Impacts Of Service User Involvement In Mental Health Nurse Training On Management Of Aggression: A Qualitative Description Research

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The involvement of mental health service users in a Higher Institution prevention and management of violence and aggression (PMVA) team's training delivery is a recognition of the contribution that the unique insights of people's lived experience can make to the development of practitioners. This research aimed to determine whether or not their contribution to PMVA training delivery influenced the staff management of patients' anger or aggression on mental health wards. The qualitative description research design was adopted for the study. Focus group interviews were used to collect data from final year mental health students and new trust staff, while semi-structured interviews were employed to collect data from experienced trust staff. A sample of feedback from previous training records was reviewed. The findings showed that: the students and new trust staff were determined to translate lessons learnt into practice; the experienced staff were reflecting lessons in ward practices; the feedback records held expressed intentions to translate lessons into practice; there were hindrances in practicing as discussed with service users. The findings confirmed those from other studies claiming that service user involvement in the education of professionals has the potential to improve practice.

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Introduction

Restrictive interventions such as physical restraint (PR) are often used to manage challenging incidents in healthcare settings particularly in mental health inpatient wards. The obligation to use such interventions with patient care in mind is emphasised in literature and guidelines (Duffy, 2017; Knowles et al., 2015; NICE, 2015; DH, 2014). Nevertheless, the potential to cause harm and indeed to be abused by staff remains a concern. Hence, physical restraint is regarded as controversial (Moran et al., 2009; Irwin, 2006). McKenna (2016) and Brophy et al. (2016) consider the use of restrictive interventions particularly physical restraint as coercive violations of the 'human rights' of those affected.

The abuse of physical restraint and its potential negative effects trigger calls nationally and internationally to eliminate or at least reduce its use (Clark et al. 2017; CQC 2017; UN 2006). Most recently, the Restraint Reduction Network (RRN) training standards accreditation was introduced to monitor a systemic progression to restraint reduction in the UK (Ridley & Leitch, 2019). Furthermore, suggestions are made for healthcare organisations to attach high importance to and direct resources towards proactive and preventative alternatives to restrictive interventions (Riahi et al., 2016; Wisdom et al., 2015). Consequently, there is a growing body of literature reporting on alternatives to physical restraint. Authors including Bowers (2014) and Foster et al. (2007) are convinced that tuning into the reasons for patient's aggressive behaviour can facilitate ways other than restrictive interventions 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'*. Reinforcing, Clarke et al. (2017) explain that the behaviour support plans (BSP) aim to proactively reduce restrictive practices through an examination of factors that can affect patients' behaviours. It is noteworthy that activities regarded as routine hospital care can in fact constitute restrictive practices (Whyte, 2016).

Invariably, a genuine effort by staff to understand all possible causes of a patient's behaviour would require working closely and collaboratively with that patient. Reiterating, authors including Allen (2011) emphasise that achieving restraint reduction might require multiple strategies including consumer participation. Following his literature review Scanlan (2010) revealed seven key strategies for restraint reduction among which was again consumer involvement. These authors and many others are in agreement that a combination of multiple strategies could result in a reduction in the use of physical restraint. Of particular interest is the inclusion of consumer/service user involvement in every listed group of interventions that could reduce the use of physical restraint. For example, emphatically included on the list of 'six core strategies' for a systematic service-based approach to reducing the use of restrictive interventions by Huckshorn (2006 p2) is employing the expertise of service users/their families/advocates to work alongside clinical staff. This 'alongside' working is sometimes referred to as co-production or service user (SU) involvement. Explaining *co-production*, Ramsden (2010 p7) 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'*. With reference to mental health and social work care, SU involvement in education and training is an acknowledgement that people who use services have valuable knowledge and expertise resulting from their lived experience of the condition … (Ryan and Carr, 2016).

SU involvement notion has driven government policies internationally (Dreissens et al., 2016; Speed et al., 2012). It has been reflected in numerous national guidelines, and initiatives including NICE (2015), Mind and NSUN (2015) and NMC (2010). 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 (DH, 2014). There has been an expanding body of literature exploring the subject area of SU involvement in the education and training of health and social care professionals (McIntosh, 2018; Happel et al., 2014). However, there still seems to be a paucity of research with regard to its deeper impact on practice learning (Alida et al.,

2013). Morgan and Jones (2009) observe that this might be due to the challenges in determining the impact of learning on practice. Such learning they argue does not happen in isolation of other learning strategies, practice and nursing students' life experiences.

Background to the research

The principal author works within a Higher Institution (HI) team that provides training on the prevention and management of violence and aggression (PMVA) in healthcare settings. The training is delivered in a non-operational setting away from the ward environment. As trainers, the team recognize the potential rift between the theoretical principles emphasized in training and the staff practice on the ward. Jordan (1994 p.418) defines theory–practice gap as '*the divide between abstract possibly esoteric concepts and the real problems of everyday clinical practice'*. Theory–practice gap, for example, 'field modifications' of restraint techniques can occur for various reasons including fear as explained by Terkelsen and Larsen (2016) and by Paterson (2007). One of the ways the team try to bridge this gap is to invite mental health service users (living in the community) who have experienced being restrained while on inpatient ward to co-train with them.

The involvement of service users in the team's training is a recognition of the contribution that the unique insights of people's lived experience can make to the development of practitioners. While SU involvement in the training of social and healthcare practitioners in a normal teaching and learning setting has become a common practice and a mandatory requirement (NMC 2010), their involvement in PMVA training, a unique subject area, is still a new phenomenon. As a pioneer of the initiative the lead author started the co-training development in 2008. It has since continued and has consistently received very positive feedback from course participants. Furthermore, the team share their experience of working together in conferences and publications including: Obi-Udeaja, Crosby and Ryan (2017), Obi-Udeaja et al. (2010) and Obi-Udeaja (2009). The service users' contribution is powerful and has the potential to influence practice. This study sought to find out whether it actually influenced the staff management of patients' anger and aggression on the wards.

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?

Methodology

The qualitative description research design (Bradshaw et al., 2017; Sandelowsk, 2000) was adopted for this research because the research question identifies with descriptive approach in assuming that there is a contribution to practice that can be abstracted from data (Lopez & Willis, 2004). The approach is in line with the principal author's research aim to produce a straight description of the phenomenon under study using participants' language and staying close to the data. Furthermore, service user involvement in PMVA training delivery is a new initiative. Authors including Polit and Beck (2012) 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 it.

Method

Two focus group interviews of ten new mental health inpatient ward staff and ten mental health final year students were conducted. Semi-structured interviews of ten experienced mental health inpatient ward staff were carried out. A review of a sample from 111 records of feedback from previous PMVA training participants was carried out.

Ethical issues

An approval for the research was obtained from the HI Health and Social Care Ethics Sub-committee. The collaborative engagement with the trust managers at the hospital sites where the semi-structured interviews took place enabled helpful information, and the gaining of permission from the relevant hospital authorities. Reflexivity, criticality and collaboration (Ravitch & Carl 2021) enabled continuous monitoring in order to promptly identify and attend to potential impact of the study on any of the stakeholders (Parahoo, 2014). Written information about the study and further information as required was promptly provided. It was explained to research participants that participation was

voluntary, and that one was free to withdraw at any point (up to one month after data analysis) without explanation. Pseudonyms were used to effect anonymity of participants.

Sampling and data collection strategies

Purposive sampling was deemed appropriate and was used for data collection because the data sources participated in the PMVA SU session and could talk about the experience (Polit & Beck 2017).

The focus group interviews conducted at the HI location collected data from the students and separately from the Trusts' new staff. Each group comprised ten male and female in the age range of 20 to 50 and 20 to 35 years respectively.

The semi-structured interviews collected data from staff at two differently located NHS hospital sites. The participants comprised six male and four female in the age range of 20 to 50 years and with one to sixteen years of practice experience. Five of the participants were staff nurses, one a charge nurse, one a ward manager, one an assistant practitioner, one an activity worker and one a Nurse Assistant Band 4.

A random sampling of one in ten yielded eleven records of feedback in the past two years from the date of the record search. This was in compliance with the HI two years archiving policy at the time of data collection. The identified records were reviewed.

The adequate sample size for each category enabled a collection of rich, powerful and sufficient responses to the research question (Fawcett & Garity, 2009). Figure 1 illustrates the sources of data. Table 1 shows the inclusion criteria for the interviews.
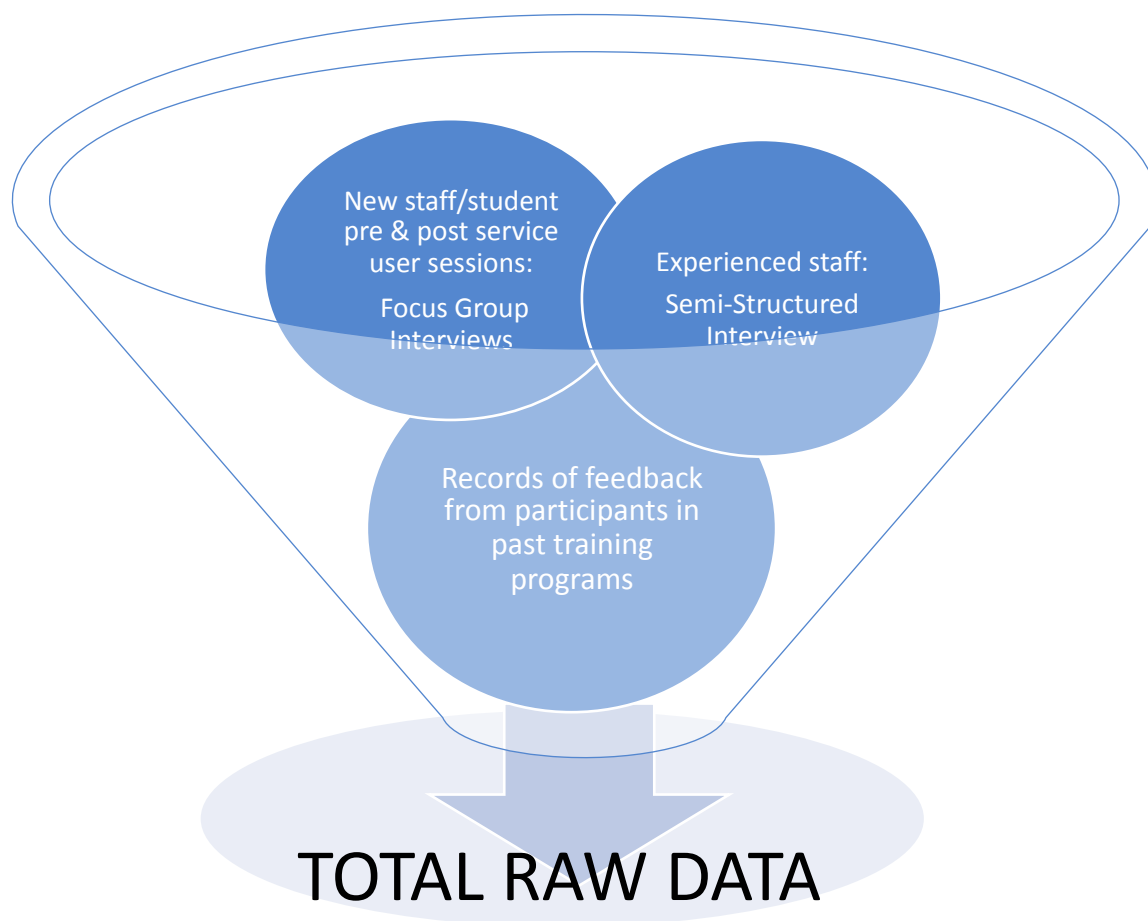
Fig 1: Diagram illustrating the sources of data collected

Table 1: Study Participants Inclusion Criteria

Focus Group Interview	Semi-structured Interview	Feedback Records
The NHS Trust mental health inpatient ward staff and	The NHS Trust mental health inpatient ward staff members	All records of feedback from PMVA training participants
The final year mental health students of a HI	Who participated in the SU session when they attended the 5Day PMVA training at least six months prior to data collection	Within the HI two years archiving policy
Who attended the 5Day PMVA training and participated in the SU		

session Who were willing to participate in the interview	Who were still working on the ward at the time of data collection Who were willing to participate	

Piloting the research instruments

Pilot studies were conducted two weeks before the first actual interview session. Approximately forty minutes were adequate for a semi-structured interview and an hour for a focus group session. To make 'non coercion' obvious, a separate room was booked for the interviews. Also, to minimise bias and to avoid trainer-trainee influence, a moderator who had no prior acquaintance with the participants was engaged. The semi-structured interview schedule refreshed the participant's memory on the SU session prior to the key questions. This was considered important as the participants might have forgotten the details of their discussion with the SUs due to time lapse. The schedule is explained in Box 1. Permission was obtained from the participants to tape-record the interviews and for the principal author and a colleague to sit at a corner to take notes.

Box 1: 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 particular and in

> the establishment generally that may constrain or enable the implementation of lessons from the SU contribution to PMVA training
>
> - The participant is given the opportunity to share any other concern, work related or not about the phenomenon

Analysis

The tape recorded responses from the participants were cross-checked for consistency with their signed written responses. Driven by the research question and the theoretical assumption (Braun & Clarke, 2013; 2006), decision was made to use the thematic analysis (TA) method. The method captures patterns (themes) across qualitative datasets and is popular with interviews and focus groups generated data (Braun et al., 2018). The emerging information from the analysis was continuously compared for consistency with the detailed notes from the field work. In consideration of the qualitative description principle and the author's insider researcher position, she reflexively kept herself close to the data in order to minimise bias. Every identified category was acknowledged and given attention irrespective of number of appearances. In the spirit of collaboration (Ravitch & Carl, 2021) the independent analysis by the second author provided a valuable second opinion. Table 2 shows the process followed in deriving the themes. Table 3 displays the themes and sub-themes used in presenting the findings. And Table 4 holds the key to the quotes from data sets.

Table 2: Process of thematic analysis (modified from Braun et al., 2018)

1. Familiarization with data	Transcribed data, written responses and sampled records of feedback read over and over. Audio-tapes listened to again and again – ideas noted and compared with those from fieldwork.
2. Generating codes	Meaning units/essences were pulled out from participants' responses. These were categorised/ coded.

3. Constructing themes	Related categories/codes were grouped together into category sets to form candidate themes. The candidate themes and their category sets were scrutinised for emergent themes and sub-themes.
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	Use themes and sub themes (Table 4) to present the findings supporting with quotes from participants. Underpin with relevant literature.

Table 3: Themes and sub-themes used in presenting the findings

Themes	Sub-themes
Service users' contribution to PMVA training	SU involvement draws attention to patient's perspectives
	It is useful for practice
Working with patients	Involve patients in their care
	Is PR always avoidable?
Challenges to implementation of SU contribution	Staffing issues
	Policies
	Environmental issues

	Allied professionals

Table 4: Key to quotes from data sets

RF	Record of feedback (from previous training)
FGT	Focus group (Trust staff)
FGS	Focus group (Students)
SS	Semi-structured interview (Experienced practitioner)
Rn	Row number
Service user PMVA trainers: Marta and Bob (pseudonyms)	

Table 14 holds the key to the quotes in the findings. Pseudonyms replace participants' names.

Findings:

Theme 1: Service users' contribution to PMVA training delivery

Service user (SU) involvement draws attention to patient's perspectives

SU involvement in PMVA training delivery meant that the participants in the training heard and discussed service users' views on physical restraint (PR), an exercise that could promote a reflection on practice. There was a keenness on the part of the study participants to hear what the SUs had to say.

> *I'm 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: FGS)***.*

The participants believed that discussions with SUs might provoke ideas of how to prevent patients' anger and aggression in the first instance or how to support and de-escalate patients when they were disturbed. That way, situations could be prevented from becoming full-blown incidents that required PR.

> *… 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? … 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)**.

Participants were impressed by the rich and balanced content of the service users' contribution. And particularly by the fact that they talked about restraint experiences that they considered as negative as well as those they perceived as positive. Apparently, this balanced view of the narrative whetted the interest of the participants and made them to engage actively in the discussion and to take seriously the lessons learnt.

> *… 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 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)**

Their contribution is useful for practice

Participants considered the contributions from the SUs as powerful, challenging them (participants) to understand and connect to patients' perspectives. The feedback from past PMVA training strongly acknowledged that the SU contribution could make a positive difference in the practice environment.

> *The SU session was the most interesting and helpful part of the whole training. … 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)**.

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 … **(Tasia: RF)**.

The diversity of responses from the focus group participants indicated how personally and differently the experience touched them. They started to question their purpose for restraining patients

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 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: FGT)**

Following their discussion with the SUs, participants became convinced about the need to debrief everybody involved in a restraint process (patient, staff and witnesses) especially the patient.

For me, what I've taken from next door (SU session) is that definitely, after the whole restraint, I've always feared that the patient is probably still very angry from the restraint. So I never really try to have that conversation with them and I always try to avoid that conversation about how they felt but now for me, 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: FGT)**.

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.

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: FGS**).

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

> *Meeting with the SUs changed the way I think about things* **(Kevin SS)**.

Clarifying with an example Kevin continued:

> *It's (PR) an intervention which as it is we have to provide information about medication to the service users. We have to provide information about psychosocial interventions. Why shouldn't we have … information on PR for the service user …?* **(Kevin SS)**.

Helen, now an experienced staff member, accessed the PMVA training as a student. She talked about the impact of the service users' session on her early practice.

> *I wasn't really restraining before the training because I was still a student ... That's why it was useful to hear from the SUs because I didn't really have a clue. So, when I did start restraining I started to use those things …* **(Helen SS)**.

Carrying on, Helen shared how the experience continued to influence her practice.

> *Yes, it has made me try to avoid using restraint. … like if someone's not taking their medication, maybe …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 started talking to patients after restraint* **(Helen SS).**

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

> *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. … 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 SS).**

Our approach with our patients determines the way they might want to relate to us in Susan's opinion. She shared how the session facilitated by Bob (SU) touched her:

> *I believe sometimes it's … the way we approach patients and sometimes staff we need to learn how to. Bob 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 having that meeting time with Bob, honestly, it really helped me* **(Susan SS).**

Similarly, Andy felt emotional about the experience. He shared what the SU suggested could lessen the trauma of PR experience:

> *He mentioned how to make it a better experience …, if you're having to restrain a person …, just letting him know what the process is, who you are and who the team is, and that has been what I have been doing …* **(Andy SS)***.*

Reflecting on their discussion with the SU who said that it took six years for him to learn what his diagnosis actually was, 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)***.*

The session with the SUs 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. 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. I try and talk to them. … 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 the relationship that you've been building. …* **(Sam SS)**.

Further to Sam's opinion, some participants said that participating in the restraint of their patients might lead to a breakdown of the therapeutic relationship with the patient. The importance of rebuilding such relationship was stressed.

> *I think as staff, we need to just be very honest. Even if … 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 FGT)**.

The above evidences show how contributions from SUs enhanced or could enhance practice. In the next session, the participants considered further ways to implement lessons learnt and took a more realistic look at physical restraint.

Theme2: Working with patients

Involve patients in their care

The session with the SUs provoked discussions on ways to reduce patients' anger and aggression such as: assessing patients on admission and maintaining an ongoing assessment, care plans based on the assessed needs and reflecting patients' preferences in the plan, all devised in partnership with patients.

> *Once you identify someone at risk of 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, for what happens afterwards …?* **(Andy SS)**.

> *It is important to engage with 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 FGT)**.

Effective communication and therapeutic relationship with the patients were considered fundamental for a conducive ward environment with minimal need for physical restraint. Timely communication the participants said, could clarify issues and aid understanding:

> *… any situation has to be assessed according to its dynamics. If you feel that it*
> *doesn't warrant physical restraint, work around it. … it's communication*
> *basically ...* **(Kevin SS)**.

Emphasizing on therapeutic relationship and on allowing patients to speak with someone to whom they relate well, Nora shared an experience:

> *I have seen a situation where the plan was that this patient had to be*
> *restrained… Everyone turned up and then the patient said, 'Oh, you're part of*
> *the team. Are you going to restrain me? Okay, I don't mind. I can talk to you*
> *but I'm not talking to this nurse. I'll take the medication from you'. …*
> *Eventually, ... you don't even have to restrain anymore, just because of the*
> *relationship that the patient has …* **(Nora FGS)**.

Is physical restraint always avoidable?

The responses from the study participants indicated that their encounter with the SU trainers made them to look critically at what happened on the wards with particular focus on preventing or de-escalating incidents and avoiding PR. But, they also acknowledged that realistically there could be situations when PR may become inevitable:

> *… many times we 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* **(Fab FGS)**.

Some participants who had been against the use of PR actually reconsidered their stance following their session with the SUs. Referring to the case of the SU with bipolar disorder who made to run into a busy road but was restrained by the staff one 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 FGT).**

The contributions from the SUs gave them food for thought the participants said, and challenged them to always consider ways to relate and work cordially with their patients so as to avoid or minimise the use of PR. But, there were work related challenges against practising as discussed with service users they said.

Theme3: Challenges to implementation of SU contribution to PMVA training

Participants considered issues that might hinder their ability to practise as discussed with the service users including:

Staffing issues

Problems directly linked to staffing at work places tended to undermine their effort to practice as discussed the participants said. Staff shortage was identified as the fundamental problem giving rise to other issues. 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. …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. …* **(Sam SS)**.

Ultimately, staff shortage could sometimes mean working with agency staff or bank staff, an unfamiliar colleague, who might not know the patients.

> *Yes, people that you don't know* **(Lucy FGS)***.*

> *In the session, they (SUs) 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. Whereas, another staff might just de-escalate that situation …* **(Lisa FGS)**

The unfamiliar staff scenario sometimes involved other challenges such as team members who trained differently and probably held a differing opinion on PR:

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

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

> *Even 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 FGS)**

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:

> *I think a lot of people in some mental health establishments like that 'gung ho', that's taking down. … They get their little bit of adrenalin going and it's like, 'Oh, we can take them down. I'm bigger than them.' …* **(Janice FGT)**

Some participants observed that the Response Team's role portrayed 'power imbalance' where an over powering number of personnel gathered at once to confront a patient whose behaviour was considered challenging:

> *I think that does unsettle people as well when you come in 8 and 10* **(Susan SS).**

> *The problem … when the alarm is called everybody just rushes in…* **(Ade FGT).**

On the other hand, the Response Team was viewed differently, even favourably when the team engaged the patient in a dialogue in order to resolve issues. As a result, the patient cooperated and no PR was involved.

> *… 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).**

The conversation with the SUs 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:

> *… 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 FGS)***.*

There was concern however that raising issues might attract negative responses from colleagues. Such could be 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. … 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* **(Ada FGT)***.*

Policies

Policies such as smoking ban caused patients to push boundaries the participants said. Asked whether the ban particularly triggered aggression in patients? Roger responded:

> *Definitely I believe so … if somebody's really unwell it might not be the right time to go about doing smoking cessation. To them it makes them feel calmer, if they could just have one cigarette … But this could be a trigger for irritation, agitation for the whole day … which can escalate further to the point where the patient might damage property or assault somebody - just to*

try and get out to smoke. … that's where the main incidents are actually

coming from these days. **(Roger SS)**.

Environmental issues

In the participants' opinion, moving patients away from a stimulating environment could de-escalate an incident and prevent PR. This could be in the form of moving to a quiet de-escalation space some said. There was concern however that such facilities were not common in mental health establishments.

> *… this is 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. … People might want fresh air. …* **(Roger SS)**.

Patient friendly establishments with secure outdoor spaces for fresh air could enhance calmness in patients the participants said. Whereas the contrast could trigger frustration and aggression and ultimately endorse the use of PR.

> *I do think the environment plays a massive part in the reduction of violence and aggression. For example, … 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)**.

Allied professionals

The non-involvement of allied professionals (Doctors, Activity Workers, Occupational Therapists (OTs)…) in patient restraint triggered a debate among the Trust staff focus group study participants. Some thought that participating in PR might negatively affect the therapeutic relationship of such professionals with patients:

> *I think the downside of allied professionals starting to restrain is that patients aren't used to them being on that side with the nurses. … I don't know how that would impact …***(Kate FGT).**

But some questioned the fairness of it all where the allied professionals would shy away from patient restraint and the nurses are left all alone to deal with it:

> *… So, the activity workers weren't trained, the OTs are not doing restraint, doctors 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 FGT)***.*

Making a crucial point, an activity worker stated that restraining in a caring manner 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' …* **(Ade FGT).**

As if summarising, a registered mental health nurse said:

> *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 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, or other professionals* **(Rose FGT)***.*

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 regard 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.

Discussion

This research aimed to determine whether or not the contribution of service users to PMVA training influenced the way that participants in the study intended to manage or actually managed disruptive incidents that involved patients. The observations by Morgan and Jones (2009) about the challenges in determining the impact of learning on practice would apply in this case. However, the research instruments for the investigation were considered robust enough to have satisfactorily answered the research question.

The service users (SUs) sought to motivate the research participants to avoid physical restraint (PR) or to use it caringly if they must. The findings showed keenness on the part of the study participants to hear what the SUs had to say. The 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 contributions affected people in different ways according to the findings. The inexperienced participants including the feedback from previous training considered the SU session the most helpful part of the PMVA training. The narrations of real life experience of physical restraint apparently touched many of them and as they put it, ingrained in them how to treat patients with respect and dignity. They vowed to reflect the lessons from the session in practice. Meanwhile, one experienced practitioner said rather simply that the experience changed her. And yet another was sure that he did not need to change his practice because he was already practising as discussed. 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 in PR situations, one tended to automatically focus on the physical aspects of PR process. Similarly in Moran et al. (2009) staff reported that restraint situations could be emotionally draining 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 the PR process.

The experienced practitioners used their respective ward scenarios to elucidate how the lessons from SU session were translated into practice. This included working closely with the patients in devising care plans for example, and engaging more with them in line with guidelines (NICE, 2015; DH, 2014; NMC, 2010). According to the behaviour support plans (Clark et al., 2017), working closely with the patient could proactively reduce restrictive practices. Resorting to PR could break relationship according to the finding. The importance of rebuilding such relationship was highlighted in the study. A participant shuddered at the thought of restraining patients and not speaking to them afterwards. It would seem like one was attacking them she concluded. Studies including Mackenna (2016) and Scanlan (2010) emphasise the importance of debriefing after PR. An honest examination of an incident by all involved could ensure the retention of relationship and perhaps even enhance it. However, an unnecessary and abusive restraint might result to the patient avoiding engagement which would make it difficult for the parties to repair the relationship (Knowles et al., 2015). Participants admitted that the contribution from the SUs challenged them to reconsider their practice. For example, some wondered why service users were not provided information on PR. This becomes a very pertinent question considering that the standards for pre-registration nursing education mandate the mental health nurses to ensure that patients 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 SU session encourages candour. So, the discussions sometimes reveal facts that potentially make the practitioners uncomfortable. Such was the case when the SU trainer shared how for six years he had no understanding about his diagnosis and was non-compliant with medication. Consequently, he was often in hospital admission, during which periods he repeatedly experienced PR. The practitioners in the session felt uncomfortable about such lapse by colleagues. In Obi-Udeaja et al. (2017) a service user believed that if the

clinicians were uncomfortable in a meeting with service users it meant that service user views were getting across. The reverse would be the case if they were comfortable.

The above findings showed obvious willingness, in fact enthusiasm to implement as discussed in the SU session. However, there were concerns about work related hindrances to practising as discussed. For example, shortage of staff was seen as the core issue that gave rise to other problems hindering their ability to give their best to patients. An example was an 'escort' that failed to happen at the agreed time due to staff shortage. Such an issue could trigger patient's anger and aggression. Staff shortage may also 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 - a situation that could hinder both de-escalation and debriefing processes. The unfamiliar staff scenario might sometimes involve other challenges such as team members who might have trained differently and may hold a different philosophy on PR. There was also concern about colleagues stuck in ways that may be non-progressive or helpful. According to Beresford and Croft (1993), some professionals find changes to traditional ways of working daunting. Equally hindering was the attitude of colleagues described as the 'gung ho' type who derived 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 they enjoy inflicting pain on others. These accounts reinforce the need for SU involvement in PMVA training, an initiative that could sensitise staff to be compassionate particularly in challenging situations like PR.

The experience of emergency response team could be unsettling for the patient and frightening when the team members are unfamiliar the study found. 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 didn't know him. He described these unknown staff as very judgemental and nasty. On the other hand, the response team was viewed differently, even favourably when the team engaged the patient in dialogue to resolve issues.

The discussions with SUs 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. It was concerning however that raising issues could attract negative responses. It explains why bad practices still happen and justifies the need for initiatives such as SU involvement in PMVA training delivery that could trigger compassion in staff and motivate them to avoid restraint or to carry it out caringly.

Some of the policies that staff had to work by, example smoking policy were identified as triggers for patients' anger and aggression and the main reasons why patients push boundaries 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 for fresh air could enhance calmness in patients. Whereas the contrast could trigger frustration and aggression and ultimately endorse PR. Wisdom et al. (2015) emphasise that administrators need to examine their environments, policies and practices in order to effectively integrate the core strategies into their situation.

The PMVA SU contribution aimed to inspire participants to avoid PR. But realistically, if PR became inevitable (NICE, 2015; Mind & NSUN, 2015), 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 – Nurse or Allied professionals.

Limitations

Gaining access to the hospitals for the semi-structured interviews had to be organised well ahead of time with the managers. They decided date and time. This meant that only the staff who were there on the day were available to us. The interview data collection method relied on the participants' ability to recall restraint practices in retrospect. In reality, some of the facts may have faded over time, raising doubts about the accuracy of data. The use of prompts, the rephrasing of questions and asking several participants again and again were

attempts to minimise this weakness. My 'insider researcher' position raised the issue of preconception. 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 & 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.

Conclusion

The participants in this study found the contribution of the service users to PMVA training as profound and important; bringing a new reality and empathy to their work. It enabled new meanings for example debriefing to be derived. The participants took away numerous lessons from the experience including to proactively seek alternatives to PR. They appeared resolved to reflect them in practice or were already doing so in the case of experienced staff. There is now a national recommendation to involve mental health service users with lived experience of physical restraint in PMVA training delivery (Ridley & Leitch 2019). This development promises a transformation of the way that physical restraint is perceived and taught and a positive impact on practice. Furthermore, this study confirms findings from previous studies which claim that service user involvement in the education and training of professionals has the potential to positively influence practice (Turnbull & Weeley 2013, Spencer et al. 2011).

Recommendations:

- PMVA training providers should involve service users in their training delivery.
- Mental health inpatient staff must continue to resourcefully employ alternatives to PR.
- Ongoing research which should also seek patients' perspectives on the subject.

Acknowledgement

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