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**The Last Resort ? Staff and client perspectives on
physical intervention.**

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Summary

This study provides feedback from research with staff and clients of a medium secure learning disability service in North-West England. Participants were asked about their experiences of incidents which required the use of physical intervention. The information was gained within an unstructured interview, participatory research framework.

The article explores clients' and staff accounts of aggressive incidents and the consequences of physical intervention. Clients cited other clients and the ward atmosphere as the main reasons for aggressive behaviour. Some clients said that the use of physical intervention to control their behaviour made them more frustrated and could bring back memories of frightening experiences.

Staff reported that incidents of aggression and the use of physical intervention was upsetting and traumatic to them, causing feelings of guilt and self-reproach. Staff said that they always used physical intervention as a last resort, although clients often reported that they thought these techniques were used more often than necessary. Time out and post-incident discussions were valued by both groups, as were strong staff/client relationships.

Introduction

When repeatedly confronted with difficult behaviours such as aggression or self-harm, services may decide that they have no alternative other than to restrict the person's range of movements by force. This is referred to as physical intervention, which is described by the British Institute of Learning Disabilities as '*any method of responding to behaviour that involves some degree of direct physical force to limit or restrict movement or mobility*' (Harris et al., 1996) p2). Physical intervention involves physical contact to restrict movement, and may not be in the 'best interests' of the service user. However, sometimes the use of these methods is unavoidable.

Although the use of physical intervention to control behaviour is controversial and could be construed as a restriction of liberty, its use is legally defensible if it is to prevent harm to clients or staff (Department of Health, 2002). Policies and procedures about physical intervention stress that any attempt to control aggressive behaviour should, as far as possible, be non-physical (Department of Health and Welsh Office, 1993). As physical intervention techniques deprive people of their liberty and can be devaluing, they should be used as a last resort and with minimum force.

It has been stated that if staff find themselves in a situation where there are no other options than to utilise physical intervention, then this should be understood to be a failure of nursing care (Hopton, 1995). Although there are articles which say that despite all skills being utilised there are times where a form of restraint has to be implemented, due to imminent danger (Simpson and Freeman, 2000).

Legally, any kind of physical intervention must use the minimum amount of force necessary, and could be construed as assault against the client. Staff training should therefore emphasise

the fact that staff cannot restrain a person without legal boundaries and consequences (Simpson and Freeman, 2000).

The present research was carried out at a medium secure forensic service for people with learning disabilities. Because of the secure nature of this service, staff are sometimes required to respond to difficult behaviour which may be hard to manage. The management of aggressive incidents is therefore of great concern to management and direct care staff.

The service's policy about responding to aggression specifies that treatment of problem behaviours is proactive as well as reactive, and for this reason, all staff at the service are trained in the prevention and de-escalation of violence as part of their induction. A two-part 'Physical Intervention' training course is also offered to staff members on the basis of need. This trains staff in the use of techniques which involve simply holding the client's limbs and restricting movement in a standing or sitting position, until aggression is no longer a threat. This does not involve moving or flexing joints or putting unnecessary pressure on any part of the body. Collectively, these techniques are known as the CITRUS model which stands for Creative Intervention Training Responses for Untoward Situations.

The physical intervention procedure at the Trust includes the following: 'Any attempt to manage aggressive behaviour should, as far as possible, be non physical. Physical restraint should only be used as a last resort and never as a matter of course. Managers and staff will consider possible causes of behaviour leading to the use of restraint, and taking these into account, positively work towards prevention of difficult or destructive behaviours.'

The following research was initiated as part of a large-scale study looking at aggression and physical intervention in a forensic learning disability service. The project involved using open-ended interviews to ask staff and clients about their experiences of incidents of aggression and physical intervention.

Literature Review

All people have a basic need to be protected from harm if faced with aggressive behaviour, and a consistent reminder throughout the literature is that healthcare staff need to be adequately trained in a number of key areas. These include actions taken to prevent aggression and violence occurring, its management should it occur, and steps to monitor and evaluate outcomes (Turnbull, 1993; Hopton, 1995).

Nurses describe aggressive experiences as psychologically traumatic and detrimental to motivation and well being (Durst et al., 1991). (Poster and Ryan, 1993) maintain that the nurse's subjective experience of distress during assault may be the best predictor of their subsequent symptoms and responses. 'The nurse's interpretation, including the patient's intent and responsibility for his or her behaviour, may be more important than the objective aspects of the assault.' (p32)

Literature reporting client perspectives on aggression management tend to focus on the use of seclusion in mental health services (Tooke and Brown, 1992; Meehan et al., 2000). Seclusion is often used when physical intervention methods fail to de-escalate a situation and can have a profound negative effect which persists for some time after the experience. Clients can experience feelings of punishment, abandonment, fear, isolation and depression (Meehan et al., 2000). Rapid tranquilisation or 'as required medication' is sometimes also used as an emergency measure.

In their 1996 (Harris et al) publication, 'Physical Interventions: A Policy Framework,' the British Institute of Learning Disabilities refers to the risks involved:

'When people with learning disabilities present challenging behaviours, it may be difficult for staff to maintain warm and positive relationships. Positive attitudes and values may be gradually undermined. Staff may be tempted to use inappropriate forms of physical intervention which undermine a person's self respect. The use of physical interventions can easily become an opportunity

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for staff to express underlying feelings of resentment or anger that have accumulated over a period of time.' (P16)

Very few studies focus on the use of physical intervention from the clients' perspectives. (Sequeira and Halstead, 2002) asked psychiatric in-patients about their experiences of physical intervention. This study found that clients can perceive restraint as a punishment, and because of lack of information about the procedures they did not know what to expect in terms of length of time and correct techniques. This resulted in feelings of panic and anger. (Bonner et al., 2002) talked to staff and patients in a psychiatric inpatient unit. Patients reported feeling distressed and ignored prior to incidents and isolated and ashamed afterwards. Patients also reported being afraid of the possibility of being restrained. Both staff and clients valued post-incident debriefing but its use was rare.

The only known study including people with learning disabilities interviewed women about their experiences (Sequeira and Halstead, 2001). This study found that clients associate physical restraint with pain or discomfort, and incidents of restraint resulted in feelings of anxiety, fear or sadness. They felt as though the staff were using physical restraint as a punishment or actually enjoying using the techniques. They also expressed that the intervention caused them to feel more aggressive towards staff.

This paper brings together two research studies, one involving staff and one involving clients, with the aim of finding the commonalities between perceptions of aggressive incidents and their management.

Method

The two parts of this study were initiated and carried out by different researchers. Staff were interviewed by a research assistant (Rebecca), and clients by a nurse researcher (Eloise). Both projects obtained ethical approval from the relevant committee.

Staff Participants

Sixteen direct care staff were involved in the research. With regard to job title, seven were nursing assistants, six were qualified learning disability nurses and three were clinical team leaders. Seven staff participants were male and nine female. Staff were interviewed by Rebecca, a research assistant.

Recruitment of staff interviewees began by picking names randomly from a list of people who had been trained in physical intervention methods. They were contacted and asked if they wanted to be involved in some research about physical intervention in response to violence and aggression. Everyone who was approached agreed to be involved.

Client Interviews

Nine clients were interviewed, seven males and two females. All of the clients were interviewed by Eloise, a nursing assistant who was well known to them - it was hoped that this would make people as comfortable as possible and elicit the most information (Norman and Parker, 1990).

Clients were recruited by the researcher, who visited the wards and asked people if they would like to be involved. Participants were not coerced into taking part and were given as much information about the study as possible.

Both samples were 'purposive' samples (Patton, 1990) which involved recruiting people who were convenient to talk to at the time and who would have something to say about the subject of physical intervention. This is often the most convenient way to conduct a qualitative study as no comparisons or control groups are necessary, and therefore people who are able to describe the phenomenon are the only appropriate subjects (Taylor and Bogdan, 1998). The groups of participants are different sizes because the researchers stopped recruiting when the analysis reached 'saturation' point, that is when no new themes were being introduced.

When all new participants are repeating and confirming previously collected data, the researcher can be satisfied that their sample is complete (Streubert and Carpenter, 1999).

Ethical Considerations

All staff and client participants were informed of their right to anonymity and confidentiality, and advised that they could opt out of the research at any time without recrimination.

Participants were assured that their names would not be recorded on any documentation and all tape-recordings would be destroyed after transcription. Prior to the interview, all participants were told about the reasons for the research, and that the research was essentially exploratory, hence no immediate changes in their working lives or service provision would transpire.

When interviewing clients, it was important to explain to the participant about the whole of the research process, including publication of reports and information about who would be reading them (Swain et al., 1998). During the interviews, if any client revealed that they had been harmed during an incident of physical intervention, Eloise was able to advise them about the formal complaints procedure. Although the clients' need for respect and privacy was recognised, it was also essential to the research that their feelings were heard and represented (Mactavish et al., 2000).

Interviews

Open, unstructured interviews were used, as an attempt to find out what the participants felt was important about this topic. This also provided a more participatory framework, in which interviewees had the scope to lead the discussion and influence the development of the conversation. The use of unstructured interviews offered the researchers the opportunity to

adjust any line of enquiry with the direction of the discussion, while at the same time exploring interesting responses and underlying motives (Robson, 1993).

By using open questions, the researchers hoped to find out issues involved on an individual basis, rather than establishing a fully preconceived agenda or structure for the research. Each interview began by asking the participant to talk about their experiences of physical intervention, and then continued with prompts as appropriate. Both researchers were mindful that interviewees are at risk of acquiescence and suggestibility, so questions were kept general and open. During the interview the researchers used prompts and encouragement to perpetuate the discussion, and occasionally summarised the previous discussion to confirm meanings (Kvale, 1996).

‘Bracketing’ is a technique which helps researchers to conduct an interview without consciously influencing the focus of discussion (Giorgi, 1990). Essentially, researchers set aside previous knowledge or personal beliefs about the phenomenon under investigation to prevent this information from interfering with the recovery of a pure description. This bracketing must be constant and ongoing (Streubert and Carpenter, 1999). Because the two researchers were keen to bracket their preconceptions about the topic, they did not review the literature before interviewing, neither did they meet to discuss their research until they had both analysed their transcripts.

Analysis

Analysis was conducted by each researcher individually, following Hycner’s (1985) guidelines for phenomenological analysis. The interviews were transcribed verbatim and studied to find common themes that emerged directly from the data, that is they were not pre-determined. Each sentence or unit of text is read and simplified or categorised, and these

categories are then grouped into umbrella elements. These can then be commented on as themes of the interviews (Hycner, 1985).

When the researchers had concluded their individual analysis, they met together to compare the themes which arose from their data. The themes which coincided between both groups of participants are commented on below.

Results

The results are organised into themes which were common to the analysis of both the staff and client interviews.

Reasons for Aggression

The main reason cited by clients for their aggression was other clients and the atmosphere on the ward.

Client: When people wind me up. Like anybody in here, people who I live with.

Eloise: How do they do that?

Client: Call me names and all of that.

The locked environment was also blamed for causing aggressive behaviour:

Client: But people get pissed off with being here. That's why a lot of people kick off.

Eloise: Through frustration?

Client: That's why a lot of people kick off, they might not like it.

Staff were sometimes cited as the reason for aggression:

Client: When you are kicking off or you've got something on your mind and staff's like not listening, you like play up and they don't listen.

Eloise: So you play up because they don't listen to you?

Client: Yes.

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Staff had a detailed understanding of the reasons for aggression, and seemed to explain aggression using individual reasons specific to the particular client. Staff also recognised that clients may need some way to communicate their frustration with living in this type of environment:

Rebecca: Why do you think people show aggressive behaviour?

Staff: It could be because they are being restricted, boredom, lack of ability. It could also be because they have a lack of communication skills and they are trying to convey their frustration. It can also be to do with the controlled environment they are kept in. They have nowhere to let off steam, so they can internalise things and let them build up over a long time.

Overall, clients cited immediate provocation and situational factors as the reasons for aggression, whereas staff attributed aggression to a number of factors which may have emerged over time.

Staff Responses to Aggression

Some staff reported being upset by clients' aggression:

Staff: She did want to go but when it hit her because I was on about my third day supporting her over there, she started with this 'I want to go back, I don't like it here.' I think I must have represented the whole of the service, so she went for me then and that, it really touched me did that, I got quite emotional about that.

Rebecca: Upset?

Staff: Oh yes, I was more embarrassed than anything because I'd felt upset by her. It was sort of, I think with most clients you keep a lot of distance from them, but I, sort of, she was a young woman and she was very likeable.

Staff also reported blaming themselves for the incident when they had overcome the initial reaction:

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Staff: I mean you can look at things, you can start blaming yourself; 'If I hadn't done this, if I hadn't done that', or you might have said something and you might just take it overboard. Instead of putting it back to them and making them responsible for their actions, you sort of take it on board, like 'we should have done this' or 'if we'd done this...'

Many of the staff reported being aware of the clients' discomfort and stressed how much they would avoid using physical intervention to deal with aggression:

Rebecca: And how did you feel?

Staff: Tired, tired of restraining and frustrating when they're not conversing with you. It felt like I'd taken all control away, I mean you must for a short time to make sure they don't hurt anybody or hurt themselves, but you can feel quite domineering I suppose. I wouldn't like to be restrained, just be pinned there.

Reasons for Physical Intervention

Clients understood the reasons for using physical intervention, every client reported that it was used in response to aggressive behaviour, or to stop someone getting hurt.

Client: When you have a temper tantrum.

Eloise: So why do you think it is used?

Client: To calm you down. To stop you hurting yourself or others.

Eloise: Can you give me an example of when this has happened to you?

Client: Going to hit staff.

Some clients expressed that they thought that physical intervention was used when they were acting up.

Eloise: When is it used?

Client: When you're naughty.

Eloise: Can you tell me a little bit about your experience of physical intervention?

Client: When I were naughty, got restrained. I kicked off, got restrained on the floor.

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All staff reported that physical intervention was used to control a situation when all other means had failed and there was risk of injury.

Staff: You get involved because you don't want anyone to be injured - staff or client.

Clients' Responses to Physical Intervention

Some clients said that the use of physical intervention did not make them calm down, it made them feel frustrated and consequently more aggressive:

Eloise: After you've been restrained how do you feel towards the staff involved?

Client: Nasty, you feel nasty towards them. You're on the floor, they sit on your legs, knees on your legs, I can't move my legs or arms. It's hard.

Eloise: Does it help you to calm down?

Client: No, it makes me want to struggle.

Other clients discussed the physical pain involved when being restrained:

Client: It gets you kicking off more because they don't know how it hurts, you're like being put back and it hurts.

Eloise: What about if it's done properly?

Client: Oh, well that's o.k., like (names staff member) did on Sunday.

Some clients were clearly upset by the incident:

Eloise: How do you feel towards staff afterwards?

Client: Talk to them by yourself, want them to listen. You're upset because you're unhappy. Me want to go to me room, they got keys, lock me door, me start, let me go sleep in me room.

Another response to the incident was the guilt felt by the client for being aggressive:

Eloise: How do you feel towards the staff afterwards?

Client: Horrible. Shouldn't have done it, guilty.

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One of the clients admitted that the intervention was necessary but felt that other methods may have helped if they were used in time:

Client: I feel alright. It was necessary that time, like I was being aggressive, I kicked the door down, I understand. But sometimes, like I say it's not necessary.. If you tell me to go into my room I *will* do.

Re-traumatisation

Some female clients reported that the use of physical intervention can bring back memories of abuse they suffered in the past.

Eloise: So does it matter to you who restrains you?

Client: Yeah, if it's men I go ballistic.

Eloise: Why is that?

Client: I don't know. 'Cause I were raped by me dad and I don't feel that, it's like (names clinical team leader) said that men shouldn't restrain me. There were men on me foot and even on me hand. I turned around and said I'll give you 3 to get off or I'll go to (staff member) and they wouldn't get off.

Three of the staff stated that they were aware of the risk of re-traumatisation, for example:

Staff: We worked with a women who was all teeth and head-butting, she'd been abused by one of her peers and when she described it to us it was heartbreaking – he held her down with her face on the bed and threatened her. When we restrained her, we had to make sure it was about telling her we weren't going to hurt her we were just trying to stop her doing whatever, but at that time we were restraining people on their front, we don't do that now.

Things that help

Clients:

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All of the clients specified that time alone in their room would help them to calm down before any physical methods are employed:

Eloise: Is there anything that could be done before getting to this point of being restrained?

Client: Well, (names staff member) knows when I'm getting worked up and says 'go to your room for a minute.' I go and talk to her about what's on me mind and she tells me to stay in for 5 minutes, I stay in for 15 to make sure then I come out lovely and calm. It's like, I'm getting resettled this year and I don't want to bugger it up, because other people bossing me about like they did when I was young, but I have a right to say yes or no to them.

Some clients mentioned that talking about their problems to members of staff would help them to calm down:

Eloise: Instead of getting to this point, is there anything that could be done differently?

Client: Talk to you, ask why you are worked up, talk to you.

Eloise: Would you be able to tell them?

Client: Yes talk to them.

Two of the clients said that physical intervention helps them to calm down:

Eloise: So did the fact that you were restrained help you to calm down?

Client: Yeah it does, I've got to admit that it does.

Clients also said that special relationships with staff helped them to remain calm:

Client: This one were about 20 minutes, mind you it were Stella's (name has been changed) shift so when she came down I settled dead easy.

Eloise: Why when Stella came down?

Client: I can talk to her a lot more easy.

Eloise: So you are saying that if Stella was there to begin with then this may not have happened?

Client: No, it wouldn't, no.

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Another client stressed the importance of trusting relationships with staff:

- Eloise: Would you feel unhappy about working with him now?
- Client: Yeah, it's a trust. I have difficulty in trusting people. I mean everyone who I like or anyone I start with, stay with, just shit on me, always do. So I have to build trust up with someone, build it up.
- Eloise: So you need to trust the staff around you.
- Client: Yeah, some people expect it from me but some people don't. Look at it the other way, I need to have respect as well, as well as the staff.
- Eloise: So you think when you are restrained it should be done respectfully?
- Client: Yeah, not hurtful and things like that.

Staff:

Staff also mentioned that physical intervention can be helpful in certain situations:

- Staff: Sometimes, however it can be a good thing. It breaks down the barriers. If someone comes onto the ward who has a history of aggressive behaviour, you may not see anything for six months and it may be good for them therapeutically for you to see what they can be like, then you can start to work with them.

Staff felt that debriefing sessions would help them deal with the upset caused by aggression:

- Staff: You need to be able to discuss it with other people who know what you mean. There is a debrief at the time from the nurse in charge, but sometimes you just need to have a moan to someone. That is hard, because there is so much going on. You might be stuck on a ward with 5 residents and you don't get a chance to talk, because you can't talk about the residents when they or their flatmates are there. New starters do get a lot of support when things like this happen, but experienced staff are just as likely to feel it.

Staff also mentioned that good staff/client relationships help:

- Staff: You have to build up a sense of trust between you. There are professional boundaries you have to work to and you have not to cross, but if you build up a good relationship

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with people, it makes these boundaries invisible, you don't feel like 'I'm staff, I'm powerful.' If you have good relationships with clients, it gives them a feeling of not being rejected, they feel cared for and it gives them power and more autonomy in their lives.'

Last Resort?

Some clients thought that the use of physical intervention was sometimes unnecessary and that staff were using these methods as punishment:

Client: All I have to say is that sometimes it's necessary and sometimes it isn't, it's stupid things for someone to be restrained about. I mean if you were going to attack someone well that's alright, but just restraining you for the hell of it...

However all the staff interviewed stressed that the use of physical intervention would be their last resort:

Staff: When you have worked with the same people for a long time, you can spot the warning signs, and try to prevent anything happening, by talking to them or distracting them. When you are not as experienced, you might jump in too soon or leave it too late to intervene safely.

Staff: It's something that's like buttering bread to some people and you can see that they've learned to cope with it that way. I mean one of the things that you hear sometimes is that ... I know that I said before that if there's any way you can avoid being involved in physical restraint then it's worth finding that other option. But then again I feel there are some times where you can't avoid a confrontation.

Discussion

Physical management of aggression involves physically restricting someone's movement, which is controversial and has ethical implications (Tarbuck, 1992); (Hopton, 1995).

However if a person is likely to come to harm, lack of intervention would be ethically

difficult to justify. The results of this study suggest that the use of physical intervention is sometimes unnecessary, and if implemented, can be distressing for clients as well as staff.

Possibly the most troubling of the results in this study is that clients sometimes feel physical pain during incidents of physical intervention, and can construe the use of these techniques as a punishment. Clients also reported that the use of physical intervention can make them feel more frustrated and aggressive, rather than calming them. These findings are consistent with the (Sequeira and Halstead, 2001) study. In that study, the authors recommend that clients should have input into how their behaviour is managed so that they know what to expect. If the client is given clear information about why certain interventions are being used then they would be less likely to construe them as punishment or respond with indignation.

The main discrepancy between staff and clients' accounts was whether physical intervention methods were used as the last resort. There was confusion expressed about the actual techniques used by staff when dealing with aggression and some of the clients felt that they had a right to complain. Some clients also felt that physical intervention methods were used when other methods would have sufficed, for example giving the clients quiet time in their rooms or talking to them about how they felt. At odds with this was the staff opinion that clients should take the responsibility for aggressive behaviour rather than blaming it on staff. There is clearly some conflict of opinion here which could be explored further. Perhaps if there was a system where staff and clients discussed the incident afterwards, both parties would learn more from the experience (Norton and Dolan, 1995). Negotiating with the client an individualised plan of response to their behaviour may give them the opportunity to learn more from these type of incidents (Hinsby and Baker, 2004).

Another alarming theme in the results was that sometimes the use of physical intervention can remind clients of abuse they may have experienced in the past. Although staff seemed to be aware of the risks involved, this is an area which should be addressed in individual

management guidelines. Other studies have commented on re-traumatisation: (Sequeira and Halstead, 2002) found that this was common; and (Bonner et al., 2002) pointed out that staff can experience these feelings as well as clients.

A positive finding from the interviews was that clients are aware of the reasons why physical intervention methods are used generally. Comments like 'to help you calm down' and 'to stop you hurting yourself and others' show that clients are well informed about procedure. Also staff demonstrated a good understanding of the reasons for clients' aggression on an individual basis. Clearly there are some good informal systems of communication which could be built on in a more formal way.

Another positive aspect of the interviews was that clients specified strategies which can help to reduce their feelings of aggression. Time out in their room, and talking about their feelings can help them to calm down in the short term; whilst building good relationships with staff was seen as very important to the clients' overall feelings of wellbeing (Lowe, 1992). Trust was seen as an important part of the professional relationship by both staff and clients. The staff/client relationship is commented upon by (Bonner et al., 2002), who report that clients value staff time and attention, and is another area which could be recognised and built on, for example by providing time specifically for relationship building. 'In order to manage violence and aggression effectively, courses should focus on the interpersonal relationships between patient, nurse and doctor, on the analysis of personal values and agendas, and how such phenomena may play a part in the expression of violence and aggression (McDougall, 1995). Staff reported that experience of working with certain people can help them to recognise and deal with aspects of their personality and behaviour. This emphasises the importance of recognising staff experience and the need for retention.

Some of the staff were concerned that clients should be encouraged to take more responsibility for their actions. Proactive strategies to implement early intervention may

enable emotional expression in more adaptive ways. Clearly, the intent should be to empower the patient to control themselves and then encourage the individual to exercise their own judgement (Tarbuck, 1992). However, it has to be recognised that staff and other residents may contribute to incidents, for example as one client said, by continually ignoring him. None of the staff acknowledged that they might have been a factor in the escalation of the incident. Indeed, the unnecessary use of physical intervention can play a part in the build up of aggravation over time, and the results suggest that clients have experienced this.

The findings from this study may be relevant to other residential learning disability services. These subjects were articulate and able to participate in a conventional interview situation which may not be representative of all learning disabled clients. It is important, however that clients' views are considered when planning behaviour management techniques. Clearly, this topic is important and controversial. Although the findings in this study relate to only a few participants, the material is rich and varied, demonstrating that further research is needed in this area.

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