Check for updates

Received: 18 March 2023 | Revised: 28 May 2023 | Accepted: 10 June 2023

DOI: 10.1111/jan.15742

EMPIRICAL RESEARCH QUALITATIVE

JAN Leading Global Nursing Research WILEY

“It's not a nice thing to do, but…”: A phenomenological study of manual physical restraint within inpatient adolescent mental health care

Michael Kodua | Winifred Oluchukwu Eboh

School of Health and Social Care, University of Essex, Colchester, UK

Correspondence
Michael Kodua, School of Health and Social Care, University of Essex, Colchester CO4 3SQ, UK.
Email: michael.kodua@nhs.net

Abstract

Aim: To explore nursing staff's experiences of using manual (physical) restraint within inpatient adolescent mental health care.

Design: This was a descriptive phenomenological study.

Methods: Individual semi-structured interviews were conducted with 12 nursing staff between March 2021 and July 2021. The nursing staff were recruited from four inpatient adolescent mental health hospitals across three National Health Service Trusts in England. Interviews were transcribed verbatim and analysed using Braun and Clarke's reflexive approach to thematic analysis.

Results: Four themes were generated from the analysis: (1) it needs to be done sometimes; (2) it's not a nice thing to do; (3) it does not really damage the therapeutic relationship; and (4) importance of team support. Despite strongly 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 physical exhaustion. Participants reported relying on each other for emotional and practical support. Three participants reported observing premature restraint use by non-permanent staff.

Conclusion: The findings detail a paradoxical picture of the nursing staff's experiences where restraint is experienced as psychologically and physically aversive yet deemed as sometimes necessary to prevent significant harm.

Reporting Method: The Standards for Reporting Qualitative Research (SRQR) checklist was used to guide reporting.

Impact: This study suggests a need for the targeting of non-permanent staff for restraint minimization interventions, and highlights how the treatment of non-permanent staff by permanent staff may contribute to avoidable restraint practices. The findings indicate several ways in which the staff-young person therapeutic relationship can be preserved in the context of restraint. However, this needs to be treated with caution given that young people's voices were missing from this study.

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.
© 2023 The Authors. *Journal of Advanced Nursing* published by John Wiley & Sons Ltd.

Patient or Public Contribution: This study focused on nursing staff's experiences.

KEYWORDS
adolescent health, phenomenology, psychiatric nursing, qualitative approaches, restraint

1 | INTRODUCTION

Manual (physical) restraint is a restrictive intervention whereby one or more persons immobilize the free body movement of another by manually holding them (Stubbs & Paterson, 2011). This type of physical restraint is not to be confused with mechanical (physical) restraint whereby equipment (e.g., cuffs or belts) is used to immobilize movement (Ryan, 2010). Manual restraint is used internationally within inpatient mental health nursing and beyond to prevent harm to patients and staff, and to administer necessary treatments (Bowers et al., 2015; Chapman et al., 2016; Lombart et al., 2020). For instance, nursing staff may use manual restraint to manage patient aggression and deliberate self-harm, and in the provision of compulsory nasogastric feeding treatments for patients with severe eating disorders (Chapman et al., 2016; Kodua et al., 2020). Additionally, manual restraint is sometimes used in the application of other restrictive interventions because manual holding may be required in order to mechanically restrain, chemically restrain or seclude patients posing significant harm risks to themselves and/or others (Ryan, 2010). Despite the protective functions of manual restraint, its use has been associated with adverse patient and staff consequences, and an international calling to minimize manual restraint has arisen (Haw et al., 2011; Wilson et al., 2017). However, manual restraint remains in widespread use globally, and has been described as a "necessary evil" within the nursing literature (Perkins et al., 2012).

2 | BACKGROUND

The literature has illustrated numerous adverse physical and psychological patient and staff outcomes consequent to manual restraint use including staff and patient emotional distress (e.g., fear and anger), staff misuse (e.g., use of excessive force), staff and patient physical injury and pain (e.g., bruises and muscle aches), staff physical exhaustion, damage to staff-patient therapeutic relationship, and even patient death (Bigwood & Crowe, 2008; Duxbury et al., 2011; Haw et al., 2011; Knowles et al., 2015; Kodua et al., 2020; Wilson et al., 2017). Consequently, the international emergence of numerous policies, laws and programmes calling for a reduction in manual restraint is not surprising (e.g., Department of Health, 2014; Duxbury et al., 2019; Royal Australian and New Zealand College of Psychiatrists, 2021). Within the United Kingdom (UK), government policy mandates that manual restraint should only be used as a last resort when less restrictive alternatives have been exhausted, and that the use of restraint should be imposed for no longer than necessary and be proportionate to the risk presented (Department of Health, 2014). However, despite such policy, there is evidence to indicate that manual restraint is not always used as a last resort within the UK and beyond (Bigwood & Crowe, 2008; Wilson et al., 2017). Manual restraint minimization programmes arguably represent some of the most effective approaches to reduce manual restraint. Drawing from elements of trauma-informed care, these multi-modal programmes include "REsTRAIN Yourself", "Safewards" and "No Force First", and have been shown to reduce manual restraint rates by 19%–26% within inpatient mental health, older adult and learning disability settings (Bowers et al., 2015; Duxbury et al., 2019; Haines-Delmont et al., 2022).

Incident rates of manual restraint have been found to be substantially higher within inpatient child and adolescent mental health settings compared to inpatient adult mental health settings. For instance, a survey study of 25 child and adolescent psychiatric units in the United States found sixfold higher rates of restrictive interventions (inclusive of manual restraint) compared to adult psychiatric units in the same state (LeBel et al., 2004). Moreover, within the UK, between September 2021 and February 2022, sixfold higher rates of restrictive interventions (inclusive of manual restraint) were recorded in National Health Service (NHS) funded inpatient child and adolescent mental health services compared to analogously funded inpatient adult mental health services within the same period (NHS Digital, n.d.). Concerningly, these figures may indicate that manual restraint is not always being used as a last resort within inpatient child and adolescent mental health care.

Despite the high reported incident rates of manual restraint use within inpatient child and adolescent mental health care, this setting has received relatively little attention in the manual restraint research literature. We could only locate one qualitative study that explored young people's and/or staff's experiences of manual restraint within an inpatient child and/or adolescent mental health setting (Kodua et al., 2020). In this in-depth interview study of nursing assistants' experiences of using manual restraint, three themes were generated which highlighted the negative psychological, physical and interpersonal consequences of restraint: "an unpleasant practice", "importance of coping" and "becoming desensitized and sensitized". This study however exclusively focused on the use of manual restraint to provide compulsory nasogastric feeding to young people with anorexia within a specialist eating disorder unit; this limits the transferability of the findings to generic inpatient child and/or adolescent mental health settings where manual restraint is predominately used for other risk contingency purposes such as in the management of patient deliberate self-harm and aggressive behaviour.

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

3 | THE STUDY

3.1 | Aim

This study aimed to explore nursing staff's experiences of using manual restraint within inpatient adolescent mental health care. The research question was "How do nursing staff experience the practice of manually restraining adolescent patients within inpatient adolescent mental health care?"

3.2 | Design

We chose to adopt a qualitative methodology to allow for a rich exploration of nursing staff's experiences of manual restraint within a setting that remains under-researched. Specifically, descriptive phenomenology was applied as it focuses on describing the lived experience of participants without adding or subtracting from it, and places emphasis on the researcher attempting to bracket their presuppositions of the phenomena under study (Langdridge, 2007). Generating the "essences" of participants' experiences is central in descriptive phenomenological research; essences refer to aspects of any experience that are invariant across perception and intersubjectively common to all those that have had that experience (Lopez & Willis, 2004).

The first author has experience of using manual restraint within inpatient adolescent mental health care, and the second author had observed manual restraint being carried out. Although we viewed our manual restraint experience as a resource to this study, and did not believe that it was effective or possible to completely bracket our experiences, we felt that applying descriptive phenomenology would enhance the credibility of the study and prevent our presuppositions from disproportionately influencing the study findings. We attempted to bracket our presuppositions by having regular reflective discussions during the design, data collection and analysis phases of the study. Additionally, the first author kept a reflective diary and adopted a mindfulness practice stance throughout the study and partook in a reflective interview about his own experience of using manual restraint prior to participant recruitment.

3.3 | Participant recruitment

Participants were recruited from five 10–15 bedded locked adolescent mental health wards across four inpatient adolescent mental health hospitals spanning three NHS Trusts in England. Four wards were psychiatric acute wards, and the remaining ward was a psychiatric intensive care ward. We recruited participants from several hospitals and NHS Trusts in an attempt to achieve maximum variation within the participant sample with respect to hospital cultures and environments.

Collectively, the four hospitals provide assessment and treatment for young people aged 11–18 years with complex mental health needs. Young people admitted to the four hospitals experience difficulties including 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 have on-site educational facilities and provide multidisciplinary treatment to young people from several professionals including psychiatrists, psychologists, nursing staff, social workers, occupational therapists, dieticians, and family therapists. Chemical restraint via intramuscular rapid tranquilization was used in all hospitals and only the psychiatric intensive care ward was equipped with a seclusion room. Mechanical restraint was not practiced within any of the hospitals.

3.4 | Participants

Participants were recruited through email advertisements, and poster advertisements displayed on staff room notice boards within the four hospitals of recruitment. The email advertisements were sent to all nursing staff by the clinical psychologists within the hospitals. A participant information sheet providing further participation details was subsequently emailed to all nursing staff that contacted the first author and responded to the email and poster advertisements. A total of 12 nursing staff agreed to participate.

Participants were a purposeful sample of 12 permanent nursing staff, and included five registered mental health nurses (RMNs), four nursing assistants (NAs) and three senior nursing assistants (SNAs). Their ages ranged from 22 to 47 years (mean = 30.1 years) and their experience of working within inpatient adolescent mental health care ranged from eight months to nearly 12 years (mean = 3.6 years). Seven identified as "female" and the remaining five identified as "male". Apart from two participants that described themselves as "Black British" and "Mixed-Race British", all participants described themselves as "White British". Five, three, two and two participants were recruited from the four hospitals respectively. All participants had received a minimum of five consecutive days of manual restraint training. We excluded temporary and agency nursing staff to ensure that only participants with sufficient experience of using manual restraint within inpatient adolescent mental health care were recruited.

3.5 | Data collection

Semi-structured interviews were conducted by the first author between March 2021 and July 2021. We chose this method of data collection to allow for an in-depth exploration of participants' experiences while eliciting the maximum amount of relevant information (Langdridge, 2007). The interviews lasted 45–96 min (mean = 71 min) and were conducted over videoconference due to restrictions placed on face-to-face research at the time of the study consequent to COVID-19. Our interview topic guide included prompts to elicit the psychological and physical experience of manual restraint, and

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

consisted of seven open-ended questions covering the following topics: the process and experience of using manual restraint within inpatient adolescent mental health care (e.g., "Can you tell me about a typical time where you were involved in manually 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 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 restraint within inpatient adolescent mental health settings?").

Despite the videoconference format of interviews, rapport was easily established and maintained, and participants spoke openly about their manual restraint experiences. Consequently, we decided to cease data collection after the twelfth interview as we felt that the richness of data collected, in combination with the narrow aim of the study, and the homogeneity of the participant sample in relation to the phenomenon under study, suggested that our study had a reasonably high information power. Malterud et al's (Malterud et al., 2016) concept of information power highlights that the more information a sample holds relative to the research question, the fewer participants that are required. All interviews were audio-recorded in preparation for verbatim transcribing.

3.6 | Data analysis

Data were analysed using inductive thematic analysis guided by Braun and Clarke's (2006, 2019) cyclical six-step reflexive approach: familiarization through transcribing and repeated reading of transcripts; coding transcripts meaningful unit-by-meaning unit; generating themes; reviewing themes; defining and naming themes and subthemes; and producing the written report whereby participant extracts are embedded within an analytical narrative. We deemed reflexive thematic analysis as an appropriate data analysis method because it acknowledges the analytical value of the researcher's subjectivity (within limits) and focuses on identifying patterns of meanings across participants within a dataset (Braun & Clarke, 2019); this is congruent with our position on bracketing, and the descriptive phenomenology objective of generating the intersubjective commonalities of participants' experiences. Additionally, the theoretical flexibility of reflexive thematic analysis means that it is compatible with the experiential, predominantly inductive and predominantly semantic orientations characteristic of a descriptive phenomenology methodology (Sundler et al., 2019).

In line with descriptive phenomenology, we adapted our inductive thematic analysis in accordance with several recommendations outlined by Sundler et al. (2019). Specifically, the re-reading of interview transcripts was approached with an open mind where conscious efforts were made to search for novel information rather than confirm what was already known. We adopted a predominantly semantic approach to coding whereby short descriptive codes were assigned to each meaningful unit of text across transcripts. In the next phase of the analysis, codes were organized into themes based on the differences and similarities between codes; this process involved searching for the intersubjective commonalities of our participants' experiences. The final phases of the analysis involved naming, defining, refining, writing-up and re-writing up the themes. Here, a conscious effort was made to notice any presuppositions and judgements that appeared, and refocus attention back to our participants' descriptions.

The first author conducted the analysis and subsequently refined the generated themes and subthemes following discussions with the second author. This constituted part of the bracketing process and ensured that the first author's lived experience of using manual restraint within inpatient adolescent mental health care did not disproportionately influence the generated themes and subthemes at the expense of our participants' experiences. We considered the final collection of themes and subthemes to represent the "essence" of our participants' experiences.

3.7 | Ethical considerations

Ethical approval was obtained from a University and NHS research ethics committee. All participants provided their informed consent by signing electronic consent forms prior to their participation. Pseudonyms were assigned to all participants and any potentially identifiable information was removed from interview transcripts.

3.8 | Rigour

In addition to the bracketing procedures we implemented to ensure rigour, we took the analysis to our participants for verification to further improve the credibility of the study. Eight participants across three hospitals responded to our member checking requests, all of which reported that the analysis had accurately captured their experiences.

4 | FINDINGS

Four themes were generated from the analysis: it needs to be done sometimes; it's not a nice thing to do; it does not really damage the therapeutic relationship; and importance of team support.

4.1 | It needs to be done sometimes

Despite trying to avoid manual restraint where possible, all participants described situations where they had judged their restraint of a young person as necessary to keep the young person, themselves or their colleagues safe from harm. Three subthemes are reported: a last resort to protect young people; a last resort to protect staff?; and the fantasy of eliminating restraint.

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

4.1.1 | A last resort to protect young people

All participants described using manual restraint as a "last resort" to protect young people from significant harm. Self-inflicted harm through self-harm behaviour such as head-banging, ligature-tying, cutting and substantial refusal of foods and fluids were the most commonly cited antecedents leading to restraint. Although participants described using non-restrictive means to manage lower-level self-harm (e.g., verbal de-escalation, distraction/grounding techniques), participants deemed restraint as necessary for more serious forms of self-harm where there was risk of substantial imminent injury:

> 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, SNA, Hospital 4)

Contrary to the use of manual restraint as a last resort, three participants from two hospitals described experiences where they had observed agency and temporary staff use manual restraint prematurely to manage self-harming young people. One participant reported that this approach to managing risk stemmed from the risk tolerance differences between agency/temporary staff and permanent staff, and the over-allocation of the former to cover one-to-one observations:

> We can often put agency staff in quite vulnerable situations [by over-allocating them to one-to-one observations] … often their first instinct is to go in and restrain to safely manage the situation [self-harming young person]. 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 described patient protective functions of manual restraint, and although participants expressed that patient injuries during 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 other patients, their safety is compromised as well because … 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)

4.1.2 | A last resort to protect staff?

Although all participants remarked that manual restraint *could* be used as a "last resort" to prevent young people from harming staff, only seven participants described first-hand experience of using manual restraint to prevent such harm. These participants reported that restraint in such circumstances was frequently the only resort to protect staff, rather than the "last resort". This was evidenced by the use of descriptions such as "the only option" and "do it right away":

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

Three participants made a distinction between using manual restraint to prevent patient self-harm and to prevent young people from harming staff. These participants highlighted that restraint was more often used as a last resort to protect young people from self-harm, but more often as an earlier resort to protect staff from the harm of young people:

> If they're 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 use of manual restraint as a staff-protecting intervention, all participants described situations where they had experienced physical pains or injuries as a consequence of using manual restraint. These experiences are reported in the subtheme "physical pain and injury" within the theme "it's not a nice thing to do", which better captures this aspect of participants' experiences.

4.1.3 | The fantasy of eliminating restraint

All participants expressed a desire to reduce manual restraint through avenues such as increased staffing, improved ward layouts and improved training of agency and temporary staff. However, such expressions were frequently overshadowed by a strong disapproval of "zero restraints" and "restraint elimination" initiatives. There was a perception that such initiatives came from external agencies (e.g., Care Quality Commission) that did not understand the substantial imminent physical harm that could occur to young people and staff without restraint. One participant even went as far as to claim that people who urged restraint elimination had no personal experience of its use:

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

> People who talk about moving away from 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. (Belinda, SNA, Hospital 4)

Five participants described how refraining from restraint in particular circumstances was incongruent with their job role of protecting young people. Again, such descriptions were verbalized in the context of opposing the absolute elimination of restraint:

> 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, SNA, Hospital 1)

Four participants reported that they desired for manual restraint to be eliminated but then described how this was not feasible. Sarah, a RMN from Hospital 2, 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".

4.2 | It's not a nice thing to do

Manually restraining young people within inpatient adolescent mental health care was an unpleasant practice for all participants, and this was evidenced by participants' descriptions of the aversive physical and emotional outcomes that they, their colleagues and young people experienced as a consequence of restraint. Phrases such as "it's not a nice thing to do" and "I don't like it" were commonly expressed. However, such phrases were frequently followed by words such as "but" in an attempt to justify restraint on safety grounds (as evidenced within the theme "it needs to be done sometimes"). 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.

4.2.1 | It's distressing for the young person

Despite acknowledging that manual restraint was sometimes necessary, all participants described the emotional distress that restraint prompted for young people. 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:

> We had a patient who we restrained for about 45 to 50 minutes, and they were just continually screaming … they were really distressed. (Belinda, SNA, Hospital 4)

All participants described experiences where they had endeavoured to make restraint 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 abuse histories, ensuring that young people were dignified in restraint, and restraining young people in the least restrictive way for the shortest time possible:

> 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, NA, Hospital 2)

Despite the reported distress that restraint caused young people, 10 participants described experiences where they believed young people had behaved in certain ways to intentionally elicit a restraint. Such young people reportedly appeared to find restraint therapeutic, and were described as using restraint 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 … they just wanted to be held. (Laura, RMN, Hospital 1)

4.2.2 | It's distressing for us

All participants described the emotional distress that they experienced as a consequence of manual restraint. Participants reported that restraint was "upsetting", "horrible" and "traumatizing" for them, and eight participants expressed their dismay at the prospect of restraining young people specifically. Three participants described experiences of restraint where they had cried or had been close to being moved to tears:

> During the restraint, I just had to look away … and all I could hear was "I'm sorry, I'm sorry", and I was like

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

> "I can't look, if I look at him, I'm going to burst into tears". It was horrible … I'm a human being and at the end of the day, it was a young boy, do you know what I mean? (Emily, NA, Hospital 1)

The use of manual restraint to prevent acute 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:

> 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". (Belinda, SNA, Hospital 4)

All participants reported experiencing several unpleasant emotions consequent to using restraint. Although anxiety, anger, guilt and sadness were explicitly cited emotions, it was anxiety and anger that were the most frequently described. All participants described feeling anxiety, particularly in the moments leading up to restraint; this was often in the context of worrying about the young person's preceding self-harm, and fearing for themselves, their colleagues and the young person being hurt in restraint:

> 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 when they applied it and whether there's any harm that's happened to them as a result … you're anxious about that too. (Paul, SNA, Hospital 1)

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

> You're in a position that is naturally making you quite angry … 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, NA, Hospital 2)

Five participants reported a reduction in their distress towards restraint over time. However, these participants were clear that restraint continued to be distressing for them. Jane, a SNA from Hospital 4, described: "you kind of do get a little bit more desensitised to it … you always feel anxious, but probably less anxious".

4.2.3 | Aggression from the young person

All participants described being subjected to aggression by some young people during restraint. Physical aggression was most commonly described, as 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 restraint. It appeared from participants' descriptions that these young people displayed such physical aggression to prevent or break out of restraint:

> 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 turned their head to the left of me and tried to bite my neck and my ear. (Greg, RMN, Hospital 3)

Five participants described deliberate attempts and actions of young people hurting staff in restraint. Such physical aggression was 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, NA, Hospital 2)

Ten participants expressed an understanding of young people's physical aggression during restraint. Some described experiences where they had reminded themselves that young people were mentally unwell in hospital for a reason, and others considered how physical aggression from young people was understandable in the context of restraint:

> 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, NA, Hospital 1)

Six participants explicitly described the verbal aggression that they experienced from young people in restraint which included swearing, shouting, insulting and name-calling. Daniel, a NA 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".

4.2.4 | Physical pain and injury

All participants described experiences of physical pain and/or injury during manual restraint. Bruises, grazes and muscle aches were commonly described injuries. Such injuries were frequently sustained by

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

participants during the execution of restraint, such as when restraining young people's legs or when transitioning from standing to floor-based positions:

> 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 post-restraint delayed onset muscle aches and stiffness. 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 NA from Hospital 2, described: "and you get up the next day and you just think, 'oh, my God, I ache everywhere'".

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

> 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, SNA, Hospital 1)

> A young person had kicked a staff member in the side and she was crying … 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, SNA, Hospital 4)

4.2.5 | 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". 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:

> When you've got somebody who's actually really upset and you're having to hold onto them; physically, it can be exhausting … especially if I've got some of the kids that are bigger than me. (Sarah, RMN, Hospital 2)

Prolonged manual restraints that could last for hours at a time due to rapid tranquilization being ineffective were described by participants as being some of the most physically exhausting:

> 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 … we had IM'd her, but they had like so much fight and energy. (Daniel, NA, Hospital 2)

Three participants explicitly described felt physical exhaustion during restraint in circumstances where they had needed to run to young people before restraining them. Such experiences were described 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 … you've then got to jump in a restraint and you're trying to get your breathing back and you're just exhausted. (Emily, NA, Hospital 1)

Four participants additionally described occasions of minimal physical exhaustion in restraint due to the minimal physical resistance displayed by some young people. Sarah, a RMN from Hospital 2, described "I guess with some restraints, physically it's not so demanding … they don't really resist too much".

4.3 | It does not really damage the therapeutic relationship

Despite the negative staff and patient outcomes of manual restraint described in the theme "it's not a nice thing to do", all participants conversely reported experiencing manual restraint as non-damaging to the staff-young person therapeutic relationship in the long-term. Three subthemes are reported: 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.

4.3.1 | Damage to the relationship from restraint is only temporary

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

> I haven't ever found that my relationship has been affected detrimentally by any restraint … Obviously, in the very short term, after the restraint, they're

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

> not necessarily wanting to see or be nice to you but I can't say long-term or longer than a day or so it's really affected any of my relationships. (Alice, NA, 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, SNA, Hospital 4)

Participants cited a number of reasons to explain why manual restraint did not damage the staff-young person relationship in the long term. Six participants attributed this to young people knowing that restraint was used 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)

Formal and informal post-restraint debriefing with young people was reported by seven participants to play an important role in preserving the staff-young person 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 relationship:

> 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)

4.3.2 | Restraint strengthens my relationships with young people

Four participants from two hospitals reported that using 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 restraint on their relationships 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 manual restraint had strengthened their relationships with young people. However, two participants highlighted the opportunity that 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:

> Sometimes I think restraint might strengthen it [the therapeutic relationship] 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 … it brings you closer to them. (Emily, NA, Hospital 1)

4.3.3 | Long-term damage to the relationship from restraint is rare

Although nearly all participants described experiences where manual restraint had resulted in temporary damage to the staff-young relationship, just three participants described witnessing or experiencing long-term damage to the relationship consequent to restraint. These participants described how such experiences were uncommon:

> 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 wouldn't talk to me for the rest of that admission. (Wayne, RMN, Hospital 1)

Contrary to this subtheme, two participants described more common occurrences where they had witnessed a breakdown in the staff-young person relationship involving their colleagues. In all reported instances the damage to the relationship was reported from the staff side only:

> 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. (Greg, RMN, Hospital 3)

4.4 | Importance of team support

The staff team was an important support system for all participants, and this was partially evidenced by participants' use of terms such as "team", "we" and "us" when describing their restraint experiences. It was clear from participants' descriptions that their colleagues were an integral practical support system during the execution of restraint, and a valued emotional support system in the aftermath of restraint. Two subthemes are reported: working together as a staff team; and looking out for each other.

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

4.4.1 | Working together as a staff team

All participants described the importance of working with their colleagues as a team when restraining young people. Teamwork processes such as effective communication, coordination and observing were reported as being integral to the safe and successful execution of restraint. Some participants described the risk of injury that could occur to young people and staff in the absence of such teamworking processes:

> 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 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, NA, Hospital 2)

Six participants reported that the standard of teamwork during a restraint was contingent on the team that they were working with on 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 temporary staff. One participant described how working in such a team could make restraint 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 non-permanent staff or a team that's not communicating well, then certain staff have to work harder. (Greg, RMN, Hospital 3)

4.4.2 | Looking out for each other

This subtheme highlights the personal support that participants provided and received from their colleagues. Six participants recounted the informal verbal emotional support that they received from their colleagues in the aftermath of a restraint. These participants described how speaking with and being listened to by their colleagues had helped them to feel "better" and "alright", particularly after participating in a 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, NA, Hospital 1)

Three participants described experiences of providing informal emotional support to their colleagues in the aftermath of a restraint. Paul, a SNA from Hospital 1, 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". Formalized post-restraint staff debriefing meetings were not frequently reported to occur due to insufficient staffing and a lack of protected time. Notwithstanding, two participants described the emotional offloading support that such meetings provided 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 … because those things can weigh on you a bit when you have to go home. (Daniel, NA, 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 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 … 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. (Jane, SNA, Hospital 4)

5 | DISCUSSION

The purpose of this study was to explore nursing staff's experiences of using manual restraint within inpatient adolescent mental health care. The findings detail a paradoxical picture of the nursing staff's experiences where restraint was experienced as psychologically and physically aversive yet deemed as sometimes necessary to prevent significant harm. We critically discuss our findings, drawing from trauma-informed care theory where appropriate.

The analysis showed that participants experienced 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 consumer settings (e.g., Bigwood & Crowe, 2008; Chapman et al., 2016; Lombart et al., 2020; Wilson et al., 2017). Despite using restraint to protect staff from patient aggression, participants overwhelmingly described using restraint to protect young people from their own self-harm; this diverges from the inpatient adult mental health care literature where self-harm initiated manual restraint incidents have not been so prevailingly described in staff's lived experience accounts (e.g., Bigwood & Crowe, 2008; Perkins et al., 2012; Wilson et al., 2017). All participants described using restraint as a "last resort", and there indeed was evidence of last resort practice (e.g., using verbal de-escalation and distraction/grounding techniques first). However, the notion of "last resort" has been criticized for

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

being an easily voiced rhetorical device that is very difficult to observe or challenge (Deveau & McDonnell, 2009). Moreover, previous studies have evidenced incorrect staff assertions of "last resort" where restraint had been avoidable (McKeown et al., 2019; Wilson et al., 2017). The above points indicate that our participants' claims of restraint as a "last resort" may not have always been legitimate.

Three participants across two hospital sites described witnessing premature restraint use by temporary/agency staff to manage self-harming young people, indicating that restraint was not always being used as a last resort. Although participants claimed that improved training of temporary/agency staff could be a viable solution to this problem, participants failed to realize their own potential role in maintaining such restraint practices. Specifically, one participant alluded that temporary/agency staff were disproportionately allocated to one-to-one patient observations; this might have reflected a wider poor treatment of such staff (Birmingham et al., 2019). Thus, temporary/agency staff, in addition to being disproportionately exposed to patient safety incidents, may have been deprived of the opportunity to access important knowledge (e.g., historical patient background information in patient records and/or withheld by permanent staff) necessary to develop trauma-informed understandings, and in turn, responses towards patient risk behaviour such as self-harm. The disproportionate allocation of non-permanent staff to purely instrumental duties (e.g., smoking breaks, patient observations) has been described in the literature, and may reflect the hierarchical and power structures that exist within inpatient mental health staff teams, and a wider poor treatment of non-permanent staff in healthcare (Birmingham et al., 2019; McKeown et al., 2019).

Although participants felt that restraint could be minimized, such expressions were frequently overshadowed by a strong disapproval of "restraint elimination" initiatives, with one participant unfairly claiming that those who urged restraint elimination had no personal experience of its use. Given that the majority of restraint reduction initiatives start from a place of minimization rather than absolute elimination (e.g., Bowers et al., 2015; Duxbury et al., 2019), this somewhat straw man fallacy response by participants may reflect a wider issue within inpatient mental health care in which concerns raised about restraint are dismissed and problematized (e.g., Meehan et al., 2022); this may come from a place of staff fear (Muir-Cochrane et al., 2018). Notwithstanding, our participants' aversion towards the elimination of restraint is in line with the views of healthcare staff in previous studies of manual restraint (Muir-Cochrane et al., 2018; Wilson et al., 2017).

It was evident from the analysis that manual restraint was a disliked practice for participants. All participants described experiencing a spectrum of unpleasant emotions consequent to using restraint (e.g., anxiety, anger, sadness), and some described their restraint experiences using terms such as "traumatising": this is despite the fact that nearly half of participants reported a reduction in restraint-related distress over time. Worryingly, physical pain and injury (e.g., bruises and muscle aches), patient physical aggression (e.g., being kicked and hit) and physical exhaustion were also commonly described hallmarks of participants' restraint experiences. The above cluster of findings are in line with previous studies in adult and child and/or adolescent consumer settings where staff have reported a reduction in their distress response to restraint over time, and described the emotional distress, patient physical aggression, physical pain and injury and physical exhaustion that they have been subjected to consequent to using restraint (Bigwood & Crowe, 2008; Chapman et al., 2016; Kodua et al., 2020; Lombart et al., 2020; Wilson et al., 2017). It has been argued that patient physical aggression to staff, although inexcusable, is understandable through a trauma-informed lens in light of the epistemic violence and explicitly violent acts that psychiatrized individuals are subjected to within the mental health system (Chapman, 2014). Our participants viewed staff-directed physical aggression from young people as understandable in the context of restraint, thereby supporting this viewpoint.

Given the aversive physical and psychological challenges that pervaded participants' experiences of restraint, and the reported infrequency at which formal post-restraint staff debriefing meetings were held, it is not surprising that participants reported frequently providing and receiving informal emotional support to and from their colleagues to cope with restraint in the aftermath (e.g., to feel "better" about their actions). While this form of debriefing has been identified as being an effective coping mechanism for staff in previous studies of restraint (Kodua et al., 2020), such debriefing, as evidenced in the present study, has also been described as serving legitimization and exculpatory purposes rather than facilitating learning from restraint events (McKeown et al., 2019). From this angle, this form of debriefing may function to relieve staff of justified restraint-related guilt and maintain the belief that the team acted correctly, contributing to the epistemic and explicit violence within the mental health system (Chapman, 2014; McKeown et al., 2019).

The most unexpected and controversial finding from the analysis was that all participants experienced manual restraint as non-damaging to the staff-young person therapeutic relationship in the long term, with some reporting a strengthening of the relationship consequent to restraint; this profoundly conflicts with the manual restraint research literature from the perspectives of patients who have described the psychological and physical harm that manual restraint has caused them, and the unrepairable damage that restraint has inflicted upon their trust of services and healthcare staff (e.g., Haw et al., 2011; Knowles et al., 2015; Wilson et al., 2017). Given the disparity with the previous research literature, the above findings, while reassuring, need to be considered critically and must not be assumed to reflect the reality of restrained young people. It is possible that our participants knowingly or unknowingly minimized the impact of restraint on the staff-young person therapeutic relationship. This assumption is strengthened by the fact that nearly half of participants reported becoming somewhat emotionally desensitized to restraint over time. Thus, desensitizing responses may have generalized to the potentially damaging effects of restraint on the therapeutic relationship, leading to the perception of restraint as being non-damaging. Nonetheless, a non-damaging impact of restraint on the therapeutic relationship has been described by a small number of staff and consumers in previous studies of restraint (Steckley & Kendrick, 2008; Wilson et al., 2017).

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

5.1 | Implications for practice

In light of the findings of our study, we highlight a number of practice implications and recommendations. Specifically, efforts to reduce manual restraint (e.g., restraint minimization programmes) also need to target non-permanent staff for intervention as opposed to solely permanent staff to have the greatest effect in reducing avoidable restraint practices. However, the indirect role that permanent staff might potentially play in maintaining avoidable restraint practices, through their treatment of non-permanent staff (e.g., disproportionately allocating them to one-to-one patient observations), also needs to be explicitly acknowledged and targeted by restraint minimization efforts to more effectively reduce avoidable restraint practices.

Given the "restraint can't be eliminated" knee-jerk response that our participants expressed towards restraint minimization, efforts to minimize restraint within inpatient child and/or adolescent mental health care and beyond need to make clear that the objective is not necessarily the absolute elimination of restraint. This might help reassure staff, reduce their fears, and in turn increase their willingness towards restraint minimization.

Efforts to reduce manual restraint need to explicitly acknowledge the restraint-related challenges that nursing staff might experience (e.g., emotional distress, patient physical aggression, tension between maintaining safety and reducing restraint) and sufficiently validate the position of nursing staff, as opposed to focusing disproportionately on change and the benefits of restraint reduction. This may ultimately improve nursing staff's openness and willingness towards adopting restraint minimization values and practices, which in turn could translate into further reduced restraint rates. Indeed, people are far more likely to be willing to change when they feel heard and validated (Bertolino, 2018; Day, 2008).

Staff debriefing after restraint events, whether formal or informal, need to emphasize learning from restraint events (e.g., how the restraint could have been avoided), rather than purely exculpating staff from their actions. This is important given that debriefing that exclusively focuses on the latter may contribute to the unwavering telling and re-telling of restraint legitimization narratives and hamper the fostering of trauma-informed understandings of patients' behaviour that in turn may maintain avoidable and even abusive restraint practices.

In harmony with what the majority of our participants reported and demonstrated, the showing of compassion (e.g., ensuring patients are dignified during restraint, considering the gender of restraining staff), the facilitation of staff-patient post-restraint debriefing meetings, and the holding of trauma-informed understandings of restraint-related patient aggression (e.g., acknowledging that patient physical aggression is understandable in the context of restraint), may be paramount in preserving the staff-young person therapeutic relationship in the context of restraint.

5.2 | Limitations and research suggestions

The participants in this study were all permanent nursing staff consequent to the exclusion of temporary/agency nursing staff. Given that temporary/agency staff often constitute a significant portion of the nursing workforce, our exclusion of these staff may have inadvertently limited the transferability of the findings beyond the research setting. Moreover, the findings of this study suggested that temporary/agency staff were more likely to use manual restraint prematurely. Consequently, valuable lived experience insights may have been missed from the exclusion of these non-permanent staff. Future research focusing on exploring the manual restraint experiences of temporary/agency staff within inpatient mental health care would be valuable in following up the findings of this study and in developing a greater understanding of the potential restraint practice differences between permanent and temporary/agency nursing staff. Additionally, future manual restraint research focusing on the recruitment of both permanent and temporary/agency staff could generate findings that are more transferable to inpatient mental health care settings.

This study exclusively explored nursing staff's experiences of manual restraint without also exploring young people's experiences. Consequently, the findings purely represent the nursing staff participants' subjective truth and cannot be assumed to reflect the subjective reality of young people also. For instance, the theme "it does not really damage the therapeutic relationship" cannot be assumed to also represent the experiences of young people. Future research that focuses on exploring the shared manual restraint experiences of 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 that of young people.

Although the construction of our interview schedule was guided by descriptive phenomenology, it is possible that the interview questions asked increased the likelihood of generating the findings that resulted, representing a limitation of the study. Thus, future research focusing on staff's manual restraint experiences within inpatient child and/or adolescent mental health care might benefit from an interpretive phenomenological methodology to enable an analysis that goes beyond participants' descriptions.

6 | CONCLUSION

This study is the first to explore nursing staff's experiences of using manual restraint within a general inpatient adolescent mental health care context. This is an important contribution to the literature given the increased need to minimize manual restraint globally, and the substantially elevated incident rates of manual restraint in child and adolescent inpatient mental health settings. The findings suggest that using manual restraint within inpatient adolescent mental health care, although deemed strongly 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. Our findings generate several implications to support international efforts to minimize restraint. Although our findings also generate some

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

practice implications for how the staff-patient therapeutic relationship might be preserved in the context of restraint, we urge that readers treat this with caution, given that young people's voices were missing from this study.

AUTHOR CONTRIBUTIONS

Michael Kodua and Winifred Oluchukwu Eboh made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. Michael Kodua and Winifred Oluchukwu Eboh were involved in drafting the manuscript or revising it critically for important intellectual content. Michael Kodua and Winifred Oluchukwu Eboh gave final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Michael Kodua and Winifred Oluchukwu Eboh agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ACKNOWLEDGEMENTS

We thank all the nursing staff that volunteered to participate in this study for without them this study would not have been possible. We also thank Dr Rebecca Alegbo and Dr Andy Sluckin for their comments during the proposal stage of this study.

FUNDING INFORMATION

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

CONFLICT OF INTEREST STATEMENT

The authors declare that there is no conflict of interest.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.15742.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ORCID

Michael Kodua https://orcid.org/0000-0001-9297-7799

REFERENCES

Bertolino, B. (2018). *Effective counselling and psychotherapy: An evidence-based approach*. Springer Publishing Company LLC.

Bigwood, S., & Crowe, M. (2008). 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International Journal of Mental Health Nursing*, *17*(3), 215–222. https://doi.org/10.1111/j.1447-0349.2008.00526.x

Birmingham, C., van de Mortel, T., Needham, J., & Latimer, S. (2019). The experiences of the agency registered nurse: An integrative literature review. *Journal of Nursing Management*, *27*(8), 1580–1587. https://doi.org/10.1111/jonm.12850

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, *52*(9), 1412–1422. https://doi.org/10.1016/j.ijnurstu.2015.05.001

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Chapman, C. (2014). Becoming perpetrator: How I came to accept restraining and confining disabled aboriginal children. In B. Burstow, B. A. LeFrançois, & S. Diamond (Eds.), *Psychiatry disrupted: Theorizing resistance and crafting the (r)evolution* (pp. 16–33). McGill University Press.

Chapman, R., Ogle, K. R., Martin, C., Rahman, A., McKenna, B., & Barnfield, J. (2016). Australian nurses' perceptions of the use of manual restraint in the emergency department: A qualitative perspective. *Journal of Clinical Nursing*, *25*(9–10), 1273–1281. https://doi.org/10.1111/jocn.13159

Day, J. (2008). *Being what you want to see*. Dog Ear Publishing LLC.

Department of Health. (2014). *Positive and proactive care: Reducing the need for restrictive interventions*. Social Care, Local Government and Care Partnership Directorate.

Deveau, R., & McDonnell, A. (2009). As the last resort: Reducing the use of restrictive physical interventions using organisational approaches. *British Journal of Learning Disabilities*, *37*(3), 172–177. https://doi.org/10.1111/j.1468-3156.2008.00536.x

Duxbury, J., Aiken, F., & Dale, C. (2011). Deaths in custody: The role of restraint. *Journal of Learning Disabilities and Offending Behaviour*, *2*, 178–189.

Duxbury, J., Baker, J., Downe, S., Jones, F., Greenwood, P., Thygesen, H., McKeown, M., Price, O., Scholes, A., Thomson, G., & Whittington, R. (2019). Minimising the use of physical restraint in acute mental health services: The outcome of the restraint reduction programme ('REsTRAIN Yourself'). *International Journal of Nursing Studies*, *95*, 40–48. https://doi.org/10.1016/j.ijnurstu.2019.03.016

Haines-Delmont, A., Goodall, K., Duxbury, J., & Tsang, A. (2022). An evaluation of the "no force first" informed organisational guide to reduce physical restraint in mental health and learning disability inpatient settings in the UK. *Frontiers in Psychiatry*, *13*, 749615. https://doi.org/10.3389/fpsyt.2022.749615

Haw, C., Stubbs, J., Bickie, A., & Stewart, I. (2011). Coercive treatments in forensic psychiatry: A study of patients' experiences and preferences. *Journal of Forensic Psychiatry & Psychology*, *22*(4), 564–585. https://doi.org/10.1080/14789949.2011.602097

Knowles, S. F., Hearne, J., & Smith, I. (2015). Physical restraint and the therapeutic relationship. *The Journal of Forensic Psychiatry & Psychology*, *26*(4), 461–475. https://doi.org/10.1080/14789949.2015.1034752

Kodua, M., Mackenzie, J. M., & Smyth, N. (2020). Nursing assistants' experiences of administering manual restraint for compulsory nasogastric feeding of young people with anorexia nervosa. *International Journal of Mental Health Nursing*, *29*(6), 1181–1191. https://doi.org/10.1111/inm.12758

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education Limited.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., & Sudders, M. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(1), 37–45. https://doi.org/10.1097/00004583-200401000-00013

Lombart, B., De Stefano, C., Dupont, D., Nadji, L., & Galinski, M. (2020). Caregivers blinded by the care: A qualitative study of physical

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

restraint in pediatric care. *Nursing Ethics*, *27*(1), 230–246. https://doi.org/10.1177/0969733019833128

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, *14*(5), 726–735. https://doi.org/10.1177/1049732304263638

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

McKeown, M., Thomson, G., Scholes, A., Jones, F., Downe, S., Price, O., Baker, J., Greenwood, P., Whittington, R., & Duxbury, J. (2019). Restraint minimisation in mental health care: Legitimate or illegitimate force? An ethnographic study. *Sociology of Health & Illness*, *42*(3), 449–464. https://doi.org/10.1111/1467-9566.13015

Meehan, T., McGovern, M., Keniry, D., Schiffmann, I., & Stedman, T. (2022). Living with restraint: Reactions of nurses and lived experience workers to restrictions placed on the use of prone restraint. *International Journal of Mental Health Nursing*, *31*(4), 888–896. https://doi.org/10.1111/inm.12993

Muir-Cochrane, E., O'Kane, D., & Oster, C. (2018). Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint. *International Journal of Mental Health Nursing*, *27*(5), 1511–1521. https://doi.org/10.1111/inm.12451

NHS Digital. (n.d.). Mental health services monthly statistics—Restrictive interventions. Retrieved June 3, 2022, from https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-hub/mental-health-services-monthly-statistics-restrictive-interventions

Perkins, E., Prosser, H., Riley, D., & Whittington, R. (2012). Physical restraint in a therapeutic setting; A necessary evil? *International Journal of Law and Psychiatry*, *35*(1), 43–49. https://doi.org/10.1016/j.ijlp.2011.11.008

Royal Australian and New Zealand College of Psychiatrists. (2021). Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-use-of-seclusion-and-restraint

Ryan, C. (2010). *Manual restraints in psychiatric settings: Empirical realities—A rare insight from patients' and nurses' perspectives*. VDM Verlag Dr. Muller Aktiengesellschaft & Co. KG.

Steckley, L., & Kendrick, A. (2008). Physical restraint in residential childcare: The experiences of young people and residential workers. *Childhood*, *15*(4), 552–569. https://doi.org/10.1177/0907568208097207

Stubbs, B., & Paterson, B. (2011). Physical restraint in mental health services: A gap in the knowledge regarding this extreme manual handling task. *Ergonomics*, *54*(9), 876–878. https://doi.org/10.1080/00140139.2011.606921

Sundler, A. J., Lindberg, E., Nilsson, C., & Palmér, L. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open*, *6*(3), 733–739. https://doi.org/10.1002/nop2.275

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *International Journal of Mental Health Nursing*, *26*(5), 500–512. https://doi.org/10.1111/inm.12382

How to cite this article: Kodua, M., & Eboh, W. O. (2023). "It's not a nice thing to do, but…": A phenomenological study of manual physical restraint within inpatient adolescent mental health care. *Journal of Advanced Nursing*, *00*, 1–14. https://doi.org/10.1111/jan.15742

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- **High-impact forum: the world's most cited nursing journal, with an Impact Factor of 2.561 – ranked 6/123 in the 2019 ISI Journal Citation Reports © (Nursing; Social Science).**
- **Most read nursing journal in the world: over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 6,000 in developing countries with free or low cost access).**
- **Fast and easy online submission:** online submission at http://mc.manuscriptcentral.com/jan.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).

13652648, 0, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jan.15742 by UNIVERSITY OF ESSEX, Wiley Online Library on [19/07/2023]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License