'Only ever as a last resort': Mental health nurses' experiences of restrictive practices

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Abstract

Nurses play a crucial role in the implementation of restrictive practices such as seclusion and restraint. Restrictive practices have been widely recognised as harmful practices and efforts to reduce **their use** have been in place for several years. While some reductions have been achieved, more information and insight into the perspectives and experiences of frontline mental health nursing staff is required if further changes are to be realised. Sixty-five respondents participated in an online survey to **investigate** Australian mental health nurses' personal experiences and opinions regarding restrictive practices. Analysis revealed restrictive practices as a complex, contested and challenging area of practice. Analysis of data revealed five main ways that restrictive practices were framed by respondents. These were: as a response to fear; to maintain safety for all; a legacy of time and place; the last resort; and, a powerful source of occupational distress. In addition, findings revealed the need to support staff involved in restrictive practices. This need could be satisfied through the implementation of

procedures to address post-restrictive **distress** at all levels of the organisation. Ensuring an optimal work environment that includes appropriate staffing, availability of supportive education and structured routine debriefing of all episodes of restrictive practice is critical in achieving further reductions in seclusion and restraint.

Keywords: restraint/physical; safety management; violence prevention/control; behaviour control/methods; patient isolation.

Introduction

Restrictive practices such as seclusion and restraint have been widely recognised as harmful practices and are considered to represent a breach of human rights (National Mental Health Consumer & Carer Forum, 2009, 2018). They are also traumatising **for** consumers **and** staff (Brophy, Hamilton, Tellez, & McSherry, 2016; Oster, Gerace, Thomson, & Muir-Cochrane, 2016; Riahi, Dawe, Stuckey, & Klassen, 2016; Rose, Perry, Rae, & Good, 2017; **Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018**) **and can result in financial impact for organisations (Goulet et al. 2017). The use of these practices is considered 'a failure in care and treatment' (National Mental Health Consumer & Carer Forum, 2009, p. 7), and there is no evidence that restrictive practices are therapeutic (NSW Government, 2017; Riahi, Thomson, & Duxbury, 2016; Sailas & Fenton, 2000).**

Government and professional bodies across Australia and internationally have committed to ensuring the reduction and elimination of restrictive practices across all settings (Melbourne Social Equity Institute, 2014; National Mental Health Working Group, 2005). Despite this commitment however, there is still evidence that seclusion and restraint continue to be used across mental health settings, mainly initiated by nurses (Allan et al., 2017; Bigwood & Crowe, 2008; Bowers et al., 2017; Bullock,

McKenna, Kelly, Furness, & Tacey, 2014; Gerace, Pamungkas, Oster, Thomson, & Muir-Cochrane, 2014; Muir-Cochrane & Gerace, 2014; Muir-Cochrane, O'Kane, & Oster, 2018; Oster et al., 2016; Te Pou oTe Whakaaro Nui, 2015). While some reductions have been achieved (NSW Government, 2017), more information and insight into the perspectives and experiences of front-line mental health nursing staff is required to achieve further progress in eliminating restrictive practices. **This study was conducted to provide further insight into Mental Health nurses' experiences of restrictive practices.**

Background

Over the past decade, there has been **international** progress towards reducing seclusion and restraint through the implementation of various frameworks and programs **(Goulet, Larue, & Dumais, 2017; Hernandez, Riahi, Stuckey, Mildon, & Klassen, 2017; Muir-Cochrane et al., 2018).** Goulet et al. (2017) undertook a systematic review to examine the effectiveness of programs designed to reduce the incidence of seclusion and restraint concluding, that these programs contained similar elements and generally reduced the incidence of restrictive practices and increased safety. The most common programs reviewed, were recovery-orientated and mostly based on either The Six Core Strategies© (Huckshorn, 2006) or the Safewards Model (Bowers, 2014).

Despite their success, there can be issues implementing and resourcing programs in a sustained way **(Fletcher, Hamilton, Kinner, & Brophy, 2019; NSW Government, 2017)**. Furthermore, and despite the use of restrictive practices declining over the past decade, the rate of reduction has slowed. It has been posited, that this could indicate either a reduced commitment to its elimination or the realisation that current strategies have achieved all that is possible (NSW Government, 2017). Supporting this theory, is the finding in Gerace and Muir-Cochrane's (2019) national survey of 512 mental health

nurses, that many do not believe that the complete elimination of restrictive practices is possible. Restrictive practices were considered inevitable in units where restrictive practices were more common, where nurses were exposed to physically aggressive, intoxicated consumers, and where there was a lack of resources. **Indeed, the difficulties balancing the reduction of restrictive practices while preventing harm to consumers and nurses is acknowledged by nursing professional bodies (NSW Nurses and Midwives' Association, 2017; Royal College of Nursing, 2018).**

It is evident that tensions exist between government and organisational efforts to reduce restrictive practices, health professionals own moral commitment to provide person-centred, dignified care for consumers and the desire for occupational safety engendering acceptance of restrictive practices (Fletcher et al., 2019). Given the role of nursing in the implementation of restrictive practices (Allan et al., 2017; Bigwood & Crowe, 2008; Bowers et al., 2017; Bullock et al., 2014; Gerace et al., 2014; Muir-Cochrane & Gerace, 2014; Muir-Cochrane et al., 2018; Oster et al., 2016; Te Pou oTe Whakaaro Nui, 2015) it is crucial to better understand nurses' experiences, attitudes and concerns about restrictive practices in order to move towards meeting organisational and professional goals in reducing the incidence of seclusion and restraint. **This will also assist to balance nurses' voices in the debate on seclusion and restraint with the vast amount of evidence collected from mental health consumers.**

Methods

Design

The aim of this study was to elucidate information from frontline mental health nurses regarding the use of restrictive practices. **Restrictive practices were defined as seclusion, and physical and mechanical restraint, as the fine line between**

chemical restraint and pro re nata administration of medications was thought to be too nuanced to explore in a survey.

An anonymous, online survey was designed using SurveyGizmo©. The survey was distributed via several channels including the survey link being emailed to members of the Australian College of Mental Health Nurses (ACMHN), and being shared on the social media sites, Twitter© and Facebook©.

Ethical approval to conduct the study was granted by [blinded] Human Ethics Research Committee.

Materials

In addition to demographic information exploring clinical experience, qualifications and experience with restrictive practices, the survey contained an open-ended question intended to explore participants' personal experiences and opinions regarding restrictive practices. This question was: *Without breaching confidentiality, can you tell us about a time you were involved in secluding or restraining a consumer, including what led to the event and how it made you feel?* **This paper is predominantly concerned with the responses to this open-ended question.**

Qualitative data were analysed thematically drawing on Braun and Clarke's (2012) method. Thematic analysis allows for the identification of patterns by comparing and contrasting participant accounts and is useful to elucidate experiences and understandings (Braun & Clarke, 2012). Coding was originally undertaken by the first author and draft themes suggested. These were evolved through discussion with the broader team and refined through the process of writing up. The COREQ statement, which is a checklist for ensuring the rigorous reporting of qualitative research **(Tong, Sainsbury, & Craig, 2007),** was used as a guide in reporting this study.

Results

Respondent Demographics

Sixty-four fully completed questionnaires were received. Most respondents were registered nurses with postgraduate qualifications in mental health (50%), followed by credentialed mental health nurses (25%), registered nurses (17%) and enrolled nurses (2%). **Of the respondents, 23% identified as male and 77% female.** Respondents held a range of postgraduate qualifications including doctoral qualifications (14%), masters by coursework (28%), and graduate diploma (23%). Respondents were drawn from all Australian states and territories; however, the majority of survey respondents currently/previously worked in New South Wales (30%) and Victoria (33%). Most respondents were still currently practicing (94%); 84.4% had been in practice for at least 9 years and most (94%) did not identify as belonging to a minority or marginalised group. Respondents had a range of direct experience with restrictive practices; including initiating seclusion and restraint (58%), assisting with restrictive interventions including actual restraining or monitoring secluded persons (26.6%); witnessed but not involved (5%); and mixed experience (10.9%). Seventy seven percent of respondents indicated that they were currently very familiar with their organisations' policy/guidelines regarding seclusion and restraint, while 23% stated they were not.

Experiences of Restrictive Practices

Analysis revealed restrictive practices as a complex, contested and challenging area of practice for our respondents, affecting them in many ways. There were five main ways that restrictive practices were framed by respondents. These were: as a response to fear; to maintain safety for all; a legacy of time and place; the last resort; and, a powerful source of occupational distress. In addition, findings revealed the need to support staff involved in restrictive practices. These perspectives and experiential aspects of restrictive practice are elucidated below.

Use of restrictive practices as a response to fear.

Fear was revealed as a powerful catalyst for decisions around implementing restrictive practices. In this context, fear pertained to the threat of experiencing direct occupational violence. Fear of experiencing violence, or of a situation escalating out of control were so strong that participants noted the rights of service users were sometimes seen as secondary to taking an action that was perceived to increase staff safety.

As a nurse manager of an acute inpatient unit, I am constantly involved with restrictive practice. I believe the service user has rights that are sometimes overlooked. I am also acutely aware of safety for all which includes staff. Staff are at time frightened of service users or at times very concerned about occupational violence (P48).

However, even during the act of restraining a service user, participants expressed concern for them. In recalling a recent event, one respondent revealed fear for self, colleagues and the service user formed a major part of the memory of the event,

The patient was very disturbed and it took five of us to restrain him enough to give him a shot. I felt frightened for myself and also for the patient (P5).

It was not only patient characteristics such as being '**disturbed'** that played an influential and driving force in the use of restrictive practices. Respondents also identified lack of staff experience and expertise in recognising early signs of escalation, and not being able to effectively deescalate situations as contributing to staff feeling scared and fearful. It was implied that these emotions contributed to the use of restrictive practices.

Seclusion in our organisation is very rare. However, one event last year was related to extreme aggression, and the staff were highly fearful. My observation of the event was that if staff are scared then the use of seclusion becomes the option for care. I felt that the situation had escalated and not been addressed adequately - but I also observed that the staff were inexperienced and had missed those triggers (P52).

Use of restrictive practices to maintain safety for all.

While seclusion and restraint were generally considered to be undesirable and suboptimal, their use was also seen as sometimes being necessary to prevent escalation of violence and maintain safety for all in the environment.

I have worked with many experienced and skilled clinicians and despite every attempt to defuse and de-escalate, staff have had to use both interventions to maintain the safety of others (P64).

Despite the fear felt by staff in threatening situations, respondents noted that nurses act to protect others in the environment when there was a threat of violence. It was also noted that while **organisational** policies **governing restrictive practices** were in place, in the heat of the moment, staff may act outside the policies, albeit with the aim of keeping others safe.

Policies should always be followed, but it should also be noted that when violent acts are being perpetrated upon anyone it is the nurses that override their own sense of self-preservation to do whatever they can to go to the assistance of others, nurses do not

examine policy or argue the nuances of policy when protecting others, they sometimes just do the best they can under the circumstances (P21).

Thus, the use of restrictive practices was considered to be sometimes necessary for the broader good.

Episodes where a patient has been violent, and staff and patients are at risk. It's not nice to seclude /restrain someone; however, staff and other patients also have a right to be safe in their workplace /place of care (P23).

Respondents clearly felt conflict between the genuine desire to reduce restrictive practice versus the potential threat that some respondents felt overrides and outweighs ideologies around least restrictive practice. The concern and duty nurses feel about keeping everyone in the environment safe, creates complexity that could be a perceived as a strong barrier that mitigates against real practice change.

We must defend ourselves against those that genuinely seek change but do so with unrealistic ideologies, against people that chase 'good' statistics instead of 'best' practice. Every time I am involved in these [new 'least restrictive] interventions I am aware of what we are asking nurses to do, the risks they take and the potential insidious damage that it may be doing to their being. I am aware that when nurses restrain and seclude that it is not for their benefit but for wellbeing of others and that those others trust and depend on those nurses to protect them (P31)

The internal conflict associated with restrictive practices was frequently expressed in the data, with nurses indicating initiation of these practices was a strategic action to ensure

safety for all. Reflecting on a recent episode of seclusion, one respondent commented, '*I felt unhappy that it had gone that far but also felt that we had no choice if we were going to keep everyone safe' (P 59).*

Previous incidents of occupational violence also had a powerful effect on attitudes and actions where the threat of violence was perceived. Respondents' narratives revealed they could be forever affected when exposed to episodes of violence and they carried a weight of responsibility felt not only for themselves and service users, but for the safety of colleagues, of everyone on the team.

Every incident of restraint and seclusion has an effect … every time effects someone and everyone is effected sometime, everyone. I remember the day a male patient with a long history of violent assaults grabbed a female nurse by the hair and slammed her head into the ground … I remember how his violence persisted until other nurses intervened to stop it. I have to remember how a nurse's career was permanently ended and I have to remember that this is the reality we face each and every day and that we must work hard to ensure others are not victims, and that every day every nurse goes home intact (P26).

Restrictive practises as a legacy of time and place

There was also the view that in some ways, restrictive practices were a legacy and reflection of routines, traditions, and attitudes that existed in the past or were organisationally or situationally specific.

Historically the act of seclusion I believe, is an act of convenience. When a consumer becomes angry and irritated, the first step is to isolate and medicate. Seclusion served this purpose. I think that more and more the focus is shifting to de-escalation with authentically wanting to reduce seclusion (P33)

In this view, strategies to eliminate seclusion represented changed understandings and approaches. Respondents with decades of experience reported witnessing changes in attitudes and reduction of restrictive practices over time.

I have been involved in many seclusion and restraint incidents over my 30 years and I am gratified to know that the rates have reduced significantly over the past 10 years. (P64).

Attitudes and views towards restrictive practices also varied according to experience and this was very notable in nurses who had come to Australia from overseas and who brought with them knowledge of other systems and responses.

One of my earlier experiences in the Australian mental health system was when a code was called and the security team attended. The decision had already been made to place the client in seclusion. I felt that we could have worked with the client to avoid this but was outnumbered and was still new to the system. I managed to debrief with the staff involved and disappointingly they all felt there was no alternative to seclusion. Coming from an environment where we didn't use seclusion, I found this very confronting and it challenged my philosophy and approach to mental health nursing (P13).

Staff were sometimes exposed to restrictive practices because of the organisational practices of third parties such as police, who some respondents reported used them almost routinely.

It was a matter of routine that the police brought people to hospital in restraints. This was almost always an excessive response and always left me feeling uncomfortable (P42).

These episodes were more frequently described as occurring within non-mental health settings including health settings such as the emergency department. Where episodes of restrictive practices had occurred in health (non-mental health) settings, mental health nurses also had to deal with the additional distress experienced by service users.

I was not involved directly but was told by a consumer his experience of being secluded in a safe assessment room for a period of 7 hours, ignored and not given toilet privileges of rights to urinate. This was very distressing as when followed up with the Emergency Department they had no insight into the trauma that they had caused and believed they had done the right thing (P51).

Restrictive practices as the last resort

Many respondents described initiating a range of interventions to avoid restrictive practices. However, despite this, there were some clinical situations in which usual de-escalation strategies were ineffective, and so in these situations, respondents indicated restrictive practices being used as a strategy of last resort.

In the event of de-escalating strategies not being successful and the situation becoming unsafe for self and others a clinically initiated time-out in seclusion can assist the person to de-escalate themselves without harm … In the event of explosive aggression and violence … an episode of seclusion is the safest way to ensure the risk of harm to self or others is reduced. In my place of work, seclusion is used to mitigate aggression (P36).

Indeed, in the presence of an immediate threat, respondents felt that careful use of restrictive strategies was sometimes the only path available. Reflecting on a recent event involving the use of restraint and seclusion, one respondent described the situation,

A person had just been admitted and was combative and psychotic. I called for additional support and we restrained the person on the bed and administered medication. We left the room and locked the door until the person was calm. The person was on 1:1 observations. I felt that we had no choice but to respond in this way as we were unable to develop any kind of rapport prior to the event (P18).

In seeking to maintain safety for all, some respondents felt the physical environment of the ward area severely limited their options for care, and left nursing staff with very few avenues for intervention.

When we have patient-to-patient assaults … I need to protect the patients on the ward and ensure they are safe. It's really tricky as my workplace doesn't have a high dependency area on any of our wards thus no in-between and we are left with only two options. Main ward or seclusion (P35).

Even when used as a last resort in the heat and complexity of the moment; during the aftermath and on reflection, respondents were sometimes able to identify strategies that may have prevented the episode from escalating to the point that restrictive practises were felt to be the only remaining option.

A consumer was punching and kicking at the nurses station demanding medication; the consumer had no prescribed medication that could be given; nursing staff attempted verbal de-escalation; consumer attacked nurse who activated a code; consumer could not be de-escalated verbally; consumer was restrained, taken to seclusion and given IMI medication; consumer was secluded for 1 hour 15 minutes before they settled enough to be allowed back onto the unit. I felt that all staff handled the situation well, I felt frustration that the consumer was not prescribed any medication that could have been utilised to help the consumer to settle (P61).

Similarly, respondents sometimes felt let down when they were exposed to violence and left to manage violent situations where the feeling was that the violence was reasonably foreseeable, and that proper plans and resources were not put in place.

During attempted de-escalation patient grabbed me by the throat, lifted me off the ground and attempted to throw me over a wall. This attempted was resisted and then the patient was restrained by myself and other members of the staff, placed in seclusion and given medication. I felt let down by the system as it consistently admits drug affected patients with extensive histories of violence without having pre-emptive management plans in place (P37).

The desire to avoid restrictive practices and ensure all other strategies were tried first sometimes led nurses to think that earlier use of restrictive practices may have prevented injury to others in the environment.

We were unable to de-escalate - consumer wanted to leave but was detained under the Mental Health Act. The situation escalated rapidly and 4 staff and 3 other consumers ended up being treated for serious injury after being assaulted by consumer before the situation was resolved by the use of seclusion. In hindsight it felt like we should have intervened earlier (P46)

Restrictive practices as a source of occupational distress

Restrictive practices were a clear source of considerable and ongoing occupational stress and distress for respondents regardless of their level of involvement.

Having worked as an RN across a number of organisations in a number of roles I have been involved from in physically restraining, forcefully medicating and secluding; as a shift leader I have initiated (and ceased) seclusions; as a manager I have reviewed seclusions. At every level of involvement, I have felt differing levels of fear, sorrow, hopelessness, and at times even anger or regret. I have never viewed seclusion or restraint as a positive outcome, though sometimes it has seemed the least bad outcome (P43).

When restrictive practices were enacted, even though staff felt they had little choice in the particular situation, those involved in the event often reported feeling distressed, and were left questioning their practices and the decision-making around the events. In

recalling a recent situation, one respondent revealed the subsequent distress felt by the nursing team.

Consumer was angry and aggressive damaging property. Staff had not engaged him well and had limited opportunity to do so beyond a certain point. Seclusion followed. We all felt awful and realised we had not fulfilled our roles appropriately (P7).

Issues around the use of restrictive practice were revealed as a catalyst for staff to review the practices of peers and colleagues, and this sometimes left staff feeling disappointed, distressed and even traumatised. Words such as *disgusted, inappropriate, unprofessional, disgraceful, upset and sickened* were used in the narratives around these incidents

A young man with first presentation psychosis was responding to auditory hallucinations and threatened the nurse speaking with him. Her response was to call security and have the man secluded and medicated. For me, the experience was unprofessional and disgraceful. The first line of intervention was to seclude him - this was inappropriate and there were other avenues that could have been explored and utilised. I was disgusted by the entire event (P8).

Respondents also reported sometimes feeling that they were put into situations where they became part of an episode of restrictive practice they did not approve or agree with and believed could have and should have been avoided. These events were often seen to be related to failure of nursing care rather than the condition or clinical needs of service users. Respondents revealed experiencing a range of negative emotions associated with these events.

I once worked alongside a nurse with limited rapport building skills and a tendency towards punitive and restrictive practice. In the presence of the patient's family members, the nurse jumped on the patient prematurely without attempts at engaging and de-escalation and completely unnecessarily took the patient to the floor. Due to the subsequent immediate escalation in risk of harm the situation necessitated me having to assist the nurse in from of horrified parents and traumatised young sibling. I felt terrible about being compelled to assist in the situation, angry towards my colleague and humiliated in the eyes of the patient and his family (P15).

Respondent narratives also highlighted the importance of engagement of the interdisciplinary team in these events and how nurses may be left feeling that other team members just want to avoid involvement. However, in recalling an event, **the respondent below** also noted the value of security staff in a situation that staff experienced as *highly charged* and *distressing.*

A pregnant woman who was very distressed and angry about being in hospital… I felt that there could have been an intensive respite and staffed alternative to inpatient admission and seclusion. Best I could do was to remain outside the seclusion room to reassure her verbally. Ethically highly charged situation. Very distressing. Most staff including doctors didn't know what to say, couldn't wait to back away from the situation. A Maori security guy was great (P22).

The need to support staff involved in restrictive practices

The level of distress to staff was revealed as a major concern and respondents indicated that more needs to be done to not only reduce the perceived need for restrictive

practices, but to better understand, recognise and support staff involved in such events. Respondents were of the view that this particular form of occupational distress is not well recognised and that there are few avenues of support.

It is never a satisfying thing to do. In fact it is traumatizing to staff as well, I believe. Myself included, constant exposure to violence from clients does as much harm in nurses as seclusion and restraint does in patients but it is not as recognized and something that should be further looked into (P50).

Many respondents recognised the level of distress and upset they had experienced and were left with residual and continuing feelings of concern about events. However, through their narratives they revealed that opportunities to debrief and discuss the event afterwards were often not sought or not available.

I brought a consumer in from the community and was with the consumer on the ward when unprovoked the consumer attacked another staff member. I was able to pull the consumer off the staff member, however a number of the staff were injured while doing so. I then initiated the restraint of the consumer and also required the use of the seclusion room to manage the situation. This was a horrific incident for the consumer(s) and staff. I was extremely upset post the incident and did not seek supervision afterwards and it wasn't discussed (P17).

From the narrative above, it can be seen that the onus to seek opportunities for debriefing seem to rest with the individual nurse and are not necessarily a routine response to the implementation of an episode of restrictive practice.

In addition to supporting staff who are left distressed or feeling angry, let-down or otherwise traumatised as a result of restrictive practices, post-event activities such as individual and group reflection and discussion could be useful where there are perceived improprieties, poor practices or breaches of policy.

An angry 19-year-old was treated very badly by a nurse, including physical abuse. He was grabbed by the nurse who was bigger than the consumer and physically taken to seclusion. … the nurse went against the policies and accepted practice. Following the incident, the nurse was unable to accept feedback from his nurse manager and unable to consider he had done anything wrong. This incident sickened me to my stomach (P49).

Discussion

Findings from this study indicate that events leading up to consumers being secluded or restrained, and the restrictive practices themselves, evoked a range of emotional responses in nurses, including fear, anger, distress, disgust and regret. Studies have shown that there is a positive correlation between anger as a result from exposure to verbal aggression such as name-calling and other types of derogatory personal insults, and the involvement of mental health nurses in restraint. However, guilt is negatively correlated with seclusion (Jalil, Huber, Sixsmith, & Dickens, 2017). Emotions felt and expressed by nurses during aggressive situations can influence staff behaviour, which can consequently trigger or maintain patient aggression (Jalil et al., 2017). The effect of nurses' emotions during seclusion and restraint events is complex and currently, has not been fully established. **However, it is acknowledged in the literature that nursing staff's emotional response to seclusion and restraint can stem from a preference for relational approaches to care being frustrated by a lack of resources, environmental limitations and organisational culture (McKeown et al., 2019).**

The majority of nurses in this study viewed restrictive practices as sometimes necessary to ensure staff and consumer safety. Seclusion and restraint have been described by mental health staff, as ‘part of the job’, ‘inevitable (Bigwood & Crowe, 2008, p. 221) and ‘a necessary evil’ (Gerace & Muir-Cochrane, 2019, p. 215). Similar to the current study, other Australian researchers have suggested that nurses are concerned about how they would manage aggressive, violent or intoxicated consumers without restrictive methods as an option (Gerace & Muir-Cochrane, 2019; Muir-Cochrane et al., 2018). **However, the justification of restrictive practices as a last resort is increasingly being questioned. Scholars have called attention to the idea, that staff framing restrictive practices as a justified last resort, is a way of managing dissonance (McKeown et al., 2019). McKeown et al. (2019, p. 11), conducted an ethnographic study in the UK and found that staff engaged in ‘legitimation narratives regarding restrictive practices’ and that these narratives contributed to a culture where restrictive practices were viewed as inevitable. Both McKeown et al. (2019) and Gerace and Muir-Cochrane (2019) advocate for a renewed focus on trauma-informed care, that was endorsed and resourced by management.**

Mental health nurses experience a higher rate of physical aggression compared to nurses in any other health care setting and other professionals within the mental health environment thus it is not surprising that fear is an issue mental health nurses face (Jalil et al., 2017; van Leeuwen & Harte, 2017). Nearly all nurses working in mental health settings have been subject to some form of assault (Renwick et al., 2019). This negatively influences all aspects of nurse wellbeing including emotional, social and psychological and can often result in physical and emotional injuries including the development of post-traumatic stress disorder (Jalil et al., 2017). Various studies have also shown, that the fear of assault influences clinical decision-making in regard to the

management of aggression, seclusion and restraint (Bigwood & Crowe, 2008; Muir-Cochrane et al., 2018). Literature conducted on the views and experiences of nurses propose that in order to conserve a safe environment, it essential that control is maintained in the acute patient setting and that nurses' fears that they might be harmed by a consumer are considered when making the decision to implement restraint (Bigwood & Crowe 2008). Fear in the workplace in the context of mental health nursing, has not been fully elucidated and given the findings from various studies such as Bigwood and Crowe (2008), Muir-Cochrane et al. (2018) and others, there is an important need to further explore this issue.

Workforce development and appropriate rostering are critical to ensure that the nursing staff working with the consumers are confident in managing the challenging situations. A survey of Australian nurses working in mental health, confirmed a correlation between staff feeling unskilled and being more likely to resort to restrictive practices (Gerace & Muir-Cochrane, 2019). Nurse and patient safety are interrelated thus risks to patient safety also pose risks to nurse safety, and vice versa (Conroy, Reo, Boucaut, Alderman, & Kitson, 2017). **Sweeney et al. (2018) drew attention to how the use of restrictive practices can cause nurses to experience vicarious trauma which can then impact on their ability to be compassionate and caring. Likewise, McKeown et al. (2019), noted that increased understanding of consumer's trauma related behaviours, could lead to a more empathetic response from mental health professionals.** A recent randomised controlled trial found that upskilling staff in evidence-based interventions, resulted in improved perceptions of care in consumers who were involuntarily **admitted to an acute mental health ward** (Wykes et al., 2018).

In Australia, current initiatives to reduce restrictive practices, acknowledge the need to ensure patient safety (NSW Ministry of Health, 2018). However, beyond reference to implementing 'minimum standards and skill requirements for all staff working in mental

health' (NSW Ministry of Health, 2018, p. 4), there is no appreciation of staff safety needs or need for support following the implementation of restrictive practices. In this current study participants had little access to formal debriefing. **Gerace et al. (2018), found similarly in a recent study of assistant in nursing supervising mental health consumers in an emergency department. Chapman (2014), who previously worked with disabled Aboriginal children in Canada, recalled debriefing following restrictive practices being reserved for new staff. This debriefing, however, was intended to foster their acceptance of the practices, not deal with their aversion to them. Likewise, McKeown et al. (2019) cautioned that rather than helping staff learn from incidents, debriefing could encourage the development of narratives to justify and legitimise the continuing reliance on seclusion and restraint.** Despite these findings, there is little evidence in health policy documents of accommodations being made to debrief or support staff who have been involved in restrictive practices **or the form this debriefing should take**.

The increasing introduction of models and frameworks to support the reduction of restrictive practices is promising. The Safewards Model which originated in England, has been trialled in several Australian states and the Australian Commission on Safety and Quality in Healthcare (ACSQH) (2018) have released guidelines for providing care for people with mental health issues and the reduction of the use of restrictive practices. These documents outline strategies for partnering with consumers, workforce development and environmental considerations. Early evaluations of Safewards indicate a decrease in staff/consumer conflict and an increase in safety (Fletcher et al., 2019). The Australian College of Mental Health Nurses (2019) recently released the Safe in Care, Safe at Work (SICSAW) Toolkit, which is based on the New Zealand (Te Pou o te Whakaaro Nui, 2013) adaption of the Six Core Strategies© checklist (Huckshorn, 2006). The adoption of the Six Core Strategies© was also championed by Mental Health Carers

NSW (2017), in their submission to a state-wide review of seclusion, restraint and observation of consumers with a mental illness in NSW Health (NSW Ministry of Health, 2018).

Unlike SafeWards or the ACSQH document, one of SICSAWs core strategies focuses on post-restrictive care for both consumers and staff. Recognising, that despite efforts to reduce and eliminate restrictive practices they still occur, this core strategy emphasises the need for those involved to reflect on the incident and that any resulting trauma or distress for consumers and staff is recognised and support provided.

Strengths and Limitations

Results from this survey only represent the views of a small number of mental health nurses in Australia. Due to the recruitment strategy, it is assumed that the majority of respondents were members of the Australian College of Mental Health Nurses. Additionally, a quarter of the respondents were credentialled mental health nurses and half had a post-graduate qualification in mental health implying increased knowledge. The views of less experienced mental health nurses, or those who did not complete the survey cannot be determined. **Despite these caveats, a strength of this study was the finding that there has been a lack of attention paid to debriefing and supporting nurses following the use of seclusion and restraint. Given Sweeney et al.'s (2018) finding, that vicarious trauma in staff can impact on compassion and care, this represents an understudied phenomena in an otherwise well-researched area of nursing practice.**

Conclusion

This survey has highlighted mental health nurses' experiences of imposing restrictive practices on mental health consumers. Analysis of the data revealed, that similar to other studies, nurses experienced fear and distress when they were involved in secluding and restraining consumers who were in danger of harming themselves or others. The use of seclusion and restraint was problematised as a sometimes-necessary last resort. Investigation of the literature revealed a focus on reform and the reduction of the use of seclusion and restraint. However, with the exception of the SICSAW document (ACMHN 2019), the safety of staff, and the need for debriefing following incidents of restrictive practices was rarely addressed.

Relevance for clinical practice

Although the national and international efforts to reduce or eliminate the use of restrictive practices in mental health facilities, and focus on patient safety, are to be commended, the experiences of staff need to also be considered. There also has to be recognition that in an imperfect world, restrictive practices will still occur. While, new initiatives and policies are implemented, it is incumbent on management to also consider the immediate and long-term safety and emotional wellbeing of staff. To support mental health nurses as they cooperate to reduce the incidence of seclusion and restraint there needs to be appropriate staffing, availability of supportive education and structured routine debriefing of all episodes of restrictive practice.

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