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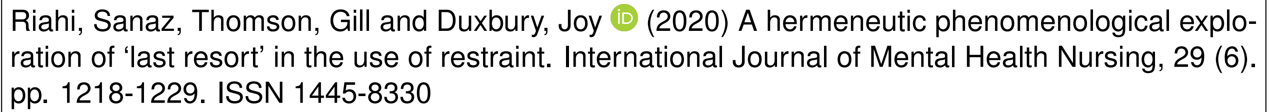

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A Hermeneutic Phenomenological Exploration of 'Last Resort' in the Use of Restraint

Journal:	*International Journal of Mental Health Nursing*
Manuscript ID	IJMHN-2019-253.R2
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Keywords:	Restraint, Mental Health, Psychiatric Nursing, Containment, Phenomenology

Abstract:	Restraining patients is a practice that dates back at least three centuries. In recent years, there has been a mandate and advocacy in various countries for organisations to shift towards the minimisation of restraint, whereby its use is only as a 'last resort'. There is growing evidence internationally indicating the negative impact of the use of restraint. However, to date there is no research specifically focusing on trying to understand the concept of 'last resort'. Further insights to explore this concept amongst mental health nurses are therefore warranted. The empirical research comprised a hermeneutic phenomenological study. By recruiting and interviewing thirteen mental health nurses from across Canada who had experiences of restraint use, the research aimed to generate a deeper understanding of the meanings and lived experiences of the concept of 'last resort'. Data was collected through fifteen in-depth interviews. Data analysis was undertaken through a hermeneutic phenomenological framework based on van Manen's approach and Heideggerian philosophy. Five Heideggerian concepts were used to illuminate 'last resort' in restraint use by mental health nurses - temporality, inauthenticity, thrownness, leaping in and leaping ahead and mood (fear). Key findings highlight the influence of nurses past experiences, how nursing staff adopt a collective (rather than individual) approach, and the dependency on knowledge and skills of others in using restraint as a 'last resort'. Overall, the lived experience of 'last resort' is comprised of many elements. This study provides insights and an initial understanding, which is hoped to advance the field of restraint minimisatio

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Abstract

Restraining patients is a practice that dates back at least three centuries. In recent years, there has been a mandate and advocacy in various countries for organisations to shift towards the minimisation of restraint, whereby its use is only as a 'last resort'. There is growing evidence internationally indicating the negative impact of the use of restraint. However, to date there is no research specifically focusing on trying to understand the concept of 'last resort'. Further insights to explore this concept amongst mental health nurses are therefore warranted.

The empirical research comprised a hermeneutic phenomenological study. By recruiting and interviewing thirteen mental health nurses from across Canada who had experiences of restraint use, the research aimed to generate a deeper understanding of the meanings and lived experiences of the concept of 'last resort'. Data was collected through fifteen in-depth interviews. Data analysis was undertaken through a hermeneutic phenomenological framework based on van Manen's approach and Heideggerian philosophy. Five Heideggerian concepts were used to illuminate 'last resort' in restraint use by mental health nurses - temporality, inauthenticity, thrownness, leaping in and leaping ahead and mood (fear). Key findings highlight the influence of nurses' past experiences, how nursing staff adopt a collective (rather than individual) approach, and the dependency on knowledge and skills of others in using restraint as a 'last resort'.

Overall, the lived experience of 'last resort' is comprised of many elements. This study provides insights and an initial understanding, which is hoped to advance the field of restraint minimisation.

Keywords: Restraint, Mental Health, Psychiatric Nursing, Containment, Phenomenology

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Introduction

Restraint is considered a coercive measure in mental health care. The term 'restraint', although lacking standardisation, has been defined as: *'measures designed to confine a patient's bodily movements'* (Sailas & Fenton, 2009, P.2). While restraint use may be perceived as warranted at times, there is growing literature highlighting its counter-therapeutic effects (Borckardt et al., 2011). As a result, in more recent years, there has been a mandate through various legislations, guidelines and papers in countries, such as Canada, USA, UK and Australia, for organisations to minimise the use of restraint, whereby its use is only as a 'last resort'. This means that restraint is used when all other alternative interventions have been exhausted (American Psychiatric Nurses Association, 2014a, 2014b; MIND 2013; National Institute for Health and Care Excellence, 2015; Registered Nurses Association of Ontario, 2012; The Royal Australian and New Zealand College of Psychiatrists, 2016). As more organisations adopt these approaches, it becomes critical to better understand why restraint use continues and what 'last resort' means in relation this practice. 'Last resort' is a key term that has surfaced in approximately the last two decades in relation to restraint use. The Care Quality Commission in the United Kingdom referred to the use of restraint as a 'last resort' intervention in their recent review of the use of the Mental Health Act (Care Quality Commission, 2011). While nurses in various studies have often referred to 'last resort' (Gerace &Muir-Cochrane, 2019; Muir-Cochrane et al., 2018; Wilson et al., 2017), there is a lack of inquiry that directly addresses the concept. There are no publications or studies that clearly describe this term or identify what this means when operationalised into day-to-day practice. This creates the opportunity for variances in understanding and application of restraint use as a 'last resort'. Essentially, the purpose of this term is to promote clinicians to deviate from the traditional practices to commonly use restraint as part of care and instead manage these situations through the use of other alternative interventions, and to refrain from the use of restraint unless absolutely necessary. Deveau and McDonnell (2009) suggest a limitation to the term 'last resort' and argue

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that the *'the reliance upon the 'last resort' principles has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge'* (p.175). Therefore, they suggest possible shortcomings of this term. Overall, given that current evidence insists that all other alternatives must be exhausted prior to the use of restraint as a 'last resort' and the continued ambiguity of the term, it becomes essential to understand mental health nurses' experience and understandings of it.

Background

Restraining patients (i.e. physically confining their movement or using devices to restrict their movement) is a practice that dates back at least three centuries (Masters, 2017). Currently, control and containment measures, such as restraint, are frequently used as first line interventions within health care settings (Foster et al., 2007; Kynoch et al., 2011). The most common circumstances where restraint is utilised are in response to violent/aggressive patient behaviour, absconding, refusal of medication, self-harm, and property damage (Bowers et al., 2012; Cowman et al., 2017; Duxbury et al., 2019; Ryan & Bowers, 2006; Southcott & Howard, 2007).

A Cochrane review undertaken to assess the effectiveness of restraint use compared to alternatives concluded that *'no controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness'* (Sailas & Fenton, 2009, p. 2). Moreover, other reviews report similar findings (Chleze et al., 2019; Muralidharan & Fenton, 2012; Nelstrop et al., 2006; Sailas & Fenton, 2012). Internationally there is growing evidence indicating that restraint use is counter-therapeutic, coercive, punishing, traumatic and unnecessary (Curran, 2007; Soininen et al., 2013).

From a Canadian context, and internationally, restraint utilisation continues to be a problem, despite various changes in the health care system mandating restraint minimisation. In Canada mandatory assessment and reporting requirements of restraint use for mental health patients does

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not exist for every province. Therefore, utilisation data is limited to the most highly populated province, Ontario. The most recent data highlights that one in four of all individuals admitted to a mental health ward experienced at least one type of coercive intervention (chemical restraint, mechanical or physical restraint, and seclusion) during their hospitalisation (Canadian Institute for Health Information, 2011). Hospitals across Canada are adopting various evidence-based models in their efforts to minimise restraint use, however, there are no formal strategies provincially or nationally and this is dependent upon each hospital's efforts and priorities.

The aim of this study was to gather the Canadian mental health nurses' perspectives and lived experiences about the use of restraint as 'last resort'. It was hoped that these findings would help to inform strategies in restraint minimisation and to prevent restraint use in mental health care.

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Methods

Design:

A hermeneutic phenomenology study underpinned by the philosophies of Heidegger was undertaken. This approach offers a methodology through which lived experiences of a particular phenomenon can be explored (Smyth, 2011). It incorporates the perspective of the individual, as well as the socio-cultural context on how events are interpreted (Aspers, 2009). This approach recognises that research cannot operate through a value-free objective standpoint and thus hermeneutic phenomenology values the perspective of the interpreter within the construction of meanings (van Manen, 1990).

Reflexivity is an essential activity in qualitative research that aids to establish confidence and trust in the findings through rigour (van Manen, 2014). Thus, as part of the study it was important to reflect on personal pre-understandings, and how biases influenced the design, collection and

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interpretation of the data (Sandelowski, 2004). These practices reflect Heidegger's fore-structures of understanding and are key within a hermeneutic phenomenological study. Reflexivity was attended to by the lead author being interviewed at the start of the study to elicit her pre-understandings, beliefs and biases towards the topic area, a reflexive diary was also maintained to record and assess how her prejudices and pre-understandings influenced the research process (refer to Table 3 for further details). The authors are from a mental health nursing and psychology background, two of whom have been involved in restraint practices.

Currently, there are different types of restraint that may be used in practice, mechanical, manual, chemical and/or seclusion. The focus of this study was on mechanical and manual restraint as many studies refer to both forms interchangeably. There are also variances in the use of mechanical and manual restraint among countries. For example some countries (such as the UK) only use manual restraint, whilst others (such as Canada) may use both. Finally, both mechanical and manual restraint serve to immobilise an individual's physical movements, while other restraint methods, e.g. seclusion, are less restrictive (Fishkind, 2005). Therefore, in this study, the term restraint refers to both mechanical and manual forms of restraint. For the purposes of this research, mechanical restraint refers to the use of *'straps, belts or other equipment to restrict movement'* (Stewart et al., 2009, p. 2). Whereas manual restraint relates to *'any occasion on which staff physically hold the patient, preventing movement, typically in order to prevent imminent harm to others or self, or to give treatment, or to initiate other methods of containment'* (Bowers et al., 2012, p. 31; Canadian Institue for Health Information, 2011).

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Data Collection:

A purposive sampling method was adopted. To reduce biases that may arise as a result of recruiting subjects from one setting (i.e. culture), mental health nurses were sought across Canada. The goal was to recruit 10-15 mental health nurses through the Canadian Federation of Mental Health

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Nurses (CFMHN) association. Overall, thirteen participants were recruited and 15 interviews completed. Two follow up interviews were completed to further understand the 'collective view' perspective that will be further elaborated on in the results. The open-ended questions asked in the semi-structured interviews are highlighted in Table 2. Ethical approval was received from an academic institution in the UK (Project 267) and a healthcare organisation in Canada (#14-009-D) prior to the start of the study.

Over a six month period the administrator of CFMHN distributed a recruitment email and poster on the main CFMHN website. An introductory telephone discussion was held to provide further details about the study for those who expressed an interest. Audio recorded semi-structured interviews took place either face-to-face or via videoconference. All interviews were transcribed and sent to the co-authors for review and feedback.

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Interpretation:

van Manen's (1997) phenomenological approach was used for the interpretation of data. This involves *'insightful invention, discovery or disclosure'* (p.79) – a free act of 'seeing' meaning and ultimately to reveal meaning and the structures of the experience (van Manen, 1997). van Manen (1997) identified a '*dynamic interplay among six research activities*' (p. 30) as a means to convey the elemental methodical structure of how hermeneutic phenomenology can be undertaken (Table 3). These activities are not necessarily sequential and van Manen insists that a systematic or procedural approach cannot be followed. This framework was used as the basis for an iterative data interpretation that included reading, reflecting and writing (see Table 3). van Manen drew on Heidegger's work (as well as others) to underpin his methodological approach, where the understanding of lived experiences of phenomenon are not based on rule-bound operation (Gadamer, 2004), rather an open act of uncovering meaning (van Manen, 1990). Hermeneutic phenomenology, unlike other phenomenological approaches, also involves the use of philosophical

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notions being used as a means to illuminate meaning. This is an inductive process whereby the findings are read in conjunction with philosophical texts to make an interpretive leap. This is a process whereby different philosophical notions enables *'you to say something more than what the participants said themselves; to uncover the meaning from between the lines, from behind the saying'* (Smyth, 2011 p.46).

Findings:

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Overall, interviews were completed from four provinces (Ontario, British Columbia, Alberta, Manitoba) across Canada. Participant demographics are reported in Table 1. The majority of the participants were female (77%), which is a close representation of the 90% female Canadian nursing workforce (Porter & Bourgeault, 2017). Most participants (85%) had 10+ years mental health nursing experience. Nine nurses were from Ontario –the most populist province in Canada. Most of the nurses had their Bachelor degree or Masters in nursing, with the exception of three who had completed a diploma.

Engaging with the data and reading and re-reading of Heidegger's philosophical texts led to the identification of five Heideggerian phenomenological concepts that represent the nurses' experiences of 'last resort' – temporality, inauthenticity, thrownness, leaping in and leaping ahead, and mood (fear) (Refer to Figure 1). These are described below together with exemplar participant quotes.

Temporality:

From Heidegger's perspective *'we are time'* and lived time is our temporal way of being in the world (Heidegger, 1996). Temporality, is the fundamental basic structure of Dasein, human everyday existence, and consists of three interconnected dimensions – the past, future and present

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(Heidegger, 1996). The concept portrays the notion of the interconnected nature of how an individual's prior experiences impacts on their current practices and future decision-making (Heidegger, 1996; Scott, 2006). The data from the study clearly illustrated Heidegger's notion of temporality in regard to the practice of 'last resort'. For example, John referred to how his past experience of being assaulted by a patient influenced his behaviours in the present time:

> '[My experiences of being assaulted] *I think tends to colour the way you respond to the next person that comes in. Even if their level of aggression or agitation isn't as severe, it tends to be seen as more severe than it is because you're expecting the worst…I think that instead of talking them to death you tend to talk to them for a couple of minutes and then it's 'okay, let's go'…'* (Int-1, Par 134).

Natalie also expressed:

> *'I think these kinds of incidents will stir up past baggage and past history and how you feel and if you've had bad experiences in your life with being out of control, then you'll often want to move in a controlling way because it creates such anxiety'* (Int-1, Part 31).

These insights thereby reflect that past events, it could overemphasise the potential for violence, which in turn impacts on efforts and motivation to engage in alternative interventions.

Inauthenticity

Heidegger believed we may exist in one of two modes; authentic and inauthentic existence. Authenticity consists of a shift in attention and engagement, a 'reclaiming of oneself' from the typical everyday ways of being (Heidegger, 1996). Inauthentic existence describes operating in the everyday existence of the 'They'. The 'They' refers to how individuals come to exist not on their own terms, but rather embrace the standards, beliefs and prejudices of society. The inauthentic Dasein therefore does not live as itself, but as 'they live', following and adopting the norms of others (Polt,

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2005). Authenticity is about our approach in the world and the challenge of bringing ourselves back from the lostness in the 'They'. Heidegger did not view inauthenticity in negative terms as it is the fundamental basis of how we are socialised into our life world. However, he did consider that inauthenticity could lead to a state of passivity, an alienated self, where one is disburdened of moral autonomy and responsibility (Heidegger, 1996).

In the study, the nurses rarely explicitly shared an experience of restraint from their own perspective. The majority of nurse participants, when describing their lived experience, used the pronoun 'we' to describe the restraint event taken place and the decisions made. This collective perspective of restraint use revealed how the nurses embraced the behaviours and beliefs of others – the 'They' of the nursing team – thereby illustrating an inauthentic state of being. This was evident when Kelly described her experience through the use of 'we' statements:

> *'We always did this in a large group focus, we didn't all take single decisions, we just all decided together what the best course would be'* (Int-1, Par 11).

Tom also acknowledged this, expressing:

> *'Whenever I was involved in restraint of patients, I was working with strong teams and sort of embracing collective decision making…no one person was saying I'm going to put that person in restraint and that's the end of it.'* (Int-2, Par 10).

Rebecca elaborated about her challenges of trying to remember one specific restraint incident, illustrating the collective perspective:

> *'But it would be really hard to differentiate a specific incident because what I gave you as a commonality it seems to be always the way it goes'* (Int-1, Par 49).

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The majority of the participants generalised their own experiences and took on a collective perspective, highlighting the inauthentic existence. Given that this concept surfaced with most participants, it felt important to revisit the issue with two of the participants for further exploration. Both Caitlin and Tom (who were interviewed) expressed that there is a strong dependency on the team during the use of restraint – thereby supporting the notion of a collective 'inauthentic' perspective. The specific examples of the kinds of collective supports necessary related to 'last resort' included: the actual application of restraint involving multiple people; requiring other nurses to take on the care of their patient assignment while they managed the escalating situation; and the dependency on the skill set or know-how of other team members during the management of the situation. Thus both Caitlin and Tom believed that the collective perspective is an accurate reflection of restraint use as a 'last resort'.

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Thrownness:

Thrownness is a basic characteristic of Dasein and relates to how we are constantly being thrown into a world of understanding that is culturally and historically significant (Thomson, 2011). In this study, nurses were constantly being 'thrown' into escalating situations, and it was the level of knowledge and experience available to them (most often amongst the team they were working with) that influenced their behaviours and responses. The level of experience and knowledge are seen as interrelated and represent the expertise and abilities of a nurse – their 'know-how'. The nurse participants heavily relied on others' know-how and experienced this to be significantly influential in 'last resort'.

Tom, for instance, considered how the team's familiarity with the other staff members that played a central role as to whether restraint was used:

'If it was a staff I was not sure of, like if it was a bunch of new hires or a bunch of on-calls that

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> *don't work very often, I might be more reactive only to make sure that we're at a point where I have the support as opposed to it being late and then realise people don't know how to handle the situation'* (Int-1, Par 59).

Tom, as well as other participants depicted how being in a team with less history could mean a quicker escalation to restraint use. Similarly, Sarah emphasised how using restraint as a 'last resort' was directly associated with the experience of the nursing staff:

> *'There tends to be more incidents on days where there are staff that maybe aren't quite as experienced'* (Int-1, Par 33).

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This reliance on the other nurses' know-how may be based on the reality that nurses do not commonly manage escalating situations by themselves and that it requires a team approach. It may also be related to the lack of training within the Canadian education settings for nurses.

Leaping-in and leaping-ahead:

Solicitude is the concern that Dasein displays towards other human beings (Heidegger, 1996). Heidegger (1996) refers to two forms of solicitude: 'leaping in' and 'leaping ahead'. 'Leaping in' is an inauthentic mode of solicitude where we are taking over from the other *'in such solicitude the other can become one who is dominated and dependent, even if this dominating is a tacit one and remains hidden'* (Heidegger, 1996, p. 158). In contrast, *'leaping ahead'* relates to working and supporting others based on their needs; where the focus is on opening up, rather than closing off possibilities (Heidegger, 1962).

'Leaping-in' surfaced in all the participants' experiences. This was revealed through the nurses' actions being based on the need to be safe and/or in control to contain the situation - where the nurses felt the need to leap in with their own decision of what needed to happen. Reaching the

place of needing to 'leap in', and take over the care of the other (Heidegger, 1996) through restraint practice is best articulated through a feeling of 'no return'. Aidan felt that 'last resort' was a situation where he had tried other interventions that were not successful and restraint was the only option available, 'leaping in' to take over the patient's behaviours. He stated:

> '*So this was truly a 'last resort' situation having exhausted all options'* (Int-1, Par 14).

Leaping-in also helped illuminate how some nurses would apply a generalised algorithm-like order of interventions in attempts to mitigate 'last resort' irrespective of the situation. While nurses could face different situations, with different individuals, who had different needs, they tried to control this uncertainty by employing these strategies regardless. These interventions often included initial attempts to administer medications, talking to the person and using seclusion. However, once these had been exhausted they felt there was no choice but to restrain the person. This was seen when Caitlin expressed:

> *'It's essentially a stepwise process, ideally we try verbal de-escalation, then try to offer PRNs, then we'll go to seclusion, and then, as a last resort, an absolute last resort, restraint'* (Int-1, Par 42-46).

Leaping ahead also emerged among some of the nurses' experiences. Heidegger (1962) describes leaping ahead as assisting the other to see themselves in their care and become 'free for it' (p. 159). Natalie described the opportunity to ground oneself as a nurse in these situations in order to not take away their care but to give it back to the patients. She stated:

> *'Some of the mantra for me would be things like asking myself am I at immediate risk of harm? Is this person at immediate risk of harm? Is someone right immediately going to get very seriously hurt unless we restrain this person right now? And if the answer to that is no – then it's like okay how can we remove the audience, how can we give time, and then how can we*

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> *make sure that we're not in that person's physical space so that we give them more distance'* (Int-1, Par 33).

Leaping ahead aligns with the patient empowerment approach in mental health care and enables the opportunity for nurses to further partner with patients in their care.

Mood (Fear):

Heidegger claims that moods reveal something important about the fundamental structure of the world and our way of being in it (Dreyfus & Wrathall, 2005). For Heidegger, moods influence how we perceive or interpret situations as well as people (Heidegger, 1996). He indicates that mood is something shared, not simply inner and private. Moods are neither merely objective or subjective properties of entities (Dreyfus & Wrathall, 2005; Naimo, 2013). Although Heidegger provides limited discussion on the mood of 'fear', he viewed fear to be an inauthentic state of being that arises when we encounter something in our lifeworld (what we experience pre-reflectively) that threatens our potentiality-for-being (Heidegger, 1996). He articulates fear to exist in relation to being fearful of something which is considered to pose a danger to oneself (Magid, 2016). Fear is a state through which rational thought becomes compromised (Heidegger, 1996). When reflecting on the nurses' experiences, fear was either implicitly or on occasion explicitly reported. For instance, some nurses highlighted a perception of risk of harm to self or others to be an object of fear. At times, it was often the '*just in case'* or *'what if'* mood of fear rather than actual risk of harm that determined restraint use. Molly illustrated her perceptions of potential risk when she shared:

> *'If the patient is potentially going to lash out and injure somebody then we use restraint' (*Int-1, Par 21).

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While at times it appeared that there was no apparent risk as a result of the *'just in case'* or *'what if'* perspectives, the shared mood of fear could influence all staff behaviours. Sarah shared her perception on how fear influenced decision-making and 'last resort', stating:

> *'Fear unfortunately plays a role in some situations. If the staff are afraid and they feel that they can't manage a situation, they may jump to putting somebody into restraints prematurely and it's something we certainly try to work on. But I get what it felt like to be* [in a situation with] *three female nurses on a night shift and you have somebody that is threatening you and security is out ploughing snow in the parking lot. You know you're alone and that the police are going to be 20 minutes away, there is an element of fear. That sometimes may drive decisions, not in all cases but it certainly I think it would be naïve to not think that it's out there and that it is a factor sometime'* (Int-1, Par 35).

Heidegger (1996) suggested that fear *'bewilders us and makes us lose our heads'* (p.137). In this study, fear may have led the nurses to view the patient as the object of fear and therefore placing the patient in restraint may help to gain control and minimise this negative emotion.

For Review Only

Discussion

This study highlights the individual, interpersonal, historical and situational intricacies in determining 'last resort'. Five Heideggerian notions have been used to highlight the complexities and realities Canadian nurses encountered when determining 'last resort' in the use of restraint. The philosophical concepts are temporality, inauthenticity, thrownness, leaping in and leaping ahead, and fear. The experiences of the participants had many similarities even though their geographical locations varied. This discussion will attempt to further illuminate the understanding

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of 'last resort' through examining and theorising the results drawing on the greater body of literature outside of hermeneutic phenomenology.

The Heideggerian interpretation of the findings in relation to inauthenticity and leaping-in align with the concept of dehumanisation. Dehumanisation is defined as '*the denial of a distinctively human mind to another person'* (Haque & Waytz, 2012, p. 177). Dehumanisation in medicine is not intended to be malicious on the part of the health care professional, rather an unconscious, *'by-product of the way humans' evolved minds interact with present widespread social practices and functional requirements in hospitals'* (Haque & Waytz, 2012, p. 177). Moreover, research has demonstrated that dehumanisation enables people to experience less moral concerns for their actions toward dehumanised others, and can justify acts that would otherwise be considered harmful (Haque & Waytz, 2012, p. 177). In this study nurses frequently described factors associated with dehumanisation in terms of applying algorithms of interventions irrespective of need, de-individuation of care, and generalisation of their experiences. Although the concept of dehumanisation and restraint use have not been formally linked, aside from a small number of qualitative studies expressing patients' perspective of feeling dehumanised when restrained (Brophy et al., 2016), insights from this study suggest that facets of it are present when nurses are determining 'last resort'.

For Review Only

The concepts of thrownness and inauthenticity reflected how nurses depended on the know-how of their peers, as well as, the collective perspective, which aligns closely with the notion of 'groupthink'. Groupthink is defined by Janis (1997) as:

> *'a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action'* (p. 237).

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Shirey (2012) highlights that in the presence of groupthink, *'groups examine few alternatives, are not highly selective in gathering data for analysis, fail to challenge assumptions, and do not look beyond the immediate environment for answers or expert direction'* (p.69). In this study nurses repeatedly reflected on the actions and decisions of other nurses rather than their own when enacting 'last resort', demonstrating conformity. Therefore, it may be as a result of groupthink that nurses continue to use restraint as a 'last resort', even when they are aware of its negative impact. The concept of groupthink has not been linked with restraint use in other literature and further exploration is needed.

For Review Only

The lived experiences of the nurses also suggested that the perceived risk in relation to dealing with aggressive patients created a mood of fear. In the wider literature, underlying and influencing factors in determining risk, such as fear, have been relatively unexplored and under-theorised (Furedi, 2006; Jacob & Holmes, 2011). Literature has illustrated that nurses working under threat are compelled to redefine their interactions and choice of interventions with patients (Duxbury & Whittington, 2005; Foster et al., 2007; Jacob & Holmes, 2011). Some studies have also demonstrated mental health staff engaging in legitimation narratives both on a collective and individual basis with respect to restrictive practices (McKeown et al., 2020; Gadsby 2018; Perkins et al., 2012). In particular, McKeown et al. (2020) recently reported mental health staff claiming various forms of justification for the use of restraint such as, patients from certain populations and protection of staff and other patients. The study also described that *'rationalising restraint as a legitimate, last resort intervention both vindicated staff actions, and condoled those who would rather not administer coercive practices'* (p.454). Similarly, the participants in this current study demonstrated the 'just in case' or 'what if' perspectives that created fear and perhaps rationalised the use of restraint for the nurses.

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The strengths of this study are that it is the first to specifically explore the concept of 'last resort' in restraint use. The use of Heideggerian concepts enabled unique perspectives of 'last resort' to be identified. Participants were from a range of mental health inpatient services across provinces in Canada, thereby increasing the transferability of findings. Although, there was a relatively small sample size, it is commensurate with other phenomenological type projects (Smythe, 2011). Furthermore, although the participants were from various provinces across Canada and not localised to one geographical location, it is important to reflect that the findings may not represent the general mental health nursing population in Canada, and there may be further qualities to reveal. Further research is needed to corroborate or refute findings. Additionally, the Canadian mental health care culture may pose unique experiences and perspectives that differ from other cultures and countries, posing a limitation in transferring the findings outside of Canada. Lastly, the inherent bias of social-desirability in social science research, where the nurses may have reported what they believed to be expected of them may be compromising. Additional qualitative insights such as observational analysis to authenticate the nurses' accounts could prove useful.

For Review Only

Conclusion

This study set out to understand the concept of 'last resort' in the use of restraint among Canadian mental health nurses. Despite much recognition in the literature regarding restraint practices in mental health, there is a lack of inquiry that directly explores 'last resort'. This study has revealed that 'last resort' is composed of many elements, where it is a complex and multidimensional phenomenon. Many of the nurses had a difficult time recalling one experience of using restraint and generalised their recollections of the incident and the patient. Moreover, nurses took on a collective perspective in determining 'last resort'. Their lived experiences showed that their past impacted their perspectives of 'last resort' in the present. There was also a dependency on the knowledge and

experience of other staff in order to mitigate the use of restraint. In addition, nurses resorted to informal generic algorithm-like approach to manage escalating situations rather than individualising care to the unique patient. Finally, 'last resort' may be determined as a result of perceived risk by nurses rather than actual risk. Further work is needed to better understand the results as mental health organisations continue their efforts in restraint minimisation. The continued understanding of 'last resort' may be critical in shifting practice and culture in mental health and restraint utilisation. The findings from this study are hoped to pave the way in this next level of understanding within the field of restraint minimisation.

For Review Only

Relevance for Clinical Practice

The findings from this study have several possible implications. Firstly, debriefing may be a helpful antidote in relation to the nurses' accounts that illustrated how temporality and fear contribute to their perceptions of 'last resort'. Unaddressed negative experiences influence people's approach over time and therefore, it is imperative that timely support and interventions are provided. Secondly, the continued adoption of recovery-oriented practices and trauma-informed care may diminish the rationalisation of restraint use based on perceived risk, and de-individuation and generalisation of patients and care. Thirdly, enhanced understanding of de-escalation techniques and how to further integrate these into practice may reduce the strong dependency nurses have on other staff members' know-how. The development of skills in de-escalation for nurses on the individual level may support greater proactive strategies in care and individuation of patient needs to mitigate restraint use. Finally, exploring staff and team practices on wards in addressing groupthink. This may include implementing reflexivity practices among the team, critical evaluation of staff performance and getting explicit feedback from patients, and addressing team member composition to include diversity among them.

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Table 1: Participant Demographics

Pseudonym	**Years of Experience as MH nurses**	**Level of Education**	**Location**
Rebecca	17	Diploma	Ontario
Tom	10	Bachelor Degree	British Columbia
Sarah	13	Diploma	Ontario
Jayne	17	Bachelor Degree	Ontario
John	15	Diploma	Ontario
Molly	18	Bachelor Degree	Alberta
Melinda	1	Bachelor Degree	Ontario
Caitlin	5	Bachelor Degree	Ontario
Natalie	39	Masters	Manitoba
Aidan	18	Bachelor Degree	Ontario
Dana	41	Masters	Manitoba
Kelly	30	Bachelor Degree	Ontario
Amanda	22	Masters	Ontario

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Table 2: open-ended questions in semi-structured interviews

Can you recall a situation where you had to place someone in restraint and tell me everything you remember about that situation? *How do you determine when restraint is used as a 'last resort'?*

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Table 3: The study's adoption of van Manen's stages of research activities (van Manen, 1997, pp. 31-34)

van Manen's Research Activity	Study's Adoption of Each Activity
1) *Turning to a phenomenon which seriously interests us and commits us to the world;*	*van Manen (1997) believes that every project of a hermeneutic phenomenological inquiry is driven by a commitment of turning to an abiding concern. In this study the available literature related to the topic was considered. The primary researcher's background, experiences and stated interest were reflected upon throughout the study. This involved participating in a pre-understanding interview to capture their perspective prior to the commencement of the study, sharing insights within the research team, and ongoing use of a reflexive diary.*
2) Investigating experience as we live it rather than as we conceptualise it;	*This component aims to establish a 'renewed contact with the original experience'. The experience one comes with is considered wisdom as a result of the practice of living, and in doing phenomenological research, this 'practical wisdom is sought in understanding of the nature of lived experience itself'. In investigating the phenomena 'last resort', in-depth semi-structured interviews with mental health nurses were conducted. All interviews were transcribed by the primary researcher, which provided an in-depth immersion into the phenomenon.*
3) Reflecting on the essential themes which characterise the phenomenon;	*van Manen describes this element as the process of reflecting and 'bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitudes of everyday life' (p.32). This process involved re-listening to the audio files and reading and re-reading of the interviews. A computer software was also used to help support data analysis. This technical solution provided a simple and flexible approach in managing large sets of textual data. It also enabled greater visual opportunities to review the texts during the ongoing manual hermeneutic phenomenological analysis.*
4) Describing the phenomenon through the art of writing and rewriting;	*van Manen believes that in order to do justice to the 'fullness' and 'ambiguity' of lifeworld, writing will need to take form of a complex process of writing and rewriting which includes re-thinking, re-flecting, and re-cognising; going back and forth between the parts and the whole. This process is the hermeneutic circle, in which the parts and the whole text are understood with reference to each other. In this study, preliminary themes were identified which were further analysed and explored through writing and rewriting. This interpretive journey spanned over multiple edits, revisions, and discussions with co-authors.*
5) Maintaining a strong and oriented pedagogical relation to the phenomenon; and	*van Manen notes that to be oriented to an object 'means that we are animated by the object in a full and human sense' (p.33) In this study the research team kept up to date with*

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	current research, and presented findings at international and national conferences and events.
6) Balancing the research context by considering parts and whole.	*van Manen explains the importance of constantly measuring the overall design of the study against the 'significance that the parts must play in the total textual structure' (p.37). He notes that it is very easy for the researcher to get too buried in writing that one finds themselves lost, not knowing where to go or what to do next. The iterative nature of data analysis and reflexivity strategies helped to achieved this such as through sharing and discussing interviews and interpretations regularly with co-authors, and presenting the study findings at various conferences and educational forums. The work of Heidegger among others are central to van Manen's approach. In this study the findings guided our reading of wider philosophical texts to identify key philosophical concepts to help illuminate the meaning of 'last resort'. An approach adopted by others who use this methodological approach (Smyth, 2011).*

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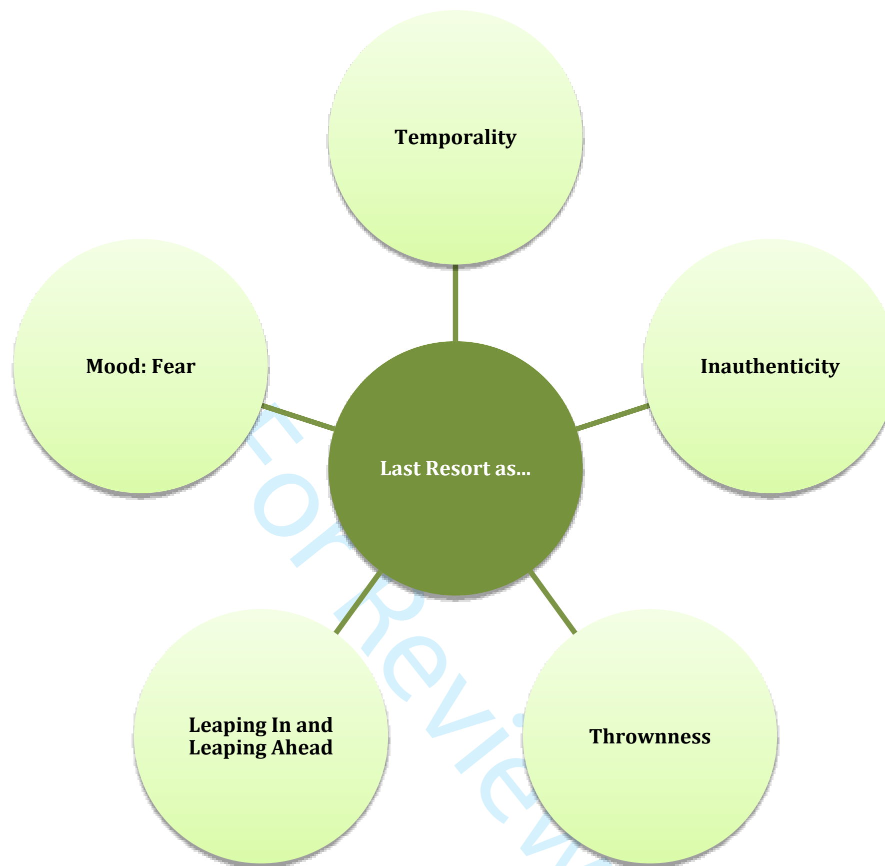
Figure 1: Visual depiction of the Heideggerian concepts



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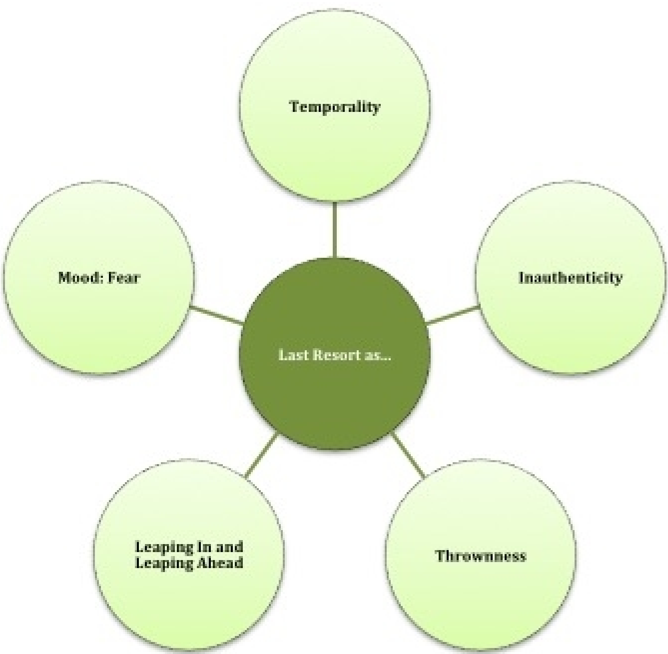

Figure 1: Visual depiction of the Heideggerian concepts

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Abstract

Restraining patients is a practice that dates back at least three centuries. In recent years, there has been a mandate and advocacy in various countries for organisations to shift towards the minimisation of restraint, whereby its use is only as a 'last resort'. There is growing evidence internationally indicating the negative impact of the use of restraint. However, to date there is no research specifically focusing on trying to understand the concept of 'last resort'. Further insights to explore this concept amongst mental health nurses are therefore warranted.

The empirical research comprised a hermeneutic phenomenological study. By recruiting and interviewing thirteen mental health nurses from across Canada who had experiences of restraint use, the research aimed to generate a deeper understanding of the meanings and lived experiences of the concept of 'last resort'. Data was collected through fifteen in-depth interviews. Data analysis was undertaken through a hermeneutic phenomenological framework based on van Manen's approach and Heideggerian philosophy. Five Heideggerian concepts were used to illuminate 'last resort' in restraint use by mental health nurses - temporality, inauthenticity, thrownness, leaping in and leaping ahead and mood (fear). Key findings highlight the influence of nurses' past experiences, how nursing staff adopt a collective (rather than individual) approach, and the dependency on knowledge and skills of others in using restraint as a 'last resort'.

Overall, the lived experience of 'last resort' is comprised of many elements. This study provides insights and an initial understanding, which is hoped to advance the field of restraint minimisation.

Keywords: Restraint, Mental Health, Psychiatric Nursing, Containment, Phenomenology

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Introduction

Restraint is considered a coercive measure in mental health care. The term 'restraint', although lacking standardisation, has been defined as: *'measures designed to confine a patient's bodily movements'* (Sailas & Fenton, 2009, P.2). While restraint use may be perceived as warranted at times, there is growing literature highlighting its counter-therapeutic effects (Borckardt et al., 2011). As a result, in more recent years, there has been a mandate through various legislations, guidelines and papers in countries, such as Canada, USA, UK and Australia, for organisations to minimise the use of restraint, whereby its use is only as a 'last resort'. This means that restraint is used when all other alternative interventions have been exhausted (American Psychiatric Nurses Association, 2014a, 2014b; MIND 2013; National Institute for Health and Care Excellence, 2015; Registered Nurses Association of Ontario, 2012; The Royal Australian and New Zealand College of Psychiatrists, 2016). As more organisations adopt these approaches, it becomes critical to better understand why restraint use continues and what 'last resort' means in relation this practice. 'Last resort' is a key term that has surfaced in approximately the last two decades in relation to restraint use. The Care Quality Commission in the United Kingdom referred to the use of restraint as a 'last resort' intervention in their recent review of the use of the Mental Health Act (Care Quality Commission, 2011). While nurses in various studies have often referred to 'last resort' (Gerace &Muir-Cochrane, 2019; Muir-Cochrane et al., 2018; Wilson et al., 2017), there is a lack of inquiry that directly addresses the concept. There are no publications or studies that clearly describe this term or identify what this means when operationalised into day-to-day practice. This creates the opportunity for variances in understanding and application of restraint use as a 'last resort'. Essentially, the purpose of this term is to promote clinicians to deviate from the traditional practices to commonly use restraint as part of care and instead manage these situations through the use of other alternative interventions, and to refrain from the use of restraint unless absolutely necessary. Deveau and McDonnell (2009) suggest a limitation to the term 'last resort' and argue

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that the *'the reliance upon the 'last resort' principles has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge'* (p.175). Therefore, they suggest possible shortcomings of this term. Overall, given that current evidence insists that all other alternatives must be exhausted prior to the use of restraint as a 'last resort' and the continued ambiguity of the term, it becomes essential to understand mental health nurses' experience and understandings of it.

Background

Restraining patients (i.e. physically confining their movement or using devices to restrict their movement) is a practice that dates back at least three centuries (Masters, 2017). Currently, control and containment measures, such as restraint, are frequently used as first line interventions within health care settings (Foster et al., 2007; Kynoch et al., 2011). The most common circumstances where restraint is utilised are in response to violent/aggressive patient behaviour, absconding, refusal of medication, self-harm, and property damage (Bowers et al., 2012; Cowman et al., 2017; Duxbury et al., 2019; Ryan & Bowers, 2006; Southcott & Howard, 2007).

A Cochrane review undertaken to assess the effectiveness of restraint use compared to alternatives concluded that *'no controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness'* (Sailas & Fenton, 2009, p. 2). Moreover, other reviews report similar findings (Chleze et al., 2019; Muralidharan & Fenton, 2012; Nelstrop et al., 2006; Sailas & Fenton, 2012). Internationally there is growing evidence indicating that restraint use is counter-therapeutic, coercive, punishing, traumatic and unnecessary (Curran, 2007; Soininen et al., 2013).

From a Canadian context, and internationally, restraint utilisation continues to be a problem, despite various changes in the health care system mandating restraint minimisation. In Canada mandatory assessment and reporting requirements of restraint use for mental health patients does

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not exist for every province. Therefore, utilisation data is limited to the most highly populated province, Ontario. The most recent data highlights that one in four of all individuals admitted to a mental health ward experienced at least one type of coercive intervention (chemical restraint, mechanical or physical restraint, and seclusion) during their hospitalisation (Canadian Institute for Health Information, 2011). Hospitals across Canada are adopting various evidence-based models in their efforts to minimise restraint use, however, there are no formal strategies provincially or nationally and this is dependent upon each hospital's efforts and priorities.

The aim of this study was to gather the Canadian mental health nurses' perspectives and lived experiences about the use of restraint as 'last resort'. It was hoped that these findings would help to inform strategies in restraint minimisation and to prevent restraint use in mental health care.

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Methods

Design:

A hermeneutic phenomenology study underpinned by the philosophies of Heidegger was undertaken. This approach offers a methodology through which lived experiences of a particular phenomenon can be explored (Smyth, 2011). It incorporates the perspective of the individual, as well as the socio-cultural context on how events are interpreted (Aspers, 2009). This approach recognises that research cannot operate through a value-free objective standpoint and thus hermeneutic phenomenology values the perspective of the interpreter within the construction of meanings (van Manen, 1990).

Reflexivity is an essential activity in qualitative research that aids to establish confidence and trust in the findings through rigour (van Manen, 2014). Thus, as part of the study it was important to reflect on personal pre-understandings, and how biases influenced the design, collection and

interpretation of the data (Sandelowski, 2004). These practices reflect Heidegger's fore-structures of understanding and are key within a hermeneutic phenomenological study. Reflexivity was attended to by the lead author being interviewed at the start of the study to elicit her pre-understandings, beliefs and biases towards the topic area, a reflexive diary was also maintained to record and assess how her prejudices and pre-understandings influenced the research process (refer to Table 3 for further details). The authors are from a mental health nursing and psychology background, two of whom have been involved in restraint practices.

Currently, there are different types of restraint that may be used in practice, mechanical, manual, chemical and/or seclusion. The focus of this study was on mechanical and manual restraint as many studies refer to both forms interchangeably. There are also variances in the use of mechanical and manual restraint among countries. For example some countries (such as the UK) only use manual restraint, whilst others (such as Canada) may use both. Finally, both mechanical and manual restraint serve to immobilise an individual's physical movements, while other restraint methods, e.g. seclusion, are less restrictive (Fishkind, 2005). Therefore, in this study, the term restraint refers to both mechanical and manual forms of restraint. For the purposes of this research, mechanical restraint refers to the use of *'straps, belts or other equipment to restrict movement'* (Stewart et al., 2009, p. 2). Whereas manual restraint relates to *'any occasion on which staff physically hold the patient, preventing movement, typically in order to prevent imminent harm to others or self, or to give treatment, or to initiate other methods of containment'* (Bowers et al., 2012, p. 31; Canadian Institue for Health Information, 2011).

Data Collection:

A purposive sampling method was adopted. To reduce biases that may arise as a result of recruiting subjects from one setting (i.e. culture), mental health nurses were sought across Canada. The goal was to recruit 10-15 mental health nurses through the Canadian Federation of Mental Health

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Nurses (CFMHN) association. Overall, thirteen participants were recruited and 15 interviews completed. Two follow up interviews were completed to further understand the 'collective view' perspective that will be further elaborated on in the results. The open-ended questions asked in the semi-structured interviews are highlighted in Table 2. Ethical approval was received from an academic institution in the UK (Project 267) and a healthcare organisation in Canada (#14-009-D) prior to the start of the study.

Over a six month period the administrator of CFMHN distributed a recruitment email and poster on the main CFMHN website. An introductory telephone discussion was held to provide further details about the study for those who expressed an interest. Audio recorded semi-structured interviews took place either face-to-face or via videoconference. All interviews were transcribed and sent to the co-authors for review and feedback.

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Interpretation:

van Manen's (1997) phenomenological approach was used for the interpretation of data. This involves *'insightful invention, discovery or disclosure'* (p.79) – a free act of 'seeing' meaning and ultimately to reveal meaning and the structures of the experience (van Manen, 1997). van Manen (1997) identified a '*dynamic interplay among six research activities*' (p. 30) as a means to convey the elemental methodical structure of how hermeneutic phenomenology can be undertaken (Table 3). These activities are not necessarily sequential and van Manen insists that a systematic or procedural approach cannot be followed. This framework was used as the basis for an iterative data interpretation that included reading, reflecting and writing (see Table 3). van Manen drew on Heidegger's work (as well as others) to underpin his methodological approach, where the understanding of lived experiences of phenomenon are not based on rule-bound operation (Gadamer, 2004), rather an open act of uncovering meaning (van Manen, 1990). Hermeneutic phenomenology, unlike other phenomenological approaches, also involves the use of philosophical

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notions being used as a means to illuminate meaning. This is an inductive process whereby the findings are read in conjunction with philosophical texts to make an interpretive leap. This is a process whereby different philosophical notions enables *'you to say something more than what the participants said themselves; to uncover the meaning from between the lines, from behind the saying'* (Smyth, 2011 p.46).

Findings:

Overall, interviews were completed from four provinces (Ontario, British Columbia, Alberta, Manitoba) across Canada. Participant demographics are reported in Table 1. The majority of the participants were female (77%), which is a close representation of the 90% female Canadian nursing workforce (Porter & Bourgeault, 2017). Most participants (85%) had 10+ years mental health nursing experience. Nine nurses were from Ontario –the most populist province in Canada. Most of the nurses had their Bachelor degree or Masters in nursing, with the exception of three who had completed a diploma.

Engaging with the data and reading and re-reading of Heidegger's philosophical texts led to the identification of five Heideggerian phenomenological concepts that represent the nurses' experiences of 'last resort' – temporality, inauthenticity, thrownness, leaping in and leaping ahead, and mood (fear) (Refer to

Can *you recall a situation where you had to place someone in restraint and tell me everything you remember about that situation?* *How do you determine when restraint is used as a 'last resort'?*

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Table 3: The study's adoption of van Manen's stages of research activities (van Manen, 1997, pp. 31-34)

van Manen's Research Activity	Study's Adoption of Each Activity
1) *Turning to a phenomenon which seriously interests us and commits us to the world;*	*van Manen (1997) believes that every project of a hermeneutic phenomenological inquiry is driven by a commitment of turning to an abiding concern. In this study the available literature related to the topic was considered. The primary researcher's background, experiences and stated interest were reflected upon throughout the study. This involved participating in a pre-understanding interview to capture their perspective prior to the commencement of*

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	the study, sharing insights within the research team, and ongoing use of a reflexive diary.
2) Investigating experience as we live it rather than as we conceptualise it;	*This component aims to establish a 'renewed contact with the original experience'. The experience one comes with is considered wisdom as a result of the practice of living, and in doing phenomenological research, this 'practical wisdom is sought in understanding of the nature of lived experience itself'. In investigating the phenomena 'last resort', in-depth semi-structured interviews with mental health nurses were conducted. All interviews were transcribed by the primary researcher, which provided an in-depth immersion into the phenomenon.*
3) Reflecting on the essential themes which characterise the phenomenon;	*van Manen describes this element as the process of reflecting and 'bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitudes of everyday life' (p.32). This process involved re-listening to the audio files and reading and re-reading of the interviews. A computer software was also used to help support data analysis. This technical solution provided a simple and flexible approach in managing large sets of textual data. It also enabled greater visual opportunities to review the texts during the ongoing manual hermeneutic phenomenological analysis.*
4) Describing the phenomenon through the art of writing and rewriting;	*van Manen believes that in order to do justice to the 'fullness' and 'ambiguity' of lifeworld, writing will need to take form of a complex process of writing and rewriting which includes re-thinking, re-flecting, and re-cognising; going back and forth between the parts and the whole. This process is the hermeneutic circle, in which the parts and the whole text are understood with reference to each other. In this study, preliminary themes were identified which were further analysed and explored through writing and rewriting. This interpretive journey spanned over multiple edits, revisions, and discussions with co-authors.*
5) Maintaining a strong and oriented pedagogical relation to the phenomenon; and	*van Manen notes that to be oriented to an object 'means that we are animated by the object in a full and human sense' (p.33) In this study the research team kept up to date with current research, and presented findings at international and national conferences and events.*
6) Balancing the research context by considering parts and whole.	*van Manen explains the importance of constantly measuring the overall design of the study against the 'significance that the parts must play in the total textual structure' (p.37). He notes that it is very easy for the researcher to get too buried in writing that one finds themselves lost, not knowing where to go or what to do next. The iterative nature of data analysis and reflexivity strategies helped to achieved this such as through sharing and discussing interviews and interpretations regularly with co-authors, and presenting the study findings at various conferences and educational*

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	forums. The work of Heidegger among others are central to van Manen's approach. In this study the findings guided our reading of wider philosophical texts to identify key philosophical concepts to help illuminate the meaning of 'last resort'. An approach adopted by others who use this methodological approach (Smyth, 2011).

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Figure 11). These are described below together with exemplar participant quotes.

Temporality:

From Heidegger's perspective *'we are time'* and lived time is our temporal way of being in the world (Heidegger, 1996). Temporality, is the fundamental basic structure of Dasein, human everyday existence, and consists of three interconnected dimensions – the past, future and present

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(Heidegger, 1996). The concept portrays the notion of the interconnected nature of how an individual's prior experiences impacts on their current practices and future decision-making (Heidegger, 1996; Scott, 2006). The data from the study clearly illustrated Heidegger's notion of temporality in regard to the practice of 'last resort'. For example, John referred to how his past experience of being assaulted by a patient influenced his behaviours in the present time:

> '[My experiences of being assaulted] *I think tends to colour the way you respond to the next person that comes in. Even if their level of aggression or agitation isn't as severe, it tends to be seen as more severe than it is because you're expecting the worst…I think that instead of talking them to death you tend to talk to them for a couple of minutes and then it's 'okay, let's go'…'* (Int-1, Par 134).

Natalie also expressed:

> *'I think these kinds of incidents will stir up past baggage and past history and how you feel and if you've had bad experiences in your life with being out of control, then you'll often want to move in a controlling way because it creates such anxiety'* (Int-1, Part 31).

These insights thereby reflect that past events, it could overemphasise the potential for violence, which in turn impacts on efforts and motivation to engage in alternative interventions.

Inauthenticity

Heidegger believed we may exist in one of two modes; authentic and inauthentic existence. Authenticity consists of a shift in attention and engagement, a 'reclaiming of oneself' from the typical everyday ways of being (Heidegger, 1996). Inauthentic existence describes operating in the everyday existence of the 'They'. The 'They' refers to how individuals come to exist not on their own terms, but rather embrace the standards, beliefs and prejudices of society. The inauthentic Dasein therefore does not live as itself, but as 'they live', following and adopting the norms of others (Polt,

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2005). Authenticity is about our approach in the world and the challenge of bringing ourselves back from the lostness in the 'They'. Heidegger did not view inauthenticity in negative terms as it is the fundamental basis of how we are socialised into our life world. However, he did consider that inauthenticity could lead to a state of passivity, an alienated self, where one is disburdened of moral autonomy and responsibility (Heidegger, 1996).

In the study, the nurses rarely explicitly shared an experience of restraint from their own perspective. The majority of nurse participants, when describing their lived experience, used the pronoun 'we' to describe the restraint event taken place and the decisions made. This collective perspective of restraint use revealed how the nurses embraced the behaviours and beliefs of others – the 'They' of the nursing team – thereby illustrating an inauthentic state of being. This was evident when Kelly described her experience through the use of 'we' statements:

> *'We always did this in a large group focus, we didn't all take single decisions, we just all decided together what the best course would be'* (Int-1, Par 11).

Tom also acknowledged this, expressing:

> *'Whenever I was involved in restraint of patients, I was working with strong teams and sort of embracing collective decision making…no one person was saying I'm going to put that person in restraint and that's the end of it.'* (Int-2, Par 10).

Rebecca elaborated about her challenges of trying to remember one specific restraint incident, illustrating the collective perspective:

> *'But it would be really hard to differentiate a specific incident because what I gave you as a commonality it seems to be always the way it goes'* (Int-1, Par 49).

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The majority of the participants generalised their own experiences and took on a collective perspective, highlighting the inauthentic existence. Given that this concept surfaced with most participants, it felt important to revisit the issue with two of the participants for further exploration. Both Caitlin and Tom (who were interviewed) expressed that there is a strong dependency on the team during the use of restraint – thereby supporting the notion of a collective 'inauthentic' perspective. The specific examples of the kinds of collective supports necessary related to 'last resort' included: the actual application of restraint involving multiple people; requiring other nurses to take on the care of their patient assignment while they managed the escalating situation; and the dependency on the skill set or know-how of other team members during the management of the situation. Thus both Caitlin and Tom believed that the collective perspective is an accurate reflection of restraint use as a 'last resort'.

Thrownness:

Thrownness is a basic characteristic of Dasein and relates to how we are constantly being thrown into a world of understanding that is culturally and historically significant (Thomson, 2011). In this study, nurses were constantly being 'thrown' into escalating situations, and it was the level of knowledge and experience available to them (most often amongst the team they were working with) that influenced their behaviours and responses. The level of experience and knowledge are seen as interrelated and represent the expertise and abilities of a nurse – their 'know-how'. The nurse participants heavily relied on others' know-how and experienced this to be significantly influential in 'last resort'.

Tom, for instance, considered how the team's familiarity with the other staff members that played a central role as to whether restraint was used:

'If it was a staff I was not sure of, like if it was a bunch of new hires or a bunch of on-calls that

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> *don't work very often, I might be more reactive only to make sure that we're at a point where I have the support as opposed to it being late and then realise people don't know how to handle the situation'* (Int-1, Par 59).

Tom, as well as other participants depicted how being in a team with less history could mean a quicker escalation to restraint use. Similarly, Sarah emphasised how using restraint as a 'last resort' was directly associated with the experience of the nursing staff:

> *'There tends to be more incidents on days where there are staff that maybe aren't quite as experienced'* (Int-1, Par 33).

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This reliance on the other nurses' know-how may be based on the reality that nurses do not commonly manage escalating situations by themselves and that it requires a team approach. It may also be related to the lack of training within the Canadian education settings for nurses.

Leaping-in and leaping-ahead:

Solicitude is the concern that Dasein displays towards other human beings (Heidegger, 1996). Heidegger (1996) refers to two forms of solicitude: 'leaping in' and 'leaping ahead'. 'Leaping in' is an inauthentic mode of solicitude where we are taking over from the other *'in such solicitude the other can become one who is dominated and dependent, even if this dominating is a tacit one and remains hidden'* (Heidegger, 1996, p. 158). In contrast, *'leaping ahead'* relates to working and supporting others based on their needs; where the focus is on opening up, rather than closing off possibilities (Heidegger, 1962).

'Leaping-in' surfaced in all the participants' experiences. This was revealed through the nurses' actions being based on the need to be safe and/or in control to contain the situation - where the nurses felt the need to leap in with their own decision of what needed to happen. Reaching the

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place of needing to 'leap in', and take over the care of the other (Heidegger, 1996) through restraint practice is best articulated through a feeling of 'no return'. Aidan felt that 'last resort' was a situation where he had tried other interventions that were not successful and restraint was the only option available, 'leaping in' to take over the patient's behaviours. He stated:

'*So this was truly a 'last resort' situation having exhausted all options'* (Int-1, Par 14).

Leaping-in also helped illuminate how some nurses would apply a generalised algorithm-like order of interventions in attempts to mitigate 'last resort' irrespective of the situation. While nurses could face different situations, with different individuals, who had different needs, they tried to control this uncertainty by employing these strategies regardless. These interventions often included initial attempts to administer medications, talking to the person and using seclusion. However, once these had been exhausted they felt there was no choice but to restrain the person. This was seen when Caitlin expressed:

'It's essentially a stepwise process, ideally we try verbal de-escalation, then try to offer PRNs, then we'll go to seclusion, and then, as a last resort, an absolute last resort, restraint' (Int-1, Par 42-46).

Leaping ahead also emerged among some of the nurses' experiences. Heidegger (1962) describes leaping ahead as assisting the other to see themselves in their care and become 'free for it' (p. 159). Natalie described the opportunity to ground oneself as a nurse in these situations in order to not take away their care but to give it back to the patients. She stated:

'Some of the mantra for me would be things like asking myself am I at immediate risk of harm? Is this person at immediate risk of harm? Is someone right immediately going to get very seriously hurt unless we restrain this person right now? And if the answer to that is no – then it's like okay how can we remove the audience, how can we give time, and then how can we

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> *make sure that we're not in that person's physical space so that we give them more distance'* (Int-1, Par 33).

Leaping ahead aligns with the patient empowerment approach in mental health care and enables the opportunity for nurses to further partner with patients in their care.

Mood (Fear):

Heidegger claims that moods reveal something important about the fundamental structure of the world and our way of being in it (Dreyfus & Wrathall, 2005). For Heidegger, moods influence how we perceive or interpret situations as well as people (Heidegger, 1996). He indicates that mood is something shared, not simply inner and private. Moods are neither merely objective or subjective properties of entities (Dreyfus & Wrathall, 2005; Naimo, 2013). Although Heidegger provides limited discussion on the mood of 'fear', he viewed fear to be an inauthentic state of being that arises when we encounter something in our lifeworld (what we experience pre-reflectively) that threatens our potentiality-for-being (Heidegger, 1996). He articulates fear to exist in relation to being fearful of something which is considered to pose a danger to oneself (Magid, 2016). Fear is a state through which rational thought becomes compromised (Heidegger, 1996). When reflecting on the nurses' experiences, fear was either implicitly or on occasion explicitly reported. For instance, some nurses highlighted a perception of risk of harm to self or others to be an object of fear. At times, it was often the '*just in case*' or '*what if*' mood of fear rather than actual risk of harm that determined restraint use. Molly illustrated her perceptions of potential risk when she shared:

> *'If the patient is potentially going to lash out and injure somebody then we use restraint' (*Int-1, Par 21).

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While at times it appeared that there was no apparent risk as a result of the *'just in case'* or *'what if'* perspectives, the shared mood of fear could influence all staff behaviours. Sarah shared her perception on how fear influenced decision-making and 'last resort', stating:

> *'Fear unfortunately plays a role in some situations. If the staff are afraid and they feel that they can't manage a situation, they may jump to putting somebody into restraints prematurely and it's something we certainly try to work on. But I get what it felt like to be* [in a situation with] *three female nurses on a night shift and you have somebody that is threatening you and security is out ploughing snow in the parking lot. You know you're alone and that the police are going to be 20 minutes away, there is an element of fear. That sometimes may drive decisions, not in all cases but it certainly I think it would be naïve to not think that it's out there and that it is a factor sometime'* (Int-1, Par 35).

Heidegger (1996) suggested that fear *'bewilders us and makes us lose our heads'* (p.137). In this study, fear may have led the nurses to view the patient as the object of fear and therefore placing the patient in restraint may help to gain control and minimise this negative emotion.

Discussion

This study highlights the individual, interpersonal, historical and situational intricacies in determining 'last resort'. Five Heideggerian notions have been used to highlight the complexities and realities Canadian nurses encountered when determining 'last resort' in the use of restraint. The philosophical concepts are temporality, inauthenticity, thrownness, leaping in and leaping ahead, and fear. The experiences of the participants had many similarities even though their geographical locations varied. This discussion will attempt to further illuminate the understanding

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of 'last resort' through examining and theorising the results drawing on the greater body of literature outside of hermeneutic phenomenology.

The Heideggerian interpretation of the findings in relation to inauthenticity and leaping-in align with the concept of dehumanisation. Dehumanisation is defined as '*the denial of a distinctively human mind to another person'* (Haque & Waytz, 2012, p. 177). Dehumanisation in medicine is not intended to be malicious on the part of the health care professional, rather an unconscious, *'by-product of the way humans' evolved minds interact with present widespread social practices and functional requirements in hospitals'* (Haque & Waytz, 2012, p. 177). Moreover, research has demonstrated that dehumanisation enables people to experience less moral concerns for their actions toward dehumanised others, and can justify acts that would otherwise be considered harmful (Haque & Waytz, 2012, p. 177). In this study nurses frequently described factors associated with dehumanisation in terms of applying algorithms of interventions irrespective of need, de-individuation of care, and generalisation of their experiences. Although the concept of dehumanisation and restraint use have not been formally linked, aside from a small number of qualitative studies expressing patients' perspective of feeling dehumanised when restrained (Brophy et al., 2016), insights from this study suggest that facets of it are present when nurses are determining 'last resort'.

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The concepts of thrownness and inauthenticity reflected how nurses depended on the know-how of their peers, as well as, the collective perspective, which aligns closely with the notion of 'groupthink'. Groupthink is defined by Janis (1997) as:

> *'a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action'* (p. 237).

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Shirey (2012) highlights that in the presence of groupthink, *'groups examine few alternatives, are not highly selective in gathering data for analysis, fail to challenge assumptions, and do not look beyond the immediate environment for answers or expert direction'* (p.69). In this study nurses repeatedly reflected on the actions and decisions of other nurses rather than their own when enacting 'last resort', demonstrating conformity. Therefore, it may be as a result of groupthink that nurses continue to use restraint as a 'last resort', even when they are aware of its negative impact. The concept of groupthink has not been linked with restraint use in other literature and further exploration is needed.

The lived experiences of the nurses also suggested that the perceived risk in relation to dealing with aggressive patients created a mood of fear. In the wider literature, underlying and influencing factors in determining risk, such as fear, have been relatively unexplored and under-theorised (Furedi, 2006; Jacob & Holmes, 2011). Literature has illustrated that nurses working under threat are compelled to redefine their interactions and choice of interventions with patients (Duxbury & Whittington, 2005; Foster et al., 2007; Jacob & Holmes, 2011). Some studies have also demonstrated mental health staff engaging in legitimation narratives both on a collective and individual basis with respect to restrictive practices (McKeown et al., 2020; Gadsby 2018; Perkins et al., 2012). In particular, McKeown et al. (2020) recently reported mental health staff claiming various forms of justification for the use of restraint such as, patients from certain populations and protection of staff and other patients. The study also described that *'rationalising restraint as a legitimate, last resort intervention both vindicated staff actions, and condoled those who would rather not administer coercive practices'* (p.454). Similarly, the participants in this current study demonstrated the 'just in case' or 'what if' perspectives that created fear and perhaps rationalised the use of restraint for the nurses.

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The strengths of this study are that it is the first to specifically explore the concept of 'last resort' in restraint use. The use of Heideggerian concepts enabled unique perspectives of 'last resort' to be identified. Participants were from a range of mental health inpatient services across provinces in Canada, thereby increasing the transferability of findings. Although, there was a relatively small sample size, it is commensurate with other phenomenological type projects (Smythe, 2011). Furthermore, although the participants were from various provinces across Canada and not localised to one geographical location, it is important to reflect that the findings may not represent the general mental health nursing population in Canada, and there may be further qualities to reveal. Further research is needed to corroborate or refute findings. Additionally, the Canadian mental health care culture may pose unique experiences and perspectives that differ from other cultures and countries, posing a limitation in transferring the findings outside of Canada. Lastly, the inherent bias of social-desirability in social science research, where the nurses may have reported what they believed to be expected of them may be compromising. Additional qualitative insights such as observational analysis to authenticate the nurses' accounts could prove useful.

Conclusion

This study set out to understand the concept of 'last resort' in the use of restraint among Canadian mental health nurses. Despite much recognition in the literature regarding restraint practices in mental health, there is a lack of inquiry that directly explores 'last resort'. This study has revealed that 'last resort' is composed of many elements, where it is a complex and multidimensional phenomenon. Many of the nurses had a difficult time recalling one experience of using restraint and generalised their recollections of the incident and the patient. Moreover, nurses took on a collective perspective in determining 'last resort'. Their lived experiences showed that their past impacted their perspectives of 'last resort' in the present. There was also a dependency on the knowledge and

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experience of other staff in order to mitigate the use of restraint. In addition, nurses resorted to informal generic algorithm-like approach to manage escalating situations rather than individualising care to the unique patient. Finally, 'last resort' may be determined as a result of perceived risk by nurses rather than actual risk. Further work is needed to better understand the results as mental health organisations continue their efforts in restraint minimisation. The continued understanding of 'last resort' may be critical in shifting practice and culture in mental health and restraint utilisation. The findings from this study are hoped to pave the way in this next level of understanding within the field of restraint minimisation.

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Relevance for Clinical Practice

The findings from this study have several possible implications. Firstly, debriefing may be a helpful antidote in relation to the nurses' accounts that illustrated how temporality and fear contribute to their perceptions of 'last resort'. Unaddressed negative experiences influence people's approach over time and therefore, it is imperative that timely support and interventions are provided. Secondly, the continued adoption of recovery-oriented practices and trauma-informed care may diminish the rationalisation of restraint use based on perceived risk, and de-individuation and generalisation of patients and care. Thirdly, enhanced understanding of de-escalation techniques and how to further integrate these into practice may reduce the strong dependency nurses have on other staff members' know-how. The development of skills in de-escalation for nurses on the individual level may support greater proactive strategies in care and individuation of patient needs to mitigate restraint use. Finally, exploring staff and team practices on wards in addressing groupthink. This may include implementing reflexivity practices among the team, critical evaluation of staff performance and getting explicit feedback from patients, and addressing team member composition to include diversity among them.

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Table 1: Participant Demographics

Pseudonym	**Years of Experience as MH nurses**	**Level of Education**	**Location**
Rebecca	17	Diploma	Ontario
Tom	10	Bachelor Degree	British Columbia
Sarah	13	Diploma	Ontario
Jayne	17	Bachelor Degree	Ontario
John	15	Diploma	Ontario
Molly	18	Bachelor Degree	Alberta
Melinda	1	Bachelor Degree	Ontario
Caitlin	5	Bachelor Degree	Ontario
Natalie	39	Masters	Manitoba
Aidan	18	Bachelor Degree	Ontario
Dana	41	Masters	Manitoba
Kelly	30	Bachelor Degree	Ontario
Amanda	22	Masters	Ontario

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Table 2: open-ended questions in semi-structured interviews

Can you recall a situation where you had to place someone in restraint and tell me everything you remember about that situation?   *How do you determine when restraint is used as a 'last resort'?*

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Table 3: The study's adoption of van Manen's stages of research activities (van Manen, 1997, pp. 31-34)

van Manen's Research Activity	Study's Adoption of Each Activity
1) *Turning to a phenomenon which seriously interests us and commits us to the world;*	*van Manen (1997) believes that every project of a hermeneutic phenomenological inquiry is driven by a commitment of turning to an abiding concern. In this study the available literature related to the topic was considered. The primary researcher's background, experiences and stated interest were reflected upon throughout the study. This involved participating in a pre-understanding interview to capture their perspective prior to the commencement of the study, sharing insights within the research team, and ongoing use of a reflexive diary.*
2) Investigating experience as we live it rather than as we conceptualise it;	*This component aims to establish a 'renewed contact with the original experience'. The experience one comes with is considered wisdom as a result of the practice of living, and in doing phenomenological research, this 'practical wisdom is sought in understanding of the nature of lived experience itself'. In investigating the phenomena 'last resort', in-depth semi-structured interviews with mental health nurses were conducted. All interviews were transcribed by the primary researcher, which provided an in-depth immersion into the phenomenon.*
3) Reflecting on the essential themes which characterise the phenomenon;	*van Manen describes this element as the process of reflecting and 'bringing into nearness that which tends to be obscure, that which tends to evade the intelligibility of our natural attitudes of everyday life' (p.32). This process involved re-listening to the audio files and reading and re-reading of the interviews. A computer software was also used to help support data analysis. This technical solution provided a simple and flexible approach in managing large sets of textual data. It also enabled greater visual opportunities to review the texts during the ongoing manual hermeneutic phenomenological analysis.*
4) Describing the phenomenon through the art of writing and rewriting;	*van Manen believes that in order to do justice to the 'fullness' and 'ambiguity' of lifeworld, writing will need to take form of a complex process of writing and rewriting which includes re-thinking, re-flecting, and re-cognising; going back and forth between the parts and the whole. This process is the hermeneutic circle, in which the parts and the whole text are understood with reference to each other. In this study, preliminary themes were identified which were further analysed and explored through writing and rewriting. This interpretive journey spanned over multiple edits, revisions, and discussions with co-authors.*
5) Maintaining a strong and oriented pedagogical relation to the phenomenon; and	*van Manen notes that to be oriented to an object 'means that we are animated by the object in a full and human sense' (p.33) In this study the research team kept up to date with*

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	current research, and presented findings at international and national conferences and events.
6) Balancing the research context by considering parts and whole.	*van Manen explains the importance of constantly measuring the overall design of the study against the 'significance that the parts must play in the total textual structure' (p.37). He notes that it is very easy for the researcher to get too buried in writing that one finds themselves lost, not knowing where to go or what to do next. The iterative nature of data analysis and reflexivity strategies helped to achieved this such as through sharing and discussing interviews and interpretations regularly with co-authors, and presenting the study findings at various conferences and educational forums. The work of Heidegger among others are central to van Manen's approach. In this study the findings guided our reading of wider philosophical texts to identify key philosophical concepts to help illuminate the meaning of 'last resort'. An approach adopted by others who use this methodological approach (Smyth, 2011).*

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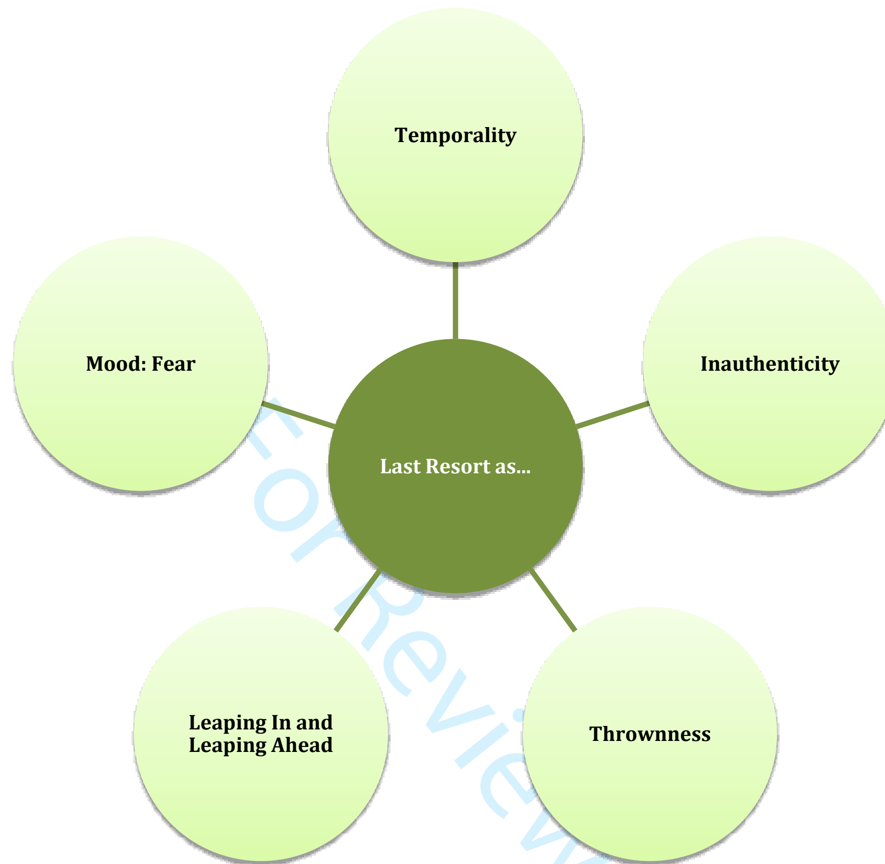
Figure 1: Visual depiction of the Heideggerian concepts



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