Exploring the impact on practice when Service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards

A project submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies

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GLOSSARY OF TERMS:

Violence in the health setting	Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work… (Health and Safety Executive 2013)
Restrictive interventions	*'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:* • *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and* • *end or reduce significantly the danger to the person or others; and* • *contain or limit the person's freedom for no longer than is necessary'* (DH 2014 p.14).
Chemical restraint	*'The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness'* (DH 2014 p.28).
Physical restraint	'*Any direct physical contact where the intervener's intention is to prevent, restrict or subdue movement of another person'* (DH 2014 p.26)
Mechanical restraint	*'The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'* (DH 2014 p.27).
Seclusion	*'The supervised confinement and isolation of a person, away from other users of services, in*

	an area from which the person is prevented from leaving.' 'Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others' (DH 2014 p.28).
Recovery model in Psychiatry A particular framework includes three types of recovery from serious mental illness	• 'clinical recovery: cure or remission of the illness • illness management: involves symptom control and long-term monitoring of the illness by both doctor and patient • personal recovery: involves functioning at one's best despite ongoing symptoms of illness' (Barber 2012)
The prevention and management of violence and aggression (PMVA) training	This training incorporates the theoretical and the physical components of knowledge and skills required to manage a challenging behaviour on the ward. It is delivered by a team of staff qualified to facilitate the training and experienced service user trainers.
Mental health service User PMVA trainer	For the purpose of this study, a mental health service user trainer is an adult male or female who has previous experience of being physically restrained whilst in a local in-patient mental health hospital ward, is now living in the community and participates in the Higher Institution PMVA training delivery.

KEY ACRONYMS

MH	Mental health
SU	Service user
SUs	Service users
SUI	Service user involvement

PMVA	Prevention and management of violence and aggression
RP	Restrictive practices
RI	Restrictive intervention
PR	Physical restraint
GSA	General Services Association
HI	Higher Institution
NHS	National Health Service
DH	Department of Health
WHO	World Health Organisation
PARS	The positive alternatives to restraint and seclusion
BSP	Behavioural support plans
RRM	Restraint reduction meeting
RRN	Restraint Reduction Network
PRN	pro re nata
TA	Thematic analysis

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CHAPTER 1

INTRODUCTION

In its report on promoting mental health, the World Health Organisation (WHO) proposed that mental health is a state of wellbeing in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO 2004 p12). Interestingly, concern has been raised about possible misunderstanding of this view of mental health. Galderisi et al (2015) argue that the definition may have unwittingly excluded certain groups such as migrants and minorities experiencing rejection and discrimination. They propose what they consider as an inclusive definition:

"*Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium*" (Galderisi et al 2015 p231).

With this in mind, we consider mental illness as characterised by alterations in thinking, mood or behaviour or some combination thereof with associated significant distress and impaired functioning (Government of Canada 2006). Going further, the agency points out that the symptoms of mental illness vary from mild to severe depending on the type of mental illness, the individual, the family and the socio-economic environment (Government of Canada 2006). In addition, it could take different forms including mood disorders, schizophrenia, anxiety disorders, personality disorders, and addictions such as substance dependence (Government of Canada 2006). A mental health condition is not a respecter of gender, age, occupation, educational level, socio-economic condition or culture. It can afflict a person directly, or indirectly through a family member, friend or colleague. In an age when the stress of living is taking a toll on

people's wellbeing particularly their mental health, anybody can become a victim of mental ill health. News media reports indicate that young people are increasingly vulnerable to mental illness particularly depression (BBC Breakfast News 2014, ITV News 2018). Smith (Metro 2014) calls it *'The pressure cooker generation'*. He likens the situation to *'sitting on a mental health time bomb'* (Metro 2014 Front page).

The reality is that mental health disorders afflict more people than society is comfortable to admit to. Approximately four hundred to five hundred million people worldwide are coping with a mental health problem (WHO 2001) and a large percentage of this population live in low and middle income countries (Patterson and Edwards 2018). According to WHO (2001), the deprived and the poor have a higher prevalence of mental, behavioural and substance use disorders. Figure 1 shows how economic deprivation and poor mental health feed into and exacerbate each other.

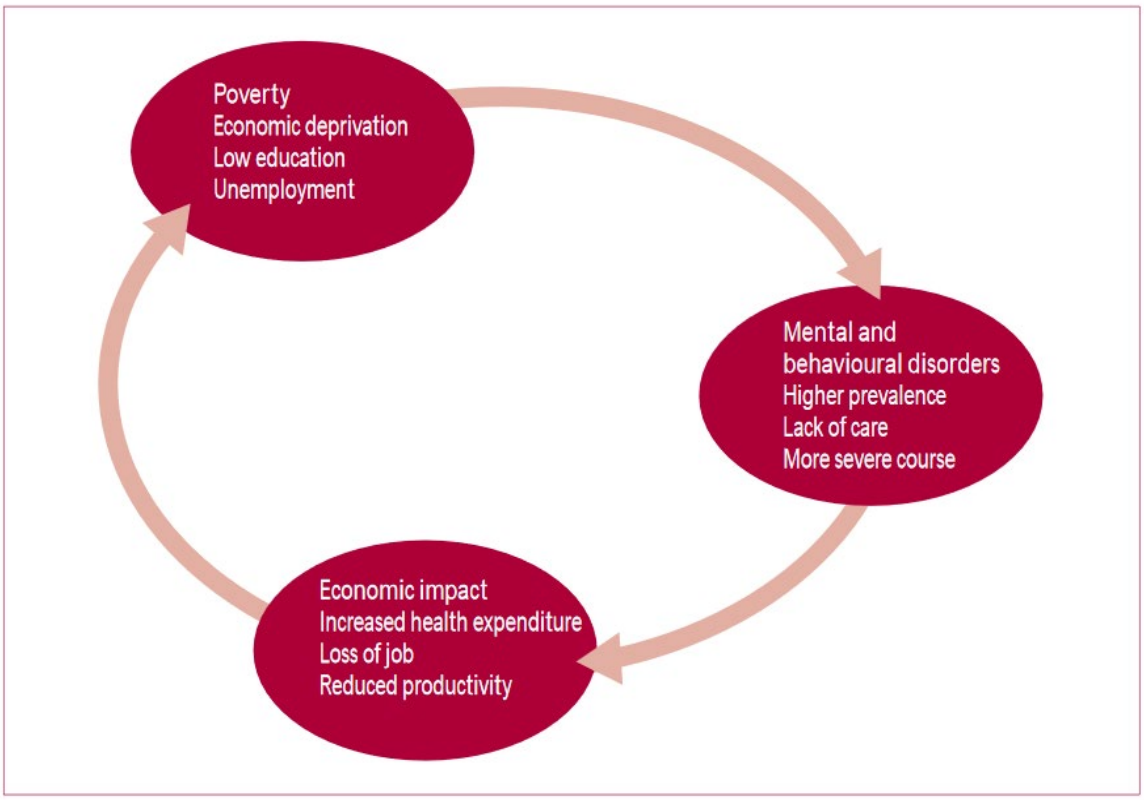


Figure1: The vicious cycle of poverty and mental disorders. Courtesy of The World Health Report 2001 - Mental Health: New Understanding, New Hope p14

> *"Poverty and associated conditions such as unemployment, low education, deprivation and homelessness, are not only widespread in poor countries, but also affect a sizeable minority of rich countries"* (WHO 2001 p13).

Consequently, in the US for example, it is estimated that one in five adults experience mental illness each year (NAMI 2019). Two or three percentage of the population in Australia (about 600,000 people) is similarly estimated to have a diagnosis of a severe mental disorder (Brophy et al. 2016 p2). In Canada, one in five people are affected by the disorder at some time in their lives (Public health Agency of Canada 2006). Here in England, one adult in six (1 in five women and 1 in eight men) cope with a common mental disorder (McManus et al. 2016). Bourke (2018) believes that ten percent of the people with whom we work take anti-depressants. Yet, mental health remains a taboo subject, especially in corporate environments and professionals dare not talk about their problems for fear of stigmatisation and possibly losing their job (Bourke 2018).

Mental health and stigmatization

Goffman explains that the term stigma refers to an 'attribute that is deeply discrediting' (Goffman 1963 p3). Stigmatization of the mentally ill is defined as "*negative marking of or marginalizing and avoiding people because they have a mental illness*" (Babic, 2010 p43). There are also psychological, social and economic consequences for the stigmatized individual (Babic 2010; Lai et al. 2000). For example, the stigma attached to schizophrenia creates a vicious cycle of alienation and discrimination that could lead to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalization which decreases the chance of recovery and normal life (The World Health Report 2001 p99). Babic (2010) and Couture and Penn (2003) found that stigmatization of the mentally ill is widespread. The fear of rejection because of their disorder forces people with mental illness to make considerable efforts to hide that aspect of their lives (Keating and Robinson 2004). Patterson and Edwards (2018) note that stigma can extend from the ill person to his or her family in many countries especially in low and middle income countries, forcing the family to take extreme

measures such as chaining and hiding their sick member in order to protect them and the family (Patterson and Edwards 2018, Read 2007). Stigma is a '*lamentable reality of mental illness, especially when it is encountered in a professionally educated workforce*' (Nash 2014 p166). A study by Nash (2014) concluded that poor staff attitudes which can lead to less conscientious levels of care can be linked to stigma. In other words, stigmatisation can influence the way we relate to or care for our mentally ill including adopting non-therapeutic care practices (Trenoweth et al. 2011). This is particularly transparent when restrictive intervention is being used to manage an incident involving a mentally ill person.

Restrictive interventions

Restrictive interventions are described as:

"*Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person's freedom for no longer than is necessary"* (DH 2014 p14).

They include interventions such as chemical restraint, mechanical restraint, physical restraint, seclusion and/or deprivation of liberty in some way. These are described in table 1 for clarity.

Table 1: Definitions of restrictive interventions (DH 2014)

Restrictive Intervention	Definition
Chemical restraint	*'The use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness'* (p.28).

Mechanical restraint	*'The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'* (p.27).
Physical restraint	*'Any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person'* (p.26).
Seclusion	*'The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.' 'Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others'* (p.28).

Authors including McKenna (2016) and Brophy et al. (2016) argue that restrictive interventions in mental health services are coercive violations of the 'human rights' of the individuals affected. Glasper (2014) also alleges in his essay that "*… people who exhibit challenging behaviour in health and social care settings are at higher risk of being subjected to restrictive interventions*" (Glasper 2014 p438). The pity of it is that the vulnerable, the very ones who beg for and rely on our care and protection are the core group of individuals in this description. No wonder the demonstration of 'outrage' by the public whenever a restrictive intervention such as physical restraint is unnecessarily used or worse, intentionally used to punish people in care.

Over the centuries, passionate efforts by individuals and bodies towards eliminating or reducing restrictive interventions have been made (Russells 2014, Winship 2006). Currently, the drive towards the elimination or reduction of restrictive interventions is being stoked by a new momentum nationally and

internationally. This momentum in McKenna's (2016) opinion was activated by the United Nations Convention on the Rights of Persons with Disabilities with particular reference to Article 15 (United Nations 2006). In Victoria, Australia for example, the 'Senior Practitioner' was established in 2007 by the Disability Act 2006 to protect the rights of people with a disability who are subjected to restrictive interventions or compulsory treatments (Webber et al. 2010). The influence of such policies and initiatives on professional practice goes without saying. While policy pronouncements at the World Health Organization level for example guides globally, countries are expected to adopt them within their respective contexts. Here in the UK, reducing restrictive practices in mental health and learning disability services has been of national importance for organisations including the Care Quality Commission (CQC 2017), the Department of Health (DH 2014) and the Royal College of Nursing (RCN 2013). For example, the public outrage regarding the abuse of physical restraint in Winterbourne View Hospital UK (BBC Panorama, 2011) and Mind's Mental Health Crisis Care: physical restraint in crisis (BBC Panorama, 2013) prompted the Department of Health to produce guiding frameworks for managing incidents that may require restrictive interventions. Most prominent of these were the Positive and Proactive Care report (DH 2014) and A Positive and Proactive workforce report (DH 2014) frameworks aimed at initiating a radical transformation of the nation's care culture with particular focus on physical restraint.

Consequently, there is a growing drive nationally and internationally to reduce and where possible, to eliminate the use of restrictive interventions especially physical restraint (McKenna 2016). This movement fires the passion in individuals and bodies to develop initiatives and models for achieving such objectives. Huckshorn (2006) for example, produced what he called the 'six core strategies' for a systematic service-based approach to reducing the use of restrictive interventions. Emphatically included on the list is 'employing the expertise of people with lived experience of mental illness to work alongside clinical staff' (Huckshorn 2006). This 'alongside' working is sometimes referred to as co-production or service user involvement.

Co-production

Explaining co-production, Ramsden (2010) states that

> *"... In practice it involves people who use services being consulted, included, and working together from the start to the end of any project that affects them"*. (Ramsden, 2010 p7).

Crepaz-Keay (2014) sees it as a collaborative involvement in which service users and professionals work together in a partnership that is as equal as possible. With regard to education and training, Carr and Ryan (2016) explain that co-production is an approach to teaching and learning with particular reference to mental health and social care based on the principle that people who use services have valuable knowledge and expertise resulting from their lived experience of the condition and of having to access services.

This notion has driven government policies internationally (Dreissens et al. 2016, Speed et al 2012) and has been reflected in numerous national guidelines, recommendations and initiatives in the UK including NICE (2015), Mind and NUSN (2015), DH (2014) and Centre for Mental Health et al. (2012). For example, the involvement and participation of people with care and support needs, their families, carers and advocates is one of the key principles underpinning the guidance framework issued by the Department of Health (2014).

There is growing literature on service user and carer involvement in the education and training of the professionals in both health and social work sectors. According to Repper and Breeze (2007), the involvement of service users in student learning motivates students to show more sensitivity and empathy and to adopt a more individualised approach in practice. Other studies have echoed this view adding that learning is deeper and transformative and could result to change in attitudes and to patient oriented practice (Speers and Lathlean 2015, Russell 2014, Stacey and Stickley 2012, Schneebeli et al. 2010, Livingston and Cooper 2004). This study explored the difference in terms of patient care that the participation of mental health service users in the prevention and management of violence and aggression (PMVA) training delivery made to staff management of disruptive incidents involving patients on mental health wards.

Rationale for the Project

I work within a higher education team that provides training on the prevention and management of violence and aggression in health settings. To help improve my team's training service, I carried out a study on the experiences of mental health service users when being restrained in local NHS inpatient wards (Obi-Udeaja 2009). The findings from the study were very insightful and thought provoking. A particular finding suggesting that when physical restraint was carried out in a patient caring manner, the patient's experience of it was positive triggered further interest. Other findings in the study raised questions about the way physical restraint was carried out in practice. In response to these findings, the PMVA team considered that the service users' experiences might provide insights that could motivate our course participants to be more patient centred in their practice of physical restraint. An agreement was thus reached with the service users and due processes (described in chapter 2) followed for them to join the PMVA training team.

Furthermore, in an effort to gain a more complete picture of what actually happens on the ward when physical restraint was used to manage incidents it was deemed necessary to explore the ward staff's views. I carried out another study (Obi-Udeaja 2016) for the award of Master in Professional Studies (MProf). The study aimed to find out staff's perspectives and experiences in their use of the model of physical restraint which we taught them. One of the themes from the study (patient centred practices during physical restraint) described the various patient caring strategies that staff employed when managing incidents involving patients. Further to this, the current study which is for the award of Doctorate in Professional Studies (DProf) aims to establish the influence, if any, of the service users' contributions to our training delivery on such a staff patient caring approach to physical restraint. In effect, this DProf project builds upon and extends the MProf study by examining whether the patient caring physical restraint practices by the clinical staff are the practical results of the new learnings acquired from participating in the service user led session during PMVA training. The project will explore the practical contributions of service users in providing training on the prevention and management of violence and aggression to mental health staff. Research evidence has revealed limited evaluation to date regarding the impact

of service user's involvement in the education and training of those who care for them (McIntosh 2018, Chambers and Hickey 2012, McCusker et al. 2012). Yet, such evaluation is essential in order to learn the actual effect if any on professional practice of this great innovation. The dissemination activities on service user participation in training provision could be enhanced with evidence based studies as this one might provide.

Context of the project

I lead the Higher Institution (HI) team that provides training to the local NHS Trust mental health inpatient ward staff and to the HI mental health nursing students on how to prevent and manage incidents of violence and aggression on the wards. The model of training, the General Services Association model lays emphasis on patient care when managing an incident that may require physical restraint (GSA 2015). The training is delivered in a non-operational setting away from the ward environment. As trainers we realise that there is a potential rift or gap between the theoretical principles which we emphasize in training and the staff practice on the ward. Jordan (1994) defines 'theory–practice' gap as "the divide between abstract, possibly esoteric concepts and the real problems of everyday clinical practice" (Jordan 1994 p.418). A theory–practice gap, for example the 'field modifications' of restraint techniques (Paterson 2007 p31), in the management of incidents involving the mentally sick can occur for various reasons including fear (Terkelsen and Larsen 2016) and stigmatization as earlier discussed. One of the ways we try to bridge this gap is to invite mental health service users (living in the community) who have had the experience of being restrained while on an inpatient ward to co-work with us in the delivery of the training.

The service user members of the training team facilitate a session on the training programme. Their session, developed on the principle of active interaction with the course participants utilizes their lived experience of physical restraint to motivate course participants to adopt a patient caring approach particularly when managing patients' anger and aggression on the ward. Their contribution to the training for over ten years that we have worked together has consistently earned positive feedback from our course participants. As a progression to this

development my team has been disseminating our experience of delivering this unique training in partnership with mental health service users through presentation at conferences and through publications including: Obi-Udeaja et al. (2010); Obi-Udeaja et al. (2016) and Obi-Udeaja et al. (2017). The response nationally and internationally reveals that this new phenomenon is steadily gaining consideration and acceptance by other training providers. Course participants and conference delegates are requested whenever possible to provide feedback. Below are some of the feedback.

PMVA course participants' feedback

'The service-user session will help me change practice. It will enable me to share knowledge with my team to communicate better with service users. It will help me address their needs and prevent violence. It will enable me to deal with violence in a better way.' (PMVA course participant)

'The involvement of service users has given me an understanding of a need to debrief patients after the procedure.' (PMVA course participant)

Director of nurses' feedback

The Director of Nursing at an NHS trust whose staff are trained by the PMVA team requested the attendance of my service user trainer colleagues and myself at the Trust in order to present to the Trust Board of Directors what the service user trainers contribute to the PMVA training. Appendix 1 was the feedback from the Director while Appendix 2 is a copy of the minutes on the presentation which is available online.

Feedback following presentations at international conferences

When we presented in an international conference in Dublin to showcase how we co-train in this unique subject area of PMVA, the chairman of the conference organising body who was not even physically present at the workshop sent an email expressing how impressed he was with the feedback he received from his

board member colleagues who attended the workshop (Appendix 4). 'Appendix 4B' was a follow-up to the communication. It led to a much bigger international conference in Copenhagen of over 600 delegates from thirty five countries. The publications following these conferences including Obi-Udeaja, Crosby and Ryan (2016) and Obi-Udeaja, Crosby and Ryan (2017) have attracted global interests in our initiative as another milestone in efforts to achieve the elimination of or at least the reduction of the use of PR in mental health inpatient wards. Interest ranges from those requesting us to present in their conferences to those requesting that we use their publication outlets. Appendix 5 is an example.

The Vice Chancellor's feedback

Following a chat with our Vice Chancellor in which I shared how my team co-train with service users who had experienced being physically restrained while in admission, the VC's interest, perhaps curiosity appeared aroused. He expressed the wish to sit in their session for a fraction of the one hour allocated to it. On the day, he not only stayed for the entire period of one hour, but remained in the session as it carried on until the staff trainers interrupted it after an hour and twenty munities. Appendix 3 was the feedback from him.

The positive feedback from different perspectives indicated that there is a place for service users' input on the issue of how patients' anger and aggression is managed on the wards.

This evaluative research is considered necessary in order to find out the influence of the initiative if any on staff practice. The findings will hopefully provide a further evidence base to support the campaign for service user involvement in PMVA training delivery.

Project Outline

This thesis comprises seven chapters:

Chapter one introduces the study. It considers the reason for the study and explains the context. The project outline is also set out here.

Chapter two will set out the terms of reference for my project, briefly explaining what I am investigating and the guiding boundaries. The research question and objectives will be displayed. The literature review which will be undertaken in this chapter will critically look at the available studies. It will explain how they shape and influence the study and where the gap(s) are.

Chapter three will examine the research methodology adopted for the study. Among the issues to be discussed are: the conceptual approach, the methods used and their limitations, the data sources and the ethical considerations.

Chapter four will discuss the project activity and the development of the data collection instruments. The factors that facilitated or hindered the research activity will be considered here. The chapter will also develop and present the data analytical process adopted for the study.

In chapter five, the key findings of the research with respect to mental health service user involvement in training on PMVA will be presented.

Chapter six will discuss the findings and endeavour to justify the interpretations. The effectiveness and the limitations of my design strategies and research methods will be discussed here. I will critically reflect on my own learning here.

Chapter seven will summarise the outcome from the study. It will make recommendations for involving mental health service users in PMVA training delivery and for evaluating their contribution and then conclude the study.

Chapter Summary

The introduction considered mental illness, its prevalence and the use of restrictive interventions to manage incidents involving the mentally sick. The age old controversy regarding physical restraint was flagged up and attention was drawn to the growing list of initiatives to eliminate or minimise its use. Categorically and consistently included on this list is the need to involve people who use services in the education and training of the professionals that care for them - the subject of this study.

The next chapter will present the aim and objectives of the study as well as explore the existing literature and related literature on the topic.

CHAPTER 2

Terms of Reference/Objectives and Literature Review

Introduction

The question that the study seeks to answer, its aim and the objectives it sets out to achieve are provided in this chapter. For clarity, the project boundaries are elucidated. The chapter explores the identified relevant literatures and related literatures on the subject. It scrutinises and reflects on how these existing materials influence the study. This critical view also aims to identify gaps in the literature the filling of which is a target for the study.

Research Question:

Can service users make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development?

Project Aim:

The aim in carrying out this project is to determine whether or not the mental health service users' contribution to the training on the prevention and management of violence and aggression influences the way that staff actually manage disruptive incidents that involve patients on the ward.

Objectives:

To explore participants' perspectives and their practice of physical restraint using focus group interview before the service user PMVA training session

To identify change in perspectives if any as a result of the training using focus group interview

To determine the implementation of changed perspectives in practice and the sustainability of changed practice using semi-structured interviews.

To examine past PMVA service user session evaluation records for indications to reflect lessons in future practice

Scope of the study

This doctoral study is concerned with the impact on practice of service users' contribution to PMVA training delivery. Its focus is on whether the lessons from such contributions influence the way that staff manage incidents of aggression and violence involving patients on their wards. The enquiry revolves around how ward staff manage incidents from the build-up stage through to the crisis stage and what happens when it is all over as depicted in figure 2.

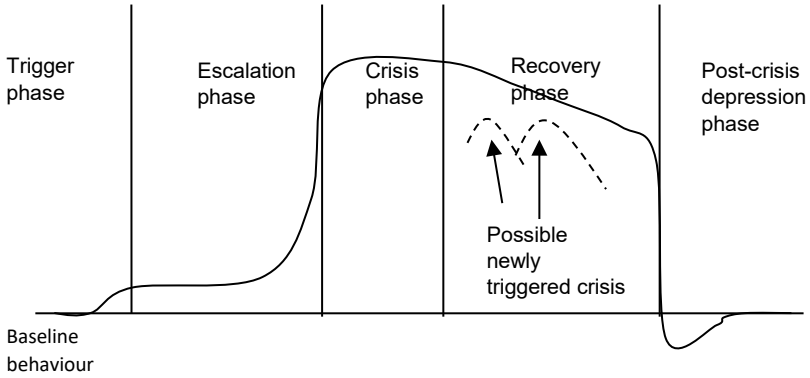


Figure 2: Phases of a typical assault cycle adapted from Kid and Stark (1995, p8)

Figure 2 shows the likely phases an incident may follow. A trigger may occur when the patient is at his baseline behaviour. De-escalation is easiest while still close to the trigger phase. If this fails, the incident may progress to a crises phase. Between the crisis and the post-crisis phases, the patient is extremely touchy and sensitive. There is need for a careful management of the situation especially at this stage. Then there is the question of what happens when it is all over - the need for debriefing and support. All of these and more are discussed by the service user trainers during their session.

LITERATURE REVIEW

Introduction

The review of related literature involves the systematic identification, location and analysis of materials related to the research topic… (Bloomberg and Volpe 2008, Hart 1998). This activity is central to how we engage in writing up our study and indeed to how we might approach the critical analysis at later stage. Nottingham (2018) opines that the literature review underpins our understanding of the ideas from our specialist field and discipline and represents our professional and academic integrity. Carrying on, she states that these 'conceptual frameworks' create the basis for how we can approach our contribution to knowledge and allow us to identify gaps in knowledge and to engage in debates on aspects that require new research in our field (Nottingham 2018). Our key objective would be to provide a clear and balanced representation of current leading theories, concepts and data relevant to our research topic (Bloomberg and Volpe 2008).

My research aims to explore and evaluate the difference if any that the service users' contribution to my team's training delivery makes to our course participants' use of physical restraint on the wards. My initial effort was to locate publications that evaluated the impact or influence of mental health service users' participation in PMVA training on staff practice of physical restraint on the wards. This search yielded no result whatsoever. It became obvious that a broadened search for related articles on the topic was necessary. It was considered that this would enable a more holistic view of the topic under study.

Literature Search strategy

In order to locate available relevant materials for my research, I carried out an extensive search of literature in various databases numerous times and at different intervals prior to and in preparation for the write-up of this study. Searches were refreshed from time to time and new materials used to update the literature review throughout the period of writing.

The databases searched included: Middlesex University Summons, the Cinahl (Cumulative Index of Nursing and Allied Health), Medline (Medical Literature

Analysis and Retrieval System Online), British Nursing Index, PsychInfo (American Psychological Association), Google Scholar, PMVA portal within 'My Learning' in Middlesex University UniHub, Middlesex University Research Repository. Furthermore, references in the identified materials were searched for relevant articles. Materials found were promptly saved in RefWorks and subsequently moved into appropriately named folders in RefWorks e.g. SUI in education/training, Impact of SUI. Table 2 shows some of the key search terms and combinations of terms used for searching.

Table 2: Key search terms and combinations of terms

Client participation OR Service user participation Patient participation Patient involvement Service user involvement Client involvement Co-production Consumer involvement AND Mental health OR Mental ill health Mental well being Mental health services AND Training OR Education Programmes Knowledge Experience Attitudes	Physical restraint OR Control & restraint Therapeutic management of aggression Physical intervention Restraint Aggression De-escalation AND Training pot AND SUI pot AND MH pot

The growth of literature in the subject area of physical restraint continues although scanty in aspects of it. These include the ethical perspective and possible innovations such as service user involvement that may help to minimise the use of physical restraint, prompting authors including McKenna (2016), Bowers et al. (2014) and Scanlan (2010) to suggest more studies on the subject. Similarly, there is emerging literature on service user involvement in education

and training of professionals, but very limited materials on the evaluation of such involvement or on its impact on practice (McIntosh 2018, Happel et al. 2014, Chambers and Hickey 2012). There was hardly anything on service user involvement in PMVA training not to mention its impact on practice. The few located materials and all relevant others were imported into the RefWorks folder for close study and scrutiny. Middlesex University Books were also searched for relevant publications and further information.

The review process was guided by methods suggested in the research texts such as Grix (2004). I critically examined and analysed each item of literature, visually searching for and pulling together themes and issues that were associated and relevant to my study. These were categorised and themes were formulated. A total of five key themes and some sub-themes were identified as shown below and the review was structured accordingly.

Themes that guide the literature review:

Physical restraint

Efforts to eliminate/minimise physical restraint

Alternatives to physical restraint

Service user involvement

- Terminology
- Definition
- Historical perspective on service user involvement
- Conflicts of views
- Service user involvement in the education and training of professionals
- The mental health sector
- Mental health service users' involvement in PMVA training in a HI
- Is it all 'tokenistic'?

Processes for meaningful involvement

Impact on practice and benefits of service user involvement (SUI) in the education and training of practitioners

Challenges of service user involvement

Culture and Leadership in the health sector

Chapter summary

Physical restraint

A form of restrictive intervention, physical restrain is described as any direct physical contact where the intervener's intention is to prevent, restrict or subdue movement of another person (Department of Health 2014). In their definition, Mohr et al. (2003) state that broadly, "Restraint" refers to physically restricting movement. Stewart et al. (2009) further explain that physical restraint could mean: the use of devices such as belt to confine the patient (mechanical restraint); the physical contact during the process of putting patients into mechanical restraint or seclusion, and physically holding the patient to prevent or restrict movement (manual restraint). In the UK manual restraint is the most commonly used approach. Consequently, our interest is on 'physically holding the patient to prevent or restrict movement'. In the context of the study therefore, physical restraint and manual restraint will be used interchangeably to mean the physical holding of the patient.

Physical restraint (PR) is generally used in the UK to manage incidents of violence and aggression. Of the different types of restrictive interventions PR seems to be the most controversial due to concern about the possibility of abuse (Knowles 2015, Obi-Udeaja 2009, Kumar 2001, Allen and Tynan 2000). In fact, Human Rights Commissions found that PR was commonly misused in many psychiatric hospitals in both industrialized and developing countries (The World Health Report 2001 p51). Consequently, the concept of manually restraining a person automatically brings to mind documentaries of some high handed restraint techniques or abusive methods of taking control of an individual that sometimes result in injuries or even death. Examples include the deaths in the UK of Gareth

Myatt who died while being restrained in a seated position at a Secure Training Centre (INQUEST 2004) and that of David [Rocky] Bennett who died whilst being restrained face down on the floor by nurses (Blofeld 2003). Hardly does it come to mind that the procedure could be in the best interest of the recipient. In resorting to PR, the front line workers in the UK such as the police officers, prison officers and health care workers for example seem to have differing philosophies regarding the use of the approach. Such philosophies are probably determined by their type of clientele, the presenting behaviours and the underlying reasons. For example, the police might be dealing with aggression/violence from individuals under the influence of alcohol and/or drugs. Their resort to restraint is often described as '*police use of force*' (Klahm IV and Tillyer, 2010 p.230). The prison officer might be dealing with frustration induced violence from the inmates. Their model of physical restraint could be seen as high handed (The Lord Carlile of Brerіew QC 2004).

The healthcare practitioners are expected to adopt a caring approach in their use of PR. This is covered in the DH (2014) and NICE (2015) frameworks intended to guide care providers along a more therapeutic approach to managing disruptive incidents. In their study for example, Bland et al (2001) viewed the achievement of therapeutic relationship based on trust and empathy as the primary purpose of psychiatric nursing. The necessity for a therapeutic relationship between the care receiver and the care giver particularly in mental health settings (Duffy 2017, Moran 2009, Gilburt et al. 2008, Bland et al. 2001, Outlaw and Lowery 1994) places even greater demand on mental health practitioners to manage incidents that require measures such as physical restraint with patient care in mind.

Restrictive interventions such as PR are often preceded by and are the end results of restrictive practices (Clark et al. 2017a, Reeves 2017). These authors argue that when a culture of control is adopted, as opposed to one of structure, restrictive practices which potentially restrict a person's rights and freedom can trigger patients' behaviours that could result in unnecessary restrictive interventions like restraint (Clark et al. 2017a, Reeves 2017). Interestingly, activities that are regarded as routine in hospital care can in fact constitute restrictive practices. According to Clark et al. (2017a) these include a hospital

admission itself which deprives one of autonomy, control and freedom to plan owns day. Whyte (2016) adds inpatient routines and hospital rules to the list of such activities, arguing that these could induce fear and uncertainty in patients who may respond by exhibiting challenging behaviours. Effectively, these authors are saying that the sources of trigger for patients' behaviours that induce restrictive interventions such as PR more often than not, rest within the institutions of care themselves. In his study, Irwin explores nurses' role in the management of aggression (Irwin 2006). He examines the nurses' impact on inpatient aggression and how management strategies affect the therapeutic value of intervention (Irwin 2006). Surely, if one is part of the cause, then one could be part of the remedy. Hence, in their study on "fear, danger and aggression…" Terkelsen and Larsen (2016) suggest the ethics of care and a dialogical approach frameworks which are understood to be patient driven including the relational and contextual perspectives. This would promote a shift away from professionally driven processes and the 'professionals have all the answers' approach (Obi-Udeaja 2017). Terkelsen and Larsen argue that such frameworks could minimise fear and aggression and subsequent resort to coercive interventions such as restraint (Terkelsen and Larsen 2016).

"Restraint has a bad reputation in mental health" (Winship 2006 p55). Kontio et al. consider the use of patients' restrictions such as restraint as "a complex ethical dilemma in psychiatric care" (Kontio et al. 2010 p65). Studies including Riahi et al. (2016) and Borckardt et al. (2011) have chronicled some of the numerous negative effects on patients, staff and all others involved, of this method of managing incidents involving mental health patients. They include all manners of physical injuries or even death and various types of psychological and emotional trauma. This potential to cause harm physically as well as psychologically, have authors labelling it a controversial management option for incidents involving mental health patients (Moran et al. 2009, Irwin 2006). Consequently, some authors warn nurses to consider the use of PR with caution and awareness of the potential impact especially the psychological effect (Knowles et al. 2015, Strout 2010, Bonner et al., 2002). Notwithstanding these concerns, evidence shows that there are situations on the hospital wards (NICE 2015, DH 2014, Duxbury et al. 2011, Winship 2006,) and on other care settings such as family (Patterson and

Edwards 2018, Read 2007) when nothing else works and restraint becomes inevitable. For example Read (2007) narrates how a father very concerned that his mentally sick son might wander off and cause harm to neighbours saw no choice but to shackle him indoors. Equally, in mental health settings in the UK, care staff resort to physically holding the patients when there is concern regarding safety (Wilson et al. 2017, Bigwood and Crowe 2008). Sacks and Walton (2014) use case examples to justify why calls to eliminate restraint and seclusion from psychiatric inpatient settings should be carefully considered. But, one might argue that such concern about safety could be very subjective. In other words, what one person sees as a risk might be viewed otherwise by another. Putting it succinctly, Trenoweth et al. (2011) conclude that one's response to a phenomenon is often guided by one's understanding of it. The authors' observation parallels Parahoo's when he states with reference to research, that the type of information we seek and how we go about collecting such information continues to change in response to the needs and beliefs of a given era (Parahoo 2006, 2014). And so it is that as our understanding of mental illness continues to evolve, so does our acceptable ways of managing the challenges encountered while caring for people with mental health problems especially with respect to PR.

Efforts to eliminate/minimise the use of physical restraint

Sadly, the mentally ill have endured all manners of intervention over the centuries. Winship retells how mechanical restraint considered less brutal than whipping, hanging or drowning (all forms of intervention for "madness") has been in use for as far back as the beginning of the 15th century (Winship 2006). Over the period, passionate efforts by individuals and bodies towards eliminating or reducing restrictive interventions have been made. According to Winship for example, the anti-restraint movement dates from the late 1700s (Winship 2006). Sacks and Walton (2014) corroborate when they link the liberation of psychiatric patients from their shackles by Pinel and Tukes at the end of the 18th century to the beginnings of modern psychiatry. Winship equally refers to the same widespread movements that resulted in the unshackling of the mentally sick patients in parts of Europe and here in the UK (Winship 2006). More recently,

concerns regarding the use of seclusion and restraint in mental health services have been raised in Australia (Brophy et al. 2016), the USA (Sacks and Walton 2014) and in parts of the developing world. The growing concern about the potential harms that physical restraint could cause give impetus to an ever increasing mandate through various legislations, guidelines and initiatives in countries including Australia, USA, and UK calling for organisations to minimise reliance on PR (Wilson et al. 2017, DH 2014, Mental Health America 2011, Disability Act 2006). While policy pronouncements at the World Health Organization level for instance guides globally, countries are expected to adopt them within their respective contexts. Putting this succinctly WHO said:

> *"Governments, as the ultimate stewards of mental health, need to set policies that will protect and improve the mental health of the population within the context of general health systems and financing arrangements" (WHO 2001 p75).*

The World Health various and encouraging directives must be among the sources of fuel stoking the current days' increasingly 'out-spoken' approaches to mental health problems. Here in the UK, the news media more often than used to be the case, allocate space and air time to mental health issues. For example, one of the BBC Breakfast News coverage on16th November 2018 (700 BST) was that fifty top business executives in the UK urged the government to give similar status to mental health at work as was given to physical health. These executives wanted the prime minister to fulfil the honour made the previous year to update the Health and Safety regulation to this effect (BBC Breakfast News 2018). Recently, the impact of inadequate resources, in particular, staff shortages in the health sector was flagged up by the Guardian newspaper in its article on the poor rating of the Accident and Emergency units by the Care Quality Commission (CQC) which organisation also found the care in mental health and learning disability inpatient units inadequate (Campbell, The Guardian 2019). Even with the various initiatives and guidelines in the UK on the provision of appropriate care and services for the mentally ill (NICE 2015, Mind and NSUN 2015, DH 2014, DH 2006, DH 2004), there is still much to be done to make life for these individuals less traumatic on the wards and in the community. This may be especially difficult as Mehta et al. (2009) found in their analysis of data-sets from

the Department of Health '*Attitudes to Mental Illness Surveys 1994 – 2003*', a decline in positive public attitudes towards the mentally ill in England and Scotland.

Various policies, guidelines and initiatives from bodies including the Care Quality Commission, Mind and National Survivor User Network and the Department of Health repeatedly emphasise the necessity for healthcare practitioners to use PR with the care of the person being restrained uppermost in their (practitioners') mind. For example, the National Institute for Health and Care Excellence (2015) section 1.4.7 'Using restrictive interventions' states:

> "*Ensure that the techniques and methods used to restrict a service user: are proportionate to the risk…, are the least restrictive option to meet the need, are used for no longer than necessary, take account of the service user's preferences… and take account of the service user's physical health…"* (NICE 2015 p33).

The second of the six cross-cutting principles and approaches of the Mental Health Action Plan 2013-2020 is on Human rights. It states:

> *"Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments"* (Mental Health Action Plan 2013-2020 p10).

Effectively, policies and guidelines are being used to redirect society's perception of the vulnerable in particular people who struggle with mental disorders and how they are cared for. However, statistical evidence shows that on a yearly basis, the mental health sector tops all others with regard to incidents of violence and aggression as shown in Table 3.

Table 3: Reported assaults against NHS staff in England. **(**Source: Health Services Journal, courtesy of the Royal College of Nursing) [Online]

	Number of trusts	Violent assaults 2015/16	Violent assaults 2016/17	Average per trust 2015/16	Average per trust 2016/17	% change 2015/16 – 2016/17
Acute/Community	104	15,469	18,720	149	180	+21.0%
Acute	57	7,970	10,510	140	184	+31.3%
Mental Health	20	16,535	17,360	826	867	+5.0%
Mental Health and Community	19	16,211	16,460	853	866	+1.5%
Specialist	15	416	523	28	35	+25.7%
Community	13	708	860	54	66	+21.5%
Ambulance	9	2,036	2,330	226	259	+14.5%
Total	**181**	**51,447**	**56,435**	**284**	**312**	**+9.7%**

Source: Health Service Journal

According to the above report based on freedom of information (FOI) requests by the Health Service Journal, the levels of violence against staff working in mental health trusts remain much higher than other types of trusts.

Some would argue that aggression and challenging behaviours in mental health settings are social realities. Hence, Wilson et al. (2017) ask whether restraint is a necessary evil? The authors warn about the need to ensure that by reducing or eliminating restraint, mental health wards neither become, nor feel unsafe to patients or staff (Wilson et al. 2017). Similar concern is shared by Sacks and Walton (2014). But there are those who hold a contrary view to the notion that restraint is a necessity in mental health settings (Mind and NUSN 2015, Curie 2005). The argument to eliminate restraint, often driven by the impact of the consumer and recovery movements, view restraint as antithetical to recovery, a consequence of its denial of autonomy to the patient (Curie 2005). Interestingly though, most of such arguments to eliminate also talk about carrying out the restraint techniques in a patient centred manner as a "last resort". This suggests an acknowledgement that there could be life threatening situations when nothing else works (Mind and NSUN 2015, Davidson 2012, Mental Health America 2011). Some studies actually found that if physical restraint is for the right reason, in the best interest of the individual concerned and is managed caringly the experience could be regarded as positive by those concerned (Winship 2006, Mind and NSUN 2015). In Larue et al. (2013) some of the patient participants felt that seclusion and restraint were helpful measures. And, Steckley (2007) found that

when physical restraint was professionally and sensitively conducted for a good reason, the therapeutic relationship and trust between staff and service user was enhanced.

But, there are instances when physical restraint has been abused and intentionally used to cause harm or to punish. A recent example in the UK was the Winterbourne View Hospital where physical restraint was repeatedly abused over a period of time (BBC Panorama 2011). In one of his studies, Paterson (2007) noted that frightened/angry staff, whether trained or untrained, may unwittingly resort to field modification of a given technique in order to gain control. While most of the staff in Knowles et al. (2015) were described as caring in their use of restraint, there were the odd ones perceived by the patient study participants as seemingly deriving some weird sense of pleasure from unfair and uncaring patient restraint. We note that the Winterbourne View Hospital residents' abuse in the UK caused public outrage and prompted government guidelines (DH 2014).

The abuse of physical restraint and its potential negative effects have triggered a growing call nationally and internationally for the elimination or at least a reduction in its use (Hext et al. 2018, Clark et al. 2017, Riding 2016, DH 2014, Deveau and Leitch 2014, Ridely and Jones 2012, UN 2006). Authors including Wilson et al. (2017) and Kontio et al. (2010) are urging for research into alternatives to PR. And so, there is increasing literature on initiatives and alternative care practices that could help to minimise incidents of conflicts and subsequently reduce or even eliminate PR in mental health settings.

Alternatives to physical restraint

The persistent concern about the negative effects of PR has intensified calls nationally (Wilson et al. 2017, Riahi et al. 2016, Allen 2011) and internationally (Terkelsen and Larsen 2016, Wisdom et al. 2015, Borckardt et al. 2011) demanding that healthcare organisations attach greater importance and direct resources towards proactive and preventative alternatives to restrictive interventions. Consequently, there is growing Literature reports on different suggestions of alternatives to restrictive interventions particularly PR and

seclusion. Wisdom et al. (2015) describe the positive alternatives to restraint and seclusion (PARS) project of the New York State Office of Mental Health. The study affirmed that adopting and implementing the Six Core Strategies to reduce the use of seclusion and restraint, a comprehensive approach developed by the National Association of State Mental Health Program Directors, actually resulted in significant decreases in restraint and seclusion episodes per 1,000 client-days (Wisdom et al. 2015). Worthy of note here is the inclusion of greater involvement of the service users in program decision making as one of the six core strategies.

Studies talk about nurses' frustration at their inability to find alternatives to restrictive interventions particularly physical restraint (Kontio et al. 2010, Bigwood and Crowe 2008). Meanwhile, authors including Foster et al. (2007) and Bowers et al. (2006) are convinced that tuning into the reasons for patient's aggressive behaviour can facilitate ways other than restrictive intervention of dealing with the problem. Hence, Kontio et al. (2010 p72) suggest sensitizing staff to "*mindful reflection on patients' feelings and thereby enable understanding of the causes and prevention of aggression*". The behaviour support plans (BSP) developed from the work of Clarke and Clarke (2014) based on a biopsychopharmacosocial approach together with an appraisal of the patient's current environment and past incidents carefully examine and identify possible factors that are contributing to the patient's behaviours (Clark et al. 2017). Reinforcing on BSP, Clark et al. (2017) state that the aim is to proactively reduce restrictive practices through the examination of contributing factors that can affect patients' behaviours.

Invariably, a genuine effort by staff to understand all possible causes of a patient's behaviour would mean working closely and collaboratively with that patient. And so Clark et al. (2017) go further to report that patients express pleasure in being asked for their input and how best they can be supported. Equally, the authors report patients' pleasure that interventions other than pro re nata (PRN) medication, restraint and seclusion are considered (Clark et al. 2017). Authors including Allen (2011), emphasise that achieving restraint reduction might require multiple strategies such as leadership/organisational change, workforce development, staff debriefing and consumer participation. This notion is reverberated by Deveau and Leitch (2014) who concluded following their study that restraint reduction meetings a variant of de-briefing could be a useful

component of such multiple strategies. Of the seven key strategies for restraint reduction that emerged from a review of literature (Scanlan 2010), policy change/leadership, debriefing, training and consumer involvement were once again on the list. In summary, these authors and many others including Riahi et al. (2016), Borckardt et al. (2011) and Huckshorn (2006) are in agreement that a combination of multiple strategies could result in a reduction in the use of restraint.

Of particular interest is the inclusion of consumer or service user involvement in every single list of interventions that could reduce the use of restraint. In recognition of the crucial role the consumer such as mental health service users could play to enhance services, most guidelines including: NICE (2015), the CQC (2017) and WHO (2010) emphasise the importance of their involvement in every aspect of service development and delivery. For example, the involvement and participation of people with care and support needs, their families, carers and advocates is enshrined in the key principles underpinning the DH 2014 guidance framework.

Service user involvement

Terminology

Changing times and shifts in societal views of the world around it would naturally trigger debates on issues considered ripe for change. The appropriate term that represents the people who receive health or social services is no exception. Literature is regularly in debate on the issue. McLaughlin (2009) critically considers the most common of the terms used including ‘consumer, client and service user’ and how these represent the shift in relationships within social work policy and practice. Service user is commonly used in literature and in practice and policy within the UK. Dreissens et al. (2016) promptly remind us to clarify what we mean when we use the term. They consider this necessary because of its interchangeable use with patients, clients, customers and so on. Indeed, Chambers and Hickey (2012) admit struggling with the definition of service user. They propose that ‘end recipient of a service’ would be consistent with what is generally meant by ‘service user’ and broad enough to be inclusive of professions

that do not usually have face-to-face contact with the public (Chambers and Hickey 2012).

The term ‘Service user’ is also criticised for emphasising just one aspect of the person – someone receiving services, at the negligence of possible services the person might be rendering such as: parenting, caring, lecturing, researching. In the opinion of Dreissens et al. (2016), each of these roles may be deemed to be a more desirable role than merely a service user. As McLaughlin observes, “*The nature of the language we use is imbued with meaning and power is dynamic and changing…*” (McLaughlin 2009 p.115). Dreissens et al. (2016) ask that we also bear in mind that a provider of service in the present can become a user in the future and vice versa.

‘Service user’ is used in this study because it is the preferred term by the service users involved in the study.

Definition

Similar to service user, the term ‘user involvement’ appears difficult to define. While there exist many definitions of the concept, none is commonly agreed (Crepaz-Keay 2014, Marit By et al. 2011). Some authors argue that the concept is not even adequately articulated and understood (Borg et al. 2009, Sahlsten et al. 2008). In an Ethnographic study of stroke patients carried out by Fudge et al. (2008), the vagueness of the concept of user involvement is cited as one of the four factors why involvement happens but mostly in the least technical areas of the practice and in areas with the least input from clinicians. The findings by Fudge et al. (2008) show that the professionals and the service users understand and practice involvement in different ways. Common aims in user involvement can aid collaborative working, and the clarification of aims is vital for subsequent measuring of the impact of user involvement assert Lea et al. (2016). But, what about the ‘uniqueness of experiences’ that may influence what one wants to get out of involvement? The Liaison and Diversion (L&D) programme (2015), a cross-government initiative with partners from NHS England, Department of Health, Home Office, Ministry of Justice and others buttressed this point when it observed that different things were important to different people at a workshop held with

different groups and representatives. For example, the programme found that women wanted access to children and advice on finances whereas older people wanted access to medication and being treated with dignity and respect. Rush (2004) proposes the need to acknowledge the differences and dialogically find a way to work positively notwithstanding. Concerned that discrepancies in perspectives and values on involvement could hinder cooperation between users and professionals, Marit By et al. (2011) suggest that a common definition of the concept including the values the parties ascribe to the core aspects is vital when working with patients and public in the health setting.

In an effort to define the concept, Tritter and McCallum (2006) describe user involvement as the feedback mechanism for the expression of consumer views, presented in the form of a constructive dialogue with the aim of reshaping the relationship between service users and professionals, and as a catalyst for wider cultural change. The Department of Health states that service user and carer involvement is an active collaboration between professionals and service users in the planning, delivery and evaluation of health and social care services and in the education and training of professionals working in those services (DH 2004, 2006). 'Together' and The National Survivor User Network (2014) define service user involvement as the active participation of a person with lived experience of mental distress in shaping their personal health plan, based on their knowledge of what works best for them. The Liaison and Diversion (L&D) programme (2015) sees it as the process by which people who are using or have used a service become involved in the planning, development and delivery of that service. Lathlean et al. (2006) describe involvement as an active and equitable collaboration between service users and professionals on the planning, delivery and evaluation of services and education. Meanwhile, WHO (1990) clarifies that patient involvement will enable people to contribute to their own health and healthcare, to the development of structures that support participation including effective empowerment of patients and advocates so that their voice is heard and not assumed

Historical perspective on service user involvement

A look back at the evolution promptly links service user groups as we know it presently to the mental health group of patients (Rose 2014, Russell 2014, Winship 2006). The journey that brought people with mental health disorders to their current status of involvement in service design and delivery and in the education and training of professionals brings to mind Trenoweth and his colleagues' argument that our response to a phenomenon is often guided by our understanding of it (Trenoweth et al. 2011). The poor understanding of mental disorder, the resultant abusive practice of psychiatry (diagnostic and therapeutic) in conjunction with the coercion involved, pushed the mental health patients to their limit and ripened them for a new social movement (Rose 2014, Russell 2014). Rush's (2004) models of user involvement where he traces the different beliefs about mental illness over the centuries and how such beliefs determined the nature of treatment given to individuals who suffered with the disorders reflect both Trenoweth et al. (2011) argument and Rose's (2014) suggestion. Using a continuum of no involvement at one end to total involvement at the other end, Rush explained what level of involvement is expected, or more accurately, is made possible for the user by the professionals at each model (Rush 2004). For example, when the belief about mental illness was that the afflicted person was suffering from moral degeneracy, the emphasis was on control and punishment including the use of chains and confinement to small spaces. Service user involvement could only have been in dreams at the time. The evolution to the medical or illness view of mental disorder meant an expectation of patients' involvement but merely for the purpose of enabling more effective service delivery by professionals and, for compliance with prescribed medication by patients. The professionals had all the answers (Obi-Udeaja et al. 2017). The patient's view hardly mattered.

Crossley (2005) recounts the birth of charitable organisations for the mentally ill between the World Wars, the configurations and re-configurations of the movements as they developed. According to Rose (2014), the 'user groups' as the organisations are now referred to emerged in the 1970s, and flourished in activities at the national level in the 1980s (Rose 2014). This was well before the legislation in support of user involvement was first enacted, namely, the UK

National Health Service and Community Care Act 1990 which became a turning point when successive administrations began to gradually emphasise service user and carer involvement in health service design and delivery (Rose 2014).

According to Rush's (2004) model of involvement, the view of mental illness that advocates total involvement is the 'Disability inclusion model' which is associated with the recovery movement. This view encourages users to take stock and set new life paths. And so, in defiance of setbacks, the service user groups determinedly and passionately continued to set new life paths, and in particular, to campaign for a place among the stakeholders who shape the health and social care services. Turnbull and Weeley (2013 p.454) suggest that:

> *"There is now considerable evidence to show that patient groups have embraced the shift in the balance of power in health care from medical paternalistic approach to a patient-centred and patient-driven approach. Expert Patient Programmes, Patients Advice and Liaison Services, The Patients Association, Patient and Public Involvement Forums and local Health watch organisations in the UK provide a flavour of this involvement"*.

Conflicts of views

Legislations, guidelines and policies nationally and internationally constantly reinforce the need for users of services to actively participate in the design and delivery of the services they receive. In the UK for example, one of the key principles underpinning the guidance framework in Positive and Proactive Care: reducing the need for restrictive interventions is that:

> *"involvement and participation of people with care and support needs, their families, carers and advocates is essential wherever practicable and subject to the person's wishes and confidentiality obligations" (DH 2014 p.16).*

One might be forgiven to think that in today's age of 'Human Rights', user involvement is a democratic right (Crawford et al. 2002), a given, and the way forward. There could not be issues. On the contrary, studies have come up with

challenges including resistance from the professionals who may think that service users need to be protected (Oliviere 2001), or who are reluctant to change a way of practice (Beresford and Croft 1993) or indeed who hold the view that service users with mental health problems are incapable of making valid statements about therapy and treatment because of their diminished cognitive state (Beresford 2002).

Equally, findings from Fudge et al. (2008) show multiple interpretations of the user involvement concept by the participants as well as small percentage of the patient population involved. These raise the question of whether involvement may be difficult to implement in some patient groups. In their contribution, Marit By et al. (2011) point out that a lack of shared understanding of what user involvement really is could hinder the promotion of the initiative. The differing views about mental health service users from being irrational and dangerous to being viewed as equal partners with health professionals has Rush (2004) proposing an acknowledgement by all parties, of the conflicts between views and genuinely seeking resolution through dialogue. A question is also raised as to whether indeed every user wants to be involved in making decisions regarding their health needs (Fudge et al. 2008). Involvement is not compulsory. If choice is a human right then one can choose whether or not to be involved. This is covered in the Department of Health's key principles *"… subject to the person's wishes…"* (DH 2014 p.16). Clearly, user involvement remains an evolving initiative that requires persistent, patient and careful moulding to become fit for purpose.

Borg et al. (2009) believe that as mental health nursing shifts from inpatient settings into community practices, so does user involvement become a vital orientation in mental health community settings. But,findings from Fudge et al. (2008) suggest that it is not necessarily the case. According to the authors, there is diverse understanding and therefore levels of commitment to user involvement especially by practitioners which need to be resolved in order to create a positive mindset for involvement initiative (Fudge et al. 2008). In their study of user-led organisations, Rose et al. found that such organisations are working in a climate of constant organisational change and complexity that force them to adapt and to change (Rose et al. 2014). The finding led the authors to conclude that:

> *"Service users and managers are working in a climate of dynamic and complex organisational change, of which user involvement is an integral part, and this has impacted on the nature of service user involvement as a new social movement"* (Rose et al. 2014 Abstract).

The authors suggest that managers attend to this reality in their interactions with service users and with their organisations (Rose et al. 2014). The question is: How prepared are the managers, indeed the professionals in the health settings for this reality - this new way of practicing? This takes us to the training and education of healthcare practitioners.

User involvement in the education and training of healthcare professionals

There is a growing understanding of the important contribution that service users can make to developing the mental health practitioners of the future (Nash 2014, McCuske et al. 2012, Obi-Udeaja et al. 2010, Tew et al. 2004). The expanding body of literature exploring the subject area (McIntosh 2018, Poreddi et al. 2016, Happel et al. 2014, Russell 2014, Terry 2013, Borg et al. 2009, Rush 2004) is one indication of the current emphasis on user and carer involvement in the education and training of health and social care professionals. In the UK, Higher Education Institutions are mandated by policies and guidelines to involve users of services in the education and training of the health and social care professionals (NICE 2015, DH 2014, NMC 2010). For example, the Nursing and Midwifery Council's (NMC) new standards for nurse education require providers to demonstrate user involvement activities and for student nurses to show user involvement skills in practice (NMC 2010). These requirements are intended to motivate educationalists to initiate and achieve meaningful user involvement across their nursing curricular. Some educationalists for various reasons may however take the view that these requirements are imposed on them and reluctantly engage in user activities just to tick boxes. Spencer et al. (2011) promptly observe that meaningful involvement signifies a clear vision with well-articulated goals, flexibility and choice, underpinned by supportive systems and culture so that the involvement activities feel more like the habit, the way things are done rather than as duties. The Liaison and Diversion (L&D) programme

(2015) state that effective service user involvement entails identifying the purpose for involvement, deciding on whom to involve and on the method that will suit the purpose. The program suggest the activities in figure 3 and argue that there are infinite ways that users can be involved.

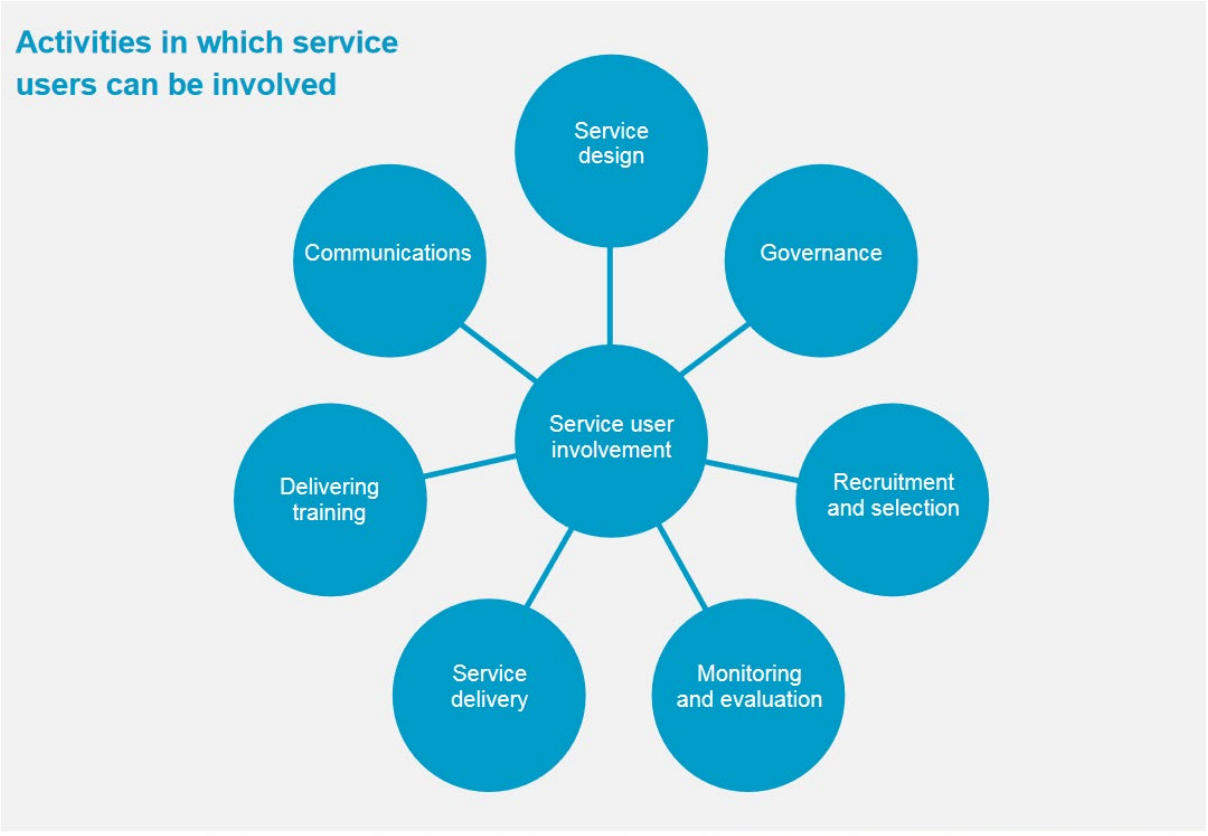


Figure 3. Curtesy of The Liaison and Diversion programme (2015 p2)

Although established in sectors of health and social care professional education in the UK especially the initial training of social workers and nurses, user involvement is still patchy (Terry 2013, Chambers and Hickey 2012, McCuske et al. 2012) particularly in post graduate and continuing professional development sectors and in medical education (Spencer et al. 2011). What is more, most of the reports on the initiative are of single educational experiences for a group of learners (Spencer et al. 2011). The authors argue that user involvement should be a routine practice.

The mental health sector

Significant literature and reviews have emerged (McIntosh 2018, Happell et al 2014, Russell 2014, McCusker et al. 2012, Perry et al. 2013, Rush 2004) confirming that user involvement has become the norm in mental health education and training. The WHO Regional Office for Europe states on user empowerment in mental health that "*Those who design and deliver mental health professionals' training should do so in systematic partnership with users and carers*" (World Health Organization 2010 p8). In the UK, service user involvement in the planning, provision and evaluation of education and training is recommended by The National Service Framework for Mental Health (Department of Health,1999). This is echoed in the Chief Nursing Officer's review of mental health nursing (Department of Health 2006) and in the Department of Health's Ten Essential Shared Capabilities (Department of Health 2004). The Nursing and Midwifery Council Standards require providers to demonstrate user involvement activities and student nurses to show user involvement skills in practice (NMC 2010). As observed by Tew et al. in 2004:

> *'If service delivery is to be characterised by an ethos of partnership, then such partnerships must also form the foundation of mental health education'* (Tew et al. 2004 p4).

Service user involvement in their own care as well as their influence on the services that support them has been linked to improved outcomes (McCabe & Priebe 2004, Gehrs & Goering1994) and to more positive therapeutic relationship between patient and staff. It is acknowledged that a great deal of mental health care is dependent on a strong therapeutic relationship based on empathy and trust between patients and nursing staff (Duffy 2017, Moran et al. 2009, Outlaw and Lowery 1994). This is an essential relationship for effective communication (Scanlan 2010, McCabe 2004).

Mental health service users' involvement in the Prevention and Management of Violence and Aggression (PMVA) training delivery

Physical restraint (PR) and manual restraint are terms used to describe the skilled, hands-on method of physical restraint involving trained, designated healthcare professionals to prevent individuals from harming themselves or endangering others (NICE 2005). Its purpose is to safely immobilise the individual concerned (NICE 2005). Manual restraint is the most commonly taught response in the UK for the management of incidents of aggression involving patients in the health settings particularly in the mental health inpatient wards. The physical and psychological harm that a poorly managed manual restraint could cause to any of the parties involved (patient, staff or observers) has been widely researched (Bowers et al. 2012, Stewart et al. 2009, Moran et al. 2009, Sequeira and Halstead 2002b, Kumar et al. 2001).

The PMVA team at my Higher Institution (HI) comprises academic staff members of the institution and mental health service users living in the community who have experienced being restrained while in admission in the NHS Trust hospitals. The team provides the PMVA training to both the local NHS Trust mental health inpatient ward staff and to the final year mental health nursing students. Ours is the General Services Association (GSA) training modelled on the National Institute for Health and Care Excellence (NICE) frame work. Issued in 2015, the NICE guideline on violence and aggression: short term management in mental health, health and community settings is intended to improve skills of staff in dealing with potentially aggressive and violent situations to ensure that they can be prevented or managed in a safe and therapeutic manner. The guideline provides a framework for dealing with violent situations before, during and after they occur, with emphasis and specific guidance on prevention and de-escalation through to safe interventions and post-incident de-brief. The GSA model which comprises theoretical and physical components promotes this philosophy. The theoretical component lays emphasis on prevention and de-escalation achieved mainly through assessment and effective communication. The physical component boasts of a hierarchy of holds that runs from low-level to high-level. Staff are expected to match the level of the patient's agitation with the appropriate hold. The effort to de-escalate the situation is ongoing throughout the process. It

is known that such an effort yields quicker results when the hold is appropriate in keeping with the philosophy of ‘patient centred physical restraint’ defined in the context of this project as a restraint process in which the patient’s physical, emotional and other ethical needs are catered to right through the process in line with the four principles of ‘person centred care’ (The Health Foundation 2014).

The patient centred philosophy may not always be reflected in practice. Paterson (2007) highlights the issue of field modification of techniques. Aware of this reality, a service user session is included in our training programme to enable course participants have a face to face discussion with service users who have experienced being restrained. As asserted by authors including Repper and Breeze (2007), Obi-Udeaja et al. (2010) involving service users in the education of future mental health practitioners is seen as important in providing students with the opportunity for developing greater awareness and understanding through the unique insights of people’s lived experience of mental health conditions and of their contact with mental health services.

My team’s co-training with service users started in 2008 when a colleague and I decided to find out whether any one of the service users already engaged in my department’s teaching and learning activities had experienced being physically restrained. Would such an individual want to join the PMVA team in order to share their experience with course participants? As it happened, one service user had, and was keen to work with the PMVA team.

Is it all ‘tokenistic’?

The meaningfulness of service user involvement either in service development and delivery or in the education and training of health and social care professionals continues to be questioned (Hatton 2016, Terry 2013, McCusker et al. 2012, Borg et al. 2009). There is lack of consensus about what constitutes meaningful involvement (Webber and Robinson, 2011). And, there is a concern that such involvement particularly in the education and training of the professionals who care for them is all but rhetoric. In other words, there is suspicion about the genuineness of such involvement and how balanced the powers of the parties are in those situations. In their concern, and in response to

the issue of imbalance of power in research situations, Gilburt et al. (2008) explained how they used emancipatory (user-led) research to ensure a balance of power between the SU researchers and the SU research participants. The crux of the argument is that the onus is on the training providers that deliver with service users to prove that their SU involvement is genuine.

Measuring meaningful involvement of users is seen as a complex exercise (McCusker et al. 2012). Notwithstanding, some authors have come up with suggestions (McCusker et al. 2012, Webber & Robinson 2012, Tew et al. 2004). Crepaz-Keay (2014) used a Delphi panel to examine indicators of effective mental health service user involvement. Although the panel reached consensus on 21 indicators, a collaborative involvement which they described as service users and professionals working together in a partnership that was as equal as possible, was their strong preference (Crepaz-Keay 2014). Clinks' (2016) guide to service user involvement, employed the whole systems approach to participation pictorially (Box 1) to illustrate an effective service user involvement.

Box 1: A whole system approach to SU involvement

Courtesy of Clinks 2016 p11, as adapted from Practice Guide: Involving children and young people in developing social care. Wright, et al., 2006. Social Care Institute for Excellence.

Similarly, a model of user and carer involvement was provided by Terry (2013). Studying these may enable one to formulate one's own prototype. Alternatively, the service users' activities could be mapped against a chosen model. Shown below are criteria proposed by Terry (2013) and Tew et al. (2004) for achieving genuine and productive user involvement.

Processes for meaningful involvement

Box 2: Achieving meaningful involvement. (Source: Tew et al. 2004 p4)

Achieving meaningful involvement depends on:

1. establishing a culture which considers the viewpoints and contributions of service users and carers to be of equal value to academic and professional perspectives
2. developing an infrastructure to recruit, support and give training to service users and carers
3. paying service users and carers at a fair rate and in ways that do not undermine their financial security
4. valuing and encouraging diversity: making sure that minority experiences and viewpoints are included
5. having a strategy for taking forward involvement that is supported by management, professional bodies and other key stakeholders. This must include appropriate funding.

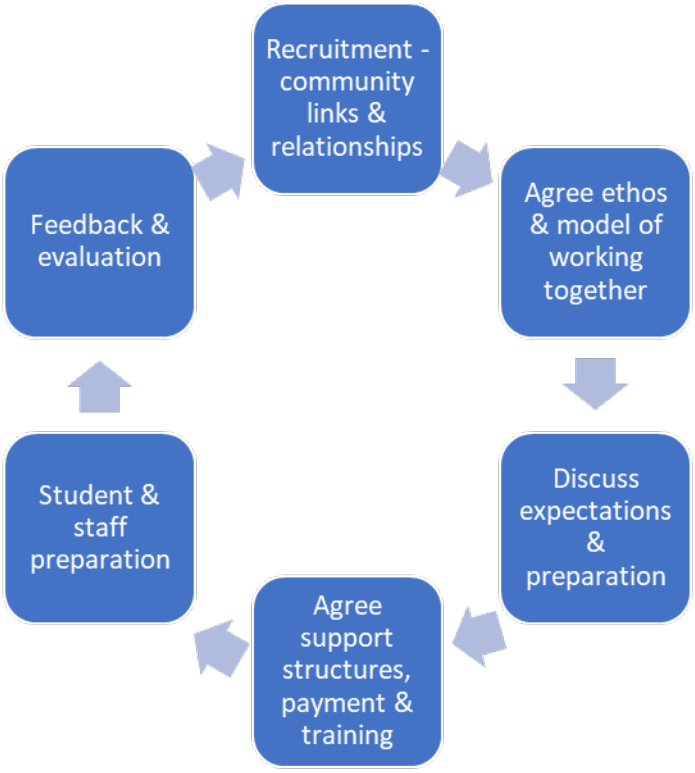


Figure 4: Essential processes in the cycle of user and carer involvement. Adapted from Terry (2013 p203)

I examined my team's service user involvement activities and made an attempt below to map them against what the staff and service users in Terry's (2013) study considered as the prerequisite processes and good practice for an effective involvement activity.

Recruitment of Service User Trainers

As explained above, the first service user trainer was recruited through the existing service user educators on the mental health nurse training programmes at my HI. The second service user trainer was recruited when I visited a local community centre for African-Caribbean mental health service users to specifically seek representation from this group. Studies including that carried out by Browne (1997) for the Campaign for Racial Equality and the Mental Health Act Commission found that 75% of all professionals interviewed thought that black clients were more likely to be seen as dangerous. By purposely recruiting from

this ethnic group, the intention was to better reflect the perceptions and experiences of staff and service users on the inpatient units.

Agree ethos and model of working together

The first service user started training with my team before the second. Prior to her joining the team, a meeting was arranged between her and two PMVA staff members. Some of the staff members had been concerned that the service users might use the training opportunity to express their anger about physical restraint and talk only about the negatives. On the contrary, this service user held a very balanced view. In the meeting, she talked about her positive and negative experiences of being restrained. The tutors were 'blown away' and convinced that the balanced and rich experiences would support the philosophy that the GSA model of training was trying to promote. An hour slot for service user session was proposed. This was agreed by both parties. It was agreed that the session would be run at the end of the course when training on physical skills would have been completed. The rationale was that the course participants would go away with the lessons from the service user session uppermost in their memories.

Expectations and preparations

The first service user was very experienced and an active member of the local community user groups. Because she was already involved in teaching and learning activities in the HI, she needed little or no induction. Our training and how the team worked were explained to her. Potential challenges and difficulties were discussed and considered. For example, sharing and discussing her restraint experiences with practitioners on the course might leave her feeling vulnerable especially as some of the practitioners on the course work within the Trust where she receives her care and treatment. She asked questions and appeared satisfied with the answers.

Support structure, payment and training

The first service user's strong educational background, her positive experience of involvement in other aspects of teaching and learning at the HI, especially teaching pre-registration nurses and the support and reflective feedback after these sessions made her feel confident about the PMVA training role.

Subsequently, she volunteered to mentor the second service user trainer when he joined the team. The second service user trainer although very keen to share his experiences of being physically restrained, was nevertheless very anxious initially about the prospect as he had not been involved at an HI setting before. Interestingly, the support and reassurances from the staff members of the team did little to soothe his anxiety. But, the moment the first service user took him under her wings, he became a different person. The two have worked consistently ever since. They regularly update and modify their delivery approach for greater impact. For instance, when they first started on the training, they used to go straight into sharing their experience of being restrained on the ward. Lead by the more experienced colleague who teaches on other modules, they continue to modify, tweak, refresh and enrich both the content and their style of delivery to suit the audience. They get remunerated for their service at the same rate as the other lecturers. The department's service user group coordinator holds the budget for the group and renders necessary support with regard to remuneration. In particular, she works with the service users to ensure that their benefits are not affected by any form of remuneration they receive.

Student and staff preparation

The PMVA training is a short course that runs from Monday to Friday consecutively. The two service user trainers lead a one hour session together on the final day of the course. Students on the course are informed about the service user session during their introduction to the course on the first day. This is also contained on the course programme. The service user trainers start their session with person introduction. They make it known that they welcome comments and questions from the participants and that they do not object to interruptions, in fact these are most welcome. In the early days of their involvement, the PMVA staff trainers used to sit in the session as a gesture of support for the service user trainers. Now, the service user trainers prefer the staff not to sit in. They seem convinced that the course participants will talk with less inhibition if the staff trainers are not in the room. In effect, our service user colleagues have control of both the content and the style of delivery of their session. An example of their demonstration of this control was when at an international conference in Dublin, we had a very well prepared and rehearsed power point for our presentation. But

just before we went in, one of them suggested that we should go in and assess our audience first, adding that if we could stimulate them for a lively interactive session then we would use the power point selectively to support the discussion. That was exactly what we did and the feedback from the delegates was very complementary. Their session, modelled along active interaction with the course participants utilizes their lived experience of physical restraint to motivate course participants to adopt a patient caring approach particularly when managing patients' anger and aggression on the ward.

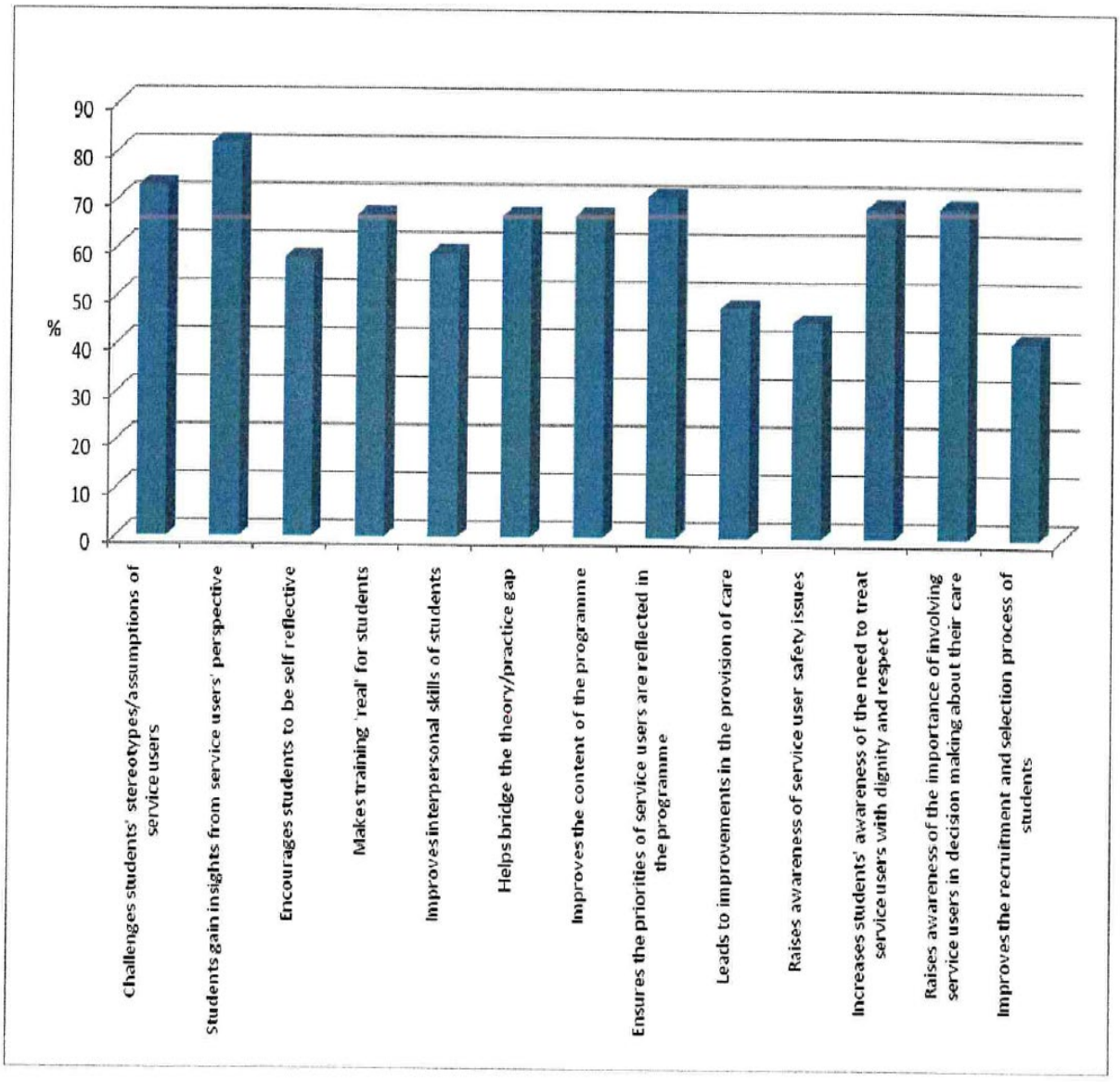
There are of course challenges including their occasional unavailability for the training. Flexibility in such situations enables alteration of the time and/or of the day for their session to suit them. They may also decide that one instead of the two of them come in to run the session. While the two service users that started this training incredibly complement each other and are totally committed to the course, the effort to expand the team by bringing in more service users has so far not been successful. This reverberates the challenges and benefits of service user involvement initiative.

Impact on practice and benefits of service user involvement (SUI) in the education and training of practitioners

Using a mixed method approach utilising both qualitative and quantitative methods of data collection, Chambers and Hickey (2012) expressed regret at the dearth of literature on the impact of SUI particularly in education and training. Highlighting this in 2014, Happel et al. in a systematic review of published work on consumer involvement in the education of health professionals, urged future research to determine the impact of consumer involvement. But the issue persists, prompting McIntosh (2018) in his study using Interpretive Phenomenological Analysis (IPA) to lament that despite the lack of evaluation and evidence relating to the impact of involvement being noted in the early 2000's, there continues to be a lack of evaluative research in the area. In their Ethnographic study, Fudge et al. (2008) referred to the challenges of determining the impact of learning on practice. And, using a structured search of the literature on service user involvement in Higher Education healthcare curricular activity,

Morgan and Jones (2009) concluded that the effect of various learning strategies on nursing practice is challenging to measure through educational research. The authors think that it is due to the complexity in directly relating the effects of specific educational strategies on practice, because, these are not delivered in isolation of other learning strategies, practice experiences and nursing students' life. The limited literature on the phenomenon however reports a strong evidence of short-term benefits for all involved - learners, service users, educators and institutions (Speers and Lathlean 2015, Russell 2014, Turnbull and Weeley 2013). Some of these benefits are illustrated in Table 4 below.

Table 4: Potential Benefits of Service User Involvement. (Source: Chambers and Hickey 2012 p.41)



From the table, it is clear that the benefit is significant in each case, with a range of 40-80 percent.

In their Health Foundation Report, Spencer et al. (2011) identified benefits for the learners including greater confidence in talking to patients, better understanding of patient viewpoints and improved communication skills. Some patients like the opportunity that involvement offers them to give something back to the community. They report benefits include self-esteem, empowerment and new

insights into their issues (Obi-Udeaja et al. 2016, Spencer et al. 2011). Educators are pleased that learners have gained valuable learning experiences made possible through the direct exposure to patient issues and through interaction with patients (Spencer et al. 2011).

With regard to the effect on behaviour and practice, there is even less evaluative research (Chambers and Hickey 2012, McCuske et al. 2012, Fudge et al. 2008). Nevertheless, studies have come up with various positive impacts on practice attributed to service user involvement. In a Comprehensive Guide for Mental Health Education, Tew et al. (2004) state that user and carer involvement can enrich students' learning by offering a more stimulating and challenging educational experience that can enable the students to practise more effectively. In their narrative, Obi-Udeaja et al. (2010), explain that SU involvement enables a forum for service users and practitioners to interactively engage in conversation about practice. Such engagement has the potential to lead to practice improvement. As observed by Kuti and Houghton (2019) in their survey using structured questionnaires with a free-text box, "*creating such interactions in a class setting and not only in practice placement areas establishes the importance of linking theory and practice*". Echoing, Turnbull and Weeley's (2013) evaluative study asserts that students can be assisted to narrow the theory-practice gap if links between theory and real life experiences are established. Putting this in perspective, Repper and Breeze (2007) in a review of the literature state that the involvement of service users in student learning motivates students to show more sensitivity and empathy and adopt a more individualised approach in practice. This is precisely the intention for SU involvement in PMVA training. Their contribution to the training aims to motivate participants to translate learning from the training into their practice of managing patients' anger and aggression, and into their practice of physical restraint when it is unavoidable.

The benefits and indeed challenges of service user involvement continue to attract interest and provoke debate by stake holders including policy makers, practitioners especially those committed to developing more participatory practices, service users and by researchers. Some studies that echo the benefits as expressed above, add that learning is deeper and transformative and could

result to change in attitudes and to patient oriented practice (Reeves 2017, Speers and Lathlean 2015, Russell 2014, Stacey and Stickley 2012, Schneebeli et al. 2010, Livingston and Cooper 2004). In addition to research studies, policy papers (WHO 2010) and guidelines (DH 2014), Mental Health Guidelines Netherlands (2013). NMC (2010) are of the opinion that user involvement in the education and training of professionals can contribute positively to improved service delivery. In a mixed methods approach using survey and semi-structured interviews Russell (2014) categorically states that enhancing practice to account for the wishes and views of the users is considered "*best practice particularly from a professional perspective within health care*" (Russell 2014 p36-37). But, the scantiness of research on the topic compelled Turnbull and Weeley (2013) to question the expectation that user involvement in teaching and learning will result in professionals capable of improved care delivery. This study will hopefully help to narrow this gap in research.

Challenges of service user involvement (SUI)

Some authors express concern about user involvement. Oliviere (2001) points out that professionals might use patient protection as an excuse not to cooperate in involvement initiatives and that such individuals may genuinely not see the importance of service user involvement. Beresford and Croft (1993) are of the opinion that professionals, particularly those who find changes to traditional ways of working daunting, may find the implementation of service user involvement challenging. The differing motives for user participation such as social opportunities, expanding knowledge, and accessing services found in the ethnographic study by Fudge et al. (2008) raise a question about the ability of service user involvement to improve services if such is not the main motive for those involved. The authors equally think that the smallness of the number involved and the diverse interpretations of what involvement is raise a question about the assumption of the user involvement policy that users generally want to participate in decision making about their needs (Fudge et al. 2008). Putting it differently, some users may not want to participate in decisions regarding their health needs. This perhaps explains why the Department of Health made

allowance for the choice to participate or not to in its key principles (DH 2014 p16). Notwithstanding the challenges, user involvement in the education and training of those that provide the services for them has become the reality in the educational sector. With regard to PMVA, the positive feedback from different perspectives (Chapter 1) indicates that there is a place for service users' input on the issue of how patients' anger and aggression is managed on the wards. The question is how conducive is the ward system for the implementation of such input? This takes us to the question of culture and leadership in the practice environment.

Culture and Leadership in the health sector

People suffering from mental illness are often painfully vulnerable. Whatever culture or setting, they rely on others to decide what they need and get. This is particularly so with regard to their health and social care needs for which they rely on the professionals including nurses to provide them with. In their cross-sectional study using an international online survey, Papadopoulos et al. (2016) equate nurses to international citizens in view of the global nature of today's world. This analogy goes without saying since the mobile world community implies that the patients as well as the nurses caring for them could come from different cultural backgrounds with inherent beliefs and values regarding mental ill health (Read 2007, Gureje et al. 2005). Trenoweth et al. (2011) argue that one's response to a phenomenon is often guided by one's understanding of it. Echoing this point, Papadopoulos et al. (2016) further identify a link between compassion and culture. Hofstede (2001) explains that culture is the collective programming of the mind distinguishing the members of one group or category of people from another.

Meanwhile, the majority of the participants in Papadopoulos et al. (2015 p4) define compassion as "*a deep awareness of the suffering of others and a wish to alleviate it*". It is this compassion, this deep awareness of another's suffering and the determination to alleviate it that the involvement of mental health service users in PMVA training which could enable insight and understanding of what it

feels like to be restrained, may help to trigger in the staff and entrench in their practice of physical restraint.

But, granted that staff have compassion and good intentions, the question remains – have they got the support mechanism for translating learning and insight from service user contribution to PMVA training into practice? Aware that this may not always be the case, Tew et al (2004) posit that:

> *"unless innovations in education and training are mirrored by developmental support to the organisations in which the students undertake the practice element of their training, and in which they subsequently work, new capabilities may be lost because they are not used"* (Tew et al 2004 p11).

This provision of support to enable the translation of learning into practice may require cultural change through effective leadership. And, as if in response, the Department of Health produced Positive and Proactive Care and A Positive and Proactive workforce intended to provide a framework to radically transform culture, leadership and professional practice with regard to restrictive practices (Department of Health 2014). The first of its four aims for the guidance is to:

> "*encourage a culture across health and social care organisations that is committed to developing therapeutic environments where physical interventions are only used as a last resort*" (DH 2014 p13).

The issue of 'culture' is regularly raised either from point of view of support for good practice or hindrance. For example, Lombardo et al. (2018) covered how proactive management of integrated services and environments (PROMISE) was developed within a particular NHS Foundation Trust to bring about culture change to decrease coercion in care and in so doing reduce the use of physical intervention. Culture was identified as the key problem by both Robert Francis and Don Berwick in their reports on the appalling failures at Mid Staffordshire NHS Trust (King's Fund 2014). According to the King's Fund (2014) the most important influence on behaviours in NHS organisations is the culture – 'the way we do things around here'. Mannion et al. (2005) explain organisational culture as the "softer" aspects of organisations and professional practice: the deep-

seated assumptions, values and working practices that have been affirmed over decades and woven into the fabric of health care delivery. Expounding, the authors state that:

> "*organizational culture encompasses "the way that things are done around here" including patterns of behaviour, systems of patronage and reward, processes of accountability as well as the shared beliefs, values and assumptions that underpin these visible manifestations*" (Mannion et al. 2005 p432).

The king's Fund has maintained keen interest in the topic of culture and leadership in the NHS. The Kings Fund believes that the most important influence on culture is leaders in organisations - what they focus on, attend to, monitor, model, reinforce and do shapes the culture (The Kings Fund 2014). This resonates with Muls et al.'s claim that:

> "*leadership across all levels can influence and inspire change in organisational culture, ensuring that the patient remains the focus of any changes in care delivery*" (Muls et al. 2015, Abstract).

Putting it succinctly, the Francis Report (2013) declares that: "*It is a truism that organisational culture is informed by the nature of its leadership. …"* (Francis Report 2013 p64).

Practice failures in the NHS inevitably result in organisational enquiries and reports, often followed by heated debates about organisational culture and leadership styles. On the latter, McCaffrey and Reinoso (2017) are adamant that transformational leadership which they perceive as a framework that uses vision, inspiration and intellectual stimulation to motivate people toward needed change is the way forward. The concept is described as inclusive of intellectual stimulation to encourage creativity and explore new ways of action within a team, individual encouragement through fostering supportive relationships, sharing ideas, open lines of communication, and personal encouragement (McCaffrey and Reinoso 2017). The authors are convinced that transformational leadership is the ultimate style for achieving patient-centred care, explained as care that

is respectful and responsive to individual patient preferences, needs, and values and ensures that the patient's values guide all clinical decisions (Institute of Medicine 2001).

However, the Gallup survey (Jones 2015) which found for the 14th year in a row, that nursing is the most trusted group in health care and the most honest and ethical profession in the United States brings into consideration the ethical leadership style. Brown and Trevino (2006) describe ethical leaders as honest, caring and principled individuals who set clear, ethical standards and make fair and balanced decisions; who communicate regularly with their followers and use rewards and punishments to uphold standards; who practise as they preach and are therefore very effective role models for ethical conduct. These values suggest that the ethical leader would role-model and support followers to apply the patient centred principle when dealing with incidents that may require restrictive intervention such as physical restraint. However, a criticism of the ethical leadership style is that it may be overly rule bound and in some situations be considered inflexible for use in contexts requiring creativity as may become necessary in managing patient's anger and potential aggression and violence.

The King's Fund on the other hand, urges a move away from the command-and-control, hierarchical leadership styles in practice towards one in which all take responsibility for ensuring high quality patient care and in which all are accountable (The King's Fund, 2014). Having carefully considered the need for greater integration between health and other agencies including social care, housing and education and the ultimate necessity for joined up activities and efforts to ensure patients have integrated, coherent and consistent care, The King's Fund (2014) proposes the collective leadership approach for the NHS. Collective leadership is explained as leaders and teams working together across boundaries, within and across organisations in the interests of patient care and community health (West 2017, The King's Fund, 2014).

In 2016, the Kings Fund identified five key elements in high quality care cultures which according to it, correspond to the values in the NHS Constitution (The Kings Fund 2016). The argument is that if everyone in an organisation consistently works to implement and support those values, they lead to a

compassionate and inclusive leadership culture (The Kings Fund 2016). Compassionate and inclusive or collective leadership is considered most powerful for positive culture change in healthcare organisations because it is the key to creating cultures that would give the NHS staff the freedom and confidence to act in the interests of patients (The Kings Fund 2016). Ten leadership behaviours linked to the five cultural elements that support collective leadership were also identified by The King's Fund (2016) as shown in table 5.

Table 5: Leadership behaviours linked to cultural elements that support collective leadership. Source: The Kings Fund (2016 p12)

Leadership behaviours		Cultural elements
Facilitating shared agreement about direction, priorities and objectives	Encouraging pride, positivity and identity in the team / organisation	**Vision and values** Constant commitment to quality of care
Ensuring effective performance	Ensuring necessary resources are available and used well	**Goals and performance** Effective, efficient, high quality performance
Modelling support and compassion	Valuing diversity and fairness	**Support and compassion** Support, compassion and inclusion for all patients and staff
Enabling learning and innovation	Helping people to grow and lead	**Learning and innovation** Continuous learning, quality improvement and innovation
Building cohesive and effective team working	Building partnerships between teams, departments, and organisations	**Team Work** Enthusiastic cooperation, team working and support within and across orgs.

The contents of table 5 are self-explanatory with regard to patients care generally. With regard to how conducive the practice environment is for translating the lessons from service user PMVA session into practice, it is clear that the content portrays an all-inclusive and enabling practice philosophy that welcomes innovation and learning in order to improve practice. Similar to the Trust that adopted PROMISE in order to reduce the use of physical restraint on their wards (Lombardo et al. 2018), the cohesive and effective teams that thrive within a compassionate, collective leadership style would not hesitate to work with service users if their input can improve service. And they certainly would not hesitate to

implement lessons from service user PMVA session that could help them to achieve a more therapeutic care on their wards in line with recommendations including the Department of Health (2014) and National Institute for Health and Care Excellence (2015).

Chapter Summary

In this chapter, I have explored issues concerning restrictive interventions with particular focus on the physical restraint of mental health patients. The expanding literature on initiatives for managing conflicts on mental health wards reaffirms the ongoing momentum to finding alternatives to PR. The review confirms that firmly seated in every suggested list of core strategies for reducing the use of restraint is the need to work with the patients or the users of services themselves. This is in line and in adherence to the numerous recommendations, legislations and policies for users of services to be involved in the design, development and delivery of services and in the education and training of the professionals that deliver services, for example, the Department of Health (2014) and the Nursing and Midwifery Council standards (2010). It further justifies my team's initiative in inviting mental health service users who have experienced being physically restrained to work with the team in delivering training and subsequently this evaluative study. The concern that such involvement may be tokenistic was picked up in the literature (Hatton 2016, Terry 2013, Borg et al. 2009). Hence, my description of the processes in the involvement of mental health service users' in my team's PMVA training. This is intended to help the reader to decide whether or not their participation in the team's training is tokenistic.

The search for an effective leadership style for the health sector identifies the collective leadership approach as a compassionate, innovative and inclusive style that perceives leadership as belonging to all. The style possesses the characteristics displayed in table 5 that could support the clinicians in their effort to translate lessons from their PMVA service user session into practice.

The chapter also identifies the dearth of research on the impact on practice of service user involvement in the education and training of healthcare professionals. And in general, the lack of SU involvement in teaching and learning

in the subject area of managing conflicts on mental health wards. These are gaps in the literature that this study could help to fill. Notably, qualitative design was identified as popular with literature on the impact of service user involvement in the education of health professionals. This observation has informed my choice of research design and methods as will be explained in the next chapter. Meanwhile, the lack of literature on the impact of service user involvement in PMVA training delivery encouraged the development of my research question and the honing of my research aims and objectives.

CHAPTER 3: Research Methodology

Introduction

In chapter two, I attempted to describe the processes involved in achieving the participation of service user trainer's in my team's training delivery. In so doing, I was asserting that their participation was non-tokenistic. Non-tokenism in such a context was essential for their contribution to be meaningful and for the current study to be worthwhile. The aim in carrying out this study was to trace the outcome of their contribution onto the hospital ward in order to determine what influence if any it had on staff practice. This chapter critically considers my research design for achieving this aim. It explains the ontological and epistemological assumptions underpinning my theoretical framework. The rationale for my choice of methodology is explained. Its advantages and disadvantages are examined. The chapter explains the methods that will be used to collect data, the justification for their choice, the potential ethical issues and how they will be managed. Issues regarding the validity and trustworthiness of data are discussed. The planned approach for data analysis is explained. My role as an 'insider' researcher, the associated advantages and disadvantages are examined.

Research elements

I start by explaining the research elements and their roles in a research process as will be reflected in my work. Ontology, the study of being (Gray 2004) is our assumption of what constitutes social reality. Put simply, it is what I, as the researcher, believe is out there to be investigated. Epistemology is the basis on which I think this belief is true. Grix (2004) very simply defines ontology as '*what is out there to know about*' and epistemology as '*what and how we can know about it*' (Grix 2004, p8). In line, Crotty (1998) describes epistemology as the complexes of assumptions buried within the research methodology, adding that it provides the context for the research process and a basis for its logic and its criteria.

Methodology refers to how a particular piece of research is undertaken, that is, the strategy towards a study (Grix 2004). It is a procedural plan adopted by the investigator in order to answer questions accurately, validly and economically (Kumar 2005). Robson (2002) describes methodology as the fundamental principle guiding the approach to an investigation on social reality. Whilst Ontology and epistemology can be considered as the foundations upon which research is built, methodology, methods and sources are closely connected to and built upon our ontological and epistemological assumptions (Grix 2004). In his work, Crotty (1998) illustrates diagrammatically the relationship between these research elements.

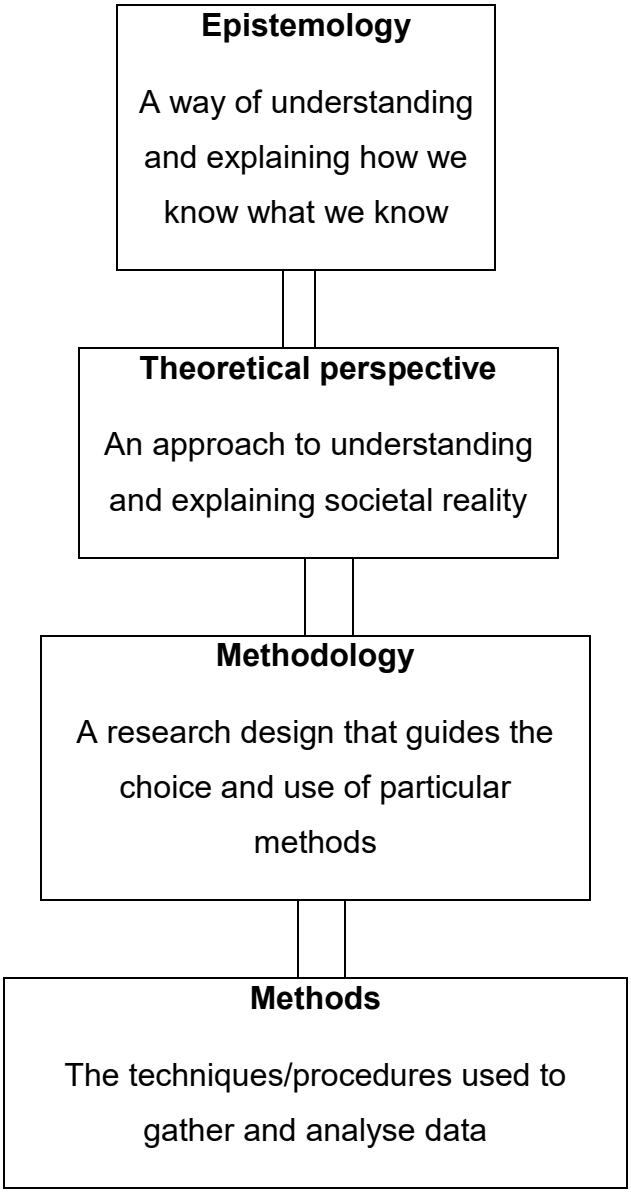


Figure 5: Relationship between research elements. (Adapted from Crotty 1998, p4)

The purpose of these four elements as stated by Crotty (1998) is to help in ensuring the soundness of our investigation and in achieving convincing outcomes. This guide was followed in my research journey.

The quest for knowledge and Research Paradigms

Information seeking has always been a pervasive activity of human life (Goldman 1999). The type of information sought and how we go about collecting such information continues to change in response to the needs and beliefs of a given era (Parahoo 2006, 2014). And all through history, different belief systems provide the framework within which phenomena can be interpreted. Examples include the mythical, the metaphysical, and the scientific beliefs that can in any case coexist, and people can be eclectic in their beliefs (Parahoo 2006). When a dominant school of thought is no longer effective for resolving research problems of the period, a crisis of confidence occurs prompting the birth of an alternative school of thought or paradigm. For example, from about the 1930s to the 1960s, the dominant epistemological paradigm in social science was objectivism whose stance is that reality consists of what is observable. Adherents of this philosophy use value-free, detached approach to gather data in order to explain phenomena (Gray 2004, Crotty 1998). Although this approach may prove effective in investigating natural science, it is seen as unfeeling, cold and inappropriate for investigations on human science.

The dominance of objectivism began to be challenged particularly with regard to investigations on human life experiences and perceptions. The argument was that such experiences and perceptions should be interpreted within context (Smith 2008). Alternative schools of thought such as interpretivism started to challenge positivism, establishing the fact that as human beings, we can hold different views on issues and differing assumptions on how to gather information on such issues. "*Different ways of viewing the world shape different ways of researching the world*" (Crotty 1998, p66). Hence, each branch of scientific enquiry is based on a set of theoretical perspectives or paradigms (Bowling 2002). Guba and Lincoln (1994 p105) define paradigm as the "*basic belief system or worldview that guides the investigator*" not only in the choice of methods but

also in the ontological and epistemological underpinnings. Clarifying, Bowling (2002) states that paradigms consist of a set of assumptions on which the research questions are based, by implication, a way of looking at the world. Elucidating further, Parahoo (2014) claims that paradigms or our view of the world would influence among other things, the way a phenomenon can be studied and the designs and methods that could provide the best answers to the sought after questions. In Table 6 Polit and Beck throw further light by displaying the characteristics of the two dominant paradigms.

Table 6: Major assumptions of positivist and naturalistic paradigms. (Courtesy of Nash 2014 as adapted from Polit and Beck 2004)

Philosophical Assumptions	Positivist Paradigm	Naturalistic Paradigm
Ontologic (What is the nature of reality)	Reality exists; there is a real world driven by real natural causes	Reality is multiple, subjective and mentally constructed by individuals
Epistemologic (The relationship between the researcher and those being researched)	The researcher is independent from those being researched	The researcher interacts with those being researched and findings are the creation of the interaction
Axiologic (What is the role of values in the inquiry)	Values are held in check – objectivity is sought	Subjectivity and values are inevitable and desirable
Methodologic (How is knowledge obtained)	Seeks generalisations	Seeks patterns
	Emphasis on discrete concepts	Emphasis on the whole
	Fixed design	Flexible design
	Quantitative information and statistical analysis	Narrative information and qualitative analysis
	Control over context	Contextualised study
	Focus on the product	Focus on product and process

While these philosophical assumptions generally inform qualitative studies, one needs to note that there is a diversity of approaches, methods and beliefs that inform qualitative investigation.

Approaches to enquiry

The scientific method of enquiry is predominantly quantitative or qualitative in approach. Quantitative approach is driven by objectivism – the notion that truth and meaning reside in their objects independently of any consciousness. It is value free and the researcher maintains a detached stance with the data source. It is number oriented, with the aim of generating research data that can be analysed using statistical methods and the findings are generalisable. The qualitative approach is concerned with people's subjective experiences and how they make sense of these (Willig, 2008). Qualitative studies use 'emergent design' (Ravitch and Carl 2021, Polit and Beck 2012). This means that although broad plans could be made initially, decision making would be ongoing based on what presents in the field. Interviews and observations are the main methods used to facilitate subjective and interactive sessions with data sources in order to collect data which is analysed through interpretation and, the findings are unique and transferable. In table 7, Moule and Goodman identify the main features of both quantitative and qualitative approaches to research.

Table 7: Contrasting elements of qualitative and quantitative approaches. (Source: Moule and Goodman 2014 p173)

Elements	Qualitative	Quantitative
Philosophical origin	Interpretivist	Positivist
Researcher relationship with the subject	Close	Distant
Researcher position in the research	Often insider	Outsider
Research strategy	Unstructured	Structured
Relationship with theory	Develops, interprets	Tests
Data collection	Observation, interviewing	Instruments
Type of data	Rich, individual	Hard, reliable
Data analysis	Interpretation	Statistical
Findings	Unique, transferable	Generalisable

It is important to note that more recently, a critical look at the contributions of these apparently opposing research approaches, sees them as actually complementary (Smith 2008, Walcott 2002, Packer and Goicoechea 2000). Mixed research methods (Onwuegbuzie 2011) continue to gain popularity. The argument is that employing both quantitative and qualitative methods complementarily in the same study can actually enhance the research outcome. As argued by Haggis (2008), approaches which declare themselves to be distinct theoretically are often surprisingly difficult to distinguish methodologically. In line, Aspers & Corte (2019) reiterate that in quantitative work a qualitative dimension is present. Crotty (1998 p41) promptly reminds us that "*it is a matter of positivism vs non-positivism, not a matter of quantitative vs qualitative*". He affirms that what turns a study into a positivist piece of work is not the use of quantitative methods but the attribution of objectivity, validity and generalisability to its findings (Crotty 1998). In their contribution, Ravitch and Carl (2021) recommend that methods best able to generate the necessary data to answer the given research question should be used.

Research design

Research design is the:

> *"overall approach to how a researcher (or research team) bridges theory and concepts with the development of research questions and the design of data collection and analysis methods for a specific study" (Ravitch and Carl 2021 p62).*

Put more simply, it is the *"overall plan for acquiring new knowledge or confirming existing knowledge*" (Macnee and McCabe 2008 p195). Or " *a plan that describes how, when and where data are to be collected and analysed*" (Parahoo 2014 p164). A good design would incorporate all the elements of research as depicted in figure 5 above. Moule and Goodman (2014) further explain that the selection of a design depends on a number of factors including: the research question to be addressed, the researcher's beliefs, resources available, consideration regarding access to data sources and ethical issues. With this in mind, the broad purposes of my research design are to plan an approach that will best address:

my research question, purposes of my study, reflect my beliefs and ensure the rigour and trustworthiness of the results (Moule and Goodman 2014, Macnee and McCabe 2008). The design will take account of the resources at my disposal, the data access and ethical issues among other things. Whatever difficulties encountered in the field, my design must be good enough to ensure that the information obtained is not compromised. My focus will be whether the design is appropriate to gain evidence robust enough to answer my research question which is whether service users can make a sustainable contribution to mental health staff practice through active participation in training and development.

To adequately investigate my research interest which is how staff (subject) manage incidents involving the use of physical restraint and whether their actions/inactions relate to lessons from service user sessions (object), the experiences and perceptions of my study participants and the contexts in which the experiences occurred must be examined. Hence, the need for a philosophy that will enable close engagement and interaction with the data sources. It is this interaction that enables understanding and sense making of the phenomenon. And because I particularly want to know about the perceptions of the staff regarding the incidents and the reasons behind their actions and inactions among other things, it becomes clear that qualitative research design driven by constructivism – the view that meaning is not discovered but constructed, and that all meaningful reality is constructed in and out of interaction between human beings and their world (Crotty 1998) will enable the required close stance and interaction with the data source and thus is the best suited for the study.

Study philosophical framework: Qualitative design

What is Qualitative design?

Following an extensive review of literature, Aspers & Corte (2019) noted the vagueness of the term ‘qualitative’ and the many different views on ‘qualitative research’ which appeared confusing due to its different meanings to different people. The authors came up with what they considered as an inclusive definition of qualitative research that captures its significant features and strengths. Qualitative research according to them is:

"an iterative process in which improved understanding to the scientific community is achieved by making new significant distinctions resulting from getting closer to the phenomenon studied" (Aspers & Corte 2019 Abstract).

In line but broadly, Ravitch and Carl define qualitative research design as one that:

"*uses interpretive research methods as a set of tools to understand individuals, groups, and phenomena in contextualised ways that reflect how people make meaning of and interpret their own experiences, themselves, each other, and the social world*" (Ravitch and Carl 2021 p2).

The authors further state that qualitative research involves systematic and contextualised research processes that enable the interpretation of human views, human approach and meaning making of experiences (Ravitch and Carl 2021). Four philosophical assumptions inform qualitative research. These are displayed in table 8.

Table 8 The philosophical assumptions that inform qualitative research (adapted from Ravitch and Carl 2021 p5)

Assumptions	Qualitative stance
Ontology (how you understand reality)	Qualitative researchers embrace multiple realities and truths, including those of the researchers and participants …
Epistemology (how you view and gain knowledge …)	Qualitative researchers contend that knowledge is developed from individuals' subjective experiences …
Axiology (what you value)	Qualitative researchers identify, acknowledge, and recon with their values and biases, as well as well as those of participants, and to see how these values influence research process and product.
Methodology (your approach to research	Qualitative researchers believe research to be interpretive and structured as naturalistic inquiry;

and the research procedures that you use)	therefore, qualitative researchers tend to use inductive methods and acknowledge the role of the researcher in shaping all aspects of a study.

In their contribution, Polit and Beck (2012) identify some characteristics that apply generally to disciplines that adopt qualitative research approach to scientific enquiries as displayed in Box 3.

Box 3: Characteristics of qualitative approach. (Adapted from Polit and Beck (2012) p266)

- They are flexible and elastic and so can adapt to presenting situations in the field
- They often involve various data collection strategies merged together (triangulation)
- They tend to be holistic, with the aim to understand the whole
- They require the researcher to be intensely involved and immersed in the data.
- They benefit from ongoing analysis and decision making from the moment data starts to come in until the saturation point is reached.

Summarising, Streubert Speziale & Carpenter (2007) reiterate that the main characteristics of qualitative methodologies are a belief in multiple realities, a commitment to identifying an approach to in-depth understanding of the phenomena, a commitment to participants' viewpoints, conducting inquiries with the minimum disruption to the natural context of the phenomenon, and reporting findings in a literary style rich in participant commentaries. The aim is to develop a rich and comprehensive understanding of a phenomenon as it is experienced, perceived and constructed by individuals within their own contexts. The results are not normally generalisable or widely applicable but can adequately describe the local context and can be transferable to other contexts (Moule and Goodman 2014)

Despite the sharing of the above common characteristics, there is a huge range and diversity in approaches to qualitative research **(**Bradshaw et al. 2017, Sandelowski 2000). This multiplicity of ways to engage in qualitative research comes with an attendant challenge declared Ravitch and Carl (2021). It compels qualitative researchers to dutifully declare their views and stance and unequivocally identify their chosen investigation approach. In so doing, they facilitate a clear understanding and critiquing of their work. Some of the more commonly used approaches for qualitative research include: ethnography, qualitative description research, grounded theory, action research, case study research, phenomenology and practitioner research. Ravitch and Carl (2021) promptly suggest that we can employ a mix of the approaches to achieve a more effective research outcome. For example, one can use a collaborative input (participatory method) to construct guiding research question for say, a case study research. It was identified in my literature review that qualitative design was popular with literature on this subject area. For this investigation, I decided to use the qualitative description research design. The reason for my choice is explained in the next section.

What is Qualitative description research (QD)?

Qualitative description research (QD) are studies that seek to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved (Caelli et al. 2003). According to Bradshaw et al. (2017), qualitative description research approaches represent the foundational and fundamental characteristics of qualitative research rather than for example focusing on culture as does ethnography or the lived experience as in phenomenology. In their work, Ravitch and Carl (2021) make a point about the non-linear but continuously intersecting nature of the traditional qualitative processes (figure 6 below) which qualitative description research design represents.

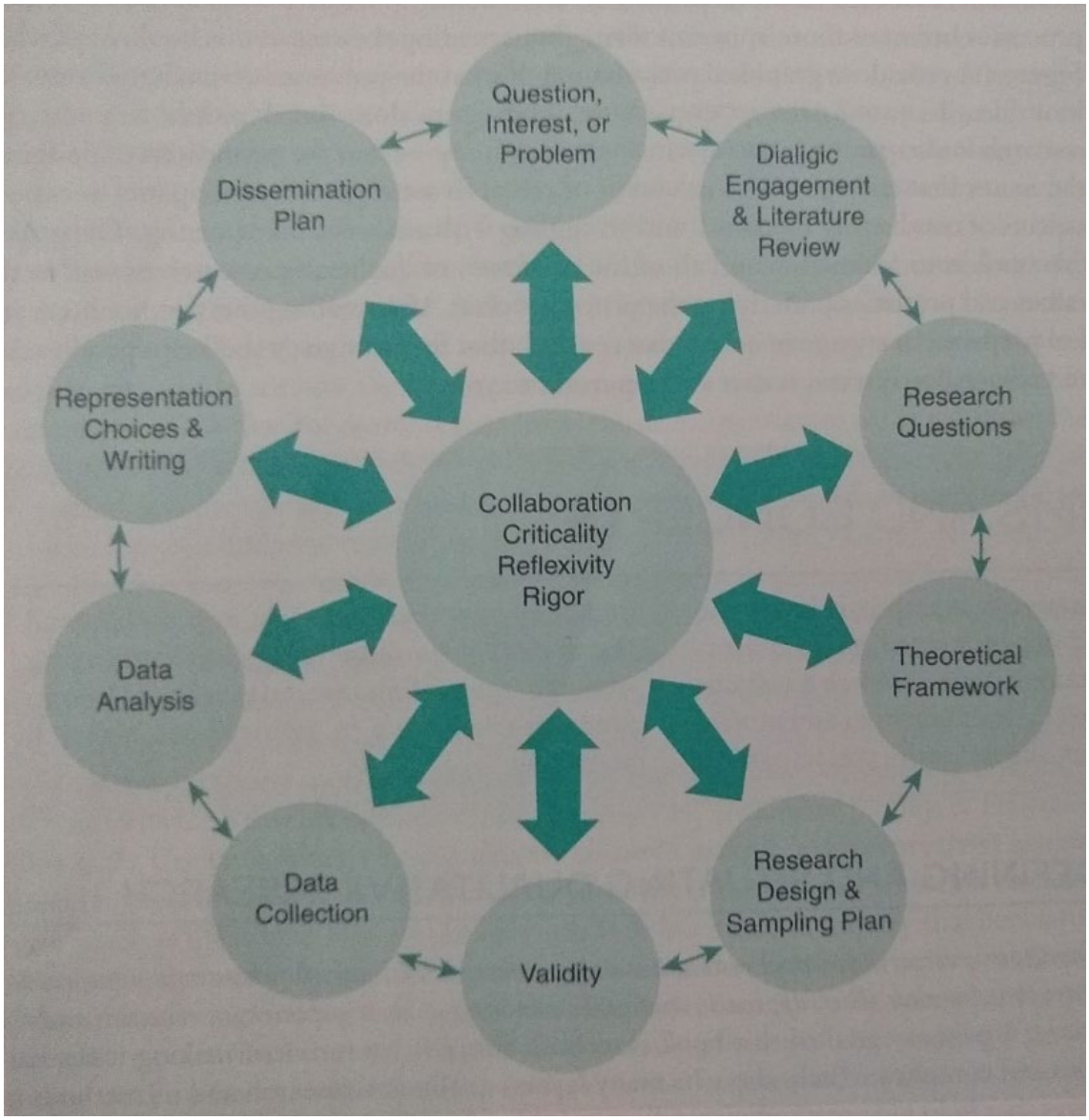


Figure 6: The dynamic elements of qualitative research (Ravitch and Carl 2021 p3)

The processes interact and build off one another in a recurring manner. For example, my research question was developed from the combination of my interest in the topic and the obvious gap as I started to review literature and to make other enquiries on the topic. As I developed my study design, I continued to refer back to my research question and to check whether my design would be robust enough to collect the required data to answer the research question. Similar interaction was maintained between all the elements till the completion of the project. Meanwhile, the vital role played by 'the four key values' of qualitative

research (criticality, reflexivity, collaboration and rigour) is emphasised by placing them centrally and using arrows to demonstrate fluidity of interaction. This is qualitative description research design in use.

The rationale for choosing qualitative description research design

My research question 'can service users make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development?' was consistent with the descriptive approach in assuming that there was a contribution to practice that could be abstracted from data (Lopez and Willis 2004). The qualitative description approach equally suited my research aim which was to produce a straight description and comprehensive summary of the phenomenon under study using participants' language and staying close to the data. Polit & Beck (2009, 2014) see qualitative description as appropriate for studies which are descriptive in nature, particularly for examining health care and nursing-related phenomena, the category under which my research topic falls. Reiterating, Kim et al (2017) and Sandelowski (2000) affirm that qualitative description research design is popular and appropriate for research questions focused on discovering the who, what, and where of events or experiences and for gaining insights from informants regarding a poorly understood phenomenon.

My research interest – the impact of service users' contribution to PMVA training on the management of physical restraint on mental health wards is a social phenomenon that falls under the academic discipline of nursing studies, a caring science (Lukose 2011) which implies close interaction between the care giver and the care receiver. The use of physical restraint to manage disruptive incidents involving mentally ill patients is a relatively new and still evolving practice that is perceived as controversial (Moran et al. 2009, Irwin 2006). Furthermore, the involvement of service users in training health care practitioners on the management of patients' aggression, in particular physical restraint training is a new phenomenon. Authors including Polit and Beck (2012) and Macnee and McCabe (2008) suggest that if we do not have adequate knowledge about a phenomenon, then it is best to use a design that would enable the description

and understanding of the phenomenon. LoBiondo-Wood and Haber (2014) however warn that little being known about a phenomenon is not enough reason to study it since such may be the case because the phenomenon is of little importance. But we recall the global interest in the subject of restrictive interventions especially physical restraint as covered in the literature review, the various recommendations (Ridley and Leitch 2019, DH 2014) and initiatives (Mind and NSUN 2015) which are all indicative of the level of interest in the phenomenon. Little is known about the topic for this study because it is one of a number of new initiatives in response to calls to reduce or eliminate the use of physical restraint. This particular initiative is about working in partnership with mental health service users who have experienced being restrained to provide training for inpatient ward staff. The qualitative description approach enabled a description and understanding of the impact on ward staff practices of the service users' contribution to the training. This in turn enabled the determination of whether such practices resulted from the contribution. The newness of service user involvement in PMVA training and therefore the need for an in-dept description of the phenomenon in order to achieve an understanding of it made the qualitative description research approach the most appropriate of the array of qualitative approaches and therefore the best choice for my research.

Philosophical Assumptions of Qualitative Description Research

The qualitative description research design shares the same assumptions as the traditional qualitative research approach displayed in table 8, p76. The approach acknowledges multiple realities and truths, including those of the researchers and participants. In so doing, qualitative research design identifies with the naturalistic approach, which creates an understanding of a phenomenon through accessing the meanings participants ascribe to them. The study of phenomena in their natural context is central, and there is the recognition that researchers could potentially influence the phenomenon that is being studied. Putting this differently, the neutral position can never be adopted by the naturalistic researchers and their philosophy is central to the phenomena under investigation (Parahoo, 2014). Buttressing this point, Bradshaw et al. (2017) see no reality without understanding

language and acknowledging the researcher's preconceptions. The authors reiterate that only through subjective interpretation can this reality be truly uncovered (Bradshaw et al. (2017). Hence the importance of the four key values of qualitative research (criticality, reflexivity, collaboration and rigour). These are identified by Ravitch and Carl (2021) as requisite for the researchers' transparent clarification of their positionality and potential influence on their study. For this research, my ontological and epistemological assumptions were in line with those expressed in the philosophical assumptions that inform qualitative research in table 8 page 76. And, I shared the philosophical underpinnings of qualitative description approach as listed here in Box 4

Box 4: Philosophical underpinnings of qualitative description approach adapted from Bradshaw et al. 2017 p2

- An inductive process (describes a picture of the phenomenon that is being studied, and can add to knowledge and develop a conceptual and/or theoretical framework).
- Is subjective (each person has their own perspective and each perspective counts). Recognises the subjectivity of the experience of not only the participant but also the researcher.
- Designed to develop an understanding and describe phenomenon (not to provide evidence for existing theoretical construction).
- Researcher is active in the research process (researcher becomes part of the phenomenon being studied as they talk directly to participants and/or observe their behaviours).
- An emic stance (an insider view which takes the perspectives and words of research participants as its starting point) but is influenced by the researcher not only because of subjectivity but also when a degree of interpretation occurs.
- Conducted in the natural setting (data collected in the natural setting of the participants who experience the phenomenon).

The methodological framework

The methodological framework guides the choice of research methods that enable the gathering of rich and comprehensive descriptions about a phenomenon of which little is known. Underpinned by the researcher's ontological and epistemological assumptions, the qualitative description methodology provides the framework to accomplish the study using a qualitative description approach. The framework requires that the researcher endeavours to stay close to the surface of the data. In other words, qualitative description does not require the researcher to move as far from the data as other qualitative designs nor does it call for as highly an abstract interpretation as those others (Lambert & Lambert, 2012). The description of the experience is entirely from the participants' perspective. The researcher's goal is to produce an account of the experience that would be accepted as accurate by most people including participants and researchers. This goal is achievable because of the low-inference nature of qualitative description design. The ability to gain inside knowledge and learn how the participants perceive their experiences is enhanced by the researcher's focus on producing rich and thick description about the phenomenon. Sequel to this point, Sullivan-Bolyai et al. (2005) identified two key elements that are constant with health care studies conducted with qualitative description design as: learning from the participants and their descriptions, and influencing practice using the knowledge. This framework guided my choice of methods used to describe and understand the impact on practice of service users' contribution to PMVA training. The plan regarding how I intended to conduct the research using the chosen methods is explained in the next section.

Methods (My plan of action)

This section explains how I intended to carry out my data collection and analysis.

Introduction

Methods are tools and processes used to gather and interpret data. (Bradshaw et al. (2017). In chapter one, I articulated my subject area and what brought me to my research question. In chapter two, the review of literature indicated that qualitative research was predominantly utilized as the approach to inquiry in the

subject area of service user involvement. I have also in this chapter shared my ontological, epistemological and methodological assumptions. For this enquiry, methods that were congruent with my research question and aim, my philosophical and methodological assumptions were employed. With this in mind, the following issues were addressed in this section: study ethics, rigour, sampling, data collection and analysis, my world view and my positionality.

Ethical issues

"Nearly all research that involve human beings … give rise to ethical issues" (Sim and Wright 2000 p.39).

Approval for this study was obtained from the Higher Institution (HI) Health and Social Care Ethics Sub-committee before starting the field work. Additionally, the partnership relationship between the HI and the trust and the collaboration with the managers at the hospital sites where the semi-structured interviews took place enabled the securing of correct and helpful information, and the gaining of permission from the relevant hospital authorities.

Various ethical issues were taken into consideration from the point of view of the study participants, the service user trainers, the NHS Trust and the Higher Institution. Reflexivity enabled me to continually monitor the impact of the study on these entities (Ravitch and Carl 2021, Parahoo 2014, Savin-Baden 2004).

Right of full disclosure/informed consent

To facilitate decisions on whether or not to participate in the study, I planned to provide the participants with adequate written information about the study (Participant Information Sheet) as well as further information along the way if required.

Right of self determination

I planned to explain that participation was voluntary, that one was free to withdraw at any point (up to one month after data analysis) without explanation, and that refusal to participate would not affect other relationships, such as the training relationship.

Right of privacy, anonymity and confidentiality

I guaranteed these rights to the participants and the stakeholders by documenting them in the information sheet and intended to use reflexivity to ensure compliance. Going in to restrain a violent individual can be extremely frightening, and staff may sometimes perform outside of recommendations. It requires a great deal of courage and trust in the interviewer to disclose truthfully what happened. I planned to reciprocate by ensuring anonymity through the use of pseudonyms for participants.

Right not to be harmed

In order to ensure that no harm was experienced by any of the stakeholders as a result of participation in the study, I planned to take certain actions such as working flexibly in the field to suit those involved and seeking and obtaining consent from all involved if important decision needed to be taken.

In training, I would take care to ensure that issues from the study did not influence the relationship with individuals on the course.

Debriefing and support would be utilized to minimize re-traumatization (Robson 2002). I planned to continually remind myself about Costley and Gibbs' argument in 2006 that ethics in research is not just about securing a signed ethical approval form, but about maintaining an ethos of care for the research subjects throughout the process and ensuring that they do not suffer harm from the research outcome (Costley and Gibbs 2006).

Appreciation

To show my gratitude towards all the participants, it would be explained that participation in the study would be acknowledged in all publications (Gibbs 2009), though participants' names would not be mentioned.

Rigour

Rigour in qualitative research is about the "*overall research quality and validity*" (Ravitch and Carl 2021 p15). Validity, also termed trustworthiness in qualitative research, refers to the various ways that researchers can demonstrate that their

research and findings are faithful to participants' experiences (Ravitch and Carl 2021). The principle of faithfulness to participants' voices and experiences for judging rigour in qualitative research comes about because qualitative researchers set their lens on the views of the people concerned in a study as opposed to a lens based on instruments or scores as would a quantitative research. Emphasizing this point, Bradshaw et al. (2017) state that the demonstration of the truth of the research participant's experience and ensuring that the individual's voice and experience is accurately represented is a fundamental responsibility of a researcher. The lenses involved in qualitative research include that of the researcher(s), the participants, and other stakeholders.

The multiplicity of the qualitative paradigm requires that specific and relevant criteria for judging trustworthiness be applied (Creswell and Miller 2000). For example, Poucher et al. (2019) noted the use of methodological coherence to ensure that the elements of qualitative research within the field of sport psychology are appropriately aligned in order to enhance rigour. Buttressing this point, Ravitch and Carl (2021) stress that trustworthiness in qualitative research should be developed in alignment with the questions, goals and context of the study. The principles of credibility, confirmability, dependability and transferability that were originally introduced and developed by Lincoln and Guba (1985) were intended to facilitate the description of rigour in qualitative research. These principles were used by Bradshaw et al. (2017) to provide means (Table 9) for researchers to demonstrate the trustworthiness of their study.

Table 9: Demonstrating rigour in qualitative Description research (Source: Bradshaw et al 2017 p6).

Criteria	Means to Support
Credibility	• Established rapport prior to commencing interviews. • Developing a trusting relationship (willingness to exchange information). • Express compassion and empathy during interviews. • Prolonged engagement. • Participants to verify the accuracy of the interview transcript (member checking).
Confirmability	• Notes recorded in a reflective journal. • An audit trail used to capture data collection and analysis process. • Description of demographics of participants. • Utilizing member-checking processes to verify data accuracy. • Findings represent the data gathered and not biased by the researcher, evidenced by inclusion of direct quotations from participants.
Dependability	• Establishment of an audit trail describing the study's procedures and processes. • Account for any changes that occur within the study.
Transferability	• Purposeful sampling. • Maintaining a reflexive journal. • Providing sufficient study details so recreation could occur. • Rich description.

As part of the research design for this study, the above principles have been expounded as follows:

Credibility

Credibility relates directly to research design and the researcher's instrument and data. It is the researcher's ability to take into consideration all of the intricacies that present in a study. Credibility validates the concept of connectedness between methods and findings of a research study. It can be demonstrated through the implementation of triangulation, member checking, prolonged engagement in the field, use of peer debriefers, having an external auditor, structuring a study to seek and attend to complexity right through a recursive research design process, establishing rapport prior to commencing interviews and in so doing encouraging voluntary sharing of information.

Transferability

Transferability refers to the fact that qualitative research is contextually bound. Because importance is placed on fidelity to participants' experience in qualitative research, the goal is not to produce findings that can be directly applied to other settings and contexts. Transferability in qualitative research therefore refers to the applicability of a study outcome to broader contexts even as it maintains its context specific quality (Ravitch and Carl 2021). The ways to achieve transferability include; a thick detailed description of data as well as the context, purposeful sampling, maintaining a reflexive journal.

Dependability

Dependability refers to the stability of data (Ravitch and Carl 2021). It entails having a reasoned argument for how data is being collected, and in the same token, the consistency of the data with the argument. Dependability also means that data are consistently and reliably answering the research questions. It is about using appropriate methods to answer the core constructs and concepts of the study. The ways to achieve dependability include; triangulation and sequencing of methods and creating a well-articulated rationale for the choices, accounting for any changes that occur

Confirmability

While qualitative researchers do not lay claim to objectivity, they nevertheless seek to achieve confirmable research findings. Equally, they aim to be explicit about biases. Ravitch and Carl (2021) explain that among the goals of confirmability are the acknowledgement and exploration of our biases and prejudices; the identification of how these influence our interpretations of data; and the mitigation of their effects using structured reflexivity processes. The ways to achieve confirmability in a research study include; implementing triangulation strategies, researcher reflexivity processes, description of demographics of participants, findings represent the data gathered and not biased by the researcher, inclusion of direct quotations from participants, utilizing member checking processes to verify data accuracy

Table 10 displays a sample of this study's claim to trustworthiness mapped against a combination of Bradshaw et al.'s (2017) suggestions on demonstrating rigour and, Ravitch and Carl's (2021) reflexive validity questions.

Table 10: A sample of this project's claim to trustworthiness. Adapted from Bradshaw et al. (2017) and Ravitch and Carl (2021)

Criteria	Evidence in the project
Credibility	Rapport was well established with participants resulting to uninhibited sharing of information. Accuracy of transcribed response verified against signed written response and a sample of member checking.
Transferability	Purposeful sampling strategy adopted Rich description of study provided so recreation could occur.

Confirmability	Description of demographics of participants. Researcher reflexivity adopted right through the research processes Findings represent the data gathered and not biased by the researcher, evidenced by inclusion of direct quotations from participants
Dependability	Triangulation of data collection methods Accounts of changes that occurred during the study.

In addition to these evidences, the limitations of this project were examined in chapter six. This further enhanced validity (Creswell and Plano Clark 2010).

Some authors are doubtful about the effectiveness of these concepts. Morse et al. (2002) for example, argue that whereas these principles are expected to demonstrate rigour, they are only evaluative because they are directed towards the end of a study rather than explicitly through the research process. Notwithstanding, the principles remain the commonly used criteria for determining trustworthiness within qualitative family. Additionally, underpinning our methodology with our philosophical assumptions, referencing back to the research question and aims during the research process and ensuring congruence between the research elements is all a fluid and continuous demonstration of rigour along the research journey. Indeed, Ravitch and Carl (2021) strongly emphasise what they term the 'horizontal values' (criticality, reflexivity, collaboration and rigour) which they position centrally on their illustration of the dynamic elements of qualitative research (Figure 6 p79). The authors argue that implementing these principles right through a research process would ensure trustworthiness of the process.

The authenticity of the contributions from individuals involved in this project

Research data collected from mental health settings were often regarded sceptically. Indeed, people with mental health problems were often stigmatised, generally viewed differently and sometimes subjected to degrading treatment or even torture because their illness was not understood (Trenoweth et al. 2011). Some may argue that my service user trainer colleagues (people with mental health problems) might not be stable enough to run a credible training session let alone provide sound information that could be helpful to the trainees. Equally, that the information from my course participants (respondents) might have elements of distortion because they did not understand mental health issues. Were such the case, then my data could be invalid. However, in this particular case I did not think that my data would be invalidated because my mental health service user trainer colleagues had insight into their illnesses and very effectively managed their conditions. As such, it was highly unlikely that there would be a 'blurring of information' because of medication side effects for example. They were members of the working population who had been contributing to teaching and learning at Higher Institution for a long time. They had been part of the PMVA team for over ten years during which time they had consistently facilitated their sessions and participated in the team's publication of a number of journal articles. We (the mental health service user colleagues and I) had travelled together within and outside the UK to present in national and international conferences including at Lancaster, Edinburgh, Dublin and Copenhagen. Their mental health had never presented a problem. Equally, the study staff respondents were experienced mental health individuals who met and dealt with mental health patients on day to day basis. The student respondents had undergone three years of training on mental health and attended hospital placements over those years. In effect, all my respondents had insight into mental health issues and would be open to talking about mental health in a much more constructive way than might otherwise be the case.

Sampling

The importance of choosing a sampling technique that is reflective of the research design and research question(s) is reiterated by Bradshaw et al. (2017). In line, Ravitch and Carl (2021) suggest a clear understanding of the goals of the research question(s) in relation to the focused context and population in order to select the participant group for the inquiry. The authors came up with the questions in box 5 to guide the selection of research participants.

Box 5: The primary questions to consider in selecting participants (Ravitch and Carl 2021 p83)

- Whom do I need to include, and for what reasons and purposes do I need to include them, given the study's goals, the specific research questions, and the context that guide the study?
- Which individuals, types of individuals, and groups are particularly knowledgeable about what I seek to learn in this study?
- What specific experiences, roles, perspectives, occupations, and/or sets of relationships do I seek to explore, and who can help me explore them?

These were helpful guiding questions which I intended to use.

Purposive sampling is a non-probability sampling technique and is one of the sampling strategies considered appropriate for qualitative studies particularly qualitative description designs (Parahoo 2014). This sampling method can facilitate the selection of participants who possess both the qualities and the experiences necessary for a study. My investigation required participants who had experience of the phenomenon. Thus, my plan was to purposively select groups of participants for the focus group interviews and likewise for the semi-structured interviews. The sampling strategy was going to be discussed further in the research activity chapter.

Data collection

Different data collection methods were considered for this project. Methods typically quantitative and highly structured were considered inappropriate for achieving rich description and understanding of staff's perspectives on restraint practices with regard to lessons from service user contribution to PMVA training. In adherence to a qualitative descriptive epistemological position, the methods for a data collection should not aspire to precisely measure the variables about the phenomenon as would a quantitative approach (Mcnee and MacCabe 2008). Rather, relying on participants' willingness to share their experiences and viewpoints, they should aspire to produce rich descriptions and enable understanding of the phenomenon (Sandelowski 2000). In line with my disclosed theoretical perspectives therefore, my qualitative description data collection methods would aim to describe and enable the understanding of my research participants' actions and in-actions when managing aggressive incidents involving patients.

A longitudinal design was considered for the study. This would have involved collecting data at more than one point in time (Polit and Beck 2012). This option was discarded due to time constraint. Instead, the study was conducted utilizing three commonly used qualitative description data collection methods (Colorafi and Evans, 2016). They included:

- Focus group interviews
- Semi-structured interviews
- Review of training evaluation records

Interviews

Interviewing involves one, as an interviewer, asking questions and hopefully receiving answers from the person being interviewed (Robson 2002). In line, Maltby et al. (2010 p56) describe it as "*one person asking another person questions and there is two-way communication in which the interviewee responds to the questions and further questions often arise as a result*". This is illustrated pictorially in figure 7.

Figure 7: Interview research method. (Source: Maltby et al. 2010 p56)

When well-conducted, an interview is a powerful tool for eliciting rich data on people's views, attitudes and the meanings that underpin their behaviours (Gray 2004). Below, Gerrish and Lathlean (2015) give some key points regarding the use of interview as a data collection method.

Box 6: Key points regarding the use of interview. (Source: Gerrish and Lathlean 2015 p387)

Key points

- Interviews can be used to collect qualitative and quantitative data and can vary in their degree of structure. The degree of structure is dictated by the research design and purpose.
- Key skills in conducting rigorous interviews include developing a well-designed data collection tool, selecting a suitable environment, establishing rapport and balancing the direction and flexibility of questioning.
- Interviews can generate rich data reflecting the perspective of participants. Interviews can be of particular value when the research focus is a sensitive area.
- Interviews are labour intensive and expensive and can introduce bias.
- Interviews provide a unique opportunity to gain insight into a range of subjects and experiences related to nursing and health services.

As stated by Gerrish and Lathlean (2015), interviews can be structured in different ways. These include; the fully structured interview involving predetermined questions, semi-structured interviews which are non-standardized, and the unstructured interview which can be completely informal. Figure 8 illustrates the different types and the appropriate data gathering tools for each.

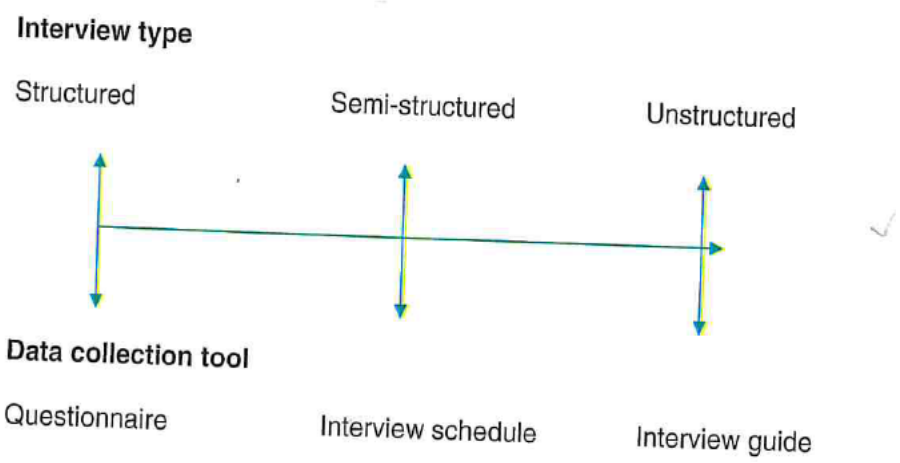


Figure 8: Types of interview. (Source: Gerrish and Lathlean 2015 p390)

Semi-Structured Interview

This is a retrospective design which was planned to be used to collect data from the experienced Trust staff study participants. The semi-structured interview was considered appropriate in the context because it was consonant with the study methodological assumptions. The plan was to use it to gather data from the mental health inpatient staff who accessed the service user session during their 5Day PMVA training at least six months prior to the data collection period.

The flexible nature of the method could enable probing for more information, clarification of answers and meanings that these experienced individuals ascribed to the phenomenon and in so doing aid understanding (Doody and Noonan 2013). An obvious disadvantage of the method was anonymity. This was to be addressed by anonymizing the transcripts (Gray 2004), and by ensuring that the interview schedule was directed at the research objectives, where validity could be enhanced (Parahoo 2006, 2014).

Focus Groups

The focus group interview was identified as one of the fitting data collection methods for qualitative description research (Colorafi and Evans 2016). A focus group collects qualitative data by engaging a small number of people (6-12) in an informal group discussion focused on a particular topic or a set of issues (Boswell

2012, Wilkinson 2008). Reiterating, Maltby et al. (2010) describe it as an extension of the interview in which a qualitative research design is used to ask a group of people for their ideas and opinions regarding a particular subject. For my qualitative description study the focus group interview would use group dynamics to stimulate discussion in order to generate rich data and gain understanding. Curtis and Redmond (2007) claim that the non-directive nature allows participants to comment, explain, disagree, and share attitudes and experiences.

The focus group interview provides a quick and cheap way of collecting large volumes of relatively unstructured data (Wilkinson 2008),but it requires a skilful moderator to conduct effectively. Some people, who find a one to one interview intimidating, may feel comfortable within a focus group. Contributions from co-participants may trigger memories thus enriching discussion and outcome. The fact that confidentiality is compromised in focus group interviews (Parahoo 2014) could be an issue for some participants. I planned to mitigate such concern by including confidentiality on the list of 'house rules' during the session and by using codes to identify participants.

My research aim was to determine whether or not the mental health service users' contribution to PMVA training influenced the way that staff actually managed disruptive incidents on the ward. My plan was to use the focus group interview to collect data from participants that came for my team's PMVA training at the end of their training. Since the study participants accessed the training as a group, it was considered likely to be more productive discussing it in a group rather than individually as would be the case in one to one interview. In the context, time would be a big factor. If the data was not collected quickly, and before the participants dispersed, the opportunity would be lost. The focus group method would enable a quick access to the participants' perspectives on the subject matter. Additionally, working in a group can help to trigger memories. The experience of violence and participation in restraint processes can be traumatic. Discussing the experience in a group and with others who shared similar experience may help to lessen the negative effect of such recall. The focus group setting would provide the opportunity to observe, listen and gain the information required to understand study participants' practices and perspectives.

My plan was to run two focus group sessions of 6-12 participants per session for the student participants and similarly for the Trust staff participants. Six to twelve participants was within the ranges suggested in the literature. Holloway and Galvin (2017) suggest 4-12. Gerrish and Lathlean (2015) suggest 5-12. Below, Maltby et al. 2010 pictorially show a focus group interview session in progress.

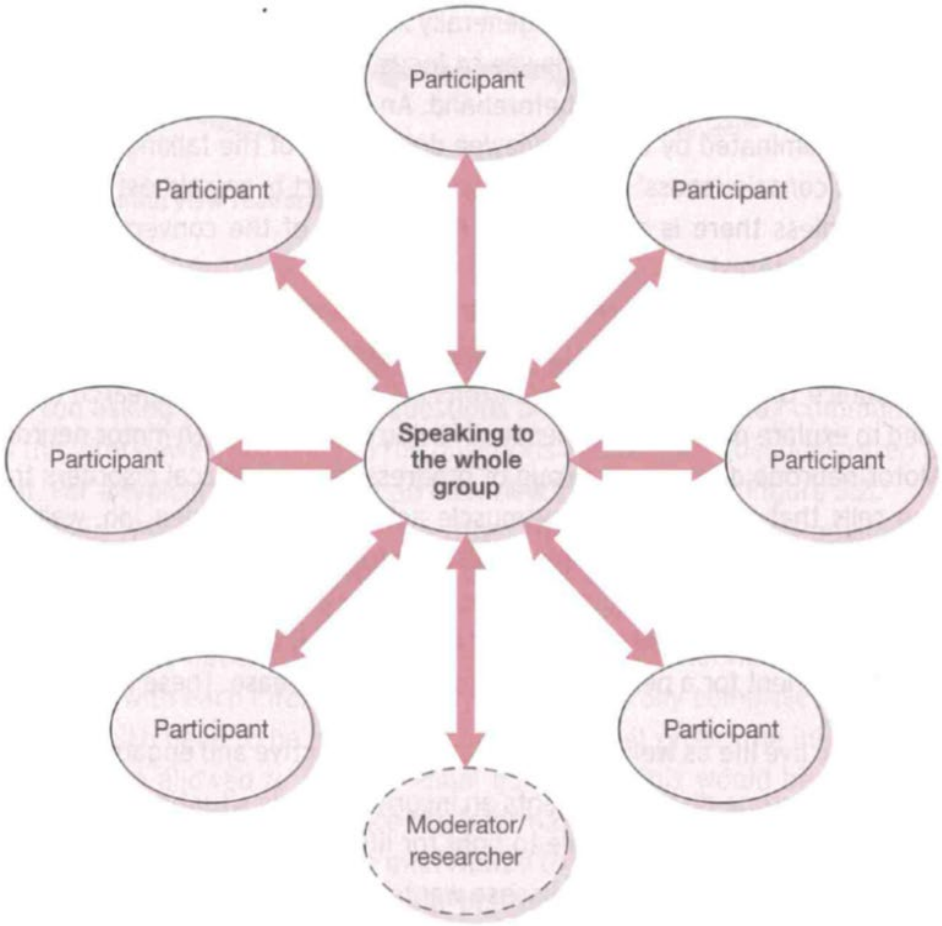


Figure 9: A Focus group in session. (Source: Maltby et al. 2010 p58)

The moderator and the participants sit in a circular format. Whoever is speaking is visible to every member who listens and makes contributions while the moderator ensures an orderly and productive session.

My plan was to conduct the data collection sessions at the HI site when the participants attended training. The final data collection activity would be carried out at the completion of the training in each case. With that arrangement, people would feel free to participate willingly and not feel coerced.

Review of feedback record on PMVA training

Document review is another fitting method for collecting data in a qualitative description research (Colorafi and Evans 2016, Sandelowski 2000). In my study context, the use of this method triangulated my data collection methods and helped to ensure the robustness of the process and to enhance rigour.

At the end of each PMVA training, the participants were usually requested to provide feedback on the service user session in addition to the feedback on the PMVA training which they provided on an NHS London standard evaluation form. They usually gave the feedback anonymously. The team members would examine the feedback which would then be scanned and electronically saved. Meanwhile, the hard copies were sent to the Department's Administration Officer who kept custody of all the training records. The plan was to critically re-examine these records for possible information that might provide additional understanding of the phenomenon. Apart from being economical, this data source had the added advantage of non-susceptibility to people's awareness and reaction to the study participation (Polit and Beck 2012). The plan was to use a structured approach to systematically examine and analyze the record of feedback from our course participants in the past two years. The decision on two years was based on the Higher Institution's archiving policy at the time of the data collection which required that documents were stored for two years only after which they must be safely disposed of. I planned a random sampling of one in ten (1:10) or one in five (1:5) if records were greater or less than one hundred respectively. For corroboration, the Department's Administration Officer was requested to provide an independent analysis of the feedback. The overall plan for the data collection is shown in table 11 below.

Table 11: Summary of the data collection plan

Study participants	**Type of PMVA training**	**Data collection instrument**	**Number of sessions**	**Number of participants**
Newly recruited mental health ward staff	5Day PMVA	Pre and post service user session focus group interviews	2	24

Final year mental health students	5Day PMVA	Pre and post service user session focus group interviews	2	24
Experienced mental health ward staff	1Day PMVA Update training	Semi-Structured interviews	Ongoing till planned number is obtained	9
Feedback from participants in past training sessions	5Day PMVA	Review of records of feedback	Sessions facilitated by the service users in the past two years	N/A

An examination of my position in this research project

In appendix 20, I shared my view of the world. This was to give the reader a sense of who I am, my beliefs and drives. In the next section, I considered my position in this research.

Insider-outsider researcher

Insider outsider does it really matter? Yes it does. Acknowledging one's position in an investigative study of this nature enables an awareness of possible issues such as ethical issues. I identified my position in this investigation. The advantages and disadvantages of conducting this study from my position were critically discussed.

The term worker researcher, insider researcher and practitioner researcher are used interchangeably in texts to mean the same thing. For example, Davison (2004) uses worker researcher in her study; Pringle et al. (2011) use insider researcher. Meanwhile, practitioner-researcher is favoured in texts including Parahoo (2014) and Fox et al. (2007)

Whilst there may be other connotations for worker-researcher position, such as, a person whose job is officially part-practitioner and part researcher, this is about a practitioner-researcher holding down a particular job who is, at same time,

involved in carrying out systematic enquiry which is of relevance to the job (Robson 2002). Fox et al. (2007) explain that a practitioner-researcher is one who is an integral part of the research process in a context where the outcomes of the investigation are implemented immediately within local practice. In contrast, an outsider-researcher operating in the traditional model is external to the setting or the organization forming the focus of the enquiry (Robson 2002).

Research within practice is regarded as research in the real world (Robson 2002), 'a messy business' he calls it. The researcher is part and parcel of the presenting phenomenon and hasn't much choice but to look at the situation holistically for a meaningful outcome. In contrast, an outsider researcher who may not be aware of all the factors at play can afford to work with aspects only, of the phenomenon that she or he considers of interest. Notwithstanding this difference, insider/outsider researcher positions are not in competition. Indeed, the practitioner-researcher investigation could be used to complement the conventional model (Parahoo 2006).

There is much literature in circulation that looks at researcher positions especially as regards their strengths and limitations, and in particular, their influence on the research process (Ravitch and Carl 2021, Pringle et al 2011, Hamberg & Johansson 1999). Interestingly, they unanimously agree that both have strengths and limitations.

An insider researcher has the knowledge, insight and opportunities to identify relevant problems for investigation. The worker research process starts with practice, is carried out within practice and by a practitioner local to the practice (Parahoo 2006). There is an advantage of familiarity with the research problem and the research environment which if handled with requisite reflexivity (Pringle et al. 2011, Polit & Beck 2008) can yield a rewarding and fulfilling outcome. Passion for the topic acts as the motivating force throughout the process. In contrast to an outsider research, the implementation of an investigation carried out within practice is not a separate step. Furthermore, an insider researcher's commitment to the project, and familiarity with the setting and the powers in control could help in the dissemination of study findings.

Undertaking a systematic study requires specific skills and knowledge of the investigative process. The outsider researcher in the traditional sense is more likely to possess such knowledge and skills as opposed to an insider. In such a context however, an insider researcher has the advantage of other types of knowledge such as, the knowledge of the organization and the people involved. A professional, she or he is likely to possess a wealth of experiential knowledge (Kolb 1984) alongside acquired tacit knowledge (Eraut 2004, Hannabuss 2000), and may be able to arrange to access additional requisite knowledge and skills for the project. The problem though is when such an individual is un-aware of missing knowledge. Hannabuss (2000 p402) describes it as "*not knowing that you do not know*".

The outsider researcher has the advantage of full time engagement with the process. The insider on the other hand, is filling the role alongside a job role. Robson (2002) suggests possible solutions to this including allocating time for the research activity by scaling down other responsibilities. Additionally, a worker researcher position could mean regular interruptions to the rhythm of the research work because of other engagements (Grix 2004). From my experience, such a limitation can equally be an advantage where such time-out enables one to reflect on the investigation and come up with better ideas.

The insider researcher has the advantage of ease of access, especially the support from work colleagues and access to the data source. The later comes with attendant problems particularly with reference to the ethics of conducting a research study with or on individuals with whom one has a relationship (Gair 2002).

Those from the objectivist school of thought who employ a quantitative approach would argue that the outsider researcher's ability to detach self from the phenomenon under investigation is an advantage. Those with constructionist/subjectivist views would counter that the insider position enabling a close stance would yield a more comprehensive result provided that reflexivity (Ravitch and Carl 2021, Yardley 2008) is brought into play to account for such close interaction especially on issues such as preconception, bias and duality of

role. I would argue that there is a place for both viewpoints depending on what is being researched.

The outsider researcher's fresh ideas, unencumbered with emotional or professional concerns could be of great benefit to an organization. It is acknowledged that an insider researcher could be so steeped in the organizational culture that problems are no longer recognized as such. The issue though is that the outsider can only interpret data within the confines of their limited understanding of the organization, a point buttressed by participants in Bridges (2001), when they state that outsider researchers are not able to properly understand and represent their experience, and that having outsiders articulate their views is intrinsically disempowering.

In this research project I held a dual position. I was an insider because I taught the physical restraint knowledge and skills (research interest) to the study participants. On the other hand, I was an outsider because I did not work in the NHS Trust, the staff study participants' establishment.

This study was driven by a need to improve practice. It was concerned with the implementation of the service user trainers' contribution to my team's training a follow-up to my earlier research on mental health patients' experience of being physically restrained on the wards. I was deeply involved in the investigation. The downside of deep involvement was that one might develop myopic views and fixed ideas on issues and miss the bigger views and possibly better options.

My choice of qualitative description research design incorporating interview methods entailed close interaction with study participants. Managing such a setting could be very challenging. A lot of issues were at play including power asymmetry (Hamberg and Johansson 1999), preconception and bias (Parahoo 2014). I was going to be interviewing individuals whom I trained and assessed on regular basis. Would they feel able to talk honestly? One way of addressing this was to have a neutral individual conduct the interviews. This was covered under research activities chapter four.

My preparation for the interview could go a long way to easing tension. Feelings of tension could be mitigated by establishing good rapport (Coolican 2009) with the participants prior to and during the interview. Every effort was made to make

the interview setting fit for purpose but not necessarily very formal. Equally, arrangements for counselling were made before any interview in-case of a re-traumatization. On power imbalance, Hamberg and Johansson (1999) suggest discussing it openly with study participants especially where one suspected that it had affected the response to questions. I believe that the rules imposed by the formal process of ethics would ensure that the researcher observes strictly the moral and ethical code guiding the research process. Such conducts hopefully address power imbalances by ensuring role transparency between researcher and participants.

My knowledge of the subject and adherence to non-pain compliance restraint philosophy (NICE 2005, 2015, GSA 2009, 2015) for example, could mean a biased perception of restraint practices. Nothing could destroy a relationship in this kind of investigative process more quickly than a lack of understanding and judging staff restraint practices out of context. Yardley (2008) highlights the importance of sensitivity to context. Reiterating, Campbell and Scott (2011) state that understanding the context of lived experience is very important.

I planned to manage the duality of my roles (PMVA trainer/researcher) carefully and reflexively. For instance, I planned to manage the environment if the practitioners accessed my team's training and the fieldwork was happening at my place of work. But, if the field work was going to be conducted at the participants' place of work, then in a reversal of roles, they knew their work environment and so would play an active role during the fieldwork. I planned to acknowledge and respect this change of roles and hoped that the outsider position would enable a fresh, neutral, macro and holistic rather than myopic view of issues in the field. I planned to keep a reflective diary (Gibbs et al. 2007) for an audit trail of the entire process in order to support the validity of the study (Yardley 2008).

In conclusion, the over-arching management strategy for the complex of issues that might occur during the fieldwork was reflexivity. By continually questioning my actions and inactions, it should be possible to achieve successful field work.

Chapter Summary

This chapter considered my choice of research approach and the theoretical framework underpinning it. My choice of methodology and the methods and plans for the data collection were explained. As of necessity, the chapter considered my world view and my positionality with regard to this enquiry. The next chapter describes how my plans were executed, the processes entailed and actually carried out during the fieldwork.

Chapter 4

Project Activity

Introduction

In chapter three, I described my research approach and explained the rationale for my choice. I explained my planned data collection methods and considered my position in the process. The literature review section meanwhile, established that service user involvement in PMVA training was a new initiative that could help to raise an awareness of the vulnerability of a patient when being restrained and trigger a determination to avoid restraint or to conduct it compassionately. The question was whether the staff were translating their newly acquired insight and learning from the service user session into practice. This chapter explains how the elements involved in collecting data in order to answer this question were developed including: the study sample and sampling technique, the data collection instruments, piloting the instruments, the field work, methods used for data analysis and the ethical issues. The chapter also considers issues that helped to facilitate or that hindered the process.

Preparation for the field work

Certain activities were carried out before the data collection was conducted. These and how they were executed are explained below.

Ethical Approval

An application for ethical approval for the study was made and obtained prior to the field work, from the Higher Institution Health and Social Care Ethics Sub-committee (Appendix 6). The collaborative engagement with the trust managers at the hospital sites where the semi-structured interviews took place enabled permission from the relevant hospital authorities.

Study Sample and Sampling strategy

A sample is a subset of the population selected through sampling techniques to represent the population to which the study is relevant (Moule and Goodman 2014). It is worth noting that a study population can be of things other than people such as trees, animals, buildings, records. Nieswiadomy (2008) argues that the method of selection and the sample size will determine how representative of the population a sample is. There are two types of sampling methods: probability and nonprobability sampling methods. Probability, sampling considered the more rigorous, uses some form of random selection in choosing samples. The result is likely to be representative. Nonprobability sampling on the other hand lacks randomization. As a result, the findings are considered less generalizable than those using probability sampling strategies. LoBiondo-Wood and Haber (2014) however argue that if a nonprobability sample reflects the target population through careful use of inclusion and exclusion criteria and is adequate in size, the representation and external validity could be enhanced.

My sampling strategy was purposive. This is a nonprobability sampling used mainly in qualitative research. It involves a deliberate choice of study participants who are accessible, and who also possess the qualities and experiences required for the study. I chose to use this sampling option because of the specific nature of my target population – mental health inpatient ward staff and nursing students who accessed my team's PMVA training, participated in the service user session and could articulate their experience of it. Sandelowski (2000) stresses the importance of researchers being able to defend their choice of sampling method.

The concept of sample size and data saturation provoke debate among qualitative researchers. Part of the argument being that because of the uniqueness of each participant's experience, data saturation cannot truly be achieved. This may be why Fawcett and Garity (2009) suggest that an adequate sample size is one that sufficiently answers the research question, the goal being to obtain cases deemed rich in information.

To achieve a wide representation (Langdridge 2007, Kumar 2005) my study population was comprised of all the Trust staff and the Higher Institution students who participated in the service user session during their 5day PMVA training

session provided by my team. The study participants for the focus groups were staff/students who attended the training when the data collection was arranged and who consented to participate in the research. The participants for the semi-structured interviews were experienced mental health Trust staff who attended the training at least six months prior to the data collection, who accessed the service user session during their training, who were still working in the Trust at the time of the data collection and who consented to participate in the research. The records for the feedback review included all the feedback on the service user session collected in the immediate past two years to the time when the information was sought in adherence to the Higher Institution archiving policy at the time. The adequate sample size for each category (see data collection) enabled rich, and sufficient data to answer the research question (Fawcett and Garity 2009). Tables 12 and 13 explain the inclusion and exclusion criteria.

Table 12: Study Participants Inclusion Criteria

Focus Group Interview	Semi-structured Interview	Records
The NHS Trust mental health inpatient ward staff and The final year mental health students of a Higher Institution Who attended the 5Day PMVA training and participated in the service user session when arrangement was made to collect data	The NHS Trust mental health inpatient ward staff members Who participated in the service user session when they attended the PMVA training at least six months prior to data collection Who were still working on the ward at the time of data collection	All records of feedback from PMVA training participants Within the two years HI archiving policy

Who were willing to participate	Who were willing to participate	

Table 13: Study Participants Exclusion Criteria

Focus Group Interview	Semi-structured Interview	Records
Students or staff who did not participate in the service user session even if they participated in the PMVA training Who did not consent to participate in the study	Staff who did not participate in the service user session even if they did the PMVA training Who were no longer working on the Trust in-patient ward Who did not consent to participate in the study	Records outside of the stipulated time period

Study Venue

The PMVA team enjoy the luxury of a room exclusively allocated to the team. I planned to conduct the interviews in the room at the end of training on the interview days.

Interview questions

I prepared what I termed “Guiding Interview Questions” which were vetted by my colleagues and my supervisors. The idea was to use these in conjunction with other prompts to maintain a flexible structure and to steer the interview back on course when a deviation occurred. The research instruments were developed differently for each type of interview.

Development of the questions for focus group discussion (Appendices 10 & 11)

During the theoretical component of the 5Day PMVA training, participants on the training had opportunities to share their experiences of aggressive and violent incidents involving mental health inpatients on the wards and how they were managed. In addition to such narratives, the service user trainers' shared experiences of being physically restrained. Issues picked up from these disclosures in combination with those that arose during training informed the development of the research instruments for the pre and post focus group discussions.

Pre- service user session focus group

This session was run when all the theoretical and physical components of the training were completed. The research instrument expected the participants in the focus group to reflect on their experience of how staff managed patients' anger and used physical restraint on the ward and to compare such with what they learnt and to share their thoughts and lessons learnt.

General background information

The demographic information from the participants (Table 16) was collected at the same time as the consent form (Appendix 9) was completed and before the interview session was started.

The research instrument

The pre- service user research instrument comprised three questions (Appendix 10). Prompts were used to follow up on participants' contributions in order to clarify them and to gain further insight. The questions were on:

1. Reflection on physical restraint (PR) generally

Reflection and perspectives on physical restraint experience at work and in the training - How do they compare? What have we learnt?

2. Sharing how we might deal with incidents requiring PR.

Participants shared their new views and modified approaches regarding the use of PR based on what they learnt from the training.

3. Opportunity for participants to bring up issues and concerns on the topic.

The PMVA training was delivered in a non-operational setting. Aware that there might be issues on the wards (the real world) that might constrain the application of an ideal PR process as learnt, this was the chance for participants to share such. Reassured by the confidentiality rule agreement, participants were able to raise and discuss their concerns.

The main purpose for the pre-service user discussion was to establish a benchmark with which to compare the participants' mindset at that stage with that after the service user session.

Post service user session focus group

This session was run on the last day of the training when all the teaching and the practice to consolidate the physical restraint skills had been completed. Having freshly acquired the restraint skills, participants are often very zealous to show off those skills and so jump in to restrain without prior effort to try alternative ways to resolve the problem. This is in spite of the trainer's persistent emphasis throughout the training on effective communication and negotiation to prevent or de-escalate patient's anger and aggression. Hence the service user session that could hopefully challenge such mindset.

The group comprised exactly of those that participated in the pre focus groups session. Their demographic information had been collected. It was therefore considered unnecessary to collect it again. However, the consent form was

requested again just in case somebody did not want to participate anymore. The form was completed before the session was started.

The research instrument for post service user session focus group

The instrument comprised five questions (Appendix 11). Similar to the pre focus group session, prompts were used to follow up on participants' contributions in order to clarify them and to gain further insight.

1. Reflection on the contributions of the service users.

This was an opportunity for the focus group participants to recall, reflect and to share their thoughts on the session with the service users.

2. Lessons from the service user session.

Participants shared their varied lessons from the session. Some of the identified lessons were unique to the individuals due obviously to prior experiences but some lessons appeared common to the participants.

3. Lessons and ward practice.

This crucially was what the whole exercise was about – ward practice. Would the lessons from the session make a difference to how incidents with patients on the ward would be managed? Some of the participants were passionate in expressing their determination to reflect learning in practice. Some appeared cautious. Hence question number four.

4. Work related issues that may affect implementation.

In terms of length of practice and experience, the group was non- homogenous. This was an opportunity for those who had been longer in practice and who may have witnessed more to share with the less exposed, the hindrances in the real world.

5. Further contribution.

A further opportunity for contributions of any kind to the discussion. Physical restraint particularly of mental health patients is controversial and topical.

Participants may have all sorts of thoughts about the phenomenon. This was the opportunity for them to air their views without worrying that they were deviating from the guide question.

Development of the questions for semi-structured interview

Similar to the focus group, the narrations of incidents involving physical restraint on the wards by ward staff when they attended their 1Day PMVA update course in addition to the service user trainers' shared experiences of being physically restrained informed the development of the interview schedule for the semi-structured interview (Appendix 12). Fairly broad questions were developed to guide the interview. The idea was to skilfully support the schedule with prompts when further clarifications were required. In contrast to a structured interview, I planned to tactfully engage in the conversation (Boswell and Cannon 2017) in order to draw out as much information as possible from my participants.

Semi-structured interview sessions

As suggested by Watson et al. (2008), the qualitative semi-structured interview was designed to capture descriptions by experienced mental health ward staff to enable the development of knowledge and insight into the impact on ward practice with respect to the service user contribution to PMVA training.

General background information

The demographic information (Table 15) was collected at the same time as the consent form was completed and before the interview was started.

The interview session

The discussion was guided using the 'interview schedule' (Appendix 12). Prompts were used to follow up on participants' contributions in order to clarify them and to gain further insight. The principle of a good interview suggests starting with

general and easy questions to relax the participant as well as to learn what is important to the individual before progressing to more specific questions (Taylor and Bogdan 1998). In line, the interview schedule started with asking when the participant accessed the service user session and what the participant thought about service user inclusion on the course. Before going into the specifics, the schedule refreshed the participant's memory on the service user session. This is considered important because some of the participants might have forgotten the details of the discussion during their service user session. The schedule is explained in Box 7.

Box 7: Explaining the semi-structured interview schedule.

- Engagement – the schedule tests how engaged the participant was during the SU session.
- Did the participant identify any points of interest in the discussion?
- The schedule wants to know whether the experience resulted in practice change or modification.
- Could the participant please use incidents on the ward to illustrate such practice change or practice modification.
- The participant may have opinions regarding the phenomenon. The schedule is interested in work related issues such as issues on the wards in particula, and in the establishment generally that may constrain or enable the implementation of lessons from the service user contribution to the PMVA training.
- Similarly to the focus group, the participant is given the opportunity to share any other concerns work related or not about the phenomenon.

Pilot Study

A trial run of data collection instruments from my experience helps to expose problems that may occur in the field.

Taking advantage of my worker researcher position, I asked the Trust's mental health wards staff members during their physical restraint refresher course. They kindly and voluntarily agreed to pilot the data collection research instrument for me. I took care to note down the details of the staff that piloted the semi-structured interview schedule for me. This was in order not to include them among those participating in the actual interview. The staff for the pilot study worked in similar or the same wards as those who provided the actual research data and regularly encountered similar challenging incidents that might require to be managed using physical restraint. The outcome of the pilot study was most helpful. Suggestions included the need for further clarifications of the interview schedule and to adjust the timing for the interviews. I had allowed an hour for each interview. The pilot study which was undertaken two weeks before the first actual interview session indicated that forty minutes was approximately adequate for each session. Critically considering how long it took them and time constraint, the pilot participants had suggested an average of forty to forty-five minutes for the interviews. All the suggestions were noted and the interview schedules were modified accordingly.

The focus groups of the Trust staff and the students were similarly piloted. The allocated time of an hour in each case was deemed adequate.

To familiarise myself with the review of records of feedback process, I carried out a trial run using feedback from three months records only. This enabled awareness of challenges including the size of the record. This led to the decision to review a sample only of the records as they were too many.

Data Collection

To reiterate, my research question was whether the contribution to PMVA training by service user trainers influenced the way that mental health inpatient ward staff responded to incidents with patients that might require physical restraint. To collect data through my chosen designs, I conducted:

1. pre and post service user session focus groups with the Trust staff and similarly with the HI final year mental health students who accessed my team's PMVA training and participated in the service user session.
2. semi-structured interviews with experienced Trust staff who accessed the service user session when they attended my team's 5Day PMVA training and who were working in the Trust's mental health inpatient wards at the time of the field work.
3. a re-examination of the records of feedback on service user session going back to two years.

These data collection methods were treated separately for the purpose of explaining how they were conducted.

The focus group interview

Introduction

Aware of the emergent nature of Qualitative research (Polit and Beck 2012), I was apprehensive, vigilant and open to the probability that my plans might need to be altered as I prepared for the project fieldwork. The most valuable resource for me at this point was the extremely busy training schedule my team was running. While this posed a hindrance because it did not afford me time to engage in my project, it however meant that the availability of study participants was assured. I could choose when to run a data collection process with the certainty that training was occurring regularly and participants would be available.

The interview

Indeed, the emergent nature (Polit and Beck 2012) of my research approach became evident during my first attempt to run the focus group with the trust staff. Although everything was carried out to the minute detail such as informing the participants about the study at the start of the training, giving out the information sheet to each participant before the focus group session as well as each participant signing the consent form, nevertheless, my colleague who was

moderating the session and I soon picked up a very subtle lack of enthusiasm from one of the twelve participants when the session started. As a result, we decided to abort the exercise and did not run the post service user interview. Notwithstanding, it was brought to my attention by the Trust representative that they preferred that employees sent on the course focused on the training and not on research. In recognition of this, I decided to modify the timing and the venue and to make 'non coercion' obvious. So, in adjustment to the plan, I booked a different venue from the PMVA training room through the HI Room Booking system. This way, any participants that went to the focus group venue, would be demonstrating their consent. Also, to minimise bias and to avoid trainer-trainee influence, I arranged for a different moderator who had no acquaintance with the participants prior to the interview.

Before handing over to the moderator during each interview, I did the introductions and proceeded to explain the project and the plan for the session. The participants were given the information sheet (Appendix 8) to read after which they were given the consent form (Appendix 9) which they all signed without coercion. They were reminded about their right not to answer any question if they did not wish to and the right to withdraw at any time without explanation. I asked their permission to set up two audio recorders (one as a back-up) as well as their permission for me and my colleague to take notes of the interview. In each case, the participants had no objections with the requests. I positioned myself in the corner listening and taking notes. The moderator who was very experienced had a naturally warm friendly manner that put people at ease. This helped to establish 'rapport' and 'trust'. The discussion was animated in each case and the data generated was rich and very thick. All the focus group sessions were run similarly. During the trust focus group session, two of the participants stated their unwillingness to participate. Their wish was gracefully accepted and respected. They were both encouraged to go and collect lunch from the interview venue notwithstanding. They did.

Another challenge encountered at the field work was when all the arrangements were made for the post SU focus group interview but then the service user failed to turn up for the SU session. I felt most concerned because my service user colleagues were very regular and punctual in attendance. And for that week's

session we were expecting only one of them. My effort to get him on the phone just to find out whether he was alright was unsuccessful. Even though we had run the pre focus group interview the previous day, the whole exercise was aborted. My service user colleague was very apologetic when I eventually got him. He had put down the wrong date for his session. At the time we were expecting him, he was in a meeting and had his mobile phone switched off when I was trying to reach him. The session was rearranged and successfully run.

Debriefing

Parahoo (2014) suggests the need for sensitivity in handling a focus group and ensuring that individuals do not suffer stress as a result of participation. This suggestion was well observed by both the moderator and self throughout the fieldwork. Physical restraint is an emotive subject. My colleague and I were quite prepared to give emotional support to any participant who needed one. But the moderator managed the sessions in such a relaxed manner that everybody appeared comfortable and to have enjoyed the sessions. Besides, the focus group participants were either students or they were staff who had started newly on the wards and who were less likely to have witnessed serious restraint incidents. Additionally, discussing in groups enabled a form of peer support for one another, an advantage of focus group approach.

It was evident that the modified arrangement worked effectively. The moderator was very experienced and skilfully used general questions to break the ice and relax the participants and give prompts to clarify contributions. The outcome on each occasion was rich and thick data.

Semi-Structured Interview

Introduction

The Trust and the HI had enjoyed very cordial partnership over the years, a relationship that my fieldwork must not jeopardise. Following the incident discussed under focus group and the concern raised by the Trust, it was agreed

that I should rearrange plans and run the semi-structured interview at the Trust sites rather than when staff came for training at the HI venue. It was suggested that I book a room at the Trust and provide lunch for the staff in order to make it convenient for them to drop in during their lunch break perhaps and grant me the interview. This was a more serious change of plan than that for the focus group. There were two different hospital sites. The interviews needed to be organised separately for each. But first, I had to get permission from each of the Hospital Matrons.

The Interview

One of the advantages of conducting the interview at my work venue was that in terms of positionality, I was an 'insider' with greater freedom to manage the situation. Taking the sessions to the Trust sites put me firmly in an 'outsider' position. There was a shift of role to the participants in the preparation for the interview and I needed to respect that. This meant adjusting my strategy to a more collaborative style where study participants were actively involved in the field work. I decided to start from the known to the unknown by enlisting the support of the staff and ward managers who attended our training. I made a long list of them. I spoke with them severally as well as in groups. Each was willing to help in any way they could. One from each site offered to book the rooms. One of the ward managers offered to announce the interview proposal in their weekly management meeting so that all the ward managers would know and so rota their staff to attend the interview. He also provided me the names and contacts for the Matrons so that I could contact them for the permission. Appendix 7 is an example of the correspondence.

On the interview dates, I witnessed first-hand the acute shortage of staff in the NHS as often reported in the news. On each occasion, I physically was trotting from ward to ward to urge the staff to attend the interview session because the managers were struggling to release them. My target had been ten participants from this source. With the relentless effort, and indeed the very appreciated cooperation and support from the managers, the shift leaders and the staff, I was

able to meet the target! It was a true demonstration of the cordial relationship my PMVA team had with our training participants.

The interview schedule was used for each session. Each participant was given the information sheet followed by the consent form which each completed. As with the focus groups, permission was sought to use the tape recorders. In line with Taylor and Bogdan's (1998) suggestions, the interviewer started each session with general questions. The tactic seemed to relax the participant in each case and to establish a rapport.

Robson (2002) opined that the quality of a flexible design study depends to a great extent on the quality of the investigator. Such personal qualities as an open and enquiring mind, being a good listener, being sensitive and responsive to contradictory evidence are essential. The interviewer who was very experienced had a naturally relaxed demeanour and seemed to transfer her composure to the participants. From my corner, I observed quietly and keenly jotting down points of special interest. The interviewer used prompts and facial expressions including head nodding to encourage the participants, to verify points, as well as to follow up on leads and hunches. The interview lasted forty minutes on average. Each session was skilfully and tactfully managed. I had much rich and full data for the effort thanks to all who generously helped in one way or another.

Debriefing

Aware that the recall could reignite past upsetting memories, I had attractively displayed the lunch in a different room from the interview room. Once the interview was finished, each participant was ushered into the refreshment room and encouraged to help herself/himself to the food and drinks. Each was engaged in a relaxing chat. The process enabled me to check that each was emotionally alright.

Table 14 represents details of the actual data collected while figure 10 shows the sources from where they were collected.

Review of records of feedback

A detailed explanation of the records of feedback was done in chapter 3. As explained there, the number of records were greater than one hundred, so, a random sampling of one in ten was used (Appendix 13). The exercise yielded eleven records of feedback in the past two years from the time of enquiry. The decision on two years was based on the HI archiving policy which required documents to be stored for two years only after which they must be safely disposed of.

Table 14: Summary of actual data collected

Study participants	**Type of PMVA training**	**Data collection instrument**	**Number of sessions**	**Number of participants**
Newly recruited mental health ward staff	5Day PMVA	Pre and post service user session focus group interviews	1 session	10
Final year mental health students	5Day PMVA	Pre and post service user session focus group interviews	1 session	10
Experienced mental health ward staff	Data collected at their site	Semi-Structured interview	Ongoing till planned number was obtained	10
Feedback from participants in past training sessions	5Day PMVA	Review of records	Sampled records from the past two years	11

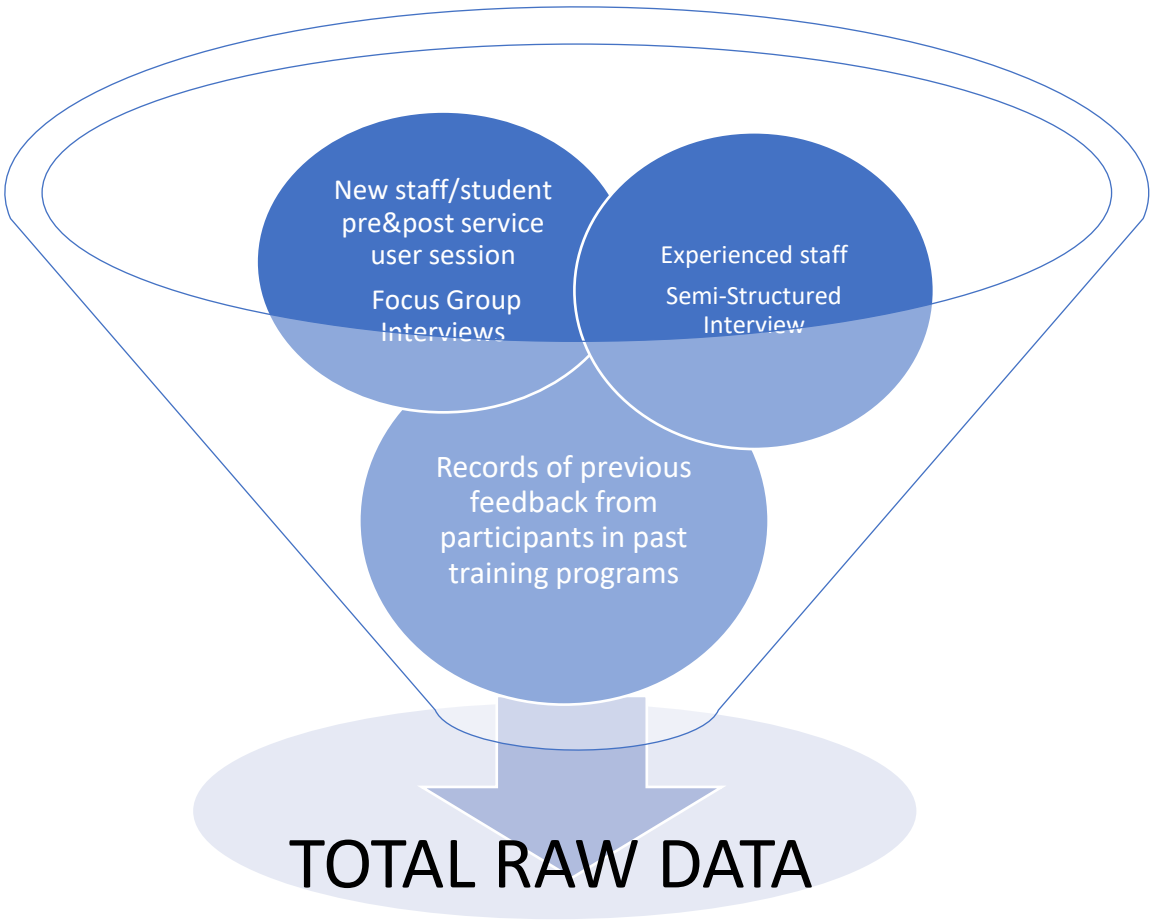


Fig 10: Diagram illustrating the actual sources of data collected.

Limitations of my data collection methods

Possibly, the main weakness of the interview data collection methods for this study was its reliance on the participant's ability to recall restraint practices in retrospect. In truth, some of the facts may have faded away over time, raising doubts about the accuracy of data. But, asking several participants again and again, the use of prompts, and rephrasing the questions might all have helped to minimise this probable limitation. Also, discussing as a group during the focus group sessions must have helped to trigger memories.

Gaining access to the hospitals for the semi-structured interviews had to be organised well ahead of time with the managers. They decided the date and time. This meant that only the staff who were there on the day were available to us. Non-anonymity of the interviewee was another limitation. The rules of confidentiality as suggested by Parahoo (2014) were observed. Participants were

reassured before each session that all necessary care would be taken to ensure anonymity. Pseudonym names and numbers were used throughout.

A major challenge for me was the fact that the topic was on my subject area. That placed me in an 'insider researcher' position (Fox et al. 2007). Knowingly or unknowingly, I might have held some preconceived ideas about the topic of investigation. Robson (2002) explains that researcher bias is what the researcher brings to the situation in terms of assumptions and preconceptions. My adoption of General Service Association's principle of 'non-pain compliance' for example could easily have made me react to narrations of pain-compliant practices. Equally, prior assumptions have been known to unwittingly distort the interpretation of qualitative data (Parahoo 2006, 2014). Additionally, the trainer-trainee relationship may have resulted in participants telling me what they thought I wanted to hear. The adoption of reflexive and collaborative practices (Ravitch and Carl, 2021) throughout the research processes, the use of a moderator for the interviews in addition to locating my seat away from the respondents hopefully helped to mitigate these potential limitations.

Data analysis

Data analysis is that stage of the research process at which the researcher tries to make sense of the information collected from the study participants. Robson (2002) explains that it is the test of the ability to think, to process information in a meaningful and useful manner.

Data components

By directing the data collection instruments at the objectives of the study the generated data was mostly qualitative. There were also some quantitative components including the demographic information on the study participants. These were listed and presented in table formats as displayed in tables 15 and 16.

Quantitative components

Two of the three methods of data collection (the semi-structured and focus group interviews) used for the study collected data from two different groups of participants each. The semi-structured method collected from experienced staff from mental health wards located in two different hospital sites. The participants comprised six male and four females in the age range of 20 to 50 years and with one to sixteen years of practice experience. Seven of the participants were qualified mental health nurses. The eighth person had BSc in Psychology, the ninth had NVQ level 3. The tenth person did not disclose qualification. Five of the participants were staff nurses, one was a charge nurse, one a ward manager, one an assistant practitioner, one an activity worker and one a Nurse Assistant Band 4. Table 15 is an 'At a glance display'.

Table 15: Demographic information on Semi-Structured Interview Participants' (Pseudonyms have been used)

Location	Participants	Gender	Age range	Ethnicity	Qualification	Job Title	Years in practice	Breath of experience
NHS mental health site A	Brian	Male	45-50	Black African	RMN	Staff Nurse	9	Various
	Steve	Male	35-40	Black African		Activity Worker	16	Various
	Sam	Male	35-40	Black British	RMN	Staff Nurse	5	Various
	Andy	Male	25-30	Mauritian	RMN	Charge Nurse	3	Acute
	Susan	Female	30-35	Black African	NVQ Level 3	Nursing Assistant Band 4	7	Various

	Olivia	Female	25-30	British	BSc Psychology	Assistant practitioner	4	Various
NHS mental health site B	Mary	Female	40-45	British Black	PGDip RMN	Staff Nurse	2+	Numerous
	Helen	Female	45-50	Swedish	BSc (Hon) MH	Staff Nurse	1	Numerous
	Kevin	Male	40-45	British	RMN	Staff Nurse	1	Various
	Roger	Male	25-30	British	RMN	Ward manager	4	Various

The focus groups interview collected data from final year mental health students and Trusts' new staff which individuals worked in various inpatient wards within the local NHS Trusts. Effectively, their experiences were varied and wide. The interviews were facilitated separately for the students and the trust staff at the HI location. Each group had ten participants in it. Table 16 shows their demographic details.

Table 16: Demographic information on Focus Groups Participants' (Pseudonyms have been used)

FG1. NHS Trust New Staff

Location	Participants	Gender	Age range	Ethnicity	Qualification	Job Title	Years in practice	Breath of experience
Higher Institution	Alice	Female	20-25	African	Healthcare assistant (HCA)	HCA	4	various
	Janice	Female	25-30	Caucasian	HCA	HCA	6	various
	Ade	Male	30-35	African	Activity Worker	Activity Worker	1	various
	Kate	Female	25-30	Mixed Race	RMN	Staff Nurse	2	various

	James	Male	30-35	Mixed Race	Activity Worker	Activity Worker	5	Numerous
	Chris	Male	25-30	Caucasian	RMN	Staff Nurse	1	various
	Pat	Female	20-25	African	Activity Worker	Activity Worker	2	various
	Rose	Female	20-25	Caucasian	RMN	Staff Nurse	1	Mental health
	Ada	Female	30-35	Mixed Race	RMN	Staff Nurse	4	Numerous
	Allop	Male	25-30	Mixed Race	RMN	Staff Nurse	1	Mental health
FG2. Higher Institution Final Year Mental Health students								
Location	Participants	Gender	Age range	Ethnicity	Qualification	Job Title	Years in practice	Breath of experience
Higher Institution	Jill	Female	25-30	White British	Student Nurse (MH)	NA	3	Various
	Fab	Male	40-45	Black African	Student Nurse (MH)	NA	13	LD and MH
	Lucy	Female	45-50	African	Student Nurse (MH)	NA	3	Various
	Tim	Male	30-35	Nepalese	Student Nurse (MH)	NA	3	Various
	Ola	Female	20-25	Black African	Student Nurse (MH)	NA	3	Various
	John	Male	25-30	White British	Student Nurse (MH)	NA	3	Various
	Vicky	Female	20-25	Black African	Student Nurse (MH)	NA	3	Various as HCA
	Lisa	Female	25-30	Mixed Race	Student Nurse (MH)	NA	3	Various
	Nora	Female	20-25	Bengali British	Student Nurse	NA	3	Various
	Val	Female	20-25	White British	Student Nurse	NA	3	Various

Qualitative components

Many authors on qualitative research approaches argue that data analysis is not a ‘bolt-on’ feature that can be ignored until all the data are collected but one that should begin during the data collection stage (Parahoo 2014, Gray 2004,). Putting it differently, analysis is vital to the data collection process as it enables the ‘it’ to be iterative and reflexive (Maltby et al. 2010). I heeded this suggestion by thinking through, theorizing, and making detailed notes of the information coming through during the field work. The field notes were used to compare the emerging information during the analysis. All relevant information including the contradictory or negative ones were treated as valuable data to be analysed.

The derivation of themes

Introduction

Authors including Moule and Goodman (2014) and Smith (2008) are convinced that qualitative analysis is a personal process and as such, there is no prescriptive method. The goal is to find commonalities and differences in the participants’ responses and then to arrange such in clusters or groups of broader, more abstract, overarching categories of meanings, usually called themes, that capture much of the data (LoBiondo-Wood and Haber 2014).

For this study, I adopted the thematic analysis (TA) method often used to analyse qualitative data. Braun et al. (2018) describe TA as a method for capturing patterns (themes) across qualitative datasets. Vaismoradi et al. (2013) view TA as an independent and reliable approach to analysis. The authors believe that the core skills learnt from using qualitative description analysis would enable researchers to conduct other forms of qualitative analysis. Echoing, Braun and Clarke (2013, 2006) see the method as a flexible approach that could be used across a range of epistemologies and research questions emphasizing that our method of analysis should be driven by our research question and our broader theoretical assumption. In explaining the shared meaning-based pattern of thematic analysis, Braun et al. (2018) describe themes as reflecting a pattern of shared meaning organised around a core concept. In their contribution, DeSantis

and Ugarriza (2000) explain that themes capture the essence and spread of meaning that occur in multiple and varied contexts and are built from smaller meaning units or codes. Braun et al. (2018) identify three approaches to TA including: Coding reliability approaches seen as partially qualitative, Reflexive approaches considered fully qualitative and Code book TA seen as sitting between coding reliability and reflexive approaches. The authors further explain that the aim of coding and theme development in reflexive TA is to provide a coherent and compelling interpretation of the data grounded in the data (Braun et al. 2018). My preferred approach 'Reflexive TA' views themes as meaning-based patterns, evident in explicit and conceptual ways, and as the output of coding. It is generally a method for across dataset analysis and popular with interviews and focus groups generated data (Braun et al. 2018).

Six guidelines for a thematic analysis of data were introduced and developed by Braun and Clarke (2006). The guidelines were followed in analysing my data including those from the review of records (Table 9).

The process of thematic analysis

Table 17: Process of thematic analysis (Source: modified from Braun et al. 2018)

1. Familiarization with data	Audiotapes were listened to again and again – ideas noted and compared with those from fieldwork. Transcribed data, written responses and sampled records of feedback were read several times.
2. Generating codes	Meaning units were pulled out from participants' responses. These were categorised and coded (Appendices 17, 18 & 19).
3. Constructing themes	Related categories/codes were grouped together into category sets to form candidate themes (Appendix 16). The candidate themes and their category sets were scrutinised for

	emergent themes and sub-themes (Appendix 16).
4. Revising and defining themes	On-going analysis and scrutinization to confirm, refine or rename themes and sub-themes
5. Reviewing and defining themes	Ensuring that theme names clearly, comprehensively and concisely capture what is meaningful about the data
6. Producing the report	Using themes, sub themes and candidate themes (Table 18) to present the findings supported with quotes from participants. Final analysis of compelling extract examples, relating analysis back to the research question, underpinning with relevant literature.

Further explanation of thematic analysis

Familiarization:

Authors including Vaismoradi et al. (2013) suggest that the entire transcript or material for analysis is read in order to get the sense of the whole. Echoing, Polit and Beck (20012) emphasise that insight and themes cannot emerge from qualitative data until complete familiarization is achieved. In line, the first of the six steps for the thematic analysis of qualitative data recommended by Braun et al. (2018) and Braun and Clark (2006) is to familiarise oneself with the data. Braun et al. (2018) strongly suggest that one immerses oneself in the data, connecting with it in different ways and making casual notes. With this in mind, I listened to the audio tapes, read the transcribed data, the written responses and the records of feedback several times to familiarize myself with the contents. The activity enabled the identification of the initial themes some of which corresponded with the ideas that came up during the interview sessions. Additional ideas were also identified.

Generating codes:

The coding phase is about "*succinctly and systematically identifying meaning throughout the data set*" (Braun et al. 20018 p11). I adopted the inductive orientation to coding by starting the analytic process from the data and working "bottom-up" to identify meaning without importing ideas (Braun et al. 20018). My aim was to generate a diverse range of codes from which to build themes. Every meaning unit or essence was acknowledged and pulled out from the participants' responses (Appendices 17, 18 & 19). This process reduced the data and produced some new displays to support the ongoing conclusion drawing. The essences were categorised and coded. Appendices 17, 18 and 19 are samples of transcripts showing how the codes were derived. They represent the different groups of data sets. This process was repeated with each semi-structured data set. The outcomes were compared, and links were established across data from all the semi-structured transcripts. The focus group data sets and the record of feedback data set were similarly treated.

Constructing themes

According to Braun et al. (2018), themes are built and given meaning through the interplay of data, researcher experience and subjectivity and the research question. Advising that the good themes are ones that tell a coherent story about the data, the authors caution that what may emerge at this phase are 'candidate themes' (Braun et al. 20018). They suggest that one of the two ways of developing codes into candidate themes is to use them as 'building blocks' where similar codes are collated with their associated data into coherent clusters of meaning that tell a story about an aspect of the dataset. In line with this thinking, my identified categories/codes from all the data sets were put in clusters of related categories/codes. See appendix 16. Each cluster or set of codes was scrutinised for an emergent candidate theme (Appendix 16). The candidate themes and their category sets were scrutinised for emergent themes and sub-themes (Appendix 16).

Revising and defining themes

I promptly realised that candidate themes were like prototypes which may not always work. By compiling all coded data for each candidate theme, I was able

to review them to ensure that the data related to a central organizing concept. Furthermore, I checked the emergent themes against the whole dataset and how each theme related to others.

Reviewing and re-defining themes.

The journey through the above phases enabled the identification of five core themes with several sub-themes across the five. I maintained an ongoing analysis in order to confirm, refine or rename the themes. The themes, sub themes, candidate themes and their category sets were set out in Appendix 16. Row numbering of each data set table to aid the identification of quotes from it was carried out. Appendices 17, 18 & 19 are samples. The coded categories identified in all the data sets were displayed for an 'at a glance' effect (Appendix 14). The themes, sub-themes and candidate themes as illustrated in table 18 below were used to present the findings.

Chapter Summary

In line with the qualitative description research principle, and considering my insider researcher position, I reflexively kept myself close to and immersed in the data in order to limit bias that could affect the result of my analysis. It was most helpful that a highly experienced colleague carried out an independent analysis of the data. This provided a most valuable second opinion on the outcome of my analysis. Additionally, the participants in both the focus groups and the semi-structured interviews had each provided a signed written response to the research instrument/schedule. This enhanced the accuracy and enabled the cross-checking for consistency with the participants' audio taped contributions. Indeed, both the written responses and the transcribed data from the focus group study participants were used for the analysis. This lent strength to the accuracy of the data and made up for the gaps where participants were over-talking in the audio recorded data. Appendices 17, 18 and 19 are samples.

In observance of the characteristics of qualitative studies, this investigation was not about the generalization of findings. Rather, it was a quest for greater understanding and deeper insight into the phenomenon - the impact on practice

of SU involvement in training on PMVA. As such, the frequency of the categories contained in the themes that were found was not as important as their significance to the study (Holloway and Wheeler 2010). Essentially, the objective of the study was to find out whether the contributions of service users to PMVA training delivery influenced staff practice with particular focus on the use of physical restraint on mental health inpatient wards. The findings were therefore judged on their contributions to the objective of the study and not on their commonality. Every identified category was acknowledged and given attention irrespective of how many times it appeared in the data sets.

Chapter five

FINDINGS

Introduction

In chapter four, I explained how the themes were derived. This chapter examines and develops the identified themes. The themes, sub-themes, candidate themes and the category/codes are displayed in Appendix 16. The categories/codes listed in the extreme left column were derived from the data collected from all the interviews (semi-structured and focus group) and from the records of feedback. Appendices 17,18 and 19 are samples. The themes listed in the extreme right column were each selected as representational of the related sub-themes. Similarly, the sub-themes were each representational of the related candidate themes each of which holds a collection or a cluster of related categories/codes.

A detailed analysis of the themes is undertaken in this chapter. The themes are presented in a sequence that hopefully flows and makes an easy reading. It follows that the categories do not necessarily display in a corresponding order to the questions that produced them. The reader can locate a quotation of interest using the row number (Rn) attached to the quote. It is important to note that a given question may contain more than one category/code.

The research schedule for the semi-structured interviews and the instruments for the focus group interviews were essentially directed at answering the research question whether service users could make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development. This resulted in an apparent similarity of responses. This similarity was however modified by the responses to the probes which searched for clarifications. Additionally, the pre SU session interview conducted with the focus groups to capture the participants' views prior to the service user session, further modified the similarity of responses. Equally, did the responses from the record of feedback which were anonymously and voluntarily given and were not guided by any data collection instrument.

The reader may also notice that some participants contributed more than others. This was partly because some people were succinct in their use of words, while others elaborated. The quest as stated in chapter three is for understanding and insight into the phenomenon. Other than prompting and encouraging participants to contribute, no attempt was made to make their contributions equal. Every additional point from a participant was welcomed and valued. The choice of which excerpts to use for illustration purpose was determined by the need to explicate and validate the findings in a way that the reader would hopefully find them helpful and convincing.

I commented only when necessary, in order to aid clarity. For the main and to allow an easy flow of the reading, I reserved my critical comments for the discussion chapter. Equally, I have used three dots to indicate that words were left out that did not contribute to the understanding of what was being said.

Table 18: The analytical Structure used in presenting the findings. Themes, Sub-Themes and Candidate Themes (Adapted from Braun et al. 2018)

Themes	Sub-themes	Candidate themes
Mental health service users' (SUs') contribution to PMVA training	An essential element of PMVA training	SUs' contribution draws attention to the patient's perspectives.
		Their contribution is invaluable.
	Translating learning into practice	SUs' contribution affects people differently.
		Their contribution is useful for practice.
	Engage with the patient.	Planning care with patients
		Effective communication

Working with patients		
		Therapeutic relationship
	Preventing physical restraint	Minimising incidents
		Is PR inevitable?
		Debriefing
Challenges to implementation of SU contribution	Staffing issues	Staff issues
		Emergency Response Team
		Breakdown in Relationship
		Raising issues
	Policies	Policies
	Environmental issues	Environmental issues
	Additional Relevant Issues	Allied professionals.

Table 18 holds the themes, sub-themes and the candidate themes derived from a combination of all the data sets. The contents of the table will be followed in presenting the findings.

Box 8: Key to the quotes from the data sets

FGTa	Focus group (Trust staff) pre SU session
FGTb	Focus group (Trust staff) post SU session
FGTw	Focus group (Trust staff) written response
FGSa	Focus group (Students) pre SU session
FGSb	Focus group (Students) post SU session
FGSw	Focus group (Students) written response
Ss	Semi-structured
Rf	Record of feedback
Rn	Row number
Service user PMVA trainers: Marta and Bob (pseudonyms)	

Box 8 holds the key to the quotes that were used in presenting the findings. Appendices 17, 18 and 19 are samples of transcripts from where the quotes were derived. Tables 15 and 16 respectively hold the demographic information including the pseudonyms on the semi-structured interview participants and the focus groups interview participants.

Theme 1: Mental health service users' contribution to PMVA training

The SU element of the PMVA training is a driven search for effective ways to prevent or at least reduce incidents on mental health wards and in so doing, to avoid the need for physical restraint (PR). If PR must happen notwithstanding, their involvement is also a search for ways to minimise the negative effects of PR on those involved, particularly the patients. SU contribution to the training is discussed across the themes. Theme one consists of two sub-themes: An essential element of PMVA training and Translating learning into practice, the findings of which are presented under their respective candidate themes.

Sub-theme A: An essential element of PMVA training

This sub-theme considered the fact that the involvement of SUs in PMVA training made it possible for the practitioners to gain knowledge and insight into the views and feelings of the recipients of physical restraints about their experience of PR. Participants' responses are displayed in the candidate themes: SU contribution draws attention to patients' perspectives and their contribution is invaluable.

SU contribution draws attention to patient's perspectives

SU involvement in PMVA training meant that the participants in the training got to hear and discuss service users' views on physical restrain, an exercise that could promote a reflection on practice. There was a keenness on the part of the study participants to hear what the service users had to say.

> *I am looking forward to the patient's session tomorrow because I think hearing from their perspective is so important because it's them who are dealing with it on a daily basis. Like I say, if there are things that we could improve or change to benefit patients, then that could reduce the amount. It's really important (Lisa FGSa Rn143-145).*

The importance of getting alternative views of physical restraint, particularly from the recipient of PR themselves was emphasised.

> *I think it (SU contribution) gives a different perspective of what PMVA's about from the person who is actually being restrained. Because, in that situation emotions are high and people can be quite aroused and quite emotional and we are looking at it from our point of view as nurses… But to actually hear it from their point of view … I think it's good to hear, to get somebody else's perspective who's actually been through it … (Roger Ss Rn2).*

Participants were impressed by the rich and balanced content of the SU session. And particularly so, by the fact that they (SUs) talked about restraint experiences they considered as negative as well as those they saw as positive. Apparently,

this balanced view of the experience whetted the interest of the practitioners and made them to engage actively in the discussion and to take seriously the lessons learnt.

> *Good to hear the good and bad examples. Explore how we all have similar emotional responses in terms of anger, sad, and how this influences our reactions to things. Generated thoughtful responses from us as we got to hear what works: communication and building therapeutic relationships. Understanding people's triggers… More time - but that's because we were interested in what they both had to say (Josh Rf Rn1)*

While the service users' balanced view of their restraint experiences was commended, the excessive use of force sometimes employed by the restraint team was lamented.

> *… It was interesting that they also had a form of a good experience in being restrained as they underlined the fact that sometimes it may save lives. However, it was also very sad to see that restraint is also used with excessive force and unnecessary techniques; definitely at times a way to just punish. Very useful to hear their perspectives (Virgie Rf Rn67)*

Participants expressed admiration for the high quality of the PMVA service user trainer's contribution to the training.

> *Yes. I have had a few encounters with service users talking about their experiences but not as prevalent in terms of detailed scenarios and talking about good experiences as well as bad experiences. That was an eye-opener in terms of how I improved my services after that training (Steve Ss Rn6).*

These excerpts were indications of how impressed the training participants were with the service users' balanced discussions of their restraint experiences, and of their eagerness to participate in the service user session.

Their contribution is invaluable.

The participants unanimously considered SU involvement in PMVA training as an important element of the training. They said that it enabled insight into patients' perspectives and made the training real.

> *Their contributions are excellent. They give a first person perspective on restraint which makes the thinking around the experience real (Alice FGTw Rn36).*

SU involvement initiative was endorsed by all the participants. They thought that the experience of physical restraint as narrated by the service users created real and vivid memories most likely to be called to mind during restraint situations.

> *I think it will always be good to involve the patient, it makes it more real. I think as a nation we just like bringing reality … and it increases your awareness and you know that picture is always in your mind. It's always in your head yes (Mary Ss Rn53-54).*

Echoing, Lisa said

> *The SU session was very good. It gave us a more detailed service user perception. Made us think about them during restraints and better way to approach restraints (Lucy FGSw Rn40).*

The contribution from the service users triggered thoughts about de-escalation and using PR only as a last resort.

> *Fabulous! Their experience really helped me to understand the effect restraints have on service users. But also helped me to acknowledge the importance of de-escalation and definitely using restraint as a last resort (Vicky FGSw Rn42).*

Participants thought that the SU contribution was truly eye-opening and essential for the training on PMVA.

> *I came from the elderly background. And when I met Bob (service User), when he spoke about his experience, that was really eye opening for me. Yeah, because I've been on the ward but I was still quite new. But after all*

the information he gave, I actually learned that sometimes you need to explain to the service users. … (Susan Ss Rn2).

Reiterating, Sam said:

… I found it quite an eye opener from their point of view in terms of what goes through their mind as they were restrained and their feelings and perceptions towards restraining. So, it was very, very important that service users were involved in the training … (Sam Ss Rn2).

In her contribution, Ola linked the contribution made by the service users to other factors relating to mental illness:

I found it quite eye opening. Brought awareness toward the various factors which surround mental illness and treatment of patients. How little can make a big difference. Importance of communication (Ola FGSw Rn41).

Some participants thought that SU contribution enabled a greater understanding of how the experience of PR might affect patients.

Very useful in enabling us as staff to listen and understand the impact of our actions and our management of restraint on patients (Chris FGTwRn40).

Reinforcing, Ada said:

I believe the contribution by the service user was very insightful. It helps you to understand how someone may feel after or when being restrained and what you should be mindful of. It can affect people very seriously for life (Ada FGTwRn42).

The participants thought that SU contribution to the training could ultimately help to change positively staff views on physical restraint.

Having service users in the training is very insightful. It could help change staff's views on restraining (Rose FGTwRn87).

The experience made one view service users differently the practitioners said.

Yeah, I think service user inclusion would make a huge difference. Yes, it makes you a much better practitioner and makes you like look at the patient from a different perspective… A greater awareness (Roger Ss Rn20-22).

Going further, participants made a suggestion for the service user session to be included in the PMVA update/refresher training.

*It would be good to get someone talking in the one day for half an hour, just to talk about their experience**…** Yeah… service user involvement on the one day refresher training (Andy Ss Rn34-38).*

On further probing Andy explained that it would be beneficial to have such discussion regularly.

I think that might be an idea. Because the last time someone ever spoke to me, in this format, was in 2015. It would be good for someone … Yeah, and just to appreciate the affect it (PR) has on people (Andy Ss Rn34-36).

The participants consistently expressed their appreciation of the contribution from the SU PMVA trainers. Their input was considered as real and vivid stories that could influence the participant's practice in situations that may require PR.

Sub-theme B: Translating learning into practice.

Participants believed that the contribution of SUs to PMVA training affected individuals in different ways. Their responses strongly indicated that the contribution was important for practice. The responses are displayed under the candidate themes: SU contribution affects people differently and Their contribution is useful for practice.

SU contribution affects people differently.

Participants thought that service user inclusion in PMVA training made a huge difference as it enabled a greater appreciation of the need to maintain good

communication with patients. They believed that SU contribution to the training affected people differently.

> *I wouldn't say I've changed my practice because I already talk to my patients and we have discussions with them. I think it effects different people in different ways (Roger Ss Rn8).*

Participants shared how the discussion with the service users gave them insight and greater understanding of patient's needs.

> *The session with the service users was very good because he made me understand things better from a patient point of view: understanding what patients feel like when in hospital, understanding how to behave to patients on a day to day, good communication, and giving one to one regularly. Try to understand patient first before making a decision to restrain patient. Always carry out a risk assessment before taking decision on patient behaviour… (Noble Rf Rn56).*

One participant was convinced that her experience with the service user changed her.

> *Yeah, it has changed me... And after that experience with Bob (SU), that gave me more understanding that before reacting, sometimes when the patient is unsettled, when they're violent don't give violence back immediately. What you need to do is try and speak to the patient … that (SU session) was really, really, good for me (Susan Ss Rn8).*

Many talked about how the experience triggered in them greater awareness of how best to relate and care for their patients.

> *It made me aware and raised my awareness of how to treat a patient and to be you know, caring and compassionate, having this professional attitude towards patients - dignity and respect you know (Mary Ss Rn29).*

Asked what he would say that he took away from the service user session, Sam responded:

> *Increased awareness of patients' feelings (Sam Ss Rn16).*

Using his observations in practice to buttress his point, Sam continued:

> *… Sometimes they don't like needles and they're being forcibly injected. So, I found that quite sad really, that there are no other interventions that are there to calm down a patient, that we have to resort to giving them an injection (Sam Ss Rn4).*

Participants spoke about issues discussed in the service user session that simply stuck in their minds.

> *… he spoke about not being able to breath properly and having trouble with his airways and that… It stuck in my mind because obviously you don't want to do that to anyone. And in the police cells and in some hospitals, people have died through that sort of thing (Andy Ss Rn28).*

Similarly, another participant shared the aspect of the discussions with the service user trainers that appeared glued in his memory:

> *One thing that stuck with me was like he mentioned when he was restrained once the staff member was very rough with him, very aggressive and saying horrible things and then he ended up seeing this man alone several years later. It was just him and this man. He said you know he remembered the man's face. It just goes to show you know, patients do remember. If you're doing something very horrible to them, being nasty, they will remember it. He remembered (Tim FGSb Rn8).*

Going by their disclosures, the participants had surely been severally affected by the contributions from the service users. Their acknowledgement of that fact appeared to be an indication of their willingness to utilise the lessons learnt.

Their contribution is useful for practice

Participants thought that the contribution from the SUs was powerful, challenging them (Practitioners) to understand and connect to patient's perspectives. A wide

range of categories had to be employed to represent the different ways the session with the SUs touched the participants (Appendix 16). Most importantly, participants said that the lesson taken away from the session enabled them to improve their practice.

The records of feedback from past PMVA training strongly acknowledged that the contribution from the service users could make a positive difference in the clinical environment.

> *The service user addition to the PMVA course was … of enormous value. It added to our understanding from all sides and can only strengthen our abilities as Practitioners (Lota RF Rn89).*

Reiterating, Tasia said:

> *The SU session was excellent as I really like his presentation about lack of debriefing and how staff lack relationship with patients. The presentation has broadened my knowledge and I hope to go and practice what I have learnt from the session in the ward (Tasia RF Rn100).*

In her contribution, Angela would go further to inspire her colleagues to practise as discussed with the service users.

> *The service user session was the most interesting and helpful part of the whole training. Hearing a real, life experience who had 1 bad experience and 1 good experience of being restrained really ingrained the whole process of how to treat a patient with respect and dignity whilst keeping them safe, as well as the importance of attitude and communication especially after restraint. It is a thought I'll remember when working and I will encourage my colleagues to do the same. (Angela RF Rn78).*

Carrying on, Angela recalled a particular point shared by the service user during the session with them.

> *The service user said it took one person to talk to her and treat her well for her life to change. For that reason, I will always take on board what she said in the session (Angela RF Rn78).*

The experienced study participants spoke subjectively and used their respective ward scenarios to elucidate how the lessons taken away from their session with the service users translated into practice.

Helen, now an experienced staff, accessed the PMVA training as a student. She talked about the impact the session with the Sus had on her early practice.

> *I wasn't really restraining before the training because I was still a student so I hadn't actually restrained before. That's why it was useful to hear from the service users because I didn't really have a clue. So, then when I did start restraining I started to use those things … (Helen Ss Rn24).*

Helen carried on to share how the experience continued to influence her practice.

> *Yes, it has made me try to avoid using restraint. I always try to minimise, like if someone's not taking their medication, maybe give them a bit more time to think about it. Talk to them a bit more rather than just saying, 'Okay we need to give this medication now' and then call the team. It's also the de-brief as well. I've started doing that. I've started talking to patients after the restraint (Helen Ss Rn10)*

Helen gave an example of her debriefing practice which according to her was useful in retaining a patient's trust.

> *Yeah, I've had to restrain someone and then I spoke to them afterwards and the trust wasn't broken. They still respected me as a professional. And I can imagine it's very easy for them to be like, 'No, this person's after me. I hate them, I don't want to speak to them'. But I think because they understood why I had to do it. Instead of them thinking that I just did it because I could. There's a difference (Helen 12-14)*

Our approach to our patients determines the way they might want to relate to us in Susan's opinion:

> *I believe sometimes it's the approach, the way we approach patients and sometimes staff we need to learn how to. Bob (the SU) has stuck in my head ever since then honestly. I came back and I said wow what an*

experience! Because I was new then and no-one had ever told me anything like that. I'd never really had a chance to have one to one because we were normally short of staff all the time. So after Bob, after having that meeting time with Bob, honestly, it really helped me (Susan Ss Rn26).

Continuing, Susan said that she uses Bob's story to try and help other patients, a role model sort of:

I was so happy that he finally got married, changed his life and I've used that to speak to other patients, which fingers crossed, some of them have not come back to the hospital. So hopefully things are getting better. Yeah hopefully (Susan Ss Rn28)

Reflecting on their discussion with the service user who said that it took six years for him to learn what his diagnosis actually were, Steve critically looked at their practice and shared his thoughts:

… We at times, don't explain to them what we think their diagnosis is. One of them (SUs) said it took about six years for a nurse to actually sit with him and say, 'Do you know what your diagnosis is?' and he said, 'Not really. I've just been given this label'. He was then told some of the symptoms that encompass this particular illness. … That's when he learned how to manage it and that's what kept him out of hospital. But before then,… he was in and out of hospital. That got me to understand that there are times when we need to ask patients … 'What's your diagnosis? Do you understand what it is?' I've been doing it since then. … I can see the effect it has in terms of trust, empathy and recovery. That's something I learned there ***(Steve SS)****.*

In his contribution Andy said:

I thought it (discussion with SUs) was quite emotional in a sense that you're hearing it from a persons' point of view, when they're going through something that is quite traumatic. It did inform my practice in a sense that you always have to remember that restraints are often unfortunate. But

you have to keep in mind that … each restraint affects them in a different way (Andy Ss Rn4).

Continuing, Andy shared what the service user suggested could lessen the trauma of the experience and his adoption of the suggestion in his practice:

And he mentioned how to make it a better experience by letting him, if you're having to restrain a person or a service user, just letting him know what the process is, who you are and who the team is, and that has been what I have done throughout my practice. And I think he said no one really met with him after his restraint and he was talking about a particular one which was quite difficult and a lot of that is meeting with the service user afterwards and seeing how they are and explaining why that happened, you know (Andy Ss Rn4).

So, does that (the lesson from SU session) change the way you treat all your patients on the ward? Sam was asked.

… It does quite a lot. Because I try as much as possible to make it final, final, last resort before we get to the point of restraining them… I try and talk to them. I try and give them option of calming down. I tell them whatever I can to calm down the situation. It works out well as well. … at least they see you've tried and the next time it builds up rapport and forms that kind of therapeutic relationship… (Sam Ss Rn12).

The focus group participants comprising newly employed staff in mental health wards and final year students ready to go into practice were asked whether the experience with the service users would make a difference to the way they would manage incidents that might require physical restraint on the ward. The diversity of responses was an evidence of how personally and differently the experience touched them. They expressed their intent to reflect learning in practice.

It was nice to hear from somebody who's been through the experience. It makes you feel like you'll be more mindful when you go back onto the wards and how a restraint can really affect them (Janice FGTb Rn20).

It (SU contribution) helps us to keep them in mind when we're restraining them because usually, when we do a restraint, it's more like about the safety of us and keeping the patient in control and in the ward. But now, when you go in, you think, 'Are they alright?' or 'How are they going to experience this? (Ada FGTb Rn21)

I will question staff for the need for restraint and ensure it is last resort (Ade FGTw Rn70)

Yes, it helps me to reflect on past restraints I have been involved in. This experience will help me to keep patients and their experiences in mind during restraint. It helps for me to have a more open mind when restraining (Chris FGTw Rn62).

I will sit with the patient and make sure I debrief after the incident or make certain a colleague has, as this is a vital part of the recovery process (Pat FGTw Rn66)

Yes, looking out for signals to violent behaviour and possibly deal with the situation, rather than leave the situation to worsen (Allop FGTw Rn67).

In this theme, participants unanimously and strongly expressed the view that contributions from mental health patients who had experienced being restrained could provide lessons to enhance practice. In the next theme, they took the notion further and considered other ways to implement lessons learnt.

Theme 2: Working with patients

In this theme, participants further discussed ways they worked that enhanced and helped to sustain good relationship with their patients. The fact that PR may sometimes become unavoidable was acknowledged and ways of minimising its negative effects considered. The theme comprises two sub-themes: Engage with patient and Preventing physical restraint. The findings are presented under their respective candidate themes.

Sub-theme C: Engage with patient

Participants considered ways of forming a good therapeutic relationship with patients that could support collaborative working and care planning with them. They unanimously considered good relationships with the patients and communication as fundamental in establishing a conducive ward environment where there is minimal need for physical restraint. Their belief appeared to be that timely and effective communication can clarify issues and aid understanding. Each had something to say on the subject mostly with reference to their session with the service users. These are presented under three candidate themes: Planning care with patients, Effective communication and Therapeutic relationship.

Planning care with patients

Discussion with the service users inspired the participants to come up with suggestions of further ways they could reduce incidents of anger and aggression from their patients such as: assessing patients on admission and maintaining an ongoing assessment, care plans based on the assessed needs and reflecting patient's preferences, all to be devised in partnership with patients.

> *So, once you identify someone that is at risk of having a restrictive intervention like restraint, it's about building a care plan and doing it with that service user about if it ever came down to the point of you having to be restrained, do you have a preference for gender, do you have a preference for who does what, do you have a preference for what happens afterwards? Things like that (Andy Ss Rn14).*

The importance of risk assessing a patient at the time of admission in order to put in place the right care plan at the start of the patient's admission was emphasised.

Patients should always be risk assessed immediately they come in the ward. This will always help to put the correct plan in place in the way of managing the situation… (Janice FGTw Rn82).

Echoing, Steve stated that involving patients in planning what concerned them and reminding them when necessary, could help in dealing with incidents. He used his own experience to buttress the point.

A practical example is the fact that when someone knows that they have underlying anger management issues and you've discussed with them what anger management is. … When they start getting angry, you can call them to the side and say, 'Remember the time when we talked about this? This is what's happening, so we've put steps in place to help with this. Do you think we can have time now to go through them?' Often, at times, they will say, 'Yeah, I would rather not kick off and have that', so I will offer them an activity to calm the situation there (Steve Ss Rn22).

Continuing, Steve believed that it was a matter of approach, that if one was non-patronising and respectful, patients would reciprocate:

I think it's all a case of the approach. If you come in respectfully to them and they can see that you're not patronising and you're actually there to offer practical help, I think they will respond (Steve Ss Rn32).

Participants specified that care plans needed to be person centred in recognition of individual differences and the uniqueness of each case.

It depends. Two cases are not the same. It's a person-centred approach and individualised care. With two patients having similar problems, you cannot use the same techniques. So, you have, to study the individual and the situation for each one (Brian Ss Rn118).

Echoing, Rose said it was about:

Treating patients as individual humans with respect regardless of their situation and circumstances (Rose FGTw Rn54)

Some of the participants expressed rather strong feelings about the need for patients to be provided with adequate information in cases where physical restraint might be required.

> *Service users should be given information regarding restraint when they are admitted to the ward. Focus on de-escalation. (Fab FGSw Rn26)*

Buttressing the point, a participant said:

> *It's (PR) an intervention which as it is that we have to provide information about medication to the service users. We have to provide information about psychosocial interventions. Why shouldn't they have, you know, well formulated, instructive information to the service user which should be in their admission pack (Kevin Ss Rn42- 44).*

Effective communication

The session with the service users appeared to have re-enthused the participants to maintain a culture of effective communication with patients - talking, listening and offering explanations where required. In that way they said patients would be reassured and issues could be resolved at the budding stage.

The importance of communication in mental health nursing was very succinctly put:

> *Communication is very, very important in Mental Health Nursing. You need to talk to people… (Brian Ss Rn 34).*

Reiterating the point, Ola said:

> *I found it (SU session) quite eye opening. Brought awareness toward the various factors which surround mental illness and treatment of patients. How little can make a big difference. Importance of communication. Maintain continuous communication with patient before and after any incident. Ask patients for their input (Ola FGSw Rn41, 52).*

Linking one of the service user's bad experiences of physical restraint to lack of communication, Jill said:

> I definitely agree with the communication part because I feel like the level of contact with the patient itself would have made a difference for Bob (SU trainer) when he said he had been on the ward for two and a half days and nobody had spoken to him (Jill FGSb RN17).

Participants carried on to share their views on communication, all reinforcing the lessons they took away from their service user session.

> *I think it was quite useful them (SUs) saying it... Even in that aggressive moment someone should try and have a word before… Because what Bob told me was really, like no-one was talking to me and the information wasn't given, they just came and… (Susan Ss Rn2)*

In her contribution, Pat emphasised the importance of communication before, during and after an incident.

> *It (SU session) highlighted that the incident is not just the point when the patient needs restraining, but it is the build-up and the de-escalation, good communication with the patient during, before and after the incident can prevent an incident from happening or reoccurring (Pat FGTw Rn55).*

The importance of talking with the patient was underscored using an analogy:

> *I can imagine if you were to restrain someone and then you don't speak to them afterwards it would feel like you're attacking them. Whereas you're doing it to try and de-escalate a situation. So, trying to get a patient to understand that it can be really effective and that's something I got from the service users. I never really looked at it like that before (Helen Ss Rn4).*

From their responses, participants perceived communication as an indispensable tool in mental health nursing. According to them, effective communication with the patient, could resolve an issue and prevent PR.

Therapeutic relationship

Comparatively, patients spent the greatest length of their time in admission with nurses than with allied professionals the participants stated.

> *We spend the longest with them. We're literally with them for the whole day. We're with them for 12 hours. The majority of their stay is with a consistent element of people, like the consultants and other members who only see them for maybe an hour at a time or not even up to that (Alice FGTb Rn65).*

Participants thought that having a good relationship with the patient was very important. They noted that such relationship could only be developed if effort was made to know the patient and their cultural background.

> *There were two service users. They told us their experiences which exposed a lot. It was a lesson to us. They taught us to be very, careful. Without knowing their needs, problems and understanding, we will not be able to give them individualised care and a person- centred care … (Brian Ss Rn10).*

Carrying on, Brian used himself to make his point:

> *As I'm talking, at times, my voice is coarse and my voice is loud. If you don't know me, you would think, 'That man is annoyed' but it's not annoyance, it's my nature and the same with some of these ethnic minorities. It's the way we talk, in fact. At times, it's better to know the background of the individual patient which also helps you to deal with him in this aggressive situation because some of them are characteristics of the individual (Brian Ss Rn66).*

Contributing, Janice said:

> *It's just about building that therapeutic relationship from the beginning and getting to know the person, I suppose (Janice FGTb Rn77).*

Reinforcing, a record of feedback states that Bob's physical restraint might not have happened had there been a therapeutic relationship with him.

> *The violent behaviour exhibited by the service user to the staff that caused him to be subjected to excessive use of force during restraint could have been avoided if there was a good therapeutic relationship established between the nurses and the patient when he was admitted to the ward (Vin Rf 34).*

Additionally, the participants thought that the effort made to know the patient and engaging with them could enhance the ability to de-escalate and minimise incidents involving them.

> *It is important to engage service users to avoid unnecessary restraints. And to look out for signals to violent behaviour and possibly deal with the situation, rather than leave the situation to worsen (Allop FGTw Rn56,67).*

Reinforcing the point, Olivia said:

> *Yeah, I think you try to engage with them more, especially when you notice that they're agitated or upset. You try to discuss things with them much more. You try to use more verbal de-escalation (Olivia SS Rn6).*

In the participants' opinion, the better one knew the patient and related well with him or her, the less likely the patient would resort to aggression and violence.

> *… I guess it depends how unwell a service user is, but I would say the more you engage and the more bridges you build with that person, the less likely they will be to become violent or aggressive. … And the more you know that patient, the more you have that relationship with them, I think the less likely they will be to be violent (Andy Ss Rn20).*

The session with the service users made one to take a critical look at the way one treated patients the participants said. They believed that problems could be resolved by talking with patients. In one participant's opinion resorting to physical restraint could break relationship.

I tell them whatever I can to calm down the situation. … At least they see you've tried and the next time it builds up rapport and forms that kind of therapeutic relationship. The moment you start restraining them, you sort of break a relationship that you've been building. For some of them, it takes you quite a while before you build it and yeah. They become mistrustful of you … (Sam Ss Rn 12).

And acknowledging that participating in the restraint of their patient might lead to a breakdown of the therapeutic relationship with the patient, participants stressed the importance of rebuilding such relationship.

I think as staff, we need to just be very honest. Even if … particularly restraints and we're part of that restraint and they might have a grudge against us. If you had that one-to-one conversation with them and let them know, 'It wasn't comfortable for me either'. Just be real with them. They can understand that (Kate FGTb Rn112).

In the participants' opinion, good therapeutic relationship with patients was vital in resolving issues and avoiding PR. If PR became inevitable and ones participation in it threatened the therapeutic relationship with the patient, the importance of rebuilding the relationship was emphasised.

Sub-theme D: Preventing physical restraint.

The data from the different sources showed that many of the study participants were of the opinion that there were things that they could do to reduce incidents that might provoke anger in patients leading sometimes to PR. Some thought that the session with service users was an ideal forum for candid discussions on the most effective ways to prevent or to minimise patients' anger and aggression in the first instance or to support and de-escalate patients when they were disturbed. That way, situations could be prevented from becoming full-blown incidents that required PR. Participants however asked whether realistically PR

could be avoided in all cases. The categories raised fitted into three candidate themes: Minimising incidents, Is PR inevitable? and Debriefing.

> *Yeah, because obviously, we'd like to do everything we can to prevent … As I said, we could get the input from the service users. For example, when they're becoming upset, angry, agitated or anything like that, if they discuss how we could best deal with them in that moment … (Olivia Ss Rn 38-42).*

Echoing, Sam said:

> *… And some of them can discuss … where maybe they are aggressive, the best skills to use to de-escalate the situation. What works for them or didn't work for them? Which could be something to get from the patients. Yeah, if you can get a few of them discussing it, you can have a rough idea of what works and what doesn't work (Sam Ss Rn21-24).*

The service user session appeared to have triggered a reflection on the subject of PR and participants were able to appreciate the sensitive nature of the process as a management option:

> *Yes, it (the SU session) provided me with a reminder of how sensitive the issue is and how staff must be mindful and take care of patients (Ada FGTw Rn64).*

Referring to human being's susceptibility to emotion, Sylvie suggested trying other solutions prior to physical restraint.

> *Like all of us, patients on the ward do feel different emotions and they can be angry as well. We should always try to de-escalate and find out what's happened before planning a restraint (Sylvie Rf 109).*

Participants reflected and shared below, how they tried to minimise incidents.

Minimising incidents.

Some participants thought that PR was not always necessary. Many suggested that PR should be avoided or at least minimised.

> *The service user session was very important as it helped me to understand the feelings and thought of the service users and also understand their views and to know that restraint is not always necessary at all times (Vera RF Rn12).*

Allso, a new staff seemed to have observed that staff sometimes based their decision to use physical restraint on the patient's history.

> *"Some physical restraints were not absolutely necessary. Staff used the physical restraint not as a last resort – but some were based on patient history of physical restraint and staff believing that the same patient would escalate into physical violent behaviour" (Allop FGTw RN11).*

Sharing how they came up with alternatives in order to avoid or reduce the need for PR Roger said:

> *"… We do talk to our patients,, we do listen to their point of views. We do want to sort of minimise any type of restraint we have on the ward… We have like practice development sessions on reducing the amount of restraints that we do and what else we could do instead. We've just started using like 'soothing boxes'…" (Roger Ss Rn24)*

Asked what soothing boxes were, Roger explained,

> *"It's like we've got like stress balls, soothing oils… just thinking outside the box. So, if you do feel angry or upset or you feel like you need to hit something you can hit your mattress. Put it up against the wall and you can hit the mattress instead. You can box the mattress" (Roger Ss Rn24).*

Continuing, Roger said that they usually involved their patients in seeking ways to minimise the need for physical restraint.

"… So, it's just about thinking outside the box and asking the patients what they would like to do. Sometimes they've got a lot of energy. You can run up and down our ward to lay it out. We don't see it as if you're unwell by doing that because we're quite open and understand that like sometimes you can be confined in one small environment. You're limited in what you can do" (Roger Ss Rn24).

In her contribution, Susan thought that sometimes all it took was to talk to the patient and to allow them to choose who administered the care to them.

"Some say, okay I want you to give me the tablets, they pick and at the end of the day you see that that patient really calms down and takes the injection from the person they want. So, you have to give them the opportunity to. That's why I said you have to talk to them because if you don't talk to her, she's going to be struggling and everything is just going to be a big fight" (Susan Ss Rn50).

Susan also believed that assessing the situation when there was an issue and allowing the patient to talk to someone with whom they related well could help to resolve the problem.

Yes, you've got to assess the patient and see if there's someone that he/she can talk to. … Someone else may have some relationship with some patients and they like speaking to that particular person. So, when that person appears it's like a calmer to patients. Oh, here you come I want to talk to you, I don't want to talk to anyone else… (Susan Ss Rn46).

Participants stated that patient's anger and aggression was often for a reason. They gave examples including dismissive attitude. This would be an issue especially if it came from the very staff to whom the patient looked up for help.

There's often very, I wouldn't say justified reasons but there are valid reasons why that person is being violent or aggressive. And that might be with someone being dismissive or it might be their mental health, or it might be a mixture of both. (Andy Ss Rn20).

The above contributions from the study participants indicated that their encounter with the service user trainers and the discussions during their sessions made them (study participants) to look critically at what happened on the wards with particular focus on preventing or de-escalating incidents and avoiding PR. The question though was whether incidents on their wards could always be prevented or de-escalated. The participants considered this in the next candidate theme.

Is PR inevitable?

Some participants thought that there were situations on the inpatient wards when physical restraint was inevitable.

> *"PR is an unfortunate but important part of mental health training that is aimed at protecting staff, other patients and the affected patient as well as a last resort to give medication" (Alice FGTw Rn2).*

Similarly, some viewed it as a necessary skill in a mental health inpatient setting even though it was not a 'nice' intervention.

> *Physical restraint of a patient is never nice, but it is something we need to have the skill to do safely as on an inpatient ward. We have to restrain patients on occasions when they put themselves or others at risk of harm (Pat FGTw Rn10).*

Reiterating, a participant said:

> *Yeah, although we use it as a last resort but many times we'll face a chaotic client and so we need to have this training; otherwise, we are dealing with it without the knowledge and we are a danger to the patient and ourselves. This course has been really, positive (Fab FGSb RN126)*

Participants unanimously and consistently referred to PR as a 'last resort' management option. Safety was seen as the reason for resorting to PR. Some participants who had been against the use of PR actually reconsidered their stance following their session with the service users.

Yes, I'm thinking also sometimes you can have restraint. Like myself, before, I always thought no restraint whatsoever. I didn't want to be involved. But now, I realise that sometimes also it's for the patient. … … to ensure their safety and protect others as well (Ola FGSb Rn11).

Referring to one of the SU scenarios when the SU in manic depression crises made to run into a busy road but was restrained by the staff, a participant said:

I've always been totally against restraint as well and I've always thought the way overall is to de-escalate. … it's (SU session) just made me think that you can de-escalate as much as you like but there are some occasions when people are really out of control. As long as it's done in a safe and controlled way, then it's necessary (Rose FGTb Rn41).

The participants' view, they could realistically be in a chaotic situation where a patient could lose all control due to mental illness. PR in such a situation according to them, could become inevitable if harm either to the patient or to others were to be avoided.

Debriefing

In view of the potential negative effects of PR, particularly following their discussion in the SU session, participants became convinced about the need to debrief everybody involved in the process (patient, staff and witnesses) especially the patient. They expressed this need severally:

It was really, helpful to hear from the service user, his personal experience of restraint. … It made me think the importance of not using excessive force when restraining and always debrief, so we can avoid another situation like that. (Sylvie Rf 109).

… I've always feared that the patient is probably still very angry from the restraint. So … I always try to avoid that conversation about how they felt but now, I feel that if after a couple of days, depending, I think I'll definitely approach them and just having that one-to-one and just ask them how they're feeling (Pat FGTb Rn 99).

Yes it (SU session) was really, really, good and I think communication about the whole restraint, talk to the patient explain what you're doing and then the importance of debrief after, yes, like the debrief part of the restraint, going back and talk and explain why it happened. Yes, how can you prevent it? It's really important to debrief, yes (Vicky FGTb Rn15).

Yeah, it's good for the patients and the staff to reflect back on the situation to understand what's actually happened and why and how it can be prevented in the future (Janice FGTb Rn111).

Yeah, well, it is more about realising that it can impact them massively and then just making sure that they're ok afterwards, and they understand what happened and why it happened (Andy Ss Rn8).

When an incident occurred particularly in a public area, those around were curious and most probably concerned. Participants talked about the need to reassure such witnesses when it was all over.

And also, in the service user session we were talking about if the restraint is done in a communal area so all the other patients are watching. It's just about going to the patient who hasn't been restrained and saying, 'are you okay'? They might feel scared of the nurses like 'oh it might happen to me if I don't do something. … to reassure them (Lisa FGSb Rn 57).

The findings above showed that participants considered the contributions made by service users to the training on PMVA as invaluable. They agreed that it directed attention to the service users' perspectives regarding PR and helped them gain insight into how PR affected patients. From their responses, it was clear that the participants were already reflecting in their practices most of the ideas suggested in their discussion with the service users. The session seemed to have strongly enthused those who did, to continue to improve on what they were already doing. And, challenged those who were lagging, behind to practise likewise. The next theme looked at potential challenges in practising as discussed in the SU session.

Theme 3: Challenges to implementation of SU contribution to PMVA training

Although the practitioners seemed very keen to take on board and implement as discussed in the SU session, these discussions were happening in the calm and cool non-operational training environment. What about in the real world? In this theme, participants considered issues that might hinder their ability to practise as discussed in the SU session. The candidate themes raised fell under four sub-themes: Staffing issues, Policies, Environmental issues and Additional relevant issues.

Sub-theme E: Staffing issues

Participants believed that problems directly, linked to staffing at the workplaces tended to undermine their effort to practice as discussed in the training. The categories in this group fitted into four candidate themes: Staff issues, Emergency Response Team, Breakdown in Relationship and Raising issues.

Staff issues

Staff shortage was identified as the fundamental problem giving rise to other issues in this candidate theme. But for one assessment unit which was regularly well staffed according to the participants all the other wards in the study area experienced staff shortage on a regular basis. Participants explained that their inability to give their best to patients was sometimes a direct result of staff shortage:

> *Yes, especially if there was a staff shortage. And somehow this feeds to patients as well … Maybe they want something now and we're really quite short on staff… Maybe an escort cannot be done at the time that they want. That can cause huge implications with everyone. And that happening, we can't get somebody to try and maybe talk with them… Sometimes they're giving medication. Another person is maybe dealing with something else and it prevents the usual de-escalation... So, you're left, (Sam Ss Rn30).*

Echoing, Susan said:

> *It's just to understand, try to understand. I know you cannot get it 100%, like getting to know a patient 100%. I think we need to learn how to communicate more and short of staff does not help it. That's a big issue. (Susan Ss Rn38).*

Ultimately, staff shortages would sometimes mean working with agency staff or bank staff. Lucy confirmed this when asked by the interviewer:

> *Yes, you do sometimes. It's more bank. Yes, people that you don't know (Lucy FGSb 33-35).*

As stated by Lucy, such a situation sometimes meant that one was working with an unfamiliar colleague, who might not know the patients. Hence Lisa's observation:

> *Because Bob (SU) was saying that if they had spoken to him and if he had told them that when he's tapping his leg that means he's getting restless. In the session, they were saying you should know your patient well. But if the agency came and they'd never met that patient and he was getting aggravated they might go straight into restraint, yes. And then the other staff might just de-escalate that situation … (Lisa FGSb Rn38)*

Faced with the challenges of working short staffed, Susan thought that it was better to work with an agency staff than work short staffed:

> *Agency, you mean when we get agencies to come and work? It's better than nothing you know (Susan Ss Rn40).*

The dilemma confronting the staff with regards to having to work with unfamiliar colleagues could get compounded when incidents requiring physical restraint occurred on the ward. As if never sure of the quality of the team with whom he would be expected to carry out PR, James very succinctly replied when asked how he would manage an incident requiring PR on the ward:

> *It will depend on the team that is assembled for the exercise (James FGTw Rn16).*

And as if to justify James' response Alice said:

> *Sometimes the team is unknown and it is hard to make time to debrief (Alice FGTw Rn69).*

We noted that debriefing after an incident was particularly emphasised as very helpful by the service users according to participants responses. It enabled closure, promoted recovery and possibly prevention of similar incidents. Yet staff shortage and having to work with unknown staff as stated above hindered the process. The unfamiliar staff scenario might sometimes involve other challenges such as team members untrained to restrain as well as members who might have trained differently:

> *I think it's a bit difficult because sometimes, there might be a different team on … Not everybody is PMVA trained all the time. I think it depends on how busy the ward is as well. Some days, our ward is constantly busy (Olivia Ss Rn48).*

Explaining further, Ada thought that untrained staff and those with different philosophy regarding PR might hold a differing opinion on the use of physical restraint:

> *If all staff are not trained in the same way or have different opinions on approach about restraint, they may be likely to use restraint unnecessarily (Ada FGTw Rn75).*

There was also concern regarding the attitude of some colleagues. Colleagues identified as 'stuck in their own ways'. Unfortunately, such ways might be non-progressive and non-helpful:

> *Even if you do your best. If you want to do all the correct things and everyone else is stuck in their own ways, it can also make it quite difficult (Val FGSb Rn27)*

Equally worrying was the attitude of colleagues described as the 'gung ho' type. The belief was that such people derived some weird sense of satisfaction from restraining patients even when it was unnecessary:

And I think a lot of people in some mental health establishments like that 'gung ho', that's taking down. Actually, sometimes they thrive on it. Men, with no disrespect. They get their little bit of adrenalin going and it's like, 'Oh, we can take them down. I'm bigger than them.' And that is what I don't like about the whole restraining. It's not always necessary (Janice FGTa Rn34).

Emergency Response Team

The strategy of a response team during an incident was sometimes viewed as a typical portrayal of 'power imbalance' where an overpowering number of personnel gathered at once to confront one patient whose behaviour was considered challenging. Some participants thought that the response team number could also appear intimidating to the patient who might respond with more aggression.

Yeah, because when we pulled the buzzer everyone comes. The rush when everyone comes like that, they feel, oh God what are they coming to do. I put myself in that situation as well. If people just come in a group like that, oh God what's going to happen to me. In my head I think oh God I better do something before … I think that does, it does unsettle people as well when you come in 8 and 10 yeah. (SusanSs Rn 22,26).

Explaining how the large number was usually achieved, Ade said:

The problem … when the alarm is called everybody just rushes in… (Ade FGTa Rn21).

Similarly, Janice shared a scenario that she witnessed which apparently disturbed her.

… All they were doing was just enquiring as to why they were unwell. They had no insight. They didn't think they were unwell, but they just wanted someone to take time to talk to them about what was going on. And this girl just pulled the alarm. Five or six heavy-handed big men came and took this woman down (Janice FGTa Rn34).

On the other hand, the Response Team could be viewed differently, even favourably when the team rather than exhibit a 'macho' behaviour, engaged the patient in a dialogue in order to resolve the issues. As a result, the patient co-operated and no PR was involved. Some of the ways that issues were resolved without restraining the patient were shared by the participants:

> *… When we explained the steps as to what we were going to do, the patient said, 'Why do you have all these people here?' Just the fact that someone said, '… They're not here just to restrain but they're here for your safety'. That reassurance got them to take their oral medication (Steve Ss Rn64).*

> *… we try to approach the situation calmly and just try to ask the patient what's actually happening from their point of view … Get a sort of small hand over from the staff. And, try to negotiate around how we can resolve this situation without it sort of escalating and people needing to be restrained or given medication by force. So, it's just about actually listening … and usually you can resolve the situation just by talking. (Roger Rn40).*

> *For example, we had a service user, she had a very particular way of what helped her during a restraint and every time we made sure she knew everyone in her response team and who would be doing what … (Andy Ss Rn16).*

In some cases, the patients appreciated the response team members' presence.

> *I don't want to reveal the ward and the gentleman was in seclusion. When we went in, he said that he feels safe because of our presence (Kevin Ss Rn68).*

The responses showed that the experience of a restraint team intervention could be terrifying for the patient. Yet, by the team modifying its behaviour, the experience could be viewed as respectful, supportive and welcomed by the patient.

Breakdown in Relationship

A breakdown in relationship between staff and patient was identified as one of the challenges to the implementation of the SU contributions to PMVA training. A breakdown in relationship could lead to the patient being neglected or an inability of the staff to fulfil certain roles because they thought that the patient might not co-operate:

> *I've always feared that the patient is probably still very angry from the restraint. So … I always try to avoid that conversation about how they felt (Pat FGTb Rn 99).*

In some cases, the patient preferred to receive the care from another staff member:

> *I don't want that lady. I want you to give me the injection. Some say, okay I want you to give me the tablets. They pick and at the end of the day you see that that patient really calms down and takes the injection from the person they wanted. So, you have to give them the opportunity to. That's why I said you have to talk to them. (Susan Ss Rn50).*

PR, particularly when used unnecessarily and abusively can cause a breakdown in patient-staff relationship.

> *The moment you start restraining them, you sort of break, change things kind of, like a relationship that you've been building. For some of them, it takes you quite a while before you build it. And yeah, they become mistrustful of you. (Sam Ss Rn12).*

These potential causes of loss of a patient's trust could lead to a broken relationship with its adverse effect on the management of incidents involving the patient.

Raising issues

The conversation with service users appeared not only to have re-enthused the participants to be more patient sensitive in their practice of PR but also to question doubtful practices and to raise issues of concern:

> *I will question staff for the need for restraint and ensure it is last resort (Ade FGTw Rn70).*

Contributing, Nora said:

> *… I think it's also like if I was restraining them to observe, like if another member of staff was doing that, maybe try and like raise it … (Nora FGTa Rn13).*

There was concern though that raising issues might attract negative responses from colleagues. Such could be demoralising and discouraging especially when it was from ones' seniors:

> *I actually said, 'You guys are hurting him. You need to move off, because he was whimpering and he was pushed up against the wall. So, it's not in any way like a proper restraint. And I was untrained. It was my first job in mental health as a healthcare assistant. And I got a proper telling off from the nurse. …that really put me off saying anything about it ever again, especially when it's coming from a nurse. Someone who's trained, got experience (Ada FGTa Rn28).*

While the session with the service users may have enthused the participants to embrace caring and compassionate practices with regard to PR, there could be implications, especially if there was lack of support, indeed downright aggressive reaction from colleagues.

Sub-theme F: Policies

Policies

Participants believed that policies such as smoking ban directly or indirectly caused problems with patients. One of the participants identified the ban as the main reason why patients pushed boundaries in order to leave the ward:

> *There's also sort of the smoking ban that's been put in place. I mean, a lot of our patients disagree with this. So, that's like one of the main triggers of people wanting to leave (Roger Ss Rn50).*

Asked whether the ban particularly triggered aggression in patients? Roger carried on:

> *Definitely I believe so… …if somebody's really unwell it might not be the right time to go on about doing smoking cessation. To them it makes them feel calmer, if they could just have one cigarette even though we know the impact on their physical health and how it works in the body, the nicotine. But this could be a trigger for irritation, agitation for the whole day literally, over one cigarette, which can escalate further to the point where the patient might damage property or assault somebody - just to try and get out to smoke. It's difficult, that's where the main incidents are actually coming from these days. (Roger Ss Rn52, 58).*

Sub-theme G: Environmental issues

Environmental issues

Participants stated that moving patients away from a stimulating environment could help in preventing an incident from escalating and requiring the restraining of a patient. This could be in the form of moving to a quiet de-escalation space some said. Patient friendly establishments with secure outdoor spaces where patients could enjoy fresh air could enhance calmness in patients the participants said. Whereas the contrast could trigger the feeling of frustration and aggression and ultimately endorse the use of PR. Participants expressed concern that calming environments were not common in present day mental health

establishments. Acknowledging that among the difficulties in dealing with aggression were the environmental factors participants said:

> *Yeah, definitely because I mean this building, it's not the newest type of building, it's not purpose built for mental health. So, we don't have like secure gardens which people would go into, … but people might want fresh air. In other hospitals, there's like secure areas… (Roger Ss Rn44).*

Buttressing the point, Andy shared his opinion:

> *I do think the environment plays a massive part in the reduction of violence and aggression. For example, it is just my own opinion, but I think wards with gardens and open spaces, it's more therapeutic so I would imagine those have less restraints. And I think being in an enclosed ward where you can't go out at all, I can imagine it is quite frustrating (Andy Ss Rn46).*

Sub-theme H: Additional Relevant Issues

The data contained a subject that at first glimpse appeared not to be directly connected to the topic of this investigation 'the impact on practice of SU contribution to PMVA training' yet was curiously related to it. This concerned a heated debate that raged briefly among a focus group's study participants regarding a particular set of professionals that worked with patients on the wards – the 'Activity Workers'. By implication, this was about whether or not allied professionals should participate in the physical restraint of patients. The categories raised in the discussion clustered under the candidate theme 'Allied Professionals'.

Allied professionals

Some participants expressed concern regarding the activity workers being required to participate in the PR of patients. They argued that until mandated to do the training, the activity workers' role had been clearly restricted to their job description within which they never got involved, beyond ensuring the safety of the other patients whenever PR was in progress. They feared that participating

in PR might negatively affect the activity workers' hitherto special therapeutic relationship with patients:

> *… when they started the role, we weren't trained at all and we'd never be expected to get involved in restraints. The idea was that we'd support de-escalation but when it happened in the ward, we were able to support the other 15 patients because we have that skill set; we had relationships with them. So, it would be interesting to see, thinking about how this is going to fit into our jobs. I don't know where it's going to fit in … (Pat FGTa Rn48).*

Emphasising the activity workers' therapeutic skills and arguing that such should not be compromised, Pat continued:

> *… We've all had over two years times when we've run groups and incidents have happened inside our group and we've been given stuff over there. And so, in that respect it would be really good but then equally you're not meant to take away from our therapeutic value on the ward… (Pat FGTa Rn51).*

Although not an activity worker herself, Kate a registered mental health nurse shared Pat's concern:

> *I think the downside of activity workers starting to restrain is that patients aren't used to activity workers being on that side with the nurses. So, I think out of all members of staff, patients get along a lot more and trust activity workers than other members of staff. I've never seen anyone have an altercation with an activity worker or an argument. They're very neutral. But now, obviously if there is an incident you have to join in and then you're going off to the other side of restraining. I don't know how that would impact. (Kate FGTa Rn61).*

But, Allop also a registered mental health nurse questioned the fairness of it all where the allied professionals would shy away from patient restraint and they, nurses, would deal with it all alone:

> *Nice to hear from the other side of the fence. So, the activity workers weren't trained, the OTs are not doing restraint, doctors don't do restraint and the physios that come once a week don't do restraint, podiatrists don't*

do restraint and everyone says, 'It will take away our therapeutic thing,' but the people who have got the most therapeutic input with the patients are the nurses and yet the nurses are expected to do restraint (Allop FGTa Rn52).

Joining in, but from the point of view of safety, Ada said:

But also, in terms of safety like as a student when I wasn't trained and I was the only one with the nurse and not being able to help when I can see them being attacked I felt it was awful. I couldn't help. I couldn't do anything and I knew I was going to get in trouble if I went in and helped. And also from the other perspective, if I was being attacked and there was activity workers, doctors and all standing around doing nothing, it's like, 'Why aren't you helping me?' 'Oh, I'm not trained.' (Ada FGTa Rn53).

Underscoring her point with regard to effective team membership, Ada added:

It's just being a team member, from my point of view (Ada FGTa Rn55)

Then Ade, himself an activity worker, made a crucial point. A point that was directly related to the topic of investigation – restraining in a patient sensitive manner. Such quality of patient restraint he argued, did not negatively affect one's relationship with the patient. If anything, it enhanced it:

I've done a lot of restraints myself. Patients, they don't forget that you've given them helping to restrain them and they know you don't hurt them. But once they're restrained badly they'll probably say, 'I'm going to get you after this.' Whereas if you do a restraint properly, I've never had issues with anyone because I try to … (Ade FGTa Rn58).

As if summarising, Rose, a registered mental health nurse said:

But then I think it should be compulsory for anyone that is working on a ward with forensic patients, we don't know our patients' backgrounds. They all potentially could be very, very, dangerous people, especially when they're unwell. So, anyone that's having any interaction with those patients I think, has to be trained, whether it's consultants, nurses, doctors or other professionals (Rose FGTa Rn59).

The richness, fullness and candidness of the above discussions demonstrates the uninhibited nature of the conversations. The issues raised such as debriefing, proactive measures to discuss PR at the point of a patient's admission into the ward, staffing issues, the wish for a continuous service user contribution to PMVA training and others will be followed up in the next chapter.

Chapter summary

The diverse as well as subjective perspectives from the participants portrayed how relaxed the atmosphere was during the interviews. With confidentiality guaranteed, they freely shared their experiences, their practices and their intentions for future practice with respect to physical restraint. In theme (1) under '*Their contribution is useful for practice'* the resolve to reflect lessons in practice was clearly expressed in the records of feedback and by the focus group participants. Meanwhile, the practising participants convincingly articulated how the lessons were being reflected in their practices. This is a vindication of my claims about my chosen design strategies. The approach enabled the close interaction that allowed in-dept probing and disclosures regarding the phenomenon of enquiry. A critical discussion of these findings follows in the next chapter.

Chapter six

Discussion

Introduction

Chapter five presented the findings from this study. These findings are critically discussed here with reference to the identified literature where applicable and necessary. The effectiveness and limitations of my design strategies and the potential limitations of the methods that I used for the study are considered. The chapter concludes with a reflection on my own learning from this research experience.

PR remains a controversial management option for incidents involving the mentally sick. The concern regarding PR triggered efforts to find alternative interventions in order to avoid or to minimize its use. Service user involvement in my team's PMVA training delivery is one such initiative. A new phenomenon, hardly any research has been conducted on it or on its impact on staff use of PR in practice. The qualitative description research strategy was adopted to answer the research question on whether service users could make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development. Critiques of the qualitative methods of enquiry come up with various reasons why they are suspicious of its ability to produce valid and trustworthy results. It is pertinent therefore to start my discussion with the effectiveness and the limitations of my design strategies and the limitations of my methods.

Study limitations

The effectiveness and the limitations of my design strategies

Critiques of qualitative research view it as anecdotal and unscientific (Parahoo 2014). The argument is that the methods used by qualitative researchers have not been shown to be valid and reliable, nor are their results generalizable. But, research connotes a systematic and rigorous collection and analysis of data

irrespective of its type. Researchers (quantitative or qualitative) must convincingly demonstrate how they obtained their data and the process they followed to analyse it. And just as important, they must explain and justify the approach adopted for the investigation. As with quantitative studies, qualitative research conducted rigorously implies explicit sampling, systematic analysis of collected data as well as the examination of contrary or opposing information.

Reliability or the consistency with which a tool measures what it is supposed to measure requires a detached stance and objectivity all of which are vital characteristics of quantitative research – an approach that is rejected by qualitative proponents who prefer to interact closely with data sources for example in interviews in order to gain insight. Such interaction is unique and cannot be replicated, even by the same interviewer. This is not seen as weakness rather getting close to data source is seen as essential in order to achieve in-depth understanding of a phenomenon which is the primary aim of a qualitative research. Meanwhile, validity refers to the accuracy with which the results reflect the investigated phenomenon (Parahoo 2014). To be worthwhile, the result of any research whether quantitative or qualitative must be credible. As regards qualitative research, the check for validity is in-built in the data collection process. This is demonstrated for example, when initial findings are scrutinised, probes used to re-check answers, which are compared with other participants' answers and checked against existing literature findings.

The comparatively small sample size in qualitative research gives rise to the approach being often criticized for non-generalizability. However, while generalization to the population is appropriate, indeed expected in a quantitative study which usually uses large sample sizes covering a large population, such is not the case with qualitative studies whose objective is primarily to develop and provide a rich and comprehensive understanding of a phenomenon as it is experienced. This can only be achieved by interacting closely with a small sample that have the required information and the capability and willingness to share it. And so, while the findings of qualitative study are true of the studied group or case, it may not be appropriate to generalise such findings to a whole population. However, there is the argument that generalisations can indeed be drawn from

and about cases and that entire fields of knowledge including ethics and law have been built from case generalisation (Sandelowski 1997).

As my phenomenon of interest is a new initiative, qualitative description research approach was considered appropriate for collecting data from the research participants. As recommended by Bradshaw et al. (2017) and Sandelowski (2000) the methods are especially useful for describing and gaining a rich and comprehensive understanding of a little-understood phenomenon as it is experienced.

Sampling

According to Bowling (2002), sampling bias can happen unless the methods of sampling ensure that all members of the study population have equal opportunity of being selected. The target population for this study was all staff and students who participated in the service user session during their 5Day PMVA training. All eligible staff and students who were present on the interview days had equal chance of being interviewed. However, the fact that the interviews took place on particular dates introduced a weakness into the sampling because eligible staff members who were not on shift on those days automatically missed the chance.

The necessity to sample only participants who participated in the SU session was a limiting factor. But by expanding the sample to include both the experienced mental health ward staff as well as those with less experience, example the final year mental health students about to go into practice, and by including practitioners from different hospital sites, this apparent limitation was mitigated. The sample size could have posed a limitation had it been too small for the required data to adequately answer the research question. But, the large sample size ensured an ample collection of full and rich data for the study.

Data collection

Gathering data retrospectively about incidents which the practitioners managed posed a credibility doubt as some of the facts may have faded away from memory.

There was also the potential for participants to adopt ‘selective memories’ in their recall of past incidents, a practice referred to as recall bias (Bowling 2002). Asking the same question in different ways (research instruments and schedule Appendices 10, 11 & 12) and the tactful use of prompts were intended to mitigate this. Additionally, by expanding the study sample to include students and staff not yet involved in patient restraint, there was an expectation that these individuals would give factual and objective accounts to balance bias tendencies that might occur in the accounts of the established practitioners. Indeed, they (the focus groups) shared freely the poor PR practices they observed on the wards.

My knowledge of the research topic placed me in a position where I might have consciously or unconsciously gone into the research arena with certain expectations. Bringing in a neutral person to facilitate the interviews, sitting away from the participants during interviews and reflecting on issues were measures intended to mitigate possible influence.

Inherent in gathering data in close interaction with the data source is the potential to draw different interpretations from data provided by the same source. Hence it is suggested that the researcher remains open to the participant in order to avoid attaching their own meaning to the experience (LoBiondo-Wood and Haber 2010, Moule & Goodman 2017). Wall et al. (2004) suggest a process of continuous reflection in trying to remove beliefs and preconceived thoughts from a research process. Right through this research process, I adopted a reflective practice to mitigate any influence that my pre-knowledge of the research topic might have on the information provided by the participants both at the point of data collection and during the analysis. The comprehensive account of the field work for this study, portrays the sampling, data collection and analytical processes. The conducive atmosphere during data collection meant that study participants were free to expound their views whatever they were. For example, while many of the participants said that their experience of the SU PMVA session changed their approach to practice, one participant stated that because he was already practising as suggested in the session it did not make him change his practice.

Discussion of findings

To reiterate, the research question was whether service users (SUs) could make sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development. An examination and discussion of the results is done here. Where necessary and appropriate, the reviewed literature is referenced to support and validate points and to elucidate conflicting views. The research aimed to determine the impact on practice of service users' contribution. As an impact study, the observations by Morgan and Jones (2009) about the challenges in determining the impact of learning on practice would apply to it. However, the research instruments for the investigation were considered robust enough to have satisfactorily answered the research question.

The PMVA service user trainers seek to motivate the participants in the training to avoid physical restraint (PR) or to use it compassionately if they must. Their session enables the participants to hear and discuss service users' views on physical restraint - an exercise that could promote a reflection on practice and subsequently practice enhancement. In their study, Wisdom et al. (2015) reiterated the important role that mental health service users who live the experience of PR could play in the scheme of things.

The findings from the study showed keenness on the part of the study participants to hear what the SUs had to say. The service users freely shared their positive and negative experiences of PR. These balanced views in the discussions apparently whetted the interest of the participants and made them engage actively in the session and to take seriously the lessons learnt.

The SU contributions affected people in different ways according to the findings. The record of feedback from past training showed that participants considered the SU session as the most helpful part of the PMVA training. The narrations of a real- life experience of physical restraint apparently touched many of them. As they stated, it ingrained in them how to treat patients with respect and dignity. They vowed to reflect the lessons from the session in their practice.

There was a variety of responses from the focus group participants when they were asked whether the experience with the service users would make a

difference to the way they would manage incidents that might require PR. It was an indication of how personally and differently the experience touched them. One said that she would question staff for the need for restraint and ensure that it was always a last resort. Another was reflective about restraints he had been involved in and said that the experience with the service users would help him to be open-minded and non-judgemental when restraining patients. Further findings showed that the study participants reflected seriously on the discussions with the service users and were resolved to improve their practice particularly by being considerate of the patient's needs before, during and after any physical restraint. One who never thought much about debriefing the patients after restraint changed as a result of the experience. She subsequently perceived debriefing as vital for recovery and would ensure that it was done. Another was determined to identify and de-escalate issues and avoid PR altogether following the experience with the service users.

The finding showed that some participants within the focus groups viewed PR disapprovingly. These individuals changed their stances following their session with the service users. One who had thought that de-escalation could sort out every incident said that her session with the SUs made her realise that de-escalation may not work when somebody was completely out of control. Numerous studies including Wilson et al. (2017), Mind and NSUN (2015), Sacks and Walton (2014) and Mental Health America (2011) found that there were situations in care settings when nothing else worked and PR became inevitable. It was in recognition of occasions when de-escalation and alternative interventions might fail that bodies in the UK including the Department of Health (2014) and NICE (2015) issued guidelines for care settings and recommended patient centred care even in such challenging situations.

According to the findings, the experienced practitioners thought that the contribution from the SUs could motivate one to view patients differently and to be a much better practitioner. One practitioner said that it raised in her an awareness of how to treat a patient and to be caring and compassionate. Another said rather simply that it had changed her. And yet another was sure that he did

not need to change his practice because he was already talking to his patients and having discussions with them. Nevertheless, this individual thought that SU contribution gave a ‘different perspective’ to what PR was about, especially he said, that in an aggressive and violent situation, emotions were heightened and nurses were looking at it from their point of view. This truth was echoed by another practitioner who said that one just went on auto-mode with the physical aspects of the restraining and did not consider the patients at that point. Similarly in Moran et al. (2009) staff report that restraint situations could be very draining emotionally and that they (staff) suppress such emotions in order to get on with the job. Consequently, such suppression might lead to emotional detachment and inability to cater for the patient during a PR process. These realities are crucially the point. They are what SU involvement in PMVA training delivery is about. A candid discussion between practitioners and service users in a neutral environment, to consider what might or might not work in preventing PR. And, if PR must happen, then for staff to try and carry out the process in a professional and compassionate manner.

The responses from the experienced staff consistently indicated a commitment to de-escalating situations in order to avoid PR. Various examples were given about how staff negotiated and navigated around issues in order to de-escalate incidents and avoid PR. The importance of de-escalation was shared by service users in Duffy (2017) and highlighted by Scanlan (2010) and by staff members in Moran et al. (2009). Communication was perceived as of utmost importance in a de-escalation process. The finding showed that the session with the service users re-enthused the participants to maintain a culture of effective communication with patients, talking, listening and offering explanations where required. In that way patients could be reassured and issues could be resolved at the budding stage. Sharing an imagination, a participant had shuddered at the thought of restraining someone and then not speaking to them afterwards. It would feel like one was attacking them she concluded. Whereas the person was doing it to try and de-escalate a situation. The service user study participants in Gilburt et al. (2008) identified communication as the central theme to their perception of relationships and an essential ingredient of their experience.

And so, notwithstanding their belief that PR had an important place in mental health inpatient units, the participants thought that the option could be avoided or at least minimally used. Communication and good relationship with the patients were high on the list of what helped them to curtail anger and aggression on the wards and in so doing avoid the need to restrain patients. Acknowledging that patients spent the greatest length of time with nurses, participants considered that good relationship with patients was most important and could only be developed if effort was made to know the patient and their cultural background. Such knowledge the participants said could help when trying to de-escalate situations because some of the behaviours were characteristics of the individual the study found. The finding showed that the experience with the SUs motivated the participants to try and engage more with the patients by discussing things a lot more with them and by adopting more verbal de-escalation strategies. It made one to take a critical look at the way one treated patients according to the participants. In one participant's opinion resorting to physical restraint could break relationship. The importance of therapeutic relation between staff and patients particularly in mental health setting was emphasised in a number of studies (Knowles et al. 2015, Russell 2014). Indeed, Bland et al (2001) found that a therapeutic relationship based on trust and empathy was the primary purpose of psychiatric nursing.

Further on relationship, the study found that patients' anger and aggression was not always without a reason. However, the more an effort was made to know the individual, and to engage with him/her respectfully, the less likely the person would resort to anger and aggression. This is in line with Foster et al. (2007) and Bowers et al. (2006) who found that tuning into the reasons for patient's aggressive behaviour can facilitate ways of dealing with the problem other than restrictive intervention. Hence, Kontio et al. (2010 p72) recommend sensitizing staff to "*mindful reflection on patients' feelings in order to enable understanding of the causes and prevention of aggression*". The intention in creating a forum such as the SU PMVA session where those who restrain and those who are restrained sit and hold candid conversations on physical restraint is to trigger the kind of mindful reflection these authors recommend.

The finding showed that the discussions with the service users brought to the attention of the participants the importance of debriefing everybody involved in a restraint process (patient, staff and witnesses) especially the patient. A participant explained how her debriefing practice was useful in retaining patients' trust. Steckley (2007) similarly reported the retention of a therapeutic relationship when both parties had an honest examination and understanding of the incident. Reinforcing, Wisdom et al. (2015) state that:

> "*Conducting effective post event debriefing plays a critical role in reducing use of restraint and seclusion but requires ongoing commitment and willingness to learn*" (Wisdom et al. 2015 p853).

The study found that the practitioners who were either afraid to talk to their patients after a physical restraint or who did not consider it necessary to debrief patients said that their discussion with the SU trainers changed their perception on the issue. The importance of debriefing after a physical restraint is further highlighted in many studies including Mackenna (2016) and Kontio (2010). In fact, a physical restraint process without debriefing and post-incident review was viewed as incomplete (Obi-Udeaja 2009).

Going further, the experienced practitioners used their respective ward scenarios to elucidate how the lessons taken away from their session with the service users translated into practice. One said that meeting the SUs changed the way he thought about things. Considering PR as an intervention and the fact that they provided information on other interventions such as medication and psychosocial interventions he wondered why they should not have a well formulated and instructive information on PR for the service users which should be in their admission pack. This becomes a very pertinent question considering that the Standards for pre-registration nursing education mandates the mental health nurse to ensure that people receive all the information they need in a language and manner that allows them to make informed choices and share decision making (NMC 2010).

The setting for the PMVA SU session encourages candour. The SU trainers encourage and facilitate uninhibited conversation with the participants. So, the discussions sometimes reveal facts that potentially make the practitioners

uncomfortable. In Obi-Udeaja et al. (2017) a service user believed that if the clinicians were comfortable in any meeting with service users it meant that the interest of service users was not represented in the meeting. Conversely, if the clinicians were uncomfortable, it meant that service user views were getting across. And so, when one of the SU trainers explained during the PMVA SU session that it took six years for him to learn his diagnosis and that over the period, he was frequently in admission and repeatedly endured PR because he had no insight into his illness and was not compliant with his medication, the practitioners who were present appeared uncomfortable about such lapse by fellow practitioners. According to the finding, an experienced practitioner took the revelation on board. He started putting the lesson into practice by ensuring that his patients understood their diagnosis. He could vow on the positive effect it had in terms of trust, empathy and recovery. Another practitioner shared how helpful he found what the service user told them that could lessen the trauma of restraint experience such as: letting him know what the process is, who are in the team and meeting with the service user afterwards to ensure that he is ok and to explain why the restraint happened.

Thoughts on the contributions of the service users were taken further as the participants considered other ways that they could implement lessons learnt. Acknowledging the sensitive nature of PR and the need to be mindful when using it, participants shared other ways they reflected the lessons from the SU contribution in their ward practice. In line with guidelines (CQC 2017, NICE 2015, DH 2014, NMC 2010) and initiatives (Mind and NSUN 2015), this entailed for example, working closely with the patients in devising care plans. In their study, Clark et al. (2017) explain that the behaviour support plans (BSP) aims to work closely with the patient. Inevitably, a genuine effort by staff to understand all possible causes of a patient's behaviour would require working closely and collaboratively with that patient. Clark et al. (2017) report patients' appreciation that their views are being sought. The finding from this study showed that the staff planned care differently for each patient in recognition of uniqueness and differing needs. Similarly to BSP, the process was conducted through close working with the patient and ensuring that their preferences were reflected in the plan. In this study, staff would assess the patient when there was an incident to determine

whether there was someone else that the patient related well with who might be able to de-escalate the situation. Thus, buttressing the importance of a close working with the patient to prevent incidents that might lead to PR or to minimise the effect if PR became inevitable.

The findings showed the participants' willingness in fact enthusiasm to implement as discussed in the SU session, or to improve and maintain standard by those already doing so. But, when one called to mind that those discussions were happening in the calm and cool non-operational training environment, caution set in. What about in the real world one asked? Did the practitioners maintain the enthusiasm back in their wards? More importantly, was the system in their establishments supportive in their effort to implement the SU contributions? In their work, Tew et al (2004) posited that innovations in education and training must be mirrored by developmental support to the organisations in which the students undertake the practice element of their training, otherwise new capabilities or in this case inspirations and motivations to enhance practice may be lost.

The findings showed a number of things which the participants considered as hinderances to their ability to practise as discussed in the SU session. Top on the list were issues directly linked to staffing at their work place which tended to undermine their effort to practice as discussed in the training. Shortage of staff was identified as the core issue that gave rise to other problems. But for one assessment unit, all the wards in the study areas experienced staff shortage on a regular basis which affected the practitioners' ability to give their best to patients. Staff shortage affected patients directly. An example was given of an escort that failed to happen at the agreed time. Such an issue could trigger patient's anger and aggression and staff shortage may preclude adequate de-escalation process. The study found that staff shortage often meant working with bank/agency staff, probably an unfamiliar colleague who may not know the patient. The dilemma of working with an unfamiliar colleague could get compounded if incidents requiring de-escalation or indeed physical restraint occurred on the ward. As already discussed, de-escalation requires knowledge of the patient and a therapeutic relationship between nurse and patient. Equally, debriefing after an incident was particularly emphasised as most helpful by the

service user trainers according to the finding. It enabled closure, promoted recovery and possibly prevention of similar incidents. Yet staff shortage and having to work with unknown staff hindered the process.

According to the findings, the unfamiliar staff scenario might sometimes involve other challenges such as team members untrained to restrain as well as members who might have trained differently and who may have different opinions about restraint and may use restraint unnecessarily. This ties in with concerns about attitude. Colleagues identified as 'stuck in their own ways' posed problems because such ways might not be progressive. As posited by Beresford and Croft (1993) some professionals find changes to traditional ways of working daunting. Such a situation may hinder efforts to implement as discussed in the SU session. Equally hindering was the attitude of colleagues described as the 'gung ho' type. Such colleagues were perceived as deriving some weird sense of satisfaction from restraining patients even when it was unnecessary. Study participants in Knowles et al. (2015) thought that the reason staff would undertake jobs that involved PR was either for the money or because they enjoy the power and inflicting pain on others. These accounts reinforce the need for SU involvement in PMVA training, an initiative that could sensitise staff to be more patient caring particularly in challenging situations like PR. As found by Repper and Breeze (2007), service user involvement in student learning show that participants demonstrate greater sensitivity and empathy.

The finding showed that the emergency response team's role in an inpatient setting could be perceived as a typical demonstration of power imbalance where an over-powering number of staff members gather at once to confront one patient whose behaviour is considered challenging. On the sound of the alarm, everybody rushes in and seeing eight or ten people all around could be unsettling for the patient according to the study. As explained by Bowers et al. (2012 p805), a large assembly of staff (a show of force) is often all that is needed to achieve capitulation from a patient. The psychological effect on the patient and probably on the witnesses of such response is anybody's guess. A particularly upsetting incident according to the finding from this study was when a vulnerable patient

only wanted somebody to talk and explain things to her. Instead, an alarm was pulled and five or six heavy-handed big men came and took her down.

The experience of emergency response team became even more frightening for the patient when the team members were unfamiliar to him or her. In Obi-Udeaja (2009) a study participant said that it felt like being restrained by two different teams of staff – the staff on his ward who knew him and whom he knew and the staff from other wards who did not know him and whom he did not know. He described these unknown staff as very judgemental and nasty. Such a scenario must have been why Ryan and Bowers (2006) suggest that if PR is deemed necessary in an establishment, then allied professionals should all be trained in the knowledge and skills for PR so that wards can be self-reliant.

Meanwhile, Bowers et al. (2012) believe that some of the restrictive interventions can be averted by trying other de-escalation strategies. In line, the findings from this research showed that the response team was viewed differently, even favourably when the team rather than exhibit a 'macho' behaviour, engaged the patient in a dialogue in order to resolve issues. As a result, the patient co-operated and no PR was involved.

A breakdown in relationship between staff and patient was identified as one of the challenges to the implementation of the SU contributions to PMVA training. Breakdown in relationship could lead to the patient being neglected or to inability of the staff to fulfil certain roles because they thought that the patient might not co-operate. An example was a participant who felt unable to facilitate a debriefing session for her patient after a PR because she was afraid that the patient was still angry with her. Unnecessary PR or one that is perceived as highhanded could result to a breakdown of relationship where a patient may feel unable to engage with the staff that had restrained him or her (Duffy 2017, Knowles *et al.* 2015, Obi-Udeaja 2009).

The findings showed that the discussion with service users appeared not only to have re-motivated the participants to be more patient caring in their practice of PR but also to question poor practices of PR and to raise issues of concern. There was concern however that raising issues might attract negative responses from colleagues and such could be discouraging particularly when it was from one's

seniors. A participant who was a care assistant at the time of the incident shared how she ‘got a proper telling off’ from the nurse for raising concern about a highhanded PR. This is a matter for great concern. It explains why bad practices still happen. Again, this justifies the need for initiatives such as SU involvement in PMVA that could bring reality into the training according to the participants and help staff to remember that the person they are restraining is a human being.

Matters were highlighted in this study that could trigger anger and aggression in patients and thereby encourage the use of restrictive interventions like PR the study found. These included policies that staff had to adhere to. The current smoking policy for the Trust was identified as the main reason why patients push boundaries in order to get out of the ward. Whyte (2016) argues that inpatient routines and hospital rules could induce fear and uncertainty in patients who may respond by exhibiting challenging behaviours that sometimes lead to PR. Participants also thought that patient friendly establishments with secure outdoor spaces where patients could enjoy fresh air could enhance calmness in patients. Whereas the contrast could trigger the feeling of frustration and aggression and ultimately endorse the use of PR. Some of the participants in this study lamented the non-patient friendly environments that their patients lived in. This brings to mind Wisdom et al. (2015) who shared how the administrators of the establishment in their study soon realized that the positive alternatives to restraint and seclusion (PARS) were not a magic wand that solved all problems. Rather, the administrators themselves needed to examine their leadership styles and practices, the facility’s environment, policies and practices in order to effectively integrate the core strategies into their situation (Wisdom et al. 2015).

The study found that one contribution stood out during an argument among the focus group participants on whether or not allied professionals should participate in the physical restraint of patients. If PR were truly unavoidable and was carried out compassionately, it should not negatively affect the therapeutic relationship with the patient a participant said. Indeed, if anything, it might even enhance it (Steckley 2007). This reinforces the case for SU involvement in PMVA training. Their contribution aims to inspire staff to avoid PR. But realistically acknowledging that there may be situations when PR is inevitable (NICE 2015, Mind and NSUN 2015, DH 2014), to carry it out with the care of the patient in mind. When such is

the case, then it is irrelevant who carries out the process – Doctor, OT, Activity Worker, Nurse or other professionals. The added advantage of training up allied professionals is that wards could become self-reliant (Ryan and Bowers 2006) and avoid the pitfalls of relying on the emergency response team.

Critical reflection on my own learning

In 'my worldview' (Appendix 20), I explained how the Work Based Programme introduced me to the qualitative alternative for investigations into lived experiences. I have remained impressed by the features of this method of enquiry such as its flexibility that enables it to accommodate changes to the plan and its ability to uncover diverse views resulting from the uniqueness of human beings. Reflecting back on the challenges during the fieldwork stage, I feel particularly satisfied about my decision to use the qualitative approach for this research. It made it possible for me to flexibly find ways to manage the changes to my initial plans. Polit and Beck (2012) identify some characteristics of the approach including flexibility and elasticity that enable it to adapt to presenting situations. In my case, I was able to rearrange the venue for the semi-structured interviews from the HI where I played the insider role in terms of preparations for the interview sessions to the study participants' NHS venue. This meant a reversal of roles. I became an outsider and I relied on the participants' help in order to prepare for the interview sessions. I was humbled by the generous offers for help from these individuals. They simply took over and swiftly organised what they could and pointed me to the right directions where necessary. The experience reinforced the importance of treating people kindly with compassionate care and its centrality to nursing. They told me that they were reciprocating my respect and kindness to them when they attended our training.

Organising the enormous volume of data for analysis was so daunting and challenging that I recall feeling like giving up. But then I heeded my supervisors' suggestion and went back to study Braun & Clarke's various publications on thematic analysis of qualitative data. The achievement of a thorough albeit painstaking analytical process for this study gives me a great sense of satisfaction. I feel as if I have taught myself an invaluable lifelong skill and

knowledge. I feel particularly satisfied indeed proud that my analytical approach enabled me to identify and give voice to every view contained in the data however uncommon. Who knows whether the uncommon views will drive change in future.

This study reported diversity in participants' perception of SU contribution to PMVA training delivery. While most thought it was eye opening and thought provoking, there were odd revelations of the effect of the experience including: one who admitted never debriefing patients after PR because she thought that the patient might be angry, but the meeting with the SU changed her practice in that regard; one who admitted that the meeting with the SU made him reconsider his attitude when restraining patients. He changed to restraining with an 'open mind' after the encounter with the service users. Although not stated, this could well be somebody who used to restrain judgmentally; one shared how she used Bob (SU) as a role model whose journey from a chaotically unwell mental health person to a successful father contributing in various ways to the society to encourage her patients. She believed that Bob's story might motivate her patients to aspire similarly.

Considering the potential rewards from these outcomes, I feel a sense of satisfaction for using the qualitative approach in this investigation. Yes, it was a lot more challenging, but it was the one with the capabilities to do the job properly. It enabled the participants to truly reflect on their practices and to consider how the lessons from the SU contribution applied to them collectively and severally.

In their study on the influence of culture on the implementation of research findings within clinical settings Scott-Findlay and Estabrooks (2006) found that to achieve a culture change, there was a need to transform 'the mind set' of the people. By making this evaluative study inclusive and enabling all the restraint staff members in the Trust including the ward managers and other key staff who had participated in the service user session to participate in the research, the transformation of the 'mind set' hopefully would happen across the board. As recommended by Schon (1983), giving professionals the opportunity to reflect on their professional actions could enhance practice. A point buttressed by Bond

(2006) who suggests that the best form of primary prevention of violence in inpatient settings is to encourage reflective practice.

The next chapter will conclude the study and make recommendations.

Chapter Summary

The contributions from the PMVA service user trainers were regarded as most helpful and useful for practice by the course participants. The findings showed that the experienced participants supporting their claims with examples had been enhancing their practice with the lessons from the SU session. There was strong intent to put the lessons into practice by participants who were yet to start practicing. On reflection, I have gained invaluable knowledge and skills in the course of doing this research.

Chapter 7

Conclusion and Recommendations.

Introduction

This chapter summarises the outcome of SU involvement in PMVA training delivery. It makes recommendations on their involvement and on exploring the influence on practice of their contribution. Importantly, it answers the research question central to this project which was whether service users could make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development. Finally, it draws a conclusion on the research.

Service user involvement

The contribution of service users to my team's training delivery since 2008 has consistently delighted the course participants. As evidenced in the findings their contribution directly influenced the way that experienced staff managed patient's anger and aggression on the wards. The experience equally provided inspirational thoughts for future practice to those yet to go into practice.

Related contributions

In addition to the training delivery, indeed as a follow up, the team has endeavoured to disseminate the philosophy that the involvement of SUs in this unique subject area tries to promote. As the person who initiated the involvement, I have coordinated and managed these dissemination activities which include presentations at national and international conferences, presentation to NHS Board members as well as publications. A sample of these is given here while a comprehensive list is contained in Appendix 21.

Obi-Udeaja, J. Kerr, C. & Weller, G. (2020). Impacts of service user involvement in mental health nurse training on management of aggression - a qualitative description research aimed at describing, in order to understand the impact on practice of the contribution made by mental health service users to PMVA training delivery. Published in December 2020, this article which can be accessed online was an outcome of my DProf project.

Obi-Udeaja et al. (2020). An account of service users' involvement in training delivery on the prevention and management of violence and aggression: the impact on practice. (This account incorporating the findings from my DProf project was a chapter contribution for a second edition of a book on the prevention and management of violence. It was requested by a Medical Consultant from one of the NHS Foundation Trusts in London. The chief Editor expressed delight with our contribution. The publication is pending.)

Crosby, K. Ryan, G. & Obi-Udeaja, J. (2017). The involvement of service users in the prevention and management of violence and aggression training. (This was a presentation at the General Services Association (GSA) 11th Annual Conference held in Newcastle. As explained in my DProf project, my SU colleagues and I were requested by this national association of trainers to come and showcase to the delegates how we worked together in delivering the PMVA training).

Obi-Udeaja, J. Crosby, K., & Ryan, G. (2017). Involving service users in teaching healthcare professionals about physical restraint. Mental Health Practice. 21, 4, 36-39. (This publication was the outcome of our congress attendance in Copenhagen in 2015 as explained below).

Ryan, G. Crosby, K & Obi-Udeaja, J. (2015). Participation in a debate on 'Meeting of the minds': closing the gap between violence research, education and practice, the 9th European Congress on Violence in Clinical Psychiatry. (As explained in my DProf project, our invitation to this congress was a direct result of our impressive presentation on how we train together at an international conference in Dublin).

The dissemination activities of my team have contributed convincingly to the growing recognition and acceptance that people with lived experience of restraint have an important role to play in the way that training on PR is developed and delivered. This research findings are a vindication of this assertion.

Developing guidelines

Following our presentation at an international conference and the subsequent publication of the conference material, the chairman of the conference organizing body emailed and expressed great pleasure with our presentation and the SU involvement initiative that we were promoting. According to him, their organization believed that service user involvement in training delivery could significantly transform the dynamic. He thought that the account of our co-training wholly vindicated their position on the matter. We convinced them he said that developing guidelines on best practice in service user involvement in PMVA training delivery should be on the following year work plan which they were exploring at that time. We were invited to participate in the exercise.

Our publications on service user involvement in PMVA training retain a pride of place in the pack of essential publications distributed to PMVA trainers during their GSA train the trainer courses. It is an immensely rewarding outcome that the Restraint Reduction Network (RRN) training standards accreditation recently introduced to monitor a systemic progression to restraint reduction in the UK emphatically stated “Training providers must ensure that people with lived experience are involved in the development and delivery of training which involves the use of restrictive interventions” (Ridley and Leitch 2019 p 42). The findings from this research are proof that this recommendation is wholly justified.

Recommendations

Based on the findings from this research, the following recommendations are made to stakeholders including PMVA training providers, Higher Institutions, Hospital Trusts, Mental Health Nursing Council, Council for Mental Health Practitioner Medicine (i.e. training of Doctors/Psychiatrists) and other health Professional Bodies, Wider stakeholder groups (for example the Police and the Prison services), Government policy makers and WHO:

1. *Involve SUs in PMVA training*

The participants in this study unanimously expressed the wish for the mental health service users who have experienced being restrained to continue contributing to PMVA training delivery. Those who were yet to go into practice felt better equipped by the experience and expressed gratitude for it. The established practitioners appeared re-inspired and re-enthused by their contribution. This study therefore recommends to all stakeholders as named above to continue to support and encourage the involvement of service users in PMVA training.

2. *Extend SU involvement to PMVA Update Training*

This will enable the invaluable contribution from SUs to filter through to practitioners who may not have experienced the SU session probably because they did their 5Day training before the innovation. Availing it to a wider group of practitioners may help to bring on board those entrenched in archaic and non-patient sensitive restraint practices. The findings from the study showed that participants with all sorts of notions and approaches to PR were touched by the richness and balanced content of the SU contribution. Obi-Udeaja et al. (2010) explained that a contributory factor to the success of SU involvement in PMVA training is that the clinicians are marvelled and pleasantly surprised to behold individuals whom they (clinicians) visualise as perpetually unwell sitting with them and efficiently and expertly facilitating a teaching and learning session. The current research further tested this early finding and affirmed that it was a transformative experience for the clinicians. Going by research findings, it can change the negative attitudes of those who experience it. The challenge is to get as many as possible to experience it because it is important for this transformation of the mind set to happen across the board. This could bring about the required culture change (Scott-Findlay and Estabrooks 2006). Extending the training to update/refresher courses may involve more service users. This is a positive thing because it will translate into empowering more service users and hopefully helping them to transform their lives for the better. This study recommends that Higher Institutions and other PMVA training providers should involve SUs and pay them commensurate remuneration.

3. Continue to seek, and develop sustainable alternatives to PR

The effort by the participants to translate lessons from SU sessions into practice must continue. There are also essential and practical support which the establishment, that is, the NHS Trusts can provide such as therapeutic facilities including secure gardens and de-escalation spaces which patients can access when needed. The need for adequate and well -trained staff goes without saying. A stable workforce that translates into the staff that know the patient and whom the patient knows is more likely to proactively prevent PR and to skilfully de-escalate situations because they know what works with a given patient. Recommendations are therefore made to NHS Trusts for: the provision and retention of adequate and well-trained staff, secure gardens, de-escalation facilities and exercise equipment in order to promote health and well-being. Smoking cessation should also be targeted for patients and staff as part of the well-being agenda for change.

4. Mandatory training for all

As suggested in the finding, all who are involved in patient care including allied professionals should be trained in PMVA. This can help to make a ward less reliant on the emergency response team who may not know the patient they are restraining. Interestingly, this is already happening. We have mental health ward Consultants accessing our training. And, as shown in this study, Activity Workers were part of the study participants. One of them who had been involved in a few PRs actually stated that if one restrains caringly, the patient may in fact be grateful that one helped him or her in a moment of need. So, the argument by some allied professionals that participating in the physical restraint of their patients might damage their therapeutic relationship with the patients does not hold. It will be the case if one restrains unnecessarily and uncaringly (allied professional or not). A recommendation is therefore made to all concerned stakeholders for inclusive training on PMVA for both nursing staff and allied professionals.

5. *Continuous research*

While feedback from various sources indicated an overwhelming satisfaction with the SU contribution to our PMVA training delivery, the question was whether such a contribution actually made a positive difference to practice. Trying to establish the impact on practice of SU contribution to PMVA training was challenging (Morgan and Jones 2009). This research is therefore a very small and humble step. It is hoped that greater steps will continue to be taken to research the phenomenon. This study would suggest that future evaluative studies should work with service users/patients in order to gain their perspectives on the matter. Additionally, targeted research funding to enable and maintain ongoing research on innovations such as this should be provided.

Conclusion: Response to the research question

This research has endeavoured to describe and understand the impact on practice when service users are involved in PMVA training delivery in local NHS mental health inpatient wards. Because SU involvement in this subject area is a new phenomenon, a qualitative description research method of enquiry was adopted for the study. This approach enabled a description and understanding of the phenomenon (Bradshaw et al. 2017, Sandelowski 2000). The research approach, the methods for data collection and analysis made it possible to appreciate, value and consider every contribution however uncommon. This in turn made it easy to confidently answer the research question:

> *Can service users make a sustainable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development?*

The findings indicate that the participants found the contribution by service users as profound and important; bringing a new reality and empathy to their work and enabling new meanings such as debriefing to be derived. The focus group participants took away various lessons from their session with the service users and appeared resolved to reflect them in practice. The lessons included:

proactively seeking alternatives to PR, debriefing patients after PR, raising issues of poor restraint practices.

Similarly, the experienced staff were planning care collaboratively with their patients and incorporating patient's preferences in the care plan. They were communicating/talking and negotiating more with their patients and trying other things that helped them to minimise patients' anger and aggression and the need to restrain. Equally, Appendix 19 provides a sample of the feedback on SU sessions from previous PMVA training participants. The feedback was given anonymously, and no research instruments were used to moderate it. Yet, each indicates honesty, sincerity as well as an intent to take seriously the lessons learnt and to reflect them in practice. These interpretations of the findings and researcher experience lead me to conclude that yes, service users can make an invaluable contribution to mental health staff practice in the prevention and management of violence and aggression through active participation in training and development.

The findings from this study may not claim to form scientific generalisations, yet there is potentially transferable learning that could be applied in other relevant contexts. As argued by Sandelowski (1997), more naturalistic generalisations can indeed be drawn from and about cases.

Research products and dissemination

Research products

Impact on mental health ward practice

This study explored the experience of mental health staff and students with regard to their session with service user PMVA trainers and considered their translation of the lessons from the session into practice. The study illuminated many participant's comments on needs and betterment of the service, which was facilitated largely through the training with SUs. The research findings held convincing evidence of transformation of the way that physical restraint was perceived and practised.

Impact on PMVA training delivery

When we first started sharing how my team co-trains with service users in this unique subject area, fellow trainers could not understand why I would propose letting the patients into the secret of how we restrain them. The General Services Association, the largest national body of trainers on PMVA in the UK invited my team (all costs paid) to its annual general conference in 2017. The association wanted us to showcase to its national and international body of trainers how we co-work in delivering the training. Consequent to our co-training delivery and dissemination activities, service user representation is now an essential in the GSA's train the trainer programme. It is humbling to see my team's publications circulated to all the trainers in the course. The findings from this research are further evidence of the positive contribution that people with lived experience of PR can make to practice and therefore the justification for their involvement.

Impact on professional bodies

Our presentation at the European Network for Training in the Management of Aggression Conference (ENTMA08), Dublin, 2014 triggered the development of guidelines on service user involvement in PMVA training delivery. To quote the Chairman of the organisation in response to our presentation, "…You have convinced me that developing guidelines on best practice in service user involvement in training should be on our next work plan…" (email communication from Dr Paterson Jan. 2015).

In 2019, the Restraint Reduction Network (RRN) training standards recommended the involvement of service users in the development and delivery of any training which involves the use of restrictive interventions (Ridley and Leitch 2019). These developments are justified by the findings from this study.

Impact on wider stakeholder groups

Individuals with mental health problems live and work within the society. The outcome of this research could therefore be applicable beyond the health

sector. Earlier in this study I talked about the use of PR by other services such as the police and the prison. It was highlighted that the models of PR employed by some of such bodies tended to be highhanded hence the tag such as '*police use of force*' (Klahm IV and Tillyer, 2010 p.230). By similarly engaging service users these bodies may gain helpful lessons for practice improvement. Indeed, the concept of service user involvement could be understood as having universal applicability to professional services. For example, within Social Worker training, School Teacher training (within specialist training for Pupil Referral Units). These developments promise a transformation of the way that PR is perceived, taught and practised in future. I would regard these as the key products of our initiative.

Dissemination

Publication

- Our first peer reviewed journal article on this project was published in December 2020 (see link in Appendix 21)
- A poster presentation on the project was also published - Work Based Learning e-Journal, Vol. 9, No. 2a, (October 2020)
- A chapter account of my team's work with service users incorporating this project was requested by a Medical Consultant from an NHS Foundation Trust in London. Our contribution has been sent to the chief editor. Publication is imminent.
- More publications particularly on conference materials and outcomes of collaboration activities on this project will follow. An example is the 7th International Conference on Professional and Practice Based Doctorates (23-26 February 2021).

Conference and Workshop Presentations

National

During our last presentation to the GSA national conference of trainers, we informed the delegates about this project which was then in progress. We plan to present the outcome to the Association at the earliest opportunity.

International

Equally, we will be presenting this impact finding to international bodies particularly ENTMA08 from whose Chairman we enjoyed very, helpful feedback, encouragement and support.

Local channels of dissemination

We are privileged to have an established annual symposia dissemination outlet within our faculty at our Higher Institution. It is our plan to utilise the outlet for dissemination of this work.

Our HI enjoy a partnership relationship with the local police services. I intend to invite the organisation as well as the local prison services for candid workshop discussion and sharing of ideas based on this project and its findings.

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Appendix 1

Feedback from the Director of nurses

From: [redacted]
Sent: 31 May 2015 23:41
To: Jane Obi-Udeaja
Cc: [redacted]
Subject: Board presentation

Dear Jane

The board presentation on Tuesday went superbly and thank you for sparing the time to come down from Hendon with Kate and Gary to make the presentation about restraint and PMVA. Your strongly communicated messages about what a 'good' restraint means by way of respect for service users and the ward community when it is done properly and equally, what the impact of poorly managed restraints mean came across powerfully. It was an impactful 25 minutes and the first time the chair has allowed extra time for this slot.

Gary and Kate's contributions were hugely helpful and thank you for letting them have the air time after your introduction, to tell their stories and to advise the board from their perspective what more could be done to improve the experience for service users of this intervention. I do not have their e mail addresses and I would be grateful if you might pass on our thanks and appreciation to them both.

This proved to be one of the most powerful patient experience sessions we have had so far and board members were still talking about it after the formal meeting closed.

I look forward to working with you on this significant issue moving forward.

[redacted] thank you for all your co-ordination for this item on patient experience and for supporting the team of colleagues on Tuesday, it makes a big difference.

With kind regards

[redacted] (DIRECTOR OF NURSING)

Appendix 2

Minutes of the NHS Trust Board of Directors meeting covering our presentation

Camden and Islington NHS
NHS Foundation Trust

MINUTES OF A MEETING OF THE CAMDEN AND ISLINGTON NHS FOUNDATION TRUST BOARD OF DIRECTORS HELD IN PUBLIC

IN THE CONFERENCE HALL, ST PANCRAS HOSPITAL, ST PANCRAS WAY, LONDON, NW1 0PE.

ON TUESDAY 26 MAY 2015 AT 2:00PM

Board Members Present:

Ms Leisha Fullick	**Chair**
Ms Pippa Aitken	**Non-Executive Director**
Mr Richard Brooman	**Deputy Trust Chair**
Mr Paul Calaminus	**Chief Operating Officer**
Ms Angela Harvey	**Non-Executive Director**
Dr Sue Goss	**Non-Executive Director**
Ms Claire Johnston	**Director of Nursing and People**
Mr Colin Plant	**Director of Integrated Care (Non-voting member)**
Ms Wendy Wallace	**Chief Executive**
Mr David Wragg	**Director of Finance**

In Attendance:

Mr Kevin Monteith	**Associate Director of Strategy and Corporate Development / Trust Secretary**
Dr Zoe Fyffe	**Patient Experience Lead (Items 15.01.072 to15.01.074 only)**
Ms Jane Obi-Udeaja	**Lecturer in Mental Health at Middlesex University – accompanied by two former service users. (Items 15.01.072 to15.01.074 only)**
Ms Joanne Shand	**Interim Associate Director of Human Resources & Organisational Development (Item 15.01.087 only)**
Mr Wayne Gilbart	**Senior Infection Control Nurse (Item 15.01.088 only)**
Mr Martin Zielinski	**Board Secretary (Minutes)**

This meeting was open to the public

GENERAL BUSINESS

15.01.072 **Welcome, Apologies & Quoracy**

Ms Fullick welcomed all those present, particularly welcoming Ms Pippa Aitken, new Non-Executive Director, to her first Board meeting. She also noted that this was Mr Brooman's first meeting since taking on the role of Deputy Trust Chair; and Mr Plant's last Board ahead of his retirement.

Apologies had been received from Ms Sarah Charles, Senior Independent Director.

The meeting was quorate.

15.01.073 **Declarations of Interest**

The copy of the register detailing all Board members' declared interests, received as part of the Board pack, was accepted as accurate.

The Board were satisfied that there was no conflict between those interests declared and any item on this meeting's agenda.

15.01.074 **Service User Presentation: Service User Involvement in the Prevention & Management of Violence & Aggression (PMVA) Training**

Ms Obi-Udeaja, Lecturer in Mental Health, and two former service users provided a presentation to the Board on PMVA highlighting the positive and negative aspects of restraint. The former service users explained that they were actively involved in PMVA training sessions for staff and they outlined the benefits they brought to the training by sharing their experiences. Staff feedback from these sessions had been very positive. It was also considered how staff could trigger an incident potentially leading to restraint and be personally affected by undertaking restraint. The ideal solution would be where a situation was defused through discussion and mediation prior to any need for restraint. It was acknowledged that there were instances where restraint remained the best option but that it should only be

undertaken therapeutically and with consideration, and never violently or as an act of punishment. The presentation was concluded with an invitation to Board members to attend one of the Trust's future PMVA training sessions.

Ms Fullick thanked the presenters and invited questions and comments from the Board.

Dr Kirchner asked if the presenters thought care would ever advance to a stage where restraint was never required. He was advised that this was unlikely as there would always be a small percentage of cases where restraint could not be avoided. It may be the only means of ensuring a service user did not harm themself or others. An honest apology or the removal of a service user from a pressurised situation was often enough to defuse a situation that may otherwise have resulted in restraint. Ms Harvey queried what would constitute a good example of restraint. She was advised that, where restraint was required, it should be with the minimum level of force and for the shortest time possible; only whilst the service user and/or others were at risk. It was important that a full debrief is held after an instance of restraint so that both the service user and staff understood what led to restraint being necessary and to evaluate how it had been undertaken. It is important that everyone involved is treated as a human being with their own feelings, thoughts and perceptions of their care.

Ms Fullick thanked everyone for their input in discussing this important topic.

Board minutes are numbered sequentially throughout the calendar year.

Appendix 3

Feedback from Higher Institution Vice Chancellor (VC)

From: [redacted]
Sent: 03 August 2018 13:01
To: Jane Obi-Udeaja <J.Obi-Udeaja@mdx.ac.uk>
Cc: [redacted]
Subject: RE: Thanks

Dear Jane

Thanks for your message, and thanks for inviting me. It was great to get an insight into your work, and I found the session extremely interesting and thought-provoking.

All the best

[redacted]

From: Jane Obi-Udeaja
Sent: 03 August 2018 12:10
To: [redacted]
Cc: [redacted]
Subject: Thanks

Dear [redacted],

Thanks for making time to attend our prevention and management of violence and aggression (PMVA) service user session yesterday and more, for staying the entire over-run period.

Perhaps I should have explained that our service user colleagues usually prefer us (the trainers) to leave the room because they believe that the course participants would talk more candidly when we their assessors are not around.

And further to your question re physical skills, the service user session is not really to teach physical skills. No. The trainers do that from Monday to Friday. Rather, the session aims to motivate course participants to do more to prevent incidents/de-escalate incidents and only restrain as a last resort. This is in line with the current national and international initiatives to eliminate/minimise restrictive interventions.

Kind regards

Jane

Appendix 4

European Network for Training in the Management of Aggression Conference (ENTMA08) Feedback

Feedback from ENTMA08 workshop participants

- "The session was great, thanks"
- "Great session Kate, Jane and Garry"
- "That was good. Thank you"
- "Excellent Thank you Best of the Symposium"

Email feedback from ENTMA08 Association Chairman (Dr [redacted])

- "It was lovely to meet you. Feedback on your presentation has been absolutely tremendous!!!"
  "Hope we can involve you in events going forward?"
- "Modesty is properly a virtue. However, one of my colleagues who attended your presentation described himself as blown away and he is not easy to impress!!"

Source: European Network for Training in the Management of Aggression (ENTMA08) conference, Dublin, November 2014

Appendix 4B

Further feedback from ENTMA08 Chairman (Dr [redacted])

From: [redacted]
Sent: 28 January 2015 21:31
To: Jane Obi-Udeaja <J.Obi-Udeaja@mdx.ac.uk>
Subject: Re: FW: the size of the conference

Hi Jane

Apologies for delay in response. Thank you very much for letting me read this. I am very very pleased that your presentation was well received. ENTMA firmly believes that service user involvement in training can significantly transform the dynamic and your account of your workshop wholly vindicates our position!

We explicitly sought presentations on the topic of service user involvement because we believe that there remain some questions about what best practice looks like. We are meeting next week to explore our work plan for next year including potential further publications. You have convinced me that develop guidelines on best practice in service user involvement in training. should be on that work plan. I will now have to convince my colleagues!

Should I be successful would you be willing to participate in such an exercise?

Kindest regards

[redacted]

Appendix 5

Example of requests for conference presentations or for publication materials

From: Journal of Nursing & Patient Care <nursing@scitechnol.org>
Sent: 22 March 2017 15:11
To: Jane Obi-Udeaja <J.Obi-Udeaja@mdx.ac.uk>
Subject: [SPAM: 9.779] Extend Research on Nursing and Patient Care
Importance: High

Dear [redacted] Jane Obi-Udeaja,

Greetings from SciTechnol - Journal of Nursing & Patient Care

We have read your valuable contribution entitled **"Service user involvement in training for the prevention and management of violence and aggression"** which made a very good impact among the readers and has added a very good valuable paper to the field of nursing and public health.

We are pleased to announce the invitation for paper submissions and invite authors to submit original research, reviews, short communications, commentaries, etc. addressing the clinical aspects in nursing and patient health care.

To view the latest articles go through **Current Issue**

Journal of Nursing & Patient Care (JNPC) mainly focuses on the dissemination of latest research on nursing and public health. The topics include, but not limited to:

- Mental Health Nursing
- Midwifery
- Nursing Science
- Nursing and Health Care
- Patient Care
- Nursing Theories
- Critical Care Nursing
- Pediatric Nursing
- Adult Nursing
- Public Health Nursing
- Clinical Nursing

For additional information, contact Editorial Office at nursing@scitechnol.com

Thanks & Best Regards,

Narise A,

Journal Coordinator,

Journal of Nursing & Patient Care

Direct: +1-702-714-70001(9034)

Customer Service: +1-702-508-2676

E-mail: nursing@scitechnol.com | nursing@scitechnol.org

www.scitechnol.com

Appendix 6

Research ethics approval letter

School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

12th October 2016

HEESC APPLICATION NUMBER: MH52 Jane Obi-Udeaja

Dear Jane

Re your application titled: "Exploring the impact on practice when Service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards"

Thank you for submitting your revised application. I can confirm that your application has been given approval from the date of this letter. This approval is valid until 31st October 2017. If you require an extension to this end date please complete Form E which can be found at http://ethics[redacted]wikispaces.net/Health+Studies

Please ensure that you contact the ethics committee via Leeann Bradley

HEethicsSubC@mdx.ac.uk if there are any changes to the study to consider possible implications for ethics approval. Please quote the application number in any correspondence.

The committee would be pleased to receive a copy of the summary of your research study when completed.

Good luck with your research.

Yours sincerely

Professor [redacted]

On behalf of the Health and Social Care Ethics Sub-Committee

Appendix 7

An example of correspondence in preparation for data collection at the Trust

From: Jane Obi-Udeaja
Sent: 21 September 2017 18:03
To: [redacted]
Subject: PMVA Evaluative Study

Hello [redacted],

I cannot adequately express my gratitude for the way you so kindly alleviated my anxiety regarding the coordinating of resources for my team's data collection effort. I dare hope we can continue to work together until the work is completed and be able to publish something out of it.

As you requested, here are the details:

- The Study: An evaluation of the mental health service users' contribution to PMVA training
- Inclusion criterion for participation: Staff who have sat in the service user session during their 5Day PMVA training at [redacted]
- Type of data collection method: Semi-Structured interview (one interviewee at a time)
- Approximate length of time for the interview – 45 mins
- Venue (Room): You promise to arrange - Thanks
- Number of participants required: 8 – 10
- We will provide lunch on the day. We will sit in the allocated room at your hospital site and wait for the participants to come in at their convenience. Perhaps if you will kindly help by spacing out the identified interviewees so that there is minimal overlap in attendance
- Apart from the 28th and the 29th of October, the Interviewer is available from Monday the 25th of September until Friday the 13th of October 2017
- I have attached the 'Info Sheet'. It gives greater details to aid decision making as to whether or not to participate. Please do not hesitate to let me know if further details are required.

Thank you very much for this help

Best regards

Jane

PS

Could you please scan those lists of names to me at your convenience. Just realised that I haven't saved all of them.

Best regards

Jane (Sent from Mail for Windows 10)

Appendix 8

Participant information sheet

Department of Mental Health, Social Work

and Integrative Medicine

School of Health and Education

[redacted]

Hendon Campus

The Burroughs

London NW4, 4BT

1. Study Title:

Exploring the impact on practice when Service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards

2. Invitation:

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

The Middlesex University Prevention and Management of Violence and Aggression (PMVA) team provides physical intervention training to Camden & Islington (C&I) NHS Trust inpatient ward staff and to the [redacted] final year mental health students. The team is aware that when faced with a violent incident on the ward, staff sometimes struggle to apply the principles learnt during PMVA

training. To help bridge the gap between theoretical principles and practice, mental health service users who have had the experience of being restrained on the ward co-train with the PMVA team in order to make learning more realistic and motivate staff to practice what is learnt.

This study aims to explore the PMVA participants' perspectives and practices in relation to the contribution made by service users to the training on PMVA.

The project forms part of training improvement and development analysis being carried out by the team. The overall aim is to use the finding as an evidence base to promote the dissemination of service user involvement in training on PMVA.

The project will also be used for the partial fulfillment of the requirements for Doctorate in Professional Studies.

4. Why have I been chosen?

We are recruiting staff and students who access the PMVA training and participate in the service users' session and who volunteer to take part in the study.

We are requesting you for further information. The next step is for you to read this information and decide whether or not you would like to take part in the project.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form a copy of which will also be given to you to keep. If you decide to take part you are still free to withdraw at any time and you do not have to give a reason. A decision not to take part or a decision to withdraw will not in any way affect the training or education you receive at the [redacted].

6. What will happen to me if I take part?

You will be asked to participate in a focus group interview or in a semi-structured interview. You will be asked questions on your thoughts about the service users' contribution to the training and whether the lessons from it influence your practice of physical restraint on the wards.

You will be able to talk about your experiences/perspectives and to make suggestions in your own words about how to improve the service user PMVA session. To avoid unnecessary interruptions and to make sure that we get everything you say, we would like to record the interview. The tape recording will be transcribed and then destroyed. The transcription will be coded for identification. Your name will not be attached.

7. What are the possible disadvantages and risks of taking part?

Going through the interview may bring back some upsetting memories of physical restraint for some people. If anything like this happens you can stop, refuse to answer questions or take time to compose yourself. Although this will be handled sensitively within the interview, if you feel upset by anything, one of the facilitators will be available to support you. In addition, we will provide all participants with contact details for available local counselling services.

8. What are the possible benefits of taking part?

Whilst there are no direct benefits for taking part in this project, some participants may find it helpful to talk to the training team or indeed to address issues from their experiences by discussing them openly with others who may have had similar experiences. Additionally, some participants may like to be involved in a project that will be used to inform the development of physical restraint training in order to support 'best practice'.

9. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the study will be kept strictly confidential and will comply with the data Protection Act. Any information about you which is used will have your name and all other personal details removed so that you cannot be recognized from it. You will not be identified in the project report.

10 What will happen to the results of the research study?

The findings of the study will be used to review the physical intervention training offered to [redacted] Trust staff and as evidence base to promote the dissemination of service user involvement in training on PMVA with the aim of reinforcing 'best practice'.

The study will also be used for the partial fulfillment of the requirement of Doctorate in Professional Studies.

If you wish, a printed summary of the report will be available from November 2018. Our contact is as shown below. Please leave your contact details if there is no answer and we will call you.

11 Who has reviewed the Study?

The project has been reviewed by the [redacted] Health and Social Care Ethics Sub-Committee (HSESC)

12 Contact for Further Information:

Jane Obi-Udeaja

Lecturer and GSA Tutor

Dept of [redacted]

School of [redacted]

The Burroughs

Hendon

London NW4 4BT

E-mail: J.Obi-Udeaja@mdx.ac.uk

Tel: 020 8411 4911

Thank you for taking the time to read this information sheet and for considering whether or not to take part in the study.

Appendix 9: Consent Form

Version Number…

Participant Identification Number:

CONSENT FORM

Title of Project: Exploring the impact on practice when Service users are involved in staff training on the prevention and management of violence and aggression in local NHS mental health inpatient wards

Name of Researcher: Jane Obi-Udeaja

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……..…for the above study and have had the opportunity to ask questions. [1]
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. [2]
3. I agree that this form that bears my name and signature may be seen by a designated auditor. [3]
4. I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers. [4]
5. I understand that my interview may be taped and subsequently transcribed. [5]
6. I agree to take part in the above study. [6]

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

(if different from researcher)_____ _____

Researcher Date Signature

1 copy for participant; 1 copy for researcher;

Appendix 10

Focus Group Interview (Pre service user session)

New Trust Staff/Students

Number:

Date:

Time:

Venue:

Now that you have covered the theoretical component and the physical skills for this course,

Q1. What are your opinions regarding the physical restraint incidents of patients that you have witnessed to date? Please provide details.

Q2. Will you deal differently with patients requiring physical restraint in the work place now that you have completed this course? Please explain?

Q3. Is there anything else you feel that you want to contribute to this discussion?

Thanks very much for your time and answers (HI PMVA Team)

Appendix 11

Focus Group Interview (Post service user session)

New Trust Staff/Students

Number:

Date:

Time:

Venue:

Q1. What are your opinions about the contribution made by the service users to the PMVA training?

Q2. What lessons if any did you take away from the session?

Q3. Will the experience make a difference to the way you will manage incidents that may require physical restraint on the ward? Please elaborate.

Q4. Are there any work related issues that may affect the way you use this learning?

Q5. Is there anything else you feel that you want to contribute to this discussion?

Thanks very much for your time and answers (HI PMVA Team)

Appendix 12

Semi-Structured Interview (Experienced Staff)

The [redacted] prevention and management of violence and aggression trainers co-train with mental health service users (living in the community) who have had the experience of being restrained while in inpatient ward. We want to evaluate this co-training practice and would appreciate your honest feedback.

What year did you participate in the service user session at the PMVA training?

What was your opinion about the inclusion of the service user session in the PMVA training?

During their session, the service users usually initiate interaction by asking the participants in the session questions such as “what makes you sad/happy/angry” linking it to causes of their sadness/happiness/anger when they were inpatients on the ward. They share their positive and negative experiences of being restrained on the word. They emphasise among other points the importance of effective communication and debriefing all parties after a physical restraint.

What aspect of the discussion did you find most interesting or thought provoking?

What aspect of the discussion did you find boring or irritating?

What would you say that you took away from the session?

Did the experience influence the way that you managed incidents of anger and aggression from your patients? Please elaborate.

Does the experience still influence the way that you manage incidents of anger and aggression from your patients? Please elaborate.

Please tell me about the physical restraint scenario(s) in which you believed that your actions/inactions were influenced by the lessons from the service user session during you r PMVA training. [Deepen the understanding from the scenario(s)]

Would you like to share further opinion about the contribution of mental health service users to PMVA training?

Do you feel that there are work related issues that could impact on the implementation of the learning from the service user contributions to PMVA training?

Are there anything else relating to this discussion that you wish to talk about?

Thanks very much for your time and answers (HI PMVA Team)

Appendix 13

Sampled Records of Feedback

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
11.	12.	13.	14.	15.	16.	17.	18.	19.	20.
21.	22.	23.	24.	25.	26.	27.	28.	29.	30.
31.	32.	33.	34.	35.	36.	37.	38.	39.	40.
41.	42.	43.	44.	45.	46.	47.	48.	49.	50.
51.	52.	53.	54.	55.	56.	57.	58.	59.	60.
61.	62.	63.	64.	65.	66.	67.	68.	69.	70.
71.	72.	73.	74.	75.	76.	77.	78.	79.	80.
81.	82.	83.	84.	85.	86.	87.	88.	89.	90.
91.	92.	93.	94.	95.	96.	97.	98.	99.	100.

Appendix 14

Identified Codes from all data

Code	Category
A.	It reveals the sus' perspective
B.	The patient's beliefs
C.	Most staff do not consider sus' feelings and needs during PR
D.	Makes you plan care differently for each individual
E.	It's insightful, eye opening, interesting, informative, educative, fabulous, excellent, humbling
F.	Saw how they felt – did not know that before
G.	Promotes empathy, sympathy and compassion
H.	Talk to patients from admission to discharge
I.	Plan care from admission
Code	Category
J.	Include them in care planning
K.	Discuss managing an aggressive situation that involves them with them
L.	Share decisions with patient (su)
M.	Engage with patients to minimise incidents
N.	Importance of communication
O.	Relationship
P.	De-escalation
Q.	Knowing the patient
R.	Culture
S.	Alternative interventions
T.	Vigilance and observation
U.	Be empathetic, respectful, not patronising
V.	Restraint is a last resort
W.	Relationship
X.	Restraint should be done by trained people
Y.	Debriefing
Z.	Staffing issues + Agency/temporary staff, Emergency Response Team
Code	Category
BB.	Training
CC.	Staff feelings and attitudes
DD.	Planning.
EE.	The team
FF.	Policies
GG.	Activities…
HH.	Environment/location, Open/outside space, …
II.	Professionalism
JJ.	Makes the training more real
KK.	It's unforgettable, important, helpful, valuable and useful for practice
LL.	It has changed me
MM.	Greater understanding
NN.	Effects of restraint
OO.	Listening to the patient
PP.	Role model
QQ.	SU preferences
RR.	Assessment

SS.	Emotions
TT.	SU contribution affects people differently
UU.	Supervision
VV.	Restraint minimisation
WW.	Assumptions about patients
Code	Category
XX.	Techniques
YY.	Safety
ZZ.	Interactive
AAA.	Is PR necessary?
BBB.	Promotes reflection
CCC.	de-escalation space
DDD.	Restraint's a sensitive issue
EEE.	Gentle coercion
FFF.	Time out
GGG.	'field modifications' of restraint
HHH.	Safer techniques
III.	Restraint is for safety
JJJ.	Explanation
KKK.	Restraint's Necessary
LLL.	Removal of trigger
MMM.	Excessive force
NNN.	Relationship breakdown
OOO.	Rebuilding relationship
PPP.	Power imbalance
QQQ.	Untrained team members
RRR.	Updating techniques
SSS.	Awareness of risks
TTT.	Caring and calming restraint
UUU.	Not punishment
VVV.	A lot to consider during restraint
Code	Category
WWW.	advanced decisions
XXX.	patients remember
YYY.	reason behind behaviour
ZZZ.	right use of physical restraint
AAAA.	awareness
BBBB.	raising issues
CCCC.	Colleagues stuck in their own ways
DDDD.	Differences in training
EEEE.	good and bad experiences of restraint
FFFF.	To be more mindful
GGGG.	patient sensitive restraint
HHHH.	Restraining because they care
IIII.	Restraint as punishment
JJJJ.	Patients spend most time with nurses
KKKK.	Prevention
LLLL.	Restraining to control
MMMM.	Safe restraint
NNNN.	Improving restraint experience

OOOO.	Injury to people involved
PPPP.	Unplanned restraint lead to injuries
QQQQ.	People just rush in
RRRR.	Reprimanded
Code	Category
SSSS.	That was discouraging
TTTT.	People are jumped
UUUU.	Confidence
VVVV.	Patient restraint and allied professionals
WWWW.	Inability to help in emergency
XXXX.	Training should be mandatory
YYYY.	Sharing learning with team members
ZZZZ.	Activity workers relationship with patients
AAAAA.	psychological aspects of restraint
BBBBB.	making a difference
CCCCC.	maintain sus' involvement
DDDDD.	Su involvement could change staff views
EEEEE.	Sus' involvement appreciated
FFFFF.	service user inclusion would make a huge difference
GGGGG.	the smoking ban
HHHHH.	su involvement is very important
IIIII.	Avoid physical restraint
Code	Category
JJJJJ.	changes the way you treat all your patients on the ward
KKKKK.	It informed my practice
LLLLL.	More of the su contribution is good
MMMMM.	It would be good to have it in the update training
NNNNN.	ward environment can reduce or trigger violence
OOOOO.	gardens and open spaces, could be therapeutic
PPPPP.	an enclosed ward where you can't go out could be frustrating
QQQQQ.	the training is really good.
RRRRR.	Physical restraint triggers auto response
SSSSS.	Physical restraint could be harsh
TTTTT.	Su contribution could help with de-escalation skills
UUUUU.	Focus training on de-escalation
VVVVV.	Unfamiliar team members
Code	Category
WWWWW	Unfamiliar and untrained colleagues could be frustrating
XXXXX.	Thought us how to work with our patients
YYYYY.	Lack of insight and Non-compliance
ZZZZZ.	Division of labour during an incident
AAAAAA.	To understand their views on how to improve the situation
BBBBBB.	They talked about good and bad experiences
CCCCCC.	They will learn how to manage their condition if they know
DDDDDD.	I can see the effect in terms of trust, empathy and recovery
EEEEEE.	That's something I learned from their input
FFFFFF.	having a receptive consultant is advantageous
GGGGGG.	every team member is equally valued
HHHHHH.	having different grades of staff has advantages
Code	Category

IIIIII.	Let the patient talk to someone with whom they relate well
JJJJJJ.	su contribution was both entertaining and of enormous value.
KKKKKK.	Su contribution can only strengthen our abilities as Practitioners
LLLLLL.	Su session has broadened my knowledge

Appendix 15

Participants' responses mapped against the identified categories

Code	Category	Focus group Students	Focus group Trust Staff	Semi-struct Brian	Semi-struct Steve	Semi-struct Sarah	Semi-struct Chris	Semi-struct Susan	Semi-struct Olivia	Semi-struct Mary	Semi-struct Helen	Semi-struct Kevin	Semi-struct Roger	Feedback Records
A.	It reveals the sus' perspective	x	x	x		x					x		x	x
B.	The patient's beliefs		x											
C.	Most staff do not consider sus' feelings and needs during PR								x				x	
D.	Makes you plan care differently for each individual		x	x			x		x					
E.	It's insightful, eye opening, interesting, informative, educative, fabulous, excellent, humbling	x	x	x	x	x	x	x			x	x		x
F.	Saw how they felt – did not know that before			x								x		
G.	Promotes empathy, sympathy and compassion			x					x	x				x

H.	Talk to patients from admission to discharge	x	x	x	x	x		x		x			x	x
I.	Plan care from admission		x							x	x	x		
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
J.	Include them in care planning	x			x	x	x		x			x	x	
K.	Discuss managing an aggressive situation that involves them with them					x			x				x	
L.	Share decisions with patient (su)													
M.	Engage with patients to minimise incidents	x	x				x	x	x	x		x	x	
N.	Importance of communication	x	x	x	x	x	x	x	x	x	x	x	x	x
O.	Relationship	x	x	x		x		x				x		x
P.	De-escalation	x	x	x	x	x		x	x	x	x	x	x	x
Q.	Knowing the patient	x	x	x										
R.	Cultural issues			x									x	
S.	Alternative interventions	x	x	x	x	x		x				x	x	
T.	Vigilance and observation								x	x		x		
U.	Be empathetic, respectful, not patronising				x									x
V.	Restraint is a last resort	x	x		x	x					x		x	x

W.	Relationship													
X.	Restraint should be done by trained people		x											
Y.	Debriefing	x	x			x	x					x		x
Z.	Staffing issues + Agency/temporary staff, Emergency Response Team		x			x		x	x				x	
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
BB.	Training	x	x	x				x			x		x	x
CC.	Staff feelings and attitudes	x	x		x		x	x	x	x		x		x
DD.	Planning.	x												
EE.	The team	x	x		x							x		x
FF.	Policies												x	
GG.	Activities…													
HH.	Environment/location, Open/outside space, …												x	
II.	Professionalism		x							x				
JJ.	Makes the training more real		x							x				
KK.	It's unforgettable, important, helpful, valuable and useful for practice	x	x	x	x		x	x		x	x	x		x
LL.	It has changed me							x			x			
MM.	Greater understanding	x	x		x			x					x	x
NN.	Effects of restraint	x	x				x	x	x		x	x		

OO.	Listening to the patient		x					x					x	
PP.	Role model							x						
QQ.	SU preferences		x			x	x		x		x		x	
RR.	Assessment	x	x			x					x			x
SS.	Emotions					x	x						x	x
TT.	SU contribution affects people differently												x	
UU.	Supervision													
VV.	Restraint minimisation	x	x									x	x	
WW.	Assumptions about patients	x			x									
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
XX.	Techniques	x	x											
YY.	Safety	x	x											
ZZ.	Interactive	x												
AAA.	Is PR necessary?		x											x
BBB.	Promotes reflection	x	x											x
CCC.	de-escalation space		x											
DDD.	Restraint's a sensitive issue													
EEE.	Gentle coercion		x											
FFF.	Time out		x											
GGG.	'field modifications' of restraint	x	x											
HHH.	Safer techniques	x	x											x
III.	Restraint is for safety		x											
JJJ.	Explanation		x		x			x				x	x	
KKK.	Restraint's Necessary	x	x											

LLL.	Removal of trigger		x		x									
MMM.	Excessive force	x	x											x
NNN.	Relationship breakdown		x			x								
OOO.	Rebuilding relationship		x											
PPP.	Power imbalance		x											
QQQ.	Untrained team members		x						x					
RRR.	Updating techniques	x	x											
SSS.	Awareness of risks	x	x											
TTT.	Caring and calming restraint	x	x											
UUU.	Not punishment		x											
VVV.	A lot to consider during restraint	x	x											
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
WWW.	advanced decisions		x											
XXX.	patients remember		x											
YYY.	reason behind behaviour	x	x				x				x			
ZZZ.	right use of physical restraint		x				x				x			
AAAA.	Awareness		x			x				x			x	
BBBB.	raising issues	x	x											
CCCC.	Colleagues stuck in their own ways		x											
DDDD.	Differences in training	x	x											
EEEE.	good and bad experiences of restraint	x	x											x

FFFF.	To be more mindful	x	x							x				
GGGG.	patient sensitive restraint	x	x				x		x			x		
HHHH.	Restraining because they care	x												
IIII.	Restraint as punishment	x												x
JJJJ.	Patients spend most time with nurses													
KKKK.	Prevention								x					
LLLL.	Restraining to control	x												
MMMM.	Safe restraint	x	x											
NNNN.	Improving restraint experience		x				x							
OOOO.	Injury to people involved	x							x					
PPPP.	Unplanned restraint lead to injuries	x												
QQQQ.	People just rush in	x												
RRRR.	Reprimanded	x												
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
SSSS.	That was discouraging	x												
TTTT.	People are jumped	x												
UUUU.	Confidence	x	x											
VVVV.	Patient restraint and allied professionals	x												
WWWW.	Inability to help in emergency	x												
XXXX.	Training should be mandatory	x												

YYYY.	Sharing learning with team members	x												x
ZZZZ.	Activity workers relationship with patients	x												
AAAAA.	psychological aspects of restraint		x											
BBBBB.	making a difference	x	x											
CCCCC.	maintain sus' involvement		x								x	x		
DDDDD.	Su involvement could change staff views		x											
EEEEE.	Sus' involvement appreciated		x				x							
FFFFF.	service user inclusion would make a huge difference					x							x	
GGGGG.	the smoking ban												x	
HHHHH.	su involvement is very important					x								x
IIIII.	Avoid physical restraint													
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
JJJJJ.	changes the way you treat all your patients on the ward					x								
KKKKK.	It informed my practice				x		x	x						x
LLLLL.	More of the su contribution is good						x							

MMMMM.	It would be good to have it in the update training						x							
NNNNN.	ward environment can reduce or trigger violence						x							
OOOOO.	gardens and open spaces, could be therapeutic						x							
PPPPP.	an enclosed ward where you can't go out could be frustrating						x							
QQQQQ.	the training is really good.						x							
RRRRR.	Physical restraint triggers auto response								x					
SSSSS.	Physical restraint could be harsh													
TTTTT.	Su contribution could help with de-escalation skills								x					
UUUUU.	Focus training on de-escalation								x					
VVVVV.	Unfamiliar team members								x					
Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
WWWWW	Unfamiliar and untrained colleagues could be frustrating								x					

XXXXX.	Thought us how to work with our patients			x										x
YYYYY.	Lack of insight and Non-compliance			x				x						
ZZZZZ.	Division of labour during an incident			x	x									
AAAAAA.	To understand their views on how to improve the situation				x									
BBBBBB.	They talked about good and bad experiences				x									
CCCCCC.	They will learn how to manage their condition if they know				x									
DDDDDD.	I can see the effect in terms of trust, empathy and recovery				x									
EEEEEE.	That's something I learned from their input				x									
FFFFFF.	having a receptive consultant is advantageous				x									
GGGGGG.	every team member is equally valued				x									
HHHHHH.	having different grades of staff has advantages				x									

Code	Category	Students	Trust Staff	Brian	Steve	Sarah	Chris	Susan	Olivia	Mary	Helen	Kevin	Roger	Records
IIIIII.	Let the patient talk to someone with whom they relate well							x						
JJJJJJ.	su contribution was both entertaining and of enormous value.													x
KKKKKK.	Su contribution can only strengthen our abilities as Practitioners													x
LLLLLL.	Su session has broadened my knowledge													x

Appendix 16

Table showing theme derivation

Codes/categories	Candidate themes (category clusters)	Sub-themes	Themes
It reveals the sus' perspective			
The patient's beliefs			
Most staff do not consider sus' feelings and needs during PR			
Makes you plan care differently for each individual			
It's insightful, eye opening, interesting, informative, educative, fabulous, excellent, humbling			
Saw how they felt – did not know that before			
Promotes empathy, sympathy and compassion			
Talk to patients from admission to discharge			
Plan care from admission			
Include them in care planning			
Discuss managing an aggressive situation that involves them with them			
Share decisions with patient (su)			
Engage with patients to minimise incidents			

Importance of communication			
Relationship			
De-escalation			
Knowing the patient			
Culture			
Alternative interventions			
Vigilance and observation			
Be empathetic, respectful, not patronising			
Restraint is a last resort			
Restraint should be done by trained people			
Debriefing			
Staffing issues + Agency/temporary staff, Emergency Response Team			
Training			
Staff feelings and attitudes			
Planning.			
The team			
Policies			
Activities…			
Environment/location, Open/outside space…			
Professionalism			
Makes the training more real			
It's unforgettable, important, helpful, valuable and useful for practice			
It has changed me			

Greater understanding			
Effects of restraint			
Listening to the patient			
Role model			
SU preferences			
Assessment			
Emotions			
SU contribution affects people differently			
Supervision			
Restraint minimisation			
Assumptions about patients			
Techniques			
Safety			
Interactive			
Is PR necessary?			
Promotes reflection			
de-escalation space			
Restraint's a sensitive issue			
Gentle coercion			
Time out			
'field modifications' of restraint			
Safer techniques			
Restraint is for safety			
Explanation			
Restraint's Necessary			
Removal of trigger			
Excessive force			
Relationship breakdown			

Rebuilding relationship			
Power imbalance			
Untrained team members			
Updating techniques			
Awareness of risks			
Caring and calming restraint			
Not punishment			
A lot to consider during restraint			
advanced decisions			
patients remember			
reason behind behaviour			
	Candidate-themes	Sub-themes	Themes
right use of physical restraint	SUs' contribution draws attention to the patient's perspectives.	An essential element of PMVA training	Theme 1 Mental health service users' (SUs') contribution to PMVA training
	It reveals the sus' perspective		
awareness	The patient's beliefs		
raising issues	They talked about good and bad experiences		
Colleagues stuck in their own ways	The importance of communication		
Differences in training	It was Interactive		
good and bad experiences of restraint	Was both entertaining and of enormous value.		
To be more mindful			
patient sensitive restraint	SU contribution is invaluable		

	It's insightful, eye opening, interesting, informative, educative, fabulous, excellent, humbling		
Restraining because they care	Makes the training more real		
Restraint as punishment	SU involvement could change staff views		
Patients spend most time with nurses	SU inclusion would make a huge difference		
Prevention	Sus' contribution could help with de-escalation skills		
Restraining to control	SU involvement is very important		
Safe restraint	More of the Sus' contribution is good		
Improving restraint experience	It would be good to have it in the update training		
Injury to people involved	Sus' involvement is appreciated		
Unplanned restraint lead to injuries	Maintain SU involvement		
People just rush in		Translating learning to practice	
Reprimanded	Su contribution affects people differently		
That was discouraging	SU contribution affects people differently		
People are jumped	It has changed me		
Confidence	SU session has broadened my knowledge		
Patient restraint and allied professionals			
Inability to help in emergency	Triggers self-awareness		
Training should be mandatory	Saw how they felt – did not know that before		

Sharing learning with team members	Promotes empathy, sympathy and compassion		
	Promotes reflection		
Activity workers relationship with patients	It is useful for practice		
psychological aspects of restraint	It's unforgettable, important, helpful, valuable and useful for practice		
making a difference	Changes the way you treat all your patients on the ward		
maintain sus' involvement	To be more mindful		
	To understand their views on how to improve the situation		
	It informed my practice		
Su involvement could change staff views	Makes you plan care differently for each individual		
Sus' involvement appreciated	Prevention		
service user inclusion would make a huge difference	Sharing learning with team members		
the smoking ban	Raising issues		
su involvement is very important	That's something I learned from their input		
Avoid physical restraint	Role model		
changes the way you treat all your patients on the ward	Making a difference		
It informed my practice	Su contribution can only strengthen our abilities as Practitioners		
More of the su contribution is good	Taught us how to work with our patients		

It would be good to have it in the update training	Plan care with patients	Engage with patients	Theme 2 Working with patients
ward environment can reduce or trigger violence	Makes you plan care differently for each individual		
gardens and open spaces, could be therapeutic	Restraint's a sensitive issue		
an enclosed ward where you can't go out could be frustrating	Plan care from admission		
the training is really good.	Include them in care planning		
Physical restraint triggers auto response	SU preferences		
Physical restraint could be harsh	Advanced decisions		
Su contribution could help with de-escalation skills	One to one communication		
Focus training on de-escalation	Talk to patients from admission to discharge		
Unfamiliar team members	Listening to the patient		
Unfamiliar and untrained colleagues could be frustrating	Explanation		
Thought us how to work with our patients	Lack of insight and Non-compliance		
Lack of insight and Non-compliance	They will learn how to manage their condition if they know		
Division of labour during an incident	Importance of effective communication		
To understand their views on how to improve the situation	I can see the effect in terms of trust, empathy and recovery		
They talked about good and bad experiences	Therapeutic relationship		
They will learn how to manage their condition if they know	Patients spend most time with nurses		

I can see the effect in terms of trust, empathy and recovery	Knowing the patient		
That's something I learned from their input	Cultural issues		
having a receptive consultant is advantageous	Relationship		
every team member is equally valued	Relationship breakdown		
having different grades of staff has advantages	Rebuilding relationship		
Let the patient talk to someone with whom they relate well	Minimising incidents and Is PR inevitable?	Preventing physical restraint	
su contribution was both entertaining and of enormous value.	Engage with patients to minimise incidents		
Su contribution can only strengthen our abilities as Practitioners	To understand their views on how to improve the situation		
Su session has broadened my knowledge	Discuss managing an aggressive situation that involves them with them		
	Share decisions with patient (SU)		
	Assessment		
	Vigilance and observation		
	Prevention		
	Debriefing		
	Be empathetic, respectful, non-patronising		
	Alternative interventions		
	Relationship		

	Knowing the patient		
	Let the patient talk to someone with whom they relate well		
			Theme 3 Challenges to implementation of SU contribution
Agency/temporary staff		Staffing issues	
Unfamiliar colleagues	Staff issues		
Untrained team members	Agency/temporary staff		
Differences in training	Unfamiliar colleagues		
Colleagues stuck in their own ways	Untrained team members		
	Differences in training		
	Colleagues stuck in their own ways		
	Emergency Response Team		
	People just rush in		
	Power imbalance		
	Listening to the patient		
	Relationship		
	Assumptions about patients		
	Staff feelings and attitudes		
	Relationship breakdown		
	Raising issues		
	Thoroughly told off		
	That was discouraging		
		Policies	
	Policies		
	The smoking ban		
	Activities…		
		Environmental issues	
	Environmental issues		
	Environment/location, Open/outside space, …		

	De-escalation space		
	Ward environment can reduce or trigger violence		
	Gardens and open spaces, could be therapeutic		
	An enclosed ward where you can't go out could be frustrating		
		Additional Relevant Issues	
	Allied professionals		
	Patient restraint and allied professionals		
	Activity workers		
	Inability to help in emergency		
	Training should be mandatory		

Appendix 17

A sample of row numbered focus group data sets

Row No	Speaker	Response	Essence	Category	Code
1.	**Pre SU SESSION**				
2.	GF.	What are your opinions regarding the physical restraint incidents of patients that you have witnessed to date? Please provide details.			
3	Jill	restraint is sometimes used without the use of de-escalating first. It is sometimes done using incorrect moves, for example too much use of force, not protecting patient's head.	without the use of de-escalating using incorrect moves use of force	De-escalation techniques Excessive force	P XX MMM
4	Fab	do not have an opinion			
5	Tim	some restraint I have seen in	different methods	Differences in training	DDDD

		practice have used different methods from what has been taught. An example of this is seeing staff members trip patients up to try and take the patient down.	trip patients up to try and take the patient down.	‘field modifications’ of restraint	GGG
6	Lucy	I’ve witnessed a patient trying to punch a staff member, staff grabbed him by the punching hand and threw him on the floor whilst other staff restrained him down.	grabbed him by the punching hand and threw	‘field modifications’ of restraint	GGG
7	Ola	it is important to only turn to restraint as a last resort. Try to de-escalate, maintain continuous communication until it is no longer affective.	restraint as a last resort. continuous communication	last resort de-escalation communication	V P N

8	Vicky	not an ethical restraint as the patient is very affected by it. It isn't very dignifying either. No experience in restraint but from what I've heard and learnt.	Unethical Un-dignifying	Effects of restraint Effects of restraint	NN NN
9	Lisa	yet to have an experience			
1	Nora	I have never witnessed a restraint during my whole three years as a student			
1	John	I haven't seen closely on my placements, however, the response team was gathering and offers med orally. After a while, the patient took the med, so don't have to restrain. Another incident was they grabbed the patient and	and offers med orally	Alternative intervention	S

		transferred to PQ ward.			
1	Val	I have witnessed patients being restrained on beds when being given depo. From the training, I learnt that this is not correct.	patients being restrained on beds	Training	BB
1	GF	Will you deal differently with patients requiring physical restraint in the work place now that you have completed this course? Please explain?			
1	Jill	first time PMVA trained. Having had the restraint done on me, I know how frightening/scary it may be. So, I will be more thoughtful. Always put patients physical health	how frightening/scary it may be I will be more thoughtful. put patients physical health first	Effects of PR Promotes reflection Safety	NN BBB YY

		first/especially when in prone.			
1	Fab	if the restraint is done correctly by trained personnel, then there is minimal risk to su	done correctly minimal risk	Techniques Safe restraint	XX MMMM
1	Tim	yes, the course has given me knowledge on how you could potentially injure yourself or a patient if you do not use a correct restraint technique.	the course has given me knowledge	Training	BB
1	Lucy	yes, I will as I now know the techniques and the right way to do it.	I now know the techniques	Training	BB
1	Ola	yes, it has caused increased awareness in the risks and the discomfort involved in the procedure. It takes away dignity, independence & freedom.	Increased awareness in the risks Deprivation of dignity, independence & freedom	Awareness of risks Effects of physical restrain	SSS NN

1	Vicky	most definitely - providing clear communication & holding the patient properly.	clear communication holding the patient properly.	communication Techniques	N XX
2	Lisa	as I have yet to observe a restraint, I cannot comment. However, when I do, I feel I will have the knowledge and skills to do it correctly + maintain patient's dignity.	knowledge and skills to do it correctly + maintain patient's dignity	Training patient sensitive restraint	BB GGGG
2	Nora	yes, I feel this course has taught me the importance of using restraint as a last resort and to try and de-escalate the situation. I feel I would be more confident in doing a restraint and not hurting anyone.	using restraint as a last resort de-escalate the situation more confidence	a last resort de-escalation confidence	V P UUUU
2	John	yes definitely, tried to use fully the whole techniques that I learnt, from			

		restraint till releasing			
2	Val	yes I will. The training has provided me with the necessary skills to restrain patients/clients appropriately and the risks involved.	necessary skills to restrain risks involved.	knowledge and skills Awareness of risks	BB SSS
2	GF	Is there anything else you feel that you want to contribute to this discussion?			
2	Jill	No			
2	Fab	service users should be given information regarding restraint when they are admitted to the ward. Focus on de-escalation	service users should be given information regarding restraint Focus on de-escalation	Inform patients de-escalation	J P
2	Tim	the training for PMVA is very good and the trainers are very helpful and encouraging. I just feel sometimes it is a	PMVA training is very good Very helpful and encouraging trainers	Training is very good helpful and encouraging trainers	BB BB BB

		lot to cover in just five days	a lot to cover	training period	
2	Lucy	I feel like staff from the wards should have refresher training for 3 days not one day.	3days refresher course	training period	BB
2	Ola	it is important to explore all avenues in order to de-escalate patients - restraint should not be an answer for every patient who is not compliant to regulations knowing patient.	explore all avenues in order to de-escalate patients	Alternatives intervention	S
3	Vicky	not at the moment.			
3	Lisa	I am looking forward to patient session as I feel hearing + understanding from the patient perspective is very important.	looking forward to patients' session su perspective is very important.	su perspectives su perspectives very important	A A KK
3	Nora	I think people should make sure they have regular updates even if	regular updates	Updates	BB

		they do not necessarily need it. I think it is good that you get to experience how it feels being restrained and you know how patients feel.	good to experience being restrained	Effects of physical restraint	NN
3	John	I haven't got any particular suggestion at the moment. However, practice is needed regularly/learning video	practice is needed regularly	practice	BB
3	Val	I feel the training should be for at least 2 weeks for students to get to grips with all the techniques. I however feel that restraining a person should be A LAST RESORT. I felt so horrible when I HAD TO GIVE AN INJECTION TO SOMEONE WHO	the training should be for at least 2 weeks LAST RESORT horrible when I HAD TO GIVE AN INJECTION..	training period last resort Staff feelings…	BB V CC

		WAS RESTRAINED!!!			
3	**Post SU SESSION**				
3	GF	What are your opinions about the contribution made by the service users to the PMVA training?			
3	Jill	really good. Got an understanding of how it feels on the other side	really good an understanding	really good understanding	KK MM
3	Fab	very enlightening. Subjective explanation which gave insight of how the su experience restraint.	very enlightening gave insight	Enlightening gave insight	E E
3	Tim	the session was very helpful. They explained their opinions on what they consider a bad and good restraint to be	very helpful.	very helpful.	KK
4	Lucy	very good. It gave us a more detailed service user	very good	very good su perspectives	KK A

		perception. Made us think about them during restraints & better way to approach restraints.	service user perception Made us think about them during restraints	to be more mindful	FFFF
4	Ola	I found it quite eye opening. Brought awareness toward the various factors which surround mental illness and treatment of patients. How little can make a big difference. Importance of communication	eye opening Brought awareness little can make a big difference communication	eye opening awareness making a difference communication	E BBBBB N
4	Vicky	fabulous. Their experience really helped me to understand the effect restraints have on service users. But also helped me to acknowledge the importance of de-escalation and definitely using restraint as a last resort	Fabulous helped me to understand de-escalation last resort	Fabulous Greater Understanding de-escalation last resort	E MM P V

4	Lisa	excellent contribution, very useful, interesting and important to hear from a service user's perspective. Service users very interactive, great examples	excellent contribution very useful, interesting and important very interactive	Excellent very useful interesting important very interactive	E KK E KK ZZ
4	Nora	it's very good to gain the perspective from the service users. It's good hearing good and bad stories about restraint to understand.	very good It's good hearing good and bad stories about restraint	very good good and bad experiences of restraint	KK EEEE
4	John	staff doesn't apply PMVA techniques appropriately & right way. They didn't de-escalate verbally before applying	de-escalation	de-escalation	P
4	Val	very helpful information. It was very nice to hear it from the service	very helpful information	informative	E

		user's point of view although very sad			
4	GF	What lessons if any did you take away from the session?			
4	Jill	debriefing and how important it is, de-escalate, find out why?, knowing the patient, building relationship	Debriefing de-escalate, knowing the patient building relationship	Debriefing de-escalation knowing the patient relationship	Y P Q O
4	Fab	importance of communication and relationship building. Focusing on de-escalation	Communication Relationship de-escalation	Communication Relationship de-escalation	N O P
5	Tim	to be mindful to always explore what the service users are feeling and don't assume they are angry due to symptoms of their illness	explore what the service users are feeling don't assume	reason behind behaviour assumption	YYY WW
5	Lucy	always debrief with all patients, including the patients that	debrief with all patients,	debriefing	Y

		witnessed the restraint			
5	Ola	maintain continuous communication with patient before and after any incident. Ask patients for their input.	continuous communication	communication	N
5	Vicky	communicating with service user throughout the restraint process is key. Debriefing and talking to patients who witnessed/involved is vital for their closure	Communicating Debriefing talking	Communication Debriefing talking	N Y H
5	Lisa	always de-escalate, communicate with the service users and very important to debrief with them but also other service users that witnessed the restraint	de-escalate, communicate debrief patients and witnesses	de-escalation Communication Debriefing	P N Y

5	Nora	the importance of communication skills both before, during and after a restraint	communication	communication	N
5	John	need to realise why the person is showing the presenting problem/act	need to realise why…	reason behind behaviour	YYY
5	Val	whenever I am called in as part of the restraint team, I will remember to put the person's safety first. One of the service users told us how a member of the staff stepped on his toe and commanded him to shut up and he never forgot that staff member.	put the person's safety first	Safety	YY
5					
5	GF	Will the experience make a difference to the way you will manage incidents that may require			

		physical restraint on the ward? Please elaborate.			
6	Jill	when restraining or watching a restraint, be aware of what is happening. If I think something is wrong, (for example inappropriate use of force) then to raise it!	be aware of what is happening. raise concerns	Awareness raising issues	T BBBB
6	Fab	yes, being proactive in identifying crisis stages and prevent crisis happening rather than reacting.	identify crisis proactively	Assessment	RR
6	Tim	yes patients will appreciate if you are not unnecessarily aggressive whilst restraining and like being debriefed as well	unnecessarily aggressive whilst restraining	Excessive force	MMM

6	Lucy	yes it will always make me think about their news and perceptions	It will always make me think about their news	Future practice	KK
6	Ola	yes, engage with patients always. Ask what they want. Consider alternatives to improve patient's care and outcome	engage with patients Consider alternatives	engage with patients alternatives interventions	M S
6	Vicky	yes, the use of minimum force is highly important	use of minimum force	techniques	BB
6	Lisa	use the minimal amount of force, follow the techniques correctly, always de-escalate	minimal amount of force de-escalate	Techniques de-escalation	B P
6	Nora	yes, ensure it's actually necessary to restrain and use your communication skills to help	ensure it's actually necessary to restrain communication	Last resort communication	V N
6	John	yes, use it in a correct way and make sure it will	use it in a correct way	Safe techniques	HHH

		not harm the patient			
6	Val	yes of course, as above. But also I will always ensure I de-escalate and restrain as last resort for safety of both staff and service users	de-escalation restrain as last resort	de-escalation last resort	P V
7	GF	Are there any work related issues that may affect the way you use this learning?			
7	Jill	don't know			
7	Fab	team competence on restraint, staffing issues	team competence staffing issues	team staffing issues	EE Z
7	Tim	I cannot think of any			
7	Lucy	no. but possibly, not having a good team that are trained	Trained team	team	EE
7	Ola	the team I work with. My own feelings if I allow them to influence	Team, own feelings	team staff feelings	EE CC

		my opinion on patient			
7	Vicky	lack of trained staff can cause an issue or lack of experience	lack of trained staff lack of experience	Training Training	BB BB
7	Lisa	staff not trained. Staff not following the correct techniques	Untrained staff	Training	BB
7	Nora	may be lack of team work and untrained staff	lack of team work untrained staff	Team	EE
7	John	location may make it difficult to apply PMVA	location may make it difficult	Location	HH
8	Val	none			
8	GF	Is there anything else you feel that you want to contribute to this discussion?			
8	Jill	none			
8	Fab	none			
8	Tim	no, it was very helpful	very helpful	very helpful	KK

8	Lucy	thank you, good, beneficial, heart-warming session	good, beneficial, heart-warming	good beneficial heart-warming	KK KK E
8	Ola	not at the moment (do not distress the patient and work on rebuilding the relationship)	rebuilding relationship	relationship	O
8	Vicky	none currently			
8	Lisa	the service users' session was a very good part of the course	very good part of the course	very good	KK
8	Nora	no			
9	John	just follow the right techniques & refresh time to time	right techniques & refresh	techniques updates	BB BB
9	Val	hearing the experience of service users who have been restrained before puts things in perspective and this should continue.	Su session should continue	Maintain Su session	KK

Appendix 18

A sample of row numbered semi-structured data sets

Row No	***Speaker***	**Response**	**Essence**	**Category**	**Code**
1.	*I:*	Ok, please put it down there. So, when you went there, were the service user's part of the training?			
2.	*IV:*	In 2015, yes.			
3.	*I:*	So, what did you think?			
4.	*IV:*	I thought it was quite emotional in a sense that you're hearing it from a persons' point of view, when they're going through something that is quite traumatic. It did inform my practice in a	it was quite emotional It did inform my practice … you always have to remember that	Su contribution was emotional It informed my practice t's unforgettable, Effects of restraint	SS KKKKK KK NN NNNN

		sense that you always have to remember that, restraints are often, unfortunate, but you have to keep in mind that you're doing it on and each restraint affects them in a different way. And he mentioned how to make it a better experience by letting him, if you're having to restrain a person or a service user, just letting him know what the process is, who you are and who the team is, and that has been what I have done throughout my practice. And he said, I think he said no one	each restraint affects them in a different way. he mentioned how to make it a better experience just letting him know what the process is, who you are and who the team is, and that has been what I have done throughout my practice. a lot of that is meeting with the service user afterwards and seeing how they are and	Improving restraint experience communication with the patient during restraint It informs my practice debriefing after physical restraint	N KKKK Y

		really met with him after his restraint and he was talking about a particular one which was quite difficult and a lot of that is meeting with the service user afterwards and seeing how they are and explaining why that happened, you know?	explaining why that happened,		
5.	*I:*	Yes, making friends with them, basically.			
6.	*IV:*	Yeah.			
7.	*I:*	Ok. So, really, you gained a great deal of insight into the other side's perception of this which made you want to be friends with them afterwards, so			

		you would arrange some kind of …			
8.	*IV:*	Yeah, well, it is more about realising that it can impact them massively and then just making sure that they're ok afterwards and they understand what happened and why it happened.	realising that it can impact them massively making sure that they're ok afterwards and they understand what happened and why it happened.	restraint affects in different ways debriefing after physical restraint	NN Y
9.	*I:*	Because you still have to continue to treat them and look after them [yeah]. You don't want to have to be fighting with them every five minutes, so, yeah, actually going back to them again and, well, as I call it,			

		making friends, building the relationship again was even more important to you there [yeah]. So, the whole thing was not at all boring …			
10	*IV:*	No.			
11	*I:*	… in what we're saying, it was thought provoking for you?			
12	*IV:*	Yes it was thought provoking, yeah, it was moving, thought provoking, interesting. It was good.	it was moving, thought provoking, interesting.	Su session was moving, thought provoking, interesting	E
13	*I:*	Because you said a little bit just up there about letting			

		them know about it, that means that you include some kind of planning in the care plan [yeah]?			
14	*IV:*	So, once you identify someone that is at risk of having a restrictive intervention like restraint, it's about building a care plan and doing it with that service user about, if it ever came down to the point of you having to be restrained, do you have a preference for gender, do you have a preference for who does what, do you have a preference with what happens	it's about building a care plan and doing it with that service user do you have a preference for…	Care planning with the patient SU preferences	J QQ

		afterwards? Things like that.			
15	*I:*	Are they happy to talk to you about that?			
16	*IV:*	Not always but sometimes and then if they're not happy, we try and do it in their best interests, as in the care plan. Some people are happy to do it and for example, we had a service user, she had a very particular way of what helped her during a restraint and every time we made sure she knew everyone in her response team and who would be doing what and how long it	we try and do it in their best interests, as in the care plan. a very particular way of what helped her during a restraint and every time we made sure she knew everyone in her response team	Right use of physical restraint patient's preferences	ZZZ QQ

		was going to go on for.			
17	*I:*	And that was good was it?			
18	*IV:*	Yeah.			
19	*I:*	Do you find that talking to them sometimes means that they don't get aggressive, before, they're reluctant to let it get too far because …			
20	*IV:*	Yeah, I guess, I mean it depends how unwell a service user is but I would say the more you engage and the more bridges you build with that person, the less likely they will be to become violent	the more you engage and the more bridges you build with that person, the less likely they will be to become violent or aggressive.	Engaging with patient and minimising violence and aggression Reason behind behaviour Staff attitude	M YYY

		or aggressive. There's often very, I wouldn't say justified reasons but there are valid reasons why that person is being violent or aggressive. And that might be with someone being dismissive or it might be their mental health, or it might be a mixture of both. And the more you know that patient, the more you have that relationship with them, I think the less likely they will be to be violent.	there are valid reasons why that person is being violent or aggressive. And that might be with someone being dismissive … the more you know that patient the more you have that relationship with them, I think the less likely they will be to be violent	Knowing the patient Therapeutic relationship Prevention	CC Q O KKKK
21	*I:*	To lead to anything that is really extreme.			

22	*IV:*	Yeah.			
23	*I:*	Ok. So, you obviously manage aggression much more differently now, from what you used to?			
24	*IV:*	Yeah I do and that does come through experience as well, just by seeing, you know, over the years, what has worked and what hasn't worked.			
25	*I:*	Did this training actually push that change?			
26	*IV:*	I think the training sparked the awareness and just making sure that you always understand that	I think the training sparked the awareness understand that the	Saw how they felt – did not know that before Restraint could be terrifying	F NN

		the person you're restraining will be terrified or it will be a negative experience for them but to try to make it the least negative as possible, if that makes sense?	person you're restraining will be terrified		
27	*I:*	Because after all, it may happen again, somewhere else.			
28	*IV:*	And he spoke about the physical implications of, they obviously stopped face down restraints unless someone happens to fall on to that restraint, but he spoke about not being able to breath properly and having	it stuck in my mind because obviously you don't want to do that to anyone	It's unforgettable …	KK

		trouble with his airways and that, it stuck in my mind because obviously you don't want to do that to anyone and in the police cells and in some hospitals, people have died through that sort of thing.			
29	*I:*	So it's not a good thing to happen.			
30	*IV:*	No.			
31	*I:*	Do you feel we could make this training better in any way?			
32	*IV:*	The whole training [yeah]. No, I think it's good, I think more of this would be good, if I'm honest.	The whole training I think it's good, I think more of this would be good,	More of the su contribution is good	LLLLL

		More, I can't remember how long he spoke for but it wasn't a massive amount of time. But I know time is quite tight in PMVA but …			
33	*I:*	So what about, maybe, more often?			
34	*IV:*	It would be good to get someone talking in the one day for half an hour, just to talk about their experience, I think that might be an idea. Because the last time someone ever spoke to me, in this format, was in 2015 but we have our one day refresher training, it would	It would be good to get someone talking in the one day for half an hour, just to talk about their experience	It would be good to have it in the update training	MMMM M

		be good for someone …			
35	*I:*	Do you want to include something like this just to sharpen your, what shall I say, your approach to [yeah] to these patients? Just to remind you?			
36	*IV:*	Yeah, and just to appreciate the affect it has on people.	just to appreciate the affect it has on people.	us' involvement appreciated	EEEEE
37	*I:*	Maybe that is a recommendation , do you want to make a comment on the bottom there, just a note to actually help us to remember that this is a recommendation for the future?	I:		

38	*IV:*	Yeah. So, I just said service user involvement on the one day refresher training.	service user involvement on the one day refresher training.	service user involvement on the refresher training	MMMM M
39	*I:*	You made a comment here about patient discussion, so, to include them in the care planning and things so that they have some idea, can you do the same for us there, make a little note there? This one about restraint scenario, you were talking about that woman?	I:		
40	*IV:*	Yeah, so, it's like personalised care plans.	it's like personalise d care plans	Makes you plan care differently for each individual	D

41	*I:*	And to share it with them so that they know that this may well be a possibility at some stage and give them some idea of what is going to happen. I suppose that's particularly important if this is a new patient for you, who hasn't got a clue what's going on?	I:		
42	*IV:*	Yeah, definitely. And especially be mindful of people with PTSD, because you could be reliving, even if they don't have it, they could be reliving, they could relive an assault they had or sexual abuse or anything like that, when you're	And especially be mindful of people with PTSD	Patient sensitive restraint	GGGG

		restraining them, because they can be quite, you know?			
43	*I:*	Do you get army people …	I:		
44	*IV:*	No, but we have had people who have been sexually assaulted and people who have had been mugged and stuff like that. And then when you see five people who have to hold them down, they can relive that.	when you see five people who have to hold them down, they can relive that.	Patient sensitive restraint	GGGG
45	*I:*	Ok. So, sort of last question, you've obviously got lots of ideas and lots of ways of dealing with patients that are different now from before,	I:		

		from what you used to do before [yeah]. Do you find that sometimes the ward situation prevents you from using your new ideas?			
46	*IV:*	The ward environment [yeah]? No but I do think the environment plays a massive part in the reduction of violence and aggression. For example, it is just my own opinion but I think wards with gardens and open spaces, it's more therapeutic so I would imagine those have less restraints. And I think being in an enclosed ward	The ward environment [yeah]? No but I do think the environment plays a massive part in the reduction of violence and aggression. wards with gardens and open spaces, it's more therapeutic an enclosed ward where you can't go	ward environment can reduce or trigger violence gardens and open spaces, could be therapeutic an enclosed ward where you can't go out could be frustrating	NNNNN OOOOO PPPPP

		where you can't go out at all, I can imagine it is quite frustrating.	out at all, I can imagine it is quite frustrating.		
47	*I:*	Ok. So, the design of places, in fact, if you think of it, the old psychiatric hospitals and places had masses of grounds where you could walk all day. Whereas here, it's really much smaller and I've noticed this morning, because I've not been in here before, you've only got a little court yard down the stairs and that's it.			
48	*IV:*	Yeah. Safire has a garden and Coral Ward has a garden but none of the other			

		wards have a garden.			
49	I:	So, basically, design of a place can be a negative, with respect to the patients?			
50	IV:	Yeah.			
51	I:	Ok. That's really interesting, I haven't thought about that at all, like the design of a place could make you feel contained and like being in prison. And that may not be very good. Ok, do you want to say anything else about the training?			
52	IV:	No, just that the training is really good.	the training is really good.	the training is really good.	QQQQQ

53	*I:*	Other than the fact that you want it more often [laugh]?			
54	*IV:*	Yeah, when you said the training, did you mean the whole five days?			
55	*I:*	Yeah.			
56	*IV:*	Yeah, it has been good, I think it's well done, it's supportive, the trainers are really good and the service user involvement is really good.	it's supportive, the service user involvement is really good.	More of the su contribution is good.	LLLLL
57	*I:*	When you worked in other places, because you've obviously been around a bit?			

58	*IV:*	I've been on different wards, I haven't necessarily been in a different …			
59	*I:*	In a different hospital?			
60	*IV:*	I trained in a different hospital.			
61	*I:*	Is this training here very different from what you got there?			
62	*IV:*	It is similar, I wouldn't say it is massively different but it isn't the same, I don't think it was the same training.			
63	*I:*	And it didn't have the same impact on you?			

64	*IV:*	To be honest, when I was training, I didn't have PMVE at all, so I didn't, I wouldn't be able to comment on that to be honest. I wouldn't say it was any better or worse, just because I didn't do it.			
65	*I:*	Do you think that is dangerous?			
66	*IV:*	No because when you are a student on the wards you're not included in the numbers. So, there will always be a certain amount of staff and then you'll be additional.			

67	*I:*	So, you're not approved for that sort of thing.			
68	*IV:*	Yeah.			
69	*I:*	That could be pretty stressful because you know one day you're going to be in there.			
70	*IV:*	That's true.			
71	*I:*	Ok, thank you very much, that's it.			
72	*IV:*	Thank you very much.			

Appendix 19

The row numbered record of feedback data set

Row No	Sample No	Response	Essence	Category	Code
1.	1	Good to hear the good and bad examples. Explore how we all have similar emotional responses, in terms of anger, sad, and how this influences our reactions to things. Generated thoughtful responses from us as we got to hear what works: communication and building therapeutic relationships. Understanding people's triggers. More time, but because we were interested in what they both had to say Debrief – going back to communication	Good to hear the good and bad examples	good and bad experiences of restraint	EEEE
			Generated thoughtful responses from us	Promotes reflection	BBB
			communication and therapeutic relationships.	Communication	N
				therapeutic relationships	O
			Understanding people's triggers.	Greater understanding	MM
			we were interested in what they both had to say	interesting	E
			Debrief	Debriefing	Y
2.	12	The PMVA training session was very intense and helpful and we were able to learn different ways and	The PMVA training session was helpful	PMVA training is helpful	BB
			techniques of restraining a patient safely.	Safer techniques	HHH

		techniques of restraining a patient safely. The service user session was also very important as it help me to understand the feelings and thought of the service users and also understand their views and to know that restraint is not always necessary at all times.	Su session is very important	su involvement is very important	HHHHH
			it help me to understand the feelings and thought of the service users	su perspectives	A
			restraint is not always necessary at all times.	Restraint is a last resort	V
3.	23	Service user feedback was very good. Highlighted the good and bad experiences. Service users need to be treated with respect and we need to empathise with them. Good eye opener to know what/find out more about them before jumping the gun.	Su session was very good	very good	KK
			Service users need to be treated with respect and we need to empathise with them.	Promotes empathy, sympathy and compassion	G
			Good eye opener	An eye opener	E
4.	34	It was quite informative to have a service user involved with this PMVA training course. This will enable us to understand how the service users feel about	It was quite informative	informative	E
			enable us to understand how the service users feel about being restrained.	su perspectives	A

		being restrained. The violent behaviour exhibited by the service user to the staff that caused him to be subjected to excessive use of force during restraint could have been avoided if there was a good therapeutic relationship established between the nurses and the patient when he was admitted to the ward and for the Consultant to ask him if he was suicidal, rather than address the issue that triggered his violent behaviour as inappropriate and did not help the patient in any way. The experience of our meeting with the service user would enable us to handle our patients sensitively and to demonstrate empathy…	restraint could have been avoided if there was a good therapeutic relationship	therapeutic relationship	O
			The experience of our meeting with the service user would enable us to handle our patients sensitively and enable us to handle our patients sensitively and to demonstrate empathy…	Thought us how to work with our patients	XXXXX
				Be empathetic and sensitive…	U

5.	45	I think the session today with the service user was a really great idea. She helped to really emphasise the importance of communication and care before restraint – if restraint is really necessary then it will come after all communication and de-escalation has been attempted. The speaker gave us insight as to how service users may experience emotion beside their illness. This session is certainly something that should happen at the end of every PMVA training course.	the session today with the service user was a really great idea.	a great idea	E
			emphasise the importance of communication and care before restraint	communication and care	N
			if restraint is really necessary then it will come after all communication and de-escalation has been attempted. restraint as a last resort	communication	N
				de-escalation	P
				last resort	V
			gave us insight as to how service users may experience emotion	insight	E
			This session is certainly something that should happen at the end of every PMVA training course.	su involvement is very important	HHHHH
6.	56	The session with the su was very good because he made me understand things better:	A very good session.	very good	KK
			He made me understand better	Greater understand	MM

		From a patient point of view Then understanding what patient feel like when in hospital Understanding how to behave to patient on a day to day Good communication, and giving one to one regularly. Try to understand patient first before making a decision to restrain patient. Always carry out a risk assessment before taking decision on patient behaviour. Always work as a team and support your team at all times.	Understanding how to behave to patient on a day to day	Thought us how to work with our patients	XXXXX
			Good communication	communicatio n	N
			Try to understand patient first before making a decision to restrain patient.	Talk to patients	H
			carry out a risk assessment before taking decision on patient behaviour	assessment	RR
			Always work as a team and support your team at all times.	Team work	EE
7.	67	The session with the service user was very interesting as it highlighted the perspective of a restraint from the receiving end. It was interesting that they also had a form of a good experience in being restrained as they underlined the	service user was very interesting	very interesting	E
			perspectives of a restraint from su end	Su perspectives	A
			they underlined the fact that sometimes it may save lives.	Restraint is necessary	AAA

		fact that sometimes it may save lives. However it was also very sad to see that restraint is also used with excessive force and unnecessary techniques; definitely at times a way to just punish. Very useful to hear their perspectives			
			very sad to see that restraint is also used with excessive force a	Excessive force	MMM
			at times a way to just punish.	restraint as punishment	IIII
			very useful to hear su perspectives	su perspectives	A
8.	78	The service user session was the most interesting and helpful part of the whole training. Hearing a real life experience who had 1 bad experience and 1 good experience of being restrained really ingrained the whole process of how to treat a patient with respect and dignity whilst keeping them safe as well as the importance of attitude and communication especially after being restrained. It is a behaviour/thoug	Su session was the most interesting and helpful part of the whole training.	the most interesting and helpful part	E KK
			ingrained the whole process of how to treat a patient with respect and dignity whilst keeping them safe as well	Be empathetic, respectful, non-patronising	U
			The importance of communication and	Communicati on	N
			attitude was highlighted	and attitude	CC
			It is a behaviour/thoug ht I'll remember when working and	It will inform my practice	KKKKK

		ht I'll remember when working and I will encourage my colleagues to do the same. The service user said it took one person to talk to her and treat her well for her life to change, for that reason, I will always take on board what she said in the session.	I will encourage my colleagues to do the same.	Sharing learning with team members	YYYY
			I will always take on board what she said in the session.	It will inform my practice	KKKKK
9.	89	The service user addition to the PMVA course was both entertaining and of enormous value. It added to our understanding from All sides, and can only strengthen our abilities as Practitioners	The su contribution was both entertaining and of enormous value.	both entertaining and of enormous value.	JJJJJJ
			It added to our understanding	Greater understanding	MM
			can only strengthen our abilities as Practitioners	Su contribution can only strengthen our abilities as Practitioners	KKKKKK
10	100	The service user came today to speak to the training group about his good and bad experiences of how staff restrain patients. The session was excellent as I really like his presentation	The su session was excellent	was excellent	E
			lack of debriefing	debriefing	Y
			staff lack relationship with patients	relationship	O
			The presentation	Su session has	LLLLLL

		about lack of debriefing and how staff lack relationship with patients. The presentation has broadened my knowledge and I hope to go and practice what I have learnt from the session in the ward.	has broadened my knowledge	broadened my knowledge	
			I hope to go and practice what I have learnt from the session in the ward.	It will inform my practice	KKKKK
11	109	It was really helpful to hear from the service user, his personal experience of restraint Like all of us, patients on the ward do feel different emotions and they can be angry as well. We should always try to de-escalate and find out what's happened before planning a restraint. It made me think the importance of not using force when restraining and always debrief, so we can avoid another situation like this.	It was really helpful to hear from the service user,	really helpful.	KK
			Like all of us, patients on the ward do feel different emotions and they can be angry	Emotions	SS
			We should always try to de-escalate and	de-escalation	P
			find out what's happened before planning a restraint.	Talk to patients	H
			made me think the importance of not using force when restraining and	Excessive force	MMM
			always debrief	debriefing after restraint	Y

		Communicating with patients is very important and will make it more safe next time a situation like that happens. Thanks.	Communicating with patients is very important	Communicati on	N

Appendix 20

My worldview

Parahoo (20014) argues that people can have different beliefs such as spiritual, religious and scientific beliefs. He further states that people could be eclectic in their belief. This means that they can borrow elements from different belief systems to help them make sense of the world around them. I can identify with this theory. I hold religious beliefs. I strongly believe that there is a power bigger than man. I believe that this power whom I call God, loves us human beings and that one of the ways that we can reciprocate this love is to be honest and fair in our dealings with fellow human beings. I also acknowledge and appreciate the achievements of man through science notwithstanding the limitations and the constant changes. Smith (1992) aptly flags up this weakness of science when he states in a guest editorial - the ethics of ignorance: "*I want to argue here that the scientific base of medicine is weak and that it would be better for everybody if that fact were more widely recognised*" (Smith 1992 p117).

As a professional hotelier, I held a senior management position in a four star hotel, and was responsible for more than two hundred and fifty staff. I loved the job and I loved working with the Hotel employees. But I resigned my post because of unfair treatment of my staff when there was a change of directors in the hotel. This is a world view I need to be mindful of to ensure that wittingly or unwittingly, it does not influence issues in the field or my interpretation of data.

I joined the health services determined to keep a low profile working in the learning disability sector. Some force however kept pointing me out and propelling me to where I least aspired to go. I found myself at a Higher Institution, a member of the PMVA training team. Again, I could have relaxed and simply delivered the training just like my colleagues. But that other force inside of me would not leave me be. The urge to do more would not abate. We give the practitioners the skills to restrain their patients - vulnerable individuals. Are the staff using the skills and knowledge as taught and with the care of the patients in mind? To find out, I decided to carry out a study on mental health service users' experience of being restrained in local NHS inpatient hospitals

(Obi-Udeaja 2009). The information from the study was so powerful and touching that my colleagues and I felt that the practitioners on our training course needed to hear it. Hence the imbedding of mental health service users' involvement in my team's training delivery. We believed that the service users' contribution to this unique subject area would support the principle of patient care during physical restraint which our model of training promotes.

In my world view of fairness and impartiality, I decided to conduct another study (patient centred physical restraint: a case study of two NHS inpatient wards (Obi-Udeaja 2016), this time with the mental health inpatient ward staff who actually carry out the restraint procedures that we teach. I wanted to get their side of the story on what actually happens during a physical restraint process. The numerous things they say that they do in an attempt to achieve patient centred physical restraint are very commendable. The study provides part of the reason for the current enquiry aimed at finding out whether such patient centred practices by staff are the result of lessons they took away from service user sessions during training.

Indicative of my world view is someone who feels discomfort when others are suffering. Someone who would readily undergo personal discomfort to alleviate another's problem. Alleviating others' problem invariably entails interacting with them and understanding their problem. This sits well with my ontological and epistemological view points and my choice of qualitative description research design as earlier discussed.

But as many authors have warned, close interaction with research subjects has its attendant challenges with regard to the ethics of research practice. Some authors including Ravitch and Carl (2021) and Fox et al. (2007) suggest a critical and reflexive examination of ones 'positionality' represented usually by the term 'insider/outsider' researcher (Pringle et al. 2011). My position in this study calls upon me to acknowledge and critically examine the possible effect that my beliefs and my experiences may have on my study participants and on my study. Putting it succinctly, Hopkins (2007) recommends that researchers should critically consider the position they adopt in relation to those being

researched, and the implications of such positions with regard to the ethics of research practice.

Appendix 21

Presentations and publications so far on the researched subject

Presentations	Publications
	Obi-Udeaja, J. Kerr, C. & Weller, G. (2020). Impacts of service user involvement in mental health nurse training on management of aggression: A Qualitative Description Research. Work Based Learning e-Journal, Vol. 9, No. 2.b. https://wblearning-ejournal.com/uploads/text_with_images/5.janeobiudeajaimpactsofserviceuserinvolvementinmentalhealthnursetraining1607381124.pdf
	Obi-Udeaja, J. KC. RG. (2020). An account of service users' involvement in training delivery on the prevention and management of violence and aggression: the impact on practice. (pending publication)
Crosby, K. Ryan, G. & Obi-Udeaja, J. (2017). The involvement of service users in the prevention and management of violence and aggression (PMVA) training. A presentation at the General Services Association (GSA) 11th Annual Conference. Newcastle 2017.	Obi-Udeaja, J. for PMVA Team. (2018). Co-Production to reduce violence and aggression on mental health wards. 11 Jul 2018 by My Care Academy, All, Co-Production, Mental Health http://www.mycareacademy.org/all/co-production-to-reduce-violence-and-aggression-on-mental-health-wards/
Crosby, K. Ryan, G. & Obi-Udeaja, J. (2015). A presentation to the Camden and Islington NHS foundation trust board of directors on PMVA highlighting the positive and negative aspects of restraint. St Pancras hospital, London.	Obi-Udeaja, J. Crosby, K., & Ryan, G. (2015). Minutes of a meeting of the Camden and Islington NHS foundation trust board of directors held in public in the conference hall, St Pancras hospital, London on the presentation to the Camden and Islington NHS foundation

	trust board of directors [Online] Appendix 2
Obi-Udeaja, J. (2016). Patient centred physical restraint: a case study of two NHS mental health inpatient wards. A poster presentation at the 5th international Conference on Violence in the Health Sector, Dublin.	Obi-Udeaja, J. (2016). Patient centred physical restraint: a case study of two NHS mental health inpatient wards. An open access repository of Middlesex University research
Ryan, G. Crosby, K & Obi-Udeaja, J. (2015). Participation in a debate on 'Meeting of the minds': closing the gap between violence research, education and practice, at the 9th European Congress on Violence in Clinical Psychiatry held in Copenhagen in October 2015.	Obi-Udeaja, J. Crosby, K., & Ryan, G. (2017).Involving service users in teaching healthcare professionals about physical restraint. Mental Health Practice. 21, 4, 36-39. **doi:** 10.7748/mhp.2017.e1238
Crosby, K. Ryan, G. & Obi-Udeaja, J. (2014). Service user involvement in training for the prevention and management of violence & aggression: A workshop presentation at the European Network for Training in the Management of Aggression (ENTMA08) Symposium, Dublin, November 2014	Obi-Udeaja, J. Crosby, K., & Ryan, G. (2016). Involving service users in training in the management of aggression. **Mental Health Practice.** 19, 7, 23-25. **doi:** 10.7748/mhp.19.7.23.s18
Crosby, K. Ryan, G. & Obi-Udeaja, J. (2012). Authenticity to action, 'Service User and Carer involvement in hard times' conference presentation, University of Central Lancashire	Obi-Udeaja, J. Crosby, K. & Ryan, G. (2012). University of Central Lancashire (UCLAN) 4th Authenticity to Action Conference: Service User and Carer Involvement in 'Hard Times' 'Numis' Report, 2nd edition 2012.
Obi-Udeaja, J. (2010). An exploration of mental health service users' and carers' experience of	Obi-Udeaja, J. (2009). An exploration of mental health service users' and carers' experience of being physically

being physically restrained in local NHS in-patient wards. A presentation at the General Services Association Annual Conference, Edinburgh.	restrained in local NHS in-patient wards. An open access repository of Middlesex University research
Crosby, K., Ryan, G. & Obi-Udeaja, J. (2010). Service user involvement in training for the therapeutic management of violence and aggression. A presentation at the General Services Association Annual Conference, Edinburgh.	Obi-Udeaja J. , Crosby K. , Ryan G. , Sukhram D. & Holmshaw J. (2010). "Service User Involvement in Training for the Therapeutic Management of Violence and Aggression", *Mental Health and Learning Disabilities Research and Practice*. 7(2). doi: https://doi.org/10.5920/mhldrp.2010.72185
Crosby, K., Ryan, G. & Obi-Udeaja, J. (2009). Service user involvement in training for the therapeutic management of violence and aggression. A workshop presentation at the Mental Health Education and Training Conference, Hendon Campus, Middlesex University	