples where lower-level self-harm had been managed using non-restrictive means such as verbal de-escalation, participants reported that using manual restraint was necessary for more serious forms of deliberate self-harm and deliberate self-harm attempts. This was the case when there was a risk of substantial imminent injury to the young person:

> If a young person has a pen and they're scratching themselves, you wouldn't necessarily restrain them . . . you might try and verbally de-escalate and then you might even go away and come back again later because you know they're not going to be in any kind of real imminent risk, whereas if it's a piece of glass or a piece of metal and they're trying to cut deeply and

> they’re doing it aggressively, that's where you'd have to physically intervene in the moment (Jane, SHCA, Hospital 4).

> A common scenario would be that somebody is hitting their head on the wall. Now usually, they wouldn’t be doing that with sufficient force that you would have to physically intervene, so you would attempt to verbally de-escalate them, and you would try various methods of distraction and grounding . . . if however they step-up and begin head-banging more violently or they move to an area where the wall has a corner . . . at that point we would step in, take an arm each and move the person away from the wall so that they won’t have to continue that dangerous head-banging (Paul, SHCA, Hospital 1).

In addition to the use of manual restraint to prevent acute deliberate self-harm, seven participants described experiences where they had applied manual restraint as a last resort intervention to facilitate the administration of necessary medical treatments via intramuscular injections and nasogastric tubes. Such medical treatments were reportedly administered to protect young people from deliberate self-harm caused by their continual refusal of physical health medication (e.g., antibiotics) and dietary nutrition:

> I think this young person had an eating disorder and had been refusing food and dietary intake for several days, so the decision was made that she would have to be tube fed fortisip [liquid nutrition supplement], so that was the purpose of the restraint (Jane, SHCA, Hospital 4).

Although patient to patient violence was not commonly reported by participants, six participants described experiences where they had used manual restraint to protect a young person from the physical harm of another when less restrictive alternatives had failed. Sarah described her experience of moving herself between two belligerent young people to prevent their harm of each other, before then participating in the manual restraint of one of the young people to transport them to a place of safety:

> There was one incident where we had two girls that went for each other and I had to get between them, and then we had to restrain the girl who probably wasn't really in the wrong, but she was the one that there was more kids against her so it was easier just to get hold of her, get her in her bedroom . . . once she was in her bedroom, she was safe away from everybody else (Sarah, RMN, Hospital 2).

Four participants from two hospitals with past experience of working on adult mental health wards made a distinction between restraint use on adult wards and the current adolescent wards that they worked on. Whilst reporting that they had observed restraint being used pre-emptively and prematurely on adult wards, they described that restraint was only used as a last resort on the current adolescent ward they worked on:

> I've worked in medium secure adults and one of the things that I really like about our ward is that we do lots and lots of verbal de-escalation and distraction techniques before we even hesitate to put hands on the person . . . other [adult] settings I've worked at, they pretty much go to restraint a lot quicker (Emily, HCA, Hospital 1).

Contrary to the reported use of manual restraint as a last resort intervention, three participants from two hospitals described experiences where they had observed agency and bank staff use manual restraint too quickly to manage deliberate self-harm behaviour of young people. Wayne, an RMN with over 11 years' inpatient adolescent mental health experience highlighted that this approach to managing risk might stem from the differences between agency/bank staff and permanent staff in their tolerance of risk:

> A lot of it boils down to the individual who's supporting and managing the situation as well. I think we can often put sort of bank staff and agency staff in quite vulnerable situations at times if they're responding to somebody who's head-banging because often their first instinct is to go in and restrain to safely manage the situation. Of course, it's not necessarily wrong, we all want to try and preserve safety, but a lot of the time . . . there's often more time than people think to be able to try and work around the situation (Wayne, RMN, Hospital 1).

Despite the patient protective functions of manual restraint that participants described, and although participants expressed that patient injuries during manual restraint were uncommon, four participants highlighted how manual restraint could compromise the safety of young people due to reducing the numbers of available staff to care for other young people. These concerns were expressed in the context of the reported two to five members of staff that could be required to manually restrain one young person:

> . . . these other patients, their safety is compromised as well because some of them are on 15 minute observations, and it's one staff member making sure that like eight people on 15 minutes are seen every 15 minutes, and that's because of the restraint that's taken away staff and cut the numbers of available staff for the other patients (Greg, RMN, Hospital 3).

A Last Resort to Protect Staff?

This subtheme poses the question that was highlighted in participants' accounts of whether manual restraint is truly used as a "last resort" to protect staff. Although all participants remarked that manual restraint *could* be used as a "last resort" to prevent a young person from harming staff, only seven participants described first-hand experience of using manual restraint to prevent a young person from harming staff. These participants reported that manual restraint in such circumstances was frequently the only resort to protect staff, rather than the "last resort". This was evidenced through the use of descriptions such as "the only option" and "do it right away":

> We always try and make sure that physical restraint is the last option that we have to use . . . if they're attacking staff, that would be then the only option because you're stopping the risk, the immediate risk (Eric, HCA, Hospital 1).

Three participants made a distinction between the use of manual restraint to prevent patient deliberate self-harm and the use of manual restraint to prevent young people from

harming staff. These participants highlighted that manual restraint was more often used as a last resort to protect young people from their own deliberate self-harm, but more often used as an earlier resort to protect staff from the harm of young people:

> If they are doing some self-harm, of course we'll try to just do some tactile support . . . However, if they start to lash out or try to harm us, then we might have to be more restrictive and use restraint (Naomi, RMN, Hospital 3).

Contrary to the reported use of manual restraint as an intervention to protect staff, all 12 participants described experiences where they had felt physical pains or had sustained injuries as a consequence of using manual restraint. These experiences are reported in the subtheme of "physical pain and injury" within the theme of "it's not a nice thing to do", which better captures this aspect of participants' experiences (see pages 116-118).

The Fantasy of Eliminating Restraint

Although all participants reported that it was possible to reduce manual restraint use within inpatient adolescent mental health care through avenues such as increased staffing numbers, improved ward layouts and improved training of agency and bank staff, it was clear from their descriptions, some of which marked by anger, that they did not feel that manual restraint could be eliminated. Several participants commented on how restraint elimination initiatives often came from non-ward-based individuals who did not understand the imminent substantial physical harm that could occur to young people and staff without the use of manual restraint. Here is an extract from Belinda that captures the pinnacle of this subtheme:

> They talk of it all the time about moving away from restraint techniques or restraint completely. People who talk about moving away from restraint techniques or restraint completely have never worked on a children and adolescent mental health ward. They've never been attacked by a child or young person, they've never watched a young person self-

> harm to the extent that they're not stopping and they're about to cause themselves imminent loss of life or at least imminent kind of wounds that require extensive treatment (Belinda, SCHA, Hospital 4).

Five participants described how eliminating restraint was incongruent with their job role of protecting young people from significant harm. One such participant reported being unwilling to refrain from using manual restraint for this very reason:

> Preventing harm is what my job is as I see it . . . It's all very well to say, "oh, you should never restrain", you watch that person banging their head on a corner of a wall and talk to them when they're completely out of control and they're completely unable to listen until they've split their skull wide open. I'm not going to do that because that's not protecting them (Paul, SCHA, Hospital 1).

Four participants reported that they desired for restraint to be eliminated within inpatient adolescent mental health care but then described how this was not feasible. For instance, Sarah, a RMN from Hospital 2 with 18 months experience, described that she would "like not to have to do it at all and not have to ever intervene physically with young people" but then continued "but I think you have to be realistic at times that you have to do it". One participant sarcastically reported that manual restraint could perhaps be eliminated if young people were kept in seclusion, but then went on to describe that it would be a struggle to find other alternatives to restraint in some circumstances:

> I think restraint is unlikely to be completely eliminated unless you're going to have each young person in seclusion . . . there's always going to be a need for physical restraint in young people and I think there's just some situations where you're really going to struggle to find another alternative (Alice, HCA, Hospital 2).

Theme Two: It's Not a Nice Thing to Do

Manually restraining young people within inpatient adolescent mental health care was an unpleasant practice for all 12 participants, and this was evidenced by their rich descriptions of the aversive physical and emotional outcomes that they, their colleagues and young people experienced as a consequence of applying manual restraint. Phrases such as "it's not a nice thing to do", "nobody wants to restrain" and "I don't like it" were commonly expressed by participants' in their interviews. Five subthemes are reported: It's distressing for the young person; It's distressing for us; Aggression from the young person; Physical pain and injury; and It's physically exhausting . . . sometimes.

It's Distressing for the Young Person

Despite being aware that manual restraint was sometimes necessary, all participants described the emotional distress that they observed young people display as a result of being manually restrained. Shouting, screaming, crying, resisting, and fighting were commonly reported responses of young people towards restraint, and many participants described such behaviour from young people as an indicator of their emotional distress. In the below passage, Belinda interprets a young person's "screaming" and "fighting" during a manual restraint incident as an indicator of their level of distress:

> We had a patient who we restrained for about 45 to 50 minutes, and they were just continually screaming. We'd try and let go and they would begin fighting again, and they were just screaming in your ear . . . they were really distressed (Belinda, SHCA, Hospital 4).

Acknowledging that manual restraint was distressing for young people, all participants described experiences where they had endeavoured to make the process less distressing for young people. Such endeavours were described compassionately, and included

verbally supporting young people during and after restraint, considering the gender of restraining staff members when young people had histories of abuse, making sure that young people were dignified in restraint, and restraining young people using the least restrictive force and for the shortest period of time possible:

> There's someone just trying to explain to the patient what is going on because it's incredibly frightening for them, and the main priority is trying to de-escalate the situation, not making it worse, and also making sure they're dignified (Laura, RMN, Hospital 1).

> We've got quite a few young girls who haven't had the most positive experience of physical contact with men, so although we don't necessarily stop using men for their restraints, we try and have females in their restraint too . . . so that young people are potentially less distressed about it as obviously it is a very distressing situation (Alice, HCA, Hospital 2).

Despite the reported negative emotional impact of manual restraint on young people, ten participants described experiences where they had believed that some young people had behaved in certain ways to intentionally elicit a restraint response from staff. Such young people reportedly appeared to find manual restraint therapeutic, and were described as using manual restraint as a means to seek physical contact:

> There's some people I've known that find restraint almost therapeutic. We've had some people in the past that have actually almost escalated in their behaviour in order to elicit that response from staff and then when you've got them in the holds, it's almost like their body relaxes and they're not even fighting against you at all, so it is that kind of thing of "why am I even holding you here?" But I think they just wanted to be held, we've had a few people like that (Laura, RMN, Hospital 1).

It's Distressing for Us

All participants described the emotional distress that they experienced as a consequence of using manual restraint. Participants reported that the practice was

"upsetting", "horrible" and "traumatising" for them amongst other terms of the like, and eight participants expressed their dismay at the prospect of manually restraining young people specifically. Three participants described experiences of manual restraint where they had either cried or had been close to being moved to tears. Such strong emotional reactions were commonly described as a consequence of witnessing a young person's distressing reaction to manual restraint:

> During the restraint, I just had to look away. I was on the arm because he was trying to claw up my hand and I was just like, "I can't look at him" and all I could hear was "I'm sorry, I'm sorry", and I was like "I can't look, if I look at him, I'm going to burst into tears". It was horrible . . . I mean, I'm a human being and at the end of the day, it was a young boy, do you know what I mean? (Emily, HCA, Hospital 1).

The use of manual restraint to prevent deliberate self-harm, and to facilitate compulsory nasogastric tube feeding of food and/or fluid refusing young people was described by five participants as being particularly distressing to execute. Again, the young person's distressing reaction to manual restraint was referenced by participants in their accounts of their own distress:

> It's really difficult if you're restraining someone to give them a nasogastric tube for an NG feed . . . that can be quite traumatising because usually the patient is very very against being NG'd . . . often there's a lot of emotion, there's tears, they're crying, there is "why are you doing this to me? let me die", it's quite traumatic and actually I would say the whole time it's very traumatic (Belinda, SHCA, Hospital 4).

All participants reported experiencing a spectrum of unpleasant emotions as a result of their use of manual restraint. Whilst anxiety, anger, guilt and sadness were explicitly cited emotions, it was the emotions of anxiety and anger that were the most frequently described by participants. All participants described feeling anxiety, particularly in the moments

leading up to a manual restraint; this was often in the context of their worrying about the young person's preceding deliberate self-harm, and their fears for themselves, their colleagues or the young person being hurt during the manual restraint process:

> . . . you're afraid because you don't want to get injured, you don't want your peers to get injured, you don't want the young person to get injured. Also, this thing that's been cut away from their neck, you don't know how long it's been there, you don't know when they applied it and whether there's any harm that's happened to them as a result of that . . . you're anxious about that too (Paul, SCHA, Hospital 1).

Nine participants described feeling anger, often in the context of being hurt by the young person in manual restraint, and in response to the young person's behaviour that had led to and/or that was perceived to be prolonging the restraint. Some participants described experiences of manual restraint where they had expressed their anger to the young person:

> You're in a position that is naturally making you quite angry with the person that's making you do something you don't want to do . . . nobody enjoys restraining somebody and when you've been in a restraint for a while, sometimes you just get like "why have you done this?", "what are you trying to get out of this?", and it's that frustration again, being quite annoyed at that young person (Alice, HCA, Hospital 2).

Five participants reported a reduction in their level of distress to restraint over time. However, these participants were clear that restraint continued to be distressing for them. Paul, a SHCA from Hospital 1 with seven years' experience described: "It's still distressing. It's still upsetting, but it doesn't have that same sort of fresh open wound shock value that it used to have". Similarly, Jane, a SHCA from Hospital 4 with eight months' experience described: "You kind of do get a little bit more desensitised to it . . . you always feel anxious, but probably less anxious".

Aggression from the Young Person

All participants described experiences where they had been subjected to aggression by some young people during manual restraint incidents. Physical aggression was the most commonly described form of aggression, and this was evidenced by the frequent occasions that the majority of participants reported being kicked, scratched, punched, pushed, head-butted, and spat at by some young people during manual restraint incidents. It appeared from participants' descriptions that these young people displayed such physical aggression in an effort to prevent or break out of restraint through any means possible:

> They can hit out at staff in restraint and do anything to get out . . . they can hit, spit, bite, kick. Personally, I've been bitten during a seated restraint. The young person was in between two staff. I was on the left and the other staff was on the right side and the young person was in the middle, and the young person turned their head to the left of me and tried to bite my neck and my ear (Greg, RMN, Hospital 3).

> Sometimes once you get them into the restraint they just freak out because they want to be let go of, so then they try and like stomp on your feet or kind of like throw themselves around a bit . . . if they manage to shake an arm free then they'll try and swing at whoever else is holding them (Daniel, HCA, Hospital 2).

> Throughout the restraint they were sort of, they have quite long nails, they were attempting to scratch at me and dig their nails into me . . . they were trying, and it was a little bit of sort of scratching (Naomi, RMN, Hospital 3).

Five participants described deliberate attempts and actions of young people hurting staff in restraint. Such young people's displays of physical aggression were described as being vindictively motivated rather than as an attempt to break out from restraint:

> Recently we've had a few patients that deliberately assault staff . . . sometimes the kicking and punching and pulling and stuff is more about struggling to get away, and sometimes it's an actual desire to hurt staff (Alice, HCA, Hospital 2).

Despite the physical aggression that participants experienced from young people in restraint, ten participants expressed an understanding of such behaviour from young people. Some participants described experiences where they had reminded themselves that young people were mentally unwell in hospital for a reason, and other participants considered how physical aggression from young people was understandable in the context of their being restrained. Below is a passage from Eric:

> Most of the time they are not actually trying to hurt staff . . . I just think if I was in their situation being held down by four, five people, I wouldn't like it and I would try to do what I could to get out, you know? It wouldn't be a nice situation (Eric, HCA, Hospital 1).

In addition to patient physical aggression, six participants explicitly described the verbal aggression that they experienced from young people in restraint. Commonly cited forms of verbal aggression included swearing, shouting, name-calling, cursing and insulting. Daniel, a HCA from Hospital 2 described: "there's lots of 'fuck off', 'get off of me', all kinds of names being called, that's a very common thing". Similarly, Laura, a RMN from Hospital 1 described: "they go from being verbally aggressive, screaming at us and telling us that we should die in a car crash on the way home . . . you do get a lot of verbal abuse".

Physical Pain and Injury

Despite reporting that injuries to young people during restraint were rare, all participants described first-hand experience where they had felt physical pain and/or had been injured as a result of applying manual restraint. Bruises, grazes and muscle aches were commonly described injuries. Such injuries were frequently sustained by participants during the execution of restraint, such as when transitioning from standing to floor-based positions or when restraining young people's legs:

> I was one of the leg people and this young person was really really strong in their legs as well, so I ended up with a little bit of a bruise on my elbow because the young person was moving their legs up and down . . . so a lot of the time in restraints, you can get a lot of bruises and it's quite common, especially if you're going to the floor and you have to sort of drop to your knees (Naomi, RMN, Hospital 3).

Five participants described experiences of delayed onset muscle aches and stiffness following their use of manual restraint. Such pains were reportedly experienced some moments after restraint, and in some cases, it was not until the following day that participants became aware of such pain. Alice, a HCA from Hospital 2 described: "and you get up the next day and you just think, 'oh, my God, I ache everywhere'". In contrast to Alice, Sarah described experiences of manual restraint where she had felt muscle stiffness "a little while after" restraint:

> Generally, I find as well, things don't hurt until a little while after, so you kind of do it [restraint] and the adrenaline just carries you, and then it's not until a little while later where you're like "oh actually I'm a bit stiff" (Sarah, RMN, Hospital 2).

Aside from bruises, grazes and muscle aches, eight participants described situations where they had either sustained or had witnessed their colleagues sustain more severe injuries during manual restraint such as rib injuries, twisted ankles, concussions, permanent nerve damage and being kicked in the side/groin. Such injuries were not described to be common, and were reportedly sustained through the physical aggression of young people or during the execution of the manual restraint itself:

> I'm currently waiting for an operation on an injury that I suffered to my ankle during a restraint . . . that was simply a matter of the restraint going to the floor and me turning to go to the floor, and my foot not turning as I wanted so my ankle snapped (Paul, SHCA, Hospital 1)

> A young person had kicked a staff member in the side, and she was crying when I came into the office, and she said she was crying because she had been kicked previously in the same place just the day before by the same young person in a restraint (Jane, SHCA, Hospital 4).

> We've had a number of rib injuries over the years where generally, when the legs aren't under control as safely as they can be and the young person sort of kicks out. There's been a number of injuries that way (Wayne, RMN, Hospital 1).

It's Physically Exhausting . . . Sometimes

Ten participants described manual restraint as a sometimes physically exhausting practice, and this was indicated by their use of terms such as "draining", "tiring" and "exhausting" when describing their experiences. The degree of physical exhaustion that participants reported experiencing in restraint was described as being contingent on the size, strength, distress, and resistance of the young person they were restraining. For young people that were considered to be strong, big, resistive, and highly distressed, participants described a more physically exhausting experience of manual restraint:

> When you've got somebody who's actually really upset and you're having to hold onto them; physically, it can be exhausting because it's quite like, physically you have to use your strength and I'm not massive, especially if I've got some of the kids that are bigger than me, that can be a bit much (Sarah, RMN, Hospital 2).

Prolonged manual restraints that could last for hours at a time due to rapid tranquilisation[2] being ineffective were described by participants as being some of the most physically exhausting. In the below passage, Daniel vividly describes the physical exhaustion that he experienced in a prolonged manual restraint involving a highly resistive young person

[2] Rapid tranquilisation refers to the use of medication to calm and/or sedate a service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression. It is used when appropriate psychological and behavioural interventions have failed (NICE, 2015).

who did not respond to being injected with rapid tranquilisation medication:

> We held her for hours, and the entire time she was straining towards getting to the wall or to the floor because she wanted to hit her head on the floor . . . it was one of the most exhausting things, just holding this person until they literally fell asleep, like they just fought until they were just so spent that they fell asleep. It was exhausting, just physically . . . we had IM'd her [injected her with rapid tranquilisation medication], but they had like so much fight and energy. They were just going for it. We literally had to use everything we had to hold them, so afterwards, you were just so tired (Daniel, HCA, Hospital 2).

Three participants explicitly described the physical exhaustion that they felt during manual restraint in circumstances where they had needed to run to the young person first before restraining them. Such circumstances were described by participants in the context of responding to panic alarms and radios for assistance:

> When we get a radio from education saying "we need assistance down here", you've got to run to that, and by the time you get there, you've then got to like, you're out of breath, you've then got to jump in a restraint and you're trying to get your breathing back and you're just exhausted (Emily, HCA, Hospital 1).

Despite the physical exhaustion that the majority of participants reported experiencing, one participant, Greg, a RMN from Hospital 3, reported "physically, I don't really feel anything physically from it [restraint]". Four participants additionally reported that the manual restraint of some young people was not physically demanding for them. This was reportedly due to the minimal physical resistance that some young people displayed during a manual restraint:

> I guess with some restraints, physically it's not so demanding, but it all depends on the person's anxiety levels, like some people, they're just a bit like "I don't want to be on the ward" but you safe hold them back and that's fine; they don't really resist too much and in that

> situation, it's not really too physically demanding. It's just a linking arms with someone really (Sarah, RMN, Hospital 2).

Theme Three: It Doesn't Really Damage the Therapeutic Relationship

Despite the described negative emotional outcomes of manual restraint for both young people and participants in the "it's not a nice thing to do" theme (see pages 111-120), the present theme highlights a somewhat contrasting description that was prevalent in all participants' accounts: that manually restraining young people has minimal damaging effects, if any, on the long-term staff-young person therapeutic relationship. This theme constitutes three subthemes: Damage to the relationship from restraint is only temporary; Restraint strengthens my relationship with young people; and Long-term damage to the relationship from restraint is rare. The below passage from Paul captures the pinnacle of this theme:

> We've got young people on the ward now that I don't have a very good relationship with that I've never laid a hand on, and other people that I've got a very good relationship with and occasionally the situation has descended to the point where we've needed to restrain them. I don't think it's relevant to your relationship with them, whether or not you restrain them (Paul, SHCA, Hospital 1).

Damage to the Relationship from Restraint is Only Temporary

Ten participants described experiences in which their use of manual restraint had resulted in either a young person being temporarily upset with them, or they themselves being temporarily upset with a young person. Such impacts on the staff-young person therapeutic relationship were described by participants as being marginal, and as having no impact on the quality of their relationships with young people in the long term:

> I haven't ever found that my relationship has been affected detrimentally by any restraint to be honest. I generally haven't really found that it's made any difference. Obviously, in the very short term, after the restraint, they're not necessarily wanting to see or be nice to you because

> you've just done something horrible, but I can't say long term or longer than a day or so it's really affected any of my relationships with the young people (Alice, HCA, Hospital 2).

> You just feel very frustrated at the whole circumstance [of restraining them], and it does sometimes change the way you view a patient, not forever, but for that moment in time, you do get quite cross and frustrated with them (Belinda, SHCA, Hospital 4).

Participants cited a number of reasons to explain why they felt that their use of manual restraint did not damage their relationships with young people in the long term. Six participants attributed this to young people knowing that the use of manual restraint was in their best interests:

> Most of them know that we're there to keep them safe. They even say "so you're there to sort of prevent me from harming myself" . . . so they're aware of that, and that our use of restraint is not personal (Greg, RMN, Hospital 3).

Additionally, debriefing with young people, either formally or informally, following manual restraint incidents was reported by seven participants to play an important role in preserving the staff-young person therapeutic relationship in the long term. Debriefing reportedly involved explaining to young people the reasons for restraint and resolving any short-term damage that might have occurred to the therapeutic relationship:

> I wonder if some of it is partly down to how you deal with it after the restraint, like the conversations that you have . . . I think, if you have like a good debrief and you explain to them that you're reasoning for it is always with their best interests at heart, I think it's harder for them to stay angry with you (Sarah, RMN, Hospital 2).

Restraint Strengthens My Relationships with Young People

Four participants from two hospitals reported that their use of manual restraint had strengthened their relationships with young people. This was evidenced by their use of terms

such as “improves”, “strengthens” and “enhanced” when describing the impact of manual restraint on the quality of their relationships with young people. Here is a passage from Wayne who expressed that he was “loathed” to report that his use of manual restraint had strengthened his therapeutic relationship with young people:

> In the majority of cases where I've had to restrain a young person on multiple occasions, it hasn't fractured the therapeutic relationship at all to be honest. If anything, I'm loathed to say it's enhanced it (Wayne, RMN, Hospital 1).

Participants described being unsure of how their use of manual restraint had strengthened their relationships with young people. However, two participants highlighted the opportunity that manual restraint had provided them to come into contact with young people at their most vulnerable times. Such opportunities reportedly helped participants get closer to young people, although the explanations for this closeness remained unclear to participants:

> I don't feel like it [restraint] breaks it [staff-young person therapeutic relationship] at all. If anything, sometimes I think it might strengthen it in a weird kind of way, and I can't really explain it but it's like, I've seen them at their worst time, I've seen them at the time that they’ve struggled the most, I've been on their journey with them . . . it brings you closer to them (Emily, HCA, Hospital 1).

Long-Term Damage to the Relationship from Restraint is Rare

Whilst nearly all participants described experiences where manual restraint had resulted in temporary damage to the therapeutic relationship, just three participants described witnessing or experiencing long-term damage to the staff-young person therapeutic relationship consequent to manual restraint. These participants described how such experiences were not common. Wayne, an RMN with over 11 years’ inpatient adolescent mental health experience described that there had only been one occasion in his career where

his use of manual restraint had damaged his relationship with a young person long term:

> I can only think of probably one scenario really where I've restrained a young person where it completely messed up any sort of therapeutic relationship. They [the young person] wouldn't talk to me for the rest of that admission (Wayne, RMN, Hospital 1).

Contrary to this subtheme, two participants described more common experiences where their colleagues had experienced long-term damage to the therapeutic relationship in the context of manual restraint. In all reported instances the damage to the therapeutic relationship was reported from the staff side of the relationship only:

> I feel that, not me, but some staff have been frustrated with caring for patients that they've had to restrain frequently, so it has affected the staff rather than the patients . . . some staff didn't want to be on that patient's one-to-one observations because that patient was in frequent restraints (Greg, RMN, Hospital 3).

Theme Four: Importance of Team Support

The staff team was an important support system for all 12 participants, and this was partially evidenced by the numerous occasions that participants used terms such as "team", "colleagues", "we" and "us" when describing their experiences of manual restraint. It was clear from participants' descriptions that their colleagues were an integral practical support system during the execution of manual restraint, and a valued emotional support system within the aftermath of manual restraint. This theme constitutes two subthemes: Working together as a staff team; and Looking out for each other.

Working Together as a Staff Team

All participants described the importance of working with their colleagues as a team in the context of restraining young people. Teamwork processes such as effectively

communicating, observing, and coordinating amongst the nursing staff team were reported by participants as being integral to the safe and successful execution of manual restraint. Some participants described the risk of injury that could occur to young people and staff in the absence of such teamworking processes during restraint:

> No matter how good each person is individually, you're never going to be able to effectively restrain somebody if you're all not working together. You're going to either bend somebody's body in a way that it shouldn't go because you're not listening and watching what other people are doing. When you go in, you need to be fairly simultaneous, otherwise somebody grabs an arm, and the young person uses their other arm to hit them (Alice, HCA, Hospital 2).

Six participants from two hospitals reported that the standard of teamwork during a restraint was contingent on the team that they were working with on their shift. These participants made a distinction between working with a "good" team and with an unskilled team. The latter team was described typically as a team that had poor communication or that included a significant number of non-familiar staff. One participant, Greg, described how working in such a team could make the restraint of a young person more physically laborious for some staff:

> It depends on your team, so if you have a good team, the team that you're working with dictates how physically draining it is, because if you're working in a team with a lot of bank staff and non-permanent staff or a team that's not communicating well, then certain staff have to work harder, so it's like a team thing . . . because restraint is like a unit, we're a team (Greg, RMN, Hospital 3).

Unlike an unskilled team that was described as having poor communication during restraint, three participants described experiences of effective communication through non-verbal means when working in a reportedly good team. In the passage below, Emily describes

how being part of a "strong team" had enabled her and her colleagues to make decisions about initiating restraint non-verbally in the moment:

> So you need to think like "okay, he's hit himself too much now", so you need to make that call for like, when should we intervene? And it's kind of like an unsaid, it's difficult to explain. When you've got a strong team like we have, you just know like, just a little look at each other and we're like, "it's time". You don't even need to say anything, it's like non-verbal kind of like "yeah, it's time" (Emily, HCA, Hospital 1).

Looking Out for Each Other

This subtheme highlights the personal support that participants provided and received from their colleagues that was evidenced in their accounts. Six participants recounted the informal verbal emotional support that they had received from their colleagues in the aftermath of manual restraint incidents. These participants described how speaking with and being listened to by their colleagues had helped them to feel better in the aftermath of such incidents. This was the case particularly when participants had participated in a manual restraint that had unsettled them:

> I remember afterwards, I went in the office, and I said "that's my first time restraining a child", and I can't remember who the nurse was, but they sat and spoke with me for a bit, so I felt alright after speaking to them (Eric, HCA, Hospital 1).

> Afterwards, he [colleague] stayed with me for like five minutes and we just had a little debrief about how I was feeling which helped . . . I think that happens informally a lot when you're working as a team (Jane, SCHA, Hospital 4).

In addition to the informal emotional support that they received from colleagues, three participants described experiences where they had provided such support to their colleagues in the aftermath of a manual restraint. Daniel, a HCA from Hospital 2 described: "we always

kind of verbally check in with each other like ‘are you okay?’, ‘are you good?’, that kind thing anytime there’s a restraint”. Similarly, Paul, a SHCA from Hospital 1 with over seven years’ experience, described: “you’ll have a chat with them and make sure they’re alright . . . if somebody is particularly affected, you might go and sit down and talk to them”. Formalised post-restraint staff debriefing meetings were not frequently reported to occur due to reported insufficient staffing numbers and a lack of protected time. Notwithstanding, two participants described the emotional offloading support that such meetings provided them when they did occur:

> Afterwards, we do try and have like a debrief process for anyone that was involved, and then there’s just a bit of like decompression that happens afterward and we always try and discuss . . . how people were feeling about it to help it get off people’s chests, because those things can weigh on you a bit when you have to go home afterward (Daniel, HCA, Hospital 2).

Aside from emotional support, seven participants described experiences where their colleagues had provided them with practical support in the context of a restraint, and where they too had done the same. Such practical support included the facilitation of preferred restraint positions and the swapping out of restraint in response to staff physical struggle:

> There are times when I've been in restraints where people have noticed that I'm struggling and just taken over from me and said “look, I'm going to take over from you now”. . . or if you know that somebody else is kind of struggling a bit physically, I’m thinking about what I can do to support them in that moment (Jane, SHCA, Hospital 4)

> I feel like a lot of the time someone will be like, “right, I'm more confident on the arm”, and someone will say “okay, I'll take the legs then” . . . people will be more than happy to swap out (Naomi, RMN, Hospital 3).

CHAPTER FOUR: DISCUSSION

Chapter Overview

This chapter serves to provide a review and critical discussion of the findings of the current study. This chapter is divided into three parts. In part one (Discussion of Results), I provide a summary of the main findings of this study and then discuss the findings in full in relation to the research literature reviewed in the introduction chapter of this thesis. In part two (Implications, Limitations and Strengths of the Study), I discuss the practice and research implications of this study and evaluate this study with respect to its limitations and strengths. Finally, in part three (Final Reflections and Conclusion), I provide an account of my final reflections on this research and then present a conclusion.

Part One: Discussion of Results

Summary of Findings

The purpose of the present descriptive phenomenological study was to explore nursing staff's experiences of using manual restraint within inpatient adolescent mental health care. To the best of my knowledge, this study is the first to explore healthcare staff's experiences of manual restraint within a general child and/or adolescent inpatient mental health care context, despite the substantially elevated reported incident rates of restrictive interventions in these settings (LeBel et al., 2004; NHS Digital, n.d.). The current study thereby adds to the limited literature base on healthcare staff's experiences of manual restraint and provides valuable insight into the experience of using manual restraint within inpatient adolescent mental health care. Twelve nursing staff participants from five wards,

across four adolescent mental health hospitals spanning three NHS Trusts participated in individual in-depth interviews. The sample was diverse with respect to age, gender, job title, experience duration and manual restraint training.

Four intersubjective themes were generated from the reflexive thematic analysis (Braun & Clarke, 2006, 2019), each with subthemes: It needs to be done…sometimes; It's not a nice thing to do; It doesn't really damage the therapeutic relationship; and Importance of team support. These themes reflect the "essences" of the nursing staff participants' experiences of using manual restraint within inpatient adolescent mental health care. Overall, although the nursing staff reported that it was sometimes necessary to use manual restraint to protect young people and staff from significant harm, they spoke with dislike about its use, and described aversive experiences of emotional distress, patient aggression, pain and injury, and physical exhaustion consequent to their manual restraint use. Moreover, the nursing staff provided and received emotional and practical support from their colleagues, and they did not report experiencing their use of manual restraint as damaging to staff-young person therapeutic relationships in the long term.

Discussion of Findings

In the following section, I discuss the findings of this study in relation to the previous relevant research literature on a theme-by-theme basis. I discuss each theme in the order in which they were reported in the Results Chapter.

It Needs to be Done . . . Sometimes

The most prevailing finding from the analysis was that all participants described experiencing manual restraint as a sometimes-necessary intervention to protect young people, themselves and their colleagues from significant harm, concurring with previous research

findings on staff's experiences of manual restraint globally in adult and child and/or adolescent service user settings (e.g., Bigwood & Crowe, 2008; Chapman et al., 2016; Lombart et al., 2020; Steckley & Kendrick, 2008; Wilson et al., 2017). No single participant in this study felt that it was possible to eliminate manual restraint completely, and some participants' accounts on restraint elimination initiatives were marked by expressions of anger. Despite reporting on experiences of using manual restraint in response to patient aggressive behaviour directed at staff and other young people, the nursing staff in this study overwhelmingly described using manual restraint to protect young people from their own deliberate self-harm behaviour, with substantial refusal of dietary intake and physical health medications, and serious head-banging, cutting, and ligature-tying being frequently cited to warrant restraint. These findings were directly evidenced within the "It needs to be done . . . sometimes" theme and peripherally transcended the remaining three generated themes, indicating that the participants' accounts were highly saturated with experiences of deliberate self-harm initiated manual restraint incidents. For instance, in a vivid participant extract within the "It's physically exhausting . . . sometimes" subtheme within the "It's not a nice thing to do" theme, Daniel described his experience of a physically exhausting manual restraint to prevent a young person from head-banging (see Results Chapter, page 119).

The above cluster of findings contrast with that of previous studies of staff's manual restraint experience in inpatient adult mental health settings which have failed to highlight so prevailingly the commonality of deliberate self-harm initiated manual restraint incidents in staff's lived experience accounts (Bailey et al., 2021; Bigwood & Crowe, 2008; Bonner et al., 2002; Perkins et al., 2012; Sequeira & Halstead, 2004; Wilson et al., 2017). In line with a previous UK study on staff, patient and relatives' views on restrictive interventions in inpatient CAMHS settings where the theme "reducing risk of harm to patients" was generated in the absence of a "reducing risk of harm to staff/others" equivalent theme (Rippon et al.,

2018), this finding may anecdotally indicate, at least within the UK, that deliberate self-harm initiated manual restraint incidents are more common in inpatient child and/or adolescent mental health settings than in adult such settings. This presumed difference may be explained by potentially higher incident rates of deliberate self-harm in inpatient child and/or adolescent mental health settings or by staff perhaps being more unwilling to allow young people to deliberately harm themselves without intervening physically. Further research however is required to justify these anecdotal musings.

With the exception of managing patient aggressive behaviour towards staff where manual restraint was often reported to be the only resort rather than the last resort, it was clear from the analysis and the presented participant extracts that the nursing staff in this study used manual restraint as a last resort intervention when other less-restrictive alternatives for managing young people's risk behaviour were exhausted or not possible; this coincides with previous research findings in adult and child and/or adolescent service user settings internationally where staff have self-reported using manual restraint as a last resort intervention (e.g., Bailey et al., 2021; Fish & Culshaw, 2005; Lombart et al., 2020; Steckley & Kendrick, 2008). The nursing staff in this study described using strategies such as verbal de-escalation, distraction, and grounding techniques to manage deliberate self-harm wherever possible, and four participants with previous inpatient adult mental health experience further highlighted that manual restraint was used far less quickly on their current adolescent wards compared to the previous adult mental health wards in which they worked. Given that "eliminating inappropriate use of restraint is particularly vital in relation to children, who are still developing both physically and emotionally" (Ridley & Leitch, 2020, p.13), this finding is reassuring. However, three nursing staff participants across two hospital sites described experiences where they had witnessed agency and bank members of nursing staff use manual restraint prematurely to manage patient deliberate self-harm behaviour, with one participant

commenting that these non-permanent staff perhaps had lower risk tolerance thresholds than that of permanent staff. This finding is congruent with that of a previous qualitative study in a UK inpatient adult mental health ward which highlighted that lowered risk tolerance thresholds could lead some staff to pre-emptively and prematurely use manual restraint to manage patient risk behaviour (Perkins et al., 2012).

From the above cluster of findings, whilst it does appear that the nursing staff in this study used manual restraint as a last resort intervention, the observed manual restraint practices of agency and bank nursing staff by three participants across two hospital sites would indicate that manual restraint was not always used as a last resort in at least these hospitals. This finding would provide some evidence to support the suggestion of the Restraint Reduction Network (2022): that the high reported restraint rates in inpatient child and adolescent mental health care indicates that "restraint is currently not being used as a 'last resort'" within these settings (p. 4).

It's Not a Nice Thing to Do

Despite describing their use of manual restraint as a sometimes-necessary intervention on the grounds of safety, it was evident in this study that the participants disliked using manual restraint, coinciding with previous research findings in inpatient adult mental health settings where staff have self-reported their dislike of using manual restraint (Bailey et al., 2021; Bigwood & Crowe, 2008; Bonner et al., 2002; Sequeira & Halstead, 2004; Wilson et al., 2017). Phrases such as "I don't like it" and "it's not a nice thing to do" were commonly expressed in participants' accounts, and all participants described the restraint-related emotional distress that they experienced. Some participants attributed their distress to the young person's distress response to being restrained, and some described their restraint experiences using terms such as "traumatising", highlighting the degree of distress that

participants experienced; this is despite the fact that nearly half of participants reported a reduction in restraint-related distress over time. These finding are in line with previous studies on staff's manual restraint experiences in both inpatient adult and child and/or adolescent mental health settings where staff have described their restraint experiences using words such as "traumatising" and "distressing" (Bailey et al., 2021; Kodua et al., 2020; Sequeira & Halstead, 2004), attributed their restraint-related distress to the patient's distress during manual restraint incidents (Bailey et al., 2021; Kodua et al., 2020), and described a reduction in their distress responses to restraint over time (Kodua et al., 2020; Sequeira & Halstead, 2004; Wilson et al., 2017). Understandably, witnessing an adolescent in a state of emotional distress during a manual restraint incident is not a pleasant experience. However, I wonder whether this is an even more unpleasant experience for the nursing staff in this study who perhaps may have had an interest in young people as evidenced by their choice of work.

The nursing staff in this study explicitly described experiencing a spectrum of unpleasant emotions (anxiety, anger, sadness and guilt) as a result of using manual restraint, indicating the substantial degree of emotional distress that they experienced. However, it was the threat-based emotions of anxiety and anger that were the most frequently cited by the participants. These emotions appeared to match the real-life threats that the nursing staff reported facing during manual restraint incidents such as the threat of being hurt, the young person being hurt, and being hurt by the young person during restraint. Previous qualitative studies on staff's manual restraint experiences in adult and child and/or adolescent service user settings have similarly highlighted the commonality of restraint-induced staff feelings of anxiety and anger in relation to the aforementioned threats reported by the participants in this study (Bailey et al., 2021; Bigwood & Crowe, 2008; Kodua et al., 2020; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008). In one particular study exploring the psychological experience of manually restraining patients on an adult mental health ward,

"anxiety", "anger" and "reduction in anxiety through familiarity with restraint" were amongst the main themes generated (Sequeira & Halstead, 2004, p. 6-7), concurring with the "It's distressing for us" subtheme in the present study.

The most worrying finding in this study concerned the aversive physical consequences that saturated participants' experiences of using manual restraint. At least the great majority of participants described restraint experiences where they had been subjected to physical pain or injury (e.g., grazes, bruises, and muscle aches), patient physical aggression (e.g., being kicked and scratched) and physical exhaustion. Of particular concern was the high number of participants (eight nursing staff) that cited examples of more severe physical injuries sustained to themselves or their colleagues, albeit uncommon, during manual restraint incidents (e.g., twisted ankles, concussions, rib injuries). These findings, together with the adverse reported psychological outcomes, paint a grim picture of the experience of manually restraining young people for the nursing staff in this study. Unfortunately, these adverse physical experiences are not unique to the participants in this study; previous studies on staff's experiences of manual restraint in adult and child and/or adolescent service user settings have equally highlighted the physical injury that staff may be subjected to (Chapman et al., 2016; Kodua et al., 2020; Lee et al., 2003; Wilson et al., 2017), the patient physical aggression that they may experience (Chapman et al., 2016; Kodua et al., 2020), and the physical exhaustion that they may experience (Hawkins et al., 2005; Kodua et al., 2020; Lombart et al., 2020) as a result of using manual restraint.

The generated themes of "It's not a nice thing to do" and "It needs to be done . . . sometimes" together, on an interpretive level, paint a conflicting picture of the nursing staff's experiences of using manual restraint. Despite their descriptions of the adverse physical and psychological outcomes of using manual restraint and their dislike of the practice, the participants experienced manual restraint as a sometimes-necessary practice that they could

not always avoid, indicating a degree of internal conflict. Although this dilemma was not explicitly described by any participant in this study, the aforementioned conflicting themes would indicate a level of internal and professional conflict for the nursing staff in this study. This anecdotal finding concurs with more manifest findings of previous research studies which have more explicitly described the internal conflict that staff may experience as a result of using manual restraint (Bailey et al., 2021; Bigwood & Crowe, 2008; Brenner et al., 2014; Chapman et al., 2016; Hawkins et al., 2005; Lombart et al., 2020; Perkins et al., 2012; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Svendsen et al., 2017; Wilson et al., 2017).

It Doesn't Really Damage the Therapeutic Relationship

By far the most unexpected and controversial finding from the analysis was that all participants experienced manual restraint as having minimal long-term damaging effects, if any, on the staff-young person therapeutic relationship. This was despite the substantial emotional distress that manual restraint prompted for young people and participants, and the physical aggression that participants reported they were subjected to by young people during manual restraint incidents. Just three participants described experiences, albeit uncommon, where their use of manual restraint had permanently damaged the staff-young person therapeutic relationship from the young person's side (e.g., young person refusing to talk to them for remainder of admission), and just two participants described witnessing occasions where their colleagues' use of manual restraint had permanently damaged the said therapeutic relationship from the staff member's side (e.g., colleagues no longer wanting to be on the young person's one-to-one observations). Although no participant explicitly denied the interpersonal challenges that manual restraint could prompt between young people and themselves (e.g., young people not wanting to speak to them; feeling angry with young

people), nearly all participants described such damage to the staff-young person therapeutic relationship as being only temporary (e.g., lasting no longer than a day).

The above cluster of findings are challenging to digest, and profoundly conflict with the manual restraint research literature from the perspectives of service users who have described the psychological and physical harm that manual restraint has caused them, and the unrepairable damage that manual restraint has inflicted upon their trust of services and healthcare staff (Brophy et al., 2016; Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002; Wilson et al., 2017). Given the disparity with the previous research literature, the findings of this study need to be considered in light of a number of important questions. For instance, were the participants' experiences of the therapeutic relationship also reflective of those of the young people they were manually restraining? Moreover, did the participants, knowingly or unknowingly, minimise the impact that manual restraint had on the therapeutic relationship in their reporting? Finally, how can the finding that manual restraint only minimally/temporarily damages the therapeutic relationship be explained, if this finding indeed did mirror young people's experiences? I will address each of these questions individually in the following paragraphs.

Given that this study exclusively explored nursing staff's experiences of manual restraint without exploring young people's experiences too, the question of whether the participants' experiences of the therapeutic relationship also reflected that of the young people they were restraining is regrettably beyond the scope of this study. It is possible however that the young people's experiences of the therapeutic relationship markedly differed from what the participants' reported in this study, given that inpatient mental health care staff and patients have been found to have markedly different views and experiences of the same jointly experienced phenomena (Duxbury & Whittington, 2005). Notwithstanding, the unique findings of this study have been replicated in a previous residential childcare

study. In this UK-based study on care staff's and young people's experiences of manual restraint, many young people described manual restraint as having "no effect" on the therapeutic relationship, and some care staff and young people reported only a short-lived effect when manual restraint did negatively impact on the said therapeutic relationship (Steckley & Kendrick, 2008, p.564). These findings mirror that of the present study and would indicate that the participants' experiences of the therapeutic relationship in this study perhaps did match that of the young people they were restraining. Could it be that manual restraint poses less of a risk of permanently damaging the therapeutic relationship in child and/or adolescent service user settings in comparison to adult service user settings? Further research is needed to address these musings.

It is possible that the participants in this study knowingly or unknowingly minimised the impact that manual restraint had on the staff-young person therapeutic relationship. This assumption is strengthened by the fact that nearly half of the participants reported becoming somewhat emotionally desensitised to manual restraint over time. For instance, Jane reported: "you kind of do get a little bit more desensitised to it". In light of the above, I therefore wonder whether the desensitisation that some of the participants described experiencing also influenced how they perceived the impact of their manual restraint practice on the staff-young person therapeutic relationship. For instance, were they desensitised to the negative consequences that their manual restraint practice might have had on the therapeutic relationship? Indeed, from the lens of Festinger's (1957) cognitive dissonance theory, such an adaptation might have helped the participants reassure themselves that their manual restraint practice was not harmful. Festinger's (1957) theory of cognitive dissonance highlights the psychological discomfort that people can experience when their behaviours do not align with their values and beliefs (e.g., "manual restraint is distressing for patients AND I manually restrain patients"), and the efforts that people make to relieve themselves of this discomfort

(e.g., believing that manual restraint causes no long-term damage to the therapeutic relationship).

Assuming that the participants' experiences of the therapeutic relationship in this study also mirrored that of the young people they were manually restraining, the finding that manual restraint only minimally and temporarily damaged the therapeutic relationship might be explained by several factors and processes that the participants themselves described. Firstly, all participants provided rich descriptions of how they genuinely used manual restraint only as a last resort (e.g., trying grounding strategies and verbal de-escalation first), and how they actively endeavoured to make the restraint process as least distressing as possible for the young person when they did have to use manual restraint (e.g., explaining to the young person what is happening, ensuring that the young person is dignified in restraint). Such compassionate manual restraint practice may have helped young people to genuinely understand that manual restraint was being used in their best interests rather than unfairly, unnecessarily or pre-emptively, and consequently, contributed to the preservation of the staff-young person therapeutic relationship; my formulation here is supported by a previous study on patients' experiences of manual restraint where patients reported feeling less anger towards staff and being more accepting of manual restraint during incidents where they felt that they had been restrained for fair and legitimate reasons (Knowles et al., 2015). Secondly, all participants described first-hand experiences of manual restraint in which the young person appeared to experience the restraint and its physical contact element as therapeutic, and in which the young person appeared to intentionally elicit a restraint response from staff. These compelling findings not only provide a potential part-explanation for the minimal therapeutic relationship damage of manual restraint observed in this study (at least from the young person's side), but are also supported by a limited body of previous manual restraint studies in adult and child and/or adolescent service user settings. These studies have similarly

highlighted how some service users, as perceived by staff, may intentionally behave in particular ways to elicit manual restraint, and use manual restraint as a means to meet their physical touch and emotional needs (Hawkins et al., 2005; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008). Thirdly, nearly all participants described understanding young people's physical aggression towards staff during manual restraint incidents in compassionate ways, such as in the context of their mental health difficulties and the coerciveness of the manual restraint process. This ability of the participants to put themselves in the young person's shoes may have helped preserve the staff-young person therapeutic relationship from the staff side following manual restraint incidents where participants or their colleagues had been subjected to physical aggression by young people. Finally, all the nursing staff in this study described practices of verbally debriefing with young people following manual restraint incidents, and more than half of participants explicitly described the important role that such post-restraint practices played in preserving the staff-young person therapeutic relationship. Thus, in the context of these findings, it is perhaps not so surprising that the theme "It doesn't really damage the therapeutic relationship" was generated. The important role played by service user-involving-post-restraint practices (e.g., debriefing with the service user) in minimising damage to the therapeutic relationship has been highlighted in a residential childcare study (Steckley & Kendrick, 2008), and recognised by the Restraint Reduction Network (2022) through the recent release of their post-incident debriefing guidance for staff.

A further controversial finding from this study was that one third of participants described experiences where their use of manual restraint had surprisingly strengthened their relationships with young people, profoundly conflicting with what service users have reported in the manual restraint literature (Brophy et al., 2016; Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002; Wilson et al., 2017). Notwithstanding, these

unorthodox findings are supported by a small body of previous research in adult and child and/or adolescent service user settings where staff have reported improvements in the staff-patient therapeutic relationship following incidents of manual restraint (Bigwood & Crowe, 2008; Steckley & Kendrick, 2008). The aforementioned third of participants in this study struggled to come to an understanding of *how* manual restraint had strengthened their relationships with young people. However, two participants were able to identify that their use of manual restraint had brought them closer to young people at their most vulnerable times, and hence presumably strengthened their therapeutic relationships. Although the above discussed findings are highly unorthodox, they are, to a degree, somewhat understandable when considered in the context of the aforementioned compassionate manual restraint practices that the participants reported adopting, which, as I have already reported, may have communicated to young people that manual restraint was being used in their best interests.

Importance of Team Support

A principal finding from this study concerned the reported importance of support from colleagues in the context of using manual restraint. It was clear from the analysis that manual restraint was a practice that required team support in its execution, and team support in its emotional management in relation to the adverse staff consequence of its use. The importance of teamworking processes such as communication, coordination and observation were reported by all participants as being crucial to the safe and successful execution of manual restraint, and some participants made a distinction between working with a "good" or "strong" team and working with a less skilled and unfamiliar team in the observed standard of manual restraint practice. For instance, some participants described how working with the former team could result in team decisions being made non-verbally about using manual restraint in the moment, and other participants described how working in the latter team could

result in a physically taxing manual restraint for some members of the restraint team. The above cluster of findings have not been explicitly reported in previous manual restraint research; consequently, I wonder whether the aforementioned teamworking processes may represent a taken for granted aspect of manual restraint practice on the part of healthcare staff and researchers. Notwithstanding, one previous pilot study exploring staff and patients' experiences of manual restraint in an inpatient adult mental health care setting did explicitly, albeit briefly, report on the importance of "good teamwork" processes in the execution of manual restraint (Bonner et al., 2002, p. 469).

A substantive finding from this study concerned how regularly the participants reported giving and receiving practical and informal verbal emotional support to and from their colleagues in the context of using manual restraint; this appeared to create a 'looking out for each other' culture, hence the selection of this subtheme name. It was apparent from the analysis that the informal verbal emotional support that the majority of participants reported receiving from and providing to their colleagues in the aftermath of manual restraint incidents played an important emotion regulatory role in the downregulation of unpleasant emotions prompted by using manual restraint (e.g., participants' reports of feeling better after talking to their colleagues). This informal emotional support and its accessibility likely represented an important coping resource for the nursing staff in this study, especially in the context of the reported infrequency at which formal post-restraint staff debriefing meetings were held, consequent to time and staffing level limitations. The above aggregate of findings are in line with that of previous manual restraint research which have highlighted the importance of informal colleague support in coping with manual restraint incidents, and the emotion regulatory function that this form of support serves (Bigwood & Crowe, 2008; Kodua et al., 2020; Sequeira & Halstead, 2004). However, these previous studies have failed to highlight

so prevailingly the reciprocal hallmark of colleague emotional and practical support described by the participants in the present study.

Part Two: Implications, Limitations and Strengths of the Study

Practice Implications

In the section herein, I discuss the practice implications of the findings from this study. The following practice implications are discussed: support for nursing staff; manual restraint minimisation efforts; preserving the therapeutic relationship; and the findings as an information tool of the challenges of manual restraint use.

Support for Nursing Staff

The findings highlighted the adverse psychological and physical outcomes that the participants in this study experienced (emotional distress, physical aggression, physical exhaustion, pain and injury) as a result of manually restraining young people. Although the participants reported valuing the emotional and practical support that they received from their nursing colleagues on an informal basis, they did not describe receiving any formal forms of support from the hospitals in which they worked. Moreover, the participants described the scarcity at which formal post-restraint staff debriefing meetings took place on their wards consequent to time and staffing level limitations. This was in spite of the emotional support that such staff debriefing meetings reportedly provided participants when they did occur. In light of these findings, it is important that inpatient child and/or adolescent mental health care service providers sufficiently support their frontline nursing staff, as opposed to leaving their staff to rely exclusively on the informal support of their colleagues. Support can include

access to sufficient supervision, post-restraint staff debriefing meetings, and optional group reflective practice sessions (e.g., delivered by ward psychologist/psychological therapist) during working hours, as well as the required staffing levels to allow these practices to occur. The adoption of such approaches by inpatient child and/or adolescent mental health care service providers could help frontline nursing staff feel valued and supported by their employers. This is critically important in light of the high staff turnover rates that may result in a healthcare organisation where frontline nursing staff feel unsupported and unvalued by their employers (Eriksson et al., 2022).

Manual Restraint Minimisation Efforts

The findings convincingly showed that the nursing staff in this study genuinely used manual restraint as a last resort intervention wherever possible to keep young people and staff safe from significant harm, despite the probable conflict that they faced between needing to sometimes use manual restraint and disliking its use. This finding occurred in spite of the high reported rates of restrictive interventions in inpatient child and adolescent mental health care settings (LeBel et al., 2004; NHS Digital, n.d.), indicating that the nursing staff in this study were probably already working hard to minimise the use of manual restraint. In light of these findings, it would be important that implementors of manual restraint minimisation programmes such as ‘Safewards’ (Bowers, 2014), ‘No Force First’ (Ashcraft & Anthony, 2008; Haines-Delmont et al., 2022) and ‘REsTRAIN YOURSELF’ (Duxbury et al., 2019a) adopt a ‘nursing staff are doing their best with what they have’ assumption when implementing such programmes in child and/or adolescent mental health wards and beyond. This might involve adapting the delivery and content of such programmes to ensure that they: explicitly acknowledge the manual restraint-related challenges that nursing staff might face (e.g., emotional distress); explicitly recognise that manual restraint cannot always be avoided

in some circumstances; and explicitly validate the efforts that nursing staff might have already made to limit manual restraint, as opposed to focusing disproportionately on change and the benefits of manual restraint reduction. These adaptions may help nursing staff feel more understood by manual restraint minimisation programmes, and consequently, become less prone to interpreting these programmes as "an unfounded criticism of their professionalism" and practice (Duxbury et al., 2019b, p. 848). Such an approach may ultimately improve the willingness of nursing staff towards adopting the values and practices of these programmes, which in turn could translate into improved manual restraint reduction outcomes beyond the 19-26% that have been observed in the manual restraint minimisation programme research literature (Bowers et al., 2015; Duxbury et al., 2019a; Haines-Delmont et al., 2022). Indeed, individuals are far more likely to be willing to change when they feel heard and validated (Bertolino, 2018; Day, 2008).

The findings indicated that three participants across two hospital sites had witnessed agency and bank members of nursing staff use manual restraint prematurely to manage patient deliberate self-harm behaviour. This observation was reported despite all participants' convincing first-hand descriptions of they themselves using manual restraint only as a last resort. These findings indicate that manual restraint minimisation programmes implemented onto child and/or adolescent mental health wards and beyond also need to target agency and bank members of nursing staff (as opposed to solely permanent nursing staff) in their training and education components in order to have the greatest effect in reducing premature and avoidable manual restraint practices. However, given the temporary and rolling nature of bank and agency staff, such an approach might be extremely difficult to achieve and would require each ward to implement a rolling-based manual restraint minimisation educational programme. Notwithstanding, alternatives ways of targeting bank and agency staff could involve the role out of agency company-delivered and NHS Professionals-delivered

mandatory manual restraint minimisation programme training; this would ensure that all agency and bank staff are manual restraint minimisation programme trained at the point of working their shifts, regardless of where they work. Additionally, it might also be effective for mental health wards to implement procedures where agency and bank members of nursing staff are briefed on the implemented manual restraint minimisation practices of the ward during nursing handover meetings; this then could help to ensure consistency in the manual restraint practices amongst agency/bank and permanent staff, and consequently, reduce the use of premature and avoidable restraint practices. The above such approaches could help further improve the 19-26% manual restraint reduction rates that have been reported in the manual restraint minimisation programme literature (Bowers et al., 2015; Duxbury et al., 2019a; Haines-Delmont et al., 2022). The aforementioned points are critically important in the context of the nearly 40,000 current unfilled NHS nursing roles (Hacker, 2022), and consequently, the increased need to rely on agency and bank members of staff in the NHS nursing staff workforce.

The analysis indicated that the participants used manual restraint as a safety management strategy predominately in response to patient deliberate self-harm and physically aggressive behaviour. The social systems theory would argue that the participants' use of manual restraint was an important stabilising influence in maintaining homeostasis of the inpatient adolescent ward social system, rather than 'the problem'. Nijman et al's (1999) clinical explanatory model of patient aggression would view the participants' use of manual restraint both as a management strategy for patient aggression and as an inadvertent reinforcer of the very environmental and interpersonal ward stressors contributing to patient aggression in the first place. Therefore, from the findings of this study, and by the assumptions of the social systems theory and Nijman et al's (1999) model, in order to reduce manual restraint effectively within inpatient adolescent mental health care and beyond,

manual restraint minimisation programmes also need to equip staff with the skills to reduce patient deliberate self-harm and physical aggression on their wards. This might involve teaching nursing staff therapeutic communication skills to reduce the staff-patient interpersonal stressors contributing to patient aggression, and equipping nursing staff with the clinical skills to coach patients to regulate their emotions and communicate their needs through more adaptive means other than self-harm and/or aggressive behaviour. The above approaches could help reduce the need for restrictive interventions such as manual restraint, and consequently, from an operant conditioning perspective, the reinforcing consequences keeping these interventions in repeated use. Indeed, if a behaviour (e.g., use of manual restraint) stops occurring or starts occurring less frequently, then the reinforcing consequences increasing the likelihood of the said behaviour occurring again also stop occurring or occur less frequently, leading to the eventual elimination or reduction of the behaviour respectively.

Preserving the Therapeutic Relationship

The findings of this study offer a number of insights into how the staff-patient therapeutic relationship might be preserved in the context of manual restraint use. Specifically, the findings indicate that nursing staff can preserve their therapeutic relationships with patients by holding post-restraint verbal debriefing meetings with restrained patients, by genuinely and clearly using less restrictive alternatives to manual restraint wherever possible (e.g., grounding techniques and verbal de-escalation), by holding compassionate understandings of patients' physically aggressive behaviour during manual restraint incidents, and by adopting a compassionate and caring approach when using manual restraint (e.g., taking obvious actions to make restraint as least distressing for the patient as possible). These practices, as indicated by this study, may help communicate to patients that

manual restraint is being used in their best interests rather than vindictively, pre-emptively or unnecessarily, and may be paramount in minimising damage to the staff-patient therapeutic relationship, and preserving the said therapeutic relationship in the context of manual restraint use. Given that improved staff-patient therapeutic relationships can reduce the overall need for restrictive interventions such as manual restraint in the first place (Restraint Reduction Network, 2022), it is thus vital that manual restraint training and refresher training programmes clearly emphasise the importance of the aforementioned therapeutic relationship-preserving practices and approaches in their courses. Brief reminders of these practices and approaches could then be frequently recommunicated to nursing staff, for example, during nursing handover meetings to improve adherence.

Findings as an Information Tool of the Challenges of Manual Restraint Use

The findings of this study can be used as a useful source of information for inpatient child and/or adolescent mental health care: service providers, manual restraint training courses, and manual restraint minimisation programmes to illustrate the potential adverse physical and psychological outcomes that using manual restraint could pose to nursing staff. The lived experience insights from this study may help child and/or adolescent mental health care service providers to become more aware of the needs of their nursing staff, and consequently, take appropriate actions to support their staff. Additionally, the lived experience insights from this study may also help relevant manual restraint training providers and relevant manual restraint minimisation programme implementors to develop a greater understanding of the challenges that inpatient child and/or adolescent mental health care nursing staff might experience in the context of using manual restraint. This then might translate into a more compassionate approach being adopted in the delivery of such training,

which in turn might help nursing staff feel more understood, and consequently, more open to changing their manual restraint practice, if required.

Limitations and Research Implications

The findings of this study need to be considered in the light of a number of methodological limitations. In the following section, the limitations of this study are discussed and suggestions for future research are made on the basis of these limitations.

Exclusion of Agency and Bank Nursing Staff

The participants in this study were all permanent nursing staff as a result of the exclusion of agency and bank nursing staff from this study. Although this exclusion criteria was applied to ensure that only nursing staff with sufficient experience of using manual restraint within inpatient adolescent mental health care were recruited, the exclusion of agency and bank staff may have inadvertently limited the transferability of the findings to inpatient adolescent mental health care settings beyond the research setting, where agency and bank staff may constitute a significant portion of the nursing staff workforce. Moreover, the findings of this study, through the observation accounts of participants, suggested that agency and bank members of nursing staff were more likely to use manual restraint prematurely to manage patient risk behaviour. Consequently, valuable lived experience insights may have been missed due to the exclusion of these non-permanent staff. For example, could it be that agency and bank staff are more fearful when responding to patient risk behaviour in the context of their limited knowledge about individual patients, given their lack of opportunity to build strong therapeutic relationship with patients compared with more regular permanent staff?

In light of the above limitation, future research focusing on exploring the manual restraint experiences of agency and bank staff within inpatient mental health care would be valuable in following up on the findings of this study and in developing a greater understanding of the potential manual restraint practice differences, and the potential reasons for this, between permanent nursing staff and agency and bank nursing staff. Such research could contribute new insights towards the already established efforts to minimise manual restraint use. Additionally, future manual restraint research focusing on the recruitment of permanent, as well as bank and agency staff could generate findings that are more transferable to inpatient mental health care settings beyond the research setting. This could then allow for more effective implications and recommendations to be discussed and made.

Uneven Representation of Hospitals of Recruitment in Sample

The participants in this study were recruited from five wards across four hospital sites, albeit within the NHS, in an effort to achieve maximum variation. However, there was an uneven representation of participants across the hospital sites, with nearly half of the final recruited participants being from one ward within one hospital site. Consequently, the findings of this study may have more reflected the participant experiences of manual restraint from this single NHS ward and hospital site; this may have limited the breadth and scope of the themes and subthemes generated from this study. Despite this limitation, two-thirds of participants across three of four hospital sites responded to member checking requests, and these participants all reported that the generated themes and subthemes had accurately captured their experiences. Notwithstanding, further research exploring staff's experiences of manual restraint within different inpatient child and/or adolescent mental health wards, including both private and government funded wards, would be valuable in clarifying the extent to which the experience described in this study is common.

Lack of Inclusion of Young People's Manual Restraint Experiences

This study exclusively explored nursing staff members' experiences of manual restraint without also exploring young people's experiences of manual restraint. Consequently, the findings from this study purely represent the nursing staff participants' subjective truth and cannot be extended with certainty to reflect the subjective reality of young people also. For instance, the theme "it doesn't really damage the therapeutic relationship" cannot be assumed in a taken for granted manner to also represent the experiences of young people. This point is further strengthened by the fact that inpatient mental health care staff and patients have been found to have markedly different views and experiences of the same jointly experienced phenomena such as seclusion (Duxbury & Whittington, 2005). In light of the above limitation, further research that focuses on exploring the shared manual restraint experiences of both nursing staff and young people or the manual restraint experiences of young people alone in inpatient child and/or adolescent mental health care would be valuable in clarifying the extent to which the experience described in this study also represents the experiences of young people.

Self-Selected Sample

The participants in this study all volunteered to participate in this study of their own accord, with those who were interested making contact with me, and with those who were not interested not making contact. Thus, the participants in this study were self-selected. Consequently, the participants may have represented those with more negative or positive experiences or those who were more outspoken. Caution is thus needed when transferring the findings of this study to other inpatient adolescent mental health care settings. Further research exploring staff's experience of manual restraint that adopts a part-snowball sampling approach to participant recruitment may perhaps motivate nursing staff to participate in the

research who otherwise would not have volunteered. In this approach, existing nursing staff participants would be encouraged to recruit or refer their nursing staff colleagues to participate in the research (Naderifar et al., 2017).

Videoconference Format of Interviews

As a result of the University of Essex COVID-19 safety policy limiting face-to-face research at the time of this study, all participant interviews were conducted exclusively over videoconference using the zoom platform. This may have negatively impacted on the richness of data collected, given the internet connection issues that occurred in some of the interviews (screen freezes and skipping, slurring audio), the virtual format of the interviews, and the difficulties that I had observing, and consequently responding sensitively to the off-camera below-the-neck body language of participants. Despite these limitations, I established a good rapport with participants in all interviews, and all participants spoke openly and richly about their manual restraint experiences, with the mean length of interviews coming in at 71 minutes. Although research has found face-to-face interviews only to be marginally superior to videoconference interviews (Krouwel et al., 2019), further research on staff's experiences of manual restraint adopting a face-to-face interview format might perhaps produce richer data.

Strengths of the Study

Despite the mentioned limitations, this study has a number of key strengths. Firstly, this study recruited a demographically diverse range of participants with respect to age, gender, duration of experience, nursing job grade and manual restraint training. Additionally, the participants were recruited from a total of five wards across four hospital sites spanning three distinct NHS Trusts. With this degree of maximum variation being achieved within the

sample, the themes generated in this study likely reflected elements of the participants' experiences of using manual restraint that were common and invariant across perception: the "essences" of their experiences. The generation of such themes are in line with the selected descriptive phenomenology methodology, and arguably increase the transferability of the findings to other inpatient child and/or adolescent mental health care settings.

Secondly, my dual position as an insider researcher (consequent to my past lived experience of using manual restraint in child and adolescent mental health care as a nursing staff, and my working on one of the wards of participant recruitment as a trainee clinical psychologist at the time of the study) and an outsider researcher (consequent to my current non-nursing role as a trainee clinical psychologist), and my disclosure of the former and latter to participants in this study allowed me to build a good rapport with participants and enter the world of their language during the interviews, while at the same time, remaining within the role of a researcher. I believe that this allowed for the collection of rich data from participants despite the virtual format of the interviews and enabled me to approach the analysis as both an insider and outsider. Moreover, my adoption of several bracketing procedures in the form of maintaining a mindfulness practice stance throughout the research and participating in, and analysing a personal reflective interview about my own previous lived experience of using manual restraint, helped me to become more aware of my insider status-routed-presuppositions and assumptions. I believe that this helped to reduce the profound influence of my presuppositions on the findings generated in this study.

Finally, to my knowledge, this study is the first to explore nursing staff's experiences of using manual restraint within general adolescent inpatient mental health care, despite the high reported rates of restricted interventions used in these settings (LeBel et al., 2004; NHS Digital, n.d.). Consequently, this study makes an original contribution to the already limited research literature on staff's experience of manual restraint and offers some unique lived

experience insights into the manual restraint practices within inpatient adolescent mental health care.

Part Three: Final Reflections and Conclusion

Final Reflections

This thesis represents the first doctorate level research project that I have conducted, the first 40,000 word piece of academic work that I have written, and the second time that I have had the privilege to conduct research in an area of my own choosing. Consequently, I have been personally and professionally invested in this thesis from its inception to its submission, and have found the entire process to be very rewarding.

Throughout the research process, I was very aware of my personal interest in the research topic, which I acknowledge partly stemmed from my own aversive previous experiences of using manual restraint within inpatient child and adolescent mental health care. Fortunately, my ongoing mindfulness practice experience helped me to become more aware of my pre-formed assumptions and preconceptions on the research topic to a degree that I believe likely reduced the profound influence of them on the findings of the study. Moreover, I was also very much aware of my desire to not intentionally or unintentionally position myself as a “saviour” in this research for the nursing staff participants; I simply wanted to describe their lived experiences of manual restraint as they themselves had reported. I believe that my decision to adopt a descriptive phenomenology rather than an interpretive phenomenology methodology was influenced by the former and latter points.

I will now reflect on two key moments. During the participant interviews and analysis phases of this study, I felt a noticeable degree of sadness when hearing and reading about the

participants' experiences of physical aggression and physical injury during manual restraint incidents. Hearing and reading about such experiences had prompted my mind to produce memories of my own experiences of physical aggression and physical injury during manual restraint. I also noticed, within the participant interviews, that I felt a strong urge to shift into "therapist mode" by desiring to offer support and validation to participants in these moments. Owing to my ongoing mindfulness practice experience, I was very pleased that I was able to notice the above memories and urges within myself, and then non-judgementally refocus my attention back to participants' descriptions and back to my position as a researcher. I believe that this repeated process of noticing what my mind was doing and bringing it back, helped me to refrain from asking leading questions based on my own assumptions during interviews, and helped me generate themes that were, as far as possible, grounded within the data during the analysis stage of the research. Of course, I acknowledge that my previous experiences would have had some influence on the generated findings.

Throughout this thesis, I have intentionally taken a juxtaposition by referring to my and the nursing staff participants' experiences of using manual restraint as my and their "lived experience". Indeed, there are over 25 instances of my use of this language in the thesis. My intention here was certainly not to minimise the perspectives of survivors of inpatient mental health services and manual restraint, to whom the term "lived experience" has typically belonged to within the manual restraint literature. I do sincerely apologise to any readers that my juxtaposed language might have offended. At the same time, I believe that mental healthcare staff can have "lived experience" too. Caring for self-harming and/or suicidal and/or aggressive patients undeniably comes with psychological and physical challenges that staff "live through"; this thesis and the previous research literature has highlighted this. I believe that in order to solve problems such as manual restraint misuse, it is more effective to understand both healthcare staff's and patients' perspectives rather than

privileging one perspective over the other through the non-inclusive use of terms such as "lived experience". I hold a dialectical worldview and believe that two conflicting things can both be true at the same time. To this end, I believe that manual restraint is distressing for patients AND staff, and that by searching for a synthesis between these two truths, we can be more effective in our journey towards minimising manual restraint for the benefit of all those involved.

I feel that I have gained an unanticipated amount of knowledge about qualitative research and manual restraint during the course of this research journey; the version of myself writing this reflective piece is certainly not the same version of myself that drafted the initial research proposal for this study. I feel a degree of satisfaction learning that my own previous lived experiences of manual restraint shared some similarities with the nursing staff participants in this study.

Conclusion

To the best of my knowledge, this research thesis reports on the first study to explore healthcare staff's experiences of using manual restraint within a general child and/or adolescent inpatient mental health care context. The current study thereby adds to the limited literature base on healthcare staff's experiences of manual restraint and provides valuable insight into the experience of using manual restraint within inpatient adolescent mental health care. This is an important contribution to the literature in the context of the increased need to minimise manual restraint practice globally, and the substantially elevated reported incident rates of restrictive interventions in child and adolescent inpatient mental health care settings. By far the most original yet controversial finding in this study concerned the majority of the nursing staff's descriptions that manual restraint was non-damaging to the staff-patient therapeutic relationship in the long-term. Although this unorthodox finding generates some

useful practice implications on how the therapeutic relationship might be preserved by staff in the context of their manual restraint practice (e.g., post-restraint debriefing with the patient), I urge that readers treat this finding with caution, given that the voices of young people were missing in this study. The findings from this study, as a whole, suggest that using manual restraint within inpatient adolescent mental health care, whilst deemed as sometimes necessary for the protection of young people and staff from significant harm, was a disliked emotionally and physically aversive practice for the nursing staff in this study. The findings have generated several key practice and research implications including: the need for healthcare organisations to adequately support their nursing staff, the need for further research on young people's and temporary nursing staff's experiences of manual restraint, and the need for manual restraint minimisation programme implementers to also target temporary nursing staff for intervention. Throughout this thesis, I have intentionally taken a juxtaposition by referring to the nursing staff participants' experiences of manual restraint as their "lived experience". I have not done this to discredit the experiences of service users; rather, I have used such language to acknowledge the psychological and physical challenges that nursing staff "live through" too consequent to their manual restraint practice.

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APPENDICES

Appendix A: Interview Schedule

1. Can you describe to me, in as much detail as you can, what (manually) physically restraining a young person involves?
    - Prompt: How does it begin?
    - Prompt: How does it end?
    - Prompt: How long does it take?
    - Prompt: Does it differ from young person to young person?

2. Can you tell me about a typical time where you were involved in (manually) physically restraining a young person at the [HOSPITAL NAME]?
    - Prompt: What was it like physically?
    - Prompt: How did you feel before/during/after?
    - Prompt: Thoughts before/during/after?

3. Could you tell me about the first time you remember where you were involved in (manually) physically restraining a young person?
    - Prompt: What was it like physically?
    - Prompt: How did you feel before/during/after the procedure?
    - Prompt: Thoughts before/during/after?
    - Prompt: How did it compare to your most recent instances?

4. Can you tell me about the best instance(s) where you were involved in (manually) physically restraining a young person at the [HOSPITAL NAME]?
    - Prompt: What was it like physically?
    - Prompt: How did you feel before/during/after the procedure?
    - Prompt: Thoughts before/during/after?

5. Can you tell me about the worst instance(s) where you were involved in (manually) physically restraining a young person at the [HOSPITAL NAME]?
    - Prompt: What was it like physically?
    - Prompt: How did you feel before/during/after the procedure?
    - Prompt: Thoughts before/during/after?

6. Can you tell me what your therapeutic relationship has been like with young people who you have restrained on multiple occasions at the [HOSPITAL NAME]?
    - Prompt: How does it compare to your relationship with other young people who you have rarely restrained?

7. Can you tell me about your views towards the use of (manual) physical restraint within adolescent inpatient mental health settings?
    - Prompt: Do you think that are any alternatives to (manual) physical restraint?

Appendix B: Recruitment Email Advertisement

Email Subject: An opportunity to talk about your Physical Restraint experience!

Dear nursing staff

Michael Kodua, a trainee clinical psychologist at the University of Essex, is conducting a research study exploring nursing staff's experiences of using manual physical restraint within adolescent inpatient mental health settings. The study is being conducted as part of a doctorate course in Clinical Psychology and is being sponsored by the University of Essex.

- **Are you a permanent nurse, healthcare assistant or support worker with experience of using Manual Physical Restraint at [HOSPITAL NAME]?**
- **Have you worked at [HOSPITAL NAME] for at least 6 months?**
- **Are you happy to talk about your experiences of Manual Physical Restraint?**

If you answered **'YES'** to all the above, please have a read of the attached participant information sheet for further information. Participating in this study will involve filling out a demographic questionnaire and having a video-conference or telephone interview lasting up to 90 minutes.

If you would like more information or you are interested in participating, please don't hesitate to contact Michael via the contact details below:

[EMAIL ADDRESS]
[PHONE NUMBER]

Kind regards

[CLINICAL PSYCHOLOGIST OF THE HOSPITAL]

Appendix C: Recruitment Poster Advertisement

University of Essex

WE WOULD LIKE TO HEAR ABOUT YOUR EXPERIENCES OF USING PHYSICAL RESTRAINT

Are you a permanent nurse, healthcare assistant or support worker with experience of using Physical Restraint at [NAME OF HOSPITAL]?

Have you worked at [NAME OF HOSPITAL] for at least 6 months?

Are you happy to talk about your experiences of Physical Restraint?

If you answered 'YES' to all the above

We would like to invite you to participate in a research study exploring Nursing Staff's Experiences of using Manual Physical Restraint within Adolescent Inpatient Mental Health Settings. The research study is being sponsored by the University of Essex and is being conducted by Michael Kodua (Trainee Clinical Psychologist), as part of a Doctorate course in Clinical Psychology.

Participating will involve having a video-conference or telephone interview lasting up to 90 minutes

If you would like more information or you are interested in participating, please contact Michael on:
Tel: [TELEPHONE NUMBER]
Email: [EMAIL ADDRESS]

Appendix D: Participant Information Sheet

Chief Investigator:
Michael Kodua
Trainee Clinical Psychologist
University of Essex
Email: [EMAIL ADDRESS]
Tel: [TELEPHONE NUMBER]

PARTICIPANT INFORMATION SHEET

Research Title: Nursing Staff's Expereinces of Using Manual Physical Restraint within Adolescent Inpatient Mental Health Care

Chief Investigator: Michael Kodua, Trainee Clinical Psychologist

You have been invited to participate in a research study that is being sponsored by the University of Essex and being conducted by Michael Kodua as part of a Doctorate course in Clinical Psychology. Before you decide whether to participate, it is important that you understand what the research is about and what it will involve. Please take your time to read the following information carefully.

What is the purpose of this study?

This study aims to explore nursing staff members' experiences of using manual physical restraint within adolescent inpatient mental health settings. It is hoped that this research will help to identify the potential training and support needs of staff in relation to restraint use within inpatient adolescent mental health settings. This research study has been reviewed and given favourable opinion by the NHS Research Ethics Committee and the University of Essex Research Ethics Committee.

Why have I been chosen?

You have been chosen because you are a permanent nursing staff member (e.g., nurse, healthcare assistant, support worker, etc) at [NAME OF HOSPITAL] and your job role involves using manual physical restraint. We require that you have at least six months' experience of working in [NAME OF HOSPITAL]. We are very interested in hearing about your experiences.

What will happen to me if I decide to take part?

You will be required to partake in a single confidential audio-recorded video-conference or telephone interview session from the comfort of your home or a private confidential space at a time and date that works best for you. The interview session will be held by Michael Kodua and last up to 90 minutes. In the interview, you will be asked questions about your experiences of using manual physical restraint within [NAME OF HOSPITAL]; you do not have to answer any questions that you do not wish to. You will also be asked to provide anonymous details of your job title, education, age, gender, ethnicity, restraint training, and the duration of your work experience at [NAME OF HOSPITAL]; you do not have to provide any details that you do not wish to. At the end of the study, you will receive verbal and written debriefing information.

You will have the choice of attending the interview through a telephone call or through video-conference using the Zoom video-conferencing platform. In order to attend a video-conference interview through Zoom, you would need to have an IPhone smartphone, Android smartphone or laptop/computer with a front facing camera and internet access. You will also need to

download the Zoom application and create a Zoom account with an email address, if you do not already have an account.

Do I have to participate?

No, participation is entirely voluntary. If you do decide to participate, you are free to withdraw at any time before or during your interview without giving a reason. You are also free to withdraw any data that you may provide at any time following your participation in the study should you no longer wish for your data to be used. We reassure you that there will be no negative repercussions for your withdrawal.

What will happen to the information I provide?

The information you provide will be confidential, anonymised, typed into a transcript by the Chief Investigator, Michael Kodua and then analysed for the purpose of this study. Each interview transcript will be assigned a numerical code, and you will not be identifiable. The transcripts and audio files will be kept securely on a password protected computer with only the research team having access to it. All audio files will be destroyed after they have been transcribed. Your anonymised interview transcript data and anonymous demographic data will be retained for 10 years, after which they will be destroyed. Anonymous quotes and extracts from your interview may be used in a written report of this study, or in an article to be published in an academic journal. However, these will be carefully selected to ensure that you cannot be identified. The findings of the study will be sent to you for verification after it has been analysed.

What will happen to my data?

Data protection regulation requires that we state the legal basis for processing information about you. In the case of research, this is 'a task in the public interest'. The University of Essex is the data controller and is responsible for looking after your information and using it properly. Sara Stock, (University of Essex Information Assurance Manager) is the data controller contact (email: dpo@essex.ac.uk).

We will need to use information from your interview for this research project. This information will include your reports of your experiences of using manual physical restraint within [NAME OF HOSPITAL], and your job title, education, age, gender, ethnicity, restraint training, and the duration of your work experience at [NAME OF HOSPITAL]. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are the benefits of participating?

We cannot promise that the study will provide any significant benefits. However, it is hoped that you will find sharing your experiences helpful. It is also hoped that the information you provide will help identify potential training and support needs of nursing staff in relation to their manual physical restraint use within adolescent inpatient mental health settings.

What are the possible disadvantages of participating?

There are no significant dangers of taking part. However, it is possible that you may become upset particularly if you are talking about something that you have found upsetting.

Factors that put yourself or others at risk

The information you provide during the interview will be kept confidential, unless you disclose any information that puts yourself or others at significant risk of harm. In these circumstances, the information may be shared to appropriate others such as your ward manager.

Further information and contact details

If you would like to participate, please contact the Chief Investigator of this research, Michael Kodua to arrange a suitable date and time for participation. If you would like more information before deciding whether to participate, please do not hesitate to contact Michael Kodua:

Chief Investigator: Michael Kodua, Trainee Clinical Psychologist, University of Essex Email: [EMAIL ADDRESS] Tel: [TELEPHONE NUMBER]

Research Supervisor: Dr Rebecca Alegbo, Lecturer in Clinical Psychology, University of Essex; Email: [EMAIL ADDRESS] Tel: [TELEPHONE NUMBER]

Research Supervisor: Dr Winifred Eboh, Senior Lecturer, School of Health and Social Care, University of Essex; Email: [EMAIL ADDRESS] Tel: [TELEPHONE NUMBER]

Concerns and Complaints

If you have any concerns about any aspect of this study or you have a complaint, in the first instance please contact Michael Kodua, the Chief Investigator of the research, using the contact details above. If you are still concerned or you think that your complaint has not been addressed to your satisfaction or you feel that you cannot approach the Chief Investigator, please contact the University of Essex, School of Health and Social Care departmental Director of Research, Dr Camille Cronin (email: [EMAIL ADDRESS]). If you are still not satisfied, please contact the University of Essex's Research Governance and Planning Manager, Sarah Manning-Press (email: [EMAIL ADDRESS]). Please include the ERAMS number which can be found at the foot of this page.

University of Essex

Thank you for considering to take part.

Appendix E: Electronic Participant Consent Form

University of Essex

PARTICIPANT CONSENT FORM

Research Title: Nursing Staff's Experiences of Using Manual Physical Restraint within Adolescent Inpatient Mental Health Care

Chief Investigator: Michael Kodua, Trainee Clinical Psychologist

I agree with the below statements (please write your initials in the adjacent boxes to the right of each statement if you agree):

1. I confirm that I have carefully read and understood the information sheet for the above research study	
2. I confirm that I have had the opportunity to ask questions, and have received satisfactory answers	
3. I understand that my participation in the above research study is entirely voluntary, and I am free to withdraw at any point in time without giving a reason	
4. I understand that this research study will involve partaking in an interview with the researcher which will be audio-recorded	
5. I understand that I do not have to answer any questions I do not wish to in participating in the above study	
6. I understand that I will not be identifiable in any written report of this research study or any publications arising from it	
7. I understand that any information I provide in the above research study will be kept confidential, unless I disclose information that puts myself or others at significant risk of harm	
8. I give permission for my anonymised quote(s) to be used in any written report or publication	
9. I consent to taking part in the above research study	

	Name	Date	Signature
Participant			
Person taking Consent			

ERAMS Number: ETH2021-0782

Appendix F: Participant Debrief Sheet

University of Essex

PARTICIPANT DEBRIEF SHEET

Research Title: Nursing Staff's Expereinces of Using Manual Physical Restraint within Adolescent Inpatient Mental Health Care

Thank you for taking part in this research study which aims to explore nursing staff members' experiences of using manual physical restraint within adolescent inpatient mental health settings.

What happens next?

The information you have provided will be anonymised, typed into a transcript by the Chief Investigator of this research, Michael Kodua and then analysed for the purpose of this study. The transcripts and audio files will be kept securely on a password protected computer with only the research team having access to it. All audio files will be destroyed after they have been transcribed. Your anonymised interview transcript data and anonymous demographic data will be retained for 10 years after which they will be destroyed. Anonymous quotes and extracts of your interview may be used in a written report of this study, or in an article to be published in an academic journal. However, these will be carefully selected to ensure that you cannot be identified. Any research documents with your personal information such as consent forms, will be stored securely as password protected PDF files on a secure University of Essex personal computer for 3 years after the end of this study. You can request for your data to be withdrawn from this study at any time without giving a reason, and without any negative repercussions.

The findings of the study will be sent to you for verification after it has been analysed. Additionally, the completed written report of the study can be sent to you once it has been written up, should you wish.

Context of this study

Manual physical restraint tends to be used by inpatient mental health nursing staff to prevent harm to patients and staff, and to administer medications and other treatments. Previous research exploring staff's experiences of manual physical restraint has highlighted the adverse physical and psychological staff consequences associated with its use such as the subjection to physical exhaustion, pain and injury, and the experience of unpleasant emotions.

There is a paucity of research exploring staff's experiences of manual physical restraint within child and/or adolescent inpatient mental health settings. Hence, the interview you participated in was designed to gain insight into this phenomenon. It is hoped that this study can help to identify some of the training and support needs of nursing staff who use manual physical restraint within adolescent inpatient mental health settings.

Wellbeing Support

We would encourage you to seek support at your NHS trust specific staff support/wellbeing service, should you wish to do so. Moreover, if you feel you would like professional psychological support to manage restraint related distress, please visit the NHS Improving Access to Psychological Therapies website (www.nhs.uk/service-search/find-a-psychological-therapies-service), where you can make a self-referral. Additionally, we would also encourage you to discuss any difficulties you may have with your supervisor or ward manager.

Concerns and Complaints

If you have any concerns about any aspect of this study or you have a complaint, in the first instance please contact Michael Kodua, the Chief Investigator of the research, using the relevant contact details below. If you are still concerned or you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the Chief Investigator, please contact the University of Essex, School of Health and Social Care departmental Director of Research, Dr Camille Cronin (email: [EMAIL ADDRESS]). If you are still not satisfied, please contact the University of Essex's Research Governance and Planning Manager, Sarah Manning-Press (email: [EMAIL ADDRESS]). Please include the ERAMS number which can be found at the foot of this page.

Chief Investigator: Michael Kodua, Trainee Clinical Psychologist, University of Essex
Email: [EMAIL ADDRESS] Tel: [TELEPHONE NUMBER]

Research Supervisor: Dr Rebecca Alegbo, Lecturer in Clinical Psychology, University of Essex; Email: [EMAIL ADDRESS] Tel: [TELEPHONE NUMBER]

Research Supervisor: Dr Winifred Eboh, Senior Lecturer, School of Health and Social Care, University of Essex; Email: [EMAIL ADDRESS] Tel: [TELEPHONE NUMBER]

University of Essex

Thank you for taking part in this research

Appendix G: Participant Demographic Questionnaire

University of Essex

Anonymous Participant Demographic Form

Please answer the questions below. You do not have to answer any questions you do not wish to

1. **What is your job title? (e.g., senior healthcare assistant)**

2. **How would you describe your gender? (e.g., female)**

3. **How old are you? (e.g., 38 years)**

4. **How would you describe your ethnicity? (e.g., White British)**

5. **How many months have you been working at the [NAME OF HOSPITAL]? (e.g., 36 months)**

6. **Approximate details about your manual physical restraint training at the [NAME OF HOSPITAL]? (e.g., 2 days training every year)**

7. **What is your level of education? Please circle all relevant options**

   - Doctoral Degree
   - Masters Degree
   - Undergraduate Degree
   - College/Secondary School Education or equivalent
   - Other (please specify)

Appendix H: Braun and Clarke's (2006) 15-Point Checklist for Quality of Thematic Analysis

Transcription	1.	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.	Yes – all transcripts were transcribed verbatim and checked several times against the audio recording for accuracy.
Coding	2.	Each data item has been given equal attention in the coding process.	Yes – each meaningful unit was given equal attention in coding process. Data were initially coded twice to ensure this.
	3.	Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive.	Yes – Data were initially coded twice to ensure this. Themes were thoroughly reviewed at the level of the coded collated data extracts.
	4.	All relevant extracts for each theme have been collated.	Yes – Data were initially coded twice to ensure this. Themes were thoroughly reviewed at the level of the coded collated data extracts
	5.	Themes have been checked against each other and back to the original data set.	Yes – Themes were thoroughly reviewed against the level of the collated data extracts, and the entire dataset of the interview transcripts
	6.	Themes are internally coherent, consistent, and distinctive.	Yes – this was confirmed by my thesis supervisor.
Analysis	7.	Data have been analysed rather than just paraphrased or described.	Yes – even though this was a descriptive phenomenology study, clear patterns in the data were presented within an analytical narrative that did not just paraphrase the data.

	8.	Analysis and data match each other – the extracts illustrate the analytic claims.	Yes – the extracts illustrate the analytical narratives accurately.
	9.	Analysis tells a convincing and well-organised story about the data and topic.	Yes – the analysis tells a coherent and convincing story about the phenomenon under study.
	10.	A good balance between analytic narrative and illustrative extracts is provided.	Yes – there is a good balance. Extracts have not been added to 'explain themselves'.
Overall	11.	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.	Yes – the entire analysis occurred over approx. a 6-month period.
Written report	12.	The assumptions about, and specific approach, thematic analysis are clearly explicated.	Yes – clear indication of reflexive thematic analysis and its grounded assumptions in the context of this study.
	13.	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.	Yes – rich detailed description of analytical process is provided with evidence of examples of memo notes, assigned codes and a photo.
	14.	The language and concepts used in the report are consistent with the epistemological position of the analysis.	Yes – the language appears to be consistent with a critical realist and interpretivist ontology and epistemology respectively.
	15.	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.	Yes – clear reference of the researcher "generating" themes. First person language predominantly used to illustrate researcher's role in knowledge production.

(Braun & Clark, 2006, p. 96)

Appendix I: HRA and HCRW Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr Michael Kodua
[redacted]

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

10 December 2020

Dear Mr Kodua

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Nursing Staff's Experiences of Administering Manual Physical Restraint within Adolescent Inpatient Mental Health Care**
IRAS project ID:	**285802**
Protocol number:	**N/A**
REC reference:	**20/PR/0733**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

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

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **285802**. Please quote this on all correspondence.

Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Sarah Manning-Press*

List of Documents

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

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Email Advertisement]	1	11 October 2020
Copies of advertisement materials for research participants [Poster Advertisement]	1	11 October 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Uni Essex Insurance Certificate]	1	20 October 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Public Liability Insurance Evidence]		
Interview schedules or topic guides for participants [Interview Schedule]	1	11 October 2020
IRAS Application Form [IRAS_Form_02112020]		02 November 2020
IRAS Application Form XML file [IRAS_Form_02112020]		02 November 2020
Letter from sponsor [Sponsor Letter from University of Essex]	1	20 October 2020
Non-validated questionnaire [Participant Demographic Form]	1	11 October 2020
Organisation Information Document [Organisation Information Document]	V2	27 November 2020
Other [Participant Debrief Sheet]	V2	27 November 2020
Participant consent form [Participant Consent Form]	1	11 October 2020
Participant information sheet (PIS) [Participant Information Sheet]	3	09 December 2020
Referee's report or other scientific critique report [Report of Scientific Critique]	1	04 March 2020
Research protocol or project proposal [Project Proposal]	1	11 October 2020
Schedule of Events or SoECAT [HRA Assessed Version]	V1.0	01 December 2020
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	08 June 2020
Summary CV for student [Student CV]	1	08 June 2020
Summary CV for supervisor (student research) [Supervisor 2 CV]	1	23 August 2020
Summary CV for supervisor (student research) [Supervisor 1 CV]	1	23 August 2020

IRAS project ID	285802

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	Study funding will be provided to sites as per the Organisation Information Document	It is expected that a Local Collaborator would be appointed at study sites.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if focus groups/interviews were held in clinical areas. Letters of Access would not be expected if they were held in non-clinical/administrative buildings.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio. A certificate of Employers' Liability Insurance has been provided for the University of Essex.

Appendix J: University of Essex Research Ethics Committee Approval

University of Essex ERAMS

18/01/2021

Mr Michael Kodua

Health and Social Care

University of Essex

Dear Michael,

Ethics Committee Decision

I am writing to advise you that your research proposal entitled "Nursing Staff's Experiences of Administering Manual Physical Restraint within Adolescent Inpatient Mental Health Care" has been reviewed by the Ethics Sub Committee 1.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Gill Green

Ethics ETH2021-0782: Mr Michael Kodua