Participation in Post Incident Reviews after Restraint in Mental Health Services

A qualitative study

by

Unn Elisabeth Hammervold

Thesis submitted in fulfilment of
the requirements for the degree of
PHILOSOPHIAE DOCTOR
(PhD)

University of
Stavanger

Faculty of Health Sciences
University of Stavanger
2021

Acknowledgements

First, I would like to express my thanks to the participants in this research project who shared your thoughts and experiences with me. You have contributed valuable knowledge and insight to a field where basic values are at stake and where scientific knowledge is scarce. Without your openness about your experiences, this study and dissertation would have been impossible.

My warmest and deepest gratitude goes to my supervisors, Hildegunn Sagvaag and Reidun Norvoll. You have both been so supportive and patient, and you have generously shared your knowledge and wisdom. I have learnt a lot from you, and I am so grateful for your support.

A special thanks to my colleagues, Kari Vevatne and Trond Grønnestad, who throughout all these years never have doubted either the project or my capacity to fulfil it. You have provided support and optimism and have all the way reminded me about the necessity of extending our knowledge about humanising mental health care.

I thank also the advisory group for their engagement and support. Your reflections and valuable comments have supported, encouraged and challenged me.

Thank you for the interest, help and encouragement from fellow PhD students in the department of public health and colleagues incidentally in the faculty.

Thank you to my colleagues in SPoR, the mental health nurses' organisation in Norway, for interest, engagement and discussions in formal and informal meetings and conferences both domestic and abroad.

Summary

Background: Evaluation of all kinds of use of force in mental health services was mandated by law in Norway in 2017. Debriefing, or "Post Incident reviews" (PIRs), have been implemented in several western countries since early 2000, often as one part of Seclusion and Restraint (S/R) reduction projects. The factual or theoretical basis of PIR's is, however, scarce despite the growing focus on prevention of harm and use of restraint in mental health services.

Aims: The overall aim of this thesis was to explore PIRs' potential to promote improvement in terms of human values like participation, influence and collaboration, according to the body of scientific knowledge and experiences developed by care receivers and care providers.

The study consisted of four steps. The specific aim of step 1 was to explore the body of scientific literature regarding PIRs. Based on the findings in step 1, the specific aim of step 2 was to explore professionals' experiences and considerations with PIRs' after having used physical and mechanical restraints in a Norwegian context. Step 3 was to explore patients' experiences and considerations with PIRs' after having physical and mechanical restraints applied to them in a Norwegian context. Step 4 was a synthesizing analysis of the results to summarize the findings regarding PIRs related to scientific knowledge and experiences from care receivers and care providers.

Methods: This thesis has a phenomenological-hermeneutic approach with an explorative design. Data were collected by means of the three sub-studies (Articles I, II and III) which contain a scoping review of 12 scientific publications and in-depth interviews with 19 multidisciplinary care providers and 10 patients. Data analyses methods include narrative descriptions (Article I and III) and qualitative content analyses (Article I, II and III).

Findings: Article I reports findings from a scoping review where the aim was to identify the prevailing knowledge basis of PIRs. PIRs were often found to be one of several components in seclusion and restraint (S/R) reduction programs, but there was no significant outcome related to PIRs alone. Patients and care providers reported participation in PIRs to *be an opportunity to review restraint events they would not have had otherwise, to promote patients' personal recovery processes and stimulate professional reflection on organizational development and care*. The review revealed, however, a knowledge gap; patients' and care providers' experiences and considerations of PIRs were scarcely explored. Consequently, the findings provided the basis for article II and III.

Article II reports care providers' experiences and considerations of PIRs. Main theme 1 was PIRs' potential to *improve the quality of care* based on *knowledge about other perspectives and solutions, increased professional and ethical awareness* and *emotional and relational processing*. Main theme 2 was *struggling to get a hold on patients' voices in the PIRs*. Care providers considered that issue to be attributable to the *patients conditions*, the *care providers' safety and skills* and the *characteristics of institutional and cultural conditions*.

Article III reports patients' experiences and considerations of PIRs. The findings resulted in two overarching themes: (1) 'PIRs as *an arena for recovery promotion* based on experiences of *being strengthened, developing new coping strategies and processing the restraint event*' and (2) 'PIRs as *continuation of coercive contexts* based on experiencing PIRs as *meaningless, feeling objectified and longing for living communication and closeness*.

Conclusion: The three sub-studies represented different knowledge sources as scientific knowledge and experiences from care receivers and care providers and were thus parts of a larger whole.

The findings show that PIRs can be an appropriate and valuable tool both to patients and care providers as PIRs were found to 1) promote the patients' personal recovery processes, (2) improve the quality of care and (3) facilitate processing of the restraint incident.

The thesis' main findings of *PIRs between authoritarian and dialogical approaches* point to both the procedure's possibilities and limitations. The study identified pitfalls that may influence patients' active participation in the PIRs. The practice of implementing PIRs as an isolated procedure, and thus not a part of a S/R reduction program, as well as unresolved care philosophies in the services seem to be limitations with respect to the Norwegian authorities' objectives with the procedure. Conducting PIRs in services that base their practices on human care philosophies and values in line with care ethics, that is, acknowledging the stakeholders' vulnerability and the power-dependence imbalance, may support and empower both patients' and care providers' participation and collaboration and thus the patients' influence in the encounters.

List of original publications

This thesis is based on the following articles, referred to in the text by their Roman numerals.

I Hammervold, U. E., Norvoll, R., Aas, R. W., & Sagvaag, H. (2019). Post-incident review after restraint in mental health care -a potential for knowledge development, recovery promotion and restraint prevention. *BMC Health Services Research, 19* (235), 1-13

II Hammervold, U. E., Norvoll, R., Vevatne, K., & Sagvaag, H. (2020). Post-incident reviews—a gift to the Ward or just another procedure? Care providers' experiences and considerations regarding post-incident reviews after restraint in mental health services. A qualitative study. *BMC Health Services Research, 20* (499), 1-13

III Hammervold, U. E., Norvoll, R., & Sagvaag, H.
Post-incident Reviews after Restraints, – Potential and Pitfalls
Patients' experiences and considerations
Submitted: *Journal of Psychiatric and Mental Health Nursing*, November 2020

Innhold

List of tables

1 Introduction

This thesis focuses on the phenomenon of debriefings, also known as Post Incident Reviews, of both patients and care providers following physical and mechanical restraint events in mental health services.

As a nurse with 20 years of experience in mental health care, I have participated in practices that involve use of mechanical and physical restraints. Afterwards, it was my responsibility as a ward leader to ensure that care providers involved in the restraint event participated in a debriefing whose aim was to map what had happened, register injuries and consider professional follow-up in the aftermath.
Increased focus on human rights and knowledge about the significance of participation in patients' personal recovery processes have contributed to reflections on the fact that the patients were not a part of the debriefing session after use of restraints. The patients' perspectives and views on what happened, and consequently their proposed solutions, were thus not requested.

Inspired by countries such as Denmark and the UK, debriefings including patients were first featured in a Norwegian public report regarding the strengthening of human rights in mental health services in (NOU 2011:9) and later mandated by law in 2017 (Psykisk helsevernloven, 1999, latest revision 2017, § 4.2).

In scientific literature, Post Incident Reviews include different terms, such as debriefing, mandatory reviews, post event discussions, post event analyses, post-seclusion review and post restraint review (Goulet & Larue, 2016). We chose the concept of Post Incident Reviews, first found in Bonner and Wellman (2010), and further referred to as PIRs (our abbreviation). In a Canadian scoping review, Goulet and Larue (2016) define a PIR as a 'complex intervention, taking place after an Seclusion/Restraint (SR) episode and targeting the patient and healthcare

team to enhance the care experience and provide meaningful learning for the patient, staff, and organisation' (p. 212).

Historically, Norwegian law allowed the use of coercive measures towards people with mental health problems beginning in the Middle Ages. The first Norwegian Mental Health Care ACT in 1848 stated the duty and the right to protect patients from harming themselves or others (Hermundstad, 1999; Kringlen, 2001; Winge, 1913).
The law was revised in 1961 and superseded by the prevailing Mental Health Care Act in 1999. Effective September 1, 2017, the Mental Health Care Act was revised with the aim of increasing patients' right of self-determination and enhancing their legal protections while under the care of mental health services.

The Norwegian Mental Health Care Act (Psykisk helsevernloven 1999) defines three groups of coercive interventions: 1) compulsive admittance to mental health services, 2) involuntary treatment by medication and 3) coercive measures such as isolation, medication and physical or mechanical restraints. The focus of this thesis is physical and mechanical restraints, which according to the law consist of a, 'mechanical or physical reaction against the patient including [the] use of straps, belts, other equipment or physically holding the patient preventing behaviour that might harm patients, care providers or (the) environment' (Psykisk helsevernloven, 1999, §4.8). I rely on this definition in this thesis. Restraint(s) will further be used as a collective term for physical and mechanical restraints.
Psykisk helsevernloven (1999) does further state that restraints are the 'last resort' when all other alternative interventions have been shown to be obviously in vain or inadequate.

A Norwegian public report (Norwegian Health Directorate, 2020) documents 4000 episodes of mechanical restraint and about 8000 episodes of physical restraint in Norwegian mental health services in 2018. The most reported basis for restraining patients seems to be actual

or imminent assault (Knutzen et al., 2012; Parke et al., 2019; Raboch et al., 2010).

In scientific literature, there are different conceptions of the background for implementing coercive measures in mental health services. Atmosphere, material surroundings, significance of relationships, communication and collaboration are central elements and professional-patient interactions seem also to play a significant role (Cowman et al., 2017; Faccio et al., 2020; Papadopoulos et al., 2012; Terkelsen & Larsen, 2016; Wilson et al., 2018).

Internationally, there are major differences between different European countries regarding use of restraints (Bak & Aggernæs, 2012; Raboch et al., 2010). The numbers of reported restraint incidents are, however, uncertain. Only some countries have national registers, and the reliability of the numbers is in question. In addition, legal rules vary, e.g., mechanical restraint is not allowed in the UK, but the UK is the country that uses the most anti-psychotic drugs (Bak & Aggernæs, 2012). Comparing Nordic countries, mechanical restraint is rarely used in Iceland and Finland and Norway have significantly lower use rates for physical and mechanical restraints than Denmark and Sweden do (Bak & Aggernæs, 2012). In addition to uncertain numbers in the different countries, variations in legislation and differences in societal attitudes, values and clinical traditions seems to form a basis for the international differences (Bak & Aggernæs, 2012; Bowers et al., 2007; Raboch et al., 2010).

2   Background

2.1   *Patients' and care providers' experiences and opinions on restraints*

Patients' and care providers' views on the use of restraints in mental health services are divided. Most of the referred studies are from western countries that are comparable with respect to social relations, cultures and practices. Wynn (2004) found in a Norwegian study that some patients expressed an understanding attitude toward the reasons for restraining them and further that restraints helped them to calm down. Bak et al. (2012) found that up to 10% of patients requested restraints to prevent themselves from acting out. In the study of Larue et al. (2013) patients considered seclusion and restraint helpful in situations characterized by loss of control. In another study, Jacob et al. (2016) found that patients' experiences of mechanical restraints were largely negative, but some patients considered restraints to have a positive impact on their mental health and general well-being. Furthermore, studies show comments that were positively oriented toward the grounds for being restrained as safety and security. This opinion was enhanced when patients saw care providers as being concerned about their needs during and after the restraint event and further presented a willingness to help and provide psychological comfort (Chien et al., 2005; Jacob et al., 2019). Chien et al. (2005) even concluded that restraint could be a therapeutic intervention on the condition that care providers provide psychological and informational support to patients during the procedure.

On the contrary, other studies indicate that mechanical restraint is the most intrusive and consequently the least approved coercive measure, according to patients (Bak et al., 2012; Huf et al., 2012; Nyttingnes et al., 2016; Whittington et al., 2009). Sailas and Fenton (2000) found in their Cochrane review, 'no controlled studies to support the continued

use of seclusion or restraint in clinical practice' (p.8). Therefore, they recommended finding alternative strategies to manage excitement and aggression.

Patients report psychological consequences such as distress, fear, regret, loneliness. They also reported that being restrained evoked memories of previous traumatic events (Cusack et al., 2018; Nyttingnes et al., 2018; Nyttingnes et al., 2016; Strout, 2010). Furthermore, they report that coercion is often accompanied by a feeling of dehumanisation and humiliation, (Norvoll & Pedersen, 2016; Nyttingnes et al., 2018; Nyttingnes et al., 2016; Terkelsen & Larsen, 2016; Wilson et al., 2017). According Hartling et al. (2013) and Hartling and Lindner (2016), humiliation is one the most common and dangerous emotional experiences in society and thus a trigger for violence.
Severe physical consequences of restraint use have been documented, such as heart problems, aspiration, rhabdomyolysis, thrombosis and even death (Cusack et al., 2018; Mohr et al., 2003; Rakhmatullina et al., 2013). Based on the potentially grave consequences of restraint use, service users and user organisations argue that coercion and restraint should be de-legitimised (Rose et al., 2017).

Care providers' attitudes toward coercive measures demonstrate a tension between a phenomenon that is considered as indispensable, but at the same time is connected to discomfort (Al-Maraira & Hayajneh, 2019; Bigwood & Crowe, 2008; Norvoll et al., 2017; Perkins et al., 2012). In ward units, milieu therapists – mainly nurses – play a central role in fostering a culture that promotes safety for all, but also in dealing with the prevention of coercion and to manage coercion events when considered inevitable (Kaucic, 2017; Riahi et al., 2016). Nurses report coercion-related consequences such as being distressed, feeling fearful, role conflicts and decreased job-satisfaction (Bigwood & Crowe, 2008; Jansen et al., 2020; Krieger et al., 2020; Wilson et al., 2017). In addition, they report negative impacts of restraints on the therapeutic relationship,

which is claimed to be a core stone in treatment and care (Bigwood & Crowe, 2008; Jansen et al., 2020; Knowles et al., 2015).

With respect to care providers' moral views of restraints, they believe them to violate patients' integrity, but they justify the restraint decision with care and control (Hem, Gjerberg, et al., 2018; Wynn, 2003). In a Norwegian study, there were extensive differences between different groups of care providers. Physicians had less moral doubt about using coercion, followed by nurses, while the psychologists were most critical towards coercion (Molewijk et al., 2017; Aasland et al., 2018). It seems, however, that individual opinions and attitudes were strong influences, as there were indications that use of coercion was not always in compliance with legislation (Husum et al., 2011; Aasland et al., 2018). Still, the participants presented a non-coercive dialogical resolution as more likely than a coercive and authoritative one.

In summary, patients and care providers have divided experiences and views on restraints use. It is difficult to say whether patients who have an understanding attitude toward restraint use actually experience restraint as beneficial, or if they – based on previous experiences and inequality in the power-dependence relationship (Emerson, 1962) – have learnt that restraint is the only solution. Consequently, they have not been supported in developing alternative, more appropriate coping skills (Slade, 2009).

Accordingly, restraint measures are intrusive and lead to negative consequences for all involved. Patients and care providers have demanded debriefings after restraint events in recent decades (Nolan et al., 1999; Petti et al., 2001; Wynn, 2004). Systematic debriefing procedures (PIRs) have been implemented, initially in the US in the early 2000s, and later in other western countries, often combined with other interventions in S/R reduction programs such as Six Core Strategies (Huckshorn, 2004; Huckshorn, 2006) and the Safewards model (Bowers, 2014).

2.2 Programs for restraint reduction

Internationally, The Six Core Strategies program, commonly implemented in United States in 2004, provides a model for S/R reduction that base on a public health prevention approach (Huckshorn, 2004; LeBel et al., 2014). The program recommends using the public health constructs of primary, secondary, and tertiary prevention interventions as a guide for S/R prevention and thus S/R reduction (Huckshorn, 2014; LeBel et al., 2014; Wieman et al., 2014). The six core strategies are (a) active leadership toward organizational change; (b) using data to inform practice; (c) developing the workforce; (d) using S/R prevention tools; (e) actively including consumers and advocates in the care setting; and (f) rigorously debriefing S/R events after they occur (Huckshorn, 2006; LeBel et al., 2010; NASMHPD, 2006).

The Six Core Strategies have showed promising results regarding S/R reduction, and they were soon adopted and implemented in several western countries, among them Canada, Australia, New Zealand, Germany, Turkey, Sweden, Finland and the United Kingdom. (LeBel et al., 2014; Putkonen et al., 2013; Wieman et al., 2014).

Norwegian authorities have for years expressed the necessity of reducing coercion in mental health services (Norvoll et al., 2008b; Norwegian Health Directorate, 2017; Norwegian Ministry of Health & Care Services, 1997-1998, 2012). One of the goals in The Norwegian Mental Care Plan (1998–2008) was increased voluntary treatment and care, and thus decreased involuntary treatment and use of coercive measures. Several public plans and resolutions have followed (Norwegian Ministry of Health and Care Services, 2006, 2012-2013), but until 2018, the use of coercion in Norway has been stable.

There are, however, significant variations in use of coercive measures between the four Norwegian Health Regions. Studies suggest that the variations may deal with different local cultures, individual differences between decision makers and differences in local experience-based

practice (Bowers et al., 2007; Husum et al., 2011). Variations in Norway have however decreased in the period 2017 – 2018 (Norwegian Health Directorate, 2020; Norwegian Ministry of Health and Care Services, 2019). The reported variations are however not unambiguous enough to conclude changes in practice.

Norwegian mental health services are now under political pressure from national governments to reduce the use of restraints as a national committee has proposed that mechanical restraint should be removed from the services within three years (Norwegian Health Directorate, 2020; Norwegian Ministry of Health and Care Services, 2019).

To my knowledge, the Six Core Strategies are still not implemented in any Norwegian mental health services. However, staff training in de-escalation has been conducted in Norwegian services for years, but the outcome of this training is unclear, as in most studies, staff training is a part of a program and the effect of each component is muddled (Guzman-Parra et al., 2020; Scanlan, 2010; Väkiparta et al., 2019). Guzman-Parra et al. (2020) suggest that it is important that all components in the Six Core Strategies be applied when the aim is S/R reduction.

Following other western countries, a few Norwegian mental health services implemented PIR procedures after PIRs were featured in a Norwegian public report on strengthening human rights in mental health services in 2011 (NOU 2011:9). The inspiration for the committee's proposal to implement PIRs was Danish legislation that for several years had instated PIRs as a mandatory procedure after use of coercion (The Danish Mental Health Care Act §4).

The guidelines to the later Norwegian law revision (2017) stated that the aims of the PIRs were learning, prevention of new restraint events and quality development (Norwegian Health Directorate, 2017). Quality is not further defined in the guidelines, which incidentally state that people with mental health challenges shall be offered services characterised of knowledge-based practice and good quality. Regarding the concept of knowledge-based practice, I rely on the descriptions in

Helsebiblioteket.no (2017) that state knowledge-based practice to include scientific knowledge, experiences from care providers and care receivers and user participation.

Quality in mental health services occupies a broad spectrum and may vary across different levels in the healthcare system as managers, care providers, patients and next of kin may have different ideas of what quality means. Public reports state that managers in the services shall strive for quality improvement that includes the employees' competence development and further securing of patients involvement in treatment and care, where being met with dignity and respect are core values (Norwegian Health Directorate, 2019; Norwegian Social and Health Directorate, 2005).

Care includes being supported to maintain basic needs in a framework of human rights, emphasizing dignity and respect (International Council of Nurses, 2012). Therefore, I will draw on this description of care in relation to PIRs' accomplishments and outcomes.

In the guidelines to The Mental Care Act, the content in the evaluation is intended to shed light on whether the most appropriate measures were chosen, if restraint was implemented at the right time, if other gentle measures could have been carried out and if the patient received adapted information prior to the implementation (Norwegian Health Directorate, 2017). The patient's assessment of what triggered the situation in which the coercion was conducted and how new episodes may be prevented is also stated as important to bring forward. Moreover, PIRs should focus on sharing and promoting common situational awareness of the time before, during and after the use of coercive measures.

 I have not found any overview with respect to the implementation rate of the PIR procedure in Norway. On request, the Norwegian Directorate of Health claims that they do not have a national overview of the degree of implementation of PIRs and currently have no plans for demanding such reporting.

2.3   PIRs – the body of knowledge

To find prevailing literature about PIRs, I started to search broadly in different databases to get an overview over the given field. It soon came up that PIRs (mostly labelled debriefing) mostly were described with respect to accidents and catastrophes and included helping personnel – and to some degree – the victims. Therefore, I turned to Medline, Cinahl and PsychInfo to do more systematic searches of scientific literature. As search terms, I used different variations of debriefing, restraint (mechanical and/or physical) and mental or psychiatric health.

Debriefings after traumatic incidents have been used for a number of years to minimize negative effects of traumatic incidents, initially for emergency service workers and later for wider ranges of traumatic events (Tuckey, 2007). The most frequently used debriefing model, Critical Incident Stress Debriefing (Mitchell, 1983), has been criticized as the involved persons are encouraged to express their emotions after a traumatic incident (Goulet & Larue, 2016). Further, in a Cochrane meta-analysis, Rose et al. (2003) found debriefing to have no effect on reducing post-traumatic stress, and in some cases even indicated a potential to increase risk. The Cochrane study has been criticized by Tuckey (2007), and Goulet and Larue (2016) argue for a debriefing model based on the concepts of psychological debriefing and reflective practice in nursing. This model, which includes patients and care providers, emphasises reflection and learning and thus the patients are not encouraged to express their emotions in the encounter. The objective will then be to help the patients manage their feelings and explore the causes for losing control (Goulet & Larue, 2016).

Fisher (2003) seems to be the first to describe debriefing as a two-step procedure after critical incidents in mental healthcare:
1) debriefing with care providers alone, in post-incident analysis aimed at evaluating what could have been done differently and making short-term plans to avoid repeating restraint use; 2) debriefing for patients and

care providers together, consisting of a detailed behaviour analysis of the events preceding restraint use by both parties.

At the starting point of this PhD project, in 2013, there was to my knowledge just a handful of studies where PIRs after restraint were described. The studies were conducted in England (Bonner et al., 2002; Bonner & Wellman, 2010) and the USA (Ashcraft & Anthony, 2008; Azeem et al., 2011; Fisher, 2003; Huckshorn, 2004; Petti et al., 2001).

Studies describing patients' and care providers' requests for PIRs and further experiences with PIRs dealt with PIRs after both restraint and seclusion events. Originally, we searched only for research exploring PIRs after restraints, given that restraint and seclusion differ in terms of legality and application, as well as their therapeutic and ethical consequences. In examining the literature, we found that only a few publications fulfilled the criterion regarding restraint alone, so we included publications that either included PIRs after restraints or PIRs after restraints and seclusion together (Arksey & O'Malley, 2005; Boland et al., 2014).

The first two studies that revealed PIRs including patients and care providers as appropriate, were an American study using mixed methods (Petti et al., 2001) and a British small pilot qualitative study (Bonner et al., 2002). The studies explored use of semi-structured interviews after seclusion and restraint, respectively, and physical restraints. In both studies, PIRs were considered to be appropriate tools to map what happened before, during and after the restraint events. Petti et al. (2001) concluded that PIRs 'can be used as learning tools for staff and patients, to track staff and patient progress, and as a way to change the culture of psychiatric settings' (p.115).

Bonner and Wellman (2010) used a survey design to evaluate whether patients and care providers found PIRs useful to review incidents of restraint in the practice setting. Ninety-seven percent of staff, and 94% of patient participants agreed this approach was useful. Furthermore,

PIRs gave them an opportunity to map the incidents that lead up to the event, how the incidents were managed, and whether the incidents could have been predicted. All participants expressed that they valued PIRs, but PIR use was sporadic for the care providers and rarer for the patients.

In several studies, results of implementing S/R reduction programs in different American services were explored (Ashcraft & Anthony, 2008; Azeem et al., 2011; Fisher, 2003; Scanlan, 2010). The results showed marked decrease in the use of restraint and seclusion in the services after implementation these programs.

Altogether, the existing studies regarding knowledge development and prevention on new restraint episodes of PIRs seemed promising. In three studies, conducting PIRs in a supporting and non-threatening atmosphere was emphasised, but this issue was not further elaborated upon (Azeem et al., 2011; Bonner & Wellman, 2010; Petti et al., 2001).

In summary, PIRs seemed to be a promising intervention with respect to S/R reduction in mental health services. The existing knowledge was immediately vague, as there was no knowledge about how the different elements in the programs contributed to S/R reduction (LeBel et al., 2014; Scanlan, 2010). Stakeholders', that is, patients' and care providers', experiences of participation in PIRs were scarcely described, as the previous studies were small projects from different contexts and with few participants.

Consequently, the results revealed a knowledge gap and a need for up-to-date knowledge and further explorations of patients' and care providers' experiences and views of PIRs.

2.4 Aims and research questions

Use of restraints in mental health services insults the principle of autonomy and is accordingly a human right violation. Consequently, the current widespread use of restraint challenges Norway's reputation as a country where human rights are valued firmly.

Therefore, based on reported restraint-related adverse effects on patients and care providers, in addition to restraint as violation of human rights, the aim of this study is to explore PIRs' potential to promote quality improvement in terms of human care values such as participation, influence and collaboration, according to the body of scientific knowledge and experiences from care receivers and care providers.

To be able to achieve the overall aim, it was relevant to ask:

1. What does the body of knowledge regarding PIRs in scientific literature consist of?
   - How are PIRs' defined and described?
   - How are PIRs conducted in practice, and what are possible variations in PIR use?
   - What are patients' and care providers' experiences of PIRs?

2. In a Norwegian context, what are professional care providers' experiences and considerations regarding the use of PIRs in practice? What do professional care providers see as the benefits and challenges of PIRs?

3. In a Norwegian context, what are patients' experiences and considerations of PIRs after restraint events? How do patients view PIRs' potential for care improvement and restraint prevention?

2.5   *Focus and delimitations*

In respect to the main aim of this thesis, the focus is PIRs after restraint events, and therefore not the restraint itself. A central aspect throughout will be patients' dependent position in mental health care services and therefore exposure to dehumanising experiences.

The procedures are already implemented in the participating services. The focuses of the empirical sub-studies are, accordingly, stakeholders' experiences and opinions, and consequently not measures of effect or comparative studies. Furthermore, the empirical studies will be experiences from a Norwegian context.

2.6   *Use of concepts*

Traditionally, people with mental health problems have been labelled as patients. According to Norwegian law, people are patients when they receive medical treatment (Norwegian Ministry of Health & Care Services, 1999, §1.3) In studies presented in Article 1, different terms are used to describe people with mental health challenges, but we chose to make use of the concept 'patient' due to the law. In article 2 and 3, we used the concept 'patients' even though some of the participants no longer were inpatients when they shared their experiences and views. The term 'service user' would then be more precise for out-patients, but for the sake of readership I chose to use the term *patient* in this thesis.

When exploring professionals' experiences and considerations, a multidisciplinary focus was chosen. Psychologists and doctors bear the formal responsibility for the decision to restrain. Milieu therapists bear the responsibility for care before, during, and after the restraint events. They also conducted PIRs when the patient's therapist was hindered. Therefore, the term *care provider* is used in this project. As most of the research with respect to milieu therapy is about nurses, and most interviewed milieu therapists were nurses, I use the term *nurse* in the thesis when I mention milieu therapists.

In the three articles, I used the terms *we* when describing the work that was a collaboration between respectively three and four authors.

In this thesis I use the term *I* based on the independence of the work.

3 Theoretical perspectives

Based on the study's overall aim and context – mental health services where use of coercion has been conducted – I move into a landscape where ethical values and human rights are at stake (Hem et al., 2014; WHO).

In general, every human being, including people with mental health problems, has the right to life, personal liberty, security and physical integrity (Council of Europe, 2019; United Nations, 1948). Use of coercion in mental health services conflicts with the principles of liberty and autonomy, central principles in the Convention on the Rights of persons with disabilities, CRPD, (United Nations, 2007). This convention aims to empower people with mental health challenges in making their own decisions regarding their own treatment and care (Freeman et al., 2015; Sugiura et al., 2020). The WHO (2004) claims that respecting and protecting human rights is fundamental for promoting mental health and thus a positive resource in the recovery processes (Gostin, 2001; Iasiello et al., 2019; Keyes et al., 2010).

When potentially dangerous situations occur in mental health services, care providers' deliberations regarding what they consider to be the patient's best interest can be explained in terms of the ethical principles of beneficence, nonmaleficence, justice and respect for autonomy (Beauchamp & Childress, 2009). Restraint events will however, even though the decision is based on these principles, violate the patient's autonomy, and may do damage and cause additional burden.

Ethical challenges regarding coercion lie on both individual and institutional levels (Norvoll et al., 2017). The individual level may comprise care providers' moral integrity, their relationship with professional ethical guidelines, their attentiveness regarding ethical issues and further language to describe ethical dilemmas and considerations. The institutional level deals with climates and cultures and further structural traits in the services as well as the services'

interactions with relevant others (Austin, 2007; Walker, 1993). Care providers describing moral uneasiness concerning coercion, relate that issue to both structural and cultural traits of the services, which consequently result in use of coercion that they consider as unnecessary, dehumanising attitudes and low quality of treatment and care (Jansen et al., 2020; Norvoll et al., 2017). However, care providers' moral uneasiness is not inappropriate, as it can function as a wake-up call and thus initiate ethical reflections in the services (Jansen et al., 2020).

As purposes of PIRs are defined to be S/R reduction through learning and quality improvement (Goulet et al., 2018; Huckshorn, 2004; Huckshorn, 2006; Norwegian Health Directorate, 2020), I find theory about care and control, power-dependence relations and care ethics relevant to illuminate the findings in the study. These perspectives will be elaborated upon in this session.

3.1 Care and control

For people with mental health challenges needing hospitalisation, care is an essential part of the treatment program. Care includes being supported to maintain basic needs in a frame of human rights, emphasizing dignity and being treated with respect (International Council of Nurses, 2012). In mental health services, nurses (including social educators and nurse assistants) are responsible for the round-the-clock care in the form of milieu therapy in the ward units. This task includes the health services' responsibility to provide physically and emotionally safe environments for all involved (Barton et al., 2009; Gooding & McSherry, 2018; Riahi et al., 2016). As care for humans with mental health problems always takes place in a context, I will initially present different care philosophies that will strongly influence on how care will be expressed in practice.

Originally, milieu therapy, which was founded by the Quakers in the 1800s, was characterized by the belief of human values as restraints and medication to control violent behaviour were considered inimical to the

ethical principles of benevolence and non-malfeasance. Overcrowding hospitals soon became a problem and consequently behaviour control became a central issue, so different coercive measures were developed, such as belts and strait jackets (Colaizzi, 2005). Behaviour control based on a disciplining approach (Foucault, 1975; Foucault & Sandmo, 2000) has then characterised mental health services up to now (Berring et al., 2015; Bracken et al., 2012; Aasland et al., 2018).

External requirements for restructuring services, as the service user movement and public recommendations emphasizing more human care philosophies imply a tension between traditional psychiatric treatment's focus on control and the new approaches (Bracken et al., 2012; Norwegian Health Directorate, 2014). Growing care philosophies are described as person-centred, recovery-based, strength-based, or trauma-informed. Common features of human care philosophies are an understanding of mental health problems within broad contexts, a view on patients as experts along with care providers and further emphasising dialogue and collaboration, values that are in line with care ethics (Gottlieb, 2014; Gottlieb & Gottlieb, 2017; Slade, 2009).

I will present two different approaches which imply different care philosophies and thus different conditions of care. The one is traditional clinical approaches, such as the biomedical and the biopsychosocial model where biomedical processes have a strong position in the understanding of mental health problems (Slade, 2009). The other approach is human care philosophies that understand mental health problems within broader contexts. I will exemplify by describing two representative models for the different approaches: the clinical recovery model and the personal recovery model. The two models are labelled as clinical models, care philosophies, framework or practices, and thus not theories (Karlsson & Borg, 2017; Slade, 2009).

The meaning of clinical recovery has emerged from professional-led research where systematic reviews and randomised controlled trials (RCT-studies) are considered to be the strongest type of knowledge (Slade, 2009). The features of clinical recovery are that recovery is an outcome or a state, it is objective and observable, it is rated by the clinical experts, and consequently not the patient, and lately that recovery is invariant across individuals (Slade, 2009). Within the clinical recovery perspective, knowledge is developed primary from systematic reviews and meta-analysis of randomised controlled trials, cohort studies, case control studies and cross-sectional studies (Slade, 2009, p.46). The professionals are within this approach experts and the patients' experiences and knowledge have low value.

A personal recovery orientation is now mental health policy in most Anglophone countries, including Norway (Leamy et al., 2011; Norwegian Health Directorate, 2014). The most cited definition of a personal recovery perspective is Bill Anthony's definition (1993):

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (p.15).

As personal recovery is described as an individual process, and not a result as in clinical recovery, that means that it is not the right way to do or experience recovery (Slade, 2009). Mental health problems must thus be understood in a context, which means focusing on everyday life instead of symptoms and pathology. In line with WHOs Comprehensive Health Action Plan (WHO, 2013), the understanding and focus of recovery has changed from an individual process to a more right-oriented, relational and social-oriented perspective. Consequently,

recovery is both a personal and social process (Norwegian Health Directorate, 2014; Topor et al., 2020).

Knowledge development within a personal recovery perspective arises from both professional and personal knowledge, consequently patients' experiences are emphasised as valuable knowledge. Aiming to include different knowledge sources, Slade (2009) suggest a constructivism position as relevant to find a balance point between subjectivism and objectivism, consequently different knowledge sources and different recovery perspectives will be appropriate in different situations.

Relevant to this thesis is a conceptual framework for personal recovery processes consisting of the five central processes: Connectedness, Hope, Identity, Meaning and Empowerment, abbreviated CHIME (Leamy et al., 2011).

Within a personal recovery-oriented framework, crises are defined as new opportunities instead of pathological relapses (Mead & Hilton, 2003; Slade, 2009). Slade (2009) argues that what professionals label as relapse gives a reductional picture of the person and one's situation, in this case a person who experiences others taking control over one's body. Therefore, he argues that the term 'crisis' gives a broader picture of the situation and has 'the potential to be a learning opportunity, or a turning point' (p. 182).

From a personally oriented perspective, the focus will be to support the patients' capacities to manage their problems in constructive ways by learning from previous events. The care providers' tasks are thus to minimise the loss of responsibility and to support identity and hope during and after the restraint event (Slade, 2009).

Consequently, the relationship between the patient and care provider, how they interact and work together, will be different than the traditional clinical recovery traditions. Within a personal recovery perspective, Slade (2009) suggests partnership relationships as appropriate for patients and care providers. Partnership relationships are based on sharing of power, the professionals' clinical expertise that is a combination of

theoretical knowledge and clinical practice and the patients' expertise-by-experience (Slade, 2009; Warne & McAndrew, 2007). As the patients are supported to keep keeps as much responsibility as one can manage, the care providers must give away some of their power (Barker, 2012; Slade, 2009). Studies indicate however that balancing control/paternalism and autonomy/responsibility are challenging to the care providers, who traditionally have implemented more control when crises have emerged (Barker, 2012; Drennan & Alred, 2012; Hornik-Lurie et al., 2018; Kvia et al., 2020; Slade et al., 2014).

In line with the growth of new care philosophies, Lisbeth Borge and Jan K. Hummelvoll (2019) argue for a renewal of the psychodynamic milieu therapy model that has had the greatest impact on theory and practice in mental health care. In the psychodynamic milieu therapy model, an individual-focused approach is emphasised wherein the care providers hold the expert role, and the patients remain in a passive role. The proposed new model is inspired by what the researchers conclude is a need, to enhance the interaction of environmental therapy and individual therapy. Milieu therapy within this socio-cultural model focuses the patients' participation and learning in a healing environment (Borge & Hummelvoll, 2019; Miller & Crabtree, 2005).

As the clinical recovery perspective has dominated mental health services until now, I find Erwin Goffman's theories (1961/1991) about total institutions and stigma relevant to illuminating findings in this thesis.
Goffman (1961/1991) explored through a participant-observational study how relatively closed organisations such as prisons, asylums and hospitals shape self-perceptions and identities and further how the inmates manage their daily lives in these settings. He found some common traits between closed organisations, total institutions, as well as a split between staff and the inmates that was characterized as mutual devaluation. The care providers did often see 'the inmates as bitter,

secretive and untrustworthy' and the inmates did often perceive the care providers as 'condescending, highhanded and mean' (p.18).

Further, Goffman (1961/1991) describes care providers' views on the patients as objects, and consequently not 'ends in themselves' which is a central value in 'people-work' (p. 74). His view on the care providers' attitudes as 'object-work' does also come into expression by documentation requirements, which mean that the patient 'must be followed by a chain of information receipts detailing what has been done to and by the patient and who had the most recent responsibility for him' (p.73).

Goffman (1961/1991) describes the inmate world's processes of 'mortification of self' as the patients are deprived of their old roles and further are subjected to degrading and humiliating treatment. In addition, they are forced into relationships in environments that cannot guarantee their personal safety. Goffman argues further that in all situations, norms are defined for behaviour. Situations are thus constructions of identity (Goffman, 1967/2005).

Goffman's Asylums (1961/1991) is however criticized for painting a too negative image mental health hospitals, mainly based on Goffman's bias against psychiatry and his methodological approach (Linn, 1968; Weinstein, 1982). Despite the criticism and the fact that Goffman's theories and considerations are from the 1960's, I consider them still relevant for understanding the role of inpatients in today's Norwegian mental health services (Nyttingnes et al., 2018; Nyttingnes et al., 2016; Aasland et al., 2018). Examples are the formal coercion used, other more subtle forms are house rules that regulate everyday tasks, such as time for coffee, watching TV or going to bed, rules that are proved to evoke frustration and acting out (Norvoll et al., 2008b; Nyttingnes et al., 2018).

3.2   Care ethics as a theoretical approach

Traditionally, care providers in mental health services have utilized classical ethical theories or the four ethical pillars (Beauchamp & Childress, 2009) to find alternative courses of action in demanding mental health service situations. Bloch and Green (2006) claim, however, that the 'classic theories may contradict one another, contribute to confusion, and immobilise the clinician' (p.7).

Further, when applying theories such as deontological ethics, utility ethics and principle-based ethics, the care providers have the role to define the patients' best interests. As mental health services as far as possible should aim at support the patients to achieve their personally valued goals, there is a need for an alternative or supplementary approach for ethical considerations when ethical dilemmas emerge (Slade, 2009; Tronto, 1993).

An alternative to the traditional ethical theories is *care ethics,* also known as ethics of care, a normative ethical theory developed by Carol Gilligan in the eighties. Care ethics is a contemporary variant of virtue theory that holds benevolence as a pronounced virtue (Gallagher, 2017; Tronto, 1993). In contrast to the other ethical theories, care ethics includes the role of emotions in moral deliberation and personal relationships are emphasised over rules. Further, care ethics regards the moral subject as inherently relational and recognizes the power imbalance between patients and care providers and the patients' and care providers' reciprocal vulnerability (Bloch & Green, 2006; Tronto, 1993). According to Bloch & Green, 'decision-making is thus grounded in the core value of humankind's capacity to extend care to people who are in need or vulnerable' (2006, p.10).

Further in this thesis, I will refer to two philosophers that have been concerned with care ethics: Joan Tronto, professor of political science from USA (1952–) and Kari Martinsen, nursing scientist and philosopher from Norway (1943–).

I consider the two philosophers Tronto and Martinsen to supplement each other as Martinsen also is a mental health nurse concerned with knowledge development in the health services, especially related to nursing.

The two philosophers are however inspired by different theoretical traditions. Tronto's care ethics is inspired by Gilligan's Anglo-American tradition, which focuses on the ethics of justice and care in close relationships, while Martinsen has incidentally contributed to the Scandinavian care ethics inspired by phenomenology and the philosophers Knud E. Løgstrup and Hans Skjervheim (Gallagher, 2017; Martinsen, 2000, 2005; Tronto, 1993).

Tronto and Martinsen are both concerned with viewing care in a socially critical perspective and they both discuss the borders between private and public care as well as class distinctions based on income and sex (Martinsen & Wærness, 1991; Tronto, 1993, 2013). They consider care to be a fundamental part of human life and view all human beings to be vulnerable and thus interdependent on each other. A moral universal principle is thus that we all through our lives will be dependent on help from others. They are further both concerned with the importance of power relations in care (Martinsen & Kjerland, 2006; Tronto, 1993).

Even though both the philosophers include societal and organisational frames as premises for professional care, I find Tronto to take a more political and society-based mandate that is claimed to be central in the moral of professions (Grimen, 2008).

Joan Tronto and Berenice Fischer (1993) define care as 'a species activity that includes everything we do to maintain, contain, and repair our "world" so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment' (p.103).

They describe four phases that are central in an ethics of care, that are 'caring about', 'taking care of', 'care giving' and 'care-receiving' (Tronto, 1993, pp.106–107). The first element is 'caring about', including concern or worry, about someone or something. The second

phase 'taking care of', involves taking responsibility for addressing the recognised unmet needs. In this thesis, the two latter phases are most relevant as 'care-giving' refers to the care providers who are responsible for performing care in the ward units, and 'care-receiving', 'the response of that which is cared for to the care' (p.127). But as the four phases are interconnected phases, also 'caring about' and 'taking care of' will be included as these phases involve recognition and taking care of needs in political and administrative levels and thus include conditions that are related to the services' care philosophies and available resources. Tronto warns against situations with inadequate resources or that the caregivers needs are not met. Their anger may thus turn to the care receivers in form of neglect, humiliation or abuse (Tronto, 1993).

Fisher and Tronto (1993) claim four ethical elements of care to arise from the four elements of care: attentiveness, responsibility, competence, and responsiveness (p.127). They describe the moral quality of attentiveness to someone's unmet needs as the first phase of care. For carrying care into effect, one must go to the next level and assign responsibility for meeting the other person's or group's unmet needs. Relationships are emphasized as central. The third phase of caring calls attention to competence in care-giving as a moral notion. The fourth phase of caring is the responsiveness from the care receivers regarding whether their needs were met or not.

According to the law, service users and their next of kin do also have a legal right to be involved in planning and execution of care based on user participation and shared decision-making (Pasient og brukerrettighetsloven, 1999; Psykisk helsevernloven, 1999, latest revision 2017). The responsiveness may thus contribute to changes in approaches and measures and signal central ethical challenges, such as vulnerability and imbalance in power-dependence relationships (Tronto, 1993).

Martinsen (2005) presents her care approach with three dimensions; a relational, a practical and a moral dimension where the latter is superior

to the others. She claims that including those perspectives prevents care from being a detached or technical matter and supposes that the care providers have professional knowledge that includes how to conduct care, including an ethical awareness and approach.

Martinsen was in the 1980's critical to existing theory in nursing that she labelled as 'causing stupidity' (Martinsen & Wærness, 1991, p.114). She perceived the existing nursing theories as positivism and detached from practice, and argued thus that scientific knowledge is not the only way to create new knowledge of care (Martinsen, 2005; Martinsen & Wærness, 1991). She argues that new knowledge also may be developed in the practice field based on collaboration between patients and care providers. Martinsen's theories of care are primarily written for nursing care, but Elin Martinsen, a medical doctor, argues that Martinsen's theories are applicable for other professionals as well (Martinsen, 2011).

As with Tronto, Martinsen is concerned with attentiveness to needs as an assumption for taking responsibility to meet others' humans needs. She argues that person-oriented professionalism involves the need to see the patient with a both a perceiving and a recording eye (Martinsen, 2000; Martinsen & Kjerland, 2006). A perceiving eye includes seeing the other person with openness where sensations and emotions are working together. In respect to the recording eye, she claims, 'By recording is meant the putting of oneself in an outside position, classifying' (Martinsen & Kjerland, 2006, p.72). The danger of seeing the other person with only the recording eye is that the person easily may be reduced to an object or a completed fact, consequently this eye is reductionistic.

Martinsen (2006) emphasises the need for a person-oriented professionalism that means using judgement to be aware of if one sees the patient with a perceiving eye characterised by openness or an academically exploring and expansive eye. This statement is a parallel to Skjervheim' s call for being aware of one's position as 'participant or

observer' (Skjervheim, 1996) in the face of the other human being. As with Martinsen, Skjervheim was critical of positivism. He warns against the tendency to neglect the meaning of the other based on one's own observations, as humanity consequently will be lost (Skjervheim, 1996). Martinsen and Skjervheim both emphasize that which eye to look with, or which position to take in relations, is not either/or, but may vary in different situations (Martinsen & Kjerland, 2006; Skjervheim, 1996).

Both Tronto (1993, 2013) and Martinsen (2005) highlight the importance of competence in caregiving as a moral notion as competence increases both the likelihood of the job being done and subsequently the quality of the care. Further, they relate competence to organizational conditions, such as access to resources like sufficient competent care providers.

Inclusive in theories of care ethics, I will draw attention to a framework for humanising healthcare. As patients admitted in mental health services, especially after being exposed to coercion, often report experiences with dehumanisation and humiliation (Boysen et al., 2019; Husum et al., 2019; Nyttingnes et al., 2016), I find Todres et al. (2009) framework for humanising healthcare relevant. Inspired by this perspective on what it means to be human, Todres et al. (2009) developed a framework consisting of eight touchstones for awareness when standing in complex situations with need for considerations. The touchstones, illustrated in Table 1, are eight dimensions, each expressed as a continuum 'stretching from the term that characterizes humanization in a positive sense; through to the term that characterizes the barrier to such a possibility' (p.69). The authors emphasise that they are not suggesting any dualism, rather a spectrum of possibilities.

Table 1 Forms of humanisation and dehumanisation

Forms of humanization	Forms of dehumanisation
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenization
Togetherness	Isolation
Sense-making	Loss of meaning
Personal journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

(Todres et al., 2009, p.70)

Todres et al. (2014); (2009) draw special attention to the human dimension '*insiderness',* which 'carries a sense of how things are for the person' (2009, p. 79). As only the person him or herself can know how the world appears to them, a person's insiderness never can be grasped absolutely by others. Insiderness is central to personal recovery philosophies where the individual is considered to be the best person to define their own interests (Slade, 2009). In contrast to insiderness, there is objectification, exemplified by being placed into a diagnostic system as mentally sick.

Further, Todres et al. (2014) argue a need for changing focus from 'shifting one's focus of understanding from the cared-for in-themselves to a focus on the cared-for-in relation to others' (p. 9). Consequently, understanding the other human being becomes relational and the patient's experience of the care will be influenced by what kind of gaze

you are looked at with and thus how you are treated by care providers (Martinsen, 2005; Todres et al., 2014).

I consider the dimensions of humanisation to be comparable to human care philosophies as a recovery-oriented framework, exemplified by the CHIME elements (Leamy et al., 2011).

3.3 Power-dependence relationships

Care is not an activity which takes place between equal and autonomous persons, but between humans who have needs and humans that can provide for those needs (Martinsen, 2005; Tronto, 1993). Power enters all human relations, but power is especially expressed in mental health providers who have a high degree of professional knowledge and further have the power to make diagnoses, to declare the patient to 'lack mental capacity' and impose treatment that includes use of coercion (Greenhalgh et al., 2015).

According Michel Foucault (1975), power and knowledge are not seen as independent entities but are inextricably related and reinforce one another. Power is based on knowledge and makes use of knowledge. Knowledge is always an exercise of power and power is always a function of knowledge. Foucault claims, however, that power is not just negative, coercive, or repressive, but may represent a productive and positive force. In mental health services, coercive power comes to expression both as open, formal coercion and as other types of pressure and persuasion, or leverage and treats from the care providers. Such dynamics may be expressed as a *coercive context* (Sjöström, 2006) or as Szmukler (2015) puts it, '*coercive shadow*', 'the fear many patients have that non-compliance may lead to the use of compulsion' (p. 259).

The American sociologist Richard Emerson (1925–1982) was the architect of power-dependence relations theory. This model can be used with respect to relations among actors that can be person-person, group-person or group-group (Emerson, 1962). Usually, social relations entail ties of mutual dependence between the actors. Each of the actors may,

based on the ties of mutual dependence support or deny, facilitate or hamper the others gratification. Consequently, 'in short, power resides implicitly in the other's dependency' (Emerson, 1962, p.32).

As a patient in mental health services, one is dependent on care providers in a period as one needs help to relieve and manage their mental health problems. In light of Emerson's theories, in the relation between a patient and the care providers, the patient's dependency will be (1) directly proportional to one's motivational investment in goals mediated by care providers and (2) inversely proportional to the availability of those goals to the patient outside of their relation. Furthermore, care providers' power over the patients can be defined by the amount of resistance on the patients potentially overcome by the care providers (Emerson, 1962, p.32).

Dependency power increases when there are no other options as the reality is when one is involuntary admitted in mental health hospitals, consequently the patient must interact with the care providers to get what one needs.

When a power imbalance occurs, as in mental health services where the patient is the most dependent and has the least power, one consequence is suppression of the patients' voices (Greenhalgh et al., 2015).

According to Emerson (1962), use of power initiates processes as *cost reduction* and *balancing operations*. Cost reduction is a process that involves a change in values, here personal and social values, which reduces the patients' pains incurred in meeting the demands of the powerful care providers.

Balancing operations deal with changes in the variables that define the structures of the power-dependence relation. To achieve more balance in power-dependence relationships, the weaker members' power should be increased. In mental health services, patients must consequently be given increased status, and care providers should increase their motivational investment in the goals defined by the patients (Emerson, 1962). As knowledge and power reinforce each other (Foucault, 1975) upgrading

the patient's experienced knowledge by requesting and recognising the knowledge may thus increase the patients' power.

4 Methodological framework

The following section describes the methodological framework applied in this thesis. The phenomenological-hermeneutical approach is described, as are further methods with descriptions of data collecting methods, participants, data analyses and ethical and methodological considerations.

4.1 Phenomenological – hermeneutic approach

The overall aim of this study was to explore PIRs' potential to promote quality improvement in terms of human care values such as participation, influence and collaboration, according to the body of scientific knowledge and experiences from care receivers and care providers.

To achieve the goal of the study, the research questions seek descriptions, insight and understanding, therefore, a phenomenological and hermeneutic scientific philosophy was relevant (Dahlberg et al., 2008; Gadamer et al., 2010). While *phenomenology* is a philosophical approach to the study of lived experiences (Dahlberg et al., 2008), *hermeneutics* is the philosophy of understanding gained through interpretation (Dahlberg et al., 2008; Gadamer et al., 2010).

As PIRs were conducted in a context, in this thesis mental health services after a prevailing restraint event, an interpretation of the experiences applying a hermeneutical approach contributed to an extended understanding of the explored phenomena, the PIR (Gadamer et al., 2010). According Hans Georg Gadamer (2010), understanding, that is more than an explanation, may be achieved through entering the hermeneutic circle, a dialectic movement between proximity and distance, parts and the whole, self and others and present and past.

4.1.1 *The researcher's pre-understanding*

A basic assumption in hermeneutics is that one never meets the world without prejudice. Gadamer et al. (2010) emphasize that our prejudice is a necessary condition for understanding what is possible. Therefore, to clarify my pre-understanding is of importance from the philosophical and methodological perspective of this thesis.

At the beginning start of my work with this project, my pre-understanding was highly influenced by my 20 years of care experiences with people with mental health problems. In the period 1992–2002, I worked as a lead nurse in a ward unit that frequently used mechanical and physical restraint. I did sometimes participate in restraint events where I later identified my emotional reactions as 'moral uneasiness' (Norvoll et al., 2017). In the actual ward unit, we had to a small extent organised systematic reflection regarding moral views on our practice.

The turning point was in the early 2000s when I joined the board of The Mental Health Nursing Group in Norwegian Nurses Association. Through this work I met previous patients and fellows that presented other perspectives and solutions that challenged my previous attitudes and practices. Consequently, my master thesis in 2009 dealt with service users' (ex-patients') experiences with restraint measures in mental health services. What affected me most through this work, was services users who told about being re-traumatised by being restrained after previous physical and sexual abuse and further the participants' statements that they were never offered PIRs afterwards. PIRs were at the time only routinely offered to care providers (Hammervold, 2009).

My pre-understanding with respect to PIRs was initially characterized by a predominant positive attitude, where I claimed to have no professional or ethical objections regarding conducting PIRs after use of coercion. This attitude was even commented on after a presentation of the project

in 2015 where the risk of bias in my research became a conversation topic.

During the interviews with patients and care providers, I experienced gradually expressed attitudes and utterances that stimulated reflections regarding PIRs. 'To be aware of my bias,' (Gadamer et al., 2010, p.241) was than a primary hermeneutic task. The interviews and reflections with my supervisors and the advisory group contributed thus to extending my previous understanding of PIRs. As an example, I became during these processes gradually aware of the PIR context as critical for the patients' experiences of the encounter.

4.1.2 *The phenomenological-hermeneutic interpretation process*

A scoping review and two empirical studies were conducted to achieve the overall aim and the study's research questions. The three sub-studies were interpreted inductively.

Understanding, or as Gadamer (2010) puts it, a fusion of horizons, was in this thesis developed as the dialogs, transcribed to written text, and me a researcher dialectically moved between the empirical findings and theory and further between the parts and the whole in a hermeneutic circle. Each sub-study was both a part and a whole, so the movement took place both within the parts and the whole of each sub-study and later each sub-study was integrated into synthesis to develop new understanding (Gadamer et al., 2010; Graneheim et al., 2017; Graneheim & Lundman, 2004).

Gadamer (2010) emphasises bringing one's own preunderstanding into play in the interpretation process. This implies the challenge to meet the data with openness and reflexivity. New expanded understanding derived from my pre-understanding arose in the interviews with patients and care providers as well as discussions with supervisors, research fellows and an advisory group that had experience (Greenhalgh et al., 2004).

4.2 Research design

Based on the overarching aim of the study, a descriptive and explorative design was found to be appropriate. The research questions were developed based on a phenomenological-hermeneutical approach where the aims were exploring, describing, and understanding. Gadamer (2010) emphasizes the influence of developing the right questions to achieve this understanding. As this study has an inductive approach, the research questions were thus developed with starting points in *how* and *what* (Blaikie & Priest, 2019).

4.3 Methods

Aiming to answer the study's primary research question, three sub-studies were conducted. The methods conducted in the sub-studies will be outlined in this section. A brief overview of the sub- studies is presented in Table 2 (Articles I–III).

Table 2 Overview over sub-studies

Title/journal	Parti-cipations	Data collection method	Analysis method
Article I: Hammervold, U. E., Norvoll, R., Aas, R. W., & Sagvaag, H. (2019). Post-incident review after restraint in mental health care -a potential for knowledge development, recovery promotion and restraint prevention. *BMC Health Services Research, 19* (235), 1-13	Scientific papers (*n* = 12)	Scoping review	Data from the quantitative papers were ordered in a matrix. Data from the qualitative papers were analysed with qualitative content analyses
Article II: Hammervold, U. E., Norvoll, R., Vevatne, K., & Sagvaag, H. (2020). Post-incident reviews—a gift to the Ward or just another procedure? Care providers' experiences and considerations regarding post-incident reviews after restraint in mental health services. A qualitative study. *BMC Health Services Research, 20* (499), 1-13	Health care providers (*n* = 19)	Individual in-depth interviews	Qualitative content analysis
Article III: Hammervold, U. E., Norvoll, R., & Sagvaag, H. Post-incident Reviews after Restraints, – Potential and Pitfalls Patients' experiences and considerations Submitted: *Journal of Psychiatric and Mental Health Nursing*, November 2020	Patients (*n* = 8)	Individual in-depth interviews	Qualitative content analysis

4.3.1 *Context and participants*

Initially, it was challenging to get access to services that would allow me to conduct the empirical part of the study. I was in contact with four services before the two participating services allowed for the study.

The context of the empirical studies is two mental health services in the same health region in Norway. The two participating services are referred to as Service 1 and Service 2. Service 1 is a university hospital that has a combination of urban and rural settings with about 457,000 inhabitants. The participants were recruited from four different ward units serving patients with serve mental health challenges as psychosis, affective disorders and/or addiction problems.

Service 2 is a community mental health centre that has a rural setting with about 150,000 inhabitants. Participants were recruited from two different wards with one defined as an acute ward. Usually, only hospitals can use coercion in Norwegian mental health services. However, some community mental health centres are given permission to use coercion based on their emergency and acute services (Norwegian Health Directorate, 2017). The patients were reported to have similar mental health challenges as in Service 1.

The services had both implemented the PIR procedure a couple of years before I conducted the interviews. The procedures were not part of a restraint reduction program, but were an isolated procedure aiming at restraint reduction. The procedures were mainly congruent, but with some differences as illustrated in table 3.

Table 3 Overview of the two participating services PIR procedures:

	University Hospital	Community Mental Health Centre
Point in time	As soon as possible after the restraint event, if possible not later than 72 hours	As soon as possible and latest by discharge
Participants	Should be led by a person not involved in the restraint incident. One care provider involved in the restraint event should participate.	Patient, eventually next of kin, contact nurse or available familiar nurse and responsible therapist
Themes in the PIR	• The patient's experience of the restraint event and how the occasion was conducted? • The patient's comprehensions of reasons for conducting restraint, the effect of the measure and if the patients considers that the event was inevitable. • The patient's comprehension of the situation, the rationale for conducting restraint and the measure's effect	• What contributed to the restraint event? • What were the care providers' arguments for conducting restraint? • How did the patient experience the restraint measure? • How did the restraint measure appear? • What does the patient want the care providers to do in similar situations?
Documen-tation	PIR documented in electronic journal as a note. The patient receives a copy and may comment on the document.	PIR documented in electronic journal as a note

The services had a multidisciplinary group of therapists. Psychiatrists and psychologists had the role of individual therapists. They often led the PIRs according to the services procedures. Nurses and social educators, many of them with special education in mental health care, were the front-liners and had the daily responsibility of the milieu therapy in the wards. A central task was thus preparation of a supportive milieu that included restraint prevention, implementing restraint measures when that was considered inevitable and further taking care of the patients after restraint use (Barton et al., 2009; Riahi et al., 2016). The milieu therapists participated in PIRs, sometimes leading them, but more often in this study as the second participant serving as representative of the milieu therapist group. Other staff members in the wards were nursing assistants and employees who do not have a bachelor's degree. They seemed not to be involved in PIRs and are consequently not focused on in this thesis.

The participating patients struggled with various mental health challenges that put them in need of being inpatients in the hospital or mental health centre for a period, either in the short or long term. Some were voluntarily admitted, while others were admitted involuntarily.

4.3.2 *Recruitment of participants*

Initially, I contacted management of the participating services, who provided permission to present the study to leaders and available care providers in the relevant care units.

The study was presented orally, focusing on background, aims, purpose, methodical approach, and ethical considerations. Those present care providers expressed immediately positively to participate in the study. I also left written information and consent forms in each ward unit.

The ward leaders contacted me then about participants, both patients and care providers, who had given their consent to set appointments for the interviews. I made the appointment for interviews with the care providers directly with the individual care provider by e-mail. No one resigned after the agreement was signed.

Appointments for interviews with the patients were done via a care provider, usually the ward leader, the doctor, or the psychologist. It was an indispensable requirement that the patient be considered to have consent skills by their therapist before an appointment was done. As consent skills may rapidly vary, I repeated the given information before starting the interviews and further aimed at being attentive to the patient's mental status during the interviews (Witham et al., 2015). Neither did patients withdraw to participate after the agreement was signed.

In addition, the two different services introduced me to two previous patients, both women, who had experienced restraints every so often but had never been offered PIRs in line with the prevailing PIR procedures. I chose after consulting my supervisors to interview the one, knowing that she had not participated in a PIR. The Data Protection Official did not have any second thoughts regarding to include her (Appendix 4). Regarding the other woman, it turned up during the interview that she had not participated in PIRs. I chose for ethical reasons to fulfil the interview.

They had both been offered an evaluation by managers in the services a couple of years after the discharge from the services. Data from the interviews were however not used in article 3, based on the journal's recommendation. However, the two ex-patients confirmed previous studies regarding patients' negative experiences of restraint events and further their longings for processing the events afterwards (Bonner et al., 2002; Hammervold, 2009; Norvoll et al., 2008b). Their experiences and views were thus included in reflections regarding my preunderstanding and further about the results.

The recruitment process turned out to be long. Interviews with the care providers were conducted from April 2015 to May 2016. The interviews with the patients were conducted from March 2015 to November 2018.

During the data collection phase, I contacted the two mental health services regularly to remind them about my project and to ask for more patient participants. The feedback was often that they had not conducted PIRs lately or that the patients did not give their consent to participate in

the study. That issue raises the challenge of gatekeeping, that is care providers who are reluctant to approach or identify potential study participants. This resistance is often justified by an assessment of patients as vulnerable, which applies, among other things, to people with mental disorders (Witham et al., 2015).

4.3.3 *The advisory group*

An advisory group consisting of persons with lived experiences from mental health services was established for providing feedback and reflections during the study (Tracy, 2010). The group consisted of two persons who had lived experiences from being inpatients, and one who has experiences as next of kin. The group provided feedback on the interview guides and reflected together with me regarding how to understand preliminary findings. Members in the group were Linda Øye (patient experience consultant), Målfrid J. Frahm Jensen (patient experience consultant) and Jofrid Haga (next of kin). The group had three meetings, the first in 2014, where focus was the interview guides, the second in 2018 and the third in 2019. In the two latter meeting, findings from the interviews were presented and discussed. The meetings lasted about two hours and were tape-recorded so I could repeatedly listen to the participants' expressions and write a report of the minutes afterwards. Inputs from the group resulted in further considerations and reflections on the further work with the thesis. The group raised the issue especially of the imbalanced relationships between patients and care providers, a central issue based on their own 'expertise- by-experience' (Slade, 2009, p.117). The group disagreed beyond that about the fairness of asking the patients in PIR if they could have managed the situation in a different way.

4.3.4 *Data collection methods*

Literature review (Article 1)

Aiming to get hold on the prevailing scientific knowledge of PIRs, a scoping review was conducted. This method was considered relevant as initially searches revealed that the scientific knowledge base of PIRs was multifaceted with respect to design, topics, and quality. Further, a scoping review has proved to be suitable for defining, describing and identifying practical implications, variations and experiences of PIRs

(Arksey & O'Malley, 2005; Armstrong et al., 2011). The literature seems to be congruent with respect to recommend scoping reviews to be suitable to inform future research (Arksey & O'Malley, 2005; Levac et al., 2010), but not recommendations to practice and policy based on lack of quality appraisals and synthesis (Lockwood et al., 2019).

We followed Arksey and O' Malley's (2005) methodological framework for scoping reviews that consists of a five-stage approach. Initially, inclusion criteria were scientific articles describing or exploring PIRs after use of restraints in mental health services published within the last ten years based on changes in the public recommendations and guidelines regarding mental health services in the actual timespan (Norwegian Health Directorate, 2014; WHO, 2015). The literature search quickly indicated that only four publications fulfilled those criteria. We therefore extended the criteria to also include scientific articles that dealt with restraint and seclusion together and extended the publication time from back to the year 2000. We did not find relevant publications before that the time point.

Studies exploring PIRs after seclusion alone were not included based on differences between restraint and seclusion when coming to legalisation, reasons for application and therapeutic and ethical consequences. Expansion of the timeframe requires attention to the political and ideological change in mental health services during the period (Norwegian Ministry of Health & Care Services, 2006; World Health Organization, 2006).

Searches in English were performed May 2018 in five databases that we considered to cover the multidisciplinary field of research: Medline, PsychInfo, Cinahl, Sociological Abstracts and Web of Science. Searching in Nordic languages was performed in the databases Idunn, Norart and SweMed. The searches centred on three main concepts: 1) restraint; mechanical OR physical, AND 2) psychiatric OR mental, AND 3) post-incident review OR debriefing. The search terms, including Medical Subject Headings (MeSH terms) and synonyms for each of the

main concepts were combined with OR. A qualified librarian in the university supported the search strategy.

It soon came up that there were no scientific articles in Nordic languages relevant to the inclusion criteria. The searches in English yielded 40 articles after duplicates were removed. Ten articles were excluded by reviewing title and abstract. Additionally, 20 articles were excluded as the study was not focused on restraints, or PIRs were only vaguely described.

In addition, we searched for theses studying the topic and performed an ancestry approach to find additional articles (Arksey & O'Malley, 2005; Boland et al., 2014). We found no theses but anchoring (studying reference lists from the retrieved publications and other reviews) resulted in two articles (Azeem et al., 2015; Fisher, 2003). Finally, we included 12 scientific articles in the review.

We chose not to include 'grey' literature in the review. Consequently, we may have missed relevant information that may have been published in books and local, non-indexed journals and unpublished literature (Boland et al., 2014). Initial searches indicated, however, that the keywords led to lots of literature about debriefing from other contexts, primarily for survivors or witnesses to catastrophes and care providers after crises. We considered therefore the utility of including this material as minimal.

In scoping reviews, critical appraisal is not mandatory (Arksey & O'Malley, 2005; Briggs, 2019). To increase credibility for eventual recommendations for practice, we chose nonetheless to evaluate the studies (Briggs, 2019).

The qualitative studies were evaluated following the critical questions of Polit and Beck (2020), which explored all phases of the review. None of the articles were excluded, but we identified weaknesses such as a lack of theoretical integration, descriptions of the study population and analysis processes.

Assessments of quantitative studies were given narrative descriptions as none of them were comparable regarding design and outcome (Arksey & O'Malley, 2005; Pawson, 2002). Consequently, equal quality criteria could not be used.

Article authors were contacted for missing or unclear data (Azeem et al., 2011; Lanthén et al., 2015). Arksey and O'Malley (2005) recommend consultations by service users and practitioners. In retrospect, I see that by doing so, my preconditions regarding the studies' topics could have been further extended and strengthened the entire study.

As BMC Health Services Research requires, the whole review process was documented in a PRISMA 2009 checklist[1].

Individual interviews (Articles II and III)

Interviews are one of the most frequently used methods for generating qualitative data (Mason, 2018). As stakeholders were asked about their experiences and reflections, their perspectives could only be constructed or reconstructed in interviews. Consequently, data generated were dependent on the interviewee's capacity to remember, verbalize, interact, and conceptualize (Mason, 2018). As restraint events include extensive stress to both patients and care providers, the memory of what happened may be influenced by both internal and external factors.

Some of the patients were still inpatients when interviewed. Internal factors such as anxiety, hearing voices and problems with assessing the reality may have affected the interviews. Furthermore, external factors such as being an inpatient subordinated by the organizational and cultural traits of the services may have been experienced as a limitation. According Riessman (2008), sharing experiences with me as a stranger may be challenging for some patients. Participation of services user

---

[1] www.prisma-statement.org

researchers in the interviews could on the other hand have contributed to the patients speaking more freely (Rose et al., 2015).6

To care providers, moral uneasiness and distress may be reinforced when recounting the actual restraint episodes and the subsequent PIRs. Consequently, they may feel the need to appear as the best version of themselves when interviewed (Fog, 2019; Norvoll et al., 2017).

There might be bias in that care providers asked the patients to participate, especially for those who still were inpatients and were dependent on the care providers. On the other side, one may assume that patients who accepted to participate were particularly critical to the practices in mental health services and consequently wanted to contribute to what they considered as necessary changes.

Gatekeeping in the research field of caring is often driven by the general assumption about patients' vulnerability and further emphasising the duty to protect the patients (Carlsson et al., 2017; Kars et al., 2016; Witham et al., 2015). Inpatients may however be particularly vulnerable based on their mental health conditioning and further in a power-dependence relation to care providers and the services. Therefore, special assessments must be taken into consideration regarding ethical standards in the study. In addition to aiming to protect the patients, care providers could also have avoided to invite patients to participate in the study based on mistaken attitudes regarding their lacking competence to participate. Improving methods for recruiting patients to research studies seem therefore to be critical (Kars et al., 2016; Walker et al., 2020).

Norwegian was the spoken language during the interviews. An audio recorder was utilized, and I transcribed verbatim the material in detail myself afterwards as 'a tape-recorded and transcribed interview text lies closer to speech than to writing, especially if the interviewer herself/himself interprets it' (Lindseth & Norberg, 2004, p.148). Pauses were marketed by empty intervals in the text, in addition the interviewee's nonverbal and para lingual communication that seemed

relevant was also marked, e.g., a flicker with the eyes or a laugh out loud (Lindseth & Norberg, 2004).

Interviews with care providers (Article 2)

The care providers were recruited from Service 1 (17 participants from four units) and 2 participants from Service 2 (same unit). All the interviews with the care providers were held in the respective health services.

Nineteen care providers agreed to participate. Their ages ranged from 23 to 59 years, and their professional experience in mental health services ranged from six months to 25 years. The multidisciplinary selection of study participants consisted of nine nurses (two women/seven men), three social educators (two women/one man), four doctors/psychiatrists (all women) and three psychologists (two women and one man).

During the interviews, I realized that I had not succeeded in giving the care providers enough information about the study's topic as they initially started to talk about defusing (immediate staff debriefing) with their colleagues (Huckshorn, 2004; NICE, 2015). In two interviews, it emerged that the participants had not participated themselves in PIRs, but they still had considerations about the procedure and its significance to the ward unit's treatment and care.
Furthermore, I struggled to get a hold on how many PIRs in which the care providers had participated, but I perceived that almost all had participated in PIRs less than five times, while four had participated more than five times.

The interviews were conducted from March 2015 to May 2016 when we concluded that information power was achieved based on Malterud et al. (2016) model for sample size in qualitative studies.
The interviews were conducted in the participants' ward units (16) or the care providers' personal offices (3). The interviews lasted from 17 to 51

minutes, with a mean time of 33 minutes. The transcripts are verbatim and consists of 229 pages, letter size 12 and line spacing 1,5.

The shortest interviews were about busy working days, especially for doctors and psychologists. During the interviews, interruptions by colleagues occurred, which might have affected the possibility of reflecting on their experiences and considerations.

Interviews with the patients (Article 3)

Ten patients agreed to participate, nine women and one man. Six participants from four units were recruited from Service 1 and (four participants from two units in Service 2. Their ages ranged from 18 to 60 years. Five of the interviewees were still inpatients while they participated in the study, and the interviews took place in the respective ward units. The inpatients could choose whether the interview should take place in their room or in another quiet room in the ward unit. They all chose the latter. Five of the interviewees were outpatients when the interviews took place, and they could choose where they preferred to be interviewed. The interviews were performed in their homes (2), the university hospital (1), a mental health centre near the service user's home (1) and my workplace, the university (1). The patients were informed about their right to include a supportive person in the interview. One patient preferred to meet me together with her psychologist, and in one interview, the unit leader insisted that a care provider should be present for the sake of my safety. The patients did all give me their consent to record the interviews. Eight patients had participated in PIRs as inpatients, two had participated in one PIR, one in two PIRs, the others were uncertain about the number of PIRs in which they had participated.

The interviews lasted between 15 minutes and 90 minutes, with mean duration of 44 minutes. The longest-running interviews were those conducted with the discharged patients. The transcripts are verbatim and consists of 182 pages, letter size 12 and line spacing 1.5. The interviews began with a short introduction about me as a researcher and the study's

aims. I stressed the right to withdraw from the interview at any time without any consequences for them.

Ideally, I would have preferred some more patients to participate as the dialogues were some weak in some of the interviews. The time did however run out for more participants, and we considered the other dimensions in the information power model as relatively strong and consequently concluded to stop recruiting more participants (Malterud et al., 2016).

4.3.5 *Data analysis methods*

The three articles involve analysis of texts: Scientific articles (Article 1) and interview transcripts (Article 2 and Article 3).

The interviews were analysed separately in different phases of the study. Initially, I started analysis of data in Article 2. As I later decided to conduct a scoping review as a part of my thesis, the data from interviews with the care providers were put aside while I finished Article 1. By restarting the analysis in Article 2 after finishing and submitting the scoping review, my preunderstanding was changed by having a broader perspective in the work and thus extended openness regarding what the participants expressed in the interviews. Systematic analysis of the interviews in Article 3 was conducted after Article 2 was finished.
The software program NVivo 12 (2016) was used in all the analysis.

Article I

The included articles varied in quality and design, six quantitative studies, four qualitative studies and two studies using mixed methods. According to Cherry et al. (2014) combining qualitative and quantitative studies within a single review is challenging as the studies are conducted in different ways and the topics are not the same. Consequently, quality

assessment, data extraction, analysis and synthesis were conducted in different steps.

As the purpose of the study included both descriptions and experiences, we chose to use qualitative content analyses by (Graneheim et al., 2017; Graneheim & Lundman, 2004).

Study characteristics, questions regarding how PIRs were defined and described, how PIRs were conducted in practice, and variations in PIR use were identified as manifest content, that is content close to the text. The identified data were placed in a matrix and compared for equalities and differences (Graneheim et al., 2017; Graneheim & Lundman, 2004).

The qualitative studies described patients' and care providers' experiences of PIRs. The data were examined by using a qualitative content analysis by identifying meaning units, categories and, with some degree of interpretation, themes across the publications (Graneheim et al., 2017; Graneheim & Lundman, 2004).

Article II

A qualitative content analysis in several steps was used as a basis for analysing the data in Article 2 (Graneheim et al., 2017; Graneheim & Lundman, 2004). This qualitative content analysis method is claimed to be well suited to analysing multifaceted, sensitive, important phenomena regarding care, especially for a topic such as PIRs with limited knowledge. The method is based on a phenomenological-hermeneutical approach with descriptions of manifest content and interpretations of latent content. The latent content is interpretations of the underlying meaning or the 'red tread' between the lines in the text (Graneheim & Lundman, 2004). The transcribed text was first read several times to get an overview and understanding of what the care providers had expressed in the interviews. Then, I made memos of the initial impressions, the naïve comprehension of what the study participant had communicated (Hsieh & Shannon, 2005). Next, the text was decontextualized, which meant breaking the data into pieces. The text was divided into meaning

units, that is constellations of words, sentences and paragraphs that were related to each other (Lindgren et al., 2020). The meaning units were then condensed and labelled as a code by two researchers (UH and HS). With the aim of understanding the care providers' experiences and considerations, three researchers conducted the next steps of the analyses, that is sorting the codes and developing sub-categories (UH, HS and KV). Sub-categories were then abstracted into themes as demonstrated in article II.

In the phenomenological-hermeneutic interpretive process, similarities and differences were identified, balancing the parts and the whole (Gadamer et al., 2010), and in collaboration with all authors and the advisory group, two main themes were identified. Lately, re-contextualisation has been conducted by discussing the results in light of current research and relevant theory (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020).

Article III

The interviews with patients were analysed by using Lindseth og Norberg's (2004) method, which consists of 6 phases. This phenomenological-hermeneutical method, especially emphasizing hermeneutics, is claimed to be suitable to grab not only what the interviewee says, but 'what they talk about' (p.146).

Initially, naïve reading gave me a sense of the whole and a naïve understanding of what the interviewee had talked about. The participants' stories were partly dramatic and touching. It could be tempting to judge them as 'right' or 'wrong'. In the early stages of the analysis it was however my task to 'bracket' my urge to judge, focusing on the participants' story and aiming to be open to new perspectives (Lindseth & Norberg, 2004). Reflecting on my role as a participant, not an observer or a listener (Skjervheim, 1996), helped me to focus on the participant's narrated story (Lindseth & Norberg, 2004). In the last part of the interpretation, the sub-themes, themes and main themes were developed

in collaboration with my supervisor H.S. and colleague K.V. in relation to the research questions, the context of the study and reflections after presenting the findings to another research group in the health faculty and the advisory group. This reflection helped me to revise, widen and deepen the understanding of the findings and contribute to the discussion on how the findings may open possibilities for alternative practices.

In the whole process, I emphasised presenting the participants' perspectives as faithfully as possible and further formulate findings in everyday language as close as the lived experience as possible (Fog, 2019; Lindseth & Norberg, 2004).

4.4 Methodological considerations/Research rigour and quality (trustworthiness)

The quality of research findings should be evaluated based on the extent to which one can establish trust and confidence in the findings (Lincoln & Guba, 1985; Polit & Beck, 2020)

4.4.1 Article I

Transparency and methodological rigor increase the legitimacy of the findings in scoping reviews (Davis et al., 2009). Therefore, we emphasised describing the entire review process as precisely and clearly as possible. Support from a qualified librarian in the search strategy and quality assessment of the selected studies increased the trustworthiness of the review. Another enhancement is that the research team in sum had sufficient content and methodological expertise for the review (Colquhoun et al., 2014; Levac et al., 2010).
We did not consult stakeholders during the review process. Doing so could have contributed to more nuanced results (Arksey & O'Malley, 2005; Levac et al., 2010).

4.4.2 *Article II and III*

In qualitative research, the criteria suggested by Polit and Beck (2020) were used to evaluate the findings' trustworthiness, that is credibility, dependability, conformability, transferability and authenticity. Trustworthiness should be a continuous process throughout the whole project (Kvale et al., 2015), and the five criteria are elaborated in the current sub-chapters.

Credibility

Credibility deals with the focus of the research and how well the findings address the aim of the study (Graneheim & Lundman, 2004). Selection of context, study participants and method for gathering data are central issues to consider.

Credibility was strengthened in sub-study II by including a sample of multidisciplinary care providers with sufficient information power about the studied topic (Malterud et al., 2016). The care providers covered though significant variations and had what we considered as relevant experiences of PIRs. The 19 care providers covered diverse specialities (nurses, social educators, psychologists, and medical doctors), which ensures representation also from different roles (therapists and milieu therapists).

Regarding sub-study III, we searched for some more study participants aiming at broader assessment and understanding of patients' experiences and considerations of PIRs. We considered the eight interviewees to contribute to sufficient information based on their being highly specific for the study's aim, as they had experiences of participating PIRs or had not being offered PIR after traumatic restraint incidents. Further, the dialogues were strong, and they presented significant variations of PIRs (Graneheim et al., 2017; Malterud et al., 2016).

To enhance credibility, we followed Graneheim & Lundman's recommendations by presenting representative quotations from the

transcribed text, as quotations may illustrate how well categories and themes cover data (Fleming et al., 2003; Graneheim & Lundman, 2004). In both empirical sub-studies, preliminary findings including quotations were incidentally presented to co-researchers, the advisory group and other research groups at the University (Graneheim & Lundman, 2004).

Transferability

Transferability is an aspect of trustworthiness that refers to whether the findings of the study can be transferred to similar contexts or are applicable to other groups (Polit & Beck, 2020).

Replication of qualitative research is however not possible, based on different researchers in different locations and different times, and consequently the participants' different characteristics and effect on each other and lately the hermeneutics processes involved in the research phases (Blaikie & Priest, 2019).

An assumption for transferability is that there is a degree of congruence between the context in which the research was conducted and the one to which the findings are to be transferred (Blaikie & Priest, 2019).

The two participating services were two of few Norwegian services that had implemented PIRs at the start of the study. Consequently, they do not represent Norwegian mental health services generally. They are however subject to the same general conditions, national directives and guidelines, and legalisation as other national mental health services. Nevertheless, the findings indicate that the two services' discourses, e.g., organizational and cultural straits are in line with suitable services. Therefore, it will be relevant that the findings may call recognition and resonance in equivalent services (Blaikie & Priest, 2019).

Furthermore, I have sought transferability all throughout the project by describing contexts, sample, data collection and analysis (Polit & Beck, 2020). An extended insight of in the ward units' contexts by participatory observation could have achieved increased understanding of the ward

units' care philosophies. The Regional Ethical Committee did however not allow for this method.

The findings are presented with the participants' quotations. It will however be the readers' assessment with respect to decide if the findings are transferable to other contexts (Graneheim & Lundman, 2004).

Dependability

Dependability in qualitative research 'refers to the stability or reliability of data over time and over conditions' (Polit & Beck, 2020, p.569). A central question relevant for dependability is whether the findings would be repeated if the research had been conducted with the same (or similar) participants in the same (or similar) context? Duplicating this study would however be difficult. Qualitative interviews are a co-creation between two unique persons (Blaikie & Priest, 2019; Graneheim & Lundman, 2004; Kvale et al., 2015), in this project me as a researcher and the study participants, the patients and the care providers. Furthermore, location and time and the hermeneutic processes involved may result in other findings (Blaikie & Priest, 2019). I made however sure that all topis in the interview guides were covered in the interviews, the follow-up questions did though change based on the interviewees' utterances and my improved knowledge of the phenomenon (Kvale et al., 2015). Aiming to strengthen dependability in the study, I have in the articles and in this thesis provided detailed explanations of all the steps in the research project (Blaikie & Priest, 2019).

The interviews were conducted in the period of 2015 to 2018, all except one before the revision of the Mental Health Care Act on 1 September 2017.
I must therefore make certain reservations that the findings may have been different if the study were conducted now, based on eventual changes in practices after the change in law. There is however evidence that patients' experiences of changes when such laws are being revised, are generally poor (Campbell et al., 2018).

Confirmability

Confirmability is concerned with objectivity, that is whether the findings reflect the participants' voices or the researchers' biases and perspectives (Polit & Beck, 2020). My preunderstanding could therefore contribute to biases, therefore continuing reflections and discussion of the researcher's role and presuppositions functioned to ensure confirmability. However, understanding is not possible independent of language and cultures (Fleming et al., 2003; Gadamer et al., 2010). The importance of having knowledge about practices in mental health services, both present and past, became especially central in the interviews with the patients, as some of their stories were painful and touching (Fog, 2019). That knowledge helped me to open and receive the patients' stories with a compassionate approach.

Authenticity

Authenticity demonstrates the extent to which researchers in qualitative studies 'fairly and faithfully show a range of different realities in the collection, analysis and interpretation of data' (Polit & Beck, 2020, p.778). Authenticity may be challenged if there is not congruence between the degree of interpretation and level of abstraction. Therefore, we were aware of this issue and worked constantly with the necessity to secure that the descriptions of categories and themes were one the same level with respect to abstraction and interpretation.

Furthermore, we increased the authenticity of the findings as we emphasised that the researchers' account corresponded closely to the study participants' account (Blaikie & Priest, 2019; Graneheim et al., 2017).

4.5 The researcher's role

My role in the project was to initiate and facilitate the working processes. I was responsible for the search processes to Regional Ethical Committee and NSD for approval of the study. I conducted and transcribed all the

interviews, and conducted the first part of the analysis – systematization and categorization – in collaboration with my main supervisor H.S. In the next steps, co-supervisor (R.N), and research colleagues Randi W. Aas (article I) and Kari Vevatne (articles II and III) engaged in the next steps of the analyses.

4.6 Ethical considerations

4.6.1 *Role as researcher*

As an experienced mental health nurse, I have experience executing restraint measures, and I understand the context of Norwegian mental health services. The familiarity with the research field may therefore be a challenge by risking taking the interviewees utterances for granted and thus not being enough curious and open to what they wanted to communicate. Therefore, I tried to focus on that risk both in the interviews and when I listened to them afterwards. I consider my stance as a researcher to be a combination of *mediator of languages* and a *reflective partner* (Blaikie & Priest, 2019, p. 45). Both stances reject the idea of detachment as my preunderstanding, marked by my interests, experiences, and assumptions, together with historical retrospectives, will have a bearing of the research results.

Based on my theoretical and empirical background, I am trained in talking to other people about difficult issues. Even though I had reflected on my role as a researcher in the front edge, I experienced in some of the first interviews with the patients that I was tempted to act like a nurse, aiming to communicate hope. I discussed some interviews with one of the supervisors aiming to get feedback that could benefit coming interviews.

Furthermore, I have tried to be conscious about my responsibility as a researcher regarding how I write about the participants, aiming to retain the original meaning of their statements through the analysis projects and further how I put things together (Carlsson et al., 2017; Fog, 2019).

4.6.2 *The interview situations*

The participants shared personal and challenging experiences in the interviews, especially the patients that related some of their restraint experiences to shame and guilt. In the interviews with the patients, I tried to be particularly conscious of the power imbalance between the interviewee and me (Fog, 2019; Kvale et al., 2015). Inspired by Gadamer et al. (2010) and Skjervheim (1996), I strived to take a 'participant position', focusing I – you and the matter itself, the contrary to an 'observer position'. As a researcher, I was therefore concerned with the participants' right to set limits on what they wanted to talk about. If I asked any questions, they felt uncomfortable answering, they were encouraged to say so, as a few of the patients did. The information provided to the patients and care providers before inclusion in the studies are presented in Appendix III.

As patients in mental health services are particularly vulnerable in interview situations based on their mental health state while being admitted and the power imbalance between them and me as a researcher (Carlsson et al., 2017; Fog, 2019), I therefore elaborate some ethical considerations regarding the interviews.
I ensured that all the patient participants, both inpatients and outpatients, had the opportunity to talk with a professional clinician afterwards if they should need any, by doing concrete appointments with the respective leaders of the ward unit or the service.
Several patient participants said in the end of the interview that they were glad to get an opportunity to contribute with their lived experiences. One of the women who had never been offered a PIR concluded that she had decided to tell her story one last time in the interview. Furthermore, she said that she hadn't talked with others about what happened when she was restrained as she talked now with me about it. On reflection, after reading the whole interview again, my impression was that using time at the particular the time point, in her own home with another person who seemed to believe what she said, may have given her that experience. I

did not during, or after the interview, register 'breaks', the phenomena that may occur if rules for communication in a defined context are violated (Fog, 2019).

Taken into consideration ethical challenges regarding studying patients' restraint experiences, I was particularly attentive to the interviewees' emotional reactions during the interview. Furthermore, due to the researcher's responsibility to the participants in the study – here people with severe mental health problems – we emphasised handling the data respectfully, especially interpretation of the data (Carlsson et al., 2017; Fog, 2019; Mason, 2018).

Some of the participants were taciturn and presented some speech where there were some difficulties maintaining consistency during the interview. As this may imply risk of fragmentation of the participant's intended meaning, we emphasised awareness about the importance of interpreting the participant's responses in accordance with his or her intentions (Elo, 2008).

4.6.3 Consent and approvals

According to Norwegian law, the study was formally evaluated by the Regional Committee for Medical and Health Research Ethics, REK, which deemed the study as outside of their responsibility because it was regarded as 'health services research' (2013/2359/REK south-east). Application for acceptance for participatory observation in the services' ward units was however rejected because it was not feasible to receive formal informed consent from every participant in the mental health wards in which the research would take place. The Norwegian Social Science Data Service did, however, assess and approve the study (ref. no. 39122). Permission was granted from the university hospital and the mental health community centre prior to the study.

In line with the Helsinki Declaration (World Medical Association, 2013), written and oral information was provided to the participants on their

right to withdraw at any stage without explanations or consequences. To the patients, especially inpatients, it was essential to repeat the information about the study, that included the interview, analyses of the interviews and a given right to publish the results (Mason, 2018).

4.6.4 *Anonymity*

Regarding anonymity, principles in Helsinki Declaration (2013) were followed in the entire study. The participants in the study were assured that their consent and anonymity were secured in the whole process.

The contact information identifying the participants was kept locked in a cupboard in a locked room. Identifiable information that emerged in the interviews were unidentified in the transcripts. Participants were allocated pseudonyms in the articles.

Particular attention has been paid to anonymising the participants' utterances, aiming to protect individual participants from being linked to any particular meaning content.

5 Findings

The findings from the three sub-studies are summarized in this chapter.

5.1 Post Incident Reviews – a potential for knowledge development, recovery promotion and restraint prevention (Article I)

Article I reports findings from a scoping review where the aim was to identify the prevailing knowledge basis of PIRs. The research questions were: (1) How are PIRs defined and described? (2) How are PIRs conducted in practice, and what are possible variations in PIR use? (3) What are patients' and care providers' experiences on PIR?

We found a dearth of studies exploring PIRs after use of restraints alone, so studies exploring PIRs after restraints and seclusion together were included. After systematically searching in multiple databases, twelve scientific publications matched the inclusions criteria. The included studies were conducted in the USA (5), Canada (3), England (2) and Sweden (2). They varied in methods and focus, and the findings were difficult to compare. The findings indicated however that S/R reduction programs including PIRs seem promising regarding reduction in frequency and duration of S/R in mental health services. PIRs were often found to be one of several components in restraint reduction programs, but there was no significant outcome related to PIRs alone.

There were few studies exploring patients' and care providers' experiences and opinions of PIRs. The few participating patients reported satisfaction over being offered a PIR and in one study service users reported PIRs as helpful in the processing of the event. Furthermore, care providers reported PIRs to 1) *be an opportunity to review restraint events, they would not have otherwise had*, and 2) *promote patients' personal recovery processes*, and 3) *stimulate professional reflection on organizational development and care.*

The conclusion was that PIRs have the potential to contribute to more professional and ethical practices regarding restraint promotion and the way restraint is executed. The PIR practices varied regarding participants, timeframe, form and content of the encounter. The review revealed a knowledge gap as patients' and care providers' experiences and considerations of PIRs were scarcely explored. Consequently, the findings provided a basis for article II and III.

5.2 Post incident reviews - a gift to the ward or just another procedure? (Article II)

Article II reports 19 multi-professional care providers' experiences and considerations regarding post incident reviews after restraint in mental health care. The analysis revealed a tension between care providers experiencing PIRs to have a *potential to improve care* and the experience of *struggling to get a hold of the patients' voices* in the encounter.

The care providers experienced PIRs to have the potential to improve the quality of care through a) *knowledge of other perspectives and solutions,* b) *increased ethical and professional awareness,* and c) *emotional and relational processing.* The interviewees talked about both alternative coping strategies to the patients and alternative professional interactions. Furthermore, the care providers experienced PIR as a genuine venue for dwelling on the incident together with the patient and thus retrospective and prospective reflections. As a result, care providers considered this common reflection to contribute to more professional and individualised care.

About half of the care providers had experienced struggling with getting a hold of the patients' voices in PIRs. They believed this challenge to be connected to 1) *patient related conditions* 2) *care provider related conditions* and 3) *structural and cultural conditions.* Patient-related conditions were about the patient's mental state and what the care providers perceived as difficult feelings after being restrained. In addition, care providers assumed that the patients' previous experiences

of lack of influence as inpatients could be a relevant argument for the patients' passivity in PIRs.

Furthermore, care providers talked about their own uncertainty over how to conduct the PIR in an optimal way for all participants, but also moral uncertainty over whether PIRs were always appropriate for the patients. Structural and cultural conditions dealt with how the PIRs were conducted when coming to the practical arrangement in terms participants, timeframe, numerous imbalances, atmosphere and communication in the encounter.

The care providers' utterances regarding PIRs in the interviews indicated a spectrum reflecting both acknowledging and disciplinary approaches in their meetings with the patients.

5.3 Post incident Reviews after Restraints, - Potential and Pitfalls (Article III)

The aim of this sub-study (Article III) was to explore patients' perspectives on participation in PIRs in relation to exploiting PIRs' intentions. The research questions were (1) What are patients' experiences and considerations about PIRs after restraint events? and (2) How do patients view PIRs' potential for care improvement and restraint prevention?

The analysis revealed two main themes. The patients experienced participation in PIRs as *an arena for recovery promotion* or PIRs as *continuation of coercive contexts.*

PIRs as an *arena for recovery promotion* confirmed PIRs' beneficial potential for the patients. Participants spoke about *being strengthened* in the PIR based on being prepared for the meeting after receiving information about the purpose of the PIR in advance and further experiences of PIR as an arena where their experiences and views were acknowledged. Furthermore, PIRs were considered as a possibility for *processing the restraint event* that several participants had experienced as physical and psychological infringement. None of the patients spoke

of damaged relationships related to the restraint event or processing relationships in the PIR.

The processing dealt with getting the care providers' comprehension of what had happened before the restraint decision and further their justification, and sometimes an apology for the care providers' handling of the situation. PIRs were also considered as an arena for *developing new coping strategies.* The patients learnt to signal a need for support earlier and received thus the necessary individual support to manage their situation when they struggled.

Patients who experienced PIRs as *continuation of coercive contexts*, spoke about not being sure if they had participated in PIRs or ordinary therapeutic consultations. Furthermore, they spoke about having no influence neither in the ward unit generally, that they considered was characterised by restrictive practices, nor in the PIR. Consequently, they considered participation in PIRs as *meaningless* and did not speak much in the encounter.

The participants did also talk about PIR experiences that they characterised as *being met as an object.* They told about their feeling of fitting into a category in a practice that was experienced as manual-based as the PIR form did not cover what they felt the need to talk about. Lastly, the participants talked about being disappointed after the PIR based on a marginal timeframe and the form and content in the encounter. They expressed *a need for living communication and closeness* in the PIR. Documentation of the PIRs was not mentioned spontaneously in the interviews. By my request, one patient in Service 1 confirmed that she had received a copy of the report that documented the PIR in which she had participated.

5.4 Synthesis of findings across sub-studies

Based on the aim of this study – to explore PIRs' potential to promote quality improvement in terms of human care values as participation – influence and collaboration according to the body of scientific

knowledge and experiences from care receivers and care providers, a synthesis of the findings in the three sub-studies will be presented.

Table 4 Overview of findings (Articles I, II and III)

Post-incident reviews – Between authoritarian and dialogical approaches				
Article I	**Article II**		**Article III**	
Theme 1 The practice of PIRs varied, so a specific manual cannot be recommended	**Main theme 1**: PIRs' potential to improve the quality of care	**Main theme 2:** Struggling to get hold of the patients' voices	**Main theme 1** PIRs as an arena for recovery promotion	**Main theme 2** PIRs as continuation of coercive practices
Theme 2 S/R reduction programs, including PIRs, contributed to significantly reducing S/R episodes	**Category 1** Knowledge about other perspectives and solutions	**Category 1** Patient related conditions	**Sub-theme 1** Being strengthened	**Sub-theme 1** Meaningless
Theme 3 Being an opportunity to review restraint events they would not have had otherwise	**Category 2** Increased professional and ethical awareness	**Category 2** Care provider related conditions	**Sub-theme 2** Developing new coping strategies	**Sub-theme 2** Feeling objectified
Theme 4 Promote patients' personal recovery processes	**Category 3** Emotional and relational processing	**Category 3** Structural and cultural related conditions	**Sub-theme 3** Processing the restraint event	**Sub-theme 3** Longing for living communication and closeness
Theme 5 Stimulate professional reflection on organizational development and care				

Table 4 shows how experiences from patients' and care providers' perspectives from a Norwegian context can contribute to the body of scientific knowledge by highlighting PIR's potential to quality improvement in mental health services. However, the empirical articles did also reveal pitfalls regarding PIRs that we have not found in previous studies and consequently were not presented in our scoping review.

The Scoping review (Article I) contributed to defining PIRs and further describing how PIRs were conducted in international practices. PIRs were commonly found to be one strategy in comprehensive S/R reduction programs in services based on human care philosophies. Furthermore, PIRs were conducted in different contexts, and in various ways when coming to either oral, or both oral and written evaluation, further participants, timeframe, and content. A supportive and non-threatening atmosphere in the PIRs was suggested. Based on the included quantitative studies, we could not confirm PIRs' contribution to the reported S/R reduction.

In sum, the three articles come together to find PIRs to be a potentially beneficial procedure to both patients and care providers. A main theme in Article I and Article III was PIRs potential to support patients' personal recovery processes. PIR's potential to improve the quality of care, a main finding in Article II, may further support the patients' recovery processes by increased professional and ethical awareness and care providers' extended knowledge about the patients' perspectives and solutions and thus more individual and adapted care.

The three articles confirmed all the value of *processing* the restraint incident in the PIR. The processing dealt however with three perspectives/dimensions; (1) reviewing the incident by mapping what happened before and during the restraint event, aiming new perspectives and solutions in the future, (2) patients' processing of the restraint event by increased understanding of what happened by getting the care

providers' perspectives and further a possibility to give their feedback and (3) care providers' possibility to present their grounds for using restraint and further processing their personal restraint related experiences. PIRs as beneficial regarding processing damaged relationships as suggested in Article I and II, was not reported from patients' perspectives.

Ethical dimensions were presented in all three articles. Articles I and II present PIRs to contribute to increased ethical awareness. The patient participants in article III pointed at ethical values through their longing for care providers' recognition of the graveness of coercive measures and further being met as human beings in the PIRs.

The empirical articles do however nuance the findings of the utility of PIRs, that were described in the scoping review. The findings in the empirical articles revealed the services' failure to stimulate the patients' engagement, and subsequently get a hold on the patients' voices in the PIRs. Patients and care providers pointed at structural and cultural frames in the services, including the power imbalance, to influence the overall outcome of the PIRs. The varying experiences were dispersed at various ward units, which indicate that the stakeholders' personal characteristics influenced on the experiences.

Seeing the findings in this thesis related to the definition of PIRs (Goulet & Larue, 2016), the findings do first and foremost confirm 'meaningful learning' (p.212) for patients and care providers as an outcome of PIRs. The second goal in the definition of Goulet and Larue (2016), 'enhancing the care experience' was not a distinct finding in this thesis, even though (a few) patients' experiences of processing the restraint event indicate this possibility.

Related to the Norwegian aims of PIRs (Norwegian Health Directorate, 2017), learning, prevention of new restraint events and quality development, the findings call attention to learning for patients and care providers as a pronounced finding. Both patients and care providers in

the empirical studies pointed at feasible restraint prevention as a result of patients' new coping strategies and the improved quality of care. Based on the study's design and limited number of participations, we cannot, however, conclude so.

Considering quality development to include care providers' competence development and patients' involvement (Norwegian Health Directorate, 2019; Norwegian Social and Health Directorate, 2005), the findings point to care providers' experiences of PIRs as a tool to improve the quality of care, a main finding in Article II.

Quality improvement in the services as an outcome of PIRs was only a finding in article I, as PIRs were found to stimulate professional reflection on organizational development and care.

Based on the findings in the three sub-studies, an assumption for aiming the defined goals on PIRs (Goulet & Larue, 2016; Norwegian Health Directorate, 2017) is seeing PIRs as a part of a greater whole, here the services' care philosophies and thus structural and cultural frames.

6 Discussion

The overall aim of this study was to explore PIRs' potential to promote quality improvement in terms of in terms of human care values such as participation, influence and collaboration, according to the body of scientific knowledge and experiences developed by care receivers and care providers in mental health services.

In this section, I will discuss the three studies and the synthesis as a whole in light of relevant theory to get a comprehensive understanding in a higher level of the hermeneutic spiral (Dahlberg et al., 2008).

6.1 Knowledge development – perspectives and assumptions

Within a framework of human care philosophies, patients' and care providers' collaboration in the practical field may result in the development of new knowledge that may benefit both parties (Martinsen, 2005; Slade, 2009). Slade (2009) claims that care providers' task within a personal recovery perspective will be to support the patients' inherent resources by working out more suitable coping strategies, as demonstrated in the empirical articles in this study. Coping strategies, which make the patient more independent, may support personal recovery processes such as empowerment, identity and hope (Leamy et al., 2011). According Martinsen (2003) independence must though not be mistaken for today's ideal of autonomy, which devalues fellowship and solidarity – central values in care ethics.

Most patients in sub-study III did not consider learning as a central outcome of the PIRs. Their experiences of *being objectified* together with the *disciplining approach* that emerged from care providers' perspectives (Article II), indicate that the patients' experiences were characterised by attitudes and practices in line with the traditional clinical recovery perspective. In light of Goffman's theories, (Goffman, 1961/1991) this perspective views patients' learning as arising in the

form of correction. Care providers' *disciplining approach* (Foucault, 2001) may thus result in counter behaviour (Foucault, 1975; Goffman, 1961/1991) in the form of patients' active resistance, such as assaults and acting-out, or passivity and non-participation, the latter demonstrated in both of the empirical articles.

According to Miller and Crabtree (2005), 'a healing landscape is a learning landscape, a terrain where hope flourishes over time' (p. 47). They underline the significance of a resource-oriented, learning-oriented, and relation-centred approach as an assumption for the healing landscape, approaches that are in line with values in human care philosophies.

In our scoping review (Article I), we discovered the necessity of a supportive and non-punishing environment (Azeem et al., 2011; Bonner & Wellman, 2010; Goulet et al., 2018; Petti et al., 2001) and further implicit in the definition of Goulet and Larue (2016) that states that PIRs are to 'enhance the care experience' (p.212). The procedures in the participating services in this study did, however, not include recommendations about environment in the PIRs. Lack of a supportive environment may thus result in patients' learning outcome in PIRs will be scarce (Faccio et al., 2020; Goffman, 1961/1991; Secker et al., 2004). The findings in the empirical articles, especially Article III, indicate that the patients' expertise by experience in a low degree has been requested and taken into account in the participating services' practices (Ekeland, 2011; Slade, 2009).

Learning for care providers as result of participation in PIRs may include listening to patients and colleagues and further reflection on own actions, that is claimed to be a central quality in knowledge production and professional development (Mann et al., 2009; Schön, 1987, 1991). Donald A. Schön (1991) introduced the concept of the ''reflective practitioner'' as he claimed that technical knowledge alone is not enough to solve complex problems on a daily basis. The reflective practitioner may extend their competence, and thus action options by

'reflection in action' and 'reflection on action'. 'Reflection in action' is reflecting in the midst of the action, often stimulated by surprise, while 'reflection on action' is returning to the experience and thus reflection after the action is finished. 'Our reflection on our past reflection-in-action may indirectly shape our future actions' (Schön, 1987, p.31). Schön's theories seem suitable in this study's context (mental health services) where new situations constantly occur – here possible or stated restraint events – where the legislation allows for interpretations and where knowledge regarding optimal care regarding prevention and managing restraint seems to be scarce described, at least in Norwegian professional textbooks.

In light of Schön's theories (1991), by 'reflection on action' in the PIRs, the care providers in this study received wider perspectives on the restraint event by hearing the patients' perspectives of what happened and their views on alternative measures. Therefore, participation in PIRs may result in changing in attitudes, and further extended repertoire of alternative measures, and thus another competence in giving care in stressful occasions (Tronto, 1993). The care may consequently be conducted more in accordance with the patients' needs, that includes to support the patients to apply their enlisted copings strategies (Slade, 2009).

As quality improvement and restraint reduction are strongly connected, as demonstrated in S/R reduction programs (Guzman-Parra et al., 2020; Huckshorn, 2004; Wieman et al., 2014), I will therefore pay attention to the fact that the two participating services neither based their practices on an explicit defined human care philosophy, nor had implemented the PIR procedure as a part of a S/R reduction program. Therefore, it is relevant to discuss whether inclusion of the other central core strategies (active leadership toward organizational change, using data to inform practice, developing the workforce, using S/R prevention tools, actively including consumers and advocates in the care setting) (Huckshorn,

2004; Wieman et al., 2014) might enhance the findings with respect to the experienced utility of PIRs.

Use of data to inform a practice that is regularly used to evaluate and discuss the services' reported episodes of S/R may contribute to an extended understanding of variations in coercion, both in each ward unit and in the service as a whole. I did not, however, during the study period, request the services' use of data as an additional strategy for restraint prevention. Further, previous studies do indicate that leadership towards organizational changes is an assumption for organisational changes. In this study, the patients' experiences of minimal influence and the care providers' uncertainty regarding PIRs indicate thus a need for attention to the two first phases in Tronto and Bernard's care model (1993), 'caring about' and 'taking care of' (p. 106). That implies challenging the services' managers with respect to the elements of care, such as attentiveness and responsibility (1993). This is related to mental health services, which attempt to facilitate organisational frames that include defining and articulating a mission and philosophy about S/R reduction and further enable care providers' competence for care-giving (Tronto, 1993) so as to ensure optimal conditions for patients, family members and care providers (Huckshorn, 2004).

In this study, the patients' experiences of minimal influence and the care providers' uncertainty regarding PIRs indicate thus a need for attention to the two first phases in the care model (Tronto, 1993), 'caring about' and 'taking care of' (p 106). Consequently, responsible managers in the services must thus, by clear leadership (Huckshorn, 2004) and the ethical care elements attentiveness and responsibility (Tronto, 1993), stimulate to strengthen the patients' inclusion in the care setting. Further, the responsibility includes to ensure that the care providers are given sufficient competence to conduct PIRs in a supportive and confidently environment. The care providers' proposals in article II, that were professional reflection, information, education, and volume training in PIRs, should therefore be taken to account.

6.2 Tied to the role as passive patient, but still met with expectations about active participation?

The results of the empirical studies indicate that care providers had expectations of active participation from the patients in the PIRs, who at the same time were dedicated to the system characterized by few opportunities to influence in other areas. Although mental health services have undergone major changes over the last decades, the participating services do still have features that may be compared to total institutions (Foucault, 2001; Goffman, 1961/1991). Despite public guidelines and laws claiming active participation when decisions should be taken, inpatients still report to be met with authoritarian attitudes and consequently marginal influence (Husum et al., 2019; Valenti et al., 2014; Waldemar et al., 2018). In this study, similar experiences were expressed in the patients' descriptions on their status as inpatients, the restraint incident itself and further in their participation in PIRs. The latter was illustrated by several patient participants' experiences of the PIR procedure form as restrictive. Examples were missing possibilities to talk about themes beyond the form and further care provider participants in the encounter who in a low degree could contribute to clear up when different comprehensions of the restraint events emerged.

According Larry Davidson et al. (2017), the purpose of mental health care is to empower the patients to take control and actively participate in decisions concerning their own treatment and care, that is supported by Norwegian authorities (Norwegian Health Directorate, 2014, 2017). According to Borge and Hummelvoll (2008); (2019), a premise for participation will however be pleasant surroundings characterised by a confirming atmosphere to facilitate learning, interaction and collaboration – processes that are fundamental to the personal recovery processes.

The findings in the empirical studies point to the power-dependence imbalance in the relationships between patients and care providers as a

barrier to patients' active participation in PIRs. According to Emerson (1962), the inpatient will be highly dependent on the care providers in a 'person-group relation' as one, especially when involuntary admitted, has few or none other options to get what one needs outside the patient - care provider relation. Related to PIRs, information about the purpose and aim of PIR seems to increase the patients' motivation for participation in the encounter, consequently the patient's dependency may be reduced based on a common understanding. On the contrary, the care providers define the goals, and the patient may, because one has no alternative, adapt based on 'the coercive shadow' (Szmukler, 2015).

In light of Emerson (1962), patients' reported passive positions in the PIRs may thus be understood as cost reduction by defining PIRs as indifferent. A corresponding strategy may be the patient's adjustment of one's master status to a 'psychiatric patient' status (Goffman, 1961/1991; 2009). By withdrawing or accepting the given identity as mentally ill, which opinions are not worth being requested, the patient may be less frustrated, but the power imbalance will not be changed (Emerson, 1962). Pursuant to Emerson, a withdrawal strategy will be a disadvantage to the patient, which agenda will not be expressed in the PIR. The care providers' advices and prepared plans may thus be ignored by the patients (Greenhalgh et al., 2015).

Extension of the power network (Emerson, 1962) related to PIRs, may by including advocacy (Levy & Payne, 2006) peers, user consultants or other trusted persons empower the patient and thus reduce the imbalance in the power-dependence relationship (Ridley et al., 2018). Provided that the patient is comfortable with the support person, one may achieve a more supportive atmosphere in PIRs, which is suggested Article I.

Emergence of status (Emerson,1962) associated with PIRs' can be achieved by including the patient in the practical planning of PIRs and further striving for an 'I - Thou' face-to-face meeting (Buber & Smith, 2004; Skjervheim, 1996) with the care providers' focusing the patient's defined goals and further a common strategy sharing the responsibility for preventing new restraint events.

Nevertheless, the findings indicate patients' basic scepticism regarding PIRs to be based on their previous experiencers as inpatients characterised by a clinical recovery perspective (Slade, 2009). Therefore, the findings, supported by Norwegian Health Directorate (2017) challenge the services' practices regarding facilitation of patients' active participation, not only in the PIRs, but in their treatment and care in general.

6.3 Care providers in tension between coercive contexts and the authorities' recommendations regarding recovery-oriented practices

Changing legal and policy contexts have created calls for new forms of decision-making by mental health care providers (Norwegian Health Directorate, 2014; Norwegian Ministry of Health & Care Services, 1999). The patients have a pronounced right to participate in decisions regarding their own treatment and care, which implies different roles for care providers than those found within traditional clinical recovery perspectives (Slade, 2009).

The findings in Articles II and III showed that care providers and patients had varied experiences and views of PIRs. The findings were however partially congruent as both groups raised the challenge of taciturn patients in the encounters. Some care providers indicated that they were attentive to the fact that *structural and cultural conditions* in the services could be an explanation for the patients' passivity, but other care providers' utterances in the interviews indicated that they strongly identified their roles to conditions described in the literature as coercive contexts (Sjöström, 2006). Patients were divided with respect to satisfaction with respect to their participation in PIRs, indicating that the individual care providers met the patients with different approaches in the PIRs and consequently had different levels of attention and competence with respect to the patients' needs in the encounter

(Martinsen, 2005; Tronto, 1993). As the participating services neither had recommendations in the procedures regarding the environment in PIR or declared themselves to base their practices on defined care philosophies as suggested in the scoping review, the individual care providers had the responsibility and position for creating the climate in the PIRs.

Despite public recommendations to establish recovery-oriented practices in Norway, there are different comprehensions of the concept 'recovery' and thus consequences in practice and further lack of systematic guidelines for how to integrate recovery-oriented policies in the best way (Brekke, 2019; Slade, 2009). Care providers must therefore deal with competing priorities between demands from public recommendations, demands from the different service systems and service users' organisations (Brekke, 2019; Le Boutillier et al., 2015; We Shall Overcome (WSO), 2021; Aarre, 2018).

The public recommendations may, however, be experienced as incompatible. On the one hand they recommend recovery-oriented practices that focus on person-centred treatment and care, emphasising the patients' liberty and right to participation. On the other hand, central authorities present constantly statutory regulations in line with the New Public Management (NPM) model that includes increased requirements for standardisation and duty of documentation (Goffman, 1961/1991; Aarre, 2018). Patients' utterances regarding PIRs based on a form (Article III) and care providers stressing the services' timeframes for the PIRs (Article II) can be understood as such examples on standardisation. According to Martinsen (2005), this standardisation will go beyond professional judgement and thus the quality of care, and consequently represent barriers to the patients' personal recovery processes.

The challenge of *getting a hold on the patients voices* in the PIRs, pursuant to Tronto (1993) lack of responsiveness from the care receivers, will consequently deprive the care providers opportunities to provide to 'caring well' (p. 108) that requires that all phases of the care process is

taken care of (Tronto, 1993). Failing to get close to the patient due to non-responsiveness may also open up the care providers' vulnerability (Todres et al., 2014). They may find themselves in complex care settings characterised by moral and professional distress based on difficulties in knowing what is optimal to do according to meet the patients' needs. Institutional constraints may thus impede their care exercise and it may be argued that the care providers 'are trapped within an institutional model' (Cowman et al., 2017, p.7) which consequently affect the treatment and care they can provide. According to Tronto (1993), inadequate resources and ignorance of care givers' needs may result in care deficits where the care givers went their frustration and anger to the care receivers. To safeguard the care providers' needs is therefore, pursuant to Martinsen (1990) and Tronto (1993), essential for maintaining their capacity for care-giving. That implicate again the authorities' and services' 'caring about' and 'taking care of' (Tronto, 1993) to organise arenas where the care providers' needs can be secured, such as competence development, that includes education and supervision, and further safeguard their personal needs to process restraint related events both individual and in ethics reflection groups (Hem, Molewijk, et al., 2018; Huckshorn, 2004; Mangaoil et al., 2018).

6.4   PIRs as an arena for recognition

An overarching aim in the revision of Mental Care Act (1999, latest revision 2017), was to increase the patients' right of self-determination and legal protection in mental health services. Evaluation of all kinds of coercion, here through PIRs, is only one of the revisions, but it is still relevant to discuss PIRs' eventual contribution to the overarching aim.

Mechanical or physical restraints are violation of both human rights and all the four ethical principles, non-maleficence, beneficence, autonomy and justice, even though the care providers may give qualified grounds for their action (Beauchamp & Childress, 2009; United Nations, 1948). In light of Goffman (1961/1991) and Foucault and Sandmo (2000), the

findings in the empirical sub-studies confirm the risk of dehumanisation based on the patients' experiences of being met as an object in PIRs (Article III) combined with the care providers' disciplining approaches referred in Article II.

According Todres et al. (2009), dehumanisation takes place when humanizing dimensions as for example insiderness, agency and sensemaking are obscured. In light of Goffman's theory of total institutions (1961/1991), there is a risk for all dehumanising dimensions (Todres et al., 2009) to appear in today's mental health services, especially related to coercion. Being dehumanised causes the patient to suffer, resulting in increased risk of aggressive behaviour and further hampering the patients' personal recovery processes (Carlsson et al., 2006).

In this study, both patients and care providers referred to what they considered to be successful PIRs regarding the dialogue and outcome. The findings in the three sub-studies point toward value dimensions which are described in personal recovery based practices (Leamy et al., 2011; Slade, 2009), Todres et al. (2009) value framework and care ethics (Martinsen & Kjerland, 2006; Tronto, 1993) as pathways to re-humanisation after traumatic and humiliating restraint related experiences.

Patients' motivation for participation in the PIRs was described as minimal (Article III). According to Slade (2009), a recovery-focused approach to patients in crisis – here by the risk of damage oneself or others – minimises the loss of personal responsibility during crises, to maintain hope during crises and support identity in and beyond the crises. Bringing those approaches into the PIRs, requires ethical values that according Martinsen (2005) arise in the relation and the practical situation. As dignity and being treated with respect are core values in care (International Council of Nurses, 2012), a starting point will be bringing these values into the context of PIRs. By drawing on care ethics that includes the power-dependence imbalance (Tronto, 1993), one must

acknowledge that without the patients' responsiveness, one has failed to achieve the purposes of PIRs.

The patient must therefore be invited into the meeting as someone whose personal expertise, views and goals are worth listening to. Pursuant to Todres et al.'s (2014) theories of re-humanisation, care providers strive to understand the 'insider' perspective, even though it can never be grasped absolutely. Todres et al. (2014) claim that the process of 'reaching towards' the other person's insiderness may be more important than knowing details about the other person. In this process, I suggest looking to Martinsen's (2006) 'the perceiving eye', which means to include emotions and to see the other person in his or her integrity. According Todres et al. (2014), emphasising 'insiderness' provides 'a concern for the well-being of the patient and this constitutes a caring power' (p.7).

Striving to understand more of the patient's experiences may also support the patient's experience of perceived dignity (Gallagher, 2004). Consequently, focus in PIRs will then be the patient's and care providers' common goals and not the patient's bad behaviour as demonstrated in Article II. Further, the care providers inspired by Skjervheim (1996), will strive to meet the patients as participants in the PIR. Within a personal recovery perspective, the care providers must thus accept to deviate ones' traditional expert role in the PIR and attempt to meeting the patient in a partnership relationship where care providers' knowledge is deployed to support the patient's self-management (Slade, 2009). By developing alternatives to using restraint in collaboration may also strengthen the other forms of humanization as togetherness, sense making and agency (Todres et al., 2009). As situations construct identity (Goffman, 1967/2005), the care providers' role in the PIRs will in light of Todres et al. (2009) be to help the patient to nuance an eventually identity as confused, dangerous or mad, by supporting insiderness, and thus perceived dignity, in addition to sense-making if the restraint situation was unclear or without memories.

Altogether, the findings in the three sub-studies indicate PIRs to be an arena for recognizing the patients by questioning and valuing the patients' expertise-by-experience. Consequently, the patients' personal recovery processes may be strengthened and further contribute to more authentic care. The latter comprise strengthening the patient's self-determination as one's individual preferences regarding restraint prevention and restraint handling are expressed in the meeting and documented in care plans. Alternative solutions and perspectives may also strengthen the patients' legal protection based on development of more gentle measures aiming restraint prevention and therefore increased protection against 'degrading treatment and punishment' (United Nations, 1948, Article 3).

Recognition may however also include a need for the care providers' recognition of grievousness of using restraint that was in demand in article III and further confirmed in the literature (Ellingsdalen, 2016; Husum et al., 2019).

Consequently, conducting PIRs based on humanising values may be an arena for patients' rehumanising and thus recognition and perceived dignity. Furthermore, by receiving responsiveness from the patients, the care providers get an opportunity to change approaches and measures aiming to provide a more ethical and person-centred care (Tronto, 1993). Striving to promote the value dimensions in PIRs may, however, be useless if treatment and care take place in a context where a care philosophy is unclear or absent.

7   Conclusion

This thesis, that includes scientific knowledge and experiences from care receivers and care providers, contributes to an extended knowledge basis of PIRs after use of restraints in mental health services.

PIRs were found to be beneficial to patients and care providers, however pitfalls were revealed, as both dialogical and authoritarian approaches in the PIRs were identified.

One main finding is that participation in PIRs may be helpful to both patients and care providers with respect to (1) developing knowledge in collaboration and (2) processing the restraint event. Provided a supportive atmosphere in the PIRs, the encounter may be an arena for patients' personal recovery processes, recognition and rehumanisation after being restrained.

For care providers, PIRs were reported to improve the quality of care by increased professional and ethical awareness and knowledge about each patient's preferences for support when crisis occur. The care providers did also find PIRs helpful with respect to emotional and relational processing, which helped them to decrease restraint related stress.

Considering this thesis' findings, Norwegian authorities' intentions with the PIR procedure, learning, prevention of repeating restraint episodes and quality development seem only to be partly fulfilled as the care providers struggled to get hold on the patients' voices in the PIRs.

Internationally, PIRs are commonly implemented as one core strategy in S/R reduction programs that report promising results regarding S/R reduction. PIRs in the participating services were implemented as an isolated procedure, and the importance of conducting PIRs in a supportive atmosphere were not included in the procedures. The findings did also indicate that the intentions with PIRs not were fulfilled in services that still seem to base their practices on clinical recovery perspectives. Therefore, the findings indicate that facilitating PIRs an

optimal way should be the PIR procedure integrated with quality improvement, service development and treatment philosophies.

8   Implications

8.1   *Implications for clinical practice*

The findings show that PIRs after restraint events, including patients and care providers, can be helpful procedures due to their potential to improve the quality of care and to support patients' personal recovery processes. As PIRs were found to be conducted both with authoritarian and dialogical approaches, the following suggestions will improve PIR practices.

PIR procedures should be integrated in a framework of quality improvement, service development and treatment philosophies. They should not be implemented as an isolated procedure.
Responsible managers in the services must thus, through clear leadership and the ethical care elements of attentiveness and responsibility, ensure that care providers are given sufficient competence to conduct PIRs in a supportive and confidential environment. Care providers' proposals in article II, which contained professional reflection, information, education, and volume training in PIRs, should therefore be considered.

The services' procedures should initially emphasize the significance of conducting PIRs in a supportive, non-punishing environment. Patients should be offered PIRs in both oral and written form. The timepoint for PIRs should be considered by assessing the patient's mental health and further be agreed upon in line with the patient's preferences. The power imbalance in the PIR should be decreased through awareness regarding number and roles of the participants. The patient should be supported in the encounter by advocacy, a peer, a family member or another trusted person.

Safeguarding the care providers' needs is essential for maintaining their capacity for caregiving. This implicates again that the services' managers must take responsibility to organise arenas where the care providers'

needs can be secured, such as competence development that includes education and supervision and further safeguards their personal need to process restraint-related events.

Consequently, conducting PIRs based on humanising values may be an arena for patients' rehumanising and thus recognition and perceived dignity. Further, by receiving responsiveness from the patients, the care providers get an opportunity to change approaches and measures aiming to provide a more ethical and person-centred care. Striving for promoting the value dimensions in PIRs may however be useless if treatment and care take place in a context where a care philosophy is unclear or absent. Therefore, the findings challenge the services' practices regarding patients' active participation, not only in the PIRs, but in their treatment and care in general.

8.2   Implications for further research

This study has illuminated both beneficial outcomes and pitfalls regarding PIRs as a procedure after the use of restraint in mental health services. The findings contribute to the body of knowledge regarding PIRs, yet further research is needed.
The following themes regarding PIRs are unexplored:

How is the legal mandate with respect to PIRs from 2017 followed in Norwegian mental health services in respect to practical implementation that includes how often PIRs actually are used after restraint events.
We do not have knowledge about how PIRs are documented and implemented in care plans. Of vital interest is how the patients' voices are included and how the new lessons and suggested alternative measures are followed up on in the milieu therapy.

As the findings indicate the services' care philosophies to influence stakeholders' experiences and opinions of PIRs, a similar study should

be conducted in services that declare their practices to be based on defined human care philosophies.

The power-dependent imbalance is conspicuous in mental health services. Patients' experiences of PIRs including advocacy or peers in PIRs should therefore be further explored.

Care providers in this study referred mostly to women as patient participants in the PIRs. Also, requirements of interview participants among the patients resulted in only one man participating. Therefore, PIR's form and content should further be explored from a gender perspective.

The findings in the empirical studies did not include PIRs to contribute to organizational development as suggested i Article I. As PIRs seem promising regarding care improvement and S/R reduction, organisational consequences should therefore be explored.

9   References

Aarre, T. F. (2018). *En mindre medisinsk psykiatri*. Universitetsforl.

Aasland, O. G., Husum, T. L., Førde, R., & Pedersen, R. (2018). Between authoritarian and dialogical approaches: Attitudes and opinions on coercion among professionals in mental health and addiction care in Norway. *International Journal Of Law And Psychiatry, 57*, 106-112.

Al-Maraira, O. A., & Hayajneh, F. A. (2019). Use of Restraint and Seclusion in Psychiatric Settings: A Literature Review. *Journal of Psychosocial Nursing & Mental Health Services, 57*(4), 32-39.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19-32.

Armstrong, R., Hall, B. J., Doyle, J., & Waters, E. (2011). 'Scoping the scope' of a cochrane review. *Journal of Public Health, 33*(1), 147-150.

Ashcraft, L., & Anthony, W. (2008). Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services. *Psychiatric Services, 59*(10), 1198-1202.

Austin, W. (2007). The ethics of everyday practice: healthcare environments as moral communities. *Advances In Nursing Science, 30*(1), 81-88.

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing 24*(1), 11-15.

Azeem, M. W., Reddy, B., Wudarsky, M., Carabetta, L., Gregory, F., & Sarofin, M. (2015). Restraint Reduction at a Pediatric Psychiatric Hospital: A Ten-Year Journey. *Journal of Child and Adolescent Psychiatric Nursing 28*(4), 180-184.

Bak, J., & Aggernæs, H. (2012). Coercion within Danish psychiatry compared with 10 other European countries. *Nordic Journal of Psychiatry, 66*(5), 297-302.

Bak, J., Brandt-Christensen, M., Sestoft, D. M., & Zoffmann, V. (2012). Mechanical Restraint—Which Interventions Prevent Episodes of Mechanical Restraint?—A Systematic Review. *Perspectives in Psychiatric Care, 48*(2), 83-94.

Barker, R. (2012). Recovery and risk. Accepting the complexity. In G. Drennan & D. Alred (Eds.), *Secure Recovery : Approaches to Recovery in Forensic Mental Health Settings*. Cullompton, US: Taylor and Francis.

Barton, S. A., Johnson, M. R., & Price, L. V. (2009, Jan). Achieving Restraint-Free on an Inpatient Behavioral Health Unit. *Journal of Psychosocial Nursing & Mental Health Services, 47*(1), 34-40.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th. ed.). Oxford University Press.

Berring, L. L., Pedersen, L., & Buus, N. (2015). Discourses of aggression in forensic mental health: a critical discourse analysis of mental health nursing staff records. *Nursing Inquiry, 22*(4), 296-305.

Bigwood, S., & Crowe, M. (2008). 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International Journal of Mental Health Nursing, 17*(3), 215-222.

Blaikie, N., & Priest, J. (2019). *Designing social research : the logic of anticipation* (3rd. ed.). Polity Press.

Bloch, S., & Green, S. A. (2006). An ethical framework for psychiatry. *British Journal of Pychiatry 188*, 7-12.

Boland, A., Cherry, M. G., & Dickson, R. (2014). *Doing a systematic review : A student's guide*. Sage.

Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing 9*(4), 465-473.

Bonner, G., & Wellman, N. (2010). Postincident review of aggression and violence in mental health settings. *Journal of Psychosocial Nursing & Mental Health Services, 48*(7), 35-40.

Borge, L., & Hummelvoll, J. K. (2008). Patients' experience of learning and gaining personal knowledge during a stay at a mental hospital. *Journal of Psychiatric and Mental Health Nursing, 15*(5), 365-373.

Borge, L., & Hummelvoll, J. K. (2019). Miljøterapi – samspill og læring i helende omgivelser. En oppdatering. *Klinisk Sygepleje, 33*(01), 40-54.

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 499-508.

Bowers, L., van der Werf, B., Vokkolainen, A., Muir-Cochrane, E., Allan, T., & Alexander, J. (2007). International variation in containment measures for disturbed psychiatric inpatients: a comparative questionnaire survey. *International Journal Of Nursing Studies, 44*(3), 357-364.

Boysen, G. A., Isaacs, R. A., Tretter, L., & Markowski, S. (2019). Evidence for blatant dehumanization of mental illness and its relation to stigma. *The Journal of Social Psychology*, 1-11.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N., Double, D., Downer, S., Evans, C., Fernando, S., Garland, M. R., Hopkins, W., Huws, R., Johnson, B., Martindale, B., Middleton, H., Moldavsky, D., Moncrieff, J., Mullins, S., Nelki, J., Pizzo, M., Rodger, J., Smyth, M., Summerfield, D., Wallace, J., & Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal Of Psychiatry: The Journal Of Mental Science, 201*(6), 430-434.

Brekke, E. (2019). *Recovery in co-occurring mental health and substance use disorders: A qualitative study of first-person and staff experiences.* University of South-Eastern Norway, Faculty of Health and Social Sciences].

Briggs, J. (2019). *JBI Reviewer's Manual*. Retrieved 2020.05.10 from https://wiki.joannabriggs.org/display/MANUAL/JBI+Reviewer %27s+Manual

Buber, M., & Smith, R. G. (2004). *I and thou* (2nd ed. with a postscript by the author. ed.). Continuum,.

Campbell, J., Brophy, L., Davidson, G., & O'Brien, A.-M. (2018). Legal capacity and the mental health social worker role: an international comparison. *Journal of Social Work Practice, 32*(2), 139-152.

Carlsson, G., Dahlberg, K., Ekebergh, M., & Dahlberg, H. (2006). Patients longing for authentic personal care: A phenomenological study of violent encounters in psychiatric settings. *Issues in Mental Health Nursing, 27*(3), 287-305.

Carlsson, I.-M., Blomqvist, M., & Jormfeldt, H. (2017). Ethical and methodological issues in qualitative studies involving people with severe and persistent mental illness such as schizophrenia and other psychotic conditions: A critical review. *International Journal of Qualitative Studies on Health and Well-being, 12*(sup2), 1368323-1368323.

Cherry, M. G., Perkins, E., Dickson, R., & Boland, A. (2014). Reviewing qualiotative evidence. In A. Boland, M. G. Cherry, & R. Dickson (Eds.), *Doing a systematic review : a student's guide* (Vol. 210). Sage.

Chien, W.-T., Chan, C. W. H., Lam, L.-W., & Kam, C. W. (2005). Psychiatric inpatients' perceptions of positive and negative aspects of physical restraint. *Patient Education and Counseling, 59*(1), 80-86.

Colaizzi, J. (2005). Seclusion & restraint: a historical perspective. *Journal of Psychosocial Nursing and Mental Health Services, 43*(2), 31-49 39p.

Colquhoun, H. L., Levac, D., O'Brien, K. K., Straus, S., Tricco, A. C., Perrier, L., Kastner, M., & Moher, D. (2014). Scoping reviews: time for clarity in definition, methods, and reporting. *Journal of Clinical Epidemiology, 67*, 1291-1294.

Council of Europe, Parliamentary Assembly (2019). *Ending coercion in mental health: the need for a human rights-based approach.* Councel of Europe. Strasbourg.

Cowman, S., Björkdahl, A., Clarke, E., Gethin, G., & Maguire, J. (2017). A descriptive survey study of violence management and priorities among psychiatric staff in mental health services, across seventeen european countries. *Journal of Psychosocial Nursing and Mental Health Services 17*(1), 1-10.

Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International Journal of Mental Health Nursing 27*(3), 1162-1176.

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research* (2nd. ed.). Studentlitteratur.

Davidson, L., Tondora, J., Pavlo, A. J., & Stanhope, V. (2017). Shared decision making within the context of recovery-oriented care. *The Mental Health Review, 22*(3), 179-190.

Davis, K., Drey, N., & Gould, D. (2009). What are scoping studies? A review of the nursing literature. *International Journal of Nursing Studies, 46*(10), 1386-1400.

Declaration of Helsinki. (2013). *World Medical Association Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects* (Vol. 310 (20). Jama.

Drennan, G., & Alred, D. (2012). *Secure Recovery: Approaches to Recovery in Forensic Mental Health Settings*. Willan Publishing.

Ekeland, T.-J. (2011). *Ny kunnskap - ny praksis. Et nytt psykisk helsevern*. Nasjonalt senter for erfaringskompetanse innen psykisk helse.

Ellingsdalen, M. (2016). Den doble krenkelsen. In B. Karlsson (Ed.), *Det går for sakte.....i arbeidet med psykisk helsearbeid og rus* (pp. 120-135). Gyldendal Akademisk.

Emerson, R. M. (1962). Power-Dependence Relations. *American Sociological Review*(1), 31. 2089716

Faccio, E., Author, A., & Rocelli, M. (2020). It's the way you treat me that makes me angry, it's not a question of madness: Good and bad practice in dealing with violence in the mental health services. *Journal of psychiatric and mental health nursing*. Retreived 2021.03.02 from: https://onlinelibrary-wiley-com.ezproxy.uis.no/doi/epdf/10.1111/jpm.12690

Fisher, W. A. M. (2003). Elements of Successful Restraint and Seclusion Reduction Programs and Their Application in a Large, Urban, State Psychiatric Hospital. *Journal of Psychiatric Practice 9*(1), 7-15.

Fleming, V., Gaidys, U., & Robb, Y. (2003). Hermeneutic research in nursing: developing a Gadamerian-based research method. *Nursing Inquiry, 10*(2), 113-120 118p.

Fog, J. (2019). *Med samtalen som udgangspunkt : det kvalitative forskningsinterview* (3. udgave uændret, 2019. ed.). Akademisk forlag.

Foucault, M. (1975). *Discipline and punish : the birth of the prison*. Allen Lane.

Foucault, M. (2001). *Madness and civilization : a history of insanity in the age of reason*. Routledge.

Foucault, M., & Sandmo, E. (2000). *Galskapens historie i opplysningens tidsalder*. Bokklubben dagens bøker.

Freeman, M. C., Kolappa, K., de Almeida, J. M. C., Kleinman, A., Makhashvili, N., Phakathi, S., Saraceno, B., & Thornicroft, G. (2015). Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. *Lancet Psychiatry, 2*(9), 844-850.

Gadamer, H.-G., Holm-Hansen, L. f., & Schaanning, E. o. (2010). *Sannhet og metode: grunntrekk i en filosofisk hermeneutikk.* Bokklubben.

Gallagher, A. (2004). Dignity and respect for dignity -- two key health professional values: implications for nursing practice. *Nursing Ethics, 11*(6), 587-599.

Gallagher, A. (2017). Care Ethics and Nursing Practice. In P. A. Scott (Ed.), *Key Concepts and Issues in Nursing Ethics* (pp. 55-68). Cham: Springer International Publishing.

Goffman, E. (1961/1991). *Asylums : essays on the social situation of mental patients and other inmates*. Penguin.

Goffman, E. (1967/2005). *Interaction ritual : essays in face-to-face behavior*. Aldine Transaction.

Goffman, E., Kristiansen, S., Hviid Jacobsen, M., & Gooseman, B. (2009). *Stigma : om afvigerens sociale identitet* (2. udg. ed.). Samfundslitteratur.

Gooding, P., & McSherry, B. (2018, 12/01). Alternatives to Compulsory Detention and Treatment and Coercive Practices in Mental Health Settings. *Journal of Law and Medicine, 26*, 300-305.

Gostin, L. O. (2001, Summer). Beyond moral claims: a human rights approach in mental health. *Cambridge quarterly of healthcare ethics :, 10*(3), 264-274.

Gottlieb, L. N. (2014). CE: Strengths-Based Nursing. *American Journal of Nursing, 114*(8), 24-32.

Gottlieb, L. N., & Gottlieb, B. (2017). Strengths-Based Nursing: A Process for Implementing a Philosophy Into Practice. *Journal of Family Nursing, 23*(3), 319-340.

Goulet, M.-H., & Larue, C. (2016). Post-seclusion and/or restraint review in psychiatry: A scoping review. *Archives of Psychiatric Nursing, 30*(1), 120-128.

Goulet, M.-H., Larue, C., & Lemieux, A. J. (2018). A pilot study of "post-seclusion and/or restraint review" intervention with patients and staff in a mental health setting. *Perspectives of Psychiatric Care, 54*(2), 212-220.

Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today 56*, 29-34.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today 24*(2), 105-112.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quarterly, 82*(4), 581-629.

Greenhalgh, T., Snow, R., Ryan, S., Rees, S., & Salisbury, H. (2015, 09/01). Six 'biases' against patients and carers in evidence-based medicine. *BMC Medicine, 13*, 200.

Grimen, H. (2008). Profesjon og profesjonsmoral. In A. Molander & L. I. Terum (Eds.), *Profesjonsstudier*. Universitetsforlaget.

Guzman-Parra, J., Aguilera-Serrano, C., Huizing, E., Bono Del Trigo, A., Villagrán, J. M., García-Sánchez, J. A., & Mayoral-Cleries, F. (2020). A regional multicomponent intervention for mechanical restraint reduction in acute psychiatric wards. *Journal of psychiatric and mental health nursing*.

Hammervold, U. E. (2009). *Brukererfaringer knyttet til anvendelse av tvang i psykisk helsevern*. University in Stavanger.

Hartling, L., Lindner, E., Spalthoff, U., & Britton, M. (2013). Humiliation: A nuclear bomb of emotions? *Psicología Política 46*, 55-76.

Hartling, L. M., & Lindner, E. G. (2016). Healing Humiliation: From Reaction to Creative Action. *Journal of Counseling & Development, 94*(4), 383-390.

Helsebiblioteket.no. (2017, 2021.02.28). *Kunnskapsbasert praksis*. Retrieved 02.28 from https://www-helsebiblioteket-no.ezproxy.uis.no/256032.cms

Hem, M. H., Gjerberg, E., Husum, T. L., & Pedersen, R. (2018). Ethical challenges when using coercion in mental healthcare: A systematic literature review. *Nursing Ethics, 25*(1), 92-110.

Hem, M. H., Molewijk, B., Gjerberg, E., Lillemoen, L., Pedersen, R., Medical, h., & Care, A. P. H. Q. o. (2018). The significance of ethics reflection groups in mental health care: A focus group study among health care professionals. *BMC Medical Ethics, 19*(1), urn:issn:1472-6939.

Hem, M. H., Molewijk, B., & Pedersen, R. (2014). Ethical challenges in connection with the use of coercion: a focus group study of health care personnel in mental health care. *BMC Medical Ethics, 15*(1), 82-82.

Hermundstad, G. (1999). *Psykiatriens historie*. Ad notam Gyldendal.

Hornik-Lurie, T., Shalev, A., Haknazar, L., Garber Epstein, P., Ziedenberg-Rehav, L., & Moran, G. S. (2018). Implementing recovery-oriented interventions with staff in a psychiatric hospital: A mixed-methods study. *Journal of Psychiatric and Mental Health Nursing, 25*(9-10), 569-581.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288.

Huckshorn, K. A. (2004). Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services 42*(9), 22-33.

Huckshorn, K. A. (2006). Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research 33*(4), 482-491.

Huckshorn, K. A. (2014). Reducing Seclusion and Restraint Use in Inpatient Settings: A Phenomenological Study of State Psychiatric Hospital Leader and Staff Experiences. *Journal of Psychosocial Nursing and Mental Health Services, 52*(11), 40-47.

Huf, G., Coutinho, E. S. F., & Adams, C. E. (2012). Physical restraints versus seclusion room for management of people with acute aggression or agitation due to psychotic illness (TREC-SAVE): a randomized trial. *Psychological Medicine, 42*(11), 2265-2273.

Husum, T., Bjørngaard, J., Finset, A., & Ruud, T. (2011). Staff attitudes and thoughts about the use of coercion in acute psychiatric wards. *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services, 46*(9), 893-901.

Husum, T. L., Legernes, E., & Pedersen, R. (2019, 2019/01/01/). "A plea for recognition" Users' experience of humiliation during mental health care. *International Journal of Law and Psychiatry, 62*, 148-153.

Iasiello, M., van Agteren, J., Keyes, C. L. M., & Cochrane, E. M. (2019). Positive mental health as a predictor of recovery from mental illness. *Journal of Affective Disorders, 251*, 227-230.

International Council of Nurses. (2012). *The ICN code of ethics for nurses*. International Council of Nurses. Retrieved 2018.10.01 from https://www.icn.ch/sites/default/files/inlinefiles/2012_ICN_Cod eofethicsfornurses_%20eng.pdf

Jacob, J. D., Holmes, D., Rioux, D., Corneau, P., & MacPhee, C. (2019). Convergence and divergence: An analysis of mechanical restraints. *Nursing Ethics, 26*(4), 1009-1026.

Jacob, T., Sahu, G., Frankel, V., Homel, P., Berman, B., & McAfee, S. (2016). Patterns of Restraint Utilization in a Community Hospital's Psychiatric Inpatient Units. *Psychiatric Quarterly, 87*(1), 31-48.

Jansen, T.-L., Hem, M. H., Dambolt, L. J., & Hanssen, I. (2020). Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands. *Nursing Ethics, 27*(5), 1315-1326.

Karlsson, B., & Borg, M. (2017). *Recovery : tradisjoner, fornyelser og praksiser*. Gyldendal akademisk.

Kars, M. C., van Thiel, G. J., van der Graaf, R., Moors, M., de Graeff, A., & van Delden, J. J. (2016). A systematic review of reasons for gatekeeping in palliative care research. *Palliative Medicine, 30*(6), 533-548.

Kaucic, A. M. (2017). *The Use of Seclusion and Restraints in the Inpatient Psychiatric Hospital Setting: A Systematic Review of the Literature,* . http://ideaexchange.uakron.edu/honors_research_projects/488

Keyes, C. L. M., Dhingra, S. S., & Simoes, E. J. (2010). Change in level of positive mental health as a predictor of future risk of mental illness. *American Journal of Public Health, 100*(12), 2366-2371.

Knowles, S. F., Hearne, J., & Smith, I. (2015). Physical restraint and the therapeutic relationship. *Journal of Forensic Psychiatry & Psychology,* 26(4), 461-475. https://doi.org/10.1080/14789949.2015.1034752

Knutzen, M., Bjørkly, S., Eidhammer, G., Lorentzen, S., Helen Mjøsund, N., Opjordsmoen, S., Sandvik, L., & Friis, S. (2012). Mechanical and pharmacological restraints in acute psychiatric wards—Why and how are they used? *Psychiatry research*.

Krieger, E., Moritz, S., Lincoln, T. M., Fischer, R., & Nagel, M. (2020). Coercion in psychiatry: A cross-sectional study on staff views and emotions. *Journal of Psychiatric and Mental Health Nursing*.

Kringlen, E. (2001). *Psykiatriens samtidshistorie*. Universitetsforl.

Kvale, S., Brinkmann, S., Anderssen, T. M., & Rygge, J. (2015). *Det kvalitative forskningsintervju* (3. utg., 2. oppl. ed.). Gyldendal akademisk.

Kvia, A., Dahl, C., Grønnestad, T., & Jensen, M. (2020, 05/04). Easier to Say 'Recovery' than to Do Recovery: Employees' Experiences of Implementing a Recovery-Oriented Practice. *International Journal of Mental Health and Addiction*.

Lanthén, K., Rask, M., & Sunnqvist, C. (2015). Psychiatric patients experiences with mechanical restraints: An interview study. *Psychiatry Journal 2015*, Article ID 748392, 8 pages.

Larue, C., Dumais, A., Boyer, R., Goulet, M.-H., Bonin, J.-P., & Baba, N. (2013). The experience of seclusion and restraint in psychiatric settings: perspectives of patients. *Issues in Mental Health Nursing, 34*.

Le Boutillier, C., Slade, M., Lawrence, V., Bird, V. J., Chandler, R., Farkas, M., Harding, C., Larsen, J., Oades, L. G., Roberts, G., Shepherd, G., Thornicroft, G., Williams, J., & Leamy, M. (2015). Competing priorities: staff perspectives on supporting recovery. *Administration and Policy in Mental Health, 42*(4), 429-438.

LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: why are best practices ignored? *Child Welfare, 89*(2), 169-187.

LeBel, J. L., Duxbury, J. A., Putkonen, A., Sprague, T., Rae, C., & Sharpe, J. (2014, Nov). Multinational experiences in reducing and preventing the use of restraint and seclusion. *Journal of Psychosocial Nursing & Mental Health Services, 52*(11), 22-29.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science : IS, 5*(1), 69.

Levy, J., & Payne, M. (2006). Welfare rights advocacy in a specialist health and social care setting: A service audit. *British Journal of Social Work, 36*(2), 323-331.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International journal of nursing studies, 108*, 103632.

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences, 18*(2), 145-153.

Linn, L. S. (1968, 1968/08/01). The Mental Hospital from the Patient Perspective. *Psychiatry, 31*(3), 213-223.

Lockwood, C., dos Santos, K. B., & Pap, R. (2019). Practical Guidance for Knowledge Synthesis: Scoping Review Methods. *Asian Nursing Research, 13*(5), 287-294.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies. *Qualitative Health Research, 26*(13), 1753-1760.

Mangaoil, R., Cleverley, K., & Peter, E. (2018). Immediate Staff Debriefing Following Seclusion or Restraint Use in Inpatient Mental Health Settings: A Scoping Review. *Clinical Nursing Research,* 1-40.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances In Health Sciences Education: Theory And Practice, 14*(4), 595-621.

Martinsen, E. (2011, 03/01). Care for Nurses Only? Medicine and the Perceiving Eye. *Health Care Analysis. An International Journal of Health, Philosophy and Policy, 19*, 15-27.

Martinsen, K. (1990). Omsorg i sykepleien – en moralsk utfordring. In G. Engelsrud & K. Jensen (Eds.), *Moderne omsorgsbilder* (pp. 61-97). Gyldendal.

Martinsen, K. (2000). *Øyet og kallet*. Fagbokforl.

Martinsen, K. (2003). *Omsorg, sykepleie og medisin: historisk-filosofiske essays*. Universitetsforl.

Martinsen, K. (2005). *Samtalen, skjønnet og evidensen*. Akribe.

Martinsen, K., & Kjerland, L. E. (2006). *Care and vulnerability*. Akribe.

Martinsen, K., & Wærness, K. (1991). *Pleie uten omsorg? : norsk sykepleie mellom pasient og profesjon* ([Ny utg.]. ed.). Pax.

Mason, J. (2018). *Qualitative researching* (Vol. ³ʳᵈ ed.). Sage.

Mead, S., & Hilton, D. (2003, Summer). Crisis and connection. *Psychiatric Rehabilitation Journal 27*(1), 87-94.

Miller, W., & Crabtree, B. (2005). Healing landscapes: Patients, relationships, and creating optimal healing places. *The journal of alternative and complementary medicine, 11*(1), s 41-49.

Mitchell, J. T. (1983). When disaster strikes...the critical incident stress debriefing process. *JEMS: A Journal Of Emergency Medical Services, 8*(1), 36-39.

Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with physical restraint. *The Canadian Journal of Psychiatry, 48*(5), 330-337.

Molewijk, B., Kok, A., Husum, T., Pedersen, R., & Aasland, O. (2017). Staff's normative attitudes towards coercion: the role of moral doubt and professional context-a cross-sectional survey study. *BMC Medical Ethics, 18*(1), 37-37.

NASMHPD. (2006). *Six Core Strategies for Reducing Seclusion and Restraint Use©*. National Association of State Mental Health Program Directors
Retrieved 2019.02.16 from https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

NICE. (2015). *Violence and aggression: Short-term management in mental health, health and community settings*. Retrieved 2021.03.07 from www.nice.org.uk/guidance/NG10

Nolan, P., Dallender, J., Soares, J., Thomsen, S., & Arnetz, B. (1999). Violence in mental health care: the experiences of mental health nurses and psychiatrists. *Journal of advanced nursing, 30*(4), 934-941.

Norvoll, R., Hatling, T., & Hem, K.-G. (2008b). *Det er nå det begynner!: hovedrapport fra prosjektet "Brukerorienterte alternativer til tvang i sykehus" (BAT)* (Vol. SINTEF A8450). SINTEF.

Norvoll, R., Hem, M. H., & Pedersen, R. (2017). The Role of Ethics in Reducing and Improving the Quality of Coercion in Mental Health Care. *HEC Forum, 29*(1), 59-74. https://doi.org/10.1007/s10730-016-9312-1

Norvoll, R., & Pedersen, R. (2016). Exploring the views of people with mental health problems' on the concept of coercion: Towards a broader socio-ethical perspective. *Social Science & Medicine, 156*, 204-211.

Norwegian Health Directorate. (2014). *Sammen om mestring. Veileder i lokalt psykisk helsearbeid og rusarbeid for voksne Et verktøy for kommuner og spesialisthelsetjenesten.* Norwegian Health Directorate.

Norwegian Health Directorate. (2017, sist faglig oppdatert 11. februar 2019). *Veileder om oppfølging av personer med store og sammensatte behov*. Norwegian Health Directorate

Norwegian Health Directorate. (2019). *Nasjonal handlingsplan for pasientsikkerhet og kvalitetsforbedring 2019 - 2023*. Norwegian Health Directorate.

Norwegian Health Directorate. (2020). *Tvang i psykisk helsevern. Status etter lovendringene i 2017.* (Vol. IS-2888). Norwegian Health Directorate.

Norwegian Ministry of Health & Care Services. (1997-1998). *Om opptrappingsplan for psykisk helse 1999 - 2006*

Lov om pasient- og brukerrettigheter (pasient- og brukerrettighetsloven), (1999). https://lovdata.no/dokument/NL/lov/1999-07-02-63

NOU 2011:9 *Økt selvbestemmelseog rettssikkerhet. Balansegangen mellom selvbestemmelsesrett og omsorgsansvar i psykisk helsevern.* Retrieved from:
https://www.regjeringen.no/contentassets/edc9f614eb884f1d988d16af6 3218953/no/pdfs/nou201120110009000dddpdfs.pdf

NOU 2019:14 *Tvangsbegrensningsloven - Forslag til felles regler om tvang og inngrep uten samtykke i helse- og omsorgstjenesten.* Retrieved from:
https://www.regjeringen.no/no/dokumenter/nou-2019-14/id2654803/?ch=1

Norwegian Social and Health Directorate. (2005). *...OG BEDRE SKAL DET BLI. Nasjonal strategi for kvalitetsforbedring i helsetjenesten*. Norwegian Social and Health Directorate.

NVivo 12. (2016). *NVivo qualitative data analysis Software; Version 12*. QSR International Pty Ltd.

Nyttingnes, O., Ruud, T., Norvoll, R., Rugkasa, J., & Hanssen-Bauer, K. (2018). A cross-sectional study of experienced coercion in adolescent mental health inpatients.(Report). *Journal of Psychosocial Nursing and Mental Health Services, 18*(1).

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care. *International Journal of Law Psychiatry 49*, 147-153.

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., & Bowers, L. (2012). The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica, 125*(6), 425-439.

Parke, S., Hunn, L., Holland, T., Preston, L., McCarthy, L., & Day, M. (2019). Restrictive interventions: a service evaluation. *Mental Health Practice, 22*(5), 20-25.

Pasient og brukerrettighetsloven. (1999). *Lov om pasient- og brukerrettigheter (pasient- og brukerrettighetsloven)*. Norwegian Ministry of Health and care services. Retrievded from: https://lovdata.no/dokument/NL/lov/1999-07-02-63

Pawson, R. (2002). Evidence-based Policy: In Search of a Method. *Evaluation, 8*(2), 157.

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*(1), 43-49.

Petti, T. A., Mohr, W. K., Somers, J. W., & Sims, L. (2001). Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. *Journal of Child and Adolescent Psychiatric Nursing, 14*(3), 115-127 113p.

Polit, D. F., & Beck, C. T. (2020). *Nursing research : generating and assessing evidence for nursing practice* (Eleventh edition.; International edition. ed.). Lippincott Williams & Wilkins.

Psykisk helsevernloven (1999). Lov om etablering og gjennomføring av psykisk helsevern (LOV-1999-07-02-62) Retrieved from https://lovdata.no/lov/1999-07-02-62

Psykisk helsevernloven med kommentarer, (2017). www.helsedirektoratet.no/rundskriv/psykisk-helsevernloven-med-kommentarer

Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O.-P., Kautiainen, H., & Tiihonen, J. (2013). Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. *Psychiatric Services, 64*(9), 850-855.

Raboch, J., Kalisová, L., Nawka, A., Kitzlerová, E., Onchev, G., Karastergiou, A., Magliano, L., Dembinskas, A., Kiejna, A., Torres-Gonzales, F., Kjellin, L., Priebe, S., & Kallert, T. W. (2010). Use of coercive measures during involuntary hospitalization: findings from ten European countries. *Psychiatric Services, 61*(10), 1012-1017.

Rakhmatullina, M., Taub, A., & Jacob, T. (2013). Morbidity and mortality associated with the utilization of restraints: A review of literature. *Psychiatric Quarterly, 84*(4), 499-512.

Riahi, S., Thomson, G., & Duxbury, J. (2016). An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint. *Journal of Psychiatric and Mental Health Nursing, 23*(2), 116-128.

Ridley, J., Newbigging, K., & Street, C. (2018). Mental health advocacy outcomes from service user perspectives. *Mental Health Review Journal, 23*(4), 280-292.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology And Psychiatric Sciences, 24*(1), 90-96.

Rose, D., Perry, E., Rae, S., & Good, N. (2017). Service user perspectives on coercion and restraint in mental health. *BJPsych. International, 14*(3), 59-61.

Rose, S., Bisson, J., & Wessely, S. (2003). A Systematic Review of Single-Session Psychological Interventions ('Debriefing') following Trauma. *Psychotherapy and Psychosomatics, 72*(4), 176-184.

Sailas, E., & Fenton, M. (2000). Seclusion and restraint for people with serious mental illnesses. *The Cochrane Database Of Systematic Reviews, 2*(Issue 1. Art. No.: CD001163.).

Scanlan, J. N. (2010). Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: What we know so far a review of the literature. *International Journal of Social Psychiatry, 56*(4), 412-423.

Schön, D. A. (1987). *Educating the reflective practitioner*. Jossey-Bass.

Schön, D. A. (1991). *The reflective practitioner : how professionals think in action*. Avebury.

Secker, J., Benson, A., Balfe, E., Lipsedge, M., Robinson, S., & Walker, J. (2004). Understanding the social context of violent and aggressive incidents on an inpatient unit. *Journal of Psychiatric and Mental Health Nursing, 11*(2), 172-178.

Sjöström, S. (2006). Invocation of coercion context in compliance communication — power dynamics in psychiatric care. *International Journal of Law and Psychiatry, 29*(1), 36-47.

Skjervheim, H. (1996). *Deltakar og tilskodar og andre essays* ([Ny utg.]. ed.). Aschehoug.

Slade, M. (2009). *Personal recovery and mental illness: a guide for mental health professionals*. Cambridge University Press.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O' Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12-20.

Strout, T. D. (2010). Perspectives on the experience of being physically restrained: An integrative review of the qualitative literature. *International Journal of Mental Health Nursing 19*(6), 416-427.

Sugiura, K., Mahomed, F., Saxena, S., & Patel, A. (2020, 01/01). An end to coercion: rights and decision-making in mental health care. *Bulletin of the World Health Organization, 98*, 52-58.

Szmukler, G. (2015). Compulsion and "coercion" in mental health care. *World Psychiatry, 14*(3), 259-261.

Terkelsen, T. B., & Larsen, I. B. (2016). Fear, danger and aggression in a Norwegian locked psychiatric ward. *Nursing Ethics, 23*(3), 308-317.

Todres, L., Galvin, K. T., & Dahlberg, K. (2014). "Caring for insiderness": phenomenologically informed insights that can guide practice. *Int J Qual Stud Health Well-being 9*, 21421-21421.

Todres, L., Galvin, K. T., & Holloway, I. (2009, 2009/01/01). The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-being 4*(2), 68-77.

Topor, A., Larsen, I. B., & Bøe, T. D. (2020). *Recovery – fra personlig reformasjon til sosial transformasjon*. Retrieved 2020.05.04 from https://madinnorway.org/2020/05/recovery-sosial-transformasjon/

Tronto, J. C. (1993). *Moral boundaries : A political argument for an ethic of care*. Routledge.

Tronto, J. C. (2013). *Caring democracy : Markets, equality, and justice (e-book)*. New York University Press.

Tuckey, M. R. (2007). Issues in the Debriefing Debate for the Emergency Services: Moving Research Outcomes Forward. *Clinical Psychology: Science and Practice, 14*(2), 106-116.

United Nations. (1948). *Universal Declaration of Human Rights* https://www.un.org/en/universal-declaration-human-rights/

United Nations. (2007). Convention on the Rights of Persons with Disabilities, CRDP, A/RES/61/611. Retrieved 2021.03.03 from https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

Valenti, E., Giacco, D., Katasakou, C., & Priebe, S. (2014). Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. *Journal of Medical Ethics, 40*(12), 832-836.

Väkiparta, L., Suominen, T., Paavilainen, E., & Kylmä, J. (2019). Using interventions to reduce seclusion and mechanical restraint use in adult psychiatric units: an integrative review. *Scandinavian Journal of Caring Sciences, 33*(4), 765-778.

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L., & Arnfred, S. (2018). Recovery orientation in mental health inpatient settings: Inpatient experiences? *International Journal Of Mental Health Nursing, 27*(3), 1177-1187.

Walker, M. U. (1993). Keeping Moral Space Open New Images of Ethics Consulting. *The Hastings Center Report, 23*(2), 33-40.

Walker, S., Potts, J., Martos, L., Barrera, A., Hancock, M., Bell, S., Geddes, J., Cipriani, A., & Henshall, C. (2020). Consent to discuss participation in research: a pilot study. *Evidence Based Mental Health, 23*(2), 77-82.

Warne, T., & McAndrew, S. (2007). Passive patient or engaged expert? Using a Ptolemaic approach to enhance mental health nurse education and practice. *International Journal of Mental Health Nursing, 16*(4), 224-229.

We Shall Overcome (WSO). (2021). *Tid for endring og paradigmeskifte* Retrieved 27.02.21 from https://wso.no/wsos-arbeid/tid-for-endring-og-paradigmeskifte/

Weinstein, R. M. (1982). Goffman's asylums and the social situation of mental patients. *Orthomolecular Psychiatry, 11*(4), 267-274.

Whittington, R., Bowers, L., Nolan, P., Simpson, A., Neil, L., Whittington, R., Bowers, L., Nolan, P., Simpson, A., & Neil, L. (2009). Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. *Psychiatric Services, 60*(6), 792-798.

WHO. *Mental health, human rights & legislation*. World Health Organization. Retrieved from https://www.who.int/mental_health/policy/legislation/en/

WHO. (2004). *Promoting Mental Health*. World Health Organization.

WHO. (2013). *Mental Health Action Plan 2013-2020* (World Health Organisation, Ed.). WHO, Department of Mental Health and Substance Abuse.

WHO. (2015). *The European Mental Health Action Plan 2013–2020*. World Health Organization.

Wieman, D. A., Camacho-Gonsalves, T., Huckshorn, K. A., & Leff, S. (2014). Multisite study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatric Services (Washington, D.C.), 65*(3), 345-351.

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (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*(5), 500-512.

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2018). Mental health inpatients' and staff members' suggestions for reducing physical restraint: A qualitative study. *Journal of Psychiatric and Mental Health Nursing, 25*(3), 188-200.

Winge, P. (1913). *Den norske sindsygeret, historisk fremstillet, 3bd.* Dybwad, 1913.

Witham, G., Beddow, A., & Haigh, C. (2015). Reflections on access: Too vulnerable to research? *Journal of Research in Nursing, 20*(1), 28-37.

Wynn, R. (2003). Staff's attitudes to the use of restraint and seclusion in a Norwegian university psychiatric hospital. *Nordic Journal of Psychiatry, 57*(6), 453-459.

Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *The Journal of Forensic Psychiatry & Psychology 15*(1), 124-144.

Articles

Article I

BMC Health Services Research

RESEARCH ARTICLE   **Open Access**

Post-incident review after restraint in mental health care -a potential for knowledge development, recovery promotion and restraint prevention. A scoping review

Unn Elisabeth Hammervold[1*] , Reidun Norvoll[2], Randi W. Aas[1,3] and Hildegunn Sagvaag[1]

Abstract

Background: Use of physical restraint is a common practice in mental healthcare, but is controversial due to risk of physical and psychological harm to patients and creating ethical dilemmas for care providers. Post-incident review (PIR), that involve patient and care providers after restraints, have been deployed to prevent harm and to reduce restraint use. However, this intervention has an unclear scientific knowledge base. Thus, the aim of this scoping review was to explore the current knowledge of PIR and to assess to what extent PIR can minimize restraint-related use and harm, support care providers in handling professional and ethical dilemmas, and improve the quality of care in mental healthcare.

Methods: Systematic searches in the MEDLINE, PsychInfo, Cinahl, Sociological Abstracts and Web of Science databases were carried out. The search terms were derived from the population, intervention and settings.

Results: Twelve studies were included, six quantitative, four qualitative and two mixed methods. The studies were from Sweden, United Kingdom, Canada and United States. The studies' design and quality varied, and PIR s' were conducted differently. Five studies explored PIR s' as a separate intervention after restraint use, in the other studies, PIR s' were described as one of several components in restraint reduction programs. Outcomes seemed promising, but no significant outcome were related to using PIR alone. Patients and care providers reported PIR to: 1) be an opportunity to review restraint events, they would not have had otherwise, and 2) promote patients' personal recovery processes, and 3) stimulate professional reflection on organizational development and care.

Conclusion: Scientific literature directly addressing PIR s' after restraint use is lacking. However, results indicate that PIR may contribute to more professional and ethical practice regarding restraint promotion and the way restraint is executed. The practice of PIR varied, so a specific manual cannot be recommended. More research on PIR use and consequences is needed, especially PIR's potential to contribute to restraint prevention in mental healthcare.

Keywords: Debriefing, Post-incident review, Restraints, Mental, Restraint reduction, Recovery-oriented care, Reflection

* Correspondence: unn.hammervold@uis.no
[1]Department of Public Health, Faculty of Health Sciences, University of Stavanger, NO-4036 Stavanger, Norway
Full list of author information is available at the end of the article

Background

Restraint is frequently used in mental healthcare in western countries, despite the lack of studies supporting the practice [1, 2]. Restraint is defined as mechanical or physical action, often using straps, belts or other equipment, intended as a last resort to hold patients in order to prevent self-injury, injuries to others, or significant damage to the environment [3]. Laws related to mental health state that the ethical principles of "proportionality" and "purposefulness" must be considered when restraint is used [3]. The principle of proportionality requires that the level of coercive measures is restricted to what is least required for that patient and that situation, and the principle of purposefulness means that coercive measures can only be used when clearly specified reasons have been stated in advance. Furthermore, the patient's needs and preferences must be taken into consideration and supported by evidence.

The use of restraint is controversial due to the possible negative consequences, including infringement of patients' autonomy and liberty and the risk of physical and psychological harm to patients and care providers [4–6].

Health care providers should base their practice on respect for fundamental human rights, preserve patients' integrity and dignity and treat them with care and respect [7, 8].

Cases in which restraint use seems inevitable can challenge this position as ethical principles may conflict with each other. For example, the principle of autonomy may conflict with the principle of inflicting harm (maleficence) in a case where a patient may cause physical harm to him or herself or to others [9]. Thus, ethical and professional imperatives point towards developing reflexive practices aimed at avoiding unnecessary restraint, improving the execution of restraint and helping patients maintain hope and identity during crises [10].

Despite the widespread use of restraint and the associated risks, few studies examine restraint from the perspectives of care and treatment planning. Restraint use is, therefore "an area that begs for research into alternative methods of assessment, caregiving, and treatment planning" ([7], p.11).

Internationally, a growing literature supports implementation of different strategies to reduce both seclusion and restraint (S/R) [11, 12]. For example, to prevent S/R, Huckshorn recommends implementing six core strategies in care environments, based on the principles of recovery: 1) workforce development 2) rigorous debriefing 3) leadership in organisational changes 4) use of data to inform practice 5) use of S/R prevention tools and 6) full inclusion of patients and families [13, 14]. Studies on the outcomes of programmes using these core strategies seem to offer promising results for S/R reduction in mental healthcare [11, 12, 15].

However, it is difficult to assess how much different interventions contribute individually to these supposedly promising results.

One of the core strategies - rigorous debriefing, has been demanded from patients and care providers after restraint incidents for several years [16–19]. Debriefing was originally a procedure used with ambulance personnel after exposure to traumatic situations in their work and was later expanded for use as an early intervention protocol for individuals exposed to a wider range of potentially traumatic events. Due to conceptual confusions and methodological issues, experts have not reached consensus on the value of debriefing [20].

William Fisher [21] however, described two main varieties of debriefing after critical incidents in mental healthcare: 1) debriefing with care providers alone, in post-incident analysis aimed at evaluating what could have been done differently and making short-term plans to avoid repeating restraint use; 2) debriefing for patients and care providers together, consisting of a detailed behaviour analysis of the events preceding restraint use by both parties. Due to the demands of user participation in mental healthcare and national guidelines on debriefing that include both patients and care providers, this review considers the later type of debriefing. Among the many terms used to refer to interventions after restraint are: debriefing procedures, post-event discussion and post-event analysis [22]. However, we have adopted the concept of post-incident reviews (PIR) used by Bonner and Wellmann [23], with the acronym "PIR".

PIR may be a promising intervention for care planning and S/R reduction in mental healthcare. On this basis, several countries have formalised the use of PIR s' for patients and care providers together [12]. However, the knowledge base of this requirement is vague, and there seems to be a lack of systematically-summarised knowledge on both the various PIR procedures available and an evaluation of their benefits and dilemmas in patient treatment [22]. This situation creates a need for state of the art of existing knowledge. The aim of this scoping review is to explore knowledge of PIR after restrains in the scientific literature and to assess to what extent can PIR s' minimise restraint-related patient harm, support care providers in handling professional and ethical dilemmas and improve the quality of care in mental healthcare. More specifically, we ask: (1) How are PIR s' defined and described? (2) How are PIR s' conducted in practice, and what are possible variations in PIR use? (3) What are patients' and care providers' experiences of PIR? Finally, the question of what are the implications of reviewing the use of PIR as a tool that might benefit both patients and care providers is discussed by drawing on a recovery-oriented framework [10] and the humanising care approach to nursing and ethics [24]. This approach is

chosen because of its potential to mitigate consequences like retraumatization and dehumanization after restraint events to the patients [5, 6]. A recovery-oriented framework emphasising personal recovery "involves living as well as possible" in spite of any mental health issues [10], and includes maintaining hope during crises [10]. Within this framework, care providers may be more likely to consider the patient as a human being in their entirety, and consequently consider the patient to be jointly responsible for finding alternative approaches to restraints, based on the patient's resources and former experiences. A humanizing care approach "provides eight philosophically informed dimensions of humanization, which together, form a framework that constitutes a comprehensive value base for considering both the potentially humanizing and dehumanizing elements in caring systems and interactions" [24]. We consider this approach might be useful to support care providers in preserving patients' integrity and dignity, even if use of restraint becomes inevitable.

Methods

To examine the body of knowledge on PIR s', we carried out a scoping review following Arksey and O'Malley's methodological framework constituting a five-stage approach. The scoping review proved to be suitable for defining and describing, as well as identifying practical implications, variations and experiences with PIRs'. Furthermore, it allowed for a broad approach to a topic of interest, as well as inclusion of studies regardless of their methodological design identifying research gaps and summarizing findings of research [25, 26].

Stage 1: identifying research questions

Initially, we performed a broad search for PIR in the available scientific and professional literature, public documents and guidelines. After becoming familiar with the literature, we developed the three research questions to guide the review.

Stage 2: identifying relevant studies

Systematic literature searches were carried out in September 2016 – May 2018 in five databases: Medline, PsychInfo, Cinahl, Sociological Abstracts and Web of Science. The search centred on three main concepts: 1) restraint; mechanical OR physical, AND 2) psychiatric OR mental, AND 3) post-incident review OR debriefing. The search terms, including Medical Subject Headings (MeSH terms) and synonyms for each of the main concepts were combined with OR. The search yielded 40 sources after duplicates were removed (see Fig. 1).

Stage 3: study selection

The original aim of the review was to describe any available scientific knowledge on PIR after restraint
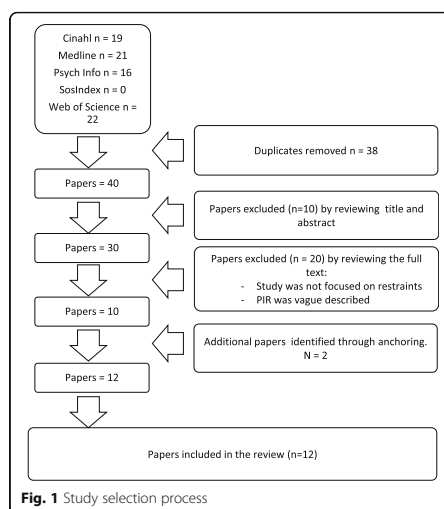

Fig. 1 Study selection process

alone, given that restraint and seclusion differ in terms of their legality and application, as well as their therapeutic and ethical consequences. In examining the literature, however, it quickly became clear that only a few publications fulfilled the criterion regarding restraint alone, so we changed the inclusion criteria in line with scoping review methodology [26]. The focus in this review will be on PIR s' after restraint, even though some publications ($n = 7$) explore restraint and seclusion together. Figure 2 presents an overview over inclusion, – and exclusion criteria.

Two authors (U.E.H. and H.S.) independently reviewed all the abstracts and keywords using the inclusion and exclusion criteria. Any studies that were disagreed upon were further discussed, and a consensus was reached for all the articles included.

In addition, an ancestry approach was performed, reviewing and scrutinising reference lists from the retrieved full-text articles and review articles where other aspects of debriefing procedures were illuminated [22, 27] to detect any additional articles not identified in the computerised literature search [25]. This approach led to the inclusion of two more publications.

Arksey and O'Malley do not require a quality appraisal of the studies included in their review [25], but that approach is disputed [28]. In order to strengthen the quality of our review, we did choose to evaluate the studies.

The qualitative studies were evaluated following Polit and Beck [29]. Weaknesses in publications were identified, including a lack of theoretical integration and descriptions of the study population, analysis processes

Inclusion criteria	Exclusion criteria
Studies in peer-reviewed scientific journals and theses	Theoretical articles, books, reviews, letters, commentaries and unpublished papers.
Studies in Nordic languages or in English	Studies in neither English nor a Nordic language
Studies exploring PIR after incidents including either restraint alone or both restraint and seclusion	Studies exploring PIR after seclusion alone
Anecdotal evidence regarding PIR from individuals or organisations	
PIR participants including patients of all ages and mental health care providers	
Professional development projects including PIR.	

Fig. 2 Overview over inclusion, – and exclusion criteria

and risk of bias. Evaluation of the quantitative publications was based on narrative descriptions as none of the publications was comparable regarding design and outcome, so equal quality criteria could not be used.

Stage 4: capturing the data
We employed an inductive approach in the analysis and synthesis of this review [30] Using NVivo 11 software [31], we carefully read the publications and examined their content related to the research questions. Study characteristics and manifest content, i.e. content close to the text [32] were identified regarding the first and second research questions, placed in a matrix and then compared for equality and differences.

Stage 5: collating, summarising and reporting the results
The search for outcomes related to research question 3 that could deal with both measurable effects on S/R reduction and patients' and care providers' experiences consisted of two steps. The results from quantitative publications were ordered into a matrix for comparison. Experiences presented in qualitative publications were examined to identify common categories and, with some degree of interpretation, find themes across studies [30].

Results
Study characteristics
We included 12 empirical scientific studies in the review, including four qualitative studies [16, 33–35], six quantitative studies [21, 23, 36–39], and two studies using mixed methods [40, 41]. Only five publications reported on empirical research studies directly addressing of PIR [16, 23, 33, 40, 41]. The others described S/R reduction projects in which PIR were a component or an established or requested intervention between patients and care providers (thus implicitly described). Table 1 includes a description of the included publications.

How are PIR s' defined and described?
Table 2 includes an overview of the results of research question 1. The term *PIR* is defined in two publications [33, 41], but descriptions of PIR indicate systematic intervention by using words as "rigorous problem solving", "detailed behaviour analyses", "chain analyses" etc. The purpose of conducting PIR was to learn how to prevent S/R through gentle, individual interventions such as talking or going for a walk and to identify and mitigate S/R-related patient harm.

Two definitions of PIR s' are related to both restraint and seclusion but vary on some points [33, 41]. Goulet and Larue define PIR as 'a complex intervention, taking place after an SR episode and targeting the patient and healthcare team to enhance the care experience and provide meaningful learning for the patient, staff, and organisation'[41,p.212]. This definition indicates that PIR are learning tools not only for patients and care providers, but also organisations. Additionally, PIR s' was usually based in public S/R reduction or quality improvement programmes. The stated treatment philosophies were (7 of 12 publications) strength-based, person-centred, trauma-informed and recovery-oriented.

How are PIR s' conducted?
The review showed that descriptions of how to conduct PIR s' in practice varied in participants, timeframe, form and content of the conversation (Table 3).

Participants
All publications, except one [16], defined the participants in PIR. In all the publications, patients and care providers participated in PIR, but the composition of care providers varied somewhat. The procedures involved participation by care providers who were both directly and not directly involved in the S/R incidents. Additionally, one procedure suggested including the treatment team, attending physician/psychiatrist and management representative [38]. In two of the most

121

Table 1 Description of the included publications

First author Date	Nation	Design/method	Aim	Setting and sample	Age group	Intervention
Petti 2001	United States	A combination data collection applying semi-structured interviews and a cross-sectional questionnaire on debriefing incidents	Explore role of PIR in a S/R reduction project	81 incidents, both patients and staff	Children and adolescents	Restraints and seclusion
Bonner 2002	United Kingdom	Descriptive pilot study Semi-structured interviews	Evaluate feasibility and helpfulness of PIR after restraints	Patients ($N = 6$) Staff ($N = 12$)	Adults	Restraints
Fisher 2003	United States	Cross-sectional study of patients and staff at clinic Observational design using questionnaire and register data from the clinic and the whole state (reference group)	Describe the results of a program to reduce S/R rates in a mental health hospital	Patients ($N = 148$; 25% response rate) Staff ($N = 112$; 15% response rate)	Adults	Restraints and seclusion
Ashcraft 2008	United States	Evaluation study with 58-month follow-up, implementing a new organisational program including PIR in two crisis clinics Registration of S/R rates	Reduce S/R use to zero S/R events	Two urban crisis centres, one small and one large	Adults	Restraints and seclusion
Bonner 2010	United Kingdom	Cross-sectional study assessing agreement on 6 statements (on a 7-point Likert scale)	Evaluate whether staff and patients found PIR helpful after restraint incidents	Patients (N = 30) Staff ($N = 30$)	Adults	Restraints
Azeem 2011	United States	Descriptive study using medical records reviewed over 33 months	Determine the effectiveness of six core strategies based on trauma-informed care at reducing S/R	Psychiatric hospital. Medical records ($N = 458$)	Children and adolescents	Restraints and seclusion
Azeem 2015	United States	Descriptive longitudinal study using register data on restraints incidents over 10 years at one clinic	Assess restraint reduction rates over 10 years in a clinic that implemented a restraint prevention programme	52-bed psychiatric hospital	Children and adolescents	Restraints
Lanthen 2015	Sweden	Descriptive design Interviews	Examine patients' experience of mechanical restraints and describe the patient care received	Former psychiatric patients. ($N = 10$)	Adults	Restraints
Ling 2015	Canada	Descriptive study Audits of a sample of patient charts containing post-restraint event patient debrief forms	Examine PIR data to understand patients' experiences before, during and after restraint events	Audits ($N = 55$)	Adults	Restraints
Riahi 2016	Canada	Retrospective register data study: registration of S/R episodes, number and average time over a 36-month evaluation period	Describe the process and value of implementing the six core strategies	Specialized, tertiary mental health care facility with 326 beds	Adolescents	Restraints and seclusion
Gustafs-son 2016	Sweden	Descriptive design Interviews	Describe nurses' thoughts and experiences of using coercive measures during forensic psychiatric care	Nurses ($N = 8$)	Adults	All kinds of coercion
Goulet 2017	Canada	Pilot study with case study design Individual semi-structured interviews with patients and staff Pre-post study assessing the prevalence of seclusion and restraint before and after PIR	Evaluate a PIR intervention implemented in an acute psychiatric care unit	Interviews: Patients (N = 3) Staff (N = 12) Pre-post study: Anonymised administrative data ($N = 195$ admissions)	Adults	Restraints and seclusion

Table 2 Definitions and descriptions of PIR

First author Date	Definitions	Descriptions		
		Purpose	Theoretical foundation or recommendations	Care philosophy
Petti 2001	Systematic debriefing	S/R reduction	Public recommendations	Strength-based care
Bonner 2002		After-incident support		
Fisher 2003	Detailed behaviour analysis	Mapping of patients' and staffs' views on S/R events and thereby S/R prevention	Public S/R reduction programme	Person-centred care
Ashcraft 2008	Chain analysis	Capturing of the viewpoints of patients who have experienced S/R	Public S/R reduction programme	Recovery-oriented care
Bonner 2010		Discussion of events at patients' own pace in a nonthreatening way	NICE guidelines	
Azeem 2011	Rigorous problem solving	S/R prevention	Public S/R reduction programme	Trauma-informed and Strength-based care
Azeem 2015	Chain analysis of incidents	Restraint prevention	Public S/R reduction programme	Recovery-oriented, person-centred and strength-based care
Lanthen 2015			Quality and safety education for nurses project	Person-centred care
Ling 2015	'an opportunity to talk about feelings, reactions, and circumstances surrounding an inpatient's restraint experience, from the inpatient's perspective'(p. 387)	'an opportunity for clinicians to assess inpatients and determine necessary follow-up care'(p.387)	Public S/R reduction programme	
Riahi 2016	Formalised service-user debriefing	Exploration of events from patients' perspectives to mitigate adverse S/R-related effects and use the lessons to inform future practice	Public S/R reduction programme	Recovery-oriented and trauma-informed care
Gustafsson 2016		Establishment of a communication forum for nurses and patients		
Goulet 2017	'a complex intervention, taking place after an SR episode and targeting the patient and healthcare team to enhance the care experience and provide meaningful learning for the patient, staff, and organization' [37]	Obtaining of patient feedback on their SR experiences	Bonner's model (2008)	

Notes: Empty cells = not described

recent selected publications, inter-professional teams and patients decided with whom patients felt most comfortable meeting in PIR [33, 41].

Timeframe
Based on the time of conducting PIR, two approaches and procedures were described: first, within a timeframe expressed in hours; and second, when the patient was considered mentally capable of participating. Stakeholders' viewpoints on the appropriate time were reported in two publications [35, 41]. One publication discussed patients' viewpoints (*n* = 3) and proposed PIR 1 week after the SR episode; however, it was unclear whether the three patients agreed on the issue [41]. Care providers' statements varied from asserting that PIR should be conducted within a certain timeframe to claiming 'too much time must not have passed' [35], or allowing wide variability in practice by minutes, hours, days and weeks [41]. Later care providers related this flexibility to when they considered the patients ready to talk about S/R and, in some cases, when the care providers themselves felt emotionally available. One publication referred: 'With patients, you

Table 3 How is PIR conducted?

First author Date	Participants	Time	Content of PIR
Petti 2001	Nursing staff other than those directly involved with the incident	As soon as the patient can respond coherently to questions	Mapping of reasons for S/R, possible prevention actions and alternative measures
Bonner 2002	Patients and staff		Participants' comprehension of what happened before, during and after the restraint event; mapping of needs for after-incident care
Fisher 2003	Patients and treatment team		Analysis of the events leading up to the S/R event and more long-term planning to avoid a repetition of S/R
Ashcraft 2008	Patients and staff		What patient and staff could have done differently and what staff could do in the future to prevent S/R
Bonner 2010	Staff, patients, caregivers and witnesses to incidents	Within 72 h	Mapping of the incident and surrounding events and consideration of what was helpful and unhelpful during the incident
Azeem 2011	Staff and patients involved	Within 48–72 h	Mapping of triggers, evaluation of interventions and possible S/R prevention alternatives and identification of traumatisation/retraumatization to patient and staff
Azeem 2015	Patients and staff involved in incidents, clinicians, physicians and sometimes hospital administrators	Within a few days	Analysis of the incident, triggers, helpful interventions and alternatives regarding S/R prevention
Lanthen 2015	Patients and staff Verbal and written follow-up		
Ling 2016	Verbal or written follow-up Participants are decided by the patient and the team	Within 24 h If an inpatient declines, new offer within 72 h	Patients' feelings, reactions and circumstances regarding the restraint experience; mapping of needs for follow-up care
Gustafsson 2016	Patients and nurses who performed the coercive measure	"too much time' should not have passed" [p. 41]	Exchange of reciprocal understandings of the S/R event
Riahi 2016	Patients and staff	As soon as possible after event is clinically indicated	Exploration of the event, identification of triggers, alternative options and identification and healing of restraint-related damage
Goulet 2017	Patients and staff members identified in the staff report	Within 24–48 h, but flexibility in practice	Review of events leading to the incident, factors involved, effect on patients and changes in future practice

Empty cells = not described

have to wait for the dust to settle, for yourself, but especially for them. If you do it the day after it's like pushing a button and triggering something that hasn't completely healed' ([41], p.216).

Form and content of the conversation
All the procedures described face-to-face meetings, while some procedures included a written evaluation in addition or as an alternative [33, 34]. Furthermore, descriptions of PIR emphasised a supportive, non-threatening atmosphere [23, 37, 40, 41].

Regarding PIR content itself, we found some differences in the procedures concerning questions for participants. All the procedures ensured that participants were asked about antecedents or triggers, any actual S/R incidents

and possible alternatives for de-escalation in similar situations. Care providers were asked whether they could have handled the situation in another way, while that question was posed to patients in only three publications [33, 36, 41]. Finally, patients were asked about their emotional reactions in various ways, ranging from open-ended questions about feelings to direct questions about level of feelings, safety during procedures, maintenance of privacy and dignity [16, 33, 34, 36, 41]. Patients could thus express the need for after-incident care. One publication referred to the possibility of using PIR as a tool for the mutual sharing of emotions between patients and care providers, with the aim of opening a dialogue that 'perhaps creates an even stronger bond of trust between patients and nurses' ([41], p.216).

Articles

Hammervold *et al. BMC Health Services Research*   (2019) 19:235   Page 8 of 13

Experiences of PIR

The experiences of PIR described in the articles included 1) measuring the outcome of S/R reduction connected to the implementation of programmes including PIR (quantitative results) and 2) stakeholders' descriptions of their experiences of participating in PIR (mostly qualitative results).

Reduction of S/R

As shown in Table 2, we found that PIR was part of S/R prevention programmes in six publications. The programmes were implemented in different institutions from acute clinics to tertiary hospitals, and the patients were children, adolescents and adults. One publication reported results from a pilot project, implementing PIR as a single intervention alone [41].

As well, no studies were randomised, but some formed control and reference groups in various ways. All the studies measured the outcomes in different ways, so it was not possible to pool the results into a meta-analysis. S/R reduction was measured in two ways: 1) reduction in the number of episodes and 2) in the duration of episodes. The results are presented as follows.

The implemented programmes including PIR contributed to significantly reducing S/R episodes [21, 36–39, 41]. Fisher [21] found a 67% decline in S/R rates when using their clinic's history data on S/R events, making the clinic their control. In addition, this clinic went from a S/R event rate 46% higher than the state average to 44% lower, using state reference data on S/R events as controls. Another study made its desired outcome no S/R incidents in 1 month. Ashcraft and Anthony [36] implemented an organisational S/R reduction programme in two clinics and continued the programme until that goal was achieved, which took 10 months regarding seclusion and 2 months regarding restraints at the small centre and 31 months regarding seclusion and 15 months regarding restraints at the large centre. Azeem et al. [37] compared the first 6 months to the last 6 months of a study period where care providers were trained in the six core strategies. Seclusion and restraint data showed 93 incidents involving 22 patients (mean 4, 2 incidents/patient) in the first 6 months versus 31 incidents involving 11 patients (mean 2, 8 incidents/patient) in the last 6 months. Another study of Azeem et al. [38] took a 10-year perspective on the programme implementation. Mechanical restraint incidents fell from 485 in 2005 to 0 in 2014, with no events in the past 3 years. Physical restraint incidents decreased by 88%, from 3033 in 2005 to 379 in 2014 [35]. Decreased duration of S/R episodes was reported in three articles [21, 39, 41]. Fisher [21] found that the duration of S/R decreased by 92% when examining their clinic's historical data on S/R events. Riahi, et al. [39] found the average length of a mechanical restraint or seclusion

incident decreased 38.9% over the 36-month evaluation period. Goulet, et al. [41] reported reduced use of seclusion, not restraint, while the median time spent in seclusion, but not restraint, decreased significantly from pre- to post-PIR.

Stakeholders' experiences of participating in PIR

Both patients and care providers reported that PIR helped promote recovery processes [34, 35, 41]. Care providers reported that PIR contributed to increased professional reflexivity, which in turn resulted in improved patient care. They also appreciated that PIR provided an opportunity to review the restraint incident.

Bonner and Wellmann [23] evaluated whether patients and care providers found PIR helpful after restraint events. A majority of the patients ($n = 30$) and care providers (n = 30) who responded to a six-question post-incident survey considered PIR helpful after restraint events ([23], p.38–39), except that 61% of care providers and 20% of the patients believed that the restraint incident could have been predicted. Risk of bias is discussed in the Bonner and Wellmann's study as all the 60 informants participated in the study [23].

Recovery promotion

Recovery promotion emerged as a theme through both patients' participation in PIR and in further issues discussed in PIR [23, 33–36, 41]. By participating in PIR, patients may have been empowered by contributing to recovery-promoting alternatives to S/R. For example, in one publication a care provider expressed; 'We have to find ways to prevent this from happening again. What can you do? What can we do? If you want to avoid this, if you want to find ways not to relapse, we have to talk about it' [41]. From care providers' perspective, PIR had the potential to strengthen the patients' identity: 'He seemed satisfied and proud to have been able to express himself and be heard' [41]. Regarding care providers' experiences, the majority of patients claimed that PIR gave them an opportunity to review restraint events they would not otherwise have had [23]. Additionally, PIR seemed to provide a way for the patients to process and stimulate an understanding of the situation by talking about it [23, 34, 41], with the aim to promote hope and connectedness. Former patients in Lanthen's study [34] considered adapting to restraint-related trauma as essential, allowing them to move on from the experience and continue their personal recovery processes.

Increased professional reflexivity

In Bonner and Wellman's study, nearly all the care providers claimed that PIR was useful for reviewing incidents of restraint and offered an opportunity to look over restraint events they would not have otherwise [23].

In chain analysis of S/R events, the patients reported S/R causes, care providers' incident management, emotions before, during and after the incident and alternative measures for future S/R events [16, 33, 34, 36, 40, 41]. The antecedents to the S/R events could be hospital and ward-level factors, such as disturbed wards, miscommunication, patients' unmet needs, conflicts between patients and care providers and patients' lack of autonomy. Further, PIR revealed that S/R incidents caused strong negative feelings among patients, who described S/R as unnecessary and punitive, fuelling anger, sadness and resentment [33, 34, 40]. In addition, S/R was related to traumatisation and re-traumatisation and damaged relations between care providers and patients [16, 33, 39, 41]. Patients and care providers who participated in PIR reflected on how care providers could meet patients' individual needs before and during S/R events by implementing alternative interventions.

A care provider expressed; "we bring some of our experience. New people bring new ideas too, so I think combining them together, you try to see what you can do better with everyone's ideas" [41]. Possible alternatives were then recorded in patients' care plans so that mitigating efforts could be implemented immediately. This individualised approach seemed to de-escalate situations, possibly helping to prevent S/R incidents [33, 34, 36, 38, 40]. Additionally, publications reported that information from PIR led to changes in organisations, but it was not always clear how these changes emerged, as they were not further described [36, 38, 40]. For example, 'perhaps the most important implication of this study is to underscore the importance of debriefing as an indicator for continuing to introduce and track elements representing cultural challenges in this organization' ([40], p.124).

Processing the incidence

Benefits for care providers were mentioned in two publications [35, 41]. Goulet et al. [41] reported that PIR not only raised awareness about the trauma experienced by patients but also helped care providers manage their own feelings. Gustafsson and Salzmann-Erikson [35] argued that systematic PIR improved the working conditions of nurses participating in coercive measures by reducing stress. In addition, nurses [35, 41] viewed PIR as a way to restore trust relationships, but we did not find any patients who said the same.

Discussion

The review shows that scientific knowledge on PIR is limited and the studies vary in quality and design. Furthermore, evaluations of S/R reduction programs are often based in local, ideal-driven development work in practice, with limited resources to conduct systematic

outcome studies and without the involvement of any larger research environment or external perspectives. These studies lack some of the rigorous design provided by, for instance, experimental design. We, therefore, cannot conclude that PIR as an individual intervention contributes to S/R reduction even though Goulet's pilot study [41] gave positive results according to seclusion. Nevertheless, S/R reduction programs we consider to be non-experimental programs developed in practice and seem to be largely effective, increasing the importance of a need for high-quality intervention research in this field of practice. Still, these methodological limitations mean that so far, we not can draw a solid overall conclusion on efficacy and, therefore, cannot recommend PIR as a mandatory procedure for S/R reduction alone.

Despite the lack of evidence for PIR contributing to S/R reduction, the results in this review indicates a contribution from PIR nevertheless. PIR could promote recovery and increase professional reflexivity, leading to improved care. These important indications are elaborated further in the following sections.

Potential of PIR for patients' personal recovery processes

The results of this review point to PIR as an effective intervention for mitigating S/R-related harm. Therefore, we believe it is relevant to discuss the results in terms of a recovery-oriented framework and a humanising care approach to nursing and ethics (10, 24). PIR represent an arena for the patient to regain status lost during the S/R event. Subject status will be an assumption for patients' active participation and engagement in planning of treatment and care [10].

According to Buber, a "Subject–Subject/I–Thou dialogue" [42] can establish "a world of relation" [42], between persons. In the context of PIR, a Subject–Subject relationship between patient and care provider is optimal, even though, in the case of mental health services providers interacting with patients, there will always be an imbalance of power between stakeholders. However, an approximate Subject–Subject relationship might be preferable to an I–It relationship [42] and support the CHIME recovery processes of Connectedness, Hope, Identity, Meaning and Empowerment, processes that are significant for personal recovery [10, 43].

Patients' expressed views on antecedents and triggers when participating in formulating care and crisis plans might promote recovery through agency and empowerment. [10, 44]. In addition, asking patients if *they* could have acted differently [34, 36, 41] minimises their loss of personal responsibility during crises, a central value in recovery-based care [10].

Within a framework of humanising care, PIR has the potential to contribute to patients' re-humanisation after S/R-related emotions that can be experienced as

dehumanising [6] as PIR can facilitate togetherness, uniqueness and sense-making [24]. These dimensions are compatible with the CHIME processes. Furthermore, PIR s' provide a forum where sense-making can occur, if care providers give patients information and explain assessments for S/R use. By getting an explanation, the patients may perceive that care providers applied the ethical principles of proportionality and purposefulness and their intentions were influenced by beneficence. Consequently, being treated like a human being can lead to patients perceiving the restraint less negatively [45].

Regarding the conflicting results from debriefing studies [20], the descriptions of PIR in the selected publications indicate planned and structured dialogues with focus on the chain analyses of the S/R incident, but with minor focus on emotions (Table 2).

From an emotion-regulation perspective, constructive, insightful and controlled processes after emotional episodes lead to positive outcomes and create opportunities to re-evaluate events, thereby supporting identity regulation, which is central in recovery processes [10, 46]. In addition, since both patients and their mental conditions vary, PIR content related to sharing emotions must be take a person-centred approach [10].

In line with a recovery-based framework, a patient's voice must be heard when it comes to PIRs' timing as well as which participants should be included in the PIR.

Therefore, 'the golden time' [35] for PIR is essential; doing it early can violate patients' integrity and uniqueness and contribute to dehumanisation through homogenisation and the loss of the personal journey [24]. However, waiting too long can increase negative feelings in patients, such as isolation and loss of meaning [34, 35].

Studies show an imbalance in PIR in terms of representing patients and care providers' voices, with care providers clearly in the majority. In two studies [33, 41], patients have some influence over which staff members participate. In other studies, the PIR procedure itself determines the participants. Thus, the system has the advantage over the patients, since they are in a dependent and usually powerless position [47]. To address this imbalance in representation, it may be helpful to invite a trusted person to participate in PIR, for example, the patient's next of kin, a supportive peer or an advocate [10, 48].

However, we did not find this alternative in the articles. Conducting PIR with care providers whom patients trust aligns with a recovery-based approach, but we will claim that care providers' perspectives may be unclear or lost if participating care providers in PIR were not present during the S/R incident.

Conducting PIR in a supportive and non-threatening attitude [23, 37, 40, 41] is in line with an atmosphere characterised by human values, which can be crucial to patients' psychological and moral perceptions of coercion in care in general [45]. In the case of PIR, care providers whose attitude is characterised by respect and who appear to be flexible, trusting, friendly and oriented towards collaboration on ideally equal terms might confirm patients as persons by promoting patients' "insiderness" [49]. Patients' well-being and identity might then be strengthened, thereby constituting caring power, the opposite of consequences of detached care [49]. PIR's potential to restore the therapeutic relationship damaged in S/R interventions was described in two publications [33, 41], but this possibility was not presented from the patients' perspective. This issue needs more exploration taking into consideration patients' views.

Potential of PIR for care providers' reflection on action and processing

Reflection is considered to be an essential quality in knowledge production and professional development [50, 51]. In results, care providers see PIR as an arena for learning by reflection on action [50] that involves reflecting on how attitudes and caring practices can change. This reflection may be useful in potential future S/R-related situations as it provides an extended repertoire of alternative reflection-in-action measures for reflecting on an incident while still benefitting the situation at hand, rather than simply reflecting on how to act differently in the future [50]. Although based on the literature we cannot conclude that PIR contribute to S/R reduction, we can highlight the potential for care providers' learning through reflection on action with patients. This reflection has the potential to promote the moral elements of care, such as attentiveness, responsibility, competence and responsiveness, and thereby improve the quality of care [52].

Furthermore, PIR gives care providers an opportunity to process S/R incidents that might create mental strain for them as professionals, although S/R-related damage to patients and strain to care providers should not be viewed as equivalent due to the power imbalance. Processing can help care providers deal with emotional and moral distress if they view restraint events as morally uneasy [53, 54]. Doing so might improve their ethical and professional care as care providers 'in touch with and guided by their values are more likely to feel inspired and empowered' [55]. The described sharing of emotions between patients and care providers [41] might be professionally controversial. However, from the recovery perspective, sharing emotions might support patients' personal recovery processes [10] if care providers do not treat PIR as an arena for their personal debriefing.

Potential of PIR for organizational development

Previous research showed that a number of perspectives regarding S/R reduction, among them workforce

development, need to be studied [10, 13]. Creating reflexive cultures, therefore, is important in addressing coercive practices, including systemic and cultural concerns [54]. As shown in the results (Table 2), PIR is often implemented in organizations with defined care philosophies based on human values that provide alternatives to deficit-based medical models by understanding deficits within broader contexts [10, 55]. These care philosophies emphasize user participation, viewing patients as experts along with care providers. In the perspective of evidence-based healthcare, aggression and agitation are related to patients' diagnosis and symptoms, suggesting that care providers perform certain actions independent of the context. The disparity between patients and care providers in Bonner and Wellmann's study regarding prediction of restraint incidents [23] may reflect a more optimistic attitude from care providers than from patients. That might indicate different frame of reference and thus, different expectations and solutions.

In recovery-based healthcare, however, patients' and care providers' reflections and ongoing dialogues on the antecedents and triggers of restraint events and inclusive environmental factors, may contribute to organisational development and care improvement, as reported in the results and supported by Goulet and Larue's definition of the debriefing procedure [22, 41]. Relevant improvement issues can include care providers' educational needs and patients' expressed needs for more supportive ward environments, and by that support patients' wellbeing [56].

Legislation, as in Norway and Denmark [3, 57], or guidelines as in United Kingdom and some states in USA [58, 59], raises the question of degree to which PIR should be standardised versus conducted in a flexible manner. PIR as a strict procedure might increase PIR's feasibility and care providers' safety when conducting an often-demanding dialogue. In a manual-based treatment organization however, PIR might be another manual to check off, risking minimizing the documented benefits of PIR reported in this review, while additionally increasing the risk of objectifying patients. The reported differences in carrying out PIR therefore, indicate that PIR cannot follow strict procedures as in a manual. Instead, PIR should be conducted in accordance with a recovery-based philosophy [10] that gives care providers the flexibility to individualise assessments regarding timeframes, participants and content.

Consequently, in addition to reflexive professional practice, care providers need to be ethically mindful and sensitive to ethically important moments in everyday practice, acknowledging them as significant [60]. In a recovery perspective, then, PIR should not be implemented as a separate procedure within organisations, but should be integrated with ethical issues, treatment philosophies, quality improvement and service development [61].

Limitations and strengths of the review

A strength of this review is that it examines a knowledge base in an area rarely explored despite professional and political guidelines recommending PIR. Another strength is the comprehensive, systematic search strategy supported by a qualified librarian and the examination of relevant reviews in both the scientific and the grey literature. According to Arksey and O'Malley [25], quality assessment of the included publications is not necessary, but we consider our narrative description of the quality of the selected publications to be a strength as methodological shortcomings affect the quality of findings.

One limitation was the lack of publications explicitly examining PIR, so the inclusion criteria were changed to articles exploring PIR after restraint alone and articles exploring PIR after restraint and seclusion together. As described, variations in the studies' design and quality required appraising and determining which studies to include. In addition, we could have missed relevant information by excluding reports published in local, non-indexed journals and books. Consultations by practitioners and patients/consumers were not included but could have produced more nuanced results [25]. We address this issue in a separate project.

Conclusion

This review of scientific literature presents PIR as an intervention with the potential to benefit patients' recovery processes, care providers' reflection on action, processing and organisational development. In sum, PIR seems to be promising for restraint (R) prevention and the promotion of a more professional, reflexive, ethical care culture in mental health services. To achieve these outcomes, PIR should be implemented in supportive environments with care philosophies based on human values and care providers' ethical mindfulness.

The recovery and humanising care approach seems to offer opportunity to prevent and process restraint events, thanks to its focus on patients' individual needs. However, its overall application needs to be further explored. In addition, it would be beneficial to further examine stakeholders' experiences of PIRs', and take into account both patients' and care providers' perspectives. The patients' dependence on the system, especially when being compulsorily detained, can however be critical to their participation in PIRs'. Thus, this issue needs to be addressed.

In both scientific studies and in society, patients' voices on the consequences of coercion and care improvement are underrepresented. This lack conflicts with 'the moral claim to call attention to the necessity of honest inclusion of everyone's perspectives in a democratic society where caring is highly participatory' [62].

Publisher's Note
Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Author details
¹Department of Public Health, Faculty of Health Sciences, University of Stavanger, NO-4036 Stavanger, Norway. ²Work Research Institute, Oslo Metropolitan University, Oslo, Norway. ³Department of Occupational Therapy, Prosthetics and Orthotics, Faculty of Health Sciences, Oslo Metropolitan University, Oslo, Norway.

References
1. Huf G, Coutinho ES, Ferreira MA, et al. TREC-SAVE: a randomised trial comparing mechanical restraints with use of seclusion for aggressive or violent seriously mentally ill people: study protocol for a randomised controlled trial. Trials. 2011;12:180.
2. Sailas E, Fenton M. Seclusion and restraint for people with serious mental illnesses. Cochrane Database of Syst Rev. 2000;2 CD001163.
3. Norwegian Health Department. The Mental Health Care Act, 1999. Act no 62 of 2 July. Relating to the provision and implementation of mental health care. (the mental health care act), with later amendments. Translated version of the Norwegian health care law on coercion: http://app.uio.no/ub/ujur/oversatte-lover/data/lov-19990702-062-eng.pdf
4. Bigwood S, Crowe M. It's part of the job, but it spoils the job': a phenomenological study of physical restraint. Int J Ment Health Nurs. 2008;17:215–22.
5. Mohr WK, Petti TA, Mohr BD. Adverse effects associated with physical restraint. Can J Psychiatr. 2003;48:330–7.
6. Cusack P, Cusack FP, McAndrew S, et al. An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. Int J Ment Health Nurs. 2018;27:1162–76.
7. Mohr WK. Restraints and the code of ethics: an uneasy fit. Arch Psychiatr Nurs. 2010;24:3–14, 11.
8. International Council of Nurses. The ICN code of ethics for nurses. 2012 https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf.
9. Beauchamp TL, Childress JF. Principles of biomedical ethics. 6th ed. ed. Oxford: Oxford University Press; 2009.
10. Slade M. Personal recovery and mental illness: a guide for mental health professionals. Cambridge: Cambridge University Press; 2009.
11. Scanlan JN. Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far, a review of the literature. Int J Soc Psychiat. 2010;56:412–23.
12. LeBel JL, Duxbury JA, Putkonen A, et al. Multinational experiences in reducing and preventing the use of restraint and seclusion. J Psychosoc Nurs Ment Health Serv. 2014;52:22–9.
13. Huckshorn KA. Reducing seclusion & restraint use in mental health settings: core strategies for prevention. J Psychosoc Nurs Ment Health Serv. 2004;42(9):22–33.
14. Huckshorn KA. Re-designing state mental health policy to prevent the use of seclusion and restraint. Admin Pol Ment Health. 2006;33:482–91.
15. Espinosa L, Harris B, Frank J, et al. Milieu improvement in psychiatry using evidence-based practices: the long and winding road of culture change. Arch Psychiatr Nurs. 2015;29:202–7.
16. Bonner G, Lowe T, Rawcliffe D, et al. Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. J Psychiatr Ment Health Nurs. 2002;9:465–73.
17. Wynn R. Psychiatric inpatients' experiences with restraint. J Forensic Psychiatry Psychol. 2004;15:124–44.
18. Larue C, Dumais A, Boyer R, et al. The experience of seclusion and restraint in psychiatric settings: perspectives of patients. Issues Ment Health Nurs. 2013;34:317–24.
19. Secker J, Benson A, Balfe E, et al. Understanding the social context of violent and aggressive incidents on an inpatient unit. J Psychiatr Ment Health Nurs. 2004;11:172–8.
20. Tuckey MR. Issues in the debriefing debate for the emergency services: moving research outcomes forward. Clin Psychol Sci Pract. 2007;14:106–16.
21. Fisher WAM. Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. J Psychiatr Pract. 2003;9(1):7–15.
22. Goulet M-H, Larue C. Post-seclusion and/or restraint review in psychiatry: a scoping review. Arch Psychiatr Nurs. 2016;30:120–8.
23. Bonner G, Wellman N. Post incident review of aggression and violence in mental health settings. J Psychosoc Nurs Ment Health Serv. 2010;48:35–40.
24. Todres L, Galvin KT, Holloway I. The humanization of healthcare: a value framework for qualitative research. Int J Qual Stud Health Well-being. 2009;4:68–77.
25. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Methodol. 2005;8:19–32.
26. Armstrong R, Hall BJ, Doyle J, Waters E. Scoping the scope' of a cochrane review. J Public Health. 2011;33(1):147–50.
27. Sutton D, Webster S and Wilson M. Debriefing following seclusion and restraint. A summary of relevant literature. The National Centre of Mental Health Research, Information and Workforce Development website: Te Pou o Te Whakaaro Nui, 2014.
28. Pham MT, Rajić A, Greig JD, Sargeant JM, Papadopoulos A, McEwen SA. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Res Syn Meth. 2014;5(4):371–85.
29. Polit DF, Beck CT. Nursing research: generating and assessing evidence for nursing practice. 9th ed. ed. Philadelphia, Pa: Wolters Kluwer Health; 2012.
30. Graneheim UH, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: a discussion paper. Nurse Educ Today. 2017;56:29–34.
31. QSR International Pty Ltd. NVivo qualitative data analysis Software; Version 11. 2016.
32. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24:105–12.
33. Ling S, Cleverley K, Perivolaris A. Understanding mental health service user experiences of restraint through debriefing: a qualitative analysis. Can J Psychiatr. 2015;60:386–92.
34. Lanthen K, Rask M, Sunnqvist C. Psychiatric patients experiences with mechanical restraints: an interview study. Psychiatry J. 2015;2015:748392.
35. Gustafsson N, Salzmann-Erikson M. Effect of complex working conditions on nurses who exert coercive measures in forensic psychiatric care. J Psychosoc Nurs Ment Health Serv. 2016;54:37–43.

Articles

Hammervold *et al. BMC Health Services Research*   (2019) 19:235   Page 13 of 13

36. Ashcraft L, Anthony W. Eliminating seclusion and restraint in recovery-oriented crisis services. Psychiatr Serv (Washington, DC). 2008;59:1198–202.
37. Azeem MW, Aujla A, Rammerth M, et al. Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. J Child Adolesc Psychiatr Nurs. 2011;24:11–5.
38. Azeem MW, Reddy B, Wudarsky M, et al. Restraint reduction at a pediatric psychiatric hospital: a ten-year journey. J Child Adolesc Psychiatr Nurs. 2015;28:180–4.
39. Riahi S, Dawe IC, Stuckey MI, et al. Implementation of the six core strategies for restraint minimization in a specialized mental health organization. J Psychosoc Nurs Ment Health Serv. 2016;54:32–9.
40. Petti TA, Mohr WK, Somers JW, Sims L. Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. J Child Adolesc Psychiatr Nurs. 2001;14:115–27, 124. 13p.
41. Goulet M-H, Larue C, Lemieux AJ. A pilot study of "post-seclusion and/or restraint review" intervention with patients and staff in a mental health setting. Perspect Psychiatr Care. 2018;54:212–20.
42. Buber M, Smith RG. I and thou. 2nd ed. London: Continuum; 2004.
43. Leamy M, Bird V, Le Boutillier C, et al. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br J Psychiatry. 2011;445–52.
44. Henderson C, Flood C, Leese M, et al. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. BMJ. 2004;329:136–40.
45. Norvoll R, Pedersen R. Patients' moral views on coercion in mental healthcare. J Nurs Ethics. 2018;25(6):796–807.
46. Zech E, Rimé B. Is talking about an emotional experience helpful? Effects on emotional recovery and perceived benefits. Clin Psychol Psychothe. 2005;12:270–87.
47. Emerson RM. Power-dependence relations. Am Sociol Rev. 1962;1:31.
48. Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. Psychiatr Rehabil J. 2004;27:392–401.
49. Todres L, Galvin KT, Dahlberg K. "caring for insiderness": phenomenologically informed insights that can guide practice. Int J Qual Stud Health Well-being. 2014;9:21421–1. https://doi.org/10.3402/qhw.v9.21421.
50. Schön DA. The reflective practitioner: how professionals think in action. Aldershot: Avebury; 1991.
51. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. Adv Health Sci Educ Theory Pract. 2009;14:595–621.
52. Tronto JC. Moral boundaries: a political argument for an ethic of care. New York: Routledge; 1993.
53. McCarthy J, Deady R. MORAL DISTRESS RECONSIDERED. J Nurs Ethics. 2008;15:254–62.
54. Norvoll R, Hem MH, Pedersen R. The role of ethics in reducing and improving the quality of coercion in mental health care. HEC Forum. 2017;29:59–74.
55. Gottlieb LN. CE: strengths-based nursing. Am J Nurs. 2014;114:24–32.
56. Slade M. Mental illness and well-being: the central importance of positive psychology and recovery approaches. BMC Health Serv Res. 2010;10.
57. Sundhedsministeriet I-o. Bekendtgørelse af lov om anvendelse af tvang i psykiatrien. Psykiatriloven, LBK nr 1729 ;. Indenrigs- og Sundhedsministeriet, 2010. English: Danish Mental Health Act (2010) § 4.5. https://www.retsinformation.dk/Forms/R0710.aspx?id=174248.
58. National Institute for Clinical Excellence, NICE (2015). Violence and aggression: short-term management in mental health, health and community settings. Retrieved February 15, 2019, www.nice.org.uk/guidance/NG10
59. Commonwealth of Massachusetts. 104 Code of Massachusetts Regulations 27.00: Licensing and Operational Standards for Mental Health Facilities. Boston: Massachusetts Department of Mental Health; 2006. Retrieved February 15, 2019, https://www.mass.gov/files/documents/2018/02/26/104cmr27.pdf
60. Guillemin M, Gillam L. Emotions, narratives, and ethical mindfulness. Acad Med. 2015;90:726–31.
61. Norvoll R, Pedersen R. Exploring the views of people with mental health problems on the concept of coercion: towards a broader socio-ethical perspective. Soc Sci Med. 2016;156:204–11.
62. Tronto JC. Caring democracy: markets, equality, and justice. New York: New York University Press; 2013.

Article II

BMC Health Services Research

RESEARCH ARTICLE   **Open Access**

Post-incident reviews—a gift to the Ward or just another procedure? Care providers' experiences and considerations regarding post-incident reviews after restraint in mental health services. A qualitative study

Unn Elisabeth Hammervold[1*] , Reidun Norvoll[2], Kari Vevatne[3] and Hildegunn Sagvaag[1]

Abstract: Public guidelines in many western countries recommend post-incident reviews (PIRs) with patients after restraint use in mental health care. PIRs are one of several elements of seclusion and restraint reduction in internationally used programmes. PIRs may improve restraint prevention, patients' recovery processes and care providers' ethical mindfulness. The knowledge base on PIRs is, however, vague. This qualitative study explores professional care providers' experiences and considerations regarding PIRs that included patients after restraint use in a Norwegian context.

Methods: Within a phenomenological hermeneutical framework, 19 multidisciplinary care providers were interviewed about their experiences and views regarding PIRs that included patients after restraint events. The interviews were performed over the period 2015–2016. Data analysis followed a data-driven stepwise approach in line with thematic content analysis. A group of two patient consultants in mental health services, and one patient's next of kin, contributed with input regarding the interview guide and analysis process.

Results: Care providers experienced PIRs as having the potential to improve the quality of care through a) knowledge of other perspectives and solutions; b) increased ethical and professional awareness; and c) emotional and relational processing. However, the care providers considered that PIRs' potential could be further exploited as they struggled to get hold on the patients' voices in the encounter. The care providers considered that issue to be attributable to the patients' conditions, the care providers' safety and skills and the characteristics of institutional and cultural conditions.

(Continued on next page)

* Correspondence: unn.hammervold@uis.no
[1]Department of Public Health, Faculty of Health Sciences, University of Stavanger, 4036 Stavanger, Norway
Full list of author information is available at the end of the article

Articles

Hammervold *et al. BMC Health Services Research*   (2020) 20:499   Page 2 of 13

(Continued from previous page)

Conclusion: Human care philosophies and a framework of care ethics seem to be preconditions for promoting patients' active participation in PIRs after restraints. Patients' voices strengthen PIRs' potential to improve care and may also contribute to restraint prevention. To minimise the power imbalance in PIRs, patients' vulnerability, dependency and perceived dignity must be recognised. Patients' individual needs and preferences should be assessed and mapped when planning PIRs, particularly regarding location, time and preferred participants. Care providers must receive training to strengthen their confidence in conducting PIRs in the best possible way. Patients' experiences with PIRs should be explored, especially if participation by trusted family members, peers or advocates may support the patients in PIRs.

Keywords: Post-incident reviews, Debriefing, Mental health, Restraint, Staff experiences, Participation, Care philosophy, Care ethics

Background

Post-incident reviews (PIRs) have been implemented in several western countries in recent years as part of seclusion and restraint (S/R) reduction programmes. Often referred to as the Six Core Strategies©, these programmes are underpinned by prevention- and trauma-informed principles. These programmes usually include a) leadership in organisational changes; b) the use of data to inform practice; c) workforce development; d) the use of S/R prevention tools; e) full inclusion of patients and their families; and f) rigorous debriefing that may include only care providers or both patients and care providers [1–3]. Restraint can be defined as a 'mechanical or physical reaction against the patient including (the) use of straps, belts, other equipment or physically holding the patient preventing behaviour that might harm patients, care providers or (the) environment' [4]. We rely on this definition in this research.

Mechanical restraint is widely considered to be among the most intrusive coercive measures, so the practice is controversial and contested [5, 6]. Consequently, much attention has been focused on restraint reduction in mental health services in recent decades [2, 7]. The international development of laws applicable to persons with psychosocial disabilities has encouraged more critical attitudes towards coercive measures, especially their use with people in vulnerable situations. This has prompted bans on all kinds of coercive measures [8]. In addition, ethical and professional imperatives urge developing reflexive practices aimed at limiting the use of coercion in morally justified cases and helping patients maintain hope and identity during crises, including the use of restraint [9, 10]. Despite the promise of these S/R reduction programmes, most studies on them have been based on development work aimed at S/R reduction, not rigorous research, so it is difficult to assess how much the different interventions have individually contributed to these supposedly promising results [2, 7, 11].

A PIR intervention is defined as 'a complex intervention, taking place after a S/R episode and targeting the patient and healthcare team to enhance the care experience and provide meaningful learning for the patient, staff, and organisation' ([12],p.127). PIRs have recently been mandated by guidelines and laws in several countries, including Norway, even though their knowledge base is vague and does not require descriptions of the services' value [2, 4]. The few studies conducted indicate that PIRs are usually implemented in services with defined care philosophies that are recovery based, strength based, person centred and trauma informed [11, 13]. These care philosophies are all founded on human values that emphasise a supportive environment, recognition of individual needs in care, and user participation by patients and care providers, both of whom are viewed as experts [9, 14, 15]. The literature describes PIR procedures including their timing, participants and themes. However, the broader question of how PIRs relate to the wider context of the organisation and culture is poorly described, although non-punitive, supportive approaches are recommended [16–18]. Human care philosophies with supportive approaches for conducting PIRs may conflict with the traditional organisation and culture of psychiatric institutions, often historically characterised by bureaucratic, hierarchical structures with paternalistic cultures that include habitual coercive practices and allow patients' voices to have only marginal effects on services [10, 19].

In previous research, patients and care providers described PIRs as an arena for knowledge development, ethical reflection and recovery promotion [11]. Care providers also saw PIRs as beneficial as they increase professional reflexivity, which, in turn, results in improved care [11, 13, 20]. Furthermore, data from PIRs have been found to be useful for understanding patients' experiences before, during and after restraint events; PIRs, therefore, are recommended to inform care plans [21]. These studies, however, included few participants, and their design and quality varied, so they have a low degree of comparability. In addition, they were published from 2001 to 2017, allowing time for different approaches

concerning care philosophies in mental health services, as well as different contexts and issues, to influence how PIRs are conducted in practice [11].

Given PIRs' potential in S/R reduction programmes, and the lack of knowledge about the core strategy of PIRs as a specific intervention and how they unfold in practice within mental health services, this research explores multidisciplinary care providers' practical experiences and considerations concerning the use of PIRs after mechanical and physical restraint in mental health services in a Norwegian context. This multidisciplinary perspective is relevant as several kinds of professionals take part in PIRs. As this study is a part of a larger project, patients' experiences and views on PIRs will be presented in another publication.

This research focuses on PIRs after physical and mechanical restraint events as these measures can have grave consequences, infringing upon patients' human rights and risking physical and mental damage to both patients and care providers [22–25]. We therefore ask:

1) What are professional care providers' experiences and considerations regarding the use of PIRs in practice?
2) What do professional care providers see as the benefits and challenges of PIRs?

The implications of the findings are discussed in relation to care ethics [26, 27] and a humanising care approach [28].

Methods
Design
To investigate professional care providers' experiences with PIRs after the use of restraint in mental health services, we considered an explorative descriptive study design with a phenomenological hermeneutical approach, as this provided relevance to the study. To access care providers' experiences and views concerning PIRs, we conducted qualitative interviews [29]. We found that Graneheim and Lundemann's [30, 31] qualitative content analysis method was well suited to analyse multifaceted, sensitive, important phenomena regarding care, especially for a topic with such limited knowledge [32]. This analysis focused on the subject and context and offered opportunities to examine manifest and descriptive content and latent and interpretive content [30, 31]. In our study, the subject was the interviewees, the context was the mental health services wards, and the content was the care providers' stories.

Setting
We conducted the study in five locked wards in two mental health services in the same health region: a

university hospital and a community mental health centre that both served patients with serious mental problems. These included psychoses or affective (bipolar) disorders, often also combined with addiction problems. The services had implemented PIRs as an intervention aimed at reducing the use of restraint but not as part of restraint reduction programmes. At the University hospital, they started an implementation project that included care providers from different ward units and a course for the employees, as well as monitoring PIR incidents. In the community mental health centre, the procedure was implemented somewhat differently over time in units were coercion was used. The two services had both written, formal procedures that were available in the start of the project. The services' procedures were mostly congruent, but with some variation. The PIR procedures included questions about the patients' and care providers' comprehension of antecedents and potential triggers for restraint events, as well as the patients' experiences of such events and their suggestions for alternative measures if similar occasions should arise. In addition, the care providers were asked about the basis for their decisions to use restraint and if they could have handled the situations differently. The patients were not asked the last question.

The PIR procedures varied according to time and participants. In the university hospital, PIRs had to be conducted within the procedural limit of 72 h from the restraint event, while in the community mental health centre, PIRs had to be conducted as soon as possible after the restraint event and no later than discharge. In that same service, the PIR participants included the patient, a milieu therapist who knew the patient, a responsible doctor or psychologist, the person responsible for the restraint decision and a relative based on the patient's preferences. The university hospital's procedures stated that PIRs should be conducted by a person not involved in the restraint incident and a care provider involved in the restraint event. This procedure also included an interpreter for non-Norwegian-speaking patients.

Sample and recruitment
The participants were purposively recruited from the interdisciplinary population of the care providers at the two participating mental health services. The inclusion criteria were that the care providers had experience with PIRs that included patients after restraint use. The ward leaders and available care providers were given both written and oral information about the study. The care providers who gave consent were then contacted by the UH to set appointments for the interviews. Nineteen care providers agreed to participate, as shown in Table 1. First author, a mental health nurse with long-lasting

Articles

Hammervold *et al. BMC Health Services Research*   (2020) 20:499   Page 4 of 13

Table 1 Overview of interdisciplinary participants

Health Care Providers	Women	Men
Nurses	2	7
Social educators *	2	1
Doctors/psychiatrists	4	0
Psychologists	2	1

*Social educators included both health and social workers qualified to work in diverse, specialised health services

experience from working in mental health services, was introduced to the participants as a 'PhD-student'. Nobody withdrew their consent to participate in the study. The participants' age ranged from 23 to 59 years, and their professional experience in mental health services ranged from 6 months to 25 years. Most providers had participated in PIRs less than five times, while four had participated more than five times.

Planning and conducting the interviews
Qualitative one-to-one interviews following a semi-structured interview guide were considered to be relevant to the exploration of the care providers' views and experiences [29]. The guide included initial questions about the participants' profession, age, years working in mental health services and experience conducting restraint and PIRs. The care providers were asked to briefly tell about a restraint event and then give a deeper description of how they experienced the PIR and share their thoughts about the patient's experiences. During the development of the interview guide, a draft was presented to two patient consultants, experts with personal experience in mental health services [33, 34]. They gave valuable input that contributed to nuancing the UH's preconceptions and so expanded the focus of the interviews. For example, the consultants viewed the definition of participants in PIRs as problematic.

The interviews were conducted in 2015 and 2016 in the participants' ward units and lasted 17–51 min, with a mean time of 33 min. The interview guide was used to ensure that the most important issues were the themes in the dialogue, but room was allowed for other issues. The participants were asked to clarify when the interviewer did not understand their statements. After 19 interviews, we considered the information power as high, based on the criteria in the model of Malterud et al.

[35], and we decided not to conduct more interviews. The interviews were tape-recorded and transcribed in verbatim in Norwegian.

Analysis
The data analysis went ahead as follows. First, UH read through the interviews several times to obtain a sense of the whole. She also wrote notes on her immediate impressions of the interviews and ideas for the eventual theoretical framework [36, 37]. Second, she systematically identified the meaning units in the text, which were words, sentences and paragraphs whose content and context had related aspects. Two authors (UH and HS) condensed and labelled the meaning units into subcategories relevant to the study aim. NVivo 12 [38] was used as a tool in the analysis process.

Third, two authors (UH and HS) created categories answering 'what' questions related to the research questions and describing the manifest content of the text. The tentative categories were discussed by three researches (UH, HS and KV) and revised. To understand the participants' experiences regarding PIRs', the final step of the analysis was to formulate the latent content of the themes in collaboration with the co-authors. The emerging themes were placed against the transcribed text and the notes on first impressions in a hermeneutic circle and then recontextualized to achieve an overall understanding [30, 31]. Table 2 gives an example of qualitative content analyses, indicating the abstraction process from categories to theme.

In the analysis process, reflexivity was emphasised through the exchange of ideas by the co-authors, and the project's advisory group consisted of the two patient consultants in mental health services and the mother who was the next of kin to a patient. UH and the advisory group discussed preliminary results based on the

Table 2 Theme, categories and subcategories

Theme	PIRs' potential to improve the quality of care		
Categories	Knowledge about other perspectives and solutions	Increased professional and ethical awareness	Emotional and relational processing
Subcategories	Developing professional skills Developing coping strategies for patients Noticing patients' expressed preferences for eventual future crises Being attentive to the patients' coercion related experiences Mapping the stakeholders' expressed experiences of antecedents and triggers	Reflecting on actions before restraint events Paying attention to the obligation to respect, listen to and learn from patients	Giving reason for restraining to the patient Excusing eventual wrongdoing Restoring the relationship with the patient

care providers' expressions in a two-hour meeting that was tape-recorded and listened to by UH as a supplement for reflections afterward. The discussions contributed other nuances and new questions that challenged the researchers' preconceptions and consequently the preliminary results [37, 39, 40]. For example, the reference group attached importance to the patients' vulnerability and power imbalance. Trustworthiness was considered to be important throughout the process and was strengthened by presenting the participants' perspectives as faithfully as possible. A professional translator translated the quotations to ensure that the original interview text was maintained.

Ethical considerations
The Norwegian Social Science Data Service (ref. no. 39122) assessed and approved the study, which followed ethical principles for research [41]. The Regional Committees on Health Research Ethics for Western Norway did not allow the researcher to be an observer in the ward units but decided that the study required no other ethical approval (2013/2359/REK south-east). In line with the Helsinki Declaration, the participants' consent and confidentiality were secured, and they were provided with written and oral information including their right to withdraw at any stage without explanation or consequences [41].

Results
The main results show a tension between care providers experiencing PIRs' (1) *potential to improve the quality of care* and the experience of (2) *struggling to get hold of the patients' voices* in the encounter. As the care providers struggled to get hold of the patients voices during

the PIRs, PIRs' potential did not seem to be utilised fully, which contradicted the aim of increasing dialogue between the care providers and patients.

Potential to improve the quality of care
The care providers related PIRs' potential to improve the quality care based on knowledge about other perspectives and solutions, as well as increase professional and ethical awareness and the care providers' emotional and relational processing.

Knowledge about other perspectives and solutions
The care providers described PIRs' as beneficial due to their potential to develop new knowledge, mainly on the individual rather than the organisational level. They considered the new knowledge to be useful to prevent and minimise restraint events and to reduce harm when restraint seemed inevitable. The patients' triggers before agitation were identified, such as excitement among the patients in the ward and the patients' experiences of disrespect from the care providers. For example, a nurse quoted a former patient: '*When you don't meet me with respect, I get angry*' [7]. The nurse perceived that this was largely related to the way they spoke to the patient.

Informed of the patients' expressed experiences, the care providers said that they developed insights into how their attitudes and behaviour could negatively influence the patients and consequently provoke situations in which the patients acted out. From the identification of these antecedents and triggers, alternative behaviours by the patients and care providers emerged. For example, when the patients became anxious, they could call on support from the care providers earlier. One patient suggested that a care provider 'could snap one's fingers in

Articles

Hammervold *et al. BMC Health Services Research*   (2020) 20:499   Page 6 of 13

front of the patient's eyes' when he 'was falling out', an action the care provider [16] declared that she would not have thought of by herself.

Diversionary activities that stimulated interactions between the stakeholders emerged as possible restraint prevention measures, as in the following statement by a social educator:

> When we saw that her gaze started flickering, and she pulled away, we thought we might help to pull her back by focusing on something. […] Many of us had a liking for tea, so we'd bring different sorts of good teas, and then we'd sit trying to identify the scent. Was it fennel? Yes, maybe it was fennel. Or could it be cardamom? In this way, we managed to break the pattern that earlier would have developed into restraint situations or relocation to a shielded room [16].

In accordance with the purpose of PIRs, the patients could share their restraint experiences during PIRs, and the stakeholders could work out how to conduct restraint with less strain on the patient if similar situations arose. As discussed by a nurse:

> We noticed that when we were lying on top of her, holding her, she cried out 'No, Dad'. And afterwards, during our talk, it turned out she'd re-traumatised situations where her father had tied her up in bed and then abused her. It was the same setting [11].

The nurse said that the information they received in the PIR initiated them to be more attentive to patients' earlier experiences with sexual assault, and that they found mechanical restraint to be less strain for the woman.

Altogether, the care providers experienced PIRs as contributing valuable insights into restraint prevention and handling.

Although PIRs may have been an important knowledge source on restraint prevention, the care providers also experienced professional and ethical dilemmas regarding to what extent they could directly follow the patients' suggestions within the framework of professional responsibility. One nurse quoted a former patient who they considered to be suicidal:

> You know, I've been told that 'You should simply have let me go'. When we've had suicidal patients, who wish to harm themselves and to escape, they tend to come up with a solution that I can't accept. That is because in my mind, it would not have been good for the patient [15].

The patients' suggestions that were considered to be related to their mental health, psychoses and suicidality demonstrated that the knowledge that emerged in PIRs could not be the only basis for actions. There was also a need for professional and ethical judgment.

Increased professional and ethical awareness

The interviewees presented PIRs as an arena for reflection on restraint events, which stimulated their professional and ethical awareness and reflexivity concerning restraint use. Restraint events raised professional and ethical challenges in which different, potentially opposing values were at stake. Consequently, restraint events affected not only the patients but also the care providers. PIRs were, therefore, presented as a genuine opportunity for the persons involved to dwell upon the events together. As described by one nurse:

> So that you don't just hurry on in a way that turns it into a forgotten incident. For such, such restraint incidents—to put it like that—using mechanical restraints, they're obviously pretty strong experiences for the one who's exposed to them but also for those who're involved in them, aren't they? They're life events for, for the patient in a way and for the staff when it comes to that [12].

The care providers viewed PIRs as stimulating both retrospective and prospective reflections. The retrospective reflections considered the past restraint event and the care providers' arguments for the event and their handling of it. The certainty that restraint violated the patients' human rights prompted the care providers to explore alternative measures. As one nurse said:

> But there's something about taking such a situation seriously so that it does not become an abuse of power on our side, but that it is or that it was an act that was necessary there and then. And then one can always talk over afterwards what might have been done differently and why. However, I would say that on a more general basis, we're becoming more conscious about our job, that's to say the way we appear, so, yes, in general, there's more ethical consciousness in our work [14].

The care providers prospectively reflected on how to apply their new knowledge if similar occasions arose in the future. The care providers considered PIRs to have the potential to contribute to more individualised professional care by being an arena to hear the patients' voices and preferences. Such care could decrease restraint events not morally or clinically justified.

Emotional and relational processing

The care providers viewed PIRs as an arena to restore their damaged relationships with the patients. Generally, the care providers described mental strain related to conduct restraint and acknowledged that their handling of restraint could infringe upon the patients' rights. Furthermore, they described a need to '*clear the air*' (participant 15) by giving the patients explanations and, in some cases, excuses and justifications for the care providers' restraint handling. In addition, contrasts between restraint use and everyday life in the unit emerged as an issue, especially for nurses and social educators, according to those working closest to the patients. One social educator [14] referred to what she experienced as a '*peculiar and demanding situation*'. One day, she restrained a patient, and the next morning, she entered that patient's room to offer a cup of coffee. She argued that taking part in PIRs could decrease her discomfort in such situations.

The care providers stressed PIRs as beneficial for their processing of restraint events. As one doctor stated:

> *It may be that health personnel feel it's a major intervention, eh, to insert a needle or something like that,* [...] *so it was important to say how I assessed the situation and where my perspective or experience met her* [the patient's] *perception of reality in a way. In any case, afterwards, I felt it was good for my part* [1].

The care providers devoted less discussion to the benefits of PIRs for the patients' processing but also pointed to opportunities for the patients to talk about their feelings of shame and guilt after acting-out episodes. Some care providers also mentioned the possibility of resuming PIRs later if the patients found something unclear or required elaboration concerning the issues discussed". As stated by one nurse:

> *Basically, I think it also would be an advantage if she* [the patient] *had any questions for me afterwards or if it was assumed that we had talked, being able to draw on the talk we had, the debriefing, that is* [12].

Struggling to get hold of the patients' voices

Half of the care providers expressed that they had experienced a failure to get hold of the patients' voices in PIRs. They told that the patients tended to be passive and taciturn, as one nurse expressed; *Perhaps I thought the patient would be more verbal* [12].

The care providers found that they experienced weak voices as challenging, since the PIRs did not contribute to alternative strategies for restraint prevention and handling.

For example, a doctor said:

> *The patient was not very responsive. Almost no eye contact, so it was not possible to discuss the situation that had triggered the physical intervention etc., it was difficult to achieve it* [17].

A psychologist described a similar experience:

> *When we brought up what might have been done to avoid it* (restraint), *it did not result in much conversation around it. It was more me asking her, and her not responding* [18].

Regarding the care providers' impression of the patients as passive, one nurse told that when asking the patient, she spoke with monosyllables. The care provider tried therefore to vary between open and closed questions

> *It was mostly the moderator who asked, and the answers were typically monosyllables. However, we consistently invited her to talk, by asking open-ended questions, and closed questions* [11].

The care providers presented different comprehensions about how to understand their struggle/failure to elicit the patients' voices to deal with *patient related conditions, care provider related conditions* and *structural and cultural conditions*. The conditions are partly imbricated but will be presented separately.

Patient related conditions

One reason given to help explain what the care providers perceived as passivity was the patients' mental state when they took part in the PIR. Regarding the stated timeframe for PIRs, per PIR procedure, some care providers stressed the need to conduct the PIR within 72 h after restraint, but this resulted in some of the patients not having time to congregate after the restraint event.

One nurse said:

> *But he is incapable of explaining things, so I believe the utility value of talking with him is not very great, at least the way he is now. He remembers very little of what happens, at least at present* [2].

Consequently, the necessity to assess the patients' health conditions before conducting the PIR was emphasised. As one nurse said:

Articles

Hammervold *et al. BMC Health Services Research*   (2020) 20:499   Page 8 of 13

There's not much purpose in having it (a PIR) *when the patient is lying in a room placed in mechanical restraints or in seclusion compared to when the patient is sitting in a chair, experiencing oneself as independent—being seen and heard* [3].

Several care providers lifted patients' difficult feelings as a possible explanation for the experienced passivity. One nurse [11] said that he perceived the patient as embarrassed in the PIR based on lot of hubbub when he was carried through the ward unit before he was restrained.

In another example a social educator expressed: *"I also believe quite many (patients) feel some guilt and shame afterwards"* [16].

The care providers considered the patients' conditions in PIRs to be characterized by confusion, shame, guilt and embarrassment. It was therefore challenging to meet the expectation of equivalence in the PIRs, and the HCP found themselves struggling to elicit the patients' voices.

Care provider related conditions

The care providers considered that their struggle to get hold of patients' voices could be a result of their lack of skills regarding how to conduct the encounter in an optimal way and insecurity about their personal safety.

Some care providers reported that they received a minimum of information and training before their first PIR, which they assumed influenced their communication with the patients. A psychologist [19] described a clumsy approach when she conducted one PIR. She related that she, the nurse and the patient had different understandings of the restraint event and thus struggled to handle the situation. Consequently, PIRs became an arena for 'fighting about the truth'. Further, moral uncertainty regarding PIRs surfaced, where it was seen as a mandatory procedure based on the risk '*to rip open old wounds after the situation had been calmed down*' (doctor, 17).

Finally, PIRs as an arena for potential exposure to violence from the patients was presented and thus so was insecurity about the care providers' personal safety in the PIR. As one nurse expressed: '*It's a bad starting point for a good conversation when the staff are afraid of the patient*' [3].

Therefore, PIRs sometimes included numerous care providers, which resulted in preponderance from the service in the encounter, an issue that was mentioned as one explanation for the patients' passivity.

To increase their security, the care providers proposed professional reflection, information, education and 'volume training' in conducting PIRs.

Structural and cultural conditions

The care providers presented several aspects that dealt with structural and cultural conditions that could affect the patients' participation in the PIRs.

The arrangement of PIRs as 'meetings' which the patients were expected and told to attend was mentioned as a possible limiting factor for the patients. One social educator indicated that this approach could reinforce the patients' sense of insecurity:

And maybe it doesn't suit the patient to have the conversation at that particular moment. It has something to do with—I've talked to a number of patients who say that 'I always become nervous when I have to walk into some room or other to have a conversation'. You raise your shoulders, and you feel a bit on guard, yes. And that's not really the best basis for recognising, sharing and communicating (what you feel) [16]

She proposed alternatives, such as conducting PIRs by '*walk and talk*' or '*sitting together in peace and quiet with a puzzle while talking*'. These alternatives addressed the patients' discomfort regarding forms, checklists and the numerical imbalance putting the patients in a minority position relative to the care providers.

Another assumed reason for the patients to be taciturn in PIRs was overly rigid descriptions of who was to take part in them. The procedures seemed to be followed strictly, with the patient, doctor or psychologist and at least one nurse participating. This problem was compounded given the brief timeframe to conduct the PIR. Some care providers thought that PIRs could have been even more beneficial to the patients if conducted after a couple of days, allowing the participating care providers to build relationships of trust with the patients and increase the patients' confidence in PIRs.

The care providers explained that the form of PIRs could hinder dialogue due to the patients' previous experiences with a sometimes-overwhelming number of forms mapping them during their stays in services. The patients' experiences of not being heard on other issues during their stay in services were another possible explanation for their passivity. The care providers, therefore, suggested also implementing PIRs after involuntary admissions, seclusion and forced medication to increase the patients' confidence in PIRs as an arena for an honest exchange of views followed by changes in care plans.

Some interviewees described PIRs as an arena for confrontation and bringing up the patients, which could influence their participation. PIRs seemed to thus be marked by an approach focused on institutional rules, the patients' deviant behaviour and a belief in the need for only the patients to learn lessons. The care providers'

Articles

Hammervold *et al. BMC Health Services Research*   (2020) 20:499   Page 9 of 13

perspectives on the antecedents of the restraint events were emphasised, and the patients' deficits were stressed rather than their experiences and resources. These confrontations with the patients are illustrated by the nurse in the following example:

> *Then we had a debriefing around the use of restraints and a debriefing around threats. It was the therapist, the patient, the care provider on that day and those who'd been involved in the incident. Those who'd been involved in the incident were called in one by one to report on how they had perceived the situation and the background to their views* [7].

Upbringing was further expressed in the care providers' appeals to the patients' common sense and responsibility, pointing to the patients' previous utterances and behaviour. One nurse exemplified this approach: *"Sure, you may bring up that story* [the most recent restraint episode] *when 'Yes, what happened then? What was it you said? What did you sort of promise me?"* [3].

The care providers acknowledged that basing PIRs on a form could negatively affect the patients but claimed that the form made them more confident in leading PIRs and further ensured that the right issues were discussed.

In practice, however, some interviewees experienced a need to seek individual approaches due to the patients' health conditions and challenges stemming from the care providers' shifts and the patients' individual preferences.

Finally, the care providers reflected on how to utilise PIRs' potential benefits by making their role in PIRs even more flexible. As one nurse expressed:

> *It would have been a good thing, I believe, if we could have shifted focus a bit from what we as professionals have a duty to do, more to the effect of it, listen even more to the patient. And we should be humbler when it comes to whether we could do it in a different way* [12].

Discussion
This study shows that care providers' experience and considerations about PIRs' have both possibilities and challenges, as PIRs' potential to improve the quality of care may not be fully utilized because the care providers' struggle to get hold of the patients' voices. As responsiveness from the patients is a central moment in the caring process, the significance of getting hold to the patients' voices in PIRs' is a critical issue [26]. This condition is especially true for nurses and social educators who play key roles in the circumstances leading up to restraint events, conducting restraint events and taking care of the patients afterwards. In addition, care

providers have an obligation, based on the moral and democratic imperatives, to include the perspectives of all those involved in the health care [27]. In order to understand the tension between PIRs' potential to improve care and the challenge to get hold of the patients' voices, we will focus on the care providers' different approaches that will have an impact on the patients' given roles in the PIRs [42]. We will first discuss the results where PIRs appear beneficial, then how staff struggled to bring out patients' voices. Finally, we will discuss how the tension in results may be reduced in practice [26, 28].

"A Gift to the Ward and Worth Its Weight in Gold When It Helps"
The results in this study indicate that care providers experience the PIR procedure as partly fulfilling the intentions of its being a tool to prevent the use of restraint use in mental health services; this is congruent with previous studies [11, 43]. The patients' and care providers' mutual reflections in PIRs may give an overview of antecedents, restraint implementing and patients' experiences and considerations regarding alternative measures in the aftermath. This *reflection on action* [44] highlights alternative, more person-centred solutions should a new crisis occur, and is based on the patients' personal knowledge that is the epistemological base of recovery oriented practices [9]. Consequently, the care providers can provide improved care to patients in a crisis based on strengthened professional knowledge and increased awareness of the moral elements of care such as attentiveness, responsibility, and responsiveness [11, 26, 45].

Originally, PIRs were introduced in S/R prevention programmes grounded in human-based care philosophies, including full inclusion of patients and their families [1]. That means changed roles for both patients and care providers [9, 42]. To the patient, that implies a changed role from passive receiver of care to active agent. In the frame of personal recovery, a crisis is an active space which can contribute to growth [9, 46]. The care providers' role will then be to minimise the loss of the patients' responsibility such as asking the patient in the PIR if one could have handled what happened before the restraint event in another way so that the result could have been less thorough. Further, the care providers' task is to communicate and represent hope during crises and support the patients' identity during and after the event [9]. Participation in PIRs may with that promote the patients' personal recovery processes by supporting empowerment, hope and identity [9, 13, 18, 20, 21, 47, 48].

Previous studies emphasise the necessity of supportive environments in PIRs [13, 16, 18, 49]. The care providers that experienced PIRs as beneficial seemed to perform an acknowledging, dialogue-oriented approach with the

patients. This approach is characterised by the values of care ethics and a humanising framework that may support the patients' human dimensions and thereby support empowerment processes and strengthen their voices in PIRs [28, 50].

Care providers' experiences and views on PIRs' potential for emotional and relational processing are in line with previous studies that suggest PIRs help the care providers' deal with emotional and moral stress [10, 11, 13, 49]. As PIRs with the patient mainly focus on the patients' experiences and considerations, care providers' personal needs for defusing after restraint events belongs to other arenas [1, 11, 51]. From patients' perspectives, we have in our review [11] found one small study suggesting PIRs are beneficial regarding patients' processing of the restraint incident [47]. Based on the scarce prevailing literature and the patients' vulnerable and dependent role in the services, we cannot conclude that the potential to process is transferable to the patients.

Based on their role as inpatients and actual health condition, the patients are for some time dependent on the care providers who have professional knowledge and the ability to help, and with that also power. Consequently, a power imbalance exists in the patient–care provider relationship, something that becomes further enhanced by restraint use [26, 52–55]. According to Emerson [56], power (in this case, the care providers' power) resides implicitly in the dependence of others (in this case, the patients). To achieve more balance in power–dependence relationships, the weaker members' power should be increased. Aiming to give the patients increased status in PIRs, the care providers should increase their motivational investment in the goals defined by the patients [56]. The patients' personal goals will be individual, but based on previous studies they may deal with the services' relational, structural and cultural conditions [23, 55, 57, 58]. An assumption for identifying the patients' goals in the PIRs is a supportive environment in an 'I–thou relationship' ([59]) where the care providers acknowledge the participants' roles to be approximate equal. Equal roles in the relationships in health services are, however, impossible in practice based on the power imbalance. A frame of care ethics may nevertheless support the patients' participation in PIRs based on the recognition of the context, the power imbalance and the moral claim to include everyone's perspectives in care [26, 27].

Perhaps I thought the patient would be more verbal

We have not found previous studies that describe the challenge to elicit patients' voices in the PIRs. Our results however indicate that some care providers' approaches and statements may reinforce the power–dependence relationship by an authoritarian approach that emphasises the patients' deviant behaviour and deficits rather than their experiences and resources [56, 60]. Further, an appeal by the care providers to the patients' common sense and responsibility before the restraint event may result in PIRs becoming an arena for conflict where the patients are confronted with, – and made responsible for their previous behaviours and statements. In light of Foucault, we understand this authoritarian measure as *a disciplining approach* [61] that may mobilise the patients' counter-power and counter-behaviour [62, 63]. Counter-behaviour can be active resistance due to a lack of other strategies available to those in dependent situations [e.g. inpatients] or protest reactions such as taking a passive role with withdrawal and attempts to evade contact [64]. The last point may be one of several explanations for the patients' passivity in PIRs, as this disciplining approach may contribute to silencing voices [61]. A disciplining approach in PIRs seems to be characterised by an 'I–it relationship', a subject–object relationship in which, according to Buber, 'the object exists only through being bounded by others' (([59]),p.12). As the patients are vulnerable and mortified during and after being restrained, they need to be met as unique subjects with care, respect and empathy [43, 55, 65]. To ask the patient in the PIR whether one could have handled the situation in another way may consequently be experienced as blaming and an additional burden [55]. Being met with a disciplining approach in the PIR, and subsequently detached care, may thus be experienced as a prolongation of coercive practices that confirm the identity as patient in a passive role and thus hamper ones' personal recovery processes [19].

In order to achieve more balance in the power-dependence relationship and thus increase the patient's power in PIRs, the patient's preferences regarding point in time, participants and context for the encounter should be recognised. In previous studies, inclusion of family members or peers in PIRs is suggested [13, 21]. The interviewees in this study did not mention that possibility, even though the community mental health centre's procedure suggested a next of kin as participant. Advocacy can also, by their role, provide a counterbalance, to ensure that the individual's personal perspectives are represented and heard in the PIR, further supporting the patients' empowerment processes [66, 67].

Finally, implementing PIRs in the two participating services was not based on defined care philosophies as described in several studies [16, 17, 48, 68]. Even though some care providers presented values and approaches in line with human based care philosophies and even struggled to get hold of the patients' voices in the PIR, the services' context seemed still to be characterized on traditional clinical recovery model's values, goals and

working practices [9, 10, 19]. Consequently, to implement PIR in line with the intentions, presupposes attention to the structural and cultural conditions in the services by recognising the power imbalance between patients and care providers', and devotes attention to the necessity of a supportive and recognising context when conducting PIRs [11, 26, 60].

Methodological considerations

A strength of this study is that we have investigated a fairly unexplored field of knowledge. In addition to contributing to the knowledge base, this study reveals a need for more exploration of PIRs. We also consider it to be a strength that three researchers participated in the analysis process, comparing the meaning units and discussing the subthemes and themes. The reference group's input to the interview guide and preliminary results helped nuance the materials and strengthen user perspectives as experts by experience [33].

The study was conducted by interviewing the care providers who volunteered to part, suggesting a potential bias in the study population. The results are context specific, which means that they show the participating care providers' experiences. The core results are, however, consistent with previous research on the utility value of PIRs [11, 12, 69]. Repeat interviews or feedback to the participants were not provided, which could further have strengthened the results. We only have data on the care providers' experiences and considerations from particular interview situations. The regional ethical committee did not approve observations of the services, so we have no observations or information on the restraint episodes and the patients' views that could have contributed to the context. The patients' perspectives, therefore, could contribute other considerations and viewpoints that need to be further explored. None of the authors were connected to the two participating mental health services, which could have been a limitation.

Conclusion

The main study findings are that care providers experience a tension between PIRs' potential to improve the quality of care and their struggle to get hold of the patients' voices. To motivate the patients' active participation, PIRs should be conducted within the context of a humanising care approach. A framework of care ethics may guide the care providers to plan PIRs along with the patients' preferences and further conduct PIRs' in a collaborative, supportive atmosphere that promotes the patients 'personal recovery processes. Studies exploring the patients' experiences with PIRs are lacking, thus there is a need for further research to get hold of their perspectives. Of pivotal interest is PIRs' potential for the patients' emotional and relational processing and the possible utility value of support from family members, peers or advocacy in the encounters. To strengthen the care providers confidence and communication skills in the PIRs' there seems to be a need for education, professional reflection opportunities and sufficient training.

Author details
[1]Department of Public Health, Faculty of Health Sciences, University of Stavanger, 4036 Stavanger, Norway. [2]Work Research Institute, Oslo Metropolitan University, Oslo, Norway. [3]Department of care and ethics, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway.

References
1. Huckshorn KA. Reducing seclusion & restraint use in mental health settings: core strategies for prevention. J Psychosoc Nurs Ment Health Serv. 2004; 42(9):22–33.
2. LeBel JL, Duxbury JA, Putkonen A, Sprague T, Rae C, Sharpe J. Multinational experiences in reducing and preventing the use of restraint and seclusion. J Psychosoc Nurs Ment Health Serv. 2014;52(11):22–9.
3. Duxbury J, Thomson G, Scholes A, Jones F, Baker J, Downe S, et al. Staff experiences and understandings of the REsTRAIN yourself initiative to minimize the use of physical restraint on mental health wards. Int J Ment Health Nurs. 2019;28(4):845–56.
4. Norwegian Mental Health Care Act. Act No. 62 of 2 July 1999 relating to the provision and implementation of mental health care (the Mental Health Care Act), with later amendments Oslo: Ministry of Health and Care

Services,; 1999b [Available from: https://app.uio.no/ub/ujur/oversatte-lover/data/lov-19990702-062-eng.pdf.

5. Krieger E, Moritz S, Weil R, Nagel M. Patients' attitudes towards and acceptance of coercion in psychiatry. Psychiatry Res. 2018;260:478–85.

6. Bak J, Aggernaes H. Coercion within Danish psychiatry compared with 10 other European countries. Nord J Psychiatry. 2012;66(5):297–01.

7. Scanlan JN. Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far a review of the literature. Int J Soc Psychiat. 2010;56(4):412–23.

8. United Nations HRC. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. In: Nations U. Geneve: United Nations, Human Rights Council; 2013. p. 23. A/HRC/22/53.

9. Slade M. Personal recovery and mental illness: a guide for mental health professionals. Cambridge: Cambridge University Press; 2009. p. 288.

10. Norvoll R, Hem MH, Pedersen R. The role of ethics in reducing and improving the quality of coercion in mental health care. HEC Forum. 2017; 29(1):59–74.

11. Hammervold UE, Norvoll R, Aas RW, Sagvaag H. Post-incident review after restraint in mental health care -a potential for knowledge development, recovery promotion and restraint prevention. A scoping review. BMC Health Serv Res. 2019;19(235):1–13 Available from: http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=136014724&scope=site.

12. Goulet M-H, Larue C. Post-seclusion and/or restraint review in psychiatry: a scoping review. Arch Psychiatr Nurs. 2016;30(1):120–8.

13. Goulet M-H, Larue C, Lemieux AJ. A pilot study of "post-seclusion and/or restraint review" intervention with patients and staff in a mental health setting. Perspect Psychiatr Care. 2018;54(2):212–20.

14. Barker P. Mental health ethics : the human context. London: Routledge; 2011. p. 378.

15. Barker P, Buchanan-Barker P. The tidal model of mental health recovery and reclamation: application in acute care settings. Issues Ment Health Nurs. 2010;31(3):171–180 10p.

16. Azeem MW, Aujla A, Rammerth M, Binsfeld G, Jones RB. Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospitaljcap. J Child Adolesc Psychiatr Nurs. 2011;24(1):11–5.

17. Azeem MW, Reddy B, Wudarsky M, Carabetta L, Gregory F, Sarofin M. Restraint reduction at a pediatric psychiatric hospital: a ten-year journey. J Child Adolesc Psychiatr Nurs. 2015;28(4):180–4.

18. Bonner G, Wellman N. Postincident review of aggression and violence in mental health settings. J Psychosoc Nurs Ment Health Serv. 2010;48(7):35–40.

19. Sjöström S. Invocation of coercion context in compliance communication — power dynamics in psychiatric care. Int J Law Psychiatry. 2006;29(1):36–47.

20. Gustafsson N, Salzmann-Erikson M. Effect of complex working conditions on nurses who exert coercive measures in forensic psychiatric care. J Psychosoc Nurs Ment Health Serv. 2016;54(9):37–43.

21. Ling S, Cleverley K, Perivolaris A. Understanding mental health service user experiences of restraint through debriefing: a qualitative analysis. Can J Psychiatr. 2015;60(9):386–92.

22. Cusack P, McAndrew S, Cusack F, Warne T. Restraining good practice: reviewing evidence of the effects of restraint from the perspective of service users and mental health professionals in the United Kingdom (UK). Int J Law Psychiatry. 2016;46:20–6.

23. Husum TL, Legernes E, Pedersen R. "A plea for recognition" Users' experience of humiliation during mental health care. Int J Law Psychiatry. 2019;62:148–53.

24. Mohr WK, Petti TA, Mohr BD. Adverse effects associated with physical restraint. Can J Psychiatr. 2003;48(5):330–7.

25. Cusack P, Cusack FP, McAndrew S, McKeown M, Duxbury J. An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. Int J Ment Health Nurs. 2018; 27(3):1162–76.

26. Tronto JC. Moral boundaries : a political argument for an ethic of care. New York: Routledge; 1993.

27. Tronto JC. Caring democracy : markets, equality, and justice (e-book). New York: New York University press; 2013.

28. Todres L, Galvin KT, Holloway I. The humanization of healthcare: a value framework for qualitative research. Int J Qual Stud Health Well-being. 2009; 4(2):68–77.

29. Mason J. Qualitative researching. 2nd ed. ed. London: Sage; 2002.

30. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105–12.

31. Graneheim UH, Lindgren B-M, Lundman B. Methodological challenges in qualitative content analysis: a discussion paper. Nurse Educ Today. 2017;56: 29–34.

32. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nurs Health Sci. 2013;15:398–405.

33. Winn S, Lindqvist S. Purposeful involvement of experts by experience. Clin Teach. 2019;16:183–8.

34. Cam Y, Bolz-Johnson M. Expert by experience: valuing patient engagement in healthcare. In: Pomey M-P, Denis J-L, Dumez V, editors. Pateint engagement how patient-provider partnerships transform Healtcare organizations. Switzerland: Springer Nature; 2019. p. 233–67.

35. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies. Qual Health Res. 2016;26(13):1753–60.

36. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15(9):1277–88.

37. Fleming V, Gaidys U, Robb Y. Hermeneutic research in nursing: developing a Gadamerian-based research method. Nurs Inq. 2003;10(2):113–20 8.

38. NVivo 12. NVivo qualitative data analysis Software; Version 12: QSR International Pty Ltd,; 2016.

39. Finlay L. "Outing" the researcher: the provenance, process, and practice of reflexivity. Qual Health Res. 2002;12(4):531–45.

40. Gadamer H-G. Truth and method. 2nd, rev. ed. translation revised by Joel Weinsheimer and Donald G. Marshall. Ed. London: Sheed & Ward; 1989.

41. Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, 310(20) (2013).

42. Goffman E, Kristiansen S, Hviid Jacobsen M, Gooseman B. Stigma : om afvigerens sociale identitet. 2. udg. ed. Samfundslitteratur: Frederiksberg; 2009.

43. Aguilera-Serrano C, Guzman-Parra J, Garcia-Sanchez JA, Moreno-Küstner B, Mayoral-Cleries F. Variables Associated With the Subjective Experience of Coercive Measures in Psychiatric Inpatients: A Systematic Review. Can J Psychiatr. 63(2):129–44. https://doi.org/10.1177/0706743717738491.

44. Schön DA. The reflective practitioner : how professionals think in action. Aldershot: Avebury; 1991.

45. Cusack L, Drioli-Phillips PG, Brown JA, Hunter S. Re-engaging concepts of professionalism to inform regulatory practices in nursing. J Nurs Regul. 2019;10(3):21–7.

46. Mead S, Hilton D. Crisis and connection. Psychiatr Rehabil J. 2003;27(1):87–94.

47. Lanthén K, Rask M, Sunnqvist C. Psychiatric Patients Experiences with Mechanical Restraints: An Interview Study. Psychiatry J. 2015;2015:748392–8.

48. Ashcraft L, Anthony W. Eliminating seclusion and restraint in recovery-oriented crisis services. Psychiatr Serv. 2008;59(10):1198–202.

49. Petti TA, Mohr WK, Somers JW, Sims L. Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. J Child Adolesc Psychiatr Nurs. 2001;14(3):115–27 13.

50. Topor A, Denhov A. Helping relationships and time: inside the black box of the working Alliance. Am J Psychiatr Rehabil. 2012;15(3):239–54.

51. Mangaoil RA, Cleverley K, Peter E. Immediate staff debriefing following seclusion or restraint use in inpatient mental health settings: a scoping review. Clin Nurs Res. 2018;1054773818791085:1–40.

52. Kittay EF. The ethics of care, dependence, and disability*. Ratio Juris. 2011; 24(1):49–58.

53. Mohr WK. Restraints and the code of ethics: an uneasy fit. Arch Psychiatr Nurs. 2010;24(1):3–14.

54. Knowles SF, Hearne J, Smith I. Physical restraint and the therapeutic relationship. J Forens Psychiatry Psychol. 2015;26(4):461–75.

55. Tingleff EB, Bradley SK, Gildberg FA, Munksgaard G, Hounsgaard L. "treat me with respect". A systematic review and thematic analysis of psychiatric patient's reported perceptions of the situations associated with the process of coercion. J Psychosoc Nurs Ment Health Serv. 2017;24(9/10):681–98.

56. Emerson RM. Power-dependence relations. Am Sociol Rev. 1962;1:31.

57. Nyttingnes O, Ruud T, Rugkåsa J. 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care. Int J Law Psychiatry. 2016;49:147–53.

58. Norvoll R, Pedersen R. Patients' moral views on coercion in mental healthcare. J Nurs Ethics. 2018;25(6):796–807.

Articles

Hammervold *et al. BMC Health Services Research*   (2020) 20:499   Page 13 of 13

59. Buber M, Smith RG. I and thou. 2 ed. with a postscript by the author. Ed. London: Continuum; 2004.
60. Ryan R, Happell B. Learning from experience: using action research to discover consumer needs in post-seclusion debriefing. Int J Ment Health Nurs. 2009;18(2):100–7 8.
61. Foucault M. Madness and civilization : a history of insanity in the age of reason. London: Routledge; 2001.
62. Foucault M, Faubion JD, Rabinow P. The essential works of Michel Foucault, 1954–1984, vol. 3. London: Allen Lane; 2001.
63. Foucault M. Discipline and punish : the birth of the prison. London: Allen Lane; 1977.
64. Tingleff EB, Hounsgaard L, Bradley SK, Gildberg FA. Forensic psychiatric patients' perceptions of situations associated with mechanical restraint: a qualitative interview study. Int J Ment Health Nurs. 2019;28(2):468–79.
65. Chien W-T, Chan CWH, Lam L-W, Kam CW. Psychiatric inpatients' perceptions of positive and negative aspects of physical restraint. Patient Educ Couns. 2005;59(1):80–6.
66. Ridley J, Newbigging K, Street C. Mental health advocacy outcomes from service user perspectives. Ment Health Rev J. 2018;23(4):280–92.
67. Levy J, Payne M. Welfare rights advocacy in a specialist health and social care setting: a service audit. Br J Soc Work. 2006;36(2):323–31.
68. Riahi S, Dawe IC, Stuckey MI, Klassen PE. Implementation of the six core strategies for restraint minimization in a specialized mental health organization. J Psychosoc Nurs Ment Health Serv. 2016;54(10):32–9.
69. Sutton D, Webster S, Wilson M. Debriefing following seclusion and restraint. A summary of relevant literature Auckland, New Zealand Te Pou o Te Whakaaro Nui; 2014 Available from: http://openrepository.aut.ac.nz/bitstream/handle/10292/9084/debriefing-following-seclusion-and-restraint-281014.pdf?sequence=2&isAllowed=y.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Article III

Post-incident Reviews after Restraints, – Potential and Pitfalls
Patients' experiences and considerations

Accessible summary

What is known about the subject?

- Restraint has negative psychological, physical, and relational consequences for mental health patients and care providers.

- Several countries have implemented seclusion and restraint (S/R) reduction programs in which Post Incident Reviews (PIRs) including patients and care providers are one of several strategies.

- Existing knowledge indicates that PIRs have a potential to contribute to S/R prevention, but patients' perspectives on PIRs are scarce.

What the paper adds to existing knowledge?

- The patients experienced PIRs as variations on a continuum from being strengthened, developing new coping strategies, and processing the restraint event to PIRs as meaningless, feeling objectified and longing for living communication and closeness.

- Characteristics of the patients and the care providers and the services' care philosophies, influence patients' experiences on PIRs as either supporting their personal recovery processes or continuation of coercive contexts.

What are the implications for practice?

- Patients' vulnerability in the PIRs must be acknowledged.

- Trusted persons or advocacy must support the patient in the PIR and thus reduce the power-dependence imbalance.

- The PIR must be conducted in a supportive, non-punishing atmosphere.

1

- Patients must influence planning for the PIR concerning timepoint and participants and themes to be discussed.

- The PIR forms should be extended to support the patients' empowerment and wellbeing.

Abstract

Introduction: Post Incident Reviews (PIRs), including patients, nurses, and other care providers, following incidents of restraints are recommended in mental health services. Few studies have examined patients' experiences and considerations concerning PIRs.

Aim: The study aims to explore patients' perspectives on PIRs in relation to how they experience participation in PIRs and further view PIRs' potential for care improvement and restraint prevention.

Method: We conducted a qualitative study based on individual interviews. Eight current and previous in-patients from two Norwegian mental health services were interviewed.

Results: The patients experienced PIRs as variations on a continuum from being strengthened, developing new coping strategies, and processing the restraint event to at the other end of the continuum, PIRs as meaningless, feeling objectified and longing for living communication and closeness.

Discussion: PIRs' beneficial potential is confirmed in the study. The findings highlight however that personal and institutional conditions influence whether patients experience PIRs as an arena for recovery promotion or PIRs as continuation of coercive contexts.

Implications for practice: To promote patients' active participation in PIRs, we recommend their active participation in planning the PIR and further conducting PIRs in a supportive atmosphere that include trusted persons, emphasising and acknowledging a dialogical approach.

2

Relevance statement

There is international consensus about the importance of restraint reduction in mental health services, based on negative consequences for all involved. Different strategies have been implemented aiming at restraint reduction. In this paper, we explore patients' perspectives on one of those strategies, Post Incident Reviews (PIRs) including patients and care providers after restraint events. The results add valuable insight to patients' perspectives regarding participation in PIRs, which are scarcely explored in previous studies. The findings support previous studies that state PIRs as a useful procedure. However, pitfalls are identified and must be considered both on the individual and institutional levels.

Keywords:

Patients' experiences, restraints, acute mental health, post incident reviews, nursing, care philosophies

Background

Although users of mental health services have for decades described experiences of dehumanisation after being restrained, physical and mechanical restraint (i.e. belts, restraint jackets, straps or physical holding) is still frequently conducted in mental health services in western countries (Dumais, Larue, Drapeau, Ménard, & Allard, 2011; Oster, Gerace, Thomson, & Muir-Cochrane, 2016; Steinert et al., 2010). Dehumanisation consists of psychological consequences such as (re)traumatisation, distress, fear and damaged therapeutic relationships, the latter a cornerstone of all treatment and care (Cusack, Cusack, McAndrew, McKeown, & Duxbury, 2018; Husum, Legernes, & Pedersen, 2019; Nyttingnes, Ruud, & Rugkåsa, 2016). In addition, grave physical consequences and even death are documented (Mohr, Petti, & Mohr, 2003; Rakhmatullina, Taub, & Jacob, 2013).

International development of laws is moving towards a more critical attitude regarding coercive measures, especially on people in vulnerable situations, that includes a ban on all kinds of such measures (Nations, 2013; United Nations, 2017a). Following the USA, several

3

European countries, Australia, New Zealand, and Canada have implemented seclusion and restraint (S/R) reduction programs where rigorous debriefing including patients and care providers together is one of several strategies. These programs, mostly implemented in services that base their practices on human care philosophies, seem promising regarding S/R reduction (Huckshorn, 2004; LeBel et al., 2014)(xxxxxx1). It is however difficult to assess how much the different interventions individually contribute to these supposedly promising results (Goulet, Larue, & Dumais, 2017) (xxxxxx 1).

Rigorous debriefing or Post-Incident Reviews (hereinafter referred to as PIRs) including patients and health care providers are the focus of this study. A PIR intervention is "a complex intervention, taking place after a S/R episode and targeting the patient and healthcare team to enhance the care experience and provide meaningful learning for the patients, staff, and organisation" (Goulet & Larue, 2016, p.127). The practice and outcomes of PIRs are scarcely explored in scientific literature, but studies indicate that PIRs are in line with recovery-oriented and reflexive, ethical care cultures in mental health services and have a potential for prevention of restraint (Goulet, Larue, & Lemieux, 2018) (xxxxxx 1+2). These potentials of PIR are particularly of importance for nurses who often engage in coercive practices and are supposed to perform care before and after restraint use.

In previous research, care providers describe PIRs as useful related to care improvement, based on knowledge about new perspectives and solutions, increased ethical awareness and opportunities for emotional and relational processing (Bonner & Wellman, 2010; Goulet et al., 2018; Gustafsson & Salzmann-Erikson, 2016) (xxxxxx 1). The potential of PIRs seems however not to be fully utilised, as about half of the multidisciplinary care providers ($n = 19$) in a previous study in the same project (xxxxxx, 2) struggled to get a hold of the patients' voices in the PIRs. The interviewed care providers related this phenomenon to the patients' mental condition and further institutional and cultural conditions (xxxxxx, 2).

4

The patients' voices about PIRs are weakly represented in scientific studies (xxxxxx 1). However, findings indicate that patients, although small samples ($n = 3/30/10$), find PIRs useful when coming to reflect on the antecedents and processing traumatic incidents afterwards (Bonner & Wellman, 2010; Goulet et al., 2018; Lanthén, Rask, & Sunnqvist, 2015). Only one pilot study, ($n=3$), (Goulet et al., 2018) refers to patients' considerations about how practical organisation of PIRs should be performed.

Lastly, aiming to describe patients' perspectives on what occurred before, during and after a restraint event, Ling, Cleverley, and Perivolaris (2015) conducted audits on patients' charts containing PIR debrief forms ($n = 55$). The researchers concluded that PIRs by a structured written form allows patients and care providers to develop greater understanding of restraint events. Further, they concluded that the information collected through PIRs should inform treatment and care plans. A limitation in Ling et al.'s study (2015) was however that care providers or interpreters in some circumstances helped the patients, or wrote answers to the questions, making it more uncertain what the patients' own voices were expressing.

Rationale, aims and research questions

The aspects of those receiving care are thus virtually absent regarding PIRs, therefore, it is our vital interest to increase knowledge of PIRs by exploring the patients' perspectives on participation in PIRs in relation to exploiting PIRs' intentions.

We ask:

What are patients' experiences and considerations about PIRs after restraint events?

How do patients view PIRs' potential for care improvement and restraint prevention?

Methods

To investigate patients' experiences and views on PIRs, we performed an explorative descriptive study design with a phenomenological hermeneutical approach to get patients' own stories about restraint events and the following PIRs. Consequently, we chose a

5

qualitative design with an inductive approach based on individual interviews. Individual interviews were appropriate to reconstruct persons' previous lived experiences (Mason, 2018), in this study, patients' lived experiences with PIRs.

Setting

The international movement towards more critical attitudes about coercive measures also applies to Norway, where the Civil ombudsman annually reveals disgraceful conditions in mental health services and consequently directs reforms (Sivilombudsmannen, 2018). Moreover, Norwegian authorities in 2017 legalised evaluation of all kinds of coercion together with the patients in mental health services aiming at knowledge development, prevention of repeating restraint events and quality improvement (Norwegian Mental Health Care Act, 1999).

We conducted the study in two Norwegian mental health services: one university hospital and one community mental health centre that according to Norwegian laws are given permission to use coercion based on their emergency and acute services (Norwegian Mental Health Care Act, 1999). Both are serving people with serious mental challenges such as psychosis and affective disorders, sometimes combined with addiction problems. The two services had implemented the PIR procedure some years before Norwegian legislation of PIRs in 2017. PIRs were implemented as an isolated intervention, neither as a part of S/R reduction program nor connected to defined care philosophies in the services.

The implementations were inspired by the British NICE guidelines (2015) and The Danish Mental Health Care Act, §4, but we did not find that they rely on any theoretical perspectives. The procedures were not revised during the study period.

6

Table 1 illustrates the two services' PIR procedures.

	University hospital	Community mental health centre
Timepoint	As soon as possible after the restraint event, if possible not later than 72 hours	As soon as possible and latest by discharge
Participants	Should be led by a person not involved in the restraint incident. One care provider involved in the restraint event should participate.	Patient, eventually next of kin, contact nurse or available familiar nurse and responsible therapist
Themes in the PIR	• The service user's experience of the restraint event and how the occasion was conducted? • The services user's comprehensions of reasons for conducting restraint, the effect of the measure and if the service user consider that the event was inevitable. • The care providers' comprehension of the situation, the rationale for conducting restraint and the measure's effect	• What contributed to the restraint event? • What were the care providers' arguments for conducting restraint? • How did the patient experience the restraint measure? • How did the restraint measure appear? • What does the patient want the care providers' to do in similar situations?
Documentation	PIR documented in electronic journal as a note. The service user receive a copy and may comment on the document.	PIR documented in electronic journal as a note

Sample and Recruitment

Inclusion criteria comprised Norwegian speaking patients above 18 years who had lived experiences of participation in minimum one PIR after being restrained. The patients' therapists assessed the patients' ability to provide informed consent before they were asked to participate in the study. Eight persons accepted participation in the period 10/2015–11/2018. Five patients were admitted in Service 1 (three different ward units) and three patients were admitted in Service 2 (the same ward unit).

Aiming at broader assessment and understanding of patients' experiences and considerations on PIRs, we would ideally recruit additional participants. We were not allowed to present the study to the patients directly, consequently we were dependent on the care providers 'efforts in the recruitment process. Despite regular enquiries to the ward units' leaders, no more participants showed up. The feedback from the services was that the restraint rate was low (Service 2), they had not conducted PIRs lately, the implementation rates on PIRs were difficult to follow, but reportedly low, (< 10% in Service 1), or the patients did not give their consent to participate in the study. Given the lack of research concerning patients' views

7

and experiences, we nevertheless found that it was of vital interest to listen to the perspectives from the eight participating patients in order to contribute to extended knowledge about PIRs.

Participants

There was a gender imbalance among the study participants, seven women and one male. There were no obvious differences in the one interview with the man compared with the interviews with the women, nor did we find such in the literature.

The participants had all experienced several episodes of restraints during their admissions, and they had all previous experiences of not being offered PIR afterwards.

Two had participated in one PIR, one in two PIRs, the others were uncertain about the number of PIRs because of confusion with ordinary therapeutic consultations.

Planning and conducting interviews

A semi structured interview guide was conducted to ensure that common themes were illuminated but based on the study's design gave room for other issues as well. During the development of the interview guide, a draft was presented to an advisory group, at this stage two patient consultants in mental health services where the one had multiple personal experiences of being restrained. They gave valuable input that contributed to nuancing the first author's preconceptions and consequently expanding the focus of the interviews.

The interviews were performed by the first author, a trained nurse with considerable clinical experiences from mental health services. Five of the interviewees were still inpatients, and the interviews took place in their respective ward units. Interviews with the outpatients were performed in line with the interviewees' preferences: the interviewee's home, in a mental health centre and the university. The interviews lasted 15– 90 minutes, mean time 44 minutes.

Aiming to get a backdrop for the PIR, the participants were initially asked to speak briefly about the restraint event, followed by questions that dealt with point in time, participants, and content in the PIR. Further, they were asked about positive and negative

8

experiences regarding PIRs, that included attention to atmosphere, climate for openness and practical proceedings. The patients were finally asked how they thought the participating care providers experienced the PIR and if they knew how the PIR was documented.

Analyses

The first author transcribed the audio-recorded interviews and analysed the interviews using NVivo 12 (2016). We found some parts of the stories so extensive and expressive that we wanted to present them as an introduction to the results. Therefore, we used elements from narrative analysis (Riessman, 2008) combined with Lindseth & Nordberg's thematic structural analysis method (2004). This method is claimed to be well suited to grab "the good and bad", not only what the interviewee says, but also "what they talk about" (Lindseth & Norberg, 2004, p.146), whereas our task was to elucidate essential meaning as it is lived in human experience.

Initially, each interview was repeatedly listened to and read as open-mindedly as possible to obtain a general impression of the whole. After this naïve reading, thematically structured analyses were conducted by identifying meaning units (one or more sentences related by their content) and further condensed meaning units. The condensed meaning units were then reflected on regarding similarities and differences, and further abstracted to subthemes and themes that are close to the participants statements (Lindseth & Norberg, 2004). To enhance the credibility of the study, the analysis has been conducted by three researchers.

In order to develop a comprehensive understanding of the patients' experiences and considerations with PIRs', the main themes were reflected on among the authors in relation to the naïve reading, the research questions, the study's context, the advisory group and relevant literature (Lindseth & Norberg, 2004). These mutual reflections contributed to revising, widening, and deepening the understanding of the findings and contributed to the discussion on how the findings may open possibilities for alternative practices.

9

In the whole process, we emphasised presenting the participants' perspectives as faithfully as possible and further formulating results in everyday language as close to the lived experience as possible (Lindseth & Norberg, 2004).

Table 2 illustrates the analysis, indicating the abstraction process from subthemes and themes, and lately main themes as a result of the theoretical analysis.

Table 2 Subthemes, themes and main themes

Main themes	PIRs as arena for recovery promotion			PIRs' as continuation of coercive practises		
Themes	Being strengthened	Developing new coping strategies	Being processing	Considering PIR as meaningless	Longing for living communication and closeness	Feeling objectified
Subthemes	Experiencing influence by participation	Exploring new strategies	Putting a full stop	Not being informed about the purpose of PIR	Lack of dialogical approach	Being met by theories and rules
	Being assessed as a responsible participant	Searching for new solutions	Getting an explanation	Being overheard	Feeling neglected	Being met et as a category
	Being asked about individual preferences			Being indifferent		

Ethical considerations

The Norwegian Social Science Data Service (ref. no.....) assessed and approved the study. The Regional Committees on Health Research Ethics (REK) decided that the study did not require further ethical approval (………). In line with the Helsinki Declaration, written and oral information were provided to the participants, including the participants' right to withdraw at any stage without explanations or consequences, and their consent and confidentiality were secured (Declaration of Helsinki, 2013).

The first author ensured beforehand that discharged participants had the possibility to contact professional care providers regarding eventually emotional reactions after the interviews.

Finally, anonymity is preserved in the text, and all names are pseudonyms.

10

Findings

The participants described the preceding restraint events differently, from indifference to variations of physical and psychological infringement. The latter spoke about feeling angry, powerless, afraid, and lonely, in addition to experiences with ripped clothes and marks on extremities.

The patients' feedback on PIRs revealed two main narratives with some overlap:

(1) Stories about *being strengthened, processing the restraint incident, and developing new coping strategies* and (2) stories about feeling PIRs as *meaningless*, *feeling like an object* and *longing for living communication and closeness.*

The results will be presented with an introductory narrated story that is elaborated with themes exemplified by quotations from the patients.

Stories about PIRs as being strengthened, processing the restraint incident, and developing new coping strategies

Two participants, discharged from respectively Service 1 and Service 2, experienced the PIR as mainly supportive, based on being strengthened, processing the restraint incident, and developing new coping strategies. They participated both in the encounter together with their therapist and contact nurse. Elisabeth (5) had PIR the day after the restraint event, while Hilda (8) had PIR at the end of the admission. Elisabeth had been restrained six times and had participated in PIRs after the last two incidents. She told about her first PIR:

> (……..) I was able to explain myself without interruptions and give a full briefing of the incident (…) no interruption, I was able to talk freely (….) Being asked directly "What do YOU think could have been done to prevent it from happening" felt good (….) they realised they had to listen to me, I learnt to give notice earlier (…..) In any case I got a new attitude to the help when I realised that they were not out to get me and that they didn't want me to suffer (....) it was as if I simply put it behind me (..) and called it off (…) therefore such talks are important; being seen, heard and believed (5)

A central theme in Elisabeth's story about PIRs was the experience of feeling *strengthened* by being met as a person whose experiences and considerations regarding the restraint incident were assessed as significant. After the previous four restraint incidents, care providers had

11

asked if she had comments about what had happened, a question she perceived as so vague that she chose not to respond. Elisabeth was therefore initially not interested in participation in the PIR. Her doctor formulated however in advance the purpose of PIR, consequently Elisabeth had a clear understanding that the aim was to get insight into each other's perspectives and thus prevent new restraint episodes. To Elisabeth, it was nearly a turning point that she understood the purpose of PIR and further experienced the encounter as an arena where she was "allowed to have a voice and became seen and believed", consequently, she perceived her experiences and views as having been acknowledged. However, even though Elisabeth (5) experienced the PIR as mainly positive, she found it inconvenient that the nurse responsible for the restraint decision had not participated in the encounter. She and the nurse had divergent apprehensions of the preceding circumstances. She proposed therefore that waiting a couple of days to include that nurse in the PIR could have ensured her interests in a more optimal way.

Like Elisabeth (5), Hilda was prepared for PIR as she and her contact nurse had reflected upon the restraint events several times beforehand. For her, it was appropriate to participate in PIR at the end of her admission. She argued that her mental condition then was improved, thus she could better use her legitimate right to "declare what you think, what they have done wrong and what they might have done differently" (8).

Both Elisabeth (5) and Hilda (8) highlighted *processing* the restraint incident as a positive aspect of the PIR. Elisabeth told about the possibility to "brief herself through the restraint event" that contributed to "putting a full stop" on it. Also, Hilda (8) drew attention to the concept "putting a full stop" by saying "you will always carry it with you, but if you're allowed to finish what you want to say, and everybody agrees how it was and what happened, you get it over and done with, you call it off pretty soon" (8).

12

Some patients said that the care providers had given them an explanation for effectuating restraint measures that contributed to increased understanding of the event. For Elisabeth, it was of utmost importance that the care providers acknowledged the grievousness of conducting coercion and consequently focused on guarding against such practice:

> They did what they thought was best and they meant no harm. And that's quite true, I guess they certainly didn't. But it's not what you want to hear (……) You need them to understand that this is a major intervention and something that should not happen. And I believe they should be more focused on that, so that it doesn't happen again (5)

Elisabeth and Hilda both spoke about PIRs as an arena for *developing new coping strategies*. Elisabeth (5) told that she in the PIR learned to ask the care providers for support before placing herself in a safe corner in the living room, something that usually initiated the restraint incidents. By understanding that the care providers had not wanted to hurt her, she became more receptive to help and collaboration with the care providers about other strategies. Hilda (8) said that in the PIR they focused on how she could be more active in taking initiatives when she struggled, and that she together with the care providers worked out a mutual agreement on how to handle situations that might provoke restraint incidents. To Hilda, receiving care in the most peaceful seclusion room helped her to calm down and thus capable of cooperation, which resulted in fewer restraint episodes.

Stories about PIRs as meaningless, feeling like an object and longing for living communication and closeness.

Other patients' experiences varied from indifference to more negative descriptions of their participation in the PIRs. They said that they found no meaning in participation in PIRs based on previous experiences of no influence in the services and experiences of their needs not being met in the PIR. Consequently, they said they did not talk much in the encounter. The following compound story represents their experiences:

> I took part in that conversation because I was told to. I guess I was a bit resigned. There's no point in talking about such unpleasantness as it doesn't help no matter what. Apart from that, PIRs are usually very short, just a few minutes really. I think it's too little, as if they really don't care that

13

much. Afterwards I was left with a bad feeling; oh – was that it? I could have said I wanted to tell my side of it, but they didn't ask. I was kind of taken aback afterwards (….) it's almost like a survey; it's what they all ask for. We're not equal, are we?

For several patients, the time point for the encounter and participants in the PIR were unclear, except from the issue that it was either a doctor or a psychologist who chaired the PIR. Some patients had trouble distinguishing PIRs from other therapeutic meetings as they said that they were not informed about the aim and purpose of the encounter. They considered participation in the PIR as *meaningless* as they did not trust PIR as an arena for real dialogue, based on previous experiences characterised by restrictive environments and lack of influence. Gerda expressed: "What I have learnt after 20 years in psychiatry is that what I have to say means nothing" (7). Several participants found the organisation and content in the PIR to confirm this attitude. They said they had no influence regarding practical arrangement of the encounter. Beth (2) said she "showed up in the PIR because she was told to". Further, several patients considered the time point of the PIR as too early after the restraint event, consequently they were not mentally capable to reflect as they otherwise could have done.

Stories about *being met like an object* dealt with the feeling of fitting into a category in a practice that was experienced as manual-based. Gerda said that "When you're in a place like this and you're under duress, it's all about following the book and principles, rules and such. They don't grasp that we're different." (7)

Cecilie (3) experienced the PIR like participation in a survey, as all the patients were asked the same questions, which she considered wrong as patients are unequal persons. She suggested that a real dialogue instead of answering questions from a form would be more meaningful to her. Even though Cecilie (3) felt disappointed after the PIR, she appreciated however being asked whether she preferred to be physically held or restrained by belts when situations got out of control.

14

Beth (2) said that in the PIR she hadn't mentioned her experience of being talked about, not with, when she was restrained, as she considered that issue not to fit in the questions asked in the procedure form.

Some patients described that they were disappointed after the PIR because of the marginal timeframe and the form and content in the encounter. By *longing for living communication and closeness*, Cecilie (3) expressed several patients' experiences when she said she had been taken aback when the PIR was rounded off, as she had a need to talk and did not experience PIR as a dialogical meeting:

> I would have made more out of it (…) I would have said some more on the issue and wanted to try and understand it in a different way. Because, with basis in a question you understand quite a lot, but you don't understand everything, do you? There's so much more behind the questions (3)

Daisy (4) said she didn't talk much in PIRs especially if she perceived the care providers as insensitive. Further, she concluded that the care providers didn't seem to care very much as PIRs' were rounded off so quickly. To accommodate her longing for closeness, she suggested that the care providers could sit down and hold her hand both when she was restrained and in the PIR. Regarding taciturnity in the encounter, some patients expressed sympathy with the care providers regarding the fact that they did not share their experiences, as Daisy expressed:

> To my mind it must be very frustrating to initiate a conversation, and when they ask why do you become restless, and what can we do, and when I just sit there, looking like a question mark, I don't know (… ……..) that must be very hard for them, and then, what are they going to do? (4)

Discussion

The findings in this study show that the patients had various experiences of PIRs that can be placed on a continuum from mainly positive, via indifference to mainly negative experiences. The findings seem however to be mostly about how the PIRs were organised and how the patients experienced being met in the encounters and as inpatients incidentally, and less about the utility of the PIRs.

15

Related to the definition of PIRs (Goulet & Larue, 2016), the findings of PIRs as beneficial, based on being strengthened, developing new coping strategies and processing the restraint event, point first and foremost to development of knowledge as an outcome of PIRs. Considering PIRs as resulting in new knowledge that contributes to more individualised care and thus may prevent repeating restraint events, is in line with care providers' experiences and views on PIRs (Ashcraft & Anthony, 2008; Bonner, Lowe, Rawcliffe, & Wellman, 2002; Goulet et al., 2018) (xxxxxx 2). We have however not found previous studies referring to patients' experiences with PIRs as a tool for knowledge development.

The other aim in the definition of PIRs, enhancing the care experience (Goulet et al., 2018), is reflected in processing the restraint event in the PIR that is in line with the study of Lanthén et al. (2015) where previous patients emphasised PIRs as a way to process the restraint experience so as to prevent restraint-related traumas. This topic: PIRs as being suitable for processing damaged relationships, as described in studies exploring care providers' experiences of PIRs (Goulet et al., 2018; Gustafsson & Salzmann-Erikson, 2016), did not come up as a finding in our study (xxxxxx 2).

The patients who described participation in PIRs positively, spoke about being prepared for the PIR, being motivated by getting information about the aim and purpose of PIRs, and further experiences of being met in a supportive atmosphere.

In light of Buber's dialogical approach (Buber & Smith, 2004), we understand these patients' experiences as being met in a Subject-Subject relation, and thus in a supportive atmosphere, which is described as a premise for PIRs (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Bonner & Wellman, 2010; Goulet et al., 2018). In a frame of personal recovery philosophy, the patients' experiences seem however to support processes like identity, hope and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Slade, 2009). Illuminated by personal recovery philosophy (Leamy et al., 2011; Slade, 2009), a

16

comprehensive understanding of these patients' experiences, is PIRs to be an opportunity *to support the patients' personal recovery processes*, assuming that the PIR is conducted in a supportive environment. This finding is in line with previous studies (Goulet et al., 2018; Gustafsson & Salzmann-Erikson, 2016; Ling et al., 2015) (xxxxxx 1).

In contrast to the positive experiences of PIRs, the findings in this study show that several patients struggled to participate actively in the PIRs. We have found this phenomenon only in one previous study, where care providers in the same project had trouble getting a hold on the patients' voices in the PIRs (xxxxxx 2).

In light of Goffman's theories (1968), experiencing PIRs as meaningless, feeling like an object and longing for living communication and closeness, the comprehensive understanding of the patients' experiences can be characterised as *continuation of coercive contexts* as the power dynamics imply that care providers typically exercise a dominant influence on planning and conducting the PIRs (Sjöström, 2006). The PIR may then, instead of contributing to increasing voluntary treatment and care, amplify a feeling of powerlessness and thus increase the use of coercive measures, the opposite of the intentions of PIRs (Goulet & Larue, 2016; Huckshorn, 2004).

To the patients, being restrained is a violation of their autonomy and liberty that often results in feeling dehumanised afterwards (Norvoll & Pedersen, 2016; Nyttingnes et al., 2016; Wilson, Rouse, Rae, & Kar Ray, 2017). Therefore, there is a need to pay attention to the vulnerability to overcome the tensions of PIRs with respect to coercive contexts (Sjöström, 2006). As dignity and being treated with respect are core values in care (International Council of Nurses, 2012), we suggest perspectives from recovery-oriented care philosophies and care ethics to support patients' active participation in PIRs (Slade, 2009; Tronto, 1993). In light of these perspectives, the patient's vulnerability and the power-dependence relationships should be considered when planning and conducting the PIRs. According to the participants in this

17

study, the timepoint for the PIR should be fixed based on the patients' mental health condition and preferences. In scientific literature, we find both stated timeframes and the necessity of individual assessments (xxxxxx 1). We have found one study describing patients' preferences on the time point (Goulet et al., 2018), where PIR one week after the restraint incident was suggested.

The power dynamics in the PIR, as we have pointed out, may suppress the patients' voices, consequently "much of the patients' agenda will not get aired in the consultation" (Greenhalgh, Snow, Ryan, Rees, & Salisbury, 2015, p.3). The predominance of care providers in the PIRs was one of several alternative explanations presented by care providers regarding their experiences of struggling to get hold of the patients' voices in PIRs (xxxxxx 2). Perspectives from theory of power-dependence relations (Emerson, 1962), may suggest strengthening the weaker member, the patient, in the PIRs. The members in power, here: the care providers, can, according to Emerson (1962) contribute to achieving more balance in the power-dependence relationship towards the other: here, the patients, by increasing their motivational investment in the goals and strategies defined and expressed by the other, here: the patients in the PIR dialogue, and further documented in care plans or joint crisis plans (Henderson et al., 2004). Further, extension of the power network (Emerson, 1962) may support the patients in PIRs by advocacy by peers, user consultants, contact nurse or other trusted persons (Levy & Payne, 2006; Ridley, Newbigging, & Street, 2018).

Within a frame of personal recovery philosophy, episodes of acting out or relapses are labelled as "crises", which indicates that the episode may be a learning opportunity (Slade, 2009). Further, a recovery focus includes minimising the patient's loss of personal responsibility during the crisis (Slade, 2009). The two participating services' procedures did however not include asking the patient whether one could have handled the situation in a different way, as suggested in other studies (Ashcraft & Anthony, 2008; Goulet et al., 2018;

18

Ling et al., 2015). Including that question in the PIR form could increase the patients'

responsibility, and accordingly support the patients' empowerment and consequently personal

recovery processes (Barker, 2012; Leamy et al., 2011; Slade, 2009). To avoid blaming the

patient, the question about other alternative strategies must however be requested in a

supportive atmosphere characterised by the "care providers' genuine presence" (Goulet et al.,

2018, p.218).

This study did not reveal explicit knowledge about PIRs' potential for care

improvement and restraint reduction at the organisational level that is suggested in a previous

study (Petti, Mohr, Somers, & Sims, 2001). The findings do however point to the importance

of services' care philosophies that emphasise patients' involvement and dialogical and

collaborative approaches. This is in line with our study where care providers who experienced

PIRs as beneficial due to potential to improve the quality of care, seemed to perform an

acknowledging, dialogue-oriented approach in the PIRs (xxxxxx 2).

Based on Tronto & Fishers' (1993) responsibility to "take care of", we address the

organisational challenges to the services' managers, that means ensuring that structural and

cultural conditions have been facilitated which safeguard the care providers' professional and

moral competence and thus provide patients' optimal treatment and care.

Methodological considerations

The strength of the study is that it explicitly sought perspectives on PIRs from persons who

had first-hand experience of PIRs' after restraint events. In addition to contributing to the

existing knowledge base, the study reveals a need for more explorations of how to support

patients to participate actively in PIRs. Even though the interviews were conducted in a period

of over three years, we consider the study's dependability to be maintained. The services' PIR

procedures and the study's interview guide were unchanged during the period. As PIRs

involve different persons, neither the PIRs nor the interviews would be identical even if

conducted in a short period of time (Blaikie & Priest, 2019).

19

Despite our desire for additional study participants, we considered the eight interviewees to contribute to sufficient information power based on their being highly specific for the study aim and that the dialogues were strong (Malterud, Siersma, & Guassora, 2016). We don't exactly know the reasons why we failed to recruit more study participants. Getting access to services who would give permission for the empirical part of the study was a challenge as several services were contacted before the two participating services permitted the study.

Further, care providers' eventual assessments of the patients as vulnerable, also raises the problem of gatekeeping, that is feeling obligated to protect the patients against issues that may threaten their well-being (Carlsson, Blomqvist, & Jormfeldt, 2017; Witham, Beddow, & Haigh, 2015). We will anyway emphasise the importance of giving ear to the few with experiences of PIRs and recommend further studies to include more patients' voices.

The criterion of credibility of the study pertains to the authors' thorough knowledge of structures and cultures in mental health services. Credibility was further strengthened as the first author discussed results with co-authors and research groups, which were further confirmed by the advisory group.

Conclusion and implications for practice

The findings in this study support previous studies that find PIRs potentially helpful to both patients and care providers. However, first and foremost, the findings support the importance of conducting PIRs in supportive environments that emphasise collaboration and an acknowledging dialogue to elicit the patients' voices in the PIRs.

As several settings seem to affect patients' experiences of PIRs, attention must be directed to both individual and structural conditions in the services. The pitfalls of conducting PIRs must be highlighted, consequently PIRs should be conducted in a frame of human care philosophies that recognises the power-dependence relationship and the patients' vulnerability

20

after restraint events. To support the patients' engagement for participation in PIRs, they should receive tailored information about the aim and purpose of the encounter.

As the patients had individual views on when and how the PIR should be conducted, they should influence the planning for the PIR: the time for the encounter, whom to participate and themes to be taken up. Trusted persons or advocacy may provide a counterbalance and support the patient in the PIR.

The PIR form in the services should be critically assessed, by (1) paying attention to the patients' motivation and capacity to take some responsibility for preventing new restraint events and (2) adding a concluding question about whether the patient needs to talk about something they have not mentioned in the PIR.

More studies are however essential to acquire knowledge of how to support patients' active participation in PIRs.

References

Ashcraft, L., & Anthony, W. (2008). Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services. *Psychiatr Serv, 59*(10), 1198-1202. doi:10.1176/appi.ps.59.10.1198

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospitaljcap. *J Child Adolesc Psychiatr Nurs, 24*(1), 11-15. doi:10.1111/j.1744-6171.2010.00262.x

Barker, R. (2012). Recovery and risk. Accepting the complexity. In G. Drennan & D. Alred (Eds.), *Secure Recovery : Approaches to Recovery in Forensic Mental Health Settings*. Cullompton: Cullompton, US: Taylor and Francis.

Blaikie, N., & Priest, J. (2019). *Designing social research : the logic of anticipation* (3rd. ed.). Cambridge, UK,Medford, MA: Polity Press.

Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *J Psychiatr Ment Health Nurs, 9*(4), 465-473. doi:10.1046/j.1365-2850.2002.00504.x

Bonner, G., & Wellman, N. (2010). Postincident review of aggression and violence in mental health settings. *J Psychosoc Nurs Ment Health Serv, 48*(7), 35-40. doi:10.3928/02793695-20100701-02

Buber, M., & Smith, R. G. (2004). *I and thou* (2nd ed. with a postscript by the author. ed.). London: Continuum,.

21

Carlsson, I.-M., Blomqvist, M., & Jormfeldt, H. (2017). Ethical and methodological issues in qualitative studies involving people with severe and persistent mental illness such as schizophrenia and other psychotic conditions: A critical review. *International Journal of Qualitative Studies on Health and Well-being, 12*(sup2), 1368323-1368323. doi:10.1080/17482631.2017.1368323

Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *Int J Ment Health Nurs, 27*(3), 1162-1176. doi:10.1111/inm.12432

Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, 310(20) C.F.R. (2013).

Dumais, A., Larue, C., Drapeau, A., Ménard, G., & Allard, M. G. (2011). Prevalence and correlates of seclusion with or without restraint in a Canadian psychiatric hospital: A 2-year retrospective audit. *Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc.), 18*(5), 394-402. doi:10.1111/j.1365-2850.2010.01679.x

Emerson, R. M. (1962). Power-Dependence Relations. *American Sociological Review*(1), 31. doi:10.2307/2089716

Goffman, E. (1968). *Asylums : essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin.

Goulet, M.-H., & Larue, C. (2016). Post-seclusion and/or restraint review in psychiatry: A scoping review. *Arch Psychiatr Nurs, 30*(1), 120-128. doi:http://dx.doi.org/10.1016/j.apnu.2015.09.001

Goulet, M.-H., Larue, C., & Dumais, A. (2017). Evaluation of seclusion and restraint reduction programs in mental health: A systematic review. *Aggression and Violent Behavior, 34*. doi:10.1016/j.avb.2017.01.019

Goulet, M.-H., Larue, C., & Lemieux, A. J. (2018). A pilot study of "post-seclusion and/or restraint review" intervention with patients and staff in a mental health setting. *Perspect Psychiatr Care, 54*(2), 212-220. doi:10.1111/ppc.12225

Greenhalgh, T., Snow, R., Ryan, S., Rees, S., & Salisbury, H. (2015). Six 'biases' against patients and carers in evidence-based medicine. *BMC Medicine, 13*, 200. doi:10.1186/s12916-015-0437-x

Gustafsson, N., & Salzmann-Erikson, M. (2016). Effect of complex working conditions on nurses who exert coercive measures in forensic psychiatric care. *J Psychosoc Nurs Ment Health Serv, 54*(9), 37-43. doi:10.3928/02793695-20160817-06

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial. *BMJ (Clinical Research Ed.), 329*(7458), 136-140. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=15240438&scope=site

Huckshorn, K. A. (2004). Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *J Psychosoc Nurs Ment Health Serv, 42*(9), 22-33. doi:http://dx.doi.org/10.3928/02793695-20141006-01.

Husum, T. L., Legernes, E., & Pedersen, R. (2019). "A plea for recognition" Users' experience of humiliation during mental health care. *Int J Law Psychiatry 62*, 148-153. doi:https://doi.org/10.1016/j.ijlp.2018.11.004

International Council of Nurses. (2012). The ICN code of ethics for nurses. Retrieved from https://www.icn.ch/sites/default/files/inlinefiles/2012_ICN_Codeofethicsfornurses_%20eng.pdf

Lanthén, K., Rask, M., & Sunnqvist, C. (2015). Psychiatric patients experiences with mechanical restraints: An interview study. *Psychiatry J, 2015*, 748392-748392, 748398pages. doi:10.1155/2015/748392

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. In *British Journal of Psychiatry* (Vol. 199, pp. 445-452).

22

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. *J Psychosoc Nurs Ment Health Serv, 52*(11), 22-29. doi:10.3928/02793695-20140915-01

Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences, 18*(2), 145-153. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2004120877&scope=site

Ling, S., Cleverley, K., & Perivolaris, A. (2015). Understanding Mental Health Service User Experiences of Restraint Through Debriefing: A Qualitative Analysis. *Can J Psychiatry, 60*(9), 386-392. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=112380803&scope=site

Mason, J. (2018). *Qualitative researching* (Vol. 3rd ed.). London,: Sage.

Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with physical restraint. *Can J Psychiatry, 48*(5), 330-337. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=10033094&scope=site

NICE. (2015, 2019.02.15). Violence and aggression: Short-term management in mental health, health and community settings. Retrieved from www.nice.org.uk/guidance/NG10

Norvoll, R., & Pedersen, R. (2016). Exploring the views of people with mental health problems' on the concept of coercion: Towards a broader socio-ethical perspective. *Soc Sci Med, 156*, 204-211. doi:http://dx.doi.org/10.1016/j.socscimed.2016.03.033

Norwegian Mental Health Care Act. Act No. 62 of 2 July 1999 relating to the provision and implementation of mental health care (the Mental Health Care Act), with later amendments. Oslo: Ministry of Health and Care Services; 1999 [Available from: https://app.uio.no/ub/ujur/oversatte-lover/data/lov-19990702-062-eng.pdf.

NVivo 12. (2016). *NVivo qualitative data analysis Software; Version 12*: QSR International Pty Ltd.

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care *Int J Law Psychiatry 49*, 147-153. doi:10.1016/j.ijlp.2016.08.009

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*(2), 183-190. doi:http://dx.doi.org/10.1016/j.colegn.2015.03.006

Petti, T. A., Mohr, W. K., Somers, J. W., & Sims, L. (2001). Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. *J Child Adolesc Psychiatr Nurs, 14*(3), 115-127 113p. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=107076065&scope=site

Rakhmatullina, M., Taub, A., & Jacob, T. (2013). Morbidity and mortality associated with the utilization of restraints: A review of literature. *Psychiatric Quarterly, 84*(4), 499-512. doi:10.1007/s11126-013-9262-6

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Los Angeles: Sage Publications.

Sivilombudsmannen. (2018). *Skjerming i psykisk helsevern - Risiko for umenneskelig behandling*. Retrieved from Oslo: https://www.sivilombudsmannen.no/wp-content/uploads/2018/12/Temarapport-2018_Skjerming-i-psykisk-helsevern.pdf

Sjöström, S. (2006). Invocation of coercion context in compliance communication — power dynamics in psychiatric care. *Int J Law Psychiatry 29*(1), 36-47. doi:10.1016/j.ijlp.2005.06.001

Slade, M. (2009). *Personal recovery and mental illness: a guide for mental health professionals*. Cambridge: Cambridge University Press.

Steinert, T., Lepping, P., Bernhardsgrütter, R., Conca, A., Hatling, T., Janssen, W., . . . Whittington, R. (2010). Incidence of seclusion and restraint in psychiatric hospitals: A literature review and survey of international trends. *Social Psychiatry and Psychiatric Epidemiology, 45*(9), 889-897. doi:10.1007/s00127-009-0132-3

Tronto, J. C. (1993). *Moral boundaries : A political argument for an ethic of care*. New York: Routledge.

23

United Nations (2013). *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*. Geneve: United Nations, Human Rights Council Retrieved from https://www.ohchr.org/documents/hrbodies/hrcouncil/regularsession/session22/a.hrc.22.53_english.pdf

United Nations. (2017a). *Mental health and human rights. Report of the United Nations High Commissioner for Human Rights*. Retrieved from New York: United Nations:

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *Int J Ment Health Nurs, 26*(5), 500-512. doi:10.1111/inm.12382

Witham, G., Beddow, A., & Haigh, C. (2015). Reflections on access: Too vulnerable to research? *Journal of Research in Nursing, 20*(1), 28-37. doi:10.1177/1744987113499338

Appendices

Appendix 1 - Interview guides patients and care providers

Interview guide

Intervju med pasienten:

Alder. Første gang innlagt? Pasientens begrunnelse for innleggelsen. Erfaringer med tvangsmidler? Erfaringer med ettersamtale?

1. Kan du kort fortelle om episoden hva som skjedde sa du ble holdt/lagt i belte? (Antatt årsak, opplevelse av tiltaket (inklusiv eventuelle skader som følge av inngrepet), oppfølging etterpå?)
2. Når ble ettersamtalen avholdt og hvem var med på den?
3. Kan du fortelle om innholdet i ettersamtalen?
4. Hvordan opplevde du ettersamtalen? Positive erfaringer? Negative erfaringer? (Her vil jeg høre etter opplevelse om atmosfære, muligheter for åpenhet, praktisk avvikling av ettersamtalen etc)
5. Hvordan tror du ettersamtalen ble opplevd av personalet som var med?
6. Dokumentasjon av samtalen?

Intervju med helsepersonell:

Alder. Utdanning? Arbeidserfaring innen psyk. helsetjeneste? Erfaringer med tvangsmidler? Erfaringer med ettersamtale?

1. Kan du kort fortelle hva som skjedde da pasienten ble holdt/lagt i belte?
2. Når ble ettersamtalen avholdt og hvem var med på den?
3. Kan du fortelle om innholdet i ettersamtalen?
4. Hvordan opplevde du ettersamtalen? Positive erfaringer? Negative erfaringer?
   (Her vil jeg høre etter opplevelse om atmosfære, muligheter for åpenhet, praktisk avvikling av ettersamtalen etc)
5. Hvordan tror du ettersamtalen ble opplevd av pasienten som var med?
6. Dokumentasjon av samtalen?

Appendix 2 - Participation information letter patients

Forespørsel til pasient om deltakelse i forskningsprosjektet

«Samtaler etter bruk av mekaniske tvangsmidler og holding   –
En kvalitativ studie om pasienter og personal sine erfaringer»

Bakgrunn og formål

Dette er et spørsmål til deg om å delta i en doktorgradsstudie for å undersøke hvilke erfaringer pasienter og helsepersonell har **med samtale** etter bruk av mekaniske tvangsmidler og holding. (Regulert i Lov om psykisk helsevern § 4.8.)

Bakgrunnen for studien er at forskning viser at mekaniske tvangsmidler og holding kan føre til både fysiske og psykiske skader for pasientene og belastninger for personalet. Derfor er det behov for mer kunnskap om hvilke erfaringer både pasienter og personal har, og om en planlagt og systematisk samtale etterpå kan bidra til andre erfaringer.

Studien er planlagt gjennomført ved Helse Bergen Psykiatrisk klinikk Sandviken og Jæren DPS.

Det tilstrebes å innhente erfaringer <u>fra pasienter og helsepersonell som har hatt en felles samtale etter anvendelse av mekaniske tvangsmidler og/eller holding.</u>

Du blir spurt om å delta fordi du har erfaring med mekaniske tvangsmidler og/eller holding og har hatt en samtale med helsepersonell om hendelsen i etterkant.

Hva innebærer deltakelse i studien?

Dersom du sier ja til å delta i studien, vil dette innebære et intervju med undertegnede om dine erfaringer med samtalen etter beltelegging og/eller holding.

Dette intervjuet vil avholdes i løpet av 2 uker etter at du eventuelt har sagt ja til å delta.

Det beregnes at intervjuet vil vare om lag 45 minutter. Samtalen vil bli tatt opp på bånd om du godkjenner dette.

Hva skjer med informasjonen om deg?

Forskeren vil ikke kjenne din identitet før du eventuelt samtykker til deltakelse.

Alle personopplysninger vil bli behandlet konfidensielt.

Samtalene slettes når de er skrevet ned. Intervjuene lagres på universitetets database. Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Intervjuet vil bli registrert som «pasient n», der n er nummer i rekken, alder og avdelingens navn.

Personidentifiserende opplysninger vil ikke deles med helseforetaket eller noen andre.

Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Universitetet i Stavanger ved administrerende direktør er databehandlingsansvarlig.

Prosjektet skal etter planen avsluttes i løpet av 2017. Opptak slettes og intervju oppbevares fortsatt som anonymisert, eventuelt slettes.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dette vil **ikke** få konsekvenser for din videre behandling. Dersom du trekker deg, vil alle opplysninger om deg slettes.

Dersom du ønsker å delta i studien, gir du beskjed til din kontaktperson i avdelingen

………………………………………………..,

Jeg vil ta kontakt med deg når du har underskrevet samtykke om å delta.

Dersom du har spørsmål til studien, er du velkommen til å ta kontakt med prosjektleder Unn Hammervold, tlf. 909 36 740.

Studien er forelagt Regional Etisk Komité, Bergen og godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

----

(Signert av prosjektdeltaker, dato)

Appendix 3 - Participation information letter care providers letter

Forespørsel til helsepersonell om deltakelse i forskningsprosjektet

«Samtaler etter bruk av mekaniske tvangsmidler og holding –

En kvalitativ studie om pasienter og personal sine erfaringer»

Bakgrunn og formål

Dette er et spørsmål til deg om å delta i en doktorgradsstudie der hensikten er å undersøke hvilke erfaringer pasienter og helsepersonell har **med samtale** etter bruk av mekaniske tvangsmidler og holding. (Regulert i Lov om psykisk helsevern § 4.8.)

Bakgrunnen for studien er at forskning viser at mekaniske tvangsmidler og holding kan føre til både fysiske og psykiske skader for pasientene og belastninger for personalet. Derfor er det behov for mer kunnskap om hvilke erfaringer både pasienter og personal har, og om en planlagt og systematisk samtale etterpå kan bidra til andre erfaringer.

Studien er planlagt gjennomført ved Helse Bergen Psykiatrisk klinikk Sandviken og Jæren DPS.

Det tilstrebes å innhente erfaringer <u>fra pasienter og helsepersonell som har hatt en felles samtale etter anvendelse av mekaniske tvangsmidler og/eller holding.</u>

Du blir spurt om å delta fordi du har erfaring med mekaniske tvangsmidler og/eller holding og har hatt en samtale med pasient om hendelsen i etterkant.

Hva innebærer deltakelse i studien?

Dersom du sier ja til å delta i studien, vil dette innebære:

Intervju med undertegnede om dine erfaringer med systematisk samtale med en pasient som har vært beltelagt eller holdt.

Dette intervjuet vil avholdes i løpet av 2 uker etter at du eventuelt har sagt ja til å delta.

Det beregnes at intervjuet vil vare om lag 45 minutter. Samtalen blir tatt opp på bånd om du godkjenner dette.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt.

Samtalene slettes når de er skrevet ned. Intervjuene lagres på universitetets database. Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende

opplysninger. En kode knytter deg til dine opplysninger til en informantliste med ditt navn og mailadresse.

Det er kun prosjektleder som har adgang til informantlisten og som kan finne tilbake til deg. Listen slettes når studien avsluttes. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Universitetet i Stavanger ved administrerende direktør er databehandlingsansvarlig.

Prosjektet skal etter planen avsluttes i løpet av 2017. Opptak slettes og intervju oppbevares fortsatt som anonymisert, evnt. slettes.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dette vil **ikke** få konsekvenser for deg. Dersom du trekker deg, vil alle opplysninger om deg bli slettet.

Som forsker her jeg en uavhengig rolle i avdelingene. Det vil si at jeg ikke er representant fra ledelsen eller noen organisasjon.
Jeg har underskrevet taushetsplikten ved sykehuset. Undersøkelsen anonymiseres og vil bli behandlet konfidensielt gjennom hele prosessen
Prosjektet er forelagt Regional komite for medisinsk etikk og godkjent av Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Unn Hammervold, tlf. 909 36 740 eller veileder Hildegunn Sagvaag, tlf. 51834236.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

----

(Signert av prosjektdeltaker, dato)

(mailadresse)

Appendix 4 - Ethical approval letters

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Gjøril Bergva	22845529	05.02.2014	2013/2359/REK sør-øst D
			Deres dato:	**Deres referanse:**
			10.12.2013	

Vår referanse må oppgis ved alle henvendelser

Til: Unn Elisabeth Hammervold

2013/2359 Samtaler etter bruk av mekaniske tvangsmidler og holding – En kvalitativ studie om pasienter og personal sine erfaringer

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 15.01.2014. Vurderingen er gjort med hjemmel i helseforskningsloven § 10, jf. forskningsetikklovens § 4.

Forskningsansvarlig: Universitetet i Stavanger
Prosjektleder: Unn Elisabeth Hammervold

Prosjektomtale (revidert av REK):
I 2009 ble det gjort vel 6000 vedtak om mekaniske tvangsmidler og holding i norsk psykisk helsevern. Internasjonale publikasjoner viser til dels alvorlige fysiske og psykiske skader hos pasienter etter bruk av tvangsmidler. Det er etablert rutiner for samtaler med personell etter bruk av tvang, men kun tilfeldig for pasienter. Denne studiens hensikt er å få kunnskap om erfaringer med ettersamtaler hos pasienter og personal etter anvendelse av mekaniske tvangsmidler og holding. Videre utforskes om disse erfaringene bidrar til endring av praksis. Det vil anvendes kvalitativ metode der innlagte pasienter og helsepersonell som var involvert i samme tvangsepisode intervjues.

Vurdering
Slik komiteen oppfatter prosjektet, er hensikten å få kunnskap om selve ettersamtalen, med fokus på pasientenes og personalets positive og negative erfaringer. Det fremgår av søknaden at prosjektet kan bidra til fagutvikling og mulig endring av praksis. Komiteen vurderer at prosjektet, slik det er presentert i søknad og protokoll, ikke vil gi ny kunnskap om helse og sykdom som sådan. Prosjektet faller derfor utenfor REKs mandat etter helseforskningsloven. Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet. Prosjektet kommer inn under de interne regler som gjelder ved forskningsansvarlig virksomhet. Det er institusjonens ansvar å sørge for at prosjektet følger gjeldende reguleringer for behandling av helseopplysninger. Ettersom prosjektet forutsettes gjennomført i samsvar med gjeldende reguleringer, vil dette ikke være til noe hinder for at resultatene kan publiseres.

Vedtak
Prosjektet faller utenfor helseforskningslovens virkeområde da det ikke oppfyller formålet, jf. § 2. Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet.

Vi ber om at alle henvendelser sendes inn med korrekt skjema via vår saksportal: http://helseforskning.etikkom.no. Dersom det ikke finnes passende skjema kan henvendelsen rettes på e-post til: post@helseforskning.etikkom.no.

Besøksadresse: Gullhaugveien 1-3, 0484 Oslo	**Telefon:** 22845511 **E-post:** post@helseforskning.etikkom.no **Web:** http://helseforskning.etikkom.no/	All post og e-post som inngår i saksbehandlingen, bes adressert til REK sør-øst og ikke til enkelte personer	Kindly address all mail and e-mails to the Regional Ethics Committee, REK sør-øst, not to individual staff

Vennligst oppgi vårt referansenummer i korrespondansen.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningslovens § 28 flg. Klagen sendes til REK sør-øst.
Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst, sendes
klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Finn Wisløff
Professor em. dr. med.
Leder

Gjøril Bergva
Rådgiver

Kopi til: hildegunn.sagvaag@uis.no; Universitetet i Stavanger ved øverste administrative ledelse:
post@uis.no

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Arne Salbu	55978498	30.09.2014	2014/1375/REK vest
			Deres dato:	**Deres referanse:**
			19.08.2014	

Vår referanse må oppgis ved alle henvendelser

Unn Elisabeth Hammervold
Institutt for helsefag

2014/1375 Samtaler etter bruk av mekaniske tvangsmidler og holding - En kvalitativ studie om pasienter og personal sine erfaringer

Forskningsansvarlig institusjon: Universitetet i Stavanger
Prosjektleder: Unn Elisabeth Hammervold

Vi viser til søknad om dispensasjon fra taushetsplikt i ovennevnte prosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 11.09.2014. Vurderingen er gjort med hjemmel i helsepersonelloven § 29 første ledd og forvaltningsloven § 13 d første ledd.

Prosjektomtale
Innenfor psykisk helsevern blir bruk av tvangsmidler regulert i Lov om psykisk helsevern (1999) § 4.8. Brukere av psykiske helsetjenester rapporterer om ulike erfaringer med tvangsmidler, - fra at de forebygger skader og redder liv, til at de medfører betydelige fysiske og psykiske tilleggsbelastninger. Systematiske samtaler etter bruk av tvang er tiltak enkelte helseforetak gjennomfører. Man vet lite om hvordan slike ettersamtaler påvirker tilleggsbelastninger og i denne studien vil vi innhente erfaringer ved systematiske ettersamtaler. Vi vil undersøke pasienters og helsepersonells erfaringer med sikte på å utvikle kunnskap som kan få konsekvenser for praksis. Fokus på erfaringer gjør kvalitativ metode relevant og analyse og fortolkning vil skje innenfor en hermeneutisk tradisjon. Datasamlingen vil være deltakende observasjon, fokusgruppeintervju og semistrukturerte dybdeintervju med pasienter og personal som har hatt ettersamtaler etter bruk av mekaniske tvangsmidler og holding.

Vurdering

Dette prosjektet gjelder organiserte ettersamtaler med pasienter etter bruk av tvangsmidler i psykisk helsevern (phvl. § 4-8-tiltak). Man ønsker å hente inn erfaringer ved systematisk bruk av ettersamtaler. Man vil også undersøke pasienters og helsepersonell sine erfaringer med sikte på å utvikle ny relevant kunnskap.

Metode vil blant annet være deltakende observasjon, og det er *alene dette elementet* i prosjektet som skal vurderes av komiteen. Prosjektet er tidligere vurdert til å falle utenfor helseforskningslovens område av en annen REK-komité. Spørsmålet for REK vest er nå om det er grunnlag for å gi dispensasjon fra taushetsplikten etter helsepersonelloven § 29 b: med andre ord gjøre unntak fra kravet om samtykke fra pasientene. For dette stilles som vilkår at «behandlingen av opplysningene er av vesentlig interesse for samfunnet og hensynet til pasientens integritet og velferd er ivaretatt».

Psykiatriske pasienter i institusjon og der mange vil være under tvunget vern, er å anse som en svært sårbar gruppe. I søknaden vurderes at mange av pasientene vil være uten samtykkekompetanse. Å kunne reservere seg fra deltakelse (dvs bli observert), anses derfor ikke som realistisk. I tillegg gjøres gjeldende den

Besøksadresse:
Armauer Hansens Hus (AHH),
Tverrfløy Nord, 2 etasje. Rom
281. Haukelandsveien 28

Telefon: 55975000
E-post: rek-vest@uib.no
Web: http://helseforskning.etikkom.no/

All post og e-post som inngår i saksbehandlingen, bes adressert til REK vest og ikke til enkelte personer

Kindly address all mail and e-mails to the Regional Ethics Committee, REK vest, not to individual staff

utfordring en stadig utskiftning av pasientpopulasjonen i avdelingene representerer.

Vurderingen av om unntak fra samtykkekravet bør gis, må hensynta at gruppen er svært sårbar. Kravene til samfunnsinteresse og ivaretakelse av integritet skjerpes her. Komiteen mener generelt det er viktig å framskaffe kunnskap omsider ved bruk av tvang innen psykisk helsevern. Vanskene med å innhente samtykke anerkjennes også. I dette prosjektet har komiteen likevel vurdert at betydningen av metoden deltakende observasjon ikke er tilstrekkelig godtgjort til å forsvare avvik fra samtykkekravet. Det er således ikke selve tvangsbruken som skal undersøkes, men bruken av ettersamtaler. Koblingen til betydningen av «konteksten» der disse finner sted blir da mindre sterkt. I lys av de sterke grunner som må være oppfylt for gjøre unntak fra samtykkekravet, har komiteen konkludert med at bruk av deltakende observasjon neppe kan generere kunnskap av en slik viktighet at dispensasjon kan rettferdiggjøres. Søknaden må derfor avslås.

Vedtak
REK vest avslår søknad om dispensasjons fra taushetsplikten etter helsepersonelloven § 29, for dette prosjektet.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningslovens § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Ansgar Berg
Prof. Dr.med
Komitéleder

Arne Salbu
rådgiver

Kopi til: hildegunn.sagvaag@uis.no

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel +47-55 58 21 17
Fax +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org nr 985 321 884

Unn Elisabeth Hammervold
Institutt for helsefag Universitetet i Stavanger
Ullandhaug
4036 STAVANGER

Vår dato: 15.10.2014   Vår ref: 39122 / 3 / MSS   Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 25.06.2014. Meldingen gjelder
prosjektet:

39122	*Samtaler etter bruk av mekaniske tvangsmidler og holding - En kvalitativ studie om pasienter og personal sine erfaringer*
Behandlingsansvarlig	*Universitetet i Stavanger, ved institusjonens øverste leder*
Daglig ansvarlig	*Unn Elisabeth Hammervold*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være
regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i
meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og
helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de
opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget
skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år
dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database,
http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.12.2017, rette en henvendelse angående status for
behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal
                              Marie Strand Schildmann

Kontaktperson: Marie Strand Schildmann tlf: 55 58 31 52
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / District Offices:
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel. +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel. +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel. +47-77 64 43 36. nsdmaa@sv.uit.no

191

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Formålet med prosjektet er å undersøke hvordan systematiske ettersamtaler mellom pasient og helsepersonell påvirker de involverte parter sin erfaring med, og forståelse av bruk av mekaniske tvangsmidler og holding.

Datamaterialet innhentes gjennom personlige intervju og gruppeintervju. Det er planlagt intervju med pasienter og helsepersonell ved helseforetak hvor planlagt og systematisk samtale med pasient om episode der mekanisk tvangsmiddel og/eller holding ble anvendt er utvalgskriteriet. En vil rekruttere pasienter og helsepersonell som har vært involvert i de samme hendelsene/situasjonene. Dette fremgår også på tilfredsstillende måte i informasjonsskrivet til de som forespørres.

Rekruttering skjer via helseforetaket. Personvernombudet legger til grunn for sin vurdering, jf. epost fra prosjektleder den 01.10.2014, at utelukkende samtykkekompetente pasienter rekrutteres. Behandlende lege/helsepersonell vurderer samtykkekompetansen før forespørsel om deltakelse i prosjektet formidles til den enkelte.

Informasjonsskriv mottatt den 07.08.2014 er tilfredsstillende utformet, men vi anbefaler at det i informasjonsskriv til pasienter tilføyes at personidentifiserende opplysninger ikke deles med helseforetaket eller noen andre. Det kan også med fordel påføres at "forsker kjenner ikke din identitet før du eventuelt samtykker til deltakelse".

Revidert informasjonsskriv skal sendes til personvernombudet@nsd.uib.no før utvalget kontaktes.

Det gjennomføres personlig intervju og fokusgruppeintervju med helsepersonell 2-3 ganger. Etter fokusgruppeintervju gjennomføres en påfølgende samtale. Dette gjentas etter ett år, muligens også etter to år. Det gjennomføres kun ett intervju med pasient og det registreres ikke direkte personidentifiserende opplysninger i den forbindelse. Intervjuene knyttes til et løpenummer, samt opplysninger om alder og avdelingens navn.

Beskrevet observasjonsstudie ved helseforetaket utgår fra prosjektopplegget, da REK ikke fant å kunne gi dispensasjon fra taushetsplikten. En legger opp til alternativt å gjennomføre observasjon av selve ettersamtalen mellom pasient og helsepersonell, basert på samtykke fra den enkelte. Dette er imidlertid ikke tatt stilling til på nåværende tidspunkt, og vår vurdering av prosjektopplegget omfatter derfor ikke en observasjonsstudie. Dersom observasjonsdelen skal gjennomføres må det sendes endringsmelding til oss om dette.

Det er ombudets vurdering at det behandles sensitive personopplysninger om helseforhold, jf. personopplysningsloven § 2, punkt 8 c).

Det legges til grunn for vår vurdering at helsepersonell i forbindelse med personlig intervju kun uttaler seg om egen opplevelse av ettersamtalen og hvordan man tror pasienten opplevde denne. Andre opplysninger om

pasienten (f.eks. atferd, diagnose etc.) utleveres ikke. I forbindelse med gruppeintervju vil det ikke diskuteres enkeltsaker eller konkrete hendelser.

Personvernombudet legger til grunn at forsker etterfølger Universitetet i Stavanger sine interne rutiner for datasikkerhet.

Forventet prosjektslutt er 31.12.2017. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette lydopptak

Dialog med NSD som gjelder pasient deltaker utenfor inklusjonskriteriene

Fra: Jørgen Wincentsen <Jorgen.Wincentsen@nsd.no>
Sendt: fredag 13. desember 2019 13.32
Til: Unn Hammervold <unn.hammervold@uis.no>
Emne: SV: Spørsmål meldeskjema 39122.

Hei Unn

Dersom rekruttering og samtykke til deltakelse fra pasienten ble gjennomført slik du beskriver det, har ikke vi noen innvendinger mot at du kan bruke data fra dette intervjuet i publikasjonen.

Vennlig hilsen,

Jørgen Wincentsen – Rådgiver | Adviser

Seksjon for personverntjenester | Data Protection Official

T: (+47) 55 58 32 29

NSD – Norsk senter for forskningsdata AS | NSD – Norwegian Centre for Research Data

Harald Hårfagres gate 29, NO-5007 Bergen

T: (+47) 55 58 21 17

postmottak@nsd.no   www.nsd.no