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Original Research

Understanding Mental Health Service User Experiences of Restraint Through Debriefing: A Qualitative Analysis

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Objective: To examine debriefing data to understand experiences before, during, and after a restraint (seclusion, chemical, and physical) event from the perspective of inpatients at a large urban mental health and addiction hospital.

Method: Audits were conducted on a purposeful sample of inpatient charts containing post-restraint event inpatient debrief forms (n = 55). Qualitative data from the forms were analyzed thematically.

Results: Loss of autonomy and related anger, conflict with staff and other inpatients, and unmet needs were the most common factors precipitating restraint events. Inpatients often reported that increased communication with staff could have prevented restraint. Inpatients described having had various negative emotional states and responses during restraint events, including fear and rejection. Post-restraint, inpatients often desired to leave the unit for fresh air or to engage in leisure activities.

Conclusions: To our knowledge, our study is the first to use debriefing form data to explore mental health inpatients' experiences of restraint. Inpatients view restraint negatively and do not experience it as a therapeutic intervention. Debriefing, guided by a form, is useful for understanding the inpatient's experience of restraint, and should be used to re-establish the therapeutic relationship and to inform plans of care. In addition, individual and collective inpatient perspectives should inform alternatives to restraint.

Comprendre les expériences de contention des utilisateurs de services de santé mentale par le compte rendu : une analyse qualitative

Objectif : Examiner les données de compte rendu pour comprendre les expériences avant, pendant, et après un épisode de contention (isolement, chimique et physique) du point de vue des patients hospitalisés d'un grand centre hospitalier urbain de santé mentale et de toxicomanie.

Méthode : Des audits ont été menés auprès d'un échantillon intentionnel de dossiers de patients hospitalisés contenant des formulaires de compte rendu (n = 55) d'après-contention de patients hospitalisés. Les données qualitatives des formulaires ont été analysées thématiquement.

Résultats : La perte d'autonomie et la colère qui s'ensuit, le conflit avec le personnel et les autres patients, et les besoins non comblés étaient les facteurs les plus communs provoquant les épisodes de contention. Les patients hospitalisés indiquaient souvent qu'une communication accrue avec le personnel aurait pu éviter la contention. Les patients décrivaient avoir connu des réactions et états émotionnels négatifs variés durant la contention, notamment la peur et le rejet. Après la contention, les patients éprouvaient souvent le désir d'aller prendre l'air à l'extérieur et de s'adonner à des loisirs.

Conclusions : À notre connaissance, notre étude est la première à utiliser les données de formulaires de compte rendu pour explorer les expériences de contention de patients de santé mentale hospitalisés. Les patients voient la contention négativement et ne la vivent pas comme une intervention thérapeutique. Le compte rendu, assisté par un formulaire, est utile pour comprendre l'expérience de contention du patient, et devrait servir à rétablir la relation thérapeutique et à éclairer les plans de soins. En outre, les perspectives individuelles et collectives des patients hospitalisés devraient éclairer le choix de solutions de rechange à la contention.

Restraint use in mental health and addictions settings is associated with concerns about safety, ethics, and human rights.[1,2] Adding to the complexity of the discussion about restraint use are differing practices among and across regions and organizations.[3,4] Evidence indicates that there are many negative physical and emotional consequences of restraint, both for inpatients and for clinicians.[5–10] In response to adverse outcomes associated with restraint, many organizations have made recommendations to reduce or eliminate the use of restraint in mental health settings.[2]

The organization that we studied, the Centre for Addiction and Mental Health (CAMH), conducted a formal Restraint Prevention Initiative from 2008 to 2011. During the initiative, efforts were made to develop strategies, systems, and processes to promote a least restrictive environment; safely reduce or replace the use of seclusion and restraint; increase the use of alternatives to restraint; and improve the quality of care for inpatients and quality of work life for care teams. One of the achievements during the Restraint Prevention Initiative was the implementation of more effective debriefing procedures for inpatients and clinicians. Restraint prevention efforts have continued beyond the 3-year initiative, and CAMH has successfully reduced its use of restraint. However, in an increasingly complex care environment, with rising inpatient acuity, it is essential to learn from inpatient debriefing and use restraint prevention strategies.

Debriefing can be defined as an opportunity to talk about feelings, reactions, and circumstances surrounding an inpatient's restraint experience, from the inpatient's perspective.[11] Debriefing is also an opportunity for clinicians to assess inpatients and determine necessary follow-up care.[11] Though there is little evidence to support a particular model of debriefing, it is widely agreed on that post-restraint debriefing is a necessity for inpatients, given the growing body of evidence indicating the traumatic impact of restraint events.[11]

Throughout our paper, restraint is used as a global term to describe mechanical restraint, chemical restraint, or seclusion. CAMH defines mechanical restraint as "the use of an appliance that restricts free movement and is attached to, adjacent to, or is worn by the client/patient."[12, p 3] Seclusion is defined as "the confinement of a client/patient in a locked room or area designated for seclusion to restrict movement from one location to another."[12, p 4] Finally, chemical restraint is defined as "a STAT [emergency] pharmacological intervention administered without the client/patient's (or substitute decision maker's) consent."[12, p 3] CAMH's Emergency Use of Chemical Restraint, Seclusion, and Mechanical Restraint policy states that restraints should only be used as a last resort when an inpatient's aggressive or violent behaviour presents an imminent, serious risk of harm to self or others.[12]

The Restraint Event Client–Patient Debriefing and Comments Form used in our study was developed during the Restraint Prevention Initiative and adapted from the Commonwealth of Massachusetts Department of Mental Health.[13] The form is meant to facilitate conversation between clinicians and inpatients and cannot be considered a validated tool. CAMH's Emergency Use of Chemical Restraints, Seclusion, and Mechanical Restraint policy requires this form to be offered to inpatients within 24 hours of release from restraint or within 24 hours of administration of chemical restraint. If an inpatient declines, the form must be offered again within 72 hours. The interprofessional team and the inpatient must decide with whom the inpatient would feel most comfortable debriefing. The intended use of the Restraint Event Client–Patient Debriefing and Comments Form is to guide and facilitate debriefing. Inpatients may choose whether to comment verbally or in writing. If inpatients opt to debrief verbally, the staff member facilitating the debriefing must complete the form in the inpatient's words.

Questions on the form inquire about antecedents to the restraint event and how restraint could have been avoided. Inpatients are also asked what they experienced and how they were affected by the restraint event. The form concludes with questions about the inpatient's desired follow-up actions, including how clinicians can assist the inpatient's recovery from the restraint event. The purpose of debriefing is to provide inpatients with an opportunity to reflect on the event and provide feedback to clinicians, and the intent is that this information be used to inform treatment and prevent future episodes of restraint. Debriefing is an expectation of CAMH, as it is an important clinical intervention that acknowledges and validates inpatient experiences of being restrained.[11] The collective inpatient perspective gathered through the post-restraint inpatient debriefing forms can inform strategies to manage common antecedents to restraint events.

Clinical Implications

- Debriefs, particularly when documented, are useful for gathering information about mental health inpatient experiences of restraint.
- Inpatients and clinicians should collaborate to develop plans of care, identifying unique triggers and comfort measures.

Limitations

- Data are limited by self-selection bias, as inpatients chose whether to complete the Restraint Event Client–Patient Debriefing and Comments Form.
- The Restraint Event Client–Patient Debriefing and Comments Form does not ask inpatients to specify which type of restraint they experienced (that is, seclusion, chemical restraint, or mechanical restraint).

Methods

Study Design

Our study examined qualitative data from the Restraint Event Client–Patient Debriefing and Comments Form.

Research Ethics Board approval allowed access to inpatient charts through the Health Records Department. Audits were completed on inpatient charts containing one or more Restraint Event Client–Patient Debriefing and Comments Forms. Where charts contained multiple forms, the earliest form was used in the audit. Forms accessed through the Health Records Department were transcribed, verbatim, onto audit forms while excluding any identifying inpatient information.

Study Sample

The study sample included inpatients who had experienced a restraint event and completed a Restraint Event Client–Patient Debriefing and Comments Form between September 2009 and February 2013. Although forms are offered to every inpatient, post-restraint, completion is optional. Among the 90 charts audited, there were 55 completed and 35 incomplete forms. The incomplete forms indicated that the inpatient had declined to participate in the debriefing. The average age of inpatients who completed the forms was 39 years (SD 13.7). More men than women completed the forms (67% and 33%, respectively). Inpatients were from various inpatient units, including schizophrenia (24%), forensics (7%), mood and anxiety (22%), general psychiatry and acute care (20%), early psychosis (20%), and geriatrics (7%).

Data Analysis

Qualitative analysis followed Braun and Clarke's[14] steps of thematic analysis. To develop familiarity and to look for meaning and patterns, data were read and re-read. Once familiar with the data, researchers established initial codes by naming concepts and ideas in the text. Data were then examined at a broader level, by reviewing initial codes and grouping them thematically. Themes were then reviewed to ensure that they meaningfully represented codes and were discrete.[14] Original data on audit forms were re-read to ensure no meaning was lost through coding and theming. Two researchers developed the themes independently, and then came together to review the themes to ensure agreement and consistency. This process uncovered 8 themes reflecting the chronology of restraint events (Table 1).

Results

Results are presented according to the natural timeline of events, and describe the inpatient's perspective of what occurred before, during, and after restraint.

Antecedents to Restraint Events

The Restraint Event Client–Patient Debriefing and Comments Form asks what the inpatient believes caused the restraint event. Inpatients often identified specific actions, such as physical or verbal aggression. Inpatients also frequently stated that they felt angry, usually secondary to lost autonomy, interpersonal tension, and unmet needs.

Lost Autonomy

Inpatients made many references to loss of autonomy when stating the reasons for their anger and subsequent restraint event. More specifically, inpatients suggested that the hospital environment prevented them from using their time as they would normally. Inpatients often wanted to leave the unit, but this freedom was restricted by unit rules or owing to concerns about inpatient safety, which resulted in inpatients' anger and perceptions of lost autonomy.

> *"I freaked out about having to stay in the hospital for a week or two with nothing to do."* [Inpatient 04]
>
> *"I wanted to go for a walk."* [Inpatient 27]
>
> *"Not having smoking privileges, being placed on a Form 1."* [Inpatient 45]
>
> *"I have a job and a valuable life which they were ruining with force against my consent."* [Inpatient 40]
>
> *"I wanted to go home and staff would not let me."* [Inpatient 37]
>
> *"I broke the phone because I wasn't allowed out for a cigarette."* [Inpatient 07]

Interpersonal Tension

Conflict with staff or other inpatients frequently precipitated inpatient anger and escalation. Conflict with staff was closely related to lost autonomy, as inpatients expressed anger to staff when their needs or desires were at odds with unit or hospital protocols. Sharing the physical environment with other unwell people was a source of tension for some inpatients, who, as a result, described reaching a breaking point. Some inpatients stated that staff did not intervene in time to de-escalate conflict occurring in the unit.

> *"She was on the phone for two hours; she had no consideration for other people."* [Inpatient 15]
>
> *"If the other patient was controlled, I wouldn't have reacted the way I did."* [Inpatient 02]
>
> *"I tried to do damage to a person, because he was making fun of me."* [Inpatient 12]
>
> *"The other party and myself had an altercation from the beginning. This is what lead to myself being in restraints."* [Inpatient 01]
>
> *"Spend more time out of the office observing escalating behaviour."* [Inpatient 50]

Feeling Unheard

Inpatients reported feeling that they were not being listened to, or that communication from staff was insufficient or inconsistent, which precipitated their anger and escalation. In addition, some inpatients stated that staff did not listen to them when they were expressing preferences for how staff might help them to manage their anger or escalating behaviours. Some inpatients indicated that restraint was unnecessary and punitive, which further fuelled their anger and resentment.

"They should have told me to wait 5 or 10 minutes, not half an hour." [Inpatient 43]

"I was telling staff that I did not need any restraint and expressed full control all along. If the staff were empathetic enough they may have understood that there was no need for forced restraints/ medications." [Inpatient 08]

"Rather than restraints, I could have been monitored by staff. Staff could have listened when I said I will take my meds and go to sleep. [Inpatient 36]

"From day to day, I thought I knew the truth. When I discover[ed] what was factual[,] I perceived that I was misled. Anger ensued." [Inpatient 32]

Feeling unheard was also closely related to inpatients' anger regarding lost autonomy. Inpatients made clear that some hospital rules and regulations, particularly about leaving the unit to go outside, were incongruent with their needs. Some inpatients expressed their distress about this lost autonomy to staff, and felt unheard if the staff were not responsive to their concerns.

During the Restraint Events

The vast majority of inpatients experienced restraint as negative, and found that it evoked fear, feelings of rejection, and desire for comfort.

Fear and Rejection

Many inpatients reported feeling fear and rejection in response to the restraint event. Inpatient fear stemmed from uncertainty about what was happening or what was going to happen to them.

"Hurt, frightened, made me feel like prey. Feel like somebody is going to cut me into pieces. I don't want to come back." [Inpatient 31]

"I didn't like it. Cold. Was like a place you are by yourself and you know they don't care. Scary. Very bad. I hope no one goes there." [Inpatient 09]

"Felt like it was torture. Not being able to move at all, very uncomfortable." [Inpatient 36]

"It was harmful to my whole being, an assault on my dignity and attack on my soul." [Inpatient 44]

"Well the staff promised a short time but left me there almost ignoring me." [Inpatient 50]

Needing Comfort

Inpatients were asked if staff could have done anything to help them while they were in restraint. Though fewer inpatients responded to this question than questions about antecedents, those who did frequently stated that they benefited from, and needed, physical comfort. When inpatients were offered physical comfort measures, they responded positively.

"Staff provided a few sheets and a blanket. Thank you." [Inpatient 05]

"Staff did the best thing, covered me with a blanket and gave me music and water too." [Inpatient 34]

"Music yes. Calming music. Reiki Relaxation." [Inpatient 30]

Post-Restraint Events

Post-restraint questions focused on how the seclusion or restraint affected the inpatient, and how staff might support inpatients to recover from the event. As indicated above, most respondents found that restraint was a negative experience, which evoked negative feelings and damaged relations with staff.

Lost Trust

Inpatients indicated negative emotions and losing trust in staff. Negative emotions included anger, resentment, and sadness.

"More angry. The nurses should never put [me] in restraint." [Inpatient 31]

"I felt there is no rationale behind many of the decisions made towards me." [Inpatient 08]

"Mentally affected me and gave me a VERY bad impression . . ." [Inpatient 46]

"Made me resentful, resentful to staff." [Inpatient 47]

"I felt sad and lonely." [Inpatient 43]

"I feel down in the dumps that I had to be locked inside." [Inpatient 22]

"It has been traumatic. I feel a victim of a corrupt system . . ." [Inpatient 40]

Neutrality

Although most inpatients described their restraint experience negatively, there were a small number of inpatients who felt unaffected by the event. However, it is important to note that many of these inpatients did state that the restraint event itself was a negative experience, but they were not affected beyond the event. Statements from this group also indicated that they had lost control and were violent owing to their illness severity. Others appreciated separation from the unit milieu, which was the source of their anger and escalation. As previously discussed, some inpatients were angered by conflict with other inpatients, and described feeling safer when they were restrained and separated from the person or people with whom they were arguing.

"It's better if someone restrains me. I banged my head too much." [Inpatient 42]

"The restraint made me feel safe or safer than how I would feel in one of the rooms." [Inpatient 49]

Change of Scenery

Many inpatients indicated a need for physical freedom as part of their recovery from the restraint incident. This freedom entailed leaving the unit to get fresh air, engaging in leisure activities, or being discharged back into the community.

Table 1 Summary of qualitative themes	
Timeline	Themes
Antecedents	Lost autonomy
	Interpersonal tension
	Feeling unheard
During restraint	Fear and rejection
	Needing comfort
After restraint	Lost trust
	Neutrality
	Change of scenery

"Yes, give me some fresh air." [Inpatient 46]

"I am ok. I just want to be outside, have my library privileges restored." [Inpatient 31]

"Treatment team let me go home and do it by outpatient treatment." [Inpatient 09]

"Help me to relax and stay focused. I am requesting a private room with a desk." [Inpatient 29]

Discussion

Antecedents to Restraint Events

Loss of autonomy as it related to the hospital environment significantly contributed to the anger that precipitated restraint events for inpatients in our study. Inpatient anger related to loss of autonomy can raise unique challenges for clinicians, who must maintain the safety of the unit while attending to inpatients who may find unit policies and procedures restrictive. It takes considerable skill to balance the needs of the person and allow choice, while working within the unique constraints of acute inpatient mental health units. However, it is critical that clinicians hone this skill, as autonomy and empowerment to make decisions are central to inpatient recovery.[15] The themes of lost autonomy and interpersonal tension are closely linked. Within lost autonomy is a clear power differential between inpatients and staff.[16] Staff expect inpatients to abide by unit policies, and tensions arise when inpatients disagree with, or challenge, expectations to maintain freedom and choice.[16] Owing to the frequency of inpatient frustration about lost autonomy, it would be beneficial for clinicians to preemptively manage these concerns by having regular conversations with inpatients about safety, ensuring compromise and choice as much as possible,[17] and providing validation. Some inpatients reported becoming angry because they could not leave the unit to smoke. CAMH is tobacco-free and requires tobacco assessments to be completed when an inpatient is admitted, and nicotine replacement options to be offered to inpatients who smoke. This is a proactive measure to mediate the discomfort of nicotine cravings in the context of safety concerns, which may reduce or eliminate opportunities to go outdoors and leave hospital property. However, it is important to note that managing nicotine cravings may not eliminate an inpatient's desire to go outdoors, as inpatients repeatedly emphasized that having a change of scenery is important to their recovery.

Feeling unheard fuelled inpatient anger and was often a contributor to interpersonal tensions. Some inpatients indicated that they were angered by the actions of other inpatients, and experienced a buildup of tension related to the hectic hospital environment, a finding noted by other studies.[5,6] When inpatients reported that staff were not responsive to the unit milieu or did not address inpatient conflict, they felt unheard. In our study and others, inpatients felt that restraint could have been avoided if individualized attention was provided before they felt out of control.[18] Both before and during restraint events, inpatients expressed a desire for consistent and reciprocal communication with staff, a finding echoed by several other studies.[5,16,18–24] Staff need to ensure effective communication with inpatients and between each other, as inconsistent messages can threaten inpatient trust. Inpatient lack of trust in staff is detrimental because inpatients are particularly vulnerable when admitted to hospital. They are dependent on staff for many basic needs, and lose a significant amount of autonomy. It is not a reasonable expectation of inpatients to engage in treatment if they do not trust their care providers. Inpatient trust must be established and maintained through consistent and collaborative communication.[25]

During Restraint Events

Restraint was a very negative experience for inpatients in our study. Fear and rejection were common emotional responses for inpatients in our study and others.[16,20,21] Another study found that fear was particularly strong when inpatients did not trust the care providers.[16] Such intense negative emotions created a need for comfort, which was articulated by inpatients in our study. The Restraint Event Client–Patient Debriefing and Comments Form inquires if staff could have done anything to help them while they were restrained. Inpatients stated that they benefited from, or desired, comfort measures, such as blankets and music, as noted in another study.[26] Evidence suggests that the use of sensory interventions can reduce inpatient distress.[27,28] Ideally, sensory and comfort interventions should be used preemptively to avoid restraint. However, it is possible that these interventions could decrease inpatient distress while experiencing restraint and potentially reduce the time spent in restraint.

Post-Restraint Events

Lost trust was a common result of restraint. Inpatients felt victimized, resentful, and unsure of the reasoning behind the restraint event. Unresolved or enhanced anger and resentment have been found by other studies and were reported by some inpatients in our study.[18,20,21,29] This indicates the importance of addressing the original source of the inpatient's anger and escalation, and discussing the inpatient's feelings about the restraint event. These negative emotional responses can challenge the inpatient's

ability to trust care providers, which could impact treatment engagement. Inpatients indicate that restraint can actually disrupt the therapeutic relationship.[29–31] However, several studies have indicated that inpatients benefit from or desire opportunities to debrief the restraint event,[18,21,22,32] which can serve as an opportunity to regain trust. In our study, inpatient experiences of restraint were understood through the information gathered through a formal debriefing process. However, our study does not explore how inpatients felt about the debriefing itself and whether they benefited from it. It would be beneficial to explore this in future research, to determine if trust in care providers was restored, and if the inpatient's desired follow-up actions were attained. It is possible that the post-restraint themes identified in our study would change in the days following the debriefing, as clinicians responded to the needs and concerns raised by inpatients through the debriefing process. A much smaller group of inpatients had neutral feelings about the restraint event. These inpatients often appreciated the opportunity to escape the unit environment or be closely monitored by staff, which has also been noted in other studies.[20,26] This indicates a need for spaces or activities inpatients can use to escape the crowded and busy unit environment, such as private bedrooms or comfort rooms, which have been shown to reduce rates of restraint.[33,34] For inpatients who need to escape but do not have a comfort room available, it may be beneficial to manage escalation by mutually agreeing on the inpatient staying in their room for a specified period of time or until feeling calmer, a practice which has shown some benefit as an alternative to restraint.[35]

Future Research

Inpatients in our study often experienced anger secondary to loss of autonomy and interpersonal tension. CAMH is currently in the process of redeveloping the hospital site, which includes new buildings and improved physical environments. Safe balconies and green space will be available to many units, which may satisfy inpatient desires for changes in scenery or fresh air. The improved therapeutic environment may change inpatient perceptions of mental health services and may make them feel more comfortable during hospitalization.[36] A similar study after the move to new inpatient units may demonstrate different findings than our study.

Other Canadian research indicates that young men with psychosis and women with bipolar disorder are most likely to experience restraint and seclusion events.[37] It would be interesting for future research to explore these profiles in relation to inpatient engagement in debriefing, factors precipitating restraint events, and potential interventions to prevent restraint.

Study Limitations

The Restraint Event Client–Patient Debriefing and Comments Form does not ask inpatients to specify whether they were secluded, physically restrained, or chemically restrained. Therefore, researchers were unaware as to which type of restraint the inpatient experienced, unless it was implied in the contents of the debriefing form. Literature suggests that inpatients have varying perceptions of different types of restraint.[38,39] Therefore, it is possible that the findings of our study would be different if the contents of the forms were analyzed according to which form of restraint the inpatient experienced. However, it is clear that, generally, inpatients experience any type of restraint as negative.

Another limitation of our study is that completion of the Restraint Event Client–Patient Debriefing and Comments Form requires some degree of attention to complete. In some circumstances, staff wrote on behalf of inpatients and captured their responses to each of the questions on the form. It is unclear how this impacted inpatient responses, and is an area to explore in future research. The information provided in our study is biased toward the inpatients who were well enough to focus on completing the form and who were also motivated to do so. In addition, inpatients experiencing language barriers would be less likely to complete the form, unless clinicians made it explicit that they would write on the inpatient's behalf or access an interpreter to assist with the completion of the form.

Conclusions

The findings of our study emphasize the importance of regular, one-to-one communication between inpatients and clinicians occurring before inpatient behaviour escalates. Often, restraint incidents described in our study demonstrated missed opportunities to connect with inpatients, which left inpatients feeling unheard and angry. Loss of autonomy secondary to the hospital environment was a significant cause of anger and escalation leading to restraint events. Clinicians should discuss unit policies and procedures and their rationale regularly with inpatients in an effort to avoid or manage inpatient anger related to loss of autonomy.

Debriefing guided by a structured form allows inpatients and staff to develop a greater understanding of restraint events. Information gathered through debriefing should be used to inform inpatient safety and treatment plans.

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