



ORIGINAL ARTICLE

Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint

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ABSTRACT: Restrictive practices continue to be used in mental health care despite increasing recognition of their harms and an international effort to reduce and ultimately eliminate their use. The aim of this qualitative study was to explore mental health nurses' views of the potential elimination of these practices. Nine focus groups were conducted with 44 mental health nurses across Australia, and the data analysed using thematic analysis. Overall, the nurses expressed significant fear about the potential elimination of restrictive practices and saw themselves as being blamed for both the use of these practices and the consequences should they be eliminated. Findings detail the conflicts facing staff in balancing the need for ward safety for everyone present while at the same time providing person-centred care. Nurses described the changing role of the mental health nurse in acute settings, being more focussed on risk assessment and medication while at the same time attempting to practise in trauma-informed person-centred ways. The impact on ward safety with increasing acuity of consumers plus the presence of forensic consumers and those affected by methamphetamine was emphasized. Change initiatives need to take into account nurses' deep concerns about the consequences of eliminating all forms of control measures in hospitals and respond to the symptoms and behaviours consumers present with and associated unpredictable and concerning behaviours. Attempts to eliminate restrictive practices should, therefore, be carefully considered and come with a clear articulation of alternatives to ensure the safety of consumers, visitors, and staff.

KEY WORDS: mental health nursing, restraint, restrictive intervention, seclusion.

INTRODUCTION

Restrictive practices such as seclusion and restraint are used in healthcare settings, such as psychiatric inpatient units and emergency departments (EDs), to

manage consumers who are aggressive or violent. However, the use of these measures has negative consequences for consumers and staff (Victorian Government Department of Health, 2013), such as re-traumatizing consumers with histories of existing

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trauma (Hammer *et al.* 2011) and damaging the therapeutic relationship between consumers and health professionals (Theodoridou *et al.* 2012). Consequently, there has been an international drive towards reducing and, ultimately, eliminating the use of these practices (LeBel *et al.* 2014).

A number of programs have been implemented worldwide, demonstrating success in reducing the rates and duration of seclusion and restraint events (Hernandez *et al.* 2017; LeBel *et al.* 2014; Madan *et al.* 2014; Victorian Government Department of Health, 2013; Fletcher *et al.* 2017; Wieman *et al.* 2014). Importantly, research has also reported that reduction in the use of restrictive practices does not lead to an increase in assaults (Smith *et al.* 2015). Building on these successes, the Restrictive Practice Working Group of the Australian Health Ministers' Advisory Council developed the 'National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services' (2016) as the next logical step towards eliminating restrictive practices in Australia.

Despite overwhelming support for reducing and eliminating the use of seclusion and restraint, and the success of reduction programs, these practices continue to be used in mental health care (Allan *et al.* 2017; Bowers *et al.* 2017; Bullock *et al.* 2014; Gerace *et al.* 2014; Muir-Cochrane *et al.* 2014; Oster *et al.* 2016; Te Pou o te Whakaaro Nui, 2017). Mental health nurses play a central role in the provision of mental health care and as such represent the staff that are most likely to use seclusion and restraint (NMHCCF, 2009). Understanding nurses' views of seclusion and restraint, and in particular on the potential for these practices to be eliminated, is, therefore, essential (Mann-Poll *et al.* 2015).

BACKGROUND

Consumers and carers, while at times identifying some benefit to restrictive practices, predominantly express negative perceptions of seclusion and restraint use and are unlikely to view these interventions as therapeutic (Brophy *et al.* 2016; Kinner *et al.* 2017). Nurses express a range of views about seclusion and restraint: from unease and avoidance, through to accepting that the use of the intervention is necessary and even therapeutic (Goethals *et al.* 2011; Happell & Koehn 2011; Maguire *et al.* 2012; Perkins *et al.* 2012). Overall, while there is support for a reduction in the use of seclusion and restraint, the majority of mental health professionals defend the continued use of some form of

restrictive practice in regard to the management of violence and aggression (Happell & Harrow 2010; Kinner *et al.* 2017), viewing these practices as a 'necessary evil' to be used as a last resort (Wilson *et al.* 2017).

There has been little research exploring the views of mental health nurses in Australia regarding the elimination of restrictive measures. This is a significant gap because research from other countries likely reflects different 'cultural, procedural and health-care practices' (Wilson *et al.* 2017, p. 501) that affect both the use of seclusion and restraint, and the potential for these practices to be eliminated. Furthermore, research tends to focus on nurses' attitudes towards the use of seclusion and restraint, and their views of reducing the use of these practices. Little is known about nurses' views on *eliminating* seclusion and restraint use in mental health care, aside from one recent Australian national survey of consumers, carers, and health professionals, reporting mixed views about the desirability and feasibility of elimination, particularly on the part of health professionals (Kinner *et al.* 2017). With the move towards eliminating restrictive practices, it is important to understand nurses' views given the key role they play in both the use of seclusion and restraint, and in the development and implementation of strategies to reduce or eliminate their use.

In this study, we report on the findings of a study investigating mental health nurses' perceptions and attitudes regarding barriers and enablers to eliminating seclusion and restraint in inpatient psychiatric settings and emergency departments (EDs) in Australia.

METHOD

Design

This was a qualitative, descriptive study using focus groups to interview mental health nurses about their views and experiences. Participants were recruited using an email membership list for the Australian College of Mental Health Nurses, who had funded the study. Potential participants were provided with information about the study and the date, time, and location in which the focus group would be conducted in their locality, and asked to RSVP their attendance. Written consent was sought from all participants. The total number of participants was 44. Unfortunately, only 45% of participants ($n = 20$) provided demographic information (summarized in Table 1). This is a limitation of the study. Flinders University human research ethics committee approved the study.

TABLE 1: *Demographics*[†]

Demographic	<i>n</i> (%)
Gender	
Female	11 (55%)
Male	9 (45%)
Age range	
25–34	1 (5%)
35–44	1 (5%)
45–54	9 (45%)
55–64	7 (35%)
65–74	2 (10%)
Highest level of education	
Diploma	3 (15%)
Bachelor's Degree	4 (20%)
Master's Degree	8 (40%)
PhD	2 (10%)
Other	3 (15%)
Type of nurse	
Registered Nurse (RN)	3 (15%)
RN with mental health qualifications/credentials	16 (80%)
Nurse practitioner	1 (5%)
Years worked in nursing (mean)	30
Years worked in mental health practice settings (mean)	21
Current area of work	
Acute inpatient ward/unit	7 (35%)
Accident and emergency	1 (5%)
Psychiatric ICU	1 (5%)
Education	4 (20%)
Community Mental Health	5 (25%)
Unit encompasses multiple areas	1 (5%)
Management	1 (5%)
Years in current position (mean)	5 years and 9 months
Predominant role	
Clinical	10 (50%)
Management	3 (15%)
Education	7 (35%)
Geographic location	
Metropolitan	10 (50%)
Regional	5 (25%)
Rural	5 (25%)

[†]Demographic information was provided by *n* = 20 participants.

Data collection

Nine focus groups were conducted in five Australian states and territories (New South Wales, Northern Territory, Victoria, Western Australia, and the Australian Capital Territory), with between three and twelve participants per group. The focus groups were conducted in capital cities and in two regional locations in 2017. A semi-structured interview guide was used exploring nurses' general attitudes to seclusion and restraint, and barriers and enablers to the reduction and elimination

of seclusion and restraint in their workplace. All facilitators had previous experience in running focus groups and in the conduct of research. A written facilitator guide was prepared and included details about the specific aspects of the focus group, ground rules, and the structured interview guide with questions and sub-questions (Table 2). Facilitators also participated in a group teleconference, which guided them through the structure and format of the focus groups. Focus groups were audiotaped and transcribed verbatim with a duration between 70 and 105 min.

Analysis

Focus groups were analysed using thematic analysis as described by Braun and Clarke (2006). Thematic analysis is used to identify patterns across the data set and was undertaken in this study to report the 'meanings and the reality of participants' (Braun & Clarke 2006, p. 81). The process began with familiarization with the data, with the authors reading through the transcripts and making notes about possible codes. The authors then met to discuss their initial ideas and finalize the codes. One of the authors then coded the transcripts, using the online software Dedoose (Version 7.6, 2017) to manage the coding process, and then collated the codes into potential themes. All authors discussed the emerging themes and agreed on the final themes.

RESULTS

That's my big fear, is that they will just [say] 'alright this is what we're going to do' [ban the use of seclusion and restraint] and you're left standing there thinking 'what are we going to do now?' That's a big fear of mine for the staff and patients. (FG 4)

This analysis presents a discussion of Australian mental health nurses' views on the potential to eliminate the use of seclusion and restraint in mental health care. The quote above exemplifies the fears expressed by nurses regarding the potential elimination of restrictive practices. Overall, the nurses believed seclusion and restraint use could not be eliminated altogether while still maintaining a safe environment:

[I]s it possible to practise without restraint? . . . in certain sections in mental health I'm going to have to say no, it's not possible because when you're dealing with human cognition and someone's not in touch with reality, no amount of de-escalation and no amount of therapeutic input is going to make the situation safe. (FG 5)

TABLE 2: Focus group questions

Area of focus	Questions
Why did you come today and what do you think you will get out of participating in the focus group discussion?	
General attitudes to seclusion and restraint (S/R)	<p>What are your general thoughts about the use of S/R in mental health units?</p> <p>Is it possible to practice without <i>seclusion</i>? If not why not?</p> <p>Is it possible to practice without the use of <i>restraint</i>? If not why not?</p> <p>Is it possible to practice without the use of <i>mechanical restraint</i>? If not why not?</p> <p>Is the training provided to you in regard to containment measures adequate?</p> <p>If not Why not?</p>
Trauma-informed Care/Recovery-based care on acute units	<p>What training and education have you had that addresses trauma-informed care and recovery-based practice?</p> <p>Can you describe what that training was?</p> <p>To what extent are you able to utilize it in the clinical environment?</p>
Barriers to the reduction of S/R	<p>What are the main barriers to the reduction of <i>seclusion</i> on your unit?</p> <p>What are the main barriers to the reduction of <i>restraint</i> on your unit?</p> <p>Out of those, what are the barriers that can be addressed?</p> <p>What are other factors?</p> <p>How can these factors be managed (reduced, changed, etc.)?</p>
De-escalation skills	<p>What training and education have you had that addressed de-escalation skills?</p> <p>Can you describe what that training was?</p> <p>To what extent are you able to utilize it in the clinical environment?</p>
Strategies for the reduction of S/R	<p>What strategies/activities have helped reduce the use of <i>restraint</i> on your unit?</p> <p>What alternative to the use of <i>restraint</i> would work, what experience do you have with these alternatives?</p>
Early intervention	<p>What early intervention or prevention of aggression initiatives have been initiated in your health service to support reduction of restrictive interventions? How successful have these been?</p>
If there was one thing you could change about the use of restraint and seclusion in your workplace/in general what would it be?	
Are there certain types of units where the use of restraint can be/cannot be totally eliminated?	

Hence, nurses' fears that should these practices be eliminated they will be left without the means to keep themselves and others safe, and ultimately be blamed for their actions:

I've been a psychiatric nurse for a long time. It's a difficult job and not getting any easier. It's very hard work. We don't get enough support and it feels a general movement to seclusion in Australia as terrible things, avoid at all costs. Somehow you're a failure as a nurse if it happens. (FG 2)

This perspective can be understood in relation to the following themes identified in the focus groups:

- The role of the nurse
- The complex and changing nature of the work environment
- Elimination of seclusion/restraint.

The role of the nurse

Person-centred care was described as a key tenet of nursing practice, referred to either directly (e.g. 'putting the client at the centre', FG 5) or indirectly in

reference to person-centred practices, such as developing rapport, focussing on the needs of the person, partnership, being empathic and respectful, provision of one-to-one nursing, and continuity of care. Restrictive practices were seen as contrary to the principles of person-centred care: '... the client isn't at the centre of care when they're getting restrained' (FG5). However, there was conflict within the nursing role with nurses expected to both provide person-centred care and be responsible for the safety of all consumers, staff, and visitors:

... you've got a duty of care to 30 people or human rights for one. (FG5)

In attempting to balance these roles, nurses erred on the side of caution; 'it's always about safety' (FG2).

Nurses described the use of seclusion and restraint as justifiable to maintain safety in situations where a consumer was being violent and/or aggressive, within a context where they are used as a last resort:

I believe it's necessary, but as a last resort, in certain situations, for the safety of staff that have to work with people and also patients sometimes are that unwell that

they need the containment for a brief period, to allow other things, medications, that sort of stuff, to take effect. But there seems to be a general push to removing that... But I think there is still some space for some restrictive interventions if it has to be done.

(FG2)

I think staff that work in mental health services and the emergency and hospital environments are exposed to higher levels of risk of aggression than the general community. I think staff need a way to safely prevent assaults against themselves and other consumers. I think there are times when restraint is required. (FG3)

Overall, the nurses expressed the view that where seclusion and restraint had been used, they were necessary, a 'good call' (FG3). Participants described the use of restrictive practices in negative terms when being overused or used unnecessarily, for example when a consumer refuses their oral medication, for minor acts of aggression such as throwing tissues, or when restrictive practices were 'not the last choice' (FG1).

Despite the overall view of seclusion and restraint as reflecting the role of the nurse in maintaining a safe environment, these practices were described as traumatic (both physically and emotionally) to consumers and staff:

Sadly, sometimes we're left with little other option but I think the majority of the staff are very aware of the trauma that [seclusion and restraint] does sort of tend to inflict on people.

(FG6)

Recognizing the trauma caused by seclusion and restraint meant that nurses acknowledged the need for these practices to be reduced. Further, nurses recognized the importance of trauma-informed care approaches for people with mental health problems and were well versed in their use. However, the complex and changing nature of the environment in which nurses work provided an imperative to continue to have these practices available to them in order for safety to be maintained. This fuelled their fears that seclusion and restraint would be eliminated.

The complex and changing nature of the work environment

A number of aspects of nurses' work environments influenced their views on the potential for seclusion and restraint to be eliminated. This included the changing nature of nurses' work, the nature of presentations to EDs and acute inpatient units, staff-related

issues, the physical environment, resourcing, and support. Together, these form the backdrop of nursing practice in which seclusion and restraint are seen as necessary tools to support nursing practice.

The changing nature of nurses' work

Focus group participants described nursing work as having undergone significant change, resulting in a shifting focus towards risk adversity – 'We're too overrun by risk' (FG1). Risk adversity was understood to underpin the legislative and policy contexts in which nurses work, and in which seclusion and restraint occur:

I think it [risk adversity] paralyses our decision making or the decision making of clinicians anyway. ...I think it feeds more restrictive practices.

(FG1)

Balancing this risk adversity with providing person-centred care was difficult for nurses, particularly with the growing trend for nurses to have less time and capacity to provide such care for mental health consumers. Mental health nurses were described as having a heavy workload, particularly with regard to paperwork and work not directly related to consumer care, limiting the time available to engage directly with consumers:

... if you've got highly trained staff that are confident to spend time deescalating - 45 minutes, two hours, whatever - and not be feeling pushed for time with other constraints of the workload, then people are less likely to utilise seclusion because they're able to spend more time using other methods.

(FG3)

Related to this is the narrowing of nurses' roles to administering medication and doing paperwork:

... the skills of the nursing staff [are] restricted now to giving out the pills, doing the IMs [intramuscular medication] and the admissions and all of that paperwork.

(FG1)

The nature of presentation to EDs and acute inpatient units

In addition to changes to nurses' work, participants described changes to mental health presentations that affected their ability to practise in an environment free of restrictive practices. In particular, the number of consumers who are a substance (principally crystalline methamphetamine: 'ice') affected was seen to have increased significantly in recent years. Participants described these consumers as unpredictable and often aggressive, as exacerbating aggressive behaviour in

other consumers, and also as resistant to efforts at de-escalation. Increasing numbers of consumers from correctional and forensic services was also raised as an issue of concern:

I think we can certainly go a long way to reduce the numbers, the times and the rates but to wipe it out altogether I'm unsure if that's possible at this point. I think acute mental health especially has changed a lot in the public sector when we receive a lot of police admissions from the watch-house and people on 'ice'.
(FG6)

Nurses also identified higher levels of acuity in the current population of mental health consumers, due to a range of factors such as inadequate management in the community, pressures relating to the relatively small number of beds available, and inadequate medication management:

I guess your patient acuity is a real issue. . . . I've got somebody who is fabulously unwell, acutely unwell, threatening – there's usually some sort of act of violence – it's pretty hard to respond in any other way.
(FG3)

Staff-related issues

Working in an environment of high consumer acuity and complexity necessitates a stable workforce of adequate numbers of skilled nurses working together to provide person-centred care. Factors such as inadequate staffing levels, high levels of staff turnover, inadequate skill mix (particularly on weekends), the casualization of nursing staff positions, and the lack of nurses trained and experienced in the field of mental health nursing were, therefore, described as increasing the likelihood of seclusion and restraint:

If something is starting and you can see it, you need to get over there quickly and intervene, and manage it and de-escalate that whole situation. But if you're busy here with somebody, and there's nobody there, there's no staff. Or you know that nurse over there's got a bad back. That one there's about to retire, and that one there's a new graduate.
(FG7)

Inadequate or infrequent education and ongoing training could also result in the use of restrictive measures where staff were seen to lack empathy and understanding of the distress of consumers, 'One of the barriers [to the reduction/elimination of seclusion/restraint] I think is people not being able to see the perspective of others' (FG1). Related to this was the issue of staff burnout:

If you're in the job and you have reached some level of burnout, and perhaps you are dismissive of clients or any of those sorts of things - and clients will pick up on this immediately - and that can cause escalation and that also concerns the heck out of me.
(FG3)

A further staff-related barrier was fear:

. . . a staff member can be hit or assaulted. The rest of the staff are very fearful. . . . So it's that adrenalin that takes place, it's also the fear factor.
(FG6)

This was a particular issue with an ageing workforce of nurses who participants saw as less able to 'deal with very physical situations and the injuries that come with them.'
(FG7).

Security staff also increasingly play a part in seclusion and restraint; 'So the clinical picture has changed because of acuity that you talked about before and now there's actually security or extra personnel onsite to help keep things settled' (FG5). Security staff were often seen as a negative addition to the ward, particularly because they are not clinicians and their practices are not person-centred. The availability of security staff might also mean nurses are less likely to use their skills to de-escalate or intervene early to manage risk, trusting in security staff to manage any situation that might arise. To some participants in this study however, the presence of security staff on the ward was seen as reassuring to nurses given the acuity and complexity of mental health consumers.

The physical environment

Staff and consumers clearly play an important part in seclusion and restraint events, but so does the physical environment in which restrictive practices occur:

In the emergency department this is a huge thing, because we're actually talking about an environment that is so not good for our clients. It's so busy. It's so over-stimulated. There are so many places to go, and people generally don't feel safe in a busy, crowded, well-lit environment.
(FG4)

Well they're the most unwell people in south-west Queensland and there's eight of them locked in a very small area, it's a recipe for disaster.
(FG6)

While an indoor environment that is cramped, dark, and with lots of corners and hidden spaces can be a fuelling ground for aggression and violence, therapeutic spaces designed specifically to facilitate communication, engagement, and healing were frequently discussed as key to eliminating the need for restrictive

practices. Outdoor spaces were also seen as important to allow consumers to move around and benefit from the sensory input a well-designed therapeutic environment can provide. However, changing these physical spaces was seen as resource intensive and unlikely to occur:

I really think ... [with the] push towards a non-secluding organisation. But I've often sat there and thought well, ... what resources are you going to give us and what redesign of the building are you going to give us?
(FG5)

Resourcing

Many of the aspects of nurses' work environment that affect their ability to practise in a person-centred way were described as resulting from a lack of resources. These include the number of beds available, the connected issues of brief admissions and short length of stay, ineffective early intervention in the community, lack of substance use/forensic mental health services, and inadequate staffing. For example, one participant discussed access to clinicians and long waiting times as 'the biggest features that we see that contributes to aggression in the emergency department' (FG4). Another commented: 'I just feel that sometimes we're constrained by the budget rather than constrained by best practice' (FG5).

Support

The final element of nurses' work environment is the extent to which there is support for eliminating seclusion and restraint. Support within the ward culture, from managers/leaders and from other nurses, was seen as vital in eliminating restrictive practices. Overall, however, the participants reported little support for them to practise in a less restrictive way. For example, participants discussed the negative effect of ward culture where nurses might enter into an environment where seclusion and restraint are routinely practised as the first option (rather than as a last resort) and where any efforts to change practise are strenuously resisted, resulting in new staff falling into line with existing practise:

The nursing culture ... impacts hugely on new staff coming into that environment and you find yourself getting wrapped up in that, 'oh this is the way we do it'. It's very hard to ... extricate yourself from that...
(FG4)

Linked to this was support from management, where managers who are supportive of efforts to

change practice can improve ward culture and work towards less restricted practice:

That culture comes, generally speaking, right from the top - that unit leadership and particularly when you've got a lot of casual staff ... so you need someone to keep tabs on that sort of thing.
(FG3)

However, nurses more commonly reported a lack of management support, particularly with regard to embedding person-centred care (and related models of recovery and trauma-informed care) into practice:

So I think that's where it often falls down. ... you can go to some fantastic conferences in the world on trauma informed care and the consumer movement and that - but if - yeah, I think it requires services to actually be in the process of moving their philosophy and open to new ways of working.
(FG5)

The elimination of seclusion and restraint

While participants saw the importance of person-centred care and reducing or eliminating the use of restrictive practices, there was an overall sense of fear that restrictive practices will be eliminated and nurses will be left with no mechanism by which to keep consumers, visitors, and staff safe. This was expressed through the use of frightening stories of what nurses had heard has happened where these practices have been reduced, and discussions about trauma to staff and other consumers from exposure to violence/aggression:

... what they've done is they've removed something and they've not replaced it with any other form of practice or intervention. Therefore, the number of assaults on staff has risen exponentially to the staff being knocked out, to staff being unconscious, broken [bones].
(FG4)

But we had somebody admitted at our hospital who went into seclusion, very high risk. The team that was on at a certain point during that seclusion fairly early on decided he didn't meet the criteria that they believed. He was let out of seclusion and he killed someone... That just raises a whole range of issues about sometimes people are secluded because they are very dangerous...
(FG2)

As discussed previously, the nurses, generally, did not think that restrictive practices could be eliminated completely. While some practices might be eliminated in some units, this was seen to involve either moving particular consumers to another environment where

restrictive practices can be used – ‘export the problem’ (Focus Group 3) – or replacing one form of restriction for another, particularly through the use of chemical restraint:

Facilitator:

... there’s increasing pressure to reduce all of these practices, to eliminate them.

Female: It’s unrealistic though. It’s ... completely unrealistic.

Male: Well no, they can enforce it. But all it means is we are sedating people to the point – I’m seeing patients sedated to the point where they’ll soil themselves. But that’s okay, because we’ve not secluded them.

Female: Yeah, and that’s it. It’s chemical restraint or it’s physical restraint. (FG3)

Given these fears, and the barriers identified in relation to the complex and changing nature of the work environment in which nurses practise, participants felt that any attempts to eliminate restrictive practices should be gradual, consultative, and come with a clear articulation of alternatives to ensure the safety of consumers, visitors, and staff. Currently, however, the nurses feel they are trapped between the policy imperative and the imperative for nurses to protect themselves and others, with nurses ultimately being ‘the scapegoats of the system’ (FG7) and blamed when restrictive practices do occur:

... this reducing seclusion seems to be nursing business for some reason and only nursing business. It seems to be a reflection of nursing care if someone is secluded or not secluded. (FG5)

I feel very strongly that there’s a perception sometimes that nurses are doing the wrong thing when they’re restraining and secluding people and I feel very strongly that nurses are not doing anything illegal and there are times where that’s legitimate. (FG5)

This interconnection of fear and blame ultimately undermines the imperative to eliminate seclusion and restraint in mental health care.

DISCUSSION

This study demonstrates that mental health nurses were deeply concerned and fearful about how they could manage aggressive or violent behaviour without restrictive measures, and the potential for being

blamed when adverse events do occur. Australian and international efforts towards the ongoing reduction and potential elimination of seclusion and restraint remain strong, yet safety issues are paramount in inpatient services. The conflict between providing person-centred care and the use of restrictive measures to manage risk is a significant issue emergent from these findings, recognized in other studies (Kinner *et al.* 2017; Wijnveld & Crowe 2010) and in particular as creating moral distress in nurses (Larsen & Terkelsen 2014). Indeed, Slemon *et al.* (2017) suggest that the risk management culture itself gives rise to and legitimizes restrictive practices. While there is a body of work about the nature of mental health care and the complexity of nurses’ roles and attitudes to restrictive measures (Bowers *et al.* 2010, 2014; Muir-Cochrane 2000; Muir-Cochrane & Duxbury 2017; Van Der Merwe *et al.* 2013), this is the first time nurses’ concerns have been articulated as fear and blame about the potential elimination of containment measures.

Perceptions of fear and blame by nurses in this study were also highlighted within the context of increasing patient acuity and the nature of presentations to EDs and acute inpatient units. As discussed in previous research (Carlson & Hall 2014), the nurses did not feel confident that they had sufficient support, resources, environment, nor adequately prepared workforce to maintain safety should seclusion and restraint be completely eliminated. A particular issue for these nurses was the effect of crystalline methamphetamine (‘ice’) use on restrictive practice. This concern is reflected in a recent Australian study that found an association between ‘ice’ use and restrictive interventions in an acute adult inpatient mental health unit (McKenna *et al.* 2017).

The built environment was also described as not conducive to a least restrictive environment. Lack of indoor and outdoor space, poor unit design, lack of natural light, and overcrowding are all barriers to quality care and recognized as such in the literature (Pollard *et al.* 2007). Further, the presence of security guards both offered safety for staff but was also perceived to increase the likelihood of seclusion and restraint. Thus, the environment remains a significant factor in initiatives to reduce or eliminate the restrictive practice.

Concerns about increasing aggression towards staff by consumers illustrated in this study are supported by research indicating that approximately 40% of consumers display aggression in some form (Bowers *et al.*

2011; Jackson *et al.* 2014), although other research indicates restraint reduction is not necessarily associated with an increase in aggression (Smith *et al.* 2015). Further, existing research draws attention to the incidence of posttraumatic stress in nurses working in acute psychiatric inpatient settings being about 10% (Jacobowitz 2013). In short, working in acute inpatient units and EDs is stressful. Any consideration of reduction initiatives, therefore, requires attention to the well-being of both consumers and mental health nurses.

Mental health nurses' accounts of fear and blame highlight the need for policies aimed at reducing or eliminating restrictive practices to 'take account of wide-ranging strategies to deal with aggression, including the provision of appropriate education and support and addressing ethical and workplace cultural issues associated with these practices' (Muir-Cochrane *et al.* 2015, p. 109). There is also increasing evidence of the usefulness of trauma-informed care in both acute inpatient and ED settings (Hall *et al.* 2016), and this can serve to guide educational and training packages and facilitate the necessary cultural changes required for restraint reduction to eventuate.

According to a recent systematic review of seclusion and restraint reduction programs in mental health (Goulet *et al.* 2017), the main components in successfully and safely reducing restrictive measures were leadership, training, postseclusion/restraint review, consumer involvement, prevention tools, and the therapeutic environment, all of which fall within the six core strategies of restraint reduction (Huckshorn 2006). However, caution is proposed as recent research found that closing seclusion rooms did not result in an overall reduction in containment practices (Bowers *et al.* 2017), as suggested by nurses in our study. The practice of seclusion and physical restraint is recognized as 'nursing business' with mixed views about how much involvement occurs from other members of the multidisciplinary team. To reduce feelings of blame and failure, it is furthermore vital that a multidisciplinary approach is harnessed in any initiatives to ensure that all health professionals are adequately prepared to practise in a person-centred, trauma-informed framework embracing least restrictive practice principles.

CONCLUSION

This is a significant Australian study of mental health nurses' understandings of the issues concerning them

within the current context of measures to reduce and ultimately eliminate the use of seclusion and restraint. Findings demonstrate the complexity of the issues articulating the fear and blame experienced by mental health nurses. This highlights the need for a reasoned and comprehensive approach to further initiatives to facilitate least restrictive inpatient care. Understanding the changing nature of the work mental health nurses undertake in EDs and inpatient settings as well as the environmental constraints on care will enhance ongoing measures to provide the best possible care for acutely unwell consumers with the judicious and minimal use of seclusion and restraint.

RELEVANCE FOR CLINICAL PRACTICE

This research provides new insights into the acuity of mental health consumers when in hospital and the challenges facing mental health nurses when attempting to practise in a least restrictive manner. Education, training, and multilevel organizational interventions are required to achieve the goals of least restrictive care. Change initiatives need to take into account nurses' deep concerns about the consequences of eliminating all forms of control measures in hospitals and respond to the symptoms and behaviours consumers present with and associated unpredictable and concerning behaviours. Attempts to eliminate restrictive practices should be carefully considered and come with a clear articulation of alternatives to ensure the safety of consumers, visitors, and staff.

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REFERENCES

- Allan, J. A., Hanson, G. D., Schroder, N. L., O'Mahony, A. J., Foster, R. M. P. & Sara, G. E. (2017). Six years of national mental health seclusion data: The Australian experience. *Australasian Psychiatry*, 25, 277–281.
- Bowers, L., Van Der Merwe, M., Hijman, H. *et al.* (2010). The practice of seclusion and time-out on English acute psychiatric wards: The City-128 Study. *Archives of Psychiatric Nursing*, 24, 275–286.

- Bowers, L., Stewart, D., Papadopoulos, C., Ross, J., Khanom, H. & Jeffery, D. (2011). Inpatient violence and aggression: A literature review. Report from the Conflict and Containment Reduction Research Program. Kings College London, Institute of Psychiatry.
- Bowers, L., Botha, M., Jarrett, M., Owiti, J. A. & Wright, S. (2014). Safewards: The empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing*, 21, 354–364.
- Bowers, L., Cullen, A. E., Achilla, E. *et al.* (2017). Seclusion and Psychiatric Intensive Care Evaluation Study (SPICES): Combined qualitative and quantitative approaches to the uses and outcomes of coercive practices in mental health services. *Health Services and Delivery Research*, 5.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J. & McSherry, B. M. (2016). Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings. *Australia Health Review*, 40, 599–604.
- Bullock, R., McKenna, B., Kelly, T., Furness, T. & Tacey, M. (2014). When reduction strategies are put in place and mental health consumers are still secluded: An analysis of clinical and sociodemographic characteristics. *International Journal of Mental Health Nursing*, 23, 506–512.
- Carlson, K. & Hall, J. M. (2014). Preventing restraint and seclusion: A multilevel grounded theory analysis. *Sage Open*, October–December, 1–12.
- Dedoose (2017). (Version 7.6) [Computer Software]. Los Angeles, CA: Sociocultural Research Consultants.
- Fletcher, J., Spittal, M., Brophy, L. *et al.* (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing*, 26, 461–471.
- Gerace, A., Pamungkas, D. R., Oster, C., Thomson, D. & Muir-Cochrane, E. (2014). The use of restraint in four general hospital emergency departments in Australia. *Australasian Psychiatry*, 22, 366–369.
- Goethals, S., Dierckx de Casterle, B. & Gastmans, C. (2011). Nurses' decision-making in cases of physical restraint: A synthesis of qualitative evidence. *Journal of Advanced Nursing*, 68, 1198–1210.
- Goulet, M.-H., Larue, C. & Dumais, A. (2017). Evaluation of seclusion and restraint reduction programs in mental health. *Aggression and Violent Behavior*, 34, 139–146.
- Hall, A., McKenna, B., Dearie, V., Maguire, T., Charleston, R. & Furness, T. (2016). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: A pilot study. *BMC Nursing*, 15, 21.
- Hammer, J. H., Springer, J., Beck, N. C., Menditto, A. & Coleman, J. (2011). The relationship between seclusion and restraint use and childhood abuse among psychiatric inpatients. *Journal of Interpersonal Violence*, 26, 567–579.
- Happell, B. & Harrow, A. (2010). Nurses' attitudes to the use of seclusion: A review of the literature. *International Journal of Mental Health Nursing*, 19, 162–168.
- Happell, B. & Koehn, S. (2011). Seclusion as a necessary intervention: The relationship between burnout, job satisfaction and therapeutic optimism and justification for the use of seclusion. *Journal of Advanced Nursing*, 67, 1222–1231.
- Hernandez, A., Riahi, S., Stuckey, M. I., Mildon, B. A. & Klassen, P. E. (2017). Multidimensional approach to restraint minimization: The journey of a specialized mental health organization. *International Journal of Mental Health Nursing*, 26, 482–490.
- Huckshorn, K. A. (2006). Six core strategies for reducing seclusion and restraint use©. [Cited 24 July 2017]. Available from: <https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf>
- Jackson, D., Wilkes, L. & Luck, L. (2014). Cues that predict violence in the hospital setting: Findings from an observational study. *Collegian*, 21, 65–70.
- Jacobowitz, W. (2013). PTSD in psychiatric nurses and other mental health providers: A review of the literature. *Issues in Mental Health Nursing*, 34, 785–795.
- Kinner, S. A., Harvey, C., Hamilton, B. *et al.* (2017). Attitudes towards seclusion and restraint in mental health settings: Findings from a large, community based survey of consumers, carers and mental health professionals. *Epidemiology and Psychiatric Sciences*, 26, 535–544.
- Larsen, I. B. & Terkelsen, T. B. (2014). Coercion in a locked psychiatric ward: Perspectives of patients and staff. *Nursing Ethics*, 21, 426–436.
- LeBel, J. L., Duxbury, J. A., Putkonen, A., Sprague, T., Rae, C. & Sharpe, J. (2014). Multinational experiences in reducing and preventing the use of restraint and seclusion. *Journal of Psychosocial Nursing*, 52, 22–29.
- Madan, A., Borckardt, J. J., Grubaugh, A. L. *et al.* (2014). Efforts to reduce seclusion and restraint use in a state psychiatric hospital: A ten-year perspective. *Psychiatric Services*, 65, 1273–1276.
- Maguire, T., Young, R. & Martin, T. (2012). Seclusion reduction in a forensic mental health setting. *Journal of Psychiatric and Mental Health Nursing*, 19, 97–106.
- Mann-Poll, P. S., Smit, A., Koekkoek, B. & Hutschemaekers, G. (2015). Seclusion as a necessary vs. an appropriate intervention: A vignette study among mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 22, 226–233.
- McKenna, B., McEvedy, S., Kelly, K. *et al.* (2017). Association of methamphetamine use and restrictive interventions in an acute adult inpatient mental health unit: A retrospective cohort study. *International Journal of Mental Health Nursing*, 26, 49–55.
- Muir-Cochrane, E. (2000). The context of care: Issues of power and control between patients and community mental health nurses. *International Journal of Nursing Practice*, 6, 292–299.

- Muir-Cochrane, E. & Duxbury, J. A. (2017). Violence and aggression in mental health-care settings. *International Journal of Mental Health Nursing*, 26, 421–422.
- Muir-Cochrane, E., Oster, C. & Gerace, A. (2014). The use of restrictive measures in an acute inpatient child and adolescent mental health service. *Archives of Psychiatric Nursing*, 28, 389–391.
- Muir-Cochrane, E. C., Bird, J. & McCann, T. (2015). Nurses' experiences of restraint and seclusion use in short-stay acute old age psychiatry inpatient units: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, 22, 109–115.
- National Mental Health Consumer & Carer Forum (NMHCCF) (2009). Ending seclusion and restraint in Australian Mental Health Services, statement prepared by the National Mental Health Consumer & Carer Forum (NMHCCF) Working Group on Seclusion & Restraint. [Cited 17 October 2017]. Available from: http://nmhccf.org.au/sites/default/files/docs/seclusion_restraint.pdf
- Oster, C., Gerace, A., Thomson, D. & Muir-Cochrane, E. (2016). Seclusion and restraint use in adult inpatient mental health care: An Australian perspective. *Collegian*, 23, 283–290.
- Perkins, E., Prosser, H., Riley, D. & Whittington, R. (2012). Physical restraint in a therapeutic setting: A necessary evil? *International Journal of Law and Psychiatry*, 35, 43–49.
- Pollard, R., Yanasak, E., Rogers, S. & Tapp, A. (2007). Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient unit. *Psychiatric Quarterly*, 78, 73–81.
- Restrictive Practice Working Group (2016). National principles to support the goal of eliminating mechanical and physical restraint in mental health services. Australian Health Ministers' Advisory Council. [Cited 17 October 2017]. Available from: <http://www.arafmi.org/wp-content/uploads/2017/05/National-Principles-to-Support-the-Goal-of-Eliminating-Restraint.pdf>
- Slemon, A., Jenkins, E. & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24, e12199.
- Smith, G. M., Ashbridge, D. M., Davis, R. H. & Steinmetz, W. (2015). Correlation between reduction of seclusion and restraint and assaults by patients in Pennsylvania's State Hospitals. *Psychiatric Services*, 66, 303–309.
- Te Pou o te Whakaaro Nui (2017). Variation in DHB Seclusion Rates. Te Pou o te Whakaaro Nui. [Cited 17 October 2017]. Available from: <https://www.tepou.co.nz/resources/Variation%20in%20DHB%20seclusion%20rates/819>
- Theodoridou, A., Schlatter, F., Ajdacic, V., Rossler, W. & Jager, M. (2012). Therapeutic relationship in the context of perceived coercion in a psychiatric population. *Psychiatry Research*, 200, 939–944.
- Van Der Merwe, M., Muir-Cochrane, E., Jones, J., Tziggili, M. & Bowers, L. (2013). Improving seclusion practice: Implications of a review of staff and patient views. *Journal of Psychiatric and Mental Health Nursing*, 20, 203–215.
- Victorian Government Department of Health (2013). Reducing restrictive interventions: literature review and document analysis. Victorian Government Department of Health. [Cited 17 October 2017]. Available from: <https://www2.health.vic.gov.au/about/publications/researchandreports/reducing-restrictive-interventions-literature-review-2013>
- Wieman, D. A., Carmacho-Gonsalves, T., Huckshorn, K. A. & Leff, S. (2014). Multisite evaluation of an evidenced-based practise to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatric Services*, 65, 345–351.
- Wijnveld, A. M. & Crowe, M. (2010). Walking a fine line: Managing the tensions associated with medication non-adherence in an acute inpatient psychiatric setting. *Journal of Clinical Nursing*, 19, 1378–1386.
- Wilson, C., Rouse, L., Rae, S. & Ray, M. K. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *International Journal of Mental Health Nursing*, 26, 500–512.