



SPECIAL ISSUE

Is restraint a ‘necessary evil’ in mental health care? Mental health inpatients’ and staff members’ experience of physical restraint

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ABSTRACT: *Restraint in mental health care has negative consequences, and guidelines/policies calling for its reduction have emerged internationally. However, there is tension between reducing restraint and maintaining safety. In order to reduce restraint, it is important to gain an understanding of the experience for all involved. The aim of the present study was to improve understanding of the experience of restraint for patients and staff with direct experience and witnesses. Interviews were conducted with 13 patients and 22 staff members from one UK National Health Service trust. The overarching theme, ‘is restraint a necessary evil?’, contained subthemes fitting into two ideas represented in the quote: ‘it never is very nice but...it’s a necessary evil’. It ‘never is very nice’ was demonstrated by the predominantly negative emotional and relational outcomes reported (distress, fear, dehumanizing, negative impact on staff/patient relationships, decreased job satisfaction). However, a common theme from both staff and patients was that, while restraint is ‘never very nice’, it is a ‘necessary evil’ when used as a last resort due to safety concerns. Mental health-care providers are under political pressure from national governments to reduce restraint, which is important in terms of reducing its negative outcomes for patients and staff; however, more research is needed into alternatives to restraint, while addressing the safety concerns of all parties. We need to ensure that by reducing or eliminating restraint, mental health wards neither become, nor feel, unsafe to patients or staff.*

KEY WORDS: *inpatient, mental health, nursing, physical restraint.*

INTRODUCTION

The use of physical restraint has long been a contentious part of mental health nursing practice. Physical restraint refers to any direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of another person (Department of Health, 2014). In mental health care, this refers to the

physical restraint of a patient by staff members in response to aggressive behaviour or treatment resistance (Care Quality Commission, 2011). It has been estimated that 12% of UK mental health patients experience physical restraint (Care Quality Commission, 2011), but its use varies within the UK (Mind, 2013) and internationally (e.g. Raboch *et al.* 2010). Chemical restraint is when medication is prescribed pro re nata (PRN) as a reaction to agitated or aggressive behaviour for the purposes of sedation (e.g. Currier & Allen 2000; Donat 2005). Chemical restraint in the UK often comes hand in hand with physical restraint, as patients are physically restrained in order to receive PRN medication. Guidelines/policies from national and local governments calling for a reduction in restraint have emerged internationally (e.g. Australian Council on

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Healthcare Standards, 2008; Curie 2005; Department of Health, 2014; LeBel 2008), conferring increased pressure on health-care providers to reduce restraint. However, there is tension in mental health care between this desire to reduce restraint and the need to provide and maintain a safe environment, which is recognized as central to the therapeutic milieu of mental health inpatient wards (e.g. Gerace *et al.* 2016; Hopkins *et al.* 2009; Muir-Cochrane *et al.* 2013). Other barriers to the reduction of restraint also exist; for example, staff attitudes, patient acuity, and ward factors (e.g. Bigwood & Crowe 2008; Bonner *et al.* 2002; Meehan *et al.* 2004). The purpose of the present study was to explore the experience of physical restraint for patients and staff within a UK National Health Service (NHS) trust in order to inform strategies for reducing or preventing restraint. This paper also addresses the tension between reducing restraint and maintaining safety in mental health care, by giving careful consideration to barriers to restraint reduction.

Background

While it has been argued that restraint is necessary for patient and staff safety, its use has negative consequences. Patients and staff report feeling distressed, fearful, angry, anxious, and frustrated (e.g. Bigwood & Crowe 2008; Bonner *et al.* 2002; Kontio *et al.* 2012; Moran *et al.* 2009; Strout 2010; Stubbs *et al.* 2008), and that restraint is damaging to the therapeutic relationship, damaging to patient relationships with services, and incompatible with caring values (e.g. Chuang & Huang 2007; Wynn 2004). A recent study conducted in Australia with family members of mental health patients who have been restrained, and patients themselves, found that restraint is a breach of human rights, retraumatizes patients, is dehumanizing, undermines recovery, and represents control that staff have over patients (Brophy *et al.* 2016). There is also limited evidence that witnessing restraint can have negative psychological implications for mental health patients (e.g. Gilbert *et al.* 2008; Mayers *et al.* 2010) and staff (e.g. O'Brien & Cole 2004). Furthermore, negative physical consequences for patients include lacerations, asphyxiation, thrombosis, and death (e.g. Department of Health and Human Services, 2006; Mohr *et al.* 2003; Paterson *et al.* 2003), and injuries among staff are well documented (e.g. Paterson & Duxbury 2007; Stubbs 2009; Stubbs *et al.* 2008).

In order to reduce restraint, it is important to gain an understanding of the experience for all involved.

Although existing studies provide insight into experiences, few have been conducted in the UK and might reflect different cultural, procedural, and health-care practices (Bowers 2014); for example, mechanical restraint is used widely internationally, but is not routinely used in the UK. Furthermore, few UK studies have examined the experience of both staff and patients in the same NHS ward environments.

In the present study, we report on the findings from a qualitative strand of an initiative called PROMISE (PROactive Management of Integrated Services and Environments) taking place within the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). The aim of the present study was to improve understanding of patients' and staff members' experience of physical restraint in CPFT adult mental health inpatient environments. The second part of the qualitative strand, related to suggestions for reducing and preventing restraint, will be reported elsewhere (C. Wilson, L. Rouse, S. Rae & M. Kar Ray, pers. comm., 2017). The overall aim of the qualitative study is to feed key findings into a coproduced, evidence-based proactive care toolkit that eliminates reliance on restraint in mental health care.

METHODS

Design

Semistructured, one-to-one interviews were conducted with CPFT mental health inpatients and staff. The study was grounded in a realist epistemological framework, where participants' responses were assumed to represent reality. Realism recognizes that there a real world exists, independent of our experience, while also acknowledging that we are suspended in webs of meaning that we ourselves spin, and therefore, there can be many layers to our reality (Moses & Knutsen 2007). Within CPFT, seclusion is rarely used, with only one seclusion suite available within the trust. Mechanical restraint is not routinely used in the UK. Therefore, the interview guide only focussed on physical and chemical restraint.

Two advisory groups were formed: one comprising staff from CPFT mental health wards with experience of using restraint, and one comprising mental health service users with experience of being restrained in CPFT wards. Feedback from these groups (e.g. regarding recruitment methods, wording of participant information sheets and interview schedules, and ethical considerations) and a multidisciplinary PROMISE steering group was incorporated into each stage of the

design. Further details of advisory group involvement will be reported elsewhere.

Ethical approval was obtained from the NHS Research Ethics Committee for the East of England and the CPFT Research and Development Department.

Participants

Participants comprised current or former inpatients who had directly experienced or witnessed physical restraint during their time as an inpatient on a CPFT adult mental health ward, and current members of CPFT staff, in any job role, who had directly restrained or witnessed the restraint of a patient on a CPFT adult mental health ward.

Staff were recruited through a recruitment email sent to all staff on adult wards by the first and second authors, recruitment posters displayed on ward noticeboards, and verbal information presented at ward meetings and trust events by the first and second authors. Patients were recruited through CPFT staff providing participant information sheets to patients who fitted the inclusion criteria (i.e. who had been restrained during an inpatient stay, and whom staff deemed well enough to talk about their experiences); recruitment posters displayed on ward noticeboards, and presentations to individual wards, service user support/advocacy groups; and voluntary organizations by the first and second authors.

Participants comprised 13 patients and 22 staff members; six males and seven females aged 18–65 years, three who witnessed restraint, and 10 who had direct experience (most of whom had also witnessed). Ten were current inpatients, and three were former inpatients. Patients had stayed on a variety of adult wards (assessment and treatment, acute and intensive care, short-term recovery, acute adult mental health, psychiatric intensive care, acute assessment, acute recovery, and personality disorder wards). Not all of the patients interviewed could remember the length or frequency of their hospital stays; however, the majority of patients had been admitted more than once to various adult wards, and the length of stay ranged from a few months to several years.

Staff members comprised seven males and 15 females; four had witnessed restraint and 18 had direct experience (with the majority also having witnessed). Staff comprised eight ward/deputy ward managers, three health-care assistants/nursing assistants, two occupational therapists, six nurses (ranging from

student nurses to senior nurses with supervisory responsibilities), two psychologists, and one housekeeper. Ages ranged from early 20s to late 50s. Length of time working within the trust varied from 4 months to 20 years, and staff members worked on a variety of adult wards.

Data collection

Participants provided written, informed consent prior to participating. Semistructured, one-to-one interviews lasting ~1 hour were conducted by the first and second authors in local community settings or on CPFT premises away from hospital wards that could cause concern about confidentiality or trigger traumatic memories. One patient requested that a staff member she trusted be present during her interview. Interviews were digitally voice-recorded and transcribed. The first and second authors are academic researchers with no prior relationship to CPFT ward staff and patients, having worked within the trust solely for the purpose and duration of the PROMISE qualitative study. During transcription, all names and any other potentially-identifying information were replaced with pseudonyms. Interview schedules were designed to encourage participants to consider their experience of physical restraint and provide suggestions for reducing/preventing restraint, and were co-developed with the advisory groups (see Appendix for the interview schedules). Findings relating to the experience of restraint are reported here.

Analysis

The data were analysed using thematic analysis, going through steps of familiarization, initial coding, searching for themes based on initial coding, review of themes, theme definition, and labelling (Braun & Clarke 2006). The data were coded and themed by the first and second authors, who independently read and reread the transcripts multiple times in order to identify themes. The first and second authors then met to discuss and agree on themes to ensure trustworthiness of the data. Further confirmation of themes took place through team discussions, with themes cross-checked and validated by the third and fourth authors, who read a sample of transcripts, and the service user advisory group commented on preliminary themes emerging from the patient interviews. The data are presented in the form of a summary of key themes evidenced with illustrative quotes.

FINDINGS

Is restraint a necessary evil?

The overarching theme that emerged from the data was the question of whether restraint is a necessary evil, with the dominant perspective on this question being neatly summed up in the words of one staff member:

It never is very nice, but I suppose it's got to be done...it's a necessary evil. (Staff member 2, witness)

The majority of patients and staff members expressed the belief that restraint is sometimes necessary, for example:

I don't think you're ever going to negate it completely simply by the nature of people's illness.
(Patient 2, witness)

At the end of the day, I think you will have some circumstances where restraint is a measure of necessary resort. (Patient 13, direct experience and witness)

I think we can reduce the number we do, it won't be eliminated...I don't think it can be ruled out.
(Staff member 4, direct experience and witness)

However, some participants questioned the necessity in all cases, and one participant, a ward manager with 18 years' experience working within the trust, did express the hope that restraint could be eliminated, although she was the only participant who expressed this view:

I hope that in the long term, we will move away from it altogether.
(Staff member 17, direct experience and witness)

Within the overarching theme, 'is restraint a necessary evil?', subthemes were identified, which fit into the two ideas represented in this pinnacle quote: 'it never is very nice but...it's got to be done...it's a necessary evil' (Staff member 2, witness). 'It never is very nice' is demonstrated by the mainly negative emotional and relational outcomes reported. Despite these negative outcomes, although it is never nice, it might be a 'necessary evil', so cannot be avoided demonstrated by the themes of: (i) safety considerations: it protects staff and patients versus putting them in danger; and (ii) the question of whether restraint is really only ever used when necessary: it's a last resort versus it's carried out when unnecessary/avoidable (with communication playing a central role in determining its necessity).

'It never is very nice'

Emotional outcomes

Distress. The most dominant theme was that restraint was distressing for both patients and staff. Four patients described being distressed in general by the experience; for example, one patient who had been restrained after refusing medication said:

I think it definitely scarred me...yes, distressing. Absolutely! (Patient 10, direct experience and witness)

One patient also described the emotional overload experienced when witnessing restraint:

Because of the nature of restraint as a visual experience, it produces another set of overload on the emotions of the other patients...I really think you know as patients we need to be able to say that's quite upsetting! (Patient 13, direct experience and witness)

Eleven staff members reported feeling distress and upset for themselves as a result of restraining patients; for example, one staff member who had been involved in hundreds of restraints over 20 years at CPFT stated:

I know there have been times when I've done it and cried afterwards because I felt so horrible.
(Staff member 9, direct experience and witness)

The majority of staff who commented on its distressing nature acknowledged the emotional impact on both themselves and patients. A few patients and staff members also reported that it was particularly distressing to experience and/or witness restraint for the first time:

When I first came to this ward, I was quite horrified by the amount of physical restraint they used 'cause I just wasn't used to that...it's really upsetting.
(Patient 7, direct experience)

I think, in the beginning, I felt it was very distressing.
(Staff member 12, direct experience and witness)

The staff member quoted above went on to explain that, over time as she learned that it is a last resort, and therefore necessary, the experience became less distressing:

Because my immediate idea was...why can't you just talk to people? You know, just talk to them, but I've since realized that it's the last resort.
(Staff member 12, direct experience and witness)

As demonstrated, most participants emphasized the distressing nature of restraint. This is in line with the

view of restraint as negative (i.e. 'never very nice'). However, two staff members downplayed the emotional impact; for example one with 9 years' experience of working at CPFT who had restrained multiple times reported no negative emotional impact on themselves as a result of restraining:

So far as possible, we don't restrain, and if we do in order to either to alleviate somebody's agitation, then it usually actually means that they are less distressed afterwards. . .so overall, I don't think I feel upset by it.
(Staff member 19, direct experience and witness)

In the above quote, restraint was not perceived as distressing due to their reflection that it was a necessary evil, as the outcome of restraint for the patient was a reduction of distress, which in turn prevented the member of staff from being distressed.

Fear. Another reported emotional response to restraint was fear. Five patients described being scared; for example, one patient reported fear at being restrained by four staff members in order to receive medication by being dragged on her knees to her bedroom:

Absolute terror! I was really scared. . .it was like something out of a horror movie. . .I was so terrified, I wet myself. I've never had such a terrifying experience in my life.
(Patient 6, direct experience and witness)

A few staff members also observed that patients they had restrained or witnessed being restrained had been fearful. One staff member, who also had past experience of being restrained as a patient, reported finding restraint scary in both roles:

I have been on the receiving end and it's a really frightening experience. . .two or three people putting hands on you and they are leading you to your bedroom and laying you down on the bed. . .it's a scary experience, but also from the point of view of the member of staff.
(Staff member 13, direct experience and witness)

A large proportion of other staff members cited feeling fearful when witnessing and/or carrying out restraint. In common with participant comments on feelings of distress described, patients and staff also commented that restraint was at its scariest when it was first experienced:

That first time is really, really quite a scary situation to find yourself in if you've never come across it before.
(Patient 1, witness)

The first one I actually witnessed. . .it just looked dreadful. . .when you first see that, it's a little bit scary.
(Staff member 2, witness)

Restraint was seen to become less frightening with experience, with experience leading to participants believing that it is necessary. For example, the above staff member went on to explain that:

I'd never seen anything like that before. . .I think it was just the fact that there were four or five people on one man and I'd never worked in mental health, so you don't think that you'd need that. It looked a bit too much, but then after a little while of working on the wards and seeing how people. . .can suddenly turn into this total whirlwind and destroy everything in sight, you know, I understand it now.
(Staff member 2, witness)

As seen in the following example, patients emphasized that fear was not only experienced in the moment of the restraint but also left a 'fear culture' on the wards and throughout the patient's entire care journey:

It left me with total fear of the whole of the mental health service people. . .that will always stay with me. . .there's just a whole terror culture on the wards. . .there's a lot of fear about it. . .it's a fear culture, which is still operating.
(Patient 6, direct experience and witness)

Therefore, the subtheme of fear contributes to the picture of restraint as a negative experience for staff and patients.

Dehumanizing. Five patients and one staff member described the experience of restraint as dehumanizing. One patient, who also had direct experience of restraint, described one incident she had witnessed:

That situation got out of control because they (other patient) weren't talked to with compassion like a decent human being. . .people aren't treated as ordinary flesh-and-blood human beings.
(Patient 6, direct experience and witness)

A student nurse who had been working on CPFT adult inpatient wards for 3 years described restraint she had witnessed as 'dehuman; it's not nice' (Staff member 10, witness).

Decreased job satisfaction. Eight staff members described that, while restraint was an accepted part of their job, it was a part that they did not like and found unpleasant; for example, one staff member with nearly

30 years' experience working in mental health care across two trusts explained:

I don't like it to be part of my job...these people are not very well and it's just a horrible thing to be doing...I don't like it, it's not part of the job that I come into work and think 'Oh good, I'm going to have a restraint today'.

(Staff member 1, direct experience and witness)

Three staff members explained that they perceived it as contradictory to the professional caring nature of their jobs, including a ward manager who had worked in CPFT adult mental health wards for 20 years:

It's something I don't like doing...it's a horrible thing...because it's not what we're here to do. We should just be caring, and it's not very caring, is it?

(Staff member 9, direct experience and witness)

Others reported that restraint led them to view their various roles differently, and even prevented them from looking forward to work or enjoying their job:

It's the dread of having to be expected to restrain patients that can make you feel differently about the job...if there's an incident of an ongoing patient...and I know that they're probably going to be required to be restrained...that makes you not look forward to getting on the ward.

(Staff member 8, direct experience and witness)

When it was at its worst, I didn't enjoy my job as much; it just felt horrible.

(Staff member 16, direct experience and witness)

In line with the view that restraint is never very nice, staff described restraint as a difficult, unpleasant part of their job. Consistent with the view that restraint is a necessary evil, despite its negative impact on their feelings towards their job, restraint was described as an accepted/expected part of the role.

Relational outcomes

Power dynamics. Four patients reported feeling a loss of control over their own lives as a result of being restrained, with comparisons made to being in prison or the army; for example, two patients who had been restrained in order to be medicated reported:

There was a lot of power and control...it's like a prison sentence...(staff) become like prison wardens...it's like being in the army; you enter the army and then you don't have any control of anything really.

(Patient 10, direct experience and witness)

I did feel that they have the power to do this to me...it's a demonstration, even if unconsciously so, of what we can do to patients at this point.

(Patient 13, direct experience and witness)

One staff member who had been involved in two restraints over the 18 months she had been working as a clinical psychologist at CPFT also acknowledged this feeling among patients:

I think part of the stigma and people's thoughts are it's a symbol of strength and power that staff have over patients.

(Staff member 12, direct experience and witness)

Restraint is, therefore, viewed as a demonstration/symbol of the power and control that staff have over patients. Combined with the negative experience of loss of control and the associated stigma, once more restraint is experienced as overwhelmingly negative.

Quality of patient-staff relationships. Seventeen participants reported a negative impact 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. For example, one patient, who described being dragged on her knees to her bedroom for forced medication, explained that the incident severely affected her relationship with staff members:

It left me with...a total distrust...a total vote of no confidence and no faith in anything they did, wanting to have absolutely nothing to do with any of them...all the time this is in my mind how they've treated me and how they treat other people, and obviously that affects relationships with them.

(Patient 6, direct experience and witness)

A health-care assistant who had restrained patients on several occasions over her 4.5 years' experience working at CPFT explained:

It's always gonna damage the therapeutic relationship...it can break down some of the trust...and then they're less likely to disclose things to you.

(Staff member 16, direct experience and witness)

Some explained that this negative impact was experienced in both the short and long term. For example, one patient, who had experienced numerous restraints for trying to abscond or to receive PRN medication, explained:

It made me very anti most of the staff...I didn't trust them because they gave me no reason to trust

them... 'cause that's a huge thing to do to somebody; to physically restrain them... it certainly didn't help you with your relationships with the staff... I was very resentful towards them... I just didn't want them near me the next day... I think, long term... you don't trust the staff that much, and I must admit I'm still pretty distrustful. I very rarely ask the staff for support and one-to-one talking.

(Patient 7, direct experience)

Similarly, an occupational therapist, who had directly restrained patients 10 times over his 2.5 years working at CPFT, reported:

There's been two or three patients that I've been involved in a restraint who have then just refused to talk to me and been verbally aggressive for the remainder of their admission... it's actually a bit upsetting and just, like you think... well that's torn it then, and it might be that... there wasn't much of a relationship at first, but you've been working on getting it... to a point where you've gained a bit of trust... and then that's it after that.

(Staff member 8, direct experience and witness)

Thus, relational outcomes in terms of patient-staff relationships were commonly described as negative. However, one patient and three staff members reported that this negative impact on relationships was only short lived; for example:

I probably forgave the staff later... I wouldn't have remembered later which staff had done it.

(Patient 4, direct experience)

You can always go back to them and have another chat with them a few days later... mostly we work through it.

(Staff member 15, direct experience and witness)

Furthermore, a few patients and staff members reported no significant impact on patient-staff relationships, with two patient witnesses even reporting a positive impact; for example:

It made my relationship with the staff better, because you respect the amount of abuse they do take from people.

(Patient 1, witness)

Therefore, restraint was mainly described as damaging the staff-patient relationship, but for some participants, it had no impact or a positive impact.

Summary

These subthemes form a picture of restraint as a negative experience for patients and staff: 'it never is very nice'. Participants emphasized the distressing, scary,

and dehumanizing nature of restraint; staff described restraint as a difficult, unpleasant part of their job; restraint was viewed as a demonstration/symbol of the power and control that staff have over patients; and relational outcomes in terms of patient-staff relationships were commonly described as negative. However, 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 and when all other efforts have failed), restraint is needed: 'it's a necessary evil'. This is outlined in the following subsections.

'It's got to be done... it's a necessary evil'

Restraint as a safety measure versus restraint as a cause of pain/injury

Different views were expressed over whether restraint protects from, or causes, physical injury. The main reasons that restraint was deemed necessary centred on safety and protection from injury, with the majority of patients and staff citing this as a necessitating factor for its use. For example, two patients who had been restrained to stop them injuring themselves or others stated:

I'm still alive and not dead... it's kept me safe.

(Patient 3, direct experience)

I know they're just doing it to help so you don't hurt anyone or hurt yourself... if it's to help, there's no other way of doing anything, so you have to restrain.

(Patient 11, direct experience)

Staff members also frequently reasoned that restraint was necessary due to safety considerations; for example, a nurse who had restrained hundreds of times over her career explained:

Why I think it is necessary is, because at that point, the patient doesn't know what they are doing, and if we leave them... then they will either hurt themselves and hurt others or damage equipment.

(Staff member 22, direct experience and witness)

The subtheme that restraint is a necessary safety measure to prevent injury to staff, other patients, and themselves, and damage to equipment, stands in contrast to the occasional descriptions of restraint as the 'cause' of physical injury to staff and patients. Several staff members reflected on physical pain and injury resulting from the restraints themselves. For example, one staff member described an incident where the restraint of a patient, who was lashing out at another patient, led to staff injuries:

The patient actually broke the rib of my colleague and actually made a connection with myself.

(Staff member 13, direct experience and witness)

Two staff members and two patients described incidences where patients had also been caused pain or injury as a result of restraints; for example:

The interventions...can cause bruising, they can hurt...unfortunately, it does happen sometimes.

(Staff member 14, direct experience and witness)

I was quite physically hurt on a couple of occasions.

(Patient 7, direct experience)

However, two patients reported that they had not experienced this: 'I never saw anybody come out battered and bruised' (Patient 1, witness) and 'They didn't hurt me when I was going through it' (Patient 12, direct experience).

Thus, conflicting themes were present on whether restraint protects patients and staff or puts them in danger. Protection supports the idea that restraint is necessary; the reported cause of injury potentially questions this.

Necessary when used as a last resort

Although most participants had the view that restraint is sometimes necessary for the safety/well-being of patients and staff, there were different views on whether restraint only ever occurs when all other options have been exhausted. In particular, participants emphasized the central role of communication in ameliorating the need for restraint. Different experiences were described of restraint as a last resort or as unnecessary/overused.

Always a last resort? Both patients and staff reported that incidences of restraint that they had experienced and/or witnessed were necessary, because restraint was used as a last resort only after other options had been exhausted:

On this ward...it's only happened two or three times that anybody's really been restrained...and that's after severe provocation; it's the last resort.

(Patient 8, direct experience and witness)

It was always absolutely the last resort...with all the will in the world, you've tried every angle possible, but it comes down to that in the end.

(Staff member 17, direct experience and witness)

However, 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. For example, one patient who had been an inpatient regularly for 15 years stated:

Sometimes I think it's necessary, because I'm doing quite a lot of harm to myself, but other times I don't think it's necessary...when I head bang...I don't think I'm doing a lot of damage, but they still restrain me...if I'm just shouting, then I don't think it's necessary, because...not everybody gets restrained for shouting.

(Patient 9, direct experience and witness)

A staff member gave an example of when he had witnessed the beginning of an unnecessary restraint that he was then able to prevent:

A staff nurse again said 'We're going to restrain Mrs X', and I said 'Why?' 'Well it's for non-medication adherence'...I said to the nurse 'Let me try then. What tablets do you want her to take?', and I went to the patient...it took me half an hour, but she took her tablets, and in that case...it wasn't necessary, but to that nurse at the time I think it was.

(Staff member 8, direct experience and witness)

Furthermore, even on occasions when restraint was viewed as necessary, participants identified lost opportunities to de-escalate and reduce the likelihood that restraint would be needed.

Therefore, while some reported their experience was that restraint was only used as a last resort (i.e. when absolutely necessary), others reported that it had been preventable. Restraint was viewed as a 'necessary evil' when it was used as a last resort, but in some cases where it was not used as a last resort, it was viewed as an unnecessary evil, and therefore, preventable. Although people gave different views (often within the same interview) on whether in their experience restraint was used as a last resort, all emphasized that it 'should' only be used as a last resort, and therefore, when necessary.

Role of communication. Communication was seen as playing a pivotal role in determining whether a situation escalated to the point where restraint would become necessary. Seven patients and 15 staff members described examples of what they perceived as effective communication from staff before, during, and/or after restraints that they witnessed or were directly involved in, which was linked to attributions of necessity for these restraints:

They (staff) try all the de-escalation, the offering of medication, and trying to talk the situation down, and a lot of the time it works.

(Staff member 2, witness)

Laying down on the floor next to her and having a chat with her whilst she was laying under the bed, and after doing that for 10 minutes, I found she would then come out, without medication, without being restrained, and you know she would then chat and she'd be okay.

(Staff member 9, direct experience or witness)

In the above examples, effective communication negated the need for restraint, supporting the idea that it is only done when necessary.

In contrast, six patients described concerns that there was a lack of communication from staff around restraint they had experienced/witnessed, which led to the conclusion that restraint was not used as a last resort, as more could have been communicated in order to prevent the restraint:

I also witnessed...a man who was obviously getting agitated...he'd been up all night...no one talked to him. By the end of the afternoon he was pulling televisions off the wall, and then of course...they raised their alarm and all piled in...there was no professional talking to him to settle him and distract him...and the poor man had to lose control.

(Patient 6, direct experience and witness)

Seven staff members also described poor examples of communication around restraint, and similar to patients, some also reflected that effective communication could have prevented restraint:

There was a lady in the corridor who had attempted to assault the doctor and they got her in a safe hold to protect (the doctor), and somebody said 'Get her head', and I said 'No, don't get her head, it's not necessary to go into a full restraint. Safe hold her, through to the de-escalation room, talk to her', which is what happened. After 5 minutes, she said 'Yeah, I wanted to hit (the doctor); I was angry'. I said 'Why?'. Quickly de-escalated and I said 'Come on, let's go for a cigarette'. You know it's a lot about how you approach people. Not jumping on them, not panicking, just giving people time. (Staff member 9, direct experience and witness)

Consequently, there were conflicting views under the theme of communication over whether restraint is always used only as a last resort, and therefore, whether it is always necessary.

DISCUSSION

The aims of the present study were to improve understanding of patients' and staff members' experience of physical restraint in CPFT adult mental health

inpatient wards, while addressing the tension between reducing restraint and maintaining safety in mental health care by giving careful consideration to barriers to restraint reduction. The present study thereby adds to the research into restraint conducted in the UK and improving understanding of the experience of restraint from all parties involved. Thirteen patients and 22 staff members who directly experienced and/or witnessed physical restraint took part in interviews. The sample was broadly representative of adult patient and staff demographics in terms of sex, age, ward type, and job role. An overarching theme was identified from the interviews: 'Is restraint a necessary evil?'. Within this overarching theme, subthemes were identified, fitting into the two ideas represented in the quote: 'it never is very nice but...it's got to be done...it's a necessary evil'. It 'never is very nice' was demonstrated by the predominantly negative emotional and relational outcomes reported. However, a common theme from both staff and patients was that, while restraint is never very nice, it is a 'necessary evil' used as a last resort to manage safety concerns.

A large proportion of patients and staff, witnesses, and those with direct experience, reported finding restraint distressing and fear-inducing, coinciding with previous findings internationally (e.g. Bigwood & Crowe 2008; Kontio *et al.* 2012; Strout 2010). Here, restraint was not only reported to cause fear at the moment of restraint, but was also reported to leave a fear culture on the wards. Patients also described restraint as dehumanizing and leading to feelings of a loss of control, expanding similar findings expressed by patients and family members of patients who had been restrained and/or secluded in Australia (Brophy *et al.* 2016). Staff members reported that restraint was a difficult part of their job, which they perceived as contrary to the caring nature of their jobs, and which decreased job satisfaction. This is consistent with previous findings that restraint 'spoils the job' (Bigwood & Crowe 2008), and that mental health nurses experience tension in balancing their therapeutic role and the provision of empathic care with the potentially incompatible duty of managing risk to ensure safety (e.g. Bigwood & Crowe 2008; Gerace *et al.* 2016). As with previous research (e.g. Chuang & Huang 2007; Wynn 2004), a large proportion of patients and staff reported that restraint had a negative impact on patient-staff relationships, which continued into the long term. However, a smaller proportion cited no impact on relationships, and two patient witnesses cited a positive impact.

Despite the numerous reported negative experiences with, and consequences of, restraint (restraint is 'never is very nice'), similar to previous findings that mental health nurses report that restraint is an integral and irreplaceable part of their job (e.g. Bigwood & Crowe 2008), most interviewees expressed the belief that restraint is sometimes necessary and cannot, or should not, be eliminated (i.e. it is a 'necessary evil'). This largely centred on issues of safety for all parties and the observation that restraint was used as a last resort. In contrast to some existing research, where staff reported that restraint is always a last resort and patients reported that restraint is sometimes unnecessary (e.g. Fish & Culshaw 2005), in the present study, both staff and patients described examples of restraint used as a last resort and times when they perceived restraint to be unnecessary. The use of communication was seen as playing a pivotal role in determining whether a situation truly necessitated the use of restraint. Previous studies have found varying staff and/or patient views over whether restraint is a necessary aspect of mental health care or is amenable to change (Bigwood & Crowe 2008; Perkins *et al.* 2012). Sullivan *et al.* (2005) recommend that mental health staff need to be able to envisage the possibility of a restraint-free environment, and it can be argued that this is not presently the case among this group. However, consistent with current UK policy/guidance on restraint (Department of Health, 2014), all those who described restraint as sometimes necessary also emphasized that restraint should only be used as a last resort, and that restraint can, and should, be reduced. Furthermore, some interviewees identified missed opportunities (particularly in relation to communication) in the lead up to restraint, which could potentially have prevented it becoming a necessity.

A few limitations from the research warrant consideration. Patients and staff from child/adolescent, older persons, learning disability, or eating disorder wards were not included, which provided a more homogenous sample, but also made the findings less generalizable to the whole mental health population. A variety of job roles were covered, which aids generalizability, but provides a less homogenous sample. However, similar themes and experiences were found across job roles, and this variety of job roles was included following recommendations from our advisory groups. Additionally, as the study relied on retrospective recollections, there could be some concern about the reliability of information provided from

former inpatients and staff members whose last experience of restraint occurred some years ago. Patients who agreed to participate might not be completely representative of the group as a whole, as the sample was self-selected, and those with particularly traumatic experiences might have felt unable to put themselves forward. It is worth noting that some patients were provided with information sheets about the study by staff (who only approached patients they deemed well enough to talk about their experience of restraint); however, posters were displayed on ward noticeboards and in ward meetings, allowing patients to self-select to take part. We had hoped to recruit more than 13 patients; however, as patient recruitment was slower and more challenging than staff recruitment, this could not be achieved within the time constraints of the study. Despite these limitations, the strengths of this research include the inclusion of both patients and staff, those with direct experience, and witnesses, and the key role that staff and patient advisory groups played in the research design.

CONCLUSION

Echoing and expanding on earlier findings, restraint in mental health care was experienced as 'never very nice', particularly in terms of negative emotional and relational outcomes. Nevertheless, patients and staff, witnesses, and those with direct experience described restraint as a 'necessary evil' that could not safely be eliminated. According to previous recommendations (Sullivan *et al.* 2005), mental health staff need to be able to envisage a restraint-free environment, and the present research demonstrates that, within CPFT, both staff and patients find a restraint-free environment difficult to envisage. Continued research is needed into patient and staff experiences with restraint and their recommendations for, and concerns about, reducing or eliminating restraint. Further research is also needed to incorporate the views of staff and patients from specialist wards. Research that supports the reduction/elimination of restraint is necessary not only because of political pressure from various national governments to reduce restraint internationally (as previously outlined e.g. Department of Health, 2014) but because we as mental health-care providers should be striving towards more humane mental health care in our services, and restraint does not fit well with the core values of care and compassion, which are at the heart of frontline service delivery.

RELEVANCE FOR CLINICAL PRACTICE

Restraint is a largely negative experience for all parties involved; however, as restraint is perceived as a necessary evil, there is widespread concern about safety if it was to be eliminated. Support is needed for staff and patients in dealing with the negative emotional, physical, and relational impacts of restraint (e.g. through effective supervision, talking therapy, and/or thorough debriefs with all parties involved), as well as addressing the worrying impact of restraint on job satisfaction in light of worldwide concerns about the recruitment/retention of health-care staff (World Health Organization, 2014). Political pressure is being put on mental health-care providers by national governments to reduce restraint, which is clearly important in terms of reducing negative outcomes for patients and staff; however, more research is needed into alternatives to restraint, while addressing the safety concerns of all parties. The comments from the present research can also form a tool for restraint-related training to show trainees the potential consequences of restraint both for patients and staff, which in turn could impact on the frequency that restraint is used. Of key importance, we need to ensure that by reducing or eliminating restraint, mental health wards neither become, nor feel, unsafe to patients or staff.

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APPENDIX : Interview guides

Patients:

1. Could you tell me a little about your time spent on CPFT inpatient mental health wards?
Probe/s: How many times have you been in a ward? How long were you in the ward/s for? How was your experience?
2. How often have you experienced/witnessed restraint?
Probe/s: When did the restraint/s occur?
3. Thinking of the time/s you have been restrained/witnessed restraint, can you tell me what happened before the restraint/s occurred?
Probe/s: What were you doing just before? Where were you? Who were you with? What was your interpretation of why you were restrained? What was the sequence of events/build up?
4. Thinking of the time/s you were restrained/witnessed restraint can you tell me about your experience of the actual restraint/s?
Probe/s: Who was involved in the restraint/s? What did they do? What did you do? How did you feel?
5. Did you talk to anyone about the restraint afterwards?
 - 5a. If yes, who did you talk to?
Probe/s: clinician/s, peers, family, friends? Was it helpful?
 - 5b. If no, would you have wanted the opportunity to?
6. Thinking of the time/s you were restrained/witnessed restraint, do you think restraint was necessary in this/these situation/s? Why?
7. What do you think could have been done instead?
8. Did the incident/s impact on your relationship with staff?
Probe/s: How did you feel about staff: Before? During? After?
9. Did the incident/s change how you felt about the ward? How?
Probe/s: Did it change your relationship with other patients?
10. Did the incident/s change how you felt about your care? How?

11. What were the outcomes of restraint/witnessing restraint for you?
Probe/s: Immediate and long-term? Were there any positives to the restraint? Any negatives?
 12. What suggestions do you have for reducing the use of restraint?
Probe/s: What could be implemented or changed on the ward to reduce the use of restraint or make it unnecessary?
 13. If you could speak to new staff about to start working in mental health care what advice would you give on avoiding the use of restraint?
 14. If you could design a service which aimed not to use restraint, what would you do?
 15. (If not already mentioned) What do you understand by proactive care?
 16. Proactive means creating or controlling a situation rather than just responding to it after it has happened. The opposite is being reactive, or waiting for things to unfold before responding. In light of this definition, do you think proactive care would make a difference to restraint on the ward?
Probe/s: Do you have any examples of when you think it has made a difference?
- Staff members:**
1. How long have you worked in CPFT inpatient mental health wards?
 2. Can you tell me about your role?
 3. How many instances of restraint have you been involved with/witnessed?
Probe/s: When did the restraint/s occur?
 4. Can you tell me about any training you have received related to restraint? (Direct experience only)
 5. Thinking of the time/s you restrained patients/witnessed restraint, can you tell me what happened before restraint occurred?
Probe/s: What was the patient doing just before? Where were they? Who were they with? What were you/other staff doing?
 6. Can you describe how the decision to use restraint was made? (Direct experience only)
Probe/s: Who? What? Why?
 7. Thinking of the time/s you restrained/witnessed restraint, can you tell me about your experience of the actual restraint?
Probe/s: Who was involved in the restraint? What did staff do? What did the patient do? How did you feel?
 8. Thinking of the time/s you have restrained/witnessed restraint, do you think restraint was necessary in this/these situation/s? Why?
 9. What do you think could have been done instead?
 10. Did the incident/s impact on your relationship with the patient? (Direct experience only)
Probe/s: How did you feel about the patient: before? During? After?
 11. Did the incident/s change how you felt about your job? How?
 12. What were the outcomes of restraint/witnessing restraint for you?
Probe/s: Immediate and long term? Any positives? Any negatives?
 13. What suggestions do you have for reducing the use of restraint?
Probe/s: What could be implemented or changed on the ward to reduce the use of restraint or make it unnecessary?
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