Restrictive Practices: The Impact of Seclusion and Restraint Events on Inpatient Staff in Psychiatric Facilities

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Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Approved by:

Dr. Jason Ward: Committee Chair

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Abstract

The purpose of this qualitative descriptive phenomenological study was to explore how staff cope with the experience of SR events at designated receiving facilities within Florida. By examining the experience of staff, the researcher aimed to understand the impact of those experiences on their attitudes toward SR, their use and knowledge of alternatives, and the factors that contribute to the decision to implement SR in the inpatient psychiatric environment. The research question explored how psychiatric staff describe their lived experiences in SR events within a designated Baker Act receiving facility. Participants were staff employed at Baker Act receiving facilities in Florida who participated in or witnessed seclusion and restraint events during their employment. Each participant was interviewed separately via Zoom utilizing a broad set of interview questions. Interviews were recorded and then transcribed for the purpose of reading, coding, and identifying emerging themes. The study identified four major themes that reflected underlying experiences of conflict, concerns for safety, ideas for improvement of practices, and an acceptance of responsibility for the failure of interventions leading to seclusion and restraint practices.

Keywords: seclusion, restraint, inpatient, psychiatric

Copyright page

Dedication

This work is dedicated in its entirety to Dr. Nadir Baksh. It remains impossible to describe the tremendous impact your kindness, compassion, understanding, and guidance had on my life and how grateful I remain for Divine Intervention that guided our paths to intersect at 421 Martin Avenue. It is with a permanent sadness in my soul that I continue to mourn your unexpected and sudden passing in the midst of our 8-year conversation. We weren't quite "done" as you would say. It is with great wonder that I embrace the ongoing dialogue that has been mysteriously granted and marvel at the mystical ways that you have kept your promises. I remember well all of your wisdom and do promise to embrace it daily as best I can in honor of your memory.

1. Be open, honest, and candid.
2. There are no coincidences.
3. Every little thing matters.
4. Make promises and keep them. Always.
5. A deal is a deal for life.
6. Listen well.
7. Be patient in all things.
8. Orchids are beautiful.
9. Follow your instincts, especially when 4-2-1 appears.
10. Enjoy the rain.
11. Whatever comes to mind!
12. Dreams do matter.
13. Embrace it!
14. Watch out for kryptonite.
15. Never forget the frame.
16. Freud was right.

In gratitude for you, Dr. Nadir Baksh. Requiescat in pace.

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Ad majorem Dei gloriam

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List of Abbreviations

American Psychiatric Nurses Association (APNA)

Center for Medicare and Medicaid Services (CMS)

Chief Executive Officer (CEO)

Coercive Measures (CM)

Debriefing Questionnaire (DQ)

Department of Children and Families (DCF)

Florida Administrative Code (FAC)

General workplace violence (WPV)

Involuntary Admission (IA)

Involuntary psychiatric admission (IPA)

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

Medical Director (MD)

Mental health nurses (MHN)

National Database of Nursing Quality Indicators (NDNQI)

Residential Treatment Centers (RTCs)

Root Cause Analysis (RCA)

Seclusion and Restraint (SR)

Sensory Modulation (SM

Substance Abuse and Mental Health Services Administration (SAMHSA)

Veteran Affairs (VA)

World Health Organization (WHO)

Chapter One: Introduction

Overview

Psychiatric units provide intense mental health treatment to the most severely afflicted patients, offering both emergency evaluation and stabilization in a secure environment. Admission is generally reserved for those who pose an imminent danger to themselves or others and must be observed and monitored regularly. Facilities that provide inpatient treatment include psychiatric hospitals, general hospitals, residential treatment centers (RTCs) for children, RTCs for adults, community mental health centers, certified community behavioral health clinics, outpatient mental health facilities, other types of residential treatment facilities, multi-setting mental health facilities, and Veterans Affairs (VA) medical centers (SAMHSA, n.d.a). In Florida, patients are admitted for inpatient psychiatric observation and treatment following a screening at designated receiving facilities that are approved by the Department of Children and Families as either a public or private hospital, crisis stabilization unit, or addictions receiving facility (Florida Mental Health Act, 2021).

Coercive measures (CM) are used in psychiatric units when there is need to intervene to prevent self-harm to a patient or to protect against dangerous behaviors that may present immediate risk of harm to staff or other patients on the unit. These measures typically include the practice of seclusion, which provides for the confinement of a patient in a locked room and restraint that may utilize either a mechanical device or a staff hold of a patient to provide immediate immobilization (Chieze et al., 2019). In Florida, the application of seclusion and restraint (SR) is justified only as an emergency measure when there is imminent danger to the identified patient, staff, or other patients on the psychiatric unit (Florida Mental Health Act, 2021). Physical restraint and seclusion interventions are challenging and risky for staff and

patients, associated with poor treatment outcomes, staff problems, and complaints from patients, yet remain a common practice on the inpatient unit (Vedana et al., 2018).

Research reveals the great complexity of staff attitudes toward the use of seclusion and restraint with a reported conflict between the provider's role to preserve patient safety and the goal to build and nurture a therapeutic relationship with psychiatric patients (Muir-Cochrane et al., 2018). Psychiatric nurses reveal personal experiences of both fear and blame associated with their roles and report ongoing struggles to prioritize patient care when faced with increased levels of aggression and violence on psychiatric units while also expressing concerns about their personal responsibility for fault when injury or harm occurs on the unit (Muir-Cochrane et al., 2018). While there is general agreement amongst psychiatric providers where the use of seclusion and restraint (SR) should be a last resort as a means to maintaining safety in psychiatric hospitals, the topic remains controversial and is debated amongst scholars, practitioners, and patient rights groups. Efforts continue to reduce and eliminate the occurrence of this practice, yet it remains a common intervention that is negatively viewed by patients and staff alike (Väkiparta et al., 2019).

The researcher aims to align this study with specific needs identified in the literature to capture and understand the experiences of inpatient psychiatric staff and how they relate to the implementation of SR (Jalil et al., 2017). Historically, the literature has focused on exploring and identifying staff attitudes and views on SR without examination of the staff experiences with SR in psychiatric settings. This lack of literature on the lived experiences of staff who participated in SR events functions as a barrier to understanding the full impact of SR on psychiatric staff and prevents successful establishment and implementation of SR reduction programs. This study aims to discover the lived experience of staff before, during, and after SR events to remedy the

gap in the literature and generate discussion on SR reduction programs that rely on input from psychiatric staff.

Background

The experience of SR events has been associated with negative consequences for patients including feelings of powerlessness, degradation, (Barnicot et al, 2017), deprivation, neglect (Askew et al., 2019), distress, and dehumanization (Barnicot et al., 2017; Cusack et al., 2016). Although studies are limited in the exploration of the staff experience of SR events, the available research demonstrates a similar trajectory of negative emotions including distress, guilt, and self-blame (Mooney & Kanyeredzi, 2021). These findings highlight the need for additional studies on how to effectively prevent SR events and create therapeutic alternatives to restrictive practices.

Historical

The use of SR has been characteristic of mental health treatment as a means of providing security, reducing the threat of self-harm or harm to others, and restoring calm to the agitated patient (Sashidharan et al., 2017). Historically, individuals with mental illness have encountered CM including SR from the early days of the asylums until modern times within the community-based care movement (Beames & Onwumere, 2022). Although most individuals who seek mental health services are not exposed to involuntary treatment and restrictive practices such as SR, there is an outcry of concern for the human rights of the vulnerable population of patients who encounter these practices (Sashidharan et al., 2017). The debate on SR extends to the late 1830s (Topp, 2018) but remains pertinent today across the globe and continues to inform research studies on improving psychiatric treatment on inpatient units.

Parallel to the concern for the patient is consideration for the inpatient psychiatric staff who participate in SR events and are often left to cope on their own without access to supportive

resources, administrative support, or adequate debriefing (Jalil et al., 2017). Brophy et al. (2016) identified physical and psychological injuries as common risks for staff who participate in SR events while also describing risk for psychological trauma for staff who witnessed SR events. Cusack et al. (2018) emphasized the presence of fear, loss of empathy, and distress as additional negative outcomes that impact staff involved in SR events. This study explores SR events from the point of view of the staff including their description of SR, how they cope with the impact, and how their lived experiences impact decision-making for future events.

Social

Research reveals a substantial cost associated with SR events relative to nurse, technician, and psychiatrist work hours dedicated to each event (Terrell et al., 2018). In addition to the investment of time, there is a measure of emotional and psychological cost for staff that is associated with the SR events (Terrell et al., 2018). Both patients and staff observe a significant negative change in their relationship following the use of restrictive practices (Mooney & Kanyeredzi, 2021). Staff describe their feelings of accountability for the application of restrictive practices whereas patients report a sense of powerlessness that leads to a breakdown in trust and a negative impact on the potential for a strong therapeutic relationship (Mooney & Kanyeredzi, 2021). This study explores the lived experience of staff as they initiate, witness, and participate in SR events with a goal to accurately depict these lived experiences to inform others and more appropriately provide training, adequate support, and effective approaches to SR reduction.

Theoretical

Research continues to identify a strong association between childhood trauma and the development of mental illness later in life (Beckett et al., 2017). Recognizing the strong presence of trauma in the inpatient population heightens the urgency with developing trauma-informed

care practices on inpatient psychiatric units with an emphasis on decreasing exposure to trauma, particularly in relation to SR events (Beckett et al., 2017). Of significant concern for the patient is the risk of harm, the loss of freedom and dignity, and the potential setback from a therapeutic standpoint (Ross, 2018). Studies on the use of seclusion and restraint (SR) demonstrate a concern for the impact on patients from a human rights perspective, likening the experience to torture (Ross, 2018). The literature continues to demonstrate the negative consequences of seclusion and restraint events for both staff and patients, yet fails to identify an appropriate and evidence-based alternative that is accepted and implemented effectively by staff (Alliskmets et al., 2020).

There are very little data identifying any benefit of SR for the patient regarding effectiveness, efficacy, or efficiency (Chieze et al., 2019; Iudici et al., 2022). The absence of evidence-based data supporting a direct benefit to the patient calls into question the legitimacy of this intervention and supports the aim to reduce and eliminate SR from practice. However, despite the lack of scientific support, SR remains a common practice worldwide where it continues to raise ethical and safety concerns for staff and patients alike. This study will broaden the discussion on the effects of SR events by examining the first-hand experiences of inpatient psychiatric staff who initiate and participate in these events.

Situation to Self

Throughout the past 10 years, I have worked for a non-profit psychiatric hospital in the Assessment Services department where all patients are received prior to admission to the adult psychiatric unit. The agency system for patient behavioral disturbances requires all staff to respond to these emergency situations and assist with de-escalation, seclusion, or seclusion and restraint of patients. My experience in these events has exposed me to a variety of negative outcomes expressed and displayed by the patients, the nurses, and the other inpatient staff who

have participated in these events. However, I am several steps away from the lived experience of staff who work directly on the psychiatric unit and I qualify more as an indirect participant. The agency incorporates SR meetings that occur on a monthly basis and are designed to report on and review the SR events. Although not a formalized analysis of data, it is helpful to observe trends that included both spikes and decreases in SR events as well as reports on staff and patient injuries. Most notable is that the attendees of this monthly meeting do not actually participate in SR events but are tasked with creation of policy, reporting of data, and the quality improvement plan aimed at SR reduction.

As a manager, I have overseen the debriefing events for staff and patients that follow these SR events and participated in the discussions that debate the availability of safe and practical alternatives, the impact on participants, and the overall negative outcome on the environment. As the family member of loved ones living with mental health conditions, I have witnessed the aftermath of SR on patients in the moment and many years later. My paternal grandmother experienced SR events as a patient in state mental hospitals in New York (NY) and my father recalls his memories of her wrapped in a straightjacket being forced from their home against her will. There is an absence of discussion on resolving identified issues and addressing staff and patient concerns as it relates to these events in both the short and longer term. Staff experiences with SR events are consistently negative, traumatic, physically and emotionally exhausting, and distressing. I remain motivated to examine the experiences of inpatient psychiatric staff and explore what they experience and how they cope with the impact.

The philosophical assumption for this research study is ontological with focus on the idea that there may be many different perspectives of SR based on the experiences of different staff members. The paradigm for the research is identified as constructivism supported by

unstructured questioning and the influence of the background and experiences of the participants on their interpretation of experiences.

Problem Statement

Despite recognition of the practice of seclusion and restraint as negative for both staff and patients, studies continue to demonstrate that staff do not believe in the complete elimination of seclusion and restraint (Gerace & Muir-Cochrane, 2019). Research reveals an interesting shift of psychiatric nurse attitudes toward seclusion and restraint from one of a therapeutic practice for the benefit of the patient, to a practice of safety that is necessary to protect themselves, other staff, and the environment (Doedens et al., 2020). Staff appear trapped in the struggle to provide effective therapeutic care while simultaneously relying on the use of SR despite the negative outcomes associated with its implementation. Research on staff experience of SR could effectively inform policies on training and support that may improve staff experience, morale, and stamina thereby leading to better retention rates.

Staff dependence on the use of restrictive practices exposes patients with mental health conditions to harmful treatment outcomes, inhumane conditions, and injury (Allikmets et al., 2020). Patients describe a sense of powerlessness, distress, and neglect that accompanies the SR experience resulting in negative perceptions of available treatment options (Barnicot et al., 2017). Additionally, patients report negative emotions including fear, trauma, and abandonment (Askew et al., 2019).

Despite global efforts to improve treatment for people with mental health conditions, there are notable failings for this population that result in experiences of abuse, isolation, and marginalization in their communities (WHO, 2019). People with mental health conditions often lose their decision-making rights, are faced with barriers to health care, and as a result,

experience lower life expectancies than the general population (WHO, 2019). The primary problem that informed this research study was that there are grave weaknesses in the system of care for people with mental health conditions that remain concealed and ignored by the very caregivers tasked to manage the care. The researcher remains motivated to explore and expose barriers to improved treatment outcomes with emphasis on the role of inpatient psychiatric staff in relation to SR events.

Purpose Statement

The purpose of this qualitative descriptive phenomenological study was to explore how staff cope with the experience of SR events at designated receiving facilities within Florida. By examining the experience of staff, the researcher aimed to understand the impact of those experiences on their attitudes toward SR, their use and knowledge of alternatives, and the factors that contribute to the decision to implement SR in the inpatient psychiatric environment.

Significance of the Study

Existing research indicates that SR events are detrimental for both patients and staff participants (Mooney & Kanyeredzi, 2021). Both report distressing experiences associated with SR and remain in agreement that the practice is coercive and results in a disruption to the therapeutic relationship (Brophy et al., 2016). Patients and staff share in their report of negative emotions associated with seclusion and restraint citing the experience of fear, trauma, neglect, and increased risk of injury (Cusack et al., 2018). The World Health Organization (WHO) identifies mental health and well-being as vital while describing the global response to these needs as inadequate and deplorable (WHO, 2019). Among the identified priorities of worldwide initiatives are efforts to reduce and eliminate the practice of SR (WHO, 2019). This global effort highlights the fact that there is an urgency attached to broadening the understanding into the

experience of SR from the perspective of staff participants who initiate, supervise, and resolve these events on the psychiatric unit.

Research Question

RQ: How do psychiatric staff describe their lived experiences in SR events within a designated receiving facility?

Definitions

Seclusion and restraint: Seclusion and restraint are described as restrictive or coercive practices that utilize force rather than cooperation from an individual to achieve a goal while limiting freedom and movement, and may include physical restraint, chemical restraint, environmental restraint, or seclusion and psychological restraint (Negroni, 2017).

Designated receiving facility: A facility approved by the Department of Children and Families that may be a public or private hospital, crisis stabilization unit, or addictions receiving facility that provides, at a minimum, emergency screening, evaluation, and short-term stabilization for mental health or substance abuse disorders and which may have an agreement with a corresponding facility for transportation and services (Florida Mental Health Act, 2021).

Coercive measures: Interventions against a person's will that prevent freedom and movement used in psychiatric settings to contain aggressive or dangerous behaviors (Chieze et al., 2019).

Incompetent to consent to treatment: A state in which a person is gravely affected by a mental illness or a substance abuse impairment resulting in the lack of capacity to make a well-reasoned, willful, and knowing decision concerning treatment (Florida Mental Health Act, 2021).

Community mental health center: This is a non-profit center that is publicly funded and contracts with the State to ensure the availability of emergency services and outpatient and inpatient services (Florida Mental Health Act, 2021).

Facility: A facility is considered to be any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons diagnosed with a mental illness or substance use impairment (Florida Mental Health Act, 2021).

Summary

Considerable research has been done to investigate the application of SR in psychiatric settings with the primary goal of understanding how to reduce and prevent use while implementing alternative interventions. Despite insight into the rationale of SR as a means of preserving safety, it remains a controversial topic with ethical, medical, and legal concerns highlighted in the literature (Al-Maraira & Hayajneh, 2019). Psychiatric patients on inpatient units retain rights and autonomy that are both jeopardized during the application of SR resulting in violations of the basic promise of care in a safe and therapeutic environment.

SR events are associated with negative consequences for staff and patients. However, there is limited understanding of staff experience of SR events and therefore a lack of insight into how that experience impacts morale, stamina, burnout, and future retention of inpatient psychiatric staff. Research indicates that inpatient staff report their natural tendency to repress and avoid any emotions associated with the SR events in order to cope with the aftermath and continue to effectively attend to their responsibilities on the unit (Goulet & Larue, 2018). This gap in understanding the provider experience of SR events limits insight into prevention measures and reduces the effectiveness of debriefing activities designed to assist staff in coping with the stress and emotion associated with these events.

More knowledge is required in order to adequately address and improve the staff experience on psychiatric units. Insight into the staff experience also has the potential to improve

the quality of patient care in these acute psychiatric settings with additional implications for better policies and procedures that appropriately manage the relevant factors associated with SR events.

Chapter Two: Literature Review

Overview

Inpatient psychiatric units are hosts to patients with diverse histories of mental illness and trauma that require specialized treatment and individual attention during inpatient stays. Staff who attend to these patients must balance the need for the prescribed treatment and the safe management of the therapeutic environment as a whole. The use of seclusion and restraint to manage violence and aggression is identified as the primary means of maintaining unit safety despite recognized negative effects that include the traumatization and dehumanization of patients and adverse effects on staff. As the primary caregivers for these patients, it appears that the role of inpatient psychiatric staff is significant in both successful treatment outcomes and the avoidance of restrictive measures. It remains relevant to examine the factors that impact the use of SR to formulate a clear perspective of the influences that affect the use of these practices, and to better inform the construction of seclusion and restrain reduction programs. While efforts at reduction of SR have resulted in some success, there is need for more comprehensive insight into the lived experiences of front-line staff who make the decision to intervene with SR and actively participate in these events. Additional research is required to develop steps toward consistent progress in the elimination of SR.

Theoretical Framework

Seclusion and restraint (SR) are considered emergency interventions for immediate use when all other therapeutic interventions have failed to restore or secure patient and staff safety on an inpatient psychiatric unit. Restrictive or coercive practices utilize force rather than cooperation from an individual to achieve a goal while also limiting freedom and movement (Negroni, 2017). These practices may include the physical restraint, chemical restraint,

environmental restraint, or seclusion and psychological restraint (Negroni, 2017). The U.S. Joint Commission on Accreditation of Healthcare Organization expands the definition of restraint as "any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body" (Negroni, 2017, p. 100). Further, it is explained that any type of physical restraints may be defined as "any manual strategy or physical or mechanical equipment that immobilizes or reduces the ability of an individual to move his or her arms, legs, body, or head freely" (Negroni, 2017, p. 100). Often used in tandem with the practice of restraint, seclusion is normally defined as "a control measure that consists of confining an individual to a location for a specific period of time and from which the person may not leave freely" (Goulet et al., 2018, p. 120).

For decades, the practice of seclusion and restraint in psychiatric facilities has remained controversial with studies citing multiple negative effects including post-traumatic stress in patients, loss of patient self-determination and rights, dehumanization and distress, and significant damage to the therapeutic relationship between inpatient staff and patients (Askew et al., 2020; Barnicot et al., 2017; Chieze et al., 2019; Mooney & Kanyeredzi, 2021). Arguments against restrictive practices also emphasize concerns that assuming control of patient behavior is unethical and infringes upon human rights and freedoms (Välimäki et al., 2017). There are significant recognized negative consequences of restrictive practices and very limited evidence supporting effectiveness or therapeutic benefit (Goulet et al., 2017). However, the literature shows that the prevalence of SR remains high and that the general worldwide consensus within the mental health community and amongst human rights organizations points toward an urgency to reduce the use of SR (Goulet et al., 2017).

Interestingly, it is noted that studies continue to demonstrate that inpatient psychiatric staff providers do not share in this attitude and believe firmly that the complete elimination of SR is not practical for the continued safe management of the therapeutic milieu of psychiatric units (Gerace & Muir-Cochrane, 2019; Lantta et al., 2020). The literature demonstrates that staff remain less likely to seek alternative interventions to avoid SR suggesting insufficient motivation and a lack of trust in the outcomes of alternative measures to SR (Lantta et al., 2020). Absent in the literature is sufficient exploration of staff experiences of SR and why they continue to rely on SR as a solution. It also demonstrates the need for more research into the understanding of staff experience on psychiatric units, their attitudes toward patients with mental illness, and their experience and attitude toward SR.

The literature does identify alternatives to SR highlighting the successful integration of clinical risk assessments prior to admission and the development of personalized treatment plans during inpatient admission as reliable interventions with a positive therapeutic effect and potential to reduce the prevalence of aggression and violence in patients (Väkiparta et al., 2019). Success in SR reduction is significantly augmented when paired with evidence-based training and education for facility staff (Griffin, 2022). Additionally, the literature identifies the roles of leadership, post-seclusion interviews, patient involvement, and prevention tools at work in the therapeutic environment as necessary components in successful SR reduction programs, yet it is also noted that each require the full participation and motivation of the inpatient psychiatric staff providers (Goulet et al., 2017). The role of the inpatient psychiatric staff providers remains essential when aiming to implement SR reduction in formalized programs as well as within individual environments where their relationship with patients is identified as a significant predictor to the use of SR (Jalil et al., 2017).

Although the actual SR event launches an immediate opposition between patients and staff, it appears that they do agree in their perception of the event as coercive with the potential for the physical and psychological injury of either party, a general disruption to care, and a breakdown of the therapeutic relationship (Brophy et al., 2016; Hawsawi et al., 2020; Kinner et al., 2017). Patients consistently report a series of negative emotions including fear, trauma, and neglect, whereas the staff remain susceptible to physical injury, fear, trauma, and loss of empathy for the patient (Cusack et al., 2018). While noting that SR is perceived as a negative experience for staff, discussions in the literature point toward the need to broaden the scope of research to include an examination of how inpatient psychiatric staff providers experience SR and which short-term and long-term factors associated with those experiences may impact the probability that SR will be utilized or prevented (Mooney & Kanyeredzi, 2021). The adverse effect of SR on psychiatric staff may negatively impact staff morale, increase emotional exhaustion, reduce hope in therapeutic outcomes, and decrease job satisfaction. In turn, lowered staff morale, increased emotional exhaustion, reduced hope in therapeutic outcomes, and lowered job satisfaction will also negatively impact staff motivation to participate in SR reduction interventions, thereby creating a permanent cycle of SR use without hope for minimizing or eliminating use in the short or long-term.

Related Literature

This review explores the emerging themes in the literature on SR including the factors of influence that predict SR events, the experience of patients and staff during SR events, and the impact of interventions and SR reduction programs. Because the use of restraint and seclusion remains a topic of debate amongst stakeholders, healthcare providers, and government bodies, it persists as relevant for researchers who must consider the experience through ethical, practical,

and evidence-based viewpoints (Välimäki et al., 2017). Historically, the debate on SR extends to the late 1830s (Topp, 2018) but remains relevant today across the globe. In light of literature findings that identify the efforts of lawmakers and policymakers as inadequate in addressing SR (Al-Maraira & Hayajneh, 2019), it appears that the responsibility for research to inform change falls to the mental health community.

Conflict between organizational and government efforts aimed at the reduction of restrictive practices reveals different goals, ideas, and principles, but also becomes a barrier to success. Mental health professionals who commit to moral and ethical practices in the treatment of their patients experience their own internal turmoil when attempting to balance that commitment with the desire to maintain safety. Additionally, they must seek to balance laws and policies that restrict SR. It remains vital to understand the experiences, perceptions, and concerns of all inpatient psychiatric staff with special emphasis on the mental health nurses who are tasked with the responsibility to maintain a safe environment for all patients while managing aggression and physical violence from patients. A deeper and more detailed understanding of these staff experiences will also lend another opinion to the ongoing debate on the practice of SR in psychiatric facilities and perhaps help pave the way toward more tangible success with reduction programs.

Prevalence

For the year 2018, the use of SR was reported by 80% of psychiatric and general hospitals in the United States (Substance Abuse and Mental Health Services Administration (SAMHSA), n.d.a). The majority of reporting facilities also acknowledged that efforts to reduce SR are in place in the form of policies and procedures at their institutions (SAMHSA, n.d.b). Recently, efforts toward the reduction of SR in psychiatric units have been moderately successful

with most achievements attributed to the use of specific programs aimed to educate and equip staff with de-escalation techniques and improve the therapeutic milieu (Goulet et al., 2017). Goulet et al. (2017) examined the overall effectiveness of SR reduction programs and identified the common components that contributed to a lowered incidence of SR and an observable improvement of unit safety. However, it is noted that although there appears to be some success with reduction efforts, there are limits to current strategies in place and the actual rate of reduction has slowed (Power et al., 2020). There is also discussion in the literature about additional factors that may hinder reduction efforts including data from Gerace and Muir-Cochrane (2019) who surveyed 512 mental health nurses about the practice of SR and concluding that many do not support the complete elimination of SR as attainable. Instead, nurses surveyed described the practice of SR as unavoidable in consideration of consistent exposure to aggressive, intoxicated, or psychotic patients on a regular basis and limits to other available options that may be used to diffuse aggressive and violent situations on the inpatient unit (Muir & Cochrane, 2019).

Despite both the controversial and in some instances illegal nature of SR, it remains a procedure that is relevant within the practice of psychiatry across the globe. In some countries, it is banned as a violation of human rights while other countries support use under specific circumstances where individuals are at risk of harming themselves or other persons on the psychiatric unit (Lykke et al., 2020). In regions where it remains practiced, there are multi-faceted efforts in place to work toward reduction and eventual elimination (Lykke et al., 2020). However, as part of this focus on reduction and elimination, there is need to develop a comprehensive view of the frequency of use of SR and how reduction programs may be impacting prevalence. Due to marked differences in legal definitions of SR across regions and

countries, recording processes, and reporting procedures, it remains difficult to develop an accurate picture of the frequency and reduction of use across different states, countries, or geographic regions (Lykke et al., 2020).

The prevalence of SR events can vary significantly within facilities across regions and even amongst facilities within the same region due to a variety of contributing factors including law, cultural differences, and differences in treatment methods (Pérez-Revuelta et al., 2021). A review of SR records across psychiatric hospitals for the period of 2013-2017 reveals significantly lower incidence rates within for-profit hospital settings in comparison to non-profit or government hospitals (Staggs, 2020). However, available data does not permit detailed insight into the influence of differences in the patient population or the characteristics of the settings that may help to explain the marked contrast between incidence rates; however, it does highlight the necessity to promote uniform reporting standards for SR events that may result in more detailed data that can inform practices.

Large studies have revealed a significant difference in the practice of SR between different hospitals without clear evidence or understanding of the reasons that predict the wide variation (Flammer et al., 2022). Studies demonstrate the clash of opposing opinions as to predictors of SR rates with clinicians pointing toward the patients themselves and the patients and their family members identifying staff as the primary instigators of such events (Aasland et al., 2018). Interpretation of patient demographic data, staff attitudes, and additional factors of influence may help to clarify the predictors of SR events and explain the discrepancies between SR rates between hospitals especially when geographic, cultural, and legal differences have been ruled out.

Staggs (2020) reported that despite the measured progress in some hospitals, there are still others with significantly high rates of SR. The success attributed to the decline of SR rates above the median between the years 2013-2017 is somewhat distorted by the variability in the rates that remain above the median (Staggs, 2020). Staggs (2020) suggested that data collection and reporting of SR be expanded to include all steps of the decision-making process, the frequency of seclusion, and the duration of the episodes.

A study on the use of SR in 111 U.S. Department of Veterans Affairs (VA) hospitals in 2014 to 2016 demonstrated that the average physical restraint hours per 1000 patient hours was 0.33 (SD, 1.27; median 0.05). For a similar period of time between 2013 and 2017, Staggs (2020) reported on the facility-level data from Hospital Compare. Staggs (2020) found that two-thirds of hospitals reported seclusion rates of ≤0.09 hours per 1,000 patient-hours, and two-thirds reported restraint rates of ≤0.15 hours per 1,000 patient-hours. However, for the same reporting period, 10% of hospitals reported rates almost five times as high and 5% of hospitals reported rates over ten times as high (Staggs, 2020). Additional findings reveal that the duration of time spent in seclusion is longer in federal government facilities in comparison to all other facilities including both profit and nonprofit settings (Staggs, 2020). Interestingly, although the rate for mechanical restraint in profit settings is lower than in nonprofit settings, there is a greater chance for chemical restraint in a for-profit setting than in a nonprofit setting (Staggs, 2020).

Factors of Influence

The literature examines a wide variety of factors that influence the practice of SR in psychiatric facilities identifying the impact of involuntary admission (IA), aggression, workplace culture, staff attitudes, staff training and experience, patient demographics, environmental influences, and staffing levels to either positively or negatively affect the incidence of SR

(Anderson et al., 2021; McKeown et al., 2019; Oostermeijer et al., 2021). Pérez-Revuelta et al. (2021) emphasized the roles of agency policies that aim to limit SR, the presence of staff specially trained in intervention and de-escalation techniques, systems and procedures that monitor SR, and importantly, the participation of family and the patient. Examination of these factors and further implementation of a multi-faceted approach to address SR events may lead to a more significant reduction of SR and improved treatment outcomes for patients on psychiatric units.

Aggression

A record of assaults within psychiatric settings from 2004 to 2017 provided by the National Database of Nursing Quality Indicators (NDNQI) revealed a total of 3519 assaults with injury that were responded to with either seclusion alone or with seclusion and some type of restraint (Staggs, 2020, 2021). The report showed that 15% of those events resulted in seclusion interventions and 30% with one seclusion and one or more type of restraint with a total of 995 events resulting in the use of both seclusion and restraint interventions (Staggs, 2020, 2021). The presence of aggression in patients remains a considerable concern in the workplace with as many as 68% of nurses working in psychiatric hospitals reporting experiencing direct contact with patient aggression or threats of the same (van Leeuwen & Harte, 2017).

Although there are some hospital characteristics that appear more closely associated with the use of SR the strongest predictor of SR is the nature of the assault (Staggs, 2020, 2021). Studies demonstrate that there is a higher incidence of the use of SR if the assault resulted in injuries (Staggs, 2020, 2021). Interestingly, it is noted that the occurrence of events characterized primarily as sexual assaults result in less frequent application of SR (Staggs, 2020, 2021). There is also additional support for this finding in the literature that identifies either aggression or

physical assault as a significant predictor in staff application of both seclusion and restraint interventions (Cole et al., 2020). Most notable, though, remains the strong association between the occurrence of severe injuries and the increase in the odds that seclusion and some type of restraint device will be employed as an immediate response to the assault (Staggs 2020, 2021).

One of the common threads in all approaches to de-escalation is the element of prevention before the act of aggression occurs (Rabenschlag et al., 2019). Research demonstrates greater effectiveness at the prevention of aggression when the efforts are viewed as collaborative by the patient and invites their participation instead of an action that is primarily ordered or directed by staff (Rabenschlag et al., 2019). However, the concept of de-escalation remains challenged because of the emphasis on primarily verbal and cognitive interventions that may not be practical for all patients (Kuivalainen et al., 2017).

Kuivalainen et al. (2017) studied 549 individuals who were treated in a psychiatric hospital finding a total of 1493 seclusion (n = 1301) and restraint (n = 192) episodes amongst the group. Interestingly, within the study group, it was observed that the highest incidence of aggression or harm was directed toward others (n = 67, 46.5%) and that self-injurious behaviors occurred only in 35 (24.3%) episodes (Kuivalainen et al., 2017). Other findings from the study showed that in 10 (6.9%) episodes there was harm to self and others, and in another 10 (6.9%) incidents, the aggression was toward objects (Kuivalainen et al., 2017). There were an additional 22 (15.3%) episodes that did not involve people or objects and the actual target of aggression could not be determined (Kuivalainen et al., 2017). Further, male patients were more likely to target others than females and female patients were more likely to engage in self-harming behaviors than anticipated by the researcher (Kuivalainen et al., 2017).

Additionally, the literature identifies various characteristics of facilities themselves that contribute to the likelihood of SR use even when controlling for the assault and patient characteristics (Cole et al., 2020). Assaults that occur in academic medical centers are more likely to result in seclusion but less likely to involve pharmacological restraint than in non-teaching hospitals (Cole et al., 2020). Likewise, assaults in federal government hospitals are less likely to involve seclusion or restraint than assaults in non-profit, non-government hospitals although federal government hospitals report longer duration of SR episodes when they do occur (Cole et al., 2020).

The literature defines general workplace violence (WPV) as a global concern with particular attention focused on the increased prevalence of violence and aggression within the health care system (Dean et al., 2021). WPV may be defined as incidents at an individual's worksite where staff are threatened, abused, or assaulted creating an explicit or implicit challenge to their safety, health, or well-being (World Health Organization, 2022). Review of the literature reveals the depth of the problem with indications that some 61.9% of healthcare workers experienced WPV including verbal threats and acts of physical violence (Liu et al., 2019). Studies show that there is a tremendous risk for violence in the workplace in healthcare settings with workers more than 16 times more likely to experience violence than in other work settings (Dean et al., 2021). In particular, the risk for WPV increases at an alarming rate for all nurses with an elevated risk for nurses on psychiatric units that is greater than in all other healthcare settings (Fletcher et al., 2021). WPV appears to be a significant factor in the discussion on SR events on psychiatric units.

Iozzino et al. (2015) highlighted the prevalence of violence in patients with a study that revealed that the staggering prevalence of violent acts may be committed by as many as one in

five patients admitted to a psychiatric unit. This elevated risk for violence on psychiatric units may be best explained by the influence of mental illness on patients leading to unpredictable and sometimes uncontrollable behaviors (Dean et al., 2021). The literature points to the acute environment of the psychiatric unit as a host to violence and aggression by patients that threatens the emotional, physical, and psychological well-being of the staff and other patients on the unit (Fletcher et al., 2021). Notably, the negative impact of WPV is observed in the quality of care, elevated costs, and decreased rates of staff retention with additional negative psychological and emotional outcomes observed for individual staff members as well as significant detrimental effects on the therapeutic environment (Dean et al., 2021; Iozzino et al., 2015).

Management of aggression and violence on psychiatric units is delegated to the nurses who must determine the most appropriate and effective response while balancing available resources in a potentially hostile environment. The literature highlights the prevalence of violence and the risk factors associated with patient aggression including impulsivity, history of violence, IPA, and extended periods of hospitalization but continues to point to the need for more patient-specific research to accurately predict and identify individual patient risk factors and create appropriate intervention strategies (Jang et al., 2022). Historically, the use of SR to manage violence was supported as an effective and readily available means to restore safety and reduce the threat of harm to patients and staff; however, the literature points toward efforts to create a direct movement away from the practice of SR in favor of reduction programs that incorporate therapeutic interventions as the primary means to prevent and manage aggressive behaviors (Beames & Onwumere, 2022).

Involuntary Psychiatric Admission

Involuntary psychiatric admission (IPA) is a practice used worldwide enabling family, caregivers, law enforcement, or professionals to make decisions about hospitalization for a person with a mental illness without consideration for the person's will (Sugiura et al., 2020). Experiences of IPA and forced treatment are widespread and are often combined with the use of physical force, seclusion and restraint, and compelled medication (Sashidharan et al., 2019). Lee and Cohen (2021) reviewed available data on emergency psychiatric admissions across the United States of America revealing a wide range of detention rates from a low of 29 (per 100,000 people) in Connecticut to a high of 966 in Florida with the mean state rate across 25 states increasing three times the mean state population increase. However, the inconsistencies in state reporting and the lack of a national standard for collection of data inhibits accurate conclusions and analysis (Lee & Cohen, 2021).

One of the most significant factors that impacts the experience of IPA for a patient is the attitude of the attending staff members toward the concept of coercion and forced treatment. Studies that explore staff attitudes towards coercion reveal the important role that they take on during incidents of violence and aggression and how this may then impact their decision to implement SR as a means of aggression management (Krieger et al., 2021). Interestingly, Aasland et al. (2018) reported on the notable differences in attitudes toward coercion across different occupational groups. The studies demonstrated that both psychiatrists and nurses exhibited stronger tendencies to assert a paternalistic view and weaker tendencies to accept patient autonomy and participation in treatment while other occupations within the field, including psychologists, supported more patient autonomy and less coercion in treatment (Aasland et al., 2018).

Although it continues to be a source of debate and contention, the practice of IPA for emergency treatment is widespread throughout the world with trends indicating an increase in these detentions worldwide (Gowda et al., 2017; Iudici et al., 2022; Seed et al., 2016). Throughout the past 20 years, Florida has measured an increase of these types of admissions with the fiscal year of 2019/2020 being the first year there was a noted decrease in that period of time (Baker Act Report, 2020). Studies demonstrate that involuntary patients are at risk for (a) negative impacts on treatment during and after psychiatric detention; (b) adverse effects on their symptoms, attitudes, behavior, and overall functioning; (c) aggressive behavior and subsequent use of coercive measures; and (d) diminished quality of life (Seed et al., 2016; Iudici et al., 2022). Canova Mosele et al. (2018) found a relationship between involuntary patients and aggression within the first 24 hours of admission and demonstrated that involuntary patients are nearly five times more likely to display violent behaviors and require coercive measures (CM) than voluntary patients.

Globally, the typical measures for the criteria for IPA include (a) the presence of a mental health diagnosis, (b) failure or unwillingness to care for oneself, (c) refusal to seek treatment, and (d) being a danger to self or others (Gowda et al., 2017). In Florida, the frame for involuntary hospitalization requires two tiers of criteria including firstly, the presence of a mental illness and either the refusal to seek an examination on a voluntary basis or the inability to determine the need for such an examination and secondly, the likelihood of neglect leading to harm to his or her well-being or the likelihood that the person will cause harm to himself or others in the near future (Florida Mental Health Act, 2021). In Florida, these involuntary admissions can be initiated through a variety of means including the circuit court via petition of family, law enforcement, physicians, and other designated mental health providers and provide

for an emergency psychiatric evaluation and potential detention for up to 72 hours (Florida Mental Health Act, 2021). Notably, there are limited means available to create an effective system of checks and balances that may result in multiple IPAs for the same individual. Florida reports that approximately 25% of all persons who were involuntarily admitted to a facility for the 2019/2020 fiscal year were subject to more than one IPA (Baker Act Report, 2020). Due to the reporting requirements of SR events in Florida, there does appear to be a means to compare incidences of SR with incidences of IPAs for the same individual as well as filter relevant data associated with the frequency of SR amongst facilities and even specific providers themselves. Florida Administrative Code (FAC) requires that all facilities, as defined in Section 394.455(10), F.S., are required to report each seclusion and restraint event to Department of Children and Families (Florida Mental Health Act, 2021). The report requires identifying data for the facility, the patient's social security number, staff credentials of the person ordering the SR, discipline of the person implementing the SR, the reason SR was initiated, the type of restraint used, any significant injuries of the patient, and the date and time the event ended (Florida Mental Health Act, 2021). The accumulation and exploration of this data may be beneficial in identifying trends specific to individuals, regions, or facilities. Research that examines the presence of aggression, SR, and multiple IPAs may also help inform the efforts toward reduction and elimination of SR as a practice.

In addition to the stigma surrounding involuntary hospitalization, there is concern that such coerced treatment breaches patient autonomy, interrupts the therapeutic alliance, fails to provide for shared decision-making in treatment, and may contribute to negative outcomes for the patient (Sashidharan et al., 2019). Although patient responses to IPA may be complex and deviate between relief and anger depending on the patient's perception of need at the point of the

involuntary admission (IA), there is a strong potential for adverse reactions to forced treatment (Sashidharan et al., 2019). Seed et al. (2016) reported on negative patient experiences associated with IPA including anger, frustration, and disagreement with the detention, which then contributed to distress and a sense of powerlessness. Not surprisingly, Cole et al. (2020) found a strong correlation between IPA and the use of CM such as SR and forced medication as a part of treatment on the psychiatric unit.

Staff

Mental health providers on psychiatric units care for persons with a wide range of mental illnesses and may face environmental, patient, and professional challenges that contribute to burnout, emotional exhaustion, and a reduced quality of life (Foster et al., 2019). A higher incident of burnout may be associated with less empathy and a lower threshold for disruption that leads to advocating for restrictive practices as a response to the violent or aggressive behaviors (Anderson et al., 2021). For mental health nurses who oversee psychiatric units, the stress that accompanies these challenges may be further compounded by exposure to workplace violence in the form of both verbal and physical aggression from patients (Jalil et al., 2017). The literature reveals that mental health nurses experience tremendous fear and concern about these behaviors and the risks associated with patient aggression for themselves, coworkers, and other patients yet also remain apprehensive about the restrictive measures that are implemented to restore safety (Muir-Cochrane et al., 2018).

Restrictive measures used in response to patient aggression and violence often include the practice of SR that is perceived as ethically challenging for mental health nurses who then experience conflict between their roles to provide both care and control on the psychiatric unit (Gerace & Muir-Cochrane, 2019). Despite the conflict, Muir-Cochrane et al. (2018) recorded

nurse concerns about the restriction or total prohibition of SR as an intervention and fears that they will be blamed for any negative concerns that outcomes for either the use of SR or the avoidance of this practice. Interestingly, Doedens et al. (2020) concluded that nurses perceive SR as an intrusive and undesirable intervention and express both the desire and the need to employ more therapeutic alternatives to resolve aggression and violent outbursts.

Kelly et al. (2016) reported on significant results from a large study involving all clinical staff (N = 1,794) at a large public mental hospital in California. Staff responded to a survey that considered their background, stressors at work, results from those stressors, and the management of those stressors (Kelly et al., 2016). Of the total participants, a majority of 70% reported assaults within the past year and associated these assault experiences with a general feeling of being unsafe while at work (Kelly et al., 2016). Also notable from the study, a total of 45 % of the participants described feeling unsafe and a majority (90%) of participants believed that there were other precautions that could be implemented to increase their safety while at work or thought that they could be more protected while at work.

Additionally, assault experiences were associated with reports of depression and anger (Kelly et al., 2016). This parallels a more recent study of nurses that revealed that the combination of experiences both before and during SR events produced a range of emotional responses that included anger, distress, disgust, and regret (Power et al., 2020). These emotional responses of the nurses may also influence the other psychiatric staff that can trigger or influence levels of patient aggression and contribute to unit events that may result in SR (Jalil et al., 2017).

Interestingly, Jalil et al. (2017) found a positive correlation between the anger that staff experience because of verbal aggression or insults and the actual decision to initiate SR. Another interesting finding is the negative correlation between staff experiences of guilt and the practice

of seclusion (Jalil et al., 2017). Although the effect of these emotional responses is still being researched, there is support in the literature for understanding their reactions from the point of frustration aggravated by limited resources, low morale, and a depressing organizational culture (McKeown et al., 2019).

Additionally, studies have demonstrated an association between staff perception of the unit and a higher incidence of SR (Kuivalainen et al., 2017). When staff perceive a higher acuity and a lack of appropriate safety measures available, there is higher implementation of seclusion and restraint in response to unit events (Kuivalainen et al., 2017). Additional staff characteristics including the balance of male versus female staff and the levels of experience of the staff member also impact the incidence of SR implementation (Kuivalainen et al., 2017). However, it is noted that there is no specific characteristic of the environment, the staff, or the patients that entirely explains the trends in the implementation of SR, but rather that the combination of factors may influence the trends (Kuivalainen et al., 2017).

Agreement is found in the literature for staff rationalization of SR use with justification developed from the standpoint of paternalism (Jo Delaney, 2018) that embraces the opinion of the staff member as superior to the patient with little to no consideration for the patient's preferences. This viewpoint is further emphasized by the nature of the IPA that removes most decisions from the patient and grants power to family, caregivers, law enforcement, and professional providers. Although the paternalistic attitude may be further complicated by an individual's experience or the policies and procedures of a single agency, it remains an important factor to consider and aligns with findings in the literature that point to the patient-staff relationship as a predictor in the avoidance of SR and the pursuit of alternative measures to reduce aggression and violence in patients (Allikmets et al., 2020).

Staff experience of aggression is observed in multiple forms including verbal abuse, physical abuse, and threats toward staff or other patients that may result in physical or emotional injury, alter staffing needs, increase costs due to injury, negatively impact morale, and decrease staff retention rates (Al-Sagarat et al., 2016). Significantly, staff attitudes toward patient aggression will also inform management and response to those aggressive behaviors and violent acts and may also be predictors of the probability of utilizing SR as an intervention. Ezeobele et al. (2019) discussed the challenge of aggressive patients in psychiatric hospitals, identifying the complications for organizations and their staff. Patient violence and aggression are described as primary concerns for psychiatric staff with subsequent impact on safety, morale, and quality of patient care (Ezeobele et al., 2019). Loof et al. (2018) identified an association between physical aggression and adverse effects on staff experience including a higher prevalence of burnout and emotional exhaustion.

Staff perception of the application of coercion impacts the management of aggression on the psychiatric unit and may be vastly different between countries, geographic regions, and states, and even within individual agency units (Krieger et al., 2021). Florida law prohibits the use of SR as a means of punishment, to compensate for staffing problems, or to facilitate convenience for staff and instructs designated receiving facilities to teach and inform staff about the restrictions for the use of this practice (Florida Mental Health Act, 2021). However, the literature demonstrates a significant lack of research into the oversight of patient care within inpatient psychiatric facilities including cases of mortality, harm, negligence, patient abuse, and patient suicide (Shields et al., 2018). News reports reflect an increase in investigations of psychiatric facilities over issues of patient deaths by suicide, homicide, and neglect (Shields et al., 2018) while facilities primarily rely on self-monitoring tools and are only subject to fines or

corrective action in the event of a complaint. Monitoring of inpatient psychiatric facilities does include a measure for the rate of seclusion and restraint but does not provide specific metrics that analyze the circumstances surrounding each individual SR event, which limits data and the potential for studies that may inform change in policy and procedures (Shields et al., 2018).

Nurses, as the primary decision-maker in SR events, admit to ongoing struggles when balancing their roles to prioritize and preserve patient care while simultaneously being challenged with patient aggression, violence, and unit disruption (Muir-Cochrane et al., 2018). As the caregivers who are responsible to the entire unit of patients, they encounter conflict when they recognize that their only safe option is SR, and report experiences of fear and blame when they initiate SR (Muir-Cochrane et al., 2018). However, the literature points out that the utmost consideration for the psychiatric nurse is the concern for ethical practice that includes not only appropriate decision-making but also developing caring, compassionate, and therapeutic attitudes toward their patients (Al-Maraira & Hayajneh, 2019). The relevance of care and compassion is significant with research indicating that the display of both is often associated with higher patient satisfaction and is an indicator of a higher quality of care (King et al., 2019). Research that examines the role of nursing care in acute psychiatric settings is needed as a measure of the quality of nursing care and to determine if there is an association between higher patient satisfaction, improved therapeutic experience, and reduced rates of SR events.

Nurse implementation of SR may challenge a patient's autonomy and right to human dignity that may cause conflict and challenge for the nurse attempting to balance responsibilities and roles while also upholding the law. Florida law emphasizes the autonomy of the patient and the right to participate in health care decisions on psychiatric units and in preparation for discharge (Florida Mental Health Act, 2021). More evidence of psychiatric nurse experiences of

SR is needed to better understand how to equip and train psychiatric staff to resolve internal conflicts and emotions while remaining true to the ethical and legal principles that define their profession.

In addition to their attention to maintaining safety on the unit through means of SR, the literature points also to other factors of influence that affect nurse decisions including most importantly, their relationship and interaction with the patients (Bregar et al., 2018; Jalil et al., 2017). Bregar et al. (2018) found that the gender of the nurse as female contributes to a higher rate of SR while Jalil et al. (2017) discusses the increased likelihood of a nurse to use SR in response to personal attacks of insults or aggression from patients. These findings point again to the need to explore the experiences of staff on inpatient psychiatric units and to seek interventions that empower staff to use problem-solving strategies with patients as a means of addressing the primary situation in advance of aggression, negative behaviors, and violence that may predict an SR event.

Although there is general agreement in the literature that the role of staff is a significant predictor in the use of SR (Bregar et al., 2018; Muir-Cochrane et al., 2018), there is less acknowledgement and study of the internal predictors including emotions such as fear that motivate staff to engage or avoid SR. Significantly, the role of emotional exhaustion and staff morale is mentioned in the literature as associated with the use of SR, with indications that it may be a precursor to SR secondary to a lowered threshold of tolerance for unit disruption and reduced empathy for the individual patients (Anderson et al., 2021). Research that explores the role of emotional exhaustion and practical coping strategies for staff may serve as a helpful addition to the current understanding of staff experiences on psychiatric units that lead to the initiation of SR practices.

The introduction of restrictive practices in an inpatient psychiatric unit may be more directly perceived as the necessary prevention of anticipated violence instead of as the last emergency intervention available to end a violent, disruptive, or harmful behavior that is interfering with safety on the unit (Bregar et al., 2018). Research that examines the specific emotional experience of staff may help identify not only the emotions associated with these events, but also a timeline that identifies appropriate times for alternative interventions. Interestingly, staff prediction of violence in psychiatric patients is associated with a realm of factors including patient attitude toward staff, their willingness to participate in the therapeutic relationship, and how they interact with staff also including a strong emphasis on how staff perceive their ability to manage the therapeutic environment (Bregar et al., 2018).

Another element explored in the literature concerning the staff on inpatient psychiatric units is the influence of workplace relationships and social conflict. Kelly et al. (2016) found that conflicts between staff adversely affected staff perception of safety and their overall sense of well-being. Notably, there were associations between intra-staff conflict and anger, physical health, and safety concerns on the psychiatric unit (Kelly et al., 2016). Predictably, employees who described themselves as reactive to conflict also reported a diminished sense of well-being and mental health whereas those who were less reactive to conflict did not report adverse effects when encountered on the unit (Kelly et al., 2016).

Research that can provide a more in-depth understanding of the impact of SR on staff will provide new knowledge regarding the individual experience of these events and increase awareness of the staff experience that may lead to ways to improve staff morale, increase job satisfaction, lower the levels of emotional exhaustion, and restore hope in therapeutic outcomes.

These research findings may also have implications for training, SR procedures, debriefing practices, and clinical supervision.

Patient Experience

The use of CM to facilitate psychiatric treatment continues to raise ethical and legal concerns although it remains regulated and supported across the world (Hofmann et al., 2022). Although the goal of SR is primarily identified as an emergency intervention to ensure that patients are protected from self-harm or to guarantee the safety of staff and other patients, it remains a negative experience for patients with emphasis on their sense of powerlessness and experience of trauma (Askew et al., 2020; Chieze et al., 2019). Estimates of traumatic stress for patients involved in SR events varies between 25% to 47% with additional concern noted for patients with past experience of trauma that may be triggered by the SR event itself (Chieze et al., 2019). Studies of patients with SR experience reveal the depth of distress and humiliation that accompanies these events with emphasis on the patient struggle to regain power within the environment often leading to increased negative behaviors that may contribute to future seclusion and restraint events (Askew et al., 2020).

Psychiatric patients generally report a negative experience of SR (Tingleff et al., 2017), identifying a loss of freedom and power that contributes to resentment, a loss of trust in the staff, and ultimately, a deterioration in the therapeutic relationship that is so critical for a positive treatment outcome (Mooney & Kanyeredzi, 2021). The SR experience itself may become further complicated by the staff-patient relationship that occurs during the actual event leading to blaming of one another for the situation (Mooney & Kanyeredzi, 2021). Existing research demonstrates that this dynamic leads to dissolution of trust and further deterioration of the therapeutic relationship (Khatib et al., 2018; Wilson et al., 2017).

Perhaps one of the most startling findings in the literature surrounding the patient experience of SR is the report of the disruption of care and complaint that basic needs are not met while in seclusion (Holmes et al., 2015; Ling et al., 2015). The experience in seclusion is accompanied by a lack of hygiene items, loss of shower time, and limited access to either blankets or pillows (Holmes et al., 2015). Patients are isolated for extended periods of time, which limits their ability to communicate needs resulting in feelings of vulnerability, neglect, and disconnection (Askew et al., 2019). This disruption of the tangible elements of care is associated with a parallel interruption in the therapeutic relationship with nurses finding agreement with patients that the SR event clearly negatively alters their connection and rapport with patients and prevents them from attending to their nursing responsibilities and providing quality nursing care (Holmes et al., 2015).

The long-standing practice of patient seclusion, which is often coupled with the use of mechanical restraint, was initially designed to protect patients from engaging in self-harm and to restore and maintain safety during episodes of violence and aggression that have disrupted the unit environment (Gerace, & Muir-Cochrane, 2019). However, the literature demonstrates the great paradox associated with SR by revealing the increased physical risk for harm to individual patients who are subject to cardiac injuries, respiratory distress, falls, and incidents of self-harm while in seclusion (Kersting et al., 2019). Despite regulations designed to prevent such risks and monitor the practice of SR, there remains a great risk for these patients (Kersting et al., 2019). Similar risks are noted for staff who experience strains and sprains in addition to increased experiences of fear, anxiety, and stress as a result of participating in SR events (Kersting et al., 2019).

Environmental Influences

In some studies, evidence points more specifically to the potential of a variety of environmental factors including unit design, patient demographics, and staffing levels to acts as influences on the prevalence of SR (Chieze et al., 2020, 2021; McKeown et al., 2019; Oostermeijer et al., 2021). Unit construction that focuses on cost without consideration for appropriate lighting, areas for privacy, and personal contact with staff is viewed negatively by patients and appears to contribute to a higher rate of restrictive practices (Oostermeijer et al., 2021). The literature also supports the significance of the physical environment as a contributing factor to improved outcomes for patients and identifies the essential components of psychiatric units that impact those outcomes including (a) security and privacy, (b) natural lighting, (c) green spaces and gardens, (d) aesthetically pleasing milieu, (e) good acoustics, (f) windows, and (g) design features that incorporate a comforting sense of home (Oostermeijer et al., 2021).

Literature findings support the creation of a positive unit environment that prioritizes patient comfort and increased access to personal and private space as a factor in reducing the prevalence of SR (Oostermeijer et al., 2021). The literature also recognizes the effect of organizational efforts to improve décor, provide recreational spaces, and modernize the therapeutic environment as significant in leading to reductions in SR events (Andersen et al., 2017). Another important element that has surfaced in several studies concerning SR reduction in the literature was the immediate availability of private and quiet areas for patients to spend time away from the noise and activity of the unit (Brophy et al., 2016; Ulrich et al., 2018). The role of a patient-focused design and structure appears to be a significant factor in the reduction of aggression, conflict, and violence on psychiatric units which may, in turn, support a lowered incidence of the application of SR.

The impact of external environmental influences on the use of SR is also explored in the literature. Recent surveys conducted by the WHO point to challenges concerning the mental health impacts of the COVID-19 pandemic with reports that 93% of countries reported detrimental impacts on their services (WHO, 2020). However, in addition to negative impacts, some measurable positive effects were noted specifically in relation to the present of aggression, violence, and the use of SR (Martin et al., 2022). Although psychiatric admissions decreased resulting in smaller unit populations, hospitals reported that the average daily rate of the use of mechanical restraints decreased as much as 100% (Martin et al., 2022).

Relevant to the discussion on SR includes exploration of another significant impact of the COVID-19 pandemic specific to Florida, namely the reduction in the initiation of IPAs across all populations (Baker Act Report, 2020). Notably, the fiscal year 2019/2020 was the first year in the past 20 years to reflect a decrease in these exams (Baker Act Report, 2020). All age groups had a decrease in involuntary exams from the previous year, with children <18 experiencing a 5.06% decrease, young adults 18-24 experiencing a 4.85% decrease, and older adults 65+ experiencing a 4.32% decrease (Baker Act Report, 2020). The overall decrease measured during this time frame across all age groups was reported at 3.98% (Baker Act Report, 2020). It may be beneficial to examine in more depth how the COVID-19 pandemic contributed to a lowered incidence of involuntary exams and how specific unit factors such as smaller populations are associated with lowered rates of SR most especially considering that all other efforts to decrease the prevalence of these exams have been unsuccessful.

Organizational Climate

The American Psychiatric Nurses Association (APNA) encourages the SR reduction and elimination efforts through organizational culture change and the creation of prevention

strategies that prevent aggression and violence (APNA, 2018). Anderson et al. (2021) found a strong association between the use of SR to manage aggression and the organizational climate in psychiatric units. Efforts to improve the organizational climate are revealed in the "Six Core Strategies" that were developed and promoted by the National Association of State Mental Health Program Directors (NASMHPD) in the USA (Rabenschlag et al., 2019).

Interestingly, one of the primary strategies is focused on the strength of the commitment of administrative officers including the Chief Executive Officer (CEO) and the medical leadership including the Medical Director (MD) or the lead psychiatrist (Rabenschlag et al., 2019). This strategy incorporates the vision and plan to reduce SR and also suggests that more direct management of SR practices will help reduce further aggression and violent behaviors (Rabenschlag et al., 2019). The second strategy requires the acquisition of data to direct and inform practices and procedures and may require more observation of trends among shifts, staff attitudes, and the characteristics of patients on the unit (Rabenschlag et al., 2019). The third strategy promotes education and training with a commitment to a recovery-based plan of treatment that is evidenced within the physical environment, documentation, and within staff attitudes (Rabenschlag et al., 2019). The fourth strategy focuses on the integration of assessment and intervention tools, and the fifth strategy promotes the use of client feedback and direction to inform practices and improvements (Rabenschlag et al., 2019). The final strategy encourages the use of debriefing following SR events with an aim on reducing the negative and oftentimes detrimental effects of SR (Rabenschlag et al., 2019).

Anderson et al. (2021) demonstrated that units with staff burnout, low psychological safety, and lowered relational climate participated in high incidences of SR events. These findings reflect the results of previous studies that demonstrate an association between

significant staff burnout and diminished empathy toward psychiatric patients that may contribute to a lower tolerance for disruptive behaviors and be a factor in the increase in use of SR (Wilczek-Rużyczka et al., 2020). Additionally, units where staff indicated less confidence in the psychological safety and reported higher incidences of aggression, there was an increase in the use of SR (Anderson et al., 2021).

Anderson et al. (2021) also found that when there are lower rates of burnout, improved engagement, psychological safety, and a better relational climate, the staff may be more motivated and able to use alternative approaches to respond to conflict and aggression. However, in contrast to other studies and predictions about the association between organizational climate variables and seclusion, Anderson et al. (2021) found more seclusion incidents on units with higher psychological safety, higher relational climate, lower burnout, and higher engagement. Importantly, Anderson et al. (2021) did find a relationship between the organizational climate, morale, and the use of SR. Further research and exploration of staff experiences may help explain why the units with better morale and perceptions of the environmental climate used seclusion at a higher rate.

Coupled with the findings of Jalil et al. (2017), which identify a positive correlation between emotional response and SR, it may be suggested that organizations focus on morale, environmental climate, and staff concerns as a means of improving safety for patients. An additional concern for the organizational climate is the adverse impact of staffing shortages. The literature points to studies that reveal that there has been an increase in nurse staffing shortages, with nurses reporting intent to change careers due to job stress, WPV, and limited support in the work environment (Kurjenluoma et al., 2017).

SR Reduction Efforts and Programs

Reduction of SR in psychiatric settings remains an important focus of efforts to improve outcomes for patients and reduce injuries, stress, and challenges for inpatient psychiatric staff. One of the core quality measures for the Center for Medicare and Medicaid Services (CMS) is the use of SR as an intervention. It is the NASMHPD who identifies several techniques to reduce SR including staff training in de-escalation interventions, behavioral reward systems, and the identification of patients more vulnerable to SR at the point of admission (Yakov et al., 2018). However, further study and exploration is needed to achieve reduction and elimination of SR in acute psychiatric settings.

CMS promotes efforts to reduce and eliminate SR and maintains a stance that encourages avoidance of SR until all other interventions have been tried and safety remains compromised (Dixon & Long, 2022). One of the initiatives toward this end was the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) that was designed to publish the use of SR by individual facilities and inform on frequency and duration of these events (Dixon & Long, 2022). The IPFQR publication provides the public with information about SR events specific to participating facilities and may assist in informing choices for health care (CMS, 2020).

Despite the introduction of intense training in therapeutic interventions and the accumulation of experience and knowledge in the application of methods to reduce the practice of seclusion and restraint, there remains a large percentage of psychiatric staff who continue to implement these restrictive practices with well-developed rationale for initiating the seclusion and restraint to justify their actions (Lantta et al., 2020). Staff appear less inclined to utilize alternative methods to preserve patient safety in the inpatient psychiatric environment, suggesting that plans and programs to minimize these restrictive practices do not adequately or

fully address the concerns of the staff or establish trust in those alternatives as viable and effective (Lantta et al., 2020). Therapeutic interventions used to reduce the incidence of seclusion and restraint demonstrate greater effectiveness when appropriately paired with the application of an informal clinical risk assessment designed to identify patients who may be in greater need of medication, increased observation, reassurance, distraction, or more individual attention from clinical staff on the psychiatric unit (Väkiparta et al., 2019).

Additionally, the introduction of personalized treatment plans is identified as one of the more effective tools in seclusion and restraint reduction programs with a strong emphasis on patient empowerment, decision-making, and strategies for achieving and maintaining personal safety that are developed with input from the patient (Väkiparta et al., 2019). However, these interventions demand full cooperation and participation of the inpatient staff to succeed, and further research into staff perceptions of the value of these interventions is needed to better inform practice. The availability of evidence-based interventions that remain under-utilized again points to the need to explore the attitudes further and more deeply toward SR of staff on inpatient units.

Research identifies the value of leadership, training, post-seclusion restraint review, patient involvement, prevention tools, and the therapeutic environment as the required components for successful seclusion and restraint reduction programs (Goulet et al., 2017). It appears critical that staff in leadership positions, particularly the attending psychiatrist, take an active role in the oversight and debriefing of seclusion and restraint events to effectively plan for appropriate interventions in the future that can act as preventative measures against additional seclusion and restraint events (Goulet et al., 2017). Initiatives to reduce the incidence of seclusion and restraint in inpatient psychiatric units are dependent on appropriate assessment,

interventions, and post-seclusion review or debriefing (Blair et al., 2017). However, it is noted that many programs lack the appropriate combination of these components due to insufficient staffing levels and a lack of staff education and training (Blair et al., 2017).

One study aimed at SR reduction conducted by Griffin (2022) was designed to integrate the combination of five components: seclusion and restraint policy revision, educational and training sessions, a debriefing questionnaire (DQ), a summary of the DQ to the manager, and a root cause analysis huddle organized by the manager. The project's failure to decrease the seclusion rate was attributed to lack of staff compliance with the interventions despite broad efforts at education on the negative effects of SR and the solutions that contribute to reduction (Griffin, 2022). Consistency is found throughout the literature for the lack of staff motivation to actively reduce the prevalence of SR events, with most reporting a consistent belief that SR elimination is not possible nor practical and must be implemented in response to aggression, assaults, and violence to restore safety on the unit.

However, in addition to identifying elements within the staff that may be useful in creating and sustaining SR reduction, efforts the literature identifies the benefit of targeting specific characteristics of high utilizers of SR to reduce and possibly eliminate SR. Recognizing that certain patient characteristics such as a diagnosis with a psychotic disorder may lead to an increased rate of SR as an intervention, it appears relevant to explore interventions designed specifically for those populations. Machingura et al. (2022) found that providing sensory modulation interventions as a means to reduce distress in individuals diagnosed with Schizophrenia was successful and also offered indications of improvement in daily life functioning. Further discussion in the literature focuses on the implementation of sensory modulation within the inpatient psychiatric setting in the form of sensory rooms, which may be

integrated into the environmental as a component of broader efforts to improve access to de-escalation methods and to reduce the incidences of SR (Yakov et al., 2018).

Patients who struggle with sensory filtering from the environment are at higher risk for sensory overload and subsequent agitation, which may contribute to higher incidences of SR (Yakov et al., 2018). Efforts to reduce the sensory overload may also contribute to lower incidences of the secondary behaviors such as agitation and aggression. The goal of sensory modulation interventions remains focused on increasing awareness of sensory preferences while also teaching ways to manage sensory stimulation (Machingura et al., 2022). Studies demonstrate that integration of sensory rooms or spaces on psychiatric units were associated with improved de-escalation, self-awareness, and the development of coping skills by the users (Yakov et al., 2018). Significantly, data from studies also demonstrated a correlation between reduced SR events and sensory modulation interventions for patients who engaged with the sensory modulation interventions (Yakov et al., 2018).

Development of seclusion and restraint reduction programs must also consider the relationship between the nurse and the patient as a significant predictor to client outcomes on psychiatric units (Jalil et al., 2017). Research highlights the incidence of nurse anger as a predictor of seclusion and restraint events particularly when the anger results from insults or personal attacks initiated by the patients (Jalil et al., 2017). Debriefing amongst the staff and support from leadership to help anticipate, process, and mediate these experiences for nurses may help improve the relationship between the nurses and the patients and ultimately contribute to a reduction in SR events (Jalil et al., 2017).

The research suggests a positive association between nurse empathy and the use of CM indicating a need to further explore the education, training, and skills of nurses to examine ways

to improve empathy as a means of reducing the use of seclusion and restraint (Doedens et al., 2019). Also relevant is the introduction of additional training in de-escalation and communication as a means to improve the therapeutic relationship and improve the potential for change in the use of CM (Dixon & Long, 2022). Studies that examine the composition of nursing teams conclude that the presence of more male nurses on a shift appears to lower the incidence of seclusion and restraint indicating a recommendation to consider the team when preparing staffing schedules as an effective means of working toward the overall reduction of restrictive practices on inpatient psychiatric units (Doedens et al, 2021).

All meaningful efforts initiated toward the reduction of the incidence of SR events in psychiatric facilities will require an emphasis on developing and implementing evidence-based solutions that involve training, preparation, and education across all staff disciplines including nurses, behavioral technicians, cafeteria staff, security, housekeeping, direct care providers, and all who interact with the patients (Griffin, 2022). This emphasis on reduction programs that incorporate an all-encompassing approach to training is associated with a lowered incidence of SR events and higher patient satisfaction in treatment that generally results in improved treatment outcomes for patients (Griffin, 2022). However, it is noted that a successful SR reduction program also includes emphasis on relevant factors before, during, and after the event and should be viewed together for analysis (Aguilera-Serrano et al., 2018). Additional factors that contribute to the success of SR reduction include the physical organization of the unit and the overall relationship between the psychiatric providers and the patients (Aguilera-Serrano et al., 2018).

Summary

This review points to the need for further examination and study to understand the factors that influence the practice of SR on inpatient psychiatric units. Discussion in the literature points strongly toward a global movement to reduce and eliminate SR as a practice and to move toward therapeutic interventions that emphasize autonomy for the patient. Although reforms within the mental health system have continued to move in this direction, there is only limited evidence of success with the implementation of SR reduction programs, and further research is needed to broaden opportunities for understanding the staff decision to implement SR. Current understanding of staff experience of SR is limited and requires further investigation.

In the next chapter, I describe the methods used to explore staff experience of SR on psychiatric units and examine how that experience may influence the application of SR. Historically, the debate on SR has endured since the 1830s with arguments both for and against this emergency practice that challenges the mental health community with both ethical and safety concerns. SR events are used to protect patients from self-harm and to preserve the safety for staff and other patients in the unit environment. However, negative, grave, and detrimental outcomes of SR events have been found to impact both staff and patients and continue to demand attention from government bodies, stakeholders, consumers, and staff (Brophy et al., 2016). Multiple factors identified in the literature contribute to the use of SR and have been identified to include IPA, staff experience and attitudes, staffing levels, patient demographics, and environmental influences (Anderson et al., 2021; McKeown et al., 2019; Oostermeijer et al., 2021).

However, there is a shortage of literature regarding the impact of the adverse effect of SR on psychiatric staff and how this may in turn negatively impact staff morale, increase emotional

exhaustion, reduce hope in therapeutic outcomes, and decrease job satisfaction. SR interventions may be emotionally stressful for staff, but the literature reveals a gap in knowledge about the specific emotions staff experience before, during, and after these events that hinders understanding into precipitating factors for these events and limits efforts toward reduction and elimination of SR. Additional research on the topic could improve understanding into the events that lead to SR incidents and help inform training and prevention programs while also assisting staff with developing self-awareness about how their own experiences contribute to SR events. SR events raise ethical and moral concerns for psychiatric providers who are faced with the dilemma of attempting to balance patient and staff safety in light of aggressive and dangerous behaviors while also safeguarding patient rights and the therapeutic alliance. The potential for a cycle of aggression and SR events is observed as a negative outcome in the literature, as SR events tend to increase patient aggression that may then lead to additional SR events and continue to expose staff to occupational hazards (Varpula et al., 2020).

Specific research that aims to define and understand staff attitudes toward psychiatric patients may be useful in determining how to integrate appropriate training, education, and therapeutic interventions that serve to modify and improve the therapeutic staff-patient relationship while also working to instill an environment based on problem-solving with the goal to prevent or avoid SR events on inpatient psychiatric units. However, it may be also relevant to consider that in addition to aiming for SR reduction, there should be efforts to simply improve the SR experience for patients. Communication, contact with staff, and participation in treatment appear as significant factors for patients and may influence their experience of CM. Additionally, the experience of respect, support, and concern displayed by staff may improve the CM experience for patients.

The importance of this research is emphasized by the literature that suggests that lowered staff morale, increased emotional exhaustion, reduced hope in therapeutic outcomes, and lowered job satisfaction will also in turn negatively impact staff motivation to participate in SR reduction interventions. Thus, the suggestion remains that further research into staff experience of SR may add new knowledge to the literature that may positively impact efforts to reduce SR use in psychiatric units. By building on the empirical study of previous researchers, this study aims to more profoundly explore the lived experiences of inpatient psychiatric staff to broaden knowledge and understanding of SR events from the perspective of staff. The next chapter provides an overview of this qualitative study using a phenomenological design that focuses on the subjective lived experiences of staff who encounter SR events on psychiatric units.

Chapter Three: Research Methodology

Overview

The purpose of this chapter is to explain the research methods for this study that examined the SR experiences of staff on inpatient psychiatric units. This qualitative study permitted a more profound comprehension of the experiences of staff related to SR events and broadened current understanding of their personal involvement in SR. This research strategy, including the methodology, design, procedures, data collection and analysis, and participants are the focus of this chapter.

This research study examined experiences regarding exposure to SR events among inpatient staff on adult psychiatric units, surveyed their attitudes toward the use of SR, and measured their knowledge and training regarding the use of SR prevention efforts. The efforts were aimed at providing staff the opportunity to explore and express their experiences and discover how those experiences impact their attitudes, job satisfaction, and use of SR. Inpatient psychiatric staff including nurses, mental health technicians, and staff therapists from Baker Act-receiving facilities in Florida were recruited to participate in interviews via a licensed version of Zoom, telephone, or in-person with the researcher.

This chapter presents the methods and research design for this dissertation study concerning the experiences of inpatient psychiatric staff as it pertains to the SR event. The chapter begins by presenting the design of the study followed by the research question; this is followed by an overview of the participants who were recruited for this study. Next, the procedures are explained beginning with securing IRB approval and the endorsement of Department of Children and Families. Next, a discussion on the data collection follows with explanation of the unstructured interview process, which is followed by a discussion on the

transcription and coding process that was used for analysis. The primary goal was to collect information that will answer research questions, allow for recommendations for future studies, and provide clinical and administrative implications for SR reduction efforts in inpatient psychiatric units. The researcher aimed to align this study with specific needs identified in the literature to capture and understand the experiences of inpatient psychiatric staff and how they relate to the implementation of SR (Jalil et al., 2017).

Design

This design is a descriptive phenomenological study that examined the lived experiences of the inpatient psychiatric staff relative to their participation in SR events. This design was selected because little is known about the direct experience of inpatient staff before, during, and after SR events despite the significance of their roles on the psychiatric unit and their direct participation in all aspects of the event. A descriptive phenomenological design facilitated a better understanding of psychiatric staff experiences while also helping to identify and address their needs and those of the patients (Shorey & Ng, 2022). Phenomenological design permitted exploration of the subjective experiences of staff and emphasized the importance of learning from the experiences of others (Neubauer et al., 2019). Of all the possibilities, it is only this design that facilitates the most powerful insight into what was experienced in an SR event and how it was experienced by the staff leading to an informed discussion on new policies, procedures, and responses for staff.

Research indicates the importance of the role of inpatient psychiatric staff in the decision to utilize SR or prevent SR events through the introduction of interventions or de-escalation techniques (Hawsawi et al., 2020). Additionally, other gaps in the research point toward the need for research that explores the experiences of the involved staff which may provide feedback that

will help to identify and describe the predictors and deterrents to SR events (Staggs, 2020, 2021). There was a strong motivation to gain understanding of the experiences of inpatient staff when exposed to SR events and to appreciate the meaning of those experiences more deeply for the staff. Qualitative methodology appeared most useful to examine the perceptions and experiences of the participants because it provided the insight and the interpretation for the experience that can lead toward the development of improved practices and policies within the field of inpatient psychiatric care (Heppner et al., 2015).

The research question was designed to explore what psychiatric staff experience before, during, and after SR events to augment understanding of these events on psychiatric units. Further research on staff experience was needed as evidence for their role in creating effective strategies for reducing coercive practices and alternatives to preserving safety in the milieu. The reduction of coercive practices demands a wide assortment of approaches (Goulet et al., 2017). However, it remains most relevant to focus on enhancing comprehension of the subjective experiences of staff who are tasked with the initiation and culmination of these events on the psychiatric units.

The researcher recognized the value of questioning as integral in understanding the lived experiences and personal perspectives of the participants. The specific formulation of the research question reflected what the researcher wanted to know about the experiences and perspectives of the participants while creating the opportunity for true exploration and reflection. However, in consideration of the discussion in Ward et al. (2018) that alerts to the potential for researcher bias and disruption to the natural flow of data when there are too many research questions, the researcher has identified one broad question. The research question was designed

to give direction for the study design and collection of data while also aiming the researcher toward discovery.

Research Question

RQ: How do psychiatric staff describe their lived experiences in SR events within a designated receiving facility?

Setting

The setting for the research was at the discretion of the researcher and the individual participants with options for on-site interviews at the participant's workplace, neutral locations as agreed upon by the researcher and the participants, or video options via Zoom.

Participants

Recommendations from Heppner et al. (2015) focus on the need to utilize criterion-based sampling when selecting participants ensuring that all will have experienced the research phenomenon and will capably express their experiences. For this research study, the criterion included (a) 9-17 inpatient psychiatric staff members who are currently employed on an adult psychiatric unit at a designated Baker Act receiving facility in Florida, (b) male and female staff with a minimum of 1,200 hours of work within the last year, and (c) exposure to a minimum of 12 SR events during the past 36 months either by direct participation or as a witness. The researcher included participant recruitment for psychiatrists, nurses, therapists, behavioral health technicians, and other employees who were identified as normal participants and decision-makers in the SR process (Jalil et al., 2017).

Initial recruitment for the general population of participants focused on all staff employed at Baker Act receiving facilities with the target population identified as those with significant exposure to SR events defined as a minimum of 12 SR events during the past 36

months. Purposive sampling procedures were used in this study to facilitate the collection of data from willing participants who are actively involved in the research topic of SR events and were able to participate in a meaningful way. Selection of purposive sampling permitted better pairing of the sample population to the aims and objectives of the research, which improved the rigor and the trustworthiness of the study (Campbell et al., 2020). A sample size of 9-17 participants was selected to best achieve saturation in this study (Hennink et al., 2022).

Procedures

The researcher began this study by seeking and securing Institutional Review Board (IRB) approval. The researcher then petitioned a meeting with the regional office of the Department of Children and Families (DCF) who oversee the designation of Baker Act receiving facilities to present the project. During this meeting the researcher described an overview of the process including the specific research questions outlined in Appendix A, potential implications for the research related to the use of SR, and the proposed methods of participant recruitment by advertisement. The researcher presented the interview questions (see Appendix A), and sought input and approval from Department of Children and Families to move forward with the project.

Following endorsement, the next step was to seek the opportunity to present a summary of the project to the directors at the next scheduled Baker Act Task Force meeting in the region. After this meeting, the researcher followed up with an email to the directors of 127 Baker Act receiving facilities in Florida, with exclusion of the researcher's place of employment, requesting permission to advertise recruitment for inpatient psychiatric staff to participate in interviews with the researcher. The researcher utilized a designated email address for questions, responses, and feedback from the advertisement and monitored it daily for responses.

The researcher contacted all responding participants to arrange interviews via Zoom with options for interview times available to accommodate all work shifts. Prior to the initial interview, the researcher offered the participants an opportunity to ask questions and express concerns. The researcher recognized the benefit of this initial meeting as a means to building rapport with each one of the participants (McGrath et al., 2019).

During the initial meeting, the researcher collected demographic data from each participant including age, gender, ethnicity, job title, and years of work experience. The selection of demographic fields was chosen to provide further analysis of SR experiences and how individual characteristics may be associated with different perceptions of the experience. The researcher provided a consent form (Appendix C) to each participant outlining the purpose of the study, confidentiality, risks and benefits, and obtaining consent to participation, including recording of interview. The researcher explained the consent to each participant with emphasis on protecting their rights, ensuring confidentiality, and explaining their option to withdraw from the study at any time.

The researcher recorded the interviews and took notes during the discussion to observe and record facial expressions and body language of the participants. The interviews were then transcribed in the next phase of data analysis. The researcher read the transcripts several times to deepen understanding of the experiences and observe phenomena related to the objectives of the study. Next, codes were identified and categorized into themes using manual coding enabling the researcher to observe connections to the content of the study.

In order to keep the data confidential, the researcher utilized cloud-based storage on her laptop computer that is password protected. The researcher conducted interviews over the course

of the next six months aiming to achieve a minimum of 9-17 participants before ending this phase and beginning the transcription for analysis.

Data Collection

The unstructured interview format is endorsed in the literature as a preferred option permitting the participants an opportunity to respond without restriction or boundaries to enhance the potential for themes to emerge independently (McGrath et al., 2019). However, recognizing the historic problem of researcher bias that is associated with qualitative research, there is need to implement procedures to reduce bias and safeguard trustworthiness (Jones & Donmoyer, 2021). Therefore, the researcher implemented the Formative Influences Timeline (FIT) strategy as part of the approach to the interview. This technique restricts bias from the researcher by encouraging the participant to respond with only prompts from the researcher but leaving open the opportunity for the researcher to continue probing based on the response of the participant (Jones & Donmoyer, 2021).

Interviews were recorded via Zoom with the researcher with permission for recording secured in advance. The researcher recognized the concern for the use of virtual modes of interviews noting the indicated concerns for the quality of responses, diminished reliance on nonverbal cues, and concern for methodological rigor (Tremblay et al., 2021). However, the researcher identified the benefits associated with virtual interviews including easier access to participants, reduced time commitment, and participants engaging more comfortably at home or in their chosen space as outweighing the potential impact of negative influences (Tremblay et al., 2021).

The researcher used open-ended questioning (see Appendix A) seeking feedback from participants relative to their personal experiences with SR, their attitudes toward SR use, their

training and education on SR reduction techniques and interventions, and inquiring about their suggestions for modifications to SR reduction alternatives and programs. Interview questions were designed to address the content of the identified research question. To promote trustworthiness, the researcher provided each participant with a copy of the transcribed interview for their approval.

Data Analysis

Descriptive data was used with the researcher relying on transcription and coding of the interviews followed by examination of emerging themes and ideas (Heppner et al., 2015). The researcher utilized a dual approach to data analysis incorporating both a traditional manual method using transcription of the interviews and using Grain software that was purchased for this research, to achieve a thorough and practical approach to data analysis with improved reliability (Maher et al., 2018; Woods et al., 2016). The transcripts of the staff interviews were read and reread and coded for words, phrases, and meanings utilizing an inductive approach to gathering data (Heppner et al., 2015). The researcher assigned colors to words, themes, and ideas that appear in the transcription and code accordingly with highlighters using this traditional method to achieve a deeper immersion in the data as the themes emerge (Maher et al., 2018).

The researcher then read the text of the interviews on the computer screen using Grain software and highlighted key areas and assigned codes to these sections. Emerging themes and responses to the interview questions were identified through the analysis. Grain software was useful to record and store any connections or notes made during the coding process and permitted comparison between the manual transcription and the electronic version achieved through the software (Woods et al., 2016). Data was stored in a private, cloud-based forum that

remained password protected throughout the study. After the required IRB retention period, any physical data will be shredded and all computer files will be deleted.

Trustworthiness and Ethical Considerations

Adler (2022) asserted that trustworthiness is essential in assessing qualitative research and that transparency is the most important element to consider. This is best achieved by clarifying the research techniques as well as the theory behind the study (Adler, 2022). Efforts to ensure trustworthiness and ensure credibility, dependability, transferability, and confirmability in this research study included (a) an audit trail that details every step of data collection and data analysis (Carcary, 2020), (b) the use of tables to collect and manage data (Cloutier & Ravasi, 2021), and (c) the use of environmental triangulation to attempt to ensure the use of more than one Baker Act receiving facility to obtain data (Stahl & King, 2020).

Ethical considerations that generally guide research practices and design are aimed to follow a specific set of guidelines that preserve and protect the participant's rights (Hilppö et al., 2019). However, the strong emphasis on these identified tasks including informed consent, explanation of the research project, and anonymity, are criticized for falling short and failing to consider ethical concerns that may arise during the study (Hilppö et al., 2019). This researcher aimed to adequately plan for ethical considerations by establishing a well-planned procedure for obtaining consent, explaining the project, and ensuring anonymity before the study began. Additionally, the researcher utilized the guidance of the American Psychological Association (APA) Ethics Code and explained (a) the participant's right to withdraw from the research at any time, (b) potential risks or adverse outcomes, (c) potential benefits of the research study, (d) the limits of confidentiality, (e) the potential incentives associated with participation, and (f) a contact number for questions or concerns (APA, 2017).

Summary

The selected qualitative method was used to examine the lived experiences of inpatient psychiatric staff to more accurately understand how their personal experience of SR influences their decision to implement or avoid the use of SR to manage the therapeutic environment. The researcher aimed for a participant group of approximately 9-17 staff members currently employed on adult psychiatric units at Baker Act receiving facilities in Florida who have worked a minimum of 1,200 hours within the last year, and have either participated in or witnessed a minimum of 12 SR events during the past 36 months. The researcher sought to demonstrate the association between the lived experiences of staff and use of SR on psychiatric units while identifying characteristics of staff including level of stamina or exhaustion, morale, and belief in the therapeutic outcome that may predict use of SR.

While there is ample evidence of the negative impact of SR on both staff and patients who participate in these events, there is a lack of insight into staff perceptions regarding SR, their ideas on reduction and elimination efforts, and their ideas for alternatives. The researcher aimed to add findings to the existing research on SR that will help illustrate the staff struggle between care and control when faced with aggression in patients. The next chapter will provide an evaluation of the results derived from the data collected by analysis of the lived experiences of inpatient psychiatric staff as related to the experience of SR events. The analysis by themes and categories will generate conclusions about these lived experiences while comparing results to previous studies.

Chapter Four: Findings

Overview

This chapter presents the results of my analysis. The purpose of this chapter is to present the analysis of data and to discuss the findings as they relate to the research question exploring the lived experiences of inpatient staff as it relates to SR events. I will describe the qualitative data collection methods utilized as well as present the findings from the research study whose purpose explored how staff cope with the experience of SR events at designated receiving facilities within Florida. The first section will present a brief description of each participant identified by a pseudonym. The second section will detail the data analysis and procedures using narrative data and themes that surfaced in the data collection. The third section will detail the results organized by theme according to the responses from the interview questions. The third section will detail the data analysis using narrative data and themes that surfaced in the data collection. The last section will report on the responses to the research question.

Data Analysis

Participants

Participants in this study included inpatient psychiatric staff members who are currently employed at a designated Baker Act receiving facility in Florida. Participants included female and male staff with a minimum of 1,200 hours of work within the last year, and exposure to a minimum of 12 SR events during the past 36 months either by direct participation or as witness. The sample included nurses, behavioral health technicians, therapists, trainers, and administrators who were recruited via advertisement through emails, flyers, and social media.

Interested participants reviewed and completed a consent form, scheduled an interview date and time, and then participated in a recorded session via Zoom. Participants were assigned a

pseudonym to protect their real identities and preserve confidentiality for their places of employment. The participants bring a total of 127 years of psychiatric work experience to the study representing a total of 10 different Baker Act receiving facilities.

Rachel: Rachel is a nurse with approximately 35 years of experience working within the field of mental health. She has worked in various capacities as a charge nurse on several different adult psychiatric units, as an administrator overseeing a large mental health facility that included acute stabilization units for patients under Baker Acts, and as an instructor of nurses.

Monica: Monica is a nurse with approximately seven years of experience working within the field of mental health with the first five years dedicated to working as a behavioral health technician in two different facilities and the last two years working as a registered nurse. She is currently the program manager for an adult psychiatric unit at a Baker Act receiving facility.

Emily: Emily is a behavioral health technician with 25 years of work experience between two different Baker Act receiving facilities in addition to a medical hospital.

Denise: Denise is a behavioral health technician with five years of work experience at one Baker Act receiving facility.

Judy: Judy is an administrator with 25 years of work experience in various roles at one Baker Act receiving facility. She is currently the Quality Improvement Manager at the same facility.

Phoebe: Emily is a Licensed Clinical Social Worker with 10 years of experience at two different Baker Act receiving facilities.

Ross: Ross is a Social Worker with 20 years of work experience in various roles at a Baker Act receiving facility. He is currently assigned as the Program Manager for the Assessment Services Department and is the primary trainer for de-escalation strategies,

management of physical aggression by the patients, and the application of restraints on patients who are placed in seclusion.

Table 1

Participants

Pseudonym	Rachel	Monica	Emily	Denise	Judy	Phoebe	Ross
Years of Experience	35	7	25	5	25	10	20
Job Title	RN	RN/BHT	BHT	BHT	ADMIN	LCSW	ADMIN
Circuit	19	19	19	19	19	19	19
Gender	F	F	F	F	F	F	M

Data Preparation and Management

Zoom recordings of each of the participant interviews were stored to a cloud-based account in Microsoft One-Drive that was password protected. Then, I manually transcribed the interviews of each of the participants into separate Word documents and stored them to the cloud-based password protected account. Each of the transcriptions was labeled with the participant's initials and assigned pseudonym for the study. Following the process of manual transcription, the Zoom recordings were uploaded to the Grain software program for transcription to gain comparison and improve reliability of the resulting data. The resulting transcripts were downloaded from the Grain software program in PDF form to the cloud-based password protected account in Microsoft OneDrive. Both versions of transcription were read and reread with the goal of becoming immersed in the data and familiar with the content.

Both versions of transcription were then compared using the compare function in Microsoft Word to highlight differences between the two documents. This comparison function of Microsoft Word permitted the merging of both documents into one where any discrepancies between the two documents could be easily viewed and analyzed. It is noted that the identified discrepancies numbered in the thousands, which necessitated further examination and review of

the transcripts. This process was repeated for each of the interviews. The resulting merged documents were then stored to the cloud-based password protected account in Microsoft One-Drive.

A line-by-line comparison of the document pairs was performed within the merged document. Areas of discrepancy were identified and then reviewed within the document before determining if they were classified as significant or insignificant. I identified word omissions in the software transcription and contraction misses in the software transcription that were then reviewed in the original audio to determine significance. An example of those discrepancies is illustrated in Table 2.

Table 2

Examples of Transcription Discrepancies

Manual Transcription	Grain Software Transcription	Significant	Insignificant
kinda	kind of		x
depending who the person might be	depending on who the person might be		x
their stay is not easy…	their stay is not an easy one		x
I know I wouldn't want to get in the gown myself	I know I wouldn't want to get the gown myself	x	
I don't know the policy and procedures	I don't know the policy procedure		x

In most instances, there were no significant discrepancies to note. In some instances (see Table 2) where there was a shift in content meaning, I returned to the audio for contextual clues to obtain the correct transcription. As noted in Table 2, one of these significant discrepancies was related to the statement, "I know I wouldn't want to get in the gown myself" transcribed by the Grain software as "I know I wouldn't want to get the gown myself." This was noted as a significant discrepancy because the Grain software altered the intent and meaning of the participant. The participant's intent was to explain her empathy with the patient who is forced to remove personal clothing and replace in with a psychiatric gown in preparation for a search and

skin assessment. The Grain software transcription altered the meaning of the participant's intentions implying that the participant did not want to retrieve or "get the gown;" therefore, this was noted as a significant discrepancy.

A new Word document for each participant was created to separate each excerpt of the manual transcription according to interview question responses. Following the conversion of the Grain software transcription from PDF to Microsoft Word, the same process was performed. I utilized tables within each document to track transcript text, researcher notes, codes, and the time and date that each first round code was created. These documents were then stored to a cloud-based account that was password protected.

The text of each transcript was then manually coded into words and phrases in two rounds. During the initial round, I used descriptive coding to generate a list of codes that surfaced in the interviews. This initial group of codes represented excerpts from each of the interviews and were developed using an inductive approach that permitted the ideas and themes to emerge from the data itself. This process resulted in a lengthy list of original codes in the form of words or short phrases. The sum of initial codes was 233. These codes were then stored in a code book (see Appendix H) created in Microsoft Word to record the meanings of each code and preserve them as a means of reference.

The second round of coding required a line-by-line approach to enable a more detailed and specific code list. The second round of coding also permitted time for closer examination to ensure that all codes were represented. Codes were refined and then categorized followed by the process of identifying and developing themes. The codes refined in this second round of code development condensed the original list from 233 to 31 codes.

Thematic Analysis Steps

Becoming Familiar with the Data

I applied a simple, 3-pronged approach to becoming familiar with the data. The first part centered on the actual manual transcription of the participant interviews that required playing and replaying the audio of each session at a reduced rate of playback speed. This occurred over the course of several days for each interview, with each interview requiring several hours to accurately transcribe in its entirety. Difficulties encountered included unintelligible responses, interference with audio, and discerning word clarity.

The second part focused on immersion in the data by reading and re-reading the manually transcribed transcript and the computer-generated transcript via Grain software. This process occurred throughout the data collection and data analysis period and with the exception of only scheduled breaks remained a daily occurrence. The third part focused on frequent listening to the audio of each session. This process occurred throughout the data collection and data analysis period and was scheduled two times weekly.

Creation of Initial Codes

Initial codes were created to represent the patterns and meanings identified in the data. Because the collection of data occurred over the period of several months, some of the coding of the transcripts began before all of the interviews were completed. Each of the transcripts was divided into sections according to content to allow for more thorough examination of each of the smaller segments of the whole. Codes were written in a column next to the transcript with room for notes and the time and date that the code was created. This process required several readings to ensure that major ideas were not missed. An example of this coding process is illustrated in Table 3.

Table 3

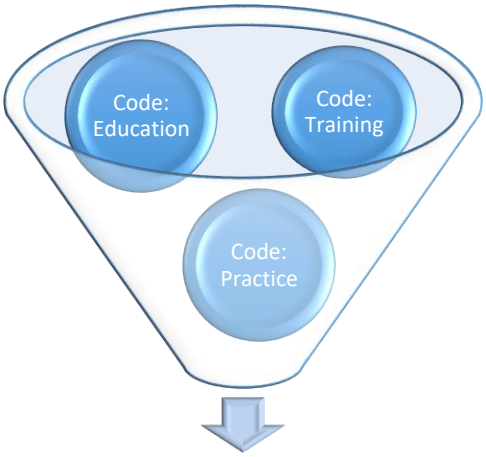
Creation of Initial Codes: The Process

Transcript	Theme	Notes	Code	Time Created
Umm, So, umm, working on an adult psychiatric unit umm definitely is a high stress environment…	Work-related stress	Initial comment – prior to interview indicated she had a "long day at work" Had experienced SR event earlier today	Work environment stressful	4/19/2023 0200 Identification of theme 5/1/2023
but also, umm you know ensuring that everyone's safe and there's a lot of detail in terms of safety that nurses specifically are responsible for on the unit	Safety Our Failure What goes wrong	Spent the day writing SR reports Reviewed SR video	Safety Nurses Responsible	4/19/2 003 0200 Identification of theme 5/3/2023

I continued this process for a second round of codes with the goal to ensure that transcription excerpts that embodied the same meaning would be labeled with the same code. When necessary, the codes were refined, which in some instances, meant combining two or more codes into one. See Figure 1.

Figure 1

Revised Code: Prevention of Seclusion and Restraint



Revised Code: Prevention of Seclusion and Restraint

Although I relied on an inductive approach to coding with a strong emphasis on description to represent the responses of the participants, there was room for incorporating interpretation and subjectivity. Interpretation permitted the development of ideas about the descriptions offered by the participants and determining relationships between these ideas. This is evidenced in Figure 1 as the original codes of training, education, and practice are merged into a revised code identified as the prevention of seclusion and restraint.

Collation of Codes with Supporting Data

Codes were handwritten on index cards and spread across the flat work area. Excerpts associated with each particular code were grouped accordingly by cutting them out and putting them with their assigned code. Throughout this process, I encountered several excerpts of text that aligned with more than one code. An example of this occurred with the following text from Emily's interview: "there's no way in calming them down and they have to go in the seclusion room because they are a risk to themselves or others" because it applied directly to the identified codes of safety, seclusion and restraint justification, and de-escalation failure. In these instances, I returned to the context to interpret the meaning associated with the text and ensure it correlated with her thoughts.

Grouping of Codes into Themes

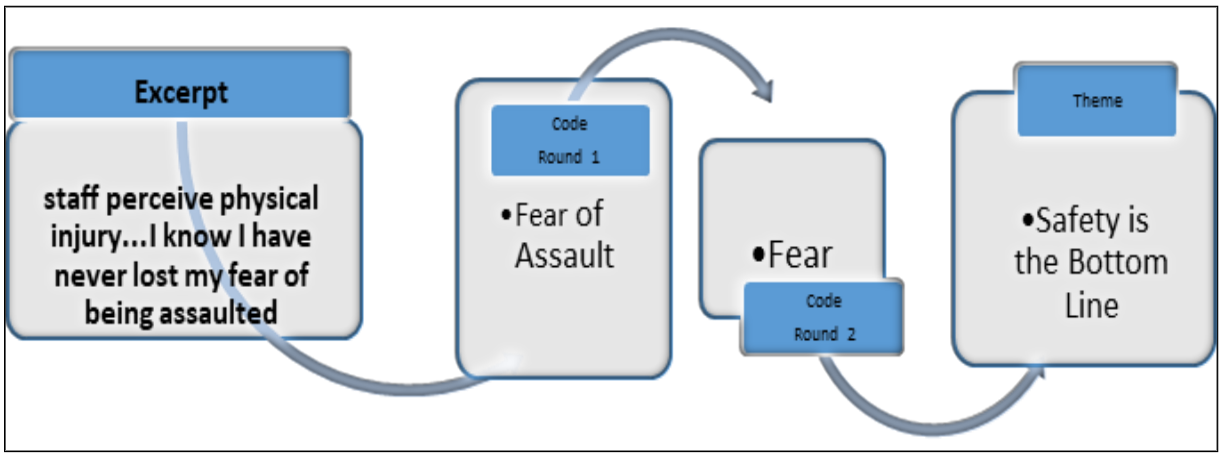
Utilizing the same approach with the codes handwritten on index cards, I sorted the codes into themes. Further study of the themes continued to determine appropriateness of single themes or subthemes. During this process, it was discovered that some codes might become themes in themselves. An example of this surfaced in the interview of the first participant, Rachel. She characterized SR events as "treatment failures" and continued to emphasize the "failures" that occur during psychiatric admissions as instrumental in producing SR events. Interestingly,

Rachel has worked in a supervisory role, a training role, and as a nurse educator where her influence over staff perceptions may be strong. Universally, participants highlighted their weaknesses, lack of training and education, and role in the development of SR events that ultimately led to the development of a theme centered on failures and responsibility for SR events.

An example of the evolution from the raw data of the participant interview through code development and evolution into theme is illustrated in Figure 2.

Figure 2

Evolution from Raw Data through Code Development and Evolution into Theme



Review and Revision of Themes

I then began a review and revision process with the themes prioritizing themes with sufficient distinct data to support them. Further analysis included questioning if the themes were suitable, made sense, and had sufficient data to support them. Themes that appeared similar were merged while themes without sufficient data to back them were removed. Themes were examined to determine if they overlapped with one another or if they contained subthemes that would need to be identified separately.

The greatest challenge in the review and revision of themes was determining if the list was complete or if there were any themes that were missing. Another challenge was restricting personal bias, curbing assumptions, and reducing the influence that ongoing exposure to SR events may be having on the identification of themes.

Narrative of Themes

I then began constructing the narrative about the data and identifying the most relevant and vivid quotes from the data to best illustrate the themes. By this point in the process, I was quite familiar with the quotes that allowed an easy process of selection of the most significant ones to complete the narrative. The narrative was completed with discussion about the analysis and interpretation of the data.

Trustworthiness

Data Collection and Analysis

To ensure trustworthiness, I employed several efforts including (a) the use of an audit trail (see Appendix I) that detailed the steps of data collection and analysis, (b) the use of tables to collect and manage data, and (c) the use of Grain transcription software for creating transcripts to compare with the manually transcribed documents.

The audit trail served as a journal of activity and permitted recognition of differences in data collection between each of the participants. For example, the first participant had expressed interest, submitted her consent form, and scheduled her interview immediately. The participant who was scheduled to be the second participant experienced internet connectivity issues and rescheduled her interview three different times to accommodate a strong internet connection. The sixth participant experienced internet connectivity issues during the interview resulting in missing audio and the need to repeat her response to a question. The audit trail provided

documentation with difficulties with the study, such as the efforts at advertisement that was significant due to the difficulties observed in obtaining qualified participants.

Interviews

To promote trustworthiness, I provided each participant with a copy of the transcribed interview for their approval. It is noted that although each participant acknowledged receipt of the transcribed interview, only five out of the seven participants returned the copy initialed with approval.

Differences from Planned Analysis

Preparation and planning included use of specific tools, techniques, and assumptions about data collection, availability and motivation of participants, and analysis. There were some departures from the plan, with accommodations made to adjust for the changes from the original plan. Failing to accurately estimate influences, costs, and practical elements resulted in some deviation from the plan for analysis.

Research Question

Plan: The plan for analysis in this study focused on one research question that was kept visible at all times during data collection.

Result: The analysis remained focused on the research question but additional questions surfaced that would have been relevant to the study. Questions are logged and may be the focus for future studies.

Data Collection

Plan: Data was to be collected objectively without interference from personal experience, opinions, or assumptions that I may have about the topic of seclusion and restraint measures.

Result: I did not anticipate the effect that ongoing participation in seclusion and restraint events may have on the study. SR events increased in intensity and frequency during the data collection stage averaging three weekly, with my participation as a staff member in one of the Baker Act receiving facilities where I am employed. During one such event, I was injured and unable to use my right hand to type for approximately one week, which delayed my work. During two separate incidents, I witnessed two colleagues severely injured by a patient during the restraint process. In both incidents, the patients bit the staff members resulting in emergency medical evaluation and ongoing monitoring for the next six months for infectious disease. During another incident, I was the primary reporter to administration for the injuries sustained by staff in the event and was required to complete incident reporting, witness statements, and Workers Compensation event paperwork. My plan for analysis did not include any measures for reducing or eliminating researcher bias specific to this personal involvement I have in the process of seclusion and restraint events.

Interview Strategy

Plan: I intended to use the FIT strategy as part of the approach to the interview to reduce bias during the interview process. It was intended to gather information about the participants' experiences working at a Baker Act receiving facility and generate an objective yet well-defined timeline that they could refer to during the interview.

Result: I did not anticipate the need to practice this strategy and become familiar with ways to integrate it naturally, nor did I anticipate the influence of a video session to interfere with use of this strategy. As a means of adjustment, I prompted the participants with only one phrase, "tell me about your experience" and permitted them to interpret that individually.

Transcription Software

Plan: I intended to purchase NVivo software to utilize as part of this study to facilitate the transcription.

Result: I did not anticipate the intricacies and cost of this software. I consulted with a few colleagues and peers who referred me to Grain software, which was simpler and more economically practical.

Environmental Triangulation

Plan: I made attempts as planned to use environmental triangulation to ensure the use of more than one Baker Act receiving facility in the study and was only partially successful.

Result: Despite numerous attempts at advertisement and promotion, I was unable to secure participation from a geographically balanced pool of participants. This part of the initial plan was unfulfilled and outside of the parameters of my control, so there were no accommodations that could be made.

Research Participants

Plan: I planned for a range of nine to 17 participants to complete the interviews.

Result: I was able to secure participation from only seven participants despite numerous efforts at promotion and advertisement through social media (see Appendix D), advertisements via email (see Appendix E), and word of mouth referrals.

Participant Criteria

Plan: The original plan submitted to IRB included criteria that limited the participants to those working as behavioral health technicians, nurses, or psychiatrists at a Baker Act receiving facility in Florida (see Appendix F).

Result: Due to expressed interest from social workers and other administrators who became aware of the study via social media postings, I submitted a request for a modification to IRB to expand the criteria to include other employees from Baker Act receiving facilities. The modification was approved by IRB and I included two administrator participants and one social worker in the study (see Appendix G).

Duration of Interviews

Plan: I planned for approximately 60-90 minutes of interview time with each of the participants.

Result: Participants averaged 22-45 minutes for each interview.

Results

Collection of data spanned an 18-week period of time, primarily because of the slow pace associated with securing qualified participants for the study and arranging interviews. Table 4 displays the primary codes developed from the interviews associated with the emergent themes.

Table 4

Primary Codes Associated with Emergent Themes

Theme	Codes
Contrast of Opinions and Practice	dehumanizing, traumatizing, lasting powerlessness, isolation, unavoidable,
Safety is the Bottom Line	threats, fear, safety, injury, crisis, agitation, escalation, combative,
Ideas for Reducing SR Events	alternatives, safety plan, training, patience, skills, de-escalation, solutions, intervention, suggestions,
Our Failure	treatment failure, assessment, mindful, responsibility, preventative care, nurse scrutiny, intolerance, responsibility

Theme 1: Contrast of Opinions and Practice

The most significant theme for the participants was the internal struggle between their opinions on SR and the application of SR measures as part of their daily work routine. The interviews revealed both the frequency of SR events and the expectation that all staff participate in some tangible way during the events as part of their normal work tasks. All participants expressed adherence to this expectation despite the resulting inner turmoil and conflict. This was most vividly portrayed by one of the participants who interrupted herself while explaining how SR events unfold bluntly stating, "you know what, to be honest, I don't like it," and then pausing for a moment to process that sentiment.

The conflict was identified in some way by all of the participants who consistently express regret about the use of SR referring to it as "a dehumanizing, humiliating experience for the client" and "pretty traumatic for the clients" and even "re-traumatizing for the client" with one participant close to tears explaining, "ok they're in restraints and then we move on…it shouldn't be… they're human beings." Yet, despite the unpleasant emotion, reaction, and negative opinion of the practice, all participants were consistent in emphasizing the necessity of SR in certain situations "for the safety of the unit" and to "help them regain control" and describing it as unavoidable because "at that point in time there's no reasoning… there's no getting through to them… there's no calming them down." All of the participants expressed the sentiment that there were times when there were no other practical, available, or identifiable options with one nurse stating, "I agree that at times it is necessary for safety reasons I don't know what else you would do in certain circumstances."

The interviews revealed a glaring conflict between dislike of the practice of SR and the perception of the practice as "necessary." This phenomenon seems to extend across all levels of

staffing from administrators to behavioral health technicians without prejudice. All participants seem to regard the practice of SR as negative, frightening, and contrary to how they would wish to engage with their patients, but they continue to implement and participate in it as part of the normal daily work routine. The struggle is well illustrated in one participant's words as she reflects on the practice of SR, "no, I mean I agree with it and I agree it is necessary and it's also important to try to avoid it" while another also reflects, "I see it is there for a reason but it would be nice if something else came out in place of it."

Although it is not specifically stated by any of the participants, there was a distinctive and nearly irreconcilable divide between their consciences and their actions when it comes to the implementation of SR. As one participant related, "I also, in being involved in many seclusion and restraints, know that there is in my opinion little to no therapeutic value for the client." All of the participants continue to work in the environment that will inevitably force them to again engage in a practice that clashes with their beliefs about patient care, yet not one suggested that this incompatibility was intolerable.

Theme 2: Safety is the Bottom Line

Another universal theme that surfaced across all of the interviews was the emphasis each of the participants placed on the preservation of the safety of their coworkers and the patients under their care. The participants identified safety as the common denominator for all decisions and opinions about the use of SR under any circumstances, with one participant emphasizing that safety concerns are the only predictors of SR events, "so the decision is completely predicated on is this person going to lash out at another human being or themselves." The strong emphasis on safety also appeared to be sufficient to justify the decision when there was hesitancy as one participant indicates, "I think sometimes it may seem sad and sometimes the client will be crying

or they're fearful and they have this delusion that you're going to kill them and sometimes that can be sad but it's also necessary, it's a safety thing."

Although the participants did not specifically define their description of a safe environment, they do speak to the patient factors that disrupt the environment, identifying instances of danger to include, "clients who are in some way threatening" or "an agitated client" or "a patient might be escalated or you know they might be posturing." Interestingly, there is almost no hesitation for the participants as they connect behaviors to SR events as though there is a distinctive criterion that mandates restrictive measures. As one nurse states, "people straight from the community they tend to be more agitated you know and they tend to have to go in that direction whether it be seclusion or restraint or ETOs also." Secondary to the observable behaviors that frequently disrupt the safety of the environment was staff perception of the potential of danger to themselves, which is summed up by one participant, "there is always the fear of being hurt."

Environmental risk management was identified by each of the nurse participants as a key part of their responsibility on a psychiatric unit. The nurse participants seemed to embrace a core sense of responsibility for preserving the safety of the milieu with emphasis on the protection of life. One nurse reflected on her experience in managing the unit as the charge nurse, "I have to work hard at ensuring that everyone's safe and there's a lot of detail in terms of safety that nurses specifically are responsible for on the unit."

Interestingly, the nurse participants reflected an acceptance of their custodial roles, "in a psychiatric setting what we are mostly doing is we are looking at behaviors and we're looking at signs and non-verbal signs that a patient might be escalated" without mention of any interference that this may cause with their primary role of ensuring that patients receive the care that they

need. The use of SR appears well-integrated into their perception of their job responsibilities as leaders of the psychiatric unit, and it is accepted as a standard element of the unit.

Theme 3: Ideas for Reducing SR Events

A common theme among the participants was the expression of ideas, motivation, and desire to move toward changes in the practices of SR. Although it was not an interview question, each of the participants independently made suggestions as to how to reduce SR events calling for more training, better supervision and guidance of staff, and the use of medication to reduce agitation and potentially prevent SR events. It appeared that the experience and observation of SR events provoked a deeper sense of ownership of the duty to improve the conditions on psychiatric units with the expressed hope that there will be a reduction in SR events. Certainly, there is evidence of reflection, ideas, and even yearning for the reduction of SR events, as one participant states, "I'm all for it…I am totally all for it…" and another elaborating further, "I think if people thought that they had an alternative, and they were taught the alternative, and they used the alternative, and they practiced the alternatives, maybe you know maybe we could reduce it even further." Interestingly, the participants sought to address issues that they themselves could directly influence either individually or by approaching the leadership at their respective facilities. Many of the participants proposed simple directives for staff to follow, with one nurse suggesting that staff work on "being more mindful of things that can overstimulate a patient and being more in tune with what the patient needs."

Additionally, participants called for "relationship building," "following very specific and individualized treatment plans," "offering medication to patients" and "more training" for staff. One participant offered proof of her facility's efforts in the direction of reducing SR events, explaining that a new staff trainer position was created to ensure "continuous training throughout

the month." Universally, there appeared to be concern for the incidences of SR and constant reflection on ways to avoid these restrictive measures in each of the facilities. Participants did not pause to question why tangible efforts in this direction are lacking, but did continue to emphasize that there should be changes made without specifying who is responsible to initiate and sustain the desired changes.

Throughout the interviews, each participant continues to underline the unavoidable nature of SR, while each one also expresses a strong desire for alternative solutions as simple as "spending more time you know trying to talk with them" and as complex as integrating "trauma informed care" and transforming the unit to ensure that reducing SR "becomes part of the DNA of the unit." Clearly, the participants are passionate about the advancement of renewed practices and innovative approaches to resolving the identified issues that prompt a SR event. Despite the negative experiences they cite in reference to SR events, "the emotions I felt in the moment, you know there's a lot of fear around that" and the disappointment, "so I see it in a sense as a treatment failure" there are valuable lessons learned that point towards improvement of patient care.

Theme 4: Our Failure

Universally, the participants recognize the shared roles of both patients and staff in creating SR events but consistently pointed to staff as the primary bearers of responsibility for the prevention and initiation of these events. While identifying patient behavior as the primary precursor to a SR event, the participants also identified the ways they perceive their own inadequacies have contributed to those behaviors and ultimately to the SR event itself. One participant emphasized the theme of failure 10 times in her interview, referring to SR events as a "treatment failure" caused by "relationship failures" and "failures in the environment," The

perception of the participants was that they are responsible for these failures, which may be the precursor to feelings of emotional exhaustion, loss of job satisfaction, and even decreased morale.

Another participant identified staff fault in failing to utilize learned intervention and de-escalation techniques, and stated how in some instances the staff may "in fact escalate a situation to the point of seclusion and restraint." That same participant emphasizes the availability of other options, "there are always alternatives" and places the burden of responsibility on the nurses who manage the unit, "you want to always be aware of what your patient is doing… you know it's mostly a continuous assessment."

The perception of staff responsibility extends from the front-line staff on the unit to the administrative levels with one administrator echoing the same sentiment as the nurse manager, "the philosophy is we need to keep eyes on people and see because we are looking for behavior that is amping up or ramping up." Participants view a direct correlation between their role to observe, monitor, and remain aware in the environment with the likelihood of SR events developing or being avoided. The participants seem to accept this responsibility, enforcing their role to always be "keeping your eyes on the crowd" with one participant with decades of experience stating, "my job has always been more or less to watch and observe our clients for safety." Another participant reflected the same idea, stating that the role of staff is to ensure that they are "really checking in with clients and seeing how they're doing," again an indication of the acceptance of that responsibility to avoid or prevent SR. She concluded with a summary of staff interventions, the use of de-escalation, and the role as observation as elements of "preventative care."

Interestingly, the participants continue to point to the necessity and need for SR to ensure safety, while at the same time describing themselves as the single most important influence in the prevention of the behaviors that lead to SR. Staff accept the idea that in order to fulfill their job responsibilities, they must act in a superhuman capacity and observe patients at all times, document and respond to any concerning behaviors, and initiate successful de-escalation efforts to prevent SR events.

Research Question Responses

The following section provides a summary of responses to the research question. The summary was developed from the participant quotes obtained during the interview process.

Central Research Question

How do psychiatric staff describe their lived experiences in SR events within a designated receiving facility?

Consistently, the data showed that the participants experience SR events through perspectives corresponding to their function at the psychiatric facility and in relation to their job tasks and responsibilities. Participants reflect a core sense of inner turmoil and conflict throughout their narratives and appear to struggle without means of reconciling the divergence between what they believe and what they practice in their respective roles. Interestingly though, there is an acceptance of this conflict and with the exception of the opportunity to reflect during this research study, there is a distinct absence of effort to resolve the incompatibility between beliefs and practices. The emergent themes provide insight into how the participants perceive themselves initiating, participating, and preventing SR events, and more importantly, begin to illuminate their areas of conflict and reveal their almost silent compliance with a practice they all despise.

Individual job functions played a significant role in the way participants experienced SR and how they viewed those experiences. Participants who provide direct patient care experienced personal conflict between protecting the safety of the unit and protecting the patients who become involved in SR events. These participants experience SR through the eyes of their patients, describing their involvement in these events within the context of the patient-staff relationship. One participant reflects on the experience as "traumatizing" for the patient and assigns responsibility to herself, "I view it as a treatment failure on my part, I failed to recognize a sign of escalation that I might have been able to intervene and so not to have the SR." Another participant recognizes the negative impact for both patients and staff, further cementing the fusion of perspectives into one, "I think it can be traumatizing, and in fact, you know for the patient and staff as well." Direct patient care participants experience SR while always remaining mindful of the patient experience.

Participants who function in administrative roles also experience this internal conflict but express a more pragmatic, less subjective connection with the SR events than their counterparts on the units. Their experience of SR is through the eyes of policy, best practices, and procedures with a defined view of the objective parameters that must be met to initiate SR and a clear interpretation of the available alternatives and options to prevent or avoid it entirely. Administrative staff appear to measure their experiences of SR according to the agency standards that govern this practice with less emphasis on the events themselves. Universally, there is agreement among all participants that SR events are negative experiences and should be a last resort solution to a situation of imminent risk of harm, but participants without daily patient contact are more convincing in their stance against the practice, as reflected by one such participant, "the person is here for treatment they are not here to be placed in a seclusion room."

Universally, the participants experience intense levels of violence and aggression as a precursor to SR events. Violence is observed as occurring in both physical and verbal instances and appears to be accepted as a normal element of the psychiatric unit. Despite expressing fear of assault and injury, staff speak of the violence as normal, everyday occurrences that are integrated into their daily routines. Participants describe exposure to patients who are "combative," "posturing," "agitated," and "threatening" with consistent reporting of fear as a result. One participant reflects on the uncertainty of violent situations, "there's always the element of nervousness, because you don't know what to expect" and then questions her own skills and resilience, "I don't know how dangerous it's gonna be, it is something I can handle, these are all things that I have to think about right away."

Participants talked about their experience of feeling inadequate to manage the situations that develop into SR events and feel poorly equipped to handle the process of SR itself. One behavioral health technician reflects on feeling incompetent to manage patients and reports recognizing the need for more training and seeking out additional support from management to fulfill this need. She states, "I have asked for help and I haven't received it" and continues to lament the lack of preparation to manage challenging behaviors among the patients, "I feel that I just feel like there's not enough training…I feel that there could always be more training."

This sense of inadequacy surfaces throughout the interviews as participants speak about their "failures" and missed opportunities "to intervene" and prevent SR events. Additionally, participants responded spontaneously, offering ideas to improve staff skills and increase available options for reducing and avoiding SR while maintaining a sense of hopefulness for change, improvement, and reduction in this practice. Interestingly, the participants view themselves as the force that can change the trajectory of SR practices in Baker Act receiving

facilities, but simultaneously blame themselves for the occurrence of SR as well as endorse it as an unavoidable and necessary practice to maintain safety on psychiatric units.

Summary

The purpose of this qualitative descriptive phenomenological study was to explore how staff experience SR events at designated Baker Act receiving facilities within Florida. This chapter provided a brief description of each participant in the study and identified their roles and experience working in Baker Act receiving facilities. The chapter presented examples of the data in tables with defined themes offering a more comprehensive summary of the data. A synopsis of the responses to the research question was included to understanding the lived experiences of psychiatric staff as it relates to SR events at Baker Act receiving facilities.

Chapter Five: Conclusion

Overview

Restrictive practices are used as emergency interventions in many different settings, such as psychiatric inpatient units, to manage violence and aggression. Although there is an abundance of research on the prevalence of SR and the urgency to reduce its use (Goulet et al., 2017) and the negative impact of SR on the patient (Allikmets et al., 2020; Barnicot et al., 2017; Mooney & Kanyeredzi, 2021), only very little attention has been given to the lived experiences of inpatient psychiatric staff who initiate, witness, and experience these events as part of their normal daily work routine (Jalil et al., 2017). Exploration of staff attitude toward SR is well-documented in the literature (Doedens et al., 2020; Gerace & Muir-Cochrane, 2019), but falls short of examining the experience of SR from the staff perspective. This leaves a gap in the understanding of this practice while also creating a barrier to SR reduction, effective training, and adequate understanding of its effect on staff. This study aimed to explore the lived experiences of SR events from the perspective of the inpatient psychiatric staff members.

This chapter begins with a summary of the research findings as it relates to the research question, which sought to examine how psychiatric staff described their lived experiences of SR events. It is followed by a discussion of those findings as they relate to literature relevant to SR previously explored in Chapter Two. The next section identifies the practical implications of the study with emphasis on relevancy to the mental health community. This is followed by an outline of the delimitations and limitations of the study identified by the researcher, recommendations for future research, and recommendations for future practices regarding the practice of SR. The chapter ends with a summary of the study.

Summary of Findings

Shared Experiences

Despite different purposes, backgrounds, and functions on the psychiatric unit, the inpatient staff and the psychiatric patients share many common experiences in the locked physical environment of the unit. The patient-centered approach that directs acute stabilization and safety on the unit ideally supports the collaboration between patients and staff in identifying goals for care and unites them in this effort. However, the use of CM may interfere with that alliance and contribute to a shared sense of fear, powerlessness, and experience of trauma for both parties.

Trauma

During the interviews, the participants expressed a wide range of views about their experiences with SR events, from aversion and discomfort, to support and defend the intervention as the only option when it comes to the safe management of violence and aggression on the unit. Participants were unified in their views of the experience as traumatic for patients and acknowledged that they may experience the same, especially when SR events are associated with injury for either staff or patients. One nurse participant reflects, “I think it can be traumatizing…and in fact you know for the patient especially…you know staff as well…though I think there’s been a lot of circumstances where staff has been injured during these interactions.”

One participant reflects on the traumatic impact of SR on patients, “So, from a client standpoint I see it as traumatizing… I often think about people that might have experienced physical abuse or rape or even combat trauma and how that must feel as a re-traumatizing situation.” Another participant reveals the complexity of the traumatic experience of SR,

"somebody had to get hurt in order for them to go into seclusion…our team would try and talk to them the best that we can but if they hurt themselves… they hurt another client or staff you know automatically seclusion…" demonstrating how occurrences of injury, traumatic in themselves, may lead to seclusion and additional trauma. Recognizing this trauma for patients seems to be associated with staff aversion to the practice and their hope for changes in practices and the establishment of effective, reliable, and practical alternatives to managing violence and aggression.

Powerlessness

Restriction of patient movement using the environmental intervention of seclusion or the mechanical means of restraint has recognized negative physical and psychological effects for both patients and staff. A significant part of the SR experience is the loss of control, and the powerlessness associated with being forced into a locked room and restrained to a bed. Participants in this study describe the large-scale response of staff to "codes," behavioral disturbances that often result in patients being overpowered and placed in seclusion and restraint. As part of that response team, one of the participants describes her role in restricting movement and eliminating power and control from the patient, "I'm usually holding something…holding a body part…maybe holding down legs or something."

Participant perception of these events continues to reflect the idea of powerlessness, "there's no way in calming them down…and they have to go in the seclusion room because they are a risk to themselves or others…they no longer have control…no rhyme or reason…and yes I've been there." Interestingly, the participants describe their own sense of powerlessness, detailing their lack of sufficient training in de-escalation techniques, the absence of practical alternatives to SR, and their inability to enact options such as medication to prevent SR events.

Participants share the experience of powerlessness with the patients they treat when it comes to SR events.

Fear

Participants agreed that the implementation of SR came because of concerns for the safety of the unit, including patients and staff. They cited the presence of violence or aggression as factors that increased the likelihood of SR to be selected as an intervention. Participants described their intentions clearly, aiming at safety, "I've been in numerous situations where no matter what you do you cannot create a safe situation for a patient and it does require either restraints or seclusion for safety of everyone including that patient."

Yet the intent to protect the unit does not blind them to the experience of the patients, as one participant observed,

> clearly somebody who is in the process of being secluded and restrained even if they're absolutely obnoxiously screaming at you and threatening you … you know it comes from a place for them of fear as well or loss of control.

Participants reflect the same experience of fear during a SR event, explained by a participant, "the whole situation and how I don't know how its gonna unfold… you know bothers me what if I let go of that leg and somebody gets kicked or somebody falls or… you know…the unknown that makes me nervous." Despite being assigned the authoritative role in these events, staff participants reflect vulnerability, and even anxiety, as they manage SR events. One participant summarizes, "approaching a seclusion and restraint situation always involves I believe a sense of staff… from a staff perspective – fear."

Themes

Analysis of the data collected through the interviews of inpatient staff who work at Baker Act receiving facilities resulted in the emergence of four distinct themes summarized as conflict, safety, SR reduction, and responsibility. In the following section, I will discuss these themes and elaborate on their relationship to each other.

Conflict of Opinions and Practice

Participants in this study were interviewed to explore and examine their lived experiences with SR events on inpatient psychiatric units at Baker Act receiving facilities. The first theme, "Conflict of Opinions and Practice," functions as a primary theme and establishes the foundation for the remaining themes. Every participant expressed or displayed conflict between their opinion on SR and their endorsement of it as a necessary practice in their work environment. Despite strong opinions about the negative impact of SR and a desire to avoid it entirely, the participants agreed that it was unavoidable and the only reliable method of restoring and ensuring safety for the milieu when patients threatened imminent harm to themselves or others or initiated any type of aggression or violence.

However, the idea of conflict represented much more than the dissonance between opinions and practice, representing also a core reaction of the participants before and during SR events. In preparation for SR events, participants expressed both a reluctance to engage and a sense of obligation, simultaneously believing there are no other alternatives in the moment but wishing they could avoid the event. During the events, participants are mindful of both their aversion and acceptance of the task to physically restrain and seclude their patients. Universally, the participants accept this conflict and continue to engage in SR practices against their desired preferences.

Safety is the Bottom Line

While the first theme spoke to the inner turmoil experienced by staff directly involved in SR events, the second theme, "Safety is the Bottom Line" spoke to the rationale and justification for SR events from the perspective of the participants. Participants cited intense encounters with violence, aggression, and threats from patients as the grounds for initiating SR events, often commenting on the unavoidable nature of SR. Every participant spoke about their concern for maintaining safety on the unit and relying on SR practices to ensure that safety. At the same time, this theme reflected the validation of participants' decisions to utilize SR even when it directly conflicted with their opinions and beliefs about the practice.

Ideas for Reducing SR Events

The third theme, "Ideas for Reducing SR Events" reflects the participants' response to the direct experience of SR events and their witness of the negative, traumatic impact it has on their coworkers and patients. All participants spoke about ideas for SR reduction without prompting or questioning, offered their input as a natural progression from their lived experiences toward hope for change and improvement in treatment. All advocated strongly for an increase in staff training and the use of SR alternatives including medication as a means to manage aggression and violence on the unit.

Our Failure

Finally, the fourth theme, "Our Failure," reveals perhaps the most significant element of participant experience in SR events. Universally, participants displayed a willing embrace of responsibility for the occurrence of SR events, firmly believing that their failure to appropriately intervene in a timely manner with patients is the cause of these events. While endorsing SR as

the only means to resolve incidences of violence and aggression, participants also blamed themselves that it occurs at all.

The research question was designed to examine how inpatient psychiatric staff experience SR events on psychiatric units at Baker Act receiving facilities. The responses to the interview questions designed to explore this were a fair mix between expected and surprising. It was easy to assume that participants would identify a strong negative experience of SR events and that they would fiercely protect restrictive measures as a means of ensuring safety. However, it was surprising to see that participants so readily assigned responsibility to themselves for these events and promoted alternatives to reduce or avoid SR altogether. Perhaps most striking though, was the experience of internal conflict between opinion and practice that the participants describe, live, and accept during SR events.

Discussion

The historical foundation for the use of SR is found in the theories of 19th century psychiatry with the belief that institutionalization in asylums was required to treat individuals with mental illness (Topp, 2018). The prevailing theory promoted the creation of a new environment within the asylums to isolate individuals from the negative influences of the outside world to foster recovery. Psychiatrists believed that this was the best option to reduce symptoms and treat patients. Overcrowding in the asylums caused conflict and problems among the patients often resulting in violence and injury. As a means of reducing these conflicts, the use of mechanical restraint was employed to help control patients while the use of seclusion helped to isolate the patient (Beames & Onwumere, 2022). Both options were viewed as a normal part of treatment.

Controversy about these SR practices first began in the late 1830s (Topp, 2018) with opposition to the practice focused strongly on the idea that it prevented socialization from occurring naturally. Throughout the centuries, the practice has remained controversial with modern studies focused on the negative effects of post-traumatic stress, dehumanization and distress, and significant damage to the therapeutic relationship between inpatient staff and patients (Askew et al., 2020; Barnicot et al., 2017; Chieze et al., 2019; Mooney & Kanyeredzi, 2021). With some 80% of psychiatric and general hospitals in the USA reporting use of SR today (SAMHSA, 2018), the debate remains relevant.

Inpatient psychiatric staff continue to implement SR despite awareness of the negative outcomes for both patients and staff (Allikmets et al., 2020). This was well-evidenced in the study, as participants cited the "traumatic" effects of SR on both staff and patients while continuing to endorse the "necessary" role of SR to protect and preserve the safety of the environment. Seemingly though, participants were oblivious to the contradiction in their endorsement of a practice that they agree is detrimental to their own well-being. This oblivion may be explained by findings in the literature that reveal staff are likely to repress any emotions associated with these events to cope with the aftermath and continue safe management of the unit (Goulet & Larue, 2018). The participants were able to justify their exposure to negative outcomes of SR experiences because they believed the use of SR to be "unavoidable." This is consistent with the literature that identifies the same belief amongst the majority of mental health nurses who cite exposure to psychotic, violent, and intoxicated patients as reason for sustaining the practice of SR (Muir & Cochrane, 2019).

Participants were unified in their belief that the practice of SR would never be eliminated entirely because it is necessary to maintain the safety of the unit. This is consistent with the

literature that points to the same belief that elimination of SR is not practical (Gerace & Muir-Cochrane, 2019; Lantta et al., 2020). However, in a stark departure from the findings in the literature that demonstrate that staff are unmotivated to seek alternative interventions to avoid SR (Lantta et al., 2020), the study participants advocated strongly for other options and were bursting with ideas for change and improvement. In some instances, their suggestions lined up almost perfectly with evidence-based practices supported by literature. Study participants supported the integration of therapeutic tools such as safety plans suggesting they may influence a reduction in SR events. This is supported in the literature with a highlight on interventions during admission that reduce the prevalence of aggression and violence in patients (Väkiparta et al., 2019). Also significant is the strong emphasis that study participants placed on the augmentation of training and education in de-escalation techniques and interventions as a means of reducing SR. This is well-supported in the literature where it is noted that SR reduction efforts are positively enhanced when aligned with training and education for the staff (Griffin, 2022).

Interestingly, the study participants were strongly focused on responsibility and blame for SR events, identifying themselves as the sole bearers of that burden. This same experience of blame during SR events associated with caregivers who are responsible for psychiatric units is reported in the literature (Muir-Cochrane et al., 2018). However, the study participants reported those feelings occurring earlier in the process, identifying themselves as the ones responsible for failing to act quickly enough to prevent SR events. Study participants consistently identified their own inadequacy and lack of access to effective and ongoing training as reasons they miss these opportunities to prevent SR.

One of the great paradoxes of the study results involves the participant focus on the preservation of unit safety as the justification for the continued use of SR. Participants were

adamant that this was the only justification for SR events and never swayed from this stance. They consistently emphasized the need to protect patients and staff by initiating SR to control violent, aggressive, or threatening behaviors. Although the use of SR is upheld as a means to protect patients and to restore safety, the evidence shows that there is considerable potential for risk and harm to patients during actual SR events, including exposure to respiratory distress, cardiac injuries, falls, and even incidents of self-harm while alone in seclusion rooms (Kersting et al., 2019). Further, the evidence shows a similar risk for staff who experience strains and sprains during these events (Kersting et al., 2019). As the participants seek to preserve safety by initiating SR, they may in fact be exposing themselves and their patients to a greater risk for harm and injury.

Staff exposure to harm and injury during SR events is a frequent occurrence in my personal work experience. During the course of this study, I personally witnessed two severe injuries sustained by staff during the attempted application of restraints on patients. Both incidents required emergency medical care and ongoing treatment. A third injury occurred without my direct witness but I assisted in the management of the incident and the follow-up with staff. Those injuries were viewed as unfortunate casualties of the work environment. It may be suggested that as a group, inpatient staff accept the risks associated with the work environment and grow accustomed to the occasional sprain, strain, or bite.

Personally, I have sustained dozens of injuries during my career at Baker Act receiving facilities. In most instances, the injuries occurred just prior to a SR event, during a patient's angry outburst, or an altercation between two patients. In two instances, the patient was experiencing psychosis and reacted to staff with aggression born out of fear. During the study, I sustained an injury during an attempt to seclude and then restrain a patient, leaving me without

the full use of my arm for several weeks. However, unlike my first such injury sustained in 2013, I did not pursue or require emergency debriefing with a therapist. Similar to the experience of the participants, there is an acceptance of the SR practice and the consequences. I walk into work with the knowledge that I may be exposed to violence and sustain physical injury without much warning.

However, these personal injuries are reminders of the negative impact of SR and in some instances can lead to traumatic stress, feelings of resentment, guilt, and even frustration with the patients in my care. It is a great challenge for all mental health practitioners to manage the impact that these feelings can have on the therapeutic relationship. However, perhaps the most profound struggle is resolving the moral conflict between the desire to treat patients and being forced to act in coercive, and in some instances, abusive ways towards those same patients.

Implications

The purpose of this section is to identify the implications this research has for the use of SR in Baker Act receiving facilities in Florida. The results hold implications for practices and policies within the mental health field that address the reduction of these restrictive practices as well as the training for staff who work at these facilities.

Practical Implications

Recognizing that inpatient psychiatric staff are a significant part of the milieu and interact daily with their patients, it follows that they are a valued resource in understanding the origin and development of SR events. Accordingly, these staff members are reliable witnesses to the impact of SR on both patients and staff, and may be the most suitable candidates for the development of post-event debriefing and SR reduction programs. However, although the participants expressed many ideas, creative solutions, and even motivation for making positive changes, they are absent

from the decision-making processes that define de-escalation trainings, SR alternatives, and support resources for staff impacted by SR events. Administrators at Baker Act receiving facilities must begin to listen attentively to their inpatient staff and invest in their feedback when making decisions about SR. Managers must also ensure that inpatient staff have the time to attend ongoing trainings and participate in debriefings after SR events.

Implications for Policies

The findings of this study encourage the development of policy modifications that may positively influence the work experience of inpatient psychiatric staff as they work toward the reduction of SR events at Baker Act receiving facilities. The research found that inpatient staff including nurses, behavioral health technicians, and therapists experienced feelings of inadequacy in managing efforts to prevent SR events and desired more comprehensive training and education with opportunity for ongoing review and updates. The study also revealed that despite their sense of inadequacy, inpatient staff have faith in therapeutic interventions as a means of SR prevention and reduction and seek to implement them whenever possible. They view themselves as responsible for initiating successful interventions and identify those interventions as essential.

Current Florida law as specified in Section 394.457(5)(b), F.S. (Florida Mental Health Act, 2021) requires initial training for new employees including verbal de-escalation intervention and techniques within their 14 hours of orientation and 12 hours of in-service training. Law also stipulates annual updates of 12 hours of training that cover all job responsibilities, skills, and knowledge required for each specific position. The study suggests that this is insufficient to meet the desired and practical needs of inpatient psychiatric staff to manage aggression, violence, and unsafe behaviors on inpatient psychiatric units. Policymakers may consider using this feedback

from staff at Baker Act receiving facilities to strengthen training programs, increase duration of required trainings, and promote a renewal of efforts to expand the curriculum on evidence-based de-escalation practices.

Delimitations and Limitations

The researcher selected a participant sample that was limited to include only inpatient psychiatric staff who work exclusively in Florida at Baker Act receiving facilities. This was done to create a pool of participants who experience the same guidelines for the use of SR permitted by Florida statutes that govern those facilities. The size of the participant sample was limited to manage lengthy interviews and transcription while still generating meaningful and reflective responses. The qualitative descriptive phenomenological design enabled the emergence of themes without the constraints of a survey or questionnaire that may have increased the size of the participant sample but would have limited meaningful responses.

One important limitation of the study was the small size of the participant sample that is not enough to provide generalizable conclusions across all inpatient psychiatric staff as it relates to SR experiences. Although the participants all share many of the same characteristics as related to SR, a small sample is not suggestive of a larger population. Another limitation is that this study did not include participants from other settings including medical hospitals, group homes, prisons, and schools, which may have supplemented the data and enhanced understanding of the SR experience. Finally, this study did not ensure equal participation from both male and female inpatient psychiatric staff that may have enhanced the findings in significant ways.

Recommendations for Future Research

Recommendations for future research should focus on the general broadening of the study to include (a) a larger number of participants; (b) participants in other states and countries

where laws and cultural norms impacting the practice of SR may influence experiences of the event; (c) participants from each region of Florida to more deeply explore how local norms, practices, and area demographics may influence the experiences of SR events; and (d) participants from private Baker Act receiving facilities to examine comparisons between the private and public facility experiences of SR events.

Recognizing that staff experience of SR events is impacted by many factors, it is suggested that future research investigate (a) staff attitudes toward workplace violence with focus on uncovering the reasons for the absolute acceptance of violence as a norm on the unit; (b) the effectiveness of training, education, and strategies designed to reduce violence, aggression, and SR events on psychiatric units; (c) the impact of educational level on attitudes toward SR; (d) the impact of staff experience of personal trauma on attitudes toward SR; (e) the role of administrative oversight; (f) the influence of staff levels of empathy on the use of SR; and (g) the impact of workplace violence injuries on the selection of SR as an intervention by injured staff.

Recommendations for Future Practice

This research illuminates the various roles of inpatient psychiatric staff, whether they are nurses, social workers, or behavioral health technicians. Each role is significant in the treatment of patients and impacts the potential for reduction or elimination of SR practices on the psychiatric unit. Evidence-based solutions aimed at the reduction of SR must be implemented with a buy-in from all the members of the unit for them to be effective.

This study provides insights into the challenges faced by inpatient psychiatric staff when attempting to balance safety for the unit with therapeutic treatment for individual patients. Inpatient psychiatric staff require guidance as they manage these challenges. Providing focused

supervision especially related to recognizing and understanding triggers of both patients and staff is suggested as part of the initiatives aimed at supporting staff.

Initiatives aimed at the reduction or elimination of SR practices must be developed with consideration of the experience of inpatient psychiatric staff who initiate, witness, and participate in SR events on a regular basis. The study illustrates the priority that staff attach to extensive and ongoing training in de-escalation techniques and interventions to achieve the goal of avoiding or reducing SR events. Future practices should include provisions for incorporating this priority as part of the policies that direct practices on the inpatient psychiatric units at Baker Act receiving facilities.

Summary

The purpose of this qualitative descriptive phenomenological study was to explore how staff describe their lived experiences of SR events at designated Baker Act receiving facilities within Florida. From the interviews, it became clear that these events are a common element on inpatient units and that staff have integrated these experiences into their work routines. It was not surprising then that they had accepted these events as a normal occurrence despite the intention to utilize them as a last resort intervention.

The degree of violence and aggression that is experienced by inpatient psychiatric staff is astounding. Stories of violence against staff resulting in injury were common. Participants expressed a silent acceptance of this reality and in turn accept SR events as a normal intervention to restore safety in the milieu. It became clear that staff experiences of these events remain challenging and that they feel woefully unprepared to avoid them.

There were several significant observations that resulted from this study. First, inpatient staff on psychiatric units are torn between their obligation to maintain safety on their units and

their negative perception of SR as a practice. Although they feel compelled to utilize SR and describe it as “unavoidable,” the participants hold unfavorable opinions about SR and express a consistent desire for alternatives. Interestingly, while they voice disdain for the practice and the harmful effects on patients and staff, they defend it as the only practical solution to resolving violence on the units. Essentially, staff remain trapped in a phenomenon of their own making.

Second, inpatient staff who are on the front-lines of the SR experience on psychiatric units hold firm to their belief that SR is a necessary tool but they continue to brainstorm, create, and hope for alternatives. They express strong feelings of inadequacy for resolving violence on the units and advocate for change through the expression of solution-focused ideas. Interventions are needed to alleviate this inadequacy, but it remains questionable if the same staff who advocate for change would be willing to refrain from the “unavoidable” use of SR.

Finally, despite their many strong opinions about the practice of SR and their vibrant ideas about change, participants remain curiously silent at their respective agencies. Absent from the interviews was discussion about expression of their opinions to management or efforts to facilitate change. Their observations of the negative impact of SR and their hope for alternatives remain unheard. Instead, they have settled into a silent acceptance of this centuries old practice behind the locked doors of the psychiatric unit.

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Appendices

Appendix A: Interview Questions

Question 1: Tell me about your experiences working on an adult psychiatric unit.

Question 2: Describe your experience with SR events.

Question 3: What is your opinion about SR?

Question 4: What impacts your decision to suggest or implement SR?

Question 5: Describe the training and education you have had regarding SR reduction techniques and interventions.

Questions 6: What is your opinion on SR reduction efforts?

Appendix B: Participant Solicitation

Research Participants Needed

Restrictive Practices: The Impact of Seclusion and Restraint on Inpatient Psychiatric Staff

Are you:

- An adult (18 years or older)?
- Employed as a psychiatrist, nurse, behavioral health technician, or other employee who has worked at least 1,200 hours within the past year at a Baker Act receiving facility?
- A participant in or witness to a minimum of 12 seclusion and restraint events during the past 36 months?

If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study.

The purpose of this research study is to explore the lived experiences of inpatient psychiatric staff as it relates to seclusion and restraint events.

Participants will be asked to:

- participate in an audio-recorded interview via Zoom or in person (60-90 minutes)
- verify their interview for accuracy (30 minutes)

Benefits include:

- opportunity to explore and reflect upon your experiences with seclusion and restraint
- opportunity to express your opinions about seclusion and restraint
- opportunity to contribute to practice changes that would benefit staff working in the inpatient psychiatric environment by reducing negative experiences associated with seclusion and restraint

If you would like to participate, contact the researcher at the phone number or email address provided below. A consent document will be given to you prior to scheduling your meeting with the researcher.

Anne C. Lotierzo, a doctoral candidate in the School of Behavioral Sciences at Liberty University, is conducting this study.

Please contact Anne C. Lotierzo at [redacted] for more information.

Appendix C: Informed Consent

Consent

Title of the Project: Restrictive Practices: The Impact of Seclusion and Restraint Events on Inpatient Psychiatric Staff

Principal Investigator: Anne C. Lotierzo, Doctoral Candidate, School of Behavioral Sciences, Liberty University

Invitation

You are invited to participate in a research study. To participate, you must:

- Be an adult (18 years or older)
- Be employed as a psychiatrist, nurse, behavioral health technician, or other employee who has worked at least 1,200 hours within the past year at a Baker Act receiving facility
- Have experienced exposure to a minimum of 12 seclusion and restraint events during the past 36 months either by direct participation or as witness

Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to understand how inpatient psychiatric staff cope with the experience of seclusion and restraint events. It seeks to understand what the experience of seclusion and restraint means to inpatient staff and how it impacts them.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Participate in an audio-recorded interview process by Zoom or in person that will take approximately 60-90 minutes.
2. Review the transcript of your interview for accuracy which will take approximately 30 minutes.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include:

- an understanding of the experiences of psychiatric inpatient staff as it relates to seclusion and restraint events
- increased knowledge of the risks to inpatient psychiatric staff who participate in seclusion and restraint events

What risk might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include:

- the possibility of emotional stress related to your experiences with seclusion and restraint

To reduce risk, I will:

- Provide you with complete information regarding the design of the research
- Rely on procedures that are consistent with comprehensive research design and avoid unnecessary risks
- Provide you with current resources for help/support as needed

I am a mandatory reporter. During this study, if I receive information about child abuse, child neglect, elder abuse, or intent to harm self or others, I will be required to report it to the appropriate authorities.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential by replacing names with pseudonyms.
- Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and in a locked file cabinet.
- After three years, all electronic records will be deleted and all hardcopy records will be shredded.
- Recordings will be stored on a password-locked computer in a locked file cabinet for three years and then deleted.
- Only the researcher and members of her doctoral committee will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address or phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Anne C. Lotierzo. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted]. You may also contact the researcher's faculty sponsor, Jason Ward, at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix D: Facebook Invite to Participate

ATTENTION FACEBOOK FRIENDS: I am conducting research as part of the requirements for a Doctoral Degree at Liberty University. The purpose of my research is to explore the lived experiences of inpatient psychiatric staff as it relates to seclusion and restraint events. To participate, you must:

- Be an adult (18 years or older)
- Be employed as a psychiatrist, nurse, behavioral health technician, or other employee who has worked at least 1,200 hours within the past year at a Baker Act receiving facility
- Have experienced exposure to a minimum of 12 seclusion and restraint events during the past 36 months either by direct participation or as witness

Participants, if willing, will be asked to participate in an interview (60-90 minutes) and verify the accuracy of their interview (30 minutes). It should take approximately 2 hours to complete the procedures listed.

If you would like to participate and meet the study criteria, please message me or contact me at [redacted] for more information or to schedule an interview. A consent document will be emailed to you prior to your interview.

Appendix E: Invitation to Participate

Dear Recipient:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a Doctoral degree. The purpose of my research is to explore the lived experiences of inpatient psychiatric staff as it relates to seclusion and restraint events and I am writing to invite eligible participants to join my study.

To participate, you must:

- Be an adult (18 years or older)
- Be employed as a psychiatrist, nurse, behavioral health technician or employee who has worked at least 1,200 hours within the past year at a Baker Act receiving facility
- Have experienced exposure to a minimum of 12 seclusion and restraint events during the past 36 months either by direct participation or as witness

Participants, if willing, will be asked to participate in an audio-recorded interview (60-90 minutes) and verify the accuracy of their interview (30 minutes). It should take approximately 2 - 21/2 hours to complete the procedures listed.

Names and other identifying information will be requested as part of this study, but the information will remain confidential.

To participate, please contact me at [redacted] for more information or to schedule an interview.

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you may sign the consent document and return it to me prior to scheduling your interview or if you have questions about the consent you may wait until our interview and sign a hard copy at that time

Sincerely,

Anne C. Lotierzo, LMHC
Doctoral Candidate
[redacted]

Appendix F: IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

February 17, 2023

Anne Lotierzo
Jason Ward

Re: IRB Exemption - IRB-FY22-23-784 Restrictive Practices: The Impact of Seclusion and Restraint on Inpatient Psychiatric Staff

Dear Anne Lotierzo, Jason Ward,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix G: IRB Modification Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

March 28, 2023

Anne Lotierzo
Jason Ward

Re: Modification - IRB-FY22-23-784 Restrictive Practices: The Impact of Seclusion and Restraint on Inpatient Psychiatric Staff

Dear Anne Lotierzo, Jason Ward,

The Liberty University Institutional Review Board (IRB) has rendered the decision below for IRB-FY22-23-784 Restrictive Practices: The Impact of Seclusion and Restraint on Inpatient Psychiatric Staff.

Decision: Exempt - Limited IRB

Your request to include employees other than psychiatrists, nurses, and behavioral health technicians as study participants has been approved. Thank you for submitting your revised study documents for our review and documentation. Your revised, stamped consent form and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study in Cayuse IRB. Your stamped consent form should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document should be made available without alteration.

Thank you for complying with the IRB's requirements for making changes to your approved study. Please do not hesitate to contact us with any questions.

We wish you well as you continue with your research.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix H: Code Book

1. **Experience:** work experience at a Baker Act receiving facility
2. **Experience witnessing seclusion and restraint:** watching/observing SR events
3. **De-escalation:** method to prevent potential violence and calm a patient on a psychiatric unit
4. **Combative:** aggressive; seeking to engage in confrontation physically; specifically, as it relates to the description of behaviors on a psychiatric unit
5. **Mindful:** conscious or aware of something; particularly awareness on the unit
6. **Debriefing:** process of discussion and review post SR event
7. **Assessment:** the evaluation or estimation of the nature, quality, or ability of someone or something; in this instance related to the current state of the psychiatric patient
8. **De-escalation:** process of reducing the intensity of a situation
9. **Training:** teaching or instructing as it relates to SR application and prevention
10. **Trauma-informed care:** implementing the five principles of safety, choice, collaboration, trustworthiness, and empowerment into care on the psychiatric unit
11. **Solutions:** answers to the SR problem; ideas that may prevent or reduce SR
12. **Important seclusion and restraint reduction tools:** ideas like safety plans, quiet rooms, and training for staff
13. **Roles in reference to seclusion and restraint:** assuming responsibility for the way SR events develop
14. **Opinion about others involved in seclusion and restraint:** thoughts, ideas, feelings about the way peers or staff interact with patients in SR events
15. **Experience of Seclusion and restraint:** reflections on participation in SR events
16. **Opinion about managing SR:** thoughts, ideas, feelings about the way SR events are managed or should be managed
17. **Opinion about why SR is initiated:** thoughts, ideas, feelings about the reasons why staff initiate SR events
18. **Fear of assault:** afraid of being assaulted or battered by patients on psych unit
19. **Opinion about SR:** thoughts, feelings, ideas about SR
20. **Description of SR:** what is involved in a SR event
21. **Personal responsibility for SR:** acceptance of accountability for SR events
22. **Fear:** emotion or belief that something is dangerous – specifically to the circumstances surrounding SR – expressed by patient or staff
23. **Threats:** verbal or physical threats of harm from a patient to a staff member on a psych unit
24. **Loss of control:** the sense of losing power in a situation; particularly as it relates a patient losing ability to control actions and words
25. **Powerlessness:** the sense of having no power or control applicable to staff or patients
26. **Dehumanizing:** patients experiencing a loss of humanity; feeling belittled
27. **Seeking improvements:** staff motivation to find alternatives to improving care on psych units
28. **Unavoidable: the sense that there are no alternatives to SR at this point in time**

29. **Traumatizing:** emotionally disturbing; applicable to staff or patients

30. **Re-traumatizing:** experiencing a trauma again – often triggered by exposure to a trauma-related trigger; used in the context of SR as the trigger that re-traumatizes patients with trauma history

31. **Personal experience of SR:** how one experiences SR whether by genuine exposure or if intentional as a part of training and education

32. **Isolation:** the sense of being alone and without human contact particularly as it relates to patients in seclusion

33. **Lasting memories of S/R experiences:** flashbacks or strong memories of S/R events as it relates to either patient or staff experience

34. **Noises:** sounds heard in a psych unit

35. **Restrained:** the result of being either held down by staff or secured with straps; unable to move; particularly as it relates to patients held against their will to a bed or to the floor following an episode where safety was threatened (personal or other)

36. **Negative memories of S/R experiences:** negative thoughts associated with recalling SR experiences; related to either patients or staff

37. **Opinion about Patient experiences of S/R:** staff opinion about how patients experience SR events on a psych unit

38. **Relationships:** association between patients and staff or between staff; connections between two or more people

39. **Trust:** relying on others; confidence in another staff member; confidence displayed by patients in staff

40. **Problems with BA system:** staff perception of flaws within the Baker Act system and how that impacts patient experience and treatment

41. **Emotions:** feelings associated with SR events

42. **Problems with tools used:** staff perception of tools used to prevent or reduce SR and how those tools are insufficient to manage SR

43. **Triggers:** events, words, emotions, situations, or any event that precedes behavior before a SR event

44. **Coping mechanisms:** positive ways that patients cope with emotions

45. **Treatment plans:** a specific plan of treatment that encompasses all of a patient's needs while on a psychiatric unit

46. **Medication:** substance used for treatment particularly as it relates to psychotropic medication for the treatment of mental illness and/or as it relates to calming or sedative effects

47. **Ethical obligations:** moral requirements as it relates to treatment of psychiatric patients

48. **Nurse responsibility:** all of the tasks associated with nursing care

49. **Tools:** mechanisms, interventions, and techniques in place specifically as it relates to the prevention or reduction of SR events

50. **Environment:** the milieu of the psychiatric unit including patients, staff, and all visible elements

51. **Quiet rooms:** rooms on a psychiatric unit designated for patient use as a break from the milieu

52. **Programming:** activities and schedule of events that structures the day on a psych unit

53. **Stuck:** Without any other options or choices

54. **Need for S/R:** reasons justifying SR

55. **Knowledge:** skills, education, and experience to make decisions

56. **Treatment failure:** when things go awry; particularly in relation to treatment on the unit and in this context contribute to a SR event

57. **Training:** skill development; practice; especially as it relates to SR alternatives or application

58. **Staff needs:** the needs of staff as it relates to completion of work duties on the psych unit

59. **Safety plans:** a specific set of plans that includes coping skills, signs of crisis, support system; essentially a blueprint for maintaining safety – in this instance used on a psychiatric unit

60. **Ideas for improvement:** thoughts, ideas, and plans for improving alternatives and interventions with the idea of avoiding SR on the psychiatric unit

61. **Scrutiny:** criticism of activities, procedures, policies, and weaknesses associated with the functioning of the psychiatric unit

62. **Upper management:** the higher level of administration that oversees, supervises, and directs a Baker Act receiving facility in Florida

63. **Ideas about S/R:** thoughts and opinions about the practice of S/R

64. **Failures of program managers:** weaknesses, lack of oversight, lack of intervention, and lack of supervision of staff particularly as it relates to the practice of SR

65. **Eliminating S/R:** The goal of eradicating this practice on psychiatric units

66. **Teaching staff:** training and educating staff in the use of alternatives to SR with special emphasis on de-escalation techniques

67. **Staff:** the persons dedicated to the work of a psychiatric unit

68. **Training programs:** programs designed to train staff particularly as it relates to the de-escalation of patients and alternatives to SR

69. **Weakness:** A sense of inadequacy

70. **Strength:** an identified skill; being strong

71. **Peers:** individuals with shared experiences of the patients they serve

72. **Suggestions:** ideas, particularly as related to SR

73. **Trauma:** exposure to an incident or series of events that are emotionally disturbing or life-threatening particularly on the psychiatric unit

74. **Satisfaction:** an act of satisfying; fulfillment; gratification. the state of being satisfied

75. **Staffing patterns:** arrangement of schedule; numbers of staff assigned to a particular shift

76. **Threats:** verbal or physical aggression that results in a staff member feeling uneasy or afraid for their safety

77. **Indications for S/R:** factors that lead to the use of S/R; justification for using S/R

78. **Calming down:** restoring a sense of calm and peace particularly following an incident on the unit that included agitation or aggression

79. **Imminent risk of harm:** the point in time where the risk of harm is immediate – particularly as it relates to the inpatient unit/milieu

80. **Staff trust:** the sense of trust between staff members on the psychiatric unit particularly as it relates to relying on one another in SR situations

81. Combative: aggressive; ready to fight; especially as it relates to patients on the psychiatric unit

82. Leadership: motivating and collaborating with a psychiatric team especially as it relates to administrators of a Baker Act receiving facility

83. Intervention: action taken to improve a situation, especially one that is approaching violence on a psychiatric unit.

84. Positivity: positive or optimistic in attitude

85. Impact on other patients: the effect of behaviors, events, or staff attitudes on patients on the unit

86. Trainers: individuals with special skill sets who teach staff members how to use de-escalation skills to prevent or avoid SR

87. Research: investigation into and study of materials and sources in order to establish facts and reach new conclusions

88. Alternatives: options that may be used to avoid S/R

89. Stressful: conditions on the psychiatric unit that causes mental or emotional stress

90. Fast-paced: moving, changing, or happening very quickly as it relates to activity on the unit

91. Diligence: careful and persistent work or effort

92. Attentiveness: paying close attention to something

93. Patient acuity: the measure of a patient's severity of illness or medical conditions including, but not limited to, the stability of physiological and psychological parameters and the dependency needs of the patient and the patient's family.

94. Nurse: a person trained to care for the sick – in this capacity a person performing these tasks on a psychiatric unit

95. Milieu: the social environment of the psychiatric unit

96. Responsibilities: things that a nurse or staff member has to do as part of their job on the psychiatric unit

97. Behaviors: the way patients act; the way patients conduct themselves, especially toward others

98. Behavioral health tech: a health professional who is responsible for the well-being of patients on a psychiatric unit

99. Negative behaviors: Hostility or aggressiveness

101. Psychiatric patient settings: environments where psychiatric patients are treated; especially as it relates to inpatient units

103. Emergency department: is a pivotal arena for the provision of acute care services

104. ETO: an emergency treatment order providing an immediate medication protocol usually to relieve agitation that is uncontrollable by other means

105. Candidate for S/R: a patient identified as potentially requiring SR; identified by a nurse

106. Assessing: the task of a nurse as it relates to determining the quality of the patient's behaviors, speech, levels of agitation and aggression

107. Signs: indicators that a behavioral health crisis is pending; indications that SR may be imminent

108. Seclusion patient fire: a specific event that occurred

109. Cases: information; situations,

110. Invasive: intrude on a person's thoughts or privacy

111. Danger: Risk of harm

112. Restraints: Devices usually in the form of straps that are used to limit a person's movement and usually applied in the context of seclusion

113. Injury: wound, pain, or physical damage sustained during work on the psychiatric unit

114. Monitoring: observing and keeping aware of a patient's behaviors

115. Safety checks: timed observations on the behavior and well-being of patients

116. Skill: ability to effectively manage a task; in this instance to de-escalate an agitated patient

117. Verbally de-escalating: an intervention for use with people who are at risk for aggression. It is basically using calm language, along with other communication techniques, to diffuse, re-direct, or de-escalate a conflicting situation

118. CPI: Crisis Prevention Institute: specialize in safe management of disruptive and aggressive behaviors

119. Agency: in this instance an organization that provides mental health services; specifically, a Baker Act receiving facility

120. Facility: a place provided for mental health services; specifically for Baker Acts

121. Safe environment: place that has sufficient measures in place to ensure safety for those in it

122. Crisis: intense difficulty, trouble, or danger.

123. Skills: the expertise, talent, and understanding needed to do a job or task but in this instance particularly related to skills needed by employees on a psychiatric unit to avoid or reduce SR events

124. Intolerance: unwillingness to accept views, beliefs, or behavior that differ from one's own expectations; as relates to staff lacking tolerance for the behaviors of their patients

125. Low tolerance: a low degree of willingness to accept behaviors or views of others when differing with your own

126. Patience: capacity to accept or tolerate delay, trouble, or suffering without getting angry or upset

127. Emotional state: the state of emotions of a person

128. Incident: an event or occurrence

129. Escape: the act of trying to leave confinement or control

131. Psychiatric patients: patients being treated for mental illness

133. Patient needs: any and all practical, emotional, physical, or psychological needs of a patient

134. Physical hold: the act of restraining a patient; restricting movement by using force to restrain a patient temporarily

136. Options: alternatives

138. Rapport: a close and harmonious relationship in which the people or groups concerned understand each other's feelings or ideas and communicate well

139. Team: the group of professional providers dedicated to caring for a psychiatric patient

140. Timing: the choice, judgment, or control of when something should be done

142. Agitation: state of anxiety or nervous excitement; often difficult to control; often coming before SR events

143. Redirectable: capable of being redirected to another activity

144. Escalation: an increase or rise in behaviors, mood, anxiety – particularly as it relates to the description of behaviors on the psychiatric unit

145. Staffing levels: the number of staff members assigned to work a specific shift

146. Hallucinations: where you hear, see, smell, taste or feel things that appear to be real but only exist in your mind

147. Client safety: the state where the client is kept safe from harm to self or from being harmed by others

159. Make it better: Improve conditions; in this instance as it relates to treatment of psychiatric patients

160. Duration of seclusion: the length of time that a patient is secluded in a room without ability to leave on their own free will

161. Prevention: the act of preventing something from happening; in this instance preventing a seclusion and restraint event from occurring

162. Last resort: the last option used; as it relates to implementing an intervention when there are no other reasonable alternatives

163. Grounding: therapeutic technique that focuses on realigning your electrical energy by reconnecting to the earth.

164. Compassion: sympathetic pity and concern for the sufferings or misfortunes of others.

165. Appreciation: recognition and enjoyment of the good qualities of someone or something.

166. Tortured minds: the experience of suffering in the mind

167. Complain: voice discontent

168. Unexpectedness: unpredictable as it relates to the environment

169. Quiet: calm, peaceful

170. Nervousness: the quality or state of being nervous

171. Help clients: provide assistance to clients; activities that assist clients

172. Code: a crisis event that requires immediate staff response; typically indicates a behavioral health crisis

173. Assistance: helping others with a task; as it relates to resolution of a crisis/code event on a psychiatric unit

174. Agitation: a state of anxiety or nervous excitement

175. Delusions: a false belief or judgment about external reality

176. Least restrictive environment: description provided by Baker Act law about the choice of environment for a patient in crisis; Baker Act law emphasizes the need to provide the least restrictive environment (meaning unlocked and in community if possible) to preserve the safety of a person

177. Holding body parts: the act of restraining a client using physical force to hold down legs, arms, etc.

178. Unbothered: a lack of concern

179. Unknown: not known in advance; unexpected

180. Safety precautions: a precaution that is taken in order to ensure that something is safe and not dangerous

181. Relief: a feeling of reassurance and relaxation following release from anxiety or distress

182. Staff hurt: injured staff members

183. Story: an account of events

184. Cautious: careful to avoid potential problems

185. Necessary: required or needed

186. Challenging: demanding; testing

187. Talking: engaging in speech; particularly as it relates to engaging with patients as a means of de-escalation

188. Safety concerns: concern or worry about the well-being and safety of patients and staff

189. Avoided: to take a different path; particularly as it relates to choosing an alternative from restrictive practices

190. Helping: assisting in some way; offering or providing benefit

191. Rewarding: providing satisfaction

192. Social worker: trained professional devoted to helping vulnerable people and communities work through challenges; in this instance specifically devoted to the psychiatric patient

193. Taking their rights away: removal of rights (particularly freedom) as it relates to patients on a psychiatric unit

194. Direct contact: in-person engagement with a patient

195. Staff safety: preserving the well-being of staff

196. Career: an occupation; work experience over a lifetime

197. part of it: participating in an event; as it relates to SR

198. observed it: witnessing an event; as it relates to SR

199. helping place client in S and R: applying restrictive measures; the act of placing the patient into Seclusion and using restraints to secure the patient to the bed

201. Very different depending on client: description of SR events

202. Procedures and step by step process: directions for SR application

203. Attempting or injuring someone else or themselves: the risk factor identified as a reason for SR

204. Focused on debriefing: concentrating on the process of debriefing or reviewing a SR event or code afterwards

205. What went well and what did not: the process of debriefing a SR event to identify strengths and weaknesses of the process

206. What could have been better: identifying aspects of the SR event that could improve

207. It's a lot for the clients and the staff: a reflection on the experience of SR

208. Review what happened: the process of debriefing after a SR event

209. It's really important to talk about what happened: opinion about the need to debrief after a SR event

210. Something serious happens: description of event

212. What the environment is looking like: the way the unit appears as it relates to the interaction of patients and their behaviors

213. Patient being combative: aggressive or threatening patient

214. Aware of your surroundings: alertness and orientation to environment

215. When a crisis happens: observation that events are at a crisis level on the psychiatric unit

216. Everything else going on: activity on the psychiatric unit

217. Senses in overload: sense of being overwhelmed by the environment

218. Safety as a priority

219. Maintaining client's safety: preserving the well-being of clients/patients

221. I don't think it ever feels good: opinion about the use of SR

222. Safest thing: identified safe practice; particularly as it relates to choosing SR because it is the safest thing to do in the moment

223. Emotionally it can be tough: opinion about the emotional impact of SR

224. You just wish you could try to deescalate: sentiment about wanting to employ de-escalation techniques to avoid SR

225. Warrants a higher level: when a more restrictive or intense level of response or treatment is needed

226. Imminent threat or safety concern: a threat or safety issue is happening soon

227. Staff should be aware: need for staff to be aware of environmental and patient **factors** that may indicate a potential behavioral health crisis is pending

228. Importance of de-escalation: emphasis on the use of de-escalation techniques

229. De-escalation does not satisfy what's happening in the moment: opinion about the failing of de-escalation in the moment

230. Verbal cues: words or noises spoken that indicate a potential crisis

231. Non-verbal cues: observable behaviors that indicate a potential crisis

232. Unusual behavior

233. Preventative care: Screening and intervention early on to prevent escalation of situations or events

Appendix I: Audit Trail Summary

Date	Task
12.27.22	Submitted proposal to IRB
2.17.2023	IRB approval
2.21.23	Email Requesting Presentation on Study to DCF
2.21.23	Approval to attend DCF meeting on 3.17.23
3.17.23	Presentation at DCF meeting
3.19.23	First round of emails to Administrators at Baker Act Receiving facilities
3.21.23	Social Media Advertisement (updated on 3/30/23)
3.23.23	Request IRB for medication to participant criteria
3.28.23	IRB approval of modification
4.1.23	Consent received from Participant Rachel
4.4.23	Interview with Participant Rachel
4.4.23	Transcribe Interview
4.5.23	Follow up emails to Administrators at Baker Act Receiving facilities
4.8.23	Consent received from Participant Monica
4.12.23	Interview with Participant Monica
4.12.23-4.13.23	Transcribe Interview
4.15.23	Consent received from Participant Denise
4.20.23	Interview with Participant Denise
4.20.23	Manually Transcribe Interview
4.26.23	Consent received from Participant Emily
5.2.23	Interview with Participant Emily
5.3.23-5.4.23	Manually Transcribe Interview
4.25.23	Consent received from Participant Judy
5.3.23	Interview with Participant Judy
5.5.23-5.6.23	Manually Transcribe Interview
5.10.23	Consent received from Participant Phoebe
5.16.23	Interview with Participant Phoebe
5.16.23-5.17.23	Manually Transcribe Interview
5.20.23	Consent received from Participant Ross
5.22.23	Interview with Participant Ross
5.24.23	Manually Transcribe Interview
5.24.23 - ongoing	Read Transcription
5.24.23	Uploaded interviews to Grain Software
5.24.23-5.26.23	Compared Grain Transcription with Manual Transcription
5.27.23-5.30.23	Initial Coding
5.30.23-6.5.23	Theme Development
6.10.23	Code modification/Theme Modification