

# Post-incident reviews after restraints—Potential and pitfalls. Patients' experiences and considerations

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## Accessible summary

### What is known about the subject?

- Restraint has negative psychological, physical and relational consequences for mental health patients and care providers.
- Several countries have implemented seclusion and restraint (S/R) reduction programmes in which post-incident reviews (PIRs) including patients and care providers are one of several strategies.
- Existing knowledge indicates that PIRs have the potential to contribute to S/R prevention, but knowledge of the patients' perspectives on PIRs is scarce.

### What the paper adds to existing knowledge?

- The paper provides in-depth knowledge about patients' experiences of being participants in PIRs after restraint events.
- Patients experience PIRs to result in being strengthened and developing new coping strategies.
- The paper reveals pitfalls when planning and conducting PIRs that make patients experience PIRs as meaningless, feel objectified or long for living communication and closeness.
- The patients' mental state, the quality of the relationships and the services' care philosophies, influence patients' experiences of PIRs as supporting their personal recovery processes or as continuation of coercive contexts.

### What are the implications for practice?

- Patients' vulnerability during the PIRs must be acknowledged.
- Trusted persons or advocacy must support the patient in the PIR and thus reduce the power-dependence imbalance.
- The PIR must be conducted in a supportive, non-punishing atmosphere.
- Patients must influence planning for the PIR concerning time point and participants and themes to be discussed.
- The PIR forms should be extended to support the patients' empowerment and well-being.

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## Abstract

**Introduction:** Post-incident reviews (PIRs), including patients, nurses and other care providers, following incidents of restraints are recommended in mental health services. Few studies have examined patients' experiences and considerations concerning PIRs.

**Aim:** The study aims to explore patients' perspectives on PIRs in relation to how they experience participation in PIRs and further view PIRs' potential for care improvement and restraint prevention.

**Method:** We conducted a qualitative study based on individual interviews. Eight current and previous inpatients from two Norwegian mental health services were interviewed.

**Results:** The patients experienced PIRs as variations on a continuum from being strengthened, developing new coping strategies and processing the restraint event to at the other end of the continuum; PIRs as meaningless, feeling objectified and longing for living communication and closeness.

**Discussion:** PIRs' beneficial potential is extended in the study. The findings highlight however that personal and institutional conditions influence whether patients experience PIRs as an arena for recovery promotion or PIRs as continuation of coercive contexts.

**Implications for practice:** We recommend patients' active participation in planning the PIR. PIRs should be conducted in a supportive atmosphere, including trusted persons, emphasizing and acknowledging a dialogical approach.

## KEYWORDS

acute mental health, care philosophies, experiences, nursing, patients, post-incident reviews, restraints

## 1 | INTRODUCTION

Although users of mental health services have for decades described experiences of dehumanization after being restrained, physical and mechanical restraint (i.e. belts, restraint jackets, straps or physical holding) is still frequently conducted in mental health services in western countries (Dumais et al., 2011; Oster et al., 2016; Steinert et al., 2010). Dehumanization consists of psychological consequences such as (re)traumatization, distress, fear and damaged therapeutic relationship, the latter a cornerstone of all treatment and care (Cusack et al., 2018; Husum et al., 2019; Nytingnes et al., 2016). In addition, grave physical consequences and even death are documented (Mohr et al., 2003; Rakhmatullina et al., 2013).

International development of laws is moving towards a more critical attitude regarding coercive measures, especially on people in vulnerable situations, that includes a ban on all kinds of such measures (United Nations, 2013, 2017a). Following the USA, several European countries, Australia, New Zealand and Canada have implemented seclusion and restraint (S/R) reduction programmes where rigorous debriefing including patients and care providers together is

one of several strategies. These programmes, mostly implemented in services that base their practices on human care philosophies, seem promising regarding S/R reduction (Hammervold et al., 2019; Huckshorn, 2004; LeBel et al., 2014). It is however difficult to assess how much the different interventions individually contribute to these supposedly promising results (Goulet et al., 2017; Hammervold et al., 2019).

Rigorous debriefing or post-incident reviews (hereinafter referred to as PIRs) including patients and healthcare providers are the focus of this study. A PIR intervention is "a complex intervention, taking place after a S/R episode and targeting the patient and healthcare team to enhance the care experience and provide meaningful learning for the patients, staff, and organisation" (Goulet & Larue, 2016, p.127). The practice and outcomes of PIRs are scarcely explored in scientific literature, but studies indicate that PIRs are in line with recovery-oriented and reflexive, ethical care cultures in mental health services and have a potential for prevention of restraint (Goulet et al., 2018; Hammervold et al., 2019, 2020). These potentials of PIR are particularly of importance for nurses who often engage in coercive practices and are supposed to perform care before and after restraint use.

In previous research, care providers describe PIRs as useful related to care improvement, based on knowledge about new perspectives and solutions, increased ethical awareness and opportunities for emotional and relational processing (Bonner & Wellman, 2010; Goulet et al., 2018; Gustafsson & Salzman-Erikson, 2016; Hammervold et al., 2019, 2020). The potential of PIRs seems however not to be fully utilized. As we documented in another study in this ongoing PhD-project, the care providers struggled to get a hold of the patients' voices in the PIRs (Hammervold et al., 2020). The interviewed care providers related this phenomenon to the patients' mental condition and further institutional and cultural conditions (Hammervold et al., 2020).

In our scoping review, we also found that patients' voices were weakly represented in scientific studies, as only four studies explored or referred to patients' perspectives on PIRs (Hammervold et al., 2019). Bonner and Wellman (2010) found in a survey study that 94% of the patients ( $n = 30$ ) found PIRs useful after restraint incidents. The patients' positive views were based on being given an opportunity to map antecedents to the restraint event and, further, give expression to how they experienced the restraint event was managed. Risk of bias is, however, discussed as the study's response rate was 100%, which the researchers linked to the participants' enthusiasm for the research project. Therefore, Bonner and Wellman (2010) declare that the findings may not reflect the views of patients who were reluctant to participate in the PIRs.

Lanthén et al. (2015) interviewed 10 out-patients about their experiences with being exposed to restraints when being admitted. The results included statements about PIRs, which the participants expressed to be helpful with respect to adapting restraint-related traumas. The researchers however problematize the participants having been currently, or previously (at some point in life), subjected to compulsory psychiatric care. Therefore, their experiences could have been retrospectively reconstructed.

Only one pilot study, ( $n = 3$ ), (Goulet et al., 2018) touches upon the patients' considerations on how practical organization of PIRs should be performed. One patient suggested that the PIR be conducted about one week after the event, while another patient emphasized the necessity of feeling safe in the encounter. As the study explored PIRs after both restraint and seclusion, and the number of patients was low, the study's information power (Malterud et al., 2016) is consequently weak.

Lastly, aiming to describe patients' perspectives on what occurred before, during and after a restraint event, Ling et al. (2015) conducted audits on patients' charts containing PIR debrief forms ( $n = 55$ ). The researchers concluded that PIRs by a structured written form allows patients and care providers to develop greater understanding of restraint events. Further, they concluded that the information collected through PIRs should inform treatment and care plans. A limitation in Ling et al. (2015) was however that care providers or interpreters in some circumstances helped the patients, or wrote answers to the questions, making it more uncertain what the patients' own voices were expressing.

In conclusion, patients' perspectives of the utility of PIRs are generally scarce. Further, we have not found studies that explore how patients experience being a participant in PIRs and what conditions may influence their participation.

## 2 | RATIONALE, AIMS AND RESEARCH QUESTIONS

The patients' aspects are virtually absent regarding participation in PIRs. Therefore, it is our vital interest to increase knowledge of PIRs by exploring the patients' perspectives on participation in PIRs in relation to exploiting PIRs' intentions.

We ask the following questions:

What are patients' experiences and considerations about participating in PIRs after restraint events?

How do patients view PIRs' potential for care improvement and restraint prevention?

## 3 | METHODS

To investigate patients' experiences and views on PIRs, we performed an explorative descriptive study design with a phenomenological hermeneutical approach to get patients' own stories about restraint events and the following PIRs. Consequently, we chose a qualitative design with an inductive approach based on individual interviews. Individual interviews were appropriate to reconstruct persons' previous lived experiences (Mason, 2018), in this study, patients' lived experiences with PIRs.

### 3.1 | Setting

The international movement towards more critical attitudes about coercive measures also applies to Norway, where the Civil ombudsman annually reveals disgraceful conditions in mental health services and consequently directs reforms (Sivilombudsmannen, 2018). Moreover, Norwegian authorities in 2017 legalized evaluation of all kinds of coercion together with the patients in mental health services aiming at knowledge development, prevention of repeating restraint events and quality improvement (Norwegian Mental Health Care Act, 1999).

We conducted the study in two Norwegian mental health services: one university hospital and one community mental health centre that according to Norwegian laws are given permission to use coercion based on their emergency and acute services (Norwegian Mental Health Care Act, 1999). Both are serving people with serious mental challenges such as psychosis and affective disorders, sometimes combined with addiction problems. The two services

had implemented the PIR procedure some years before Norwegian legislation of PIRs in 2017. PIRs were implemented as an isolated intervention, neither as a part of S/R reduction programme nor connected to defined care philosophies in the services.

The implementations were inspired by the British NICE guidelines (2015) and The Danish Mental Health Care Act, §4, but we did not find that they rely on any theoretical perspectives. The procedures were not revised during the study period.

Table 1 illustrates the two services' PIR procedures.

### 3.2 | Sample and recruitment

Inclusion criteria comprised Norwegian speaking patients above 18 years who had lived experiences of participation in minimum one PIR after being restrained. The patients' therapists assessed the patients' ability to provide informed consent before they were asked to participate in the study. Eight persons accepted participation in the period 10/2015–11/2018.

Five patients were admitted in Service 1 (three different ward units), and three patients were admitted in Service 2 (the same ward unit).

Aiming at broader assessment and understanding of patients' experiences and considerations on PIRs, we would ideally recruit additional participants. We were not allowed to present the study to the patients directly, consequently we were dependent on the care providers' efforts in the recruitment process. Despite regular enquiries to the ward units' leaders, no more participants showed up. The feedback from the services was that the restraint rate was low (Service 2), they had not conducted PIRs lately, the implementation rates on PIRs were difficult to follow, but reportedly low, (<10% in Service 1), or the patients did not give their consent to participate in the study. Given the lack of research concerning patients' views and experiences, we nevertheless found that it was of vital interest to listen to the perspectives from the eight participating patients in order to contribute to extended knowledge about PIRs.

### 3.3 | Participants

There was a gender imbalance among the study participants, seven women and one man. There were no obvious differences in the one interview with the man compared with the interviews with the women, nor did we find focus on gender in the literature.

The participants had all experienced several episodes of restraints during their admissions, and they had all previous experiences of not being offered PIR afterwards.

Four participants were still inpatients when interviewed, while the four other participants were discharged from the services. The inpatients talked about recent participation in PIRs, three of the outpatients had participated in PIRs during the last three months and one had participated in a PIR 2 ½ year before the interview. Two participants had participated in one PIR, one in two PIRs, the others were uncertain about the number of PIRs because of confusion with ordinary therapeutic consultations.

### 3.4 | Planning and conducting interviews

A semi-structured interview guide was conducted to ensure that common themes were illuminated but based on the study's design gave room for other issues as well. During the development of the interview guide, a draft was presented to an advisory group, at this stage two patient consultants in mental health services where the one had multiple personal experiences of being restrained. They gave valuable input that contributed to nuancing the first author's preconceptions and consequently expanding the focus of the interviews.

The interviews were performed by the first author, a trained nurse with considerable clinical experiences from mental health services. Four of the interviewees were still inpatients, and the interviews took place in their respective ward units. Interviews with the outpatients were performed in line with the interviewees' preferences: the interviewee's home, in a mental health centre and the university. The interviews lasted 15–90 min, mean time 44 min.

TABLE 1 The two services' PIR procedures

	University hospital	Community mental health centre
Time point	As soon as possible after the restraint event, if possible not later than 72 h	As soon as possible and latest by discharge
Participants	Should be led by a person not involved in the restraint incident. One care provider involved in the restraint event should participate.	Patient, eventually next of kin, contact nurse or available familiar nurse and responsible therapist
Themes in the PIR	<ul style="list-style-type: none"> <li>The service user's experience of the restraint event and how the occasion was conducted?</li> <li>The services user's comprehensions of reasons for conducting restraint, the effect of the measure and if the service user consider that the event was inevitable.</li> <li>The care providers' comprehension of the situation, the rationale for conducting restraint and the measure's effect</li> </ul>	<ul style="list-style-type: none"> <li>What contributed to the restraint event?</li> <li>What were the care providers' arguments for conducting restraint?</li> <li>How did the patient experience the restraint measure?</li> <li>How did the restraint measure appear?</li> <li>What does the patient want the care providers to do in similar situations?</li> </ul>
Documentation	PIR documented in electronic journal as a note. The service user receive a copy and may comment on the document.	PIR documented in electronic journal as a note

Aiming to get a backdrop for the PIR, the participants were initially asked to speak briefly about the restraint event, followed by questions that dealt with point in time, participants and content in the PIR. Further, they were asked about positive and negative experiences regarding PIRs, which included attention to atmosphere, climate for openness and practical proceedings. The patients were finally asked how they thought the participating care providers experienced the PIR and if they knew how the PIR was documented.

### 3.5 | Analyses

The first author transcribed the audio-recorded interviews and analysed the interviews using NVivo 12 (2016). We found some parts of the stories so extensive and expressive that we wanted to present them as an introduction to the results. Therefore, we used elements from narrative analysis (Riessman, 2008) combined with Lindseth and Norberg (2004). This method is claimed to be well suited to grab “the good and bad,” not only what the interviewee says, but also “what they talk about” (Lindseth & Norberg, 2004, p.146), whereas our task was to elucidate essential meaning as it is lived in human experience.

Initially, each interview was repeatedly listened to and read as open-mindedly as possible to obtain a general impression of the whole. After this naïve reading, thematically structured analyses were conducted by identifying meaning units (one or more sentences related by their content) and further condensed meaning units. The condensed meaning units were then reflected on regarding similarities and differences and further abstracted to subthemes and themes that are close to the participants statements (Lindseth & Norberg, 2004). To enhance the credibility of the study, the analysis has been carried out by three researchers.

In order to develop a comprehensive understanding of the patients' experiences and considerations with PIRs', the main themes were reflected on among the authors in relation to the naïve reading, the research questions, the study's context, the advisory group and relevant literature (Lindseth & Norberg, 2004). These mutual reflections contributed to revising, widening and deepening the understanding of the findings and contributed to the discussion on how the findings may open possibilities for alternative practices.

In the whole process, we emphasized presenting the participants' perspectives as faithfully as possible and further formulating results in everyday language as close to the lived experience as possible (Lindseth & Norberg, 2004).

Table 2 illustrates the analysis, indicating the abstraction process from subthemes and themes, and lately main themes as a result of the theoretical analysis.

### 3.6 | Ethical considerations

The Norwegian Social Science Data Service (ref.nr. 39122) assessed and approved the study. The Regional Committees on Health

TABLE 2 Subthemes, themes and main themes

Main themes	PIRs as arena for recovery promotion	PIRs as continuation of coercive practices
Themes	Being strengthened	Longing for living communication and closeness
	Developing new coping strategies	Feeling objectified
Subthemes	Being processing	Feeling neglected
	Putting a full stop	Being met by theories and rules
	Exploring new strategies	Being met as a category
	Searching for new solutions	
	Experiencing influence by participation	
	Being assessed as a responsible participant	
	Being asked about individual preferences	
		Considering PIR as meaningless
		Not being informed about the purpose of PIR
		Being overheard
		Being indifferent

Research Ethics (REK) decided that the study did not require further ethical approval (project number 2013/2359). In line with the Helsinki Declaration, written and oral information were provided to the participants, including the participants' right to withdraw at any stage without explanations or consequences, and their consent and confidentiality were secured (Declaration of Helsinki, 2013).

The first author ensured beforehand that discharged participants had the possibility to contact professional care providers regarding eventually emotional reactions after the interviews.

Finally, anonymity is preserved in the text, and all names are pseudonyms.

## 4 | FINDINGS

The participants described the preceding restraint events differently, from indifference to

variations of physical and psychological infringement. The latter spoke about feeling angry, powerless, afraid and lonely, in addition to experiences with ripped clothes and marks on extremities.

The patients' feedback on PIRs revealed two main narratives with some overlap:

(1) Stories about being strengthened, processing the restraint incident, and developing new coping strategies and (2) stories about feeling PIRs as meaningless, feeling like an object and longing for living communication and closeness.

The results will be presented with an introductory narrated story that is elaborated with themes exemplified by quotations from the patients.

### 4.1 | Stories about PIRs as being strengthened, processing the restraint incident and developing new coping strategies

Two participants, discharged from respectively Service 1 and Service 2, experienced the PIR as mainly supportive, based on being strengthened, processing the restraint incident and developing new coping strategies. They participated both in the encounter together with their therapist and contact nurse. Elisabeth (5) had PIR the day after the restraint event, while Hilda (8) had PIR at the end of the admission. Elisabeth had been restrained six times and had participated in PIRs after the last two incidents. She told about her first PIR:

(.....) I was able to explain myself without interruptions and give a full briefing of the incident (...) no interruption, I was able to talk freely (...) Being asked directly "What do YOU think could have been done to prevent it from happening" felt good (...) they realised they had to listen to me, I learnt to give notice earlier (.....) In any case I got a new attitude to the help when I realised that they were not out to get me and that

they didn't want me to suffer (...) it was as if I simply put it behind me (..) and called it off (...) therefore such talks are important; being seen, heard and believed (5)

A central theme in Elisabeth's story about PIRs was the experience of feeling *strengthened* by being met as a person whose experiences and considerations regarding the restraint incident were assessed as significant. After the previous four restraint incidents, care providers had asked if she had comments about what had happened, a question she perceived as so vague that she chose not to respond. Elisabeth was therefore initially not interested in participation in the PIR. Her doctor formulated however in advance the purpose of PIR, consequently Elisabeth had a clear understanding that the aim was to get insight into each other's perspectives and thus prevent new restraint episodes. To Elisabeth, it was nearly a turning point that she understood the purpose of PIR and further experienced the encounter as an arena where she was "allowed to have a voice and became seen and believed," consequently, she perceived her experiences and views as having been acknowledged. However, even though Elisabeth (5) experienced the PIR as mainly positive, she found it inconvenient that the nurse responsible for the restraint decision had not participated in the encounter. She and the nurse had divergent apprehensions of the preceding circumstances. She proposed therefore that waiting a couple of days to include that nurse in the PIR could have ensured her interests in a more optimal way.

Like Elisabeth (5), Hilda was prepared for PIR as she and her contact nurse had reflected upon the restraint events several times beforehand. For her, it was appropriate to participate in PIR at the end of her admission. She argued that her mental condition then was improved; thus, she could better use her legitimate right to "declare what you think, what they have done wrong and what they might have done differently" (8).

Both Elisabeth (5) and Hilda (8) highlighted *processing* the restraint incident as a positive aspect of the PIR. Elisabeth told about the possibility to "brief herself through the restraint event" that contributed to "putting a full stop" on it. Also, Hilda (8) drew attention to the concept "putting a full stop" by saying "you will always carry it with you, but if you're allowed to finish what you want to say, and everybody agrees how it was and what happened, you get it over and done with, you call it off pretty soon" (8).

Some patients said that the care providers had given them an explanation for effectuating restraint measures that contributed to increased understanding of the event.

For Elisabeth, it was of utmost importance that the care providers acknowledged the grievousness of conducting coercion and consequently focused on guarding against such practice:

They did what they thought was best and they meant no harm. And that's quite true, I guess they certainly didn't. But it's not what you want to hear (.....) You need them to understand that this is a major intervention and something that should not happen. And I

believe they should be more focused on that, so that it doesn't happen again (5)

Elisabeth and Hilda both spoke about PIRs as an arena for *developing new coping strategies*. Elisabeth (5) told that she in the PIR learned to ask the care providers for support before placing herself in a safe corner in the living room, something that usually initiated the restraint incidents. By understanding that the care providers had not wanted to hurt her, she became more receptive to help and collaboration with the care providers about other strategies. Hilda (8) said that in the PIR they focused on how she could be more active in taking initiatives when she struggled and that she together with the care providers worked out a mutual agreement on how to handle situations that might provoke restraint incidents. To Hilda, receiving care in the most peaceful seclusion room helped her to calm down and thus capable of cooperation, which resulted in fewer restraint episodes.

#### 4.2 | Stories about PIRs as meaningless, feeling like an object and longing for living communication and closeness

Other patients' experiences varied from indifference to more negative descriptions of their participation in the PIRs. They said that they found no meaning in participation in PIRs based on previous experiences of no influence in the services and experiences of their needs not being met in the PIR. Consequently, they said they did not talk much in the encounter. The following compound story represents their experiences:

I took part in that conversation because I was told to. I guess I was a bit resigned. There's no point in talking about such unpleasantness as it doesn't help no matter what. Apart from that, PIRs are usually very short, just a few minutes really. I think it's too little, as if they really don't care that much. Afterwards I was left with a bad feeling; oh – was that it? I could have said I wanted to tell my side of it, but they didn't ask. I was kind of taken aback afterwards (...) it's almost like a survey; it's what they all ask for. We're not equal, are we?

For several patients, the time point for the encounter and participants in the PIR were unclear, except from the issue that it was either a doctor or a psychologist who chaired the PIR. Some patients had trouble distinguishing PIRs from other therapeutic meetings as they said that they were not informed about the aim and purpose of the encounter. They considered participation in the PIR as *meaningless* as they did not trust PIR as an arena for real dialogue, based on previous experiences characterized by restrictive environments and lack of influence. Gerda expressed: "What I have learnt after 20 years in psychiatry is that what I have to say means nothing" (7). Several participants found the organization and content in the PIR to confirm

this attitude. They said they had no influence regarding practical arrangement of the encounter. Beth (2) said she "showed up in the PIR because she was told to." Further, several patients considered the time point of the PIR as too early after the restraint event, consequently they were not mentally capable to reflect as they otherwise could have done.

Stories about *being met like an object* dealt with the feeling of fitting into a category in a practice that was experienced as manual-based. Gerda said that "When you're in a place like this and you're under duress, it's all about following the book and principles, rules and such. They don't grasp that we're different." (7).

Cecilie (3) experienced the PIR like participation in a survey, as all the patients were asked the same questions, which she considered wrong as patients are unequal persons. She suggested that a real dialogue instead of answering questions from a form would be more meaningful to her. Even though Cecilie (3) felt disappointed after the PIR, she appreciated however being asked whether she preferred to be physically held or restrained by belts when situations got out of control.

Beth (2) said that in the PIR she had not mentioned her experience of being talked about, not with, when she was restrained, as she considered that issue not to fit in the questions asked in the procedure form.

Some patients described that they were disappointed after the PIR because of the marginal timeframe and the form and content in the encounter. By *longing for living communication and closeness*, Cecilie (3) expressed several patients' experiences when she said she had been taken aback when the PIR was rounded off, as she had a need to talk and did not experience PIR as a dialogical meeting:

I would have made more out of it (...) I would have said some more on the issue and wanted to try and understand it in a different way. Because, with basis in a question you understand quite a lot, but you don't understand everything, do you? There's so much more behind the questions (3)

Daisy (4) said she did not talk much in PIRs especially if she perceived the care providers as insensitive. Further, she concluded that the care providers didn't seem to care very much as PIRs' were rounded off so quickly. To accommodate her longing for closeness, she suggested that the care providers could sit down and hold her hand both when she was restrained and in the PIR. Regarding taciturnity in the encounter, some patients expressed sympathy with the care providers regarding the fact that they did not share their experiences, as Daisy expressed:

To my mind it must be very frustrating to initiate a conversation, and when they ask why do you become restless, and what can we do, and when I just sit there, looking like a question mark, I don't know (... ..) that must be very hard for them, and then, what are they going to do? (4)

## 5 | DISCUSSION

### 5.1 | Main findings

The main findings in this study show that the patients had various experiences of PIRs that can be placed on a continuum from mainly positive, via indifference to mainly negative experiences. The findings seem however to be mostly about how the PIRs were organized and how the patients experienced being met in the encounters and as inpatients incidentally, and less about the utility of the PIRs.

Related to the definition of PIRs (Goulet & Larue, 2016), the findings of PIRs as beneficial, based on being strengthened, developing new coping strategies and processing the restraint event, point first and foremost to development of knowledge as an outcome of PIRs. Patients experiencing the development of new coping strategies in PIRs are, as far as we know, a finding undescribed in previous studies. Within a personal recovery perspective (Slade 2009), new coping strategies imply that the patients are empowered by keeping some responsibility should new crises occur. The care providers' role will then be to support the patient to adopt the new strategies aimed at preventing the use of restraint (Slade, 2009).

The other aim in the definition of PIRs, enhancing the care experience (Goulet et al., 2018), was reflected in processing the restraint event in the PIR. That finding is in line with the study of Lanthén et al. (2015) where previous patients emphasized PIRs as a way to process the restraint experience so as to prevent restraint-related traumas. This topic, PIRs as being suitable for processing damaged relationships, as described in studies exploring care providers' experiences of PIRs (Goulet et al., 2018; Gustafsson & Salzman-Erikson, 2016; Hammervold et al., 2020), did not come up as a finding in our study.

The patients who described participation in PIRs positively, emphasized being prepared for the PIR, being motivated by getting information about the aim and purpose of PIRs, and further experiences of being met in a supportive atmosphere.

In light of Buber's dialogical approach (Buber & Smith, 2004), we understand these patients' experiences as being met in a Subject-Subject relation, and thus in a supportive atmosphere, which is described as a premise for PIRs (Azeem et al., 2011; Bonner & Wellman, 2010; Goulet et al., 2018). In a frame of personal recovery philosophy, the patients' experiences seem thus to support processes like agency, identity, hope and empowerment (Leamy et al., 2011; Slade, 2009). Therefore, a comprehensive understanding of these patients' experiences is PIRs to be an opportunity to support the patients' personal recovery processes, assuming that the PIR is conducted in a supportive environment. This finding is in line with previous studies expressing care providers' experiences of PIRs (Hammervold et al., 2019), but it is only hinted at in studies that explore patients' perspectives on PIRs (Goulet et al., 2018; Ling et al., 2015).

In contrast to the positive experiences of PIRs, the findings in our study show that several patients struggled to participate actively in the PIRs. We have only found this phenomenon in one previous

study in the same project, a case where care providers had trouble gaining access to the patients' voices in the PIRs (Hammervold et al., 2020). The care providers suggested several factors to influence, among them the services' procedures that claimed PIRs be conducted within 72 h after the restraint event. The care providers reflected then that PIRs were conducted before the patient had time to congregate afterwards (Hammervold et al., 2020).

The fact that several patients in this study experienced the PIR as indifferent or negative and had vague memories about the time point and content in the encounter indicates that the patient's mental condition and consequent ability to participate in the encounter was not sufficiently assessed.

The findings in this study show that the patients' lack of engagement in the PIRs are closely related to the institutional contexts still characterized by features of total institutions (Goffman, (1961/1991)). The institutional context, and thus the PIR context where the power imbalance between patient and care providers is prominent, contributed therefore to patients' experiences of the PIR as a *continuation of coercive contexts* (Sjöström, 2006). Consequently, the patients' lack of engagement concerning participation in PIRs may be interpreted as an expression of counterpower (Goffman, (1961/1991)), a resistance towards the perceived coercive contexts or lack of belief that their opinions actually matter.

The power dynamics in mental health services are particularly stark, and they may, according Greenhalgh et al., (2015), suppress the patients' voices. Consequently, "much of the patients' agenda will not get aired in the consultation" (Greenhalgh et al., 2015, p.3). As being restrained often results in feeling dehumanized (Norvoll & Pedersen, 2016; Nytingnes et al., 2016; Wilson et al., 2017), the patient will thus participate in the PIR in a particularly vulnerable position. According Sjöström (2006), various sources enhance the power imbalance such as the patient's role as an inpatient who needs help, the expert-layman nature of the relation and authoritarian traditions in mental health services.

Theory of power-dependence relations (Emerson, 1962) may further illuminate the power imbalance between the patient and the care providers in the PIRs. Emerson points out that treating persons or groups as actors in a power network may be useful when analysing complex power structures. He describes these as *balancing operations*, that is, changes in some variables that may reduce the imbalance in the relationships. The first operation, "withdrawal," can be recognized in this study's participants who were indifferent or reluctant participate in the PIR, a strategy Emerson (1962) describes as appropriate when the relation's weaker member considers the relation unbalanced and to their disadvantage.

The predominance of care providers in the PIRs was one of several alternative explanations presented by care providers regarding their experiences of struggling to get a hold of the patients' voices in PIRs (Hammervold et al., 2020). The patients in this study did not express the numerical imbalance as important; the quality of the relationships between the patient and the care providers seemed, however, to influence the patient's perceived experience of the



encounter. Understanding the quality of the relationship and the encounter, according to Emerson's (1962) second balancing operation, "extension of the power network," highlights vulnerability and being in minority. Emerson (1962) claims that the formation of new relationships by including new members in the network not only contributes to increased numerous balances, but it may also improve the interactions.

The findings show that the two patients who experienced the PIR as positive, point to the information available beforehand, the supportive environment and the care providers' statements that the aim of PIR was the prevention of repeating restraint events. In light of Emerson (1962), the care providers thus increased motivational investment in the goals and strategies defined and expressed by the weaker part, here the patient. In addition, this third balancing operation, emergence of status, will by acknowledging the patients' expertise by experience contribute to reducing the power imbalance (Sjöström, 2006).

Within a frame of personal recovery philosophy, episodes of acting out or relapses are labelled as "crises," which indicates that the episode may be a learning opportunity (Slade, 2009). The participating services' PIR procedures did not, however, include asking the patient whether one could have managed the situation in a different way, as suggested in other studies (Ashcraft & Anthony, 2008; Goulet et al., 2018; Ling et al., 2015). Being asked about alternative ways of handling, the situation in a supportive atmosphere could increase the patients' responsibility, and accordingly support the patients' empowerment and consequently their personal recovery processes (Barker, 2012; Leamy et al., 2011; Slade, 2009). In a disciplining environment (Goffman, (1961/1991)), question about alternative strategies may, however, be perceived as blaming, thus increasing the patient's vulnerability.

This study did not reveal explicit knowledge about PIRs' potential for care improvement and restraint reduction at the organizational level that is suggested in a previous study (Petti et al., 2001). The findings do however point to the importance of services' care philosophies that emphasize patients' involvement and dialogical and collaborative approaches. This is in line with another study in this PhD-project where care providers who experienced PIRs as beneficial due to potential to improve the quality of care, seemed to perform an acknowledging, dialogue-oriented approach in the PIRs (Hammervold et al., 2020).

Based on Tronto & Fishers' (1993) responsibility to "take care of," we address the organizational challenges to the services' managers, that means ensuring that structural and cultural conditions have been facilitated which safeguard the care providers' professional and moral competence and thus provide patients' optimal treatment and care.

## 5.2 | What the study adds to existing research

This study provides in-depth knowledge about patients' experiences of being participants in PIRs.

The study extends the knowledge about PIRs' potential to be an arena for patients to be strengthened and develop new coping strategies.

The study contributes with knowledge of potential pitfalls, such as the patients' position of powerlessness that may hamper the patients' motivation for, and participation in, the PIRs.

The study extends knowledge of the importance of the services' care philosophies related to care generally, as well as how the PIRs are planned and conducted.

## 6 | METHODOLOGICAL CONSIDERATIONS

The strength of the study is that it explicitly sought perspectives on PIRs from persons who had first-hand experience of PIRs' after restraint events. In addition to contributing to the existing knowledge base, the study reveals a need for more explorations of how to support patients to participate actively in PIRs. Even though the interviews were conducted in a period of over three years, we consider the study's dependability to be maintained. The services' PIR procedures and the study's interview guide were unchanged during the period. As PIRs involve different persons, neither the PIRs nor the interviews would be identical even if conducted in a short period of time (Blaikie & Priest, 2019).

Despite our desire for additional study participants, we considered the eight interviewees to contribute to sufficient information power based on their being highly specific for the study aim and that the dialogues were strong (Malterud et al., 2016).

A limitation may be that the two participants who experienced PIRs positive had been outpatients for some time when they were interviewed (3 months and 2 ½ years). That fact actualizes the challenge of retrospective interviewing months and even years after the conducted PIR, as memories and emotions may be reconstructed or stirred up both by time, personal growth and the development of new concepts and ways of thinking (Dahlberg et al., 2008; Repstad, 2007; Slade, 2009). Therefore, reflecting about PIRs months or years after the experience may cause the patient to see the beneficial aspects of the PIR more clearly than after just a few days. Patients' considerations of their participation in PIRs should thus be explored both in the short and long term. Nevertheless, we consider the participants' comprehensions when interviewed to have an important function as we all bring our stories of the past to consciousness today to deal with an uncertain future (Ochs, 1997).

We do not exactly know the reasons why we failed to recruit more study participants. Getting access to services who would give permission for the empirical part of the study was a challenge as several services were contacted before the two participating services permitted the study.

Further, care providers' eventual assessments of the patients as vulnerable, also raises the problem of gatekeeping, that is feeling obligated to protect the patients against issues that may threaten



their well-being (Carlsson et al., 2017; Witham et al., 2015). We will anyway emphasize the importance of giving ear to the few with experiences of PIRs and recommend further studies to include more patients' voices.

The criterion of credibility of the study pertains to the authors' thorough knowledge of structures and cultures in mental health services. Credibility was further strengthened as the first author discussed results with co-authors and research groups, which were further confirmed by the advisory group.

## 7 | CONCLUSION AND IMPLICATIONS FOR PRACTICE

The findings in this study extend knowledge from previous studies that find PIRs potentially helpful to both patients and care providers as PIRs may contribute to the development of the patients' coping strategies. However, first and foremost, the findings support the importance of conducting PIRs in supportive environments that emphasize collaboration and an acknowledging dialogue to elicit the patients' voices in the PIRs.

As the findings mirror that mental health services still base their practices on clinical recovery perspectives that have features from total institutions, attention must be directed to both individual and structural conditions in the services. The pitfalls of conducting PIRs must be highlighted, consequently PIRs should be conducted in a frame of human care philosophies that recognizes the power-dependence relationship and the patients' vulnerability after restraint events.

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Aiming to strengthen the weaker member, the patient, in the PIRs, the members in power, here the care providers, can contribute to achieve more balance in the power-dependence relationship by increasing their motivational investment in the goals and strategies defined and expressed by the patients in the PIR dialogue and further documented in care plans or joint crisis plans (Henderson et al., 2004).

To support the patients' engagement for participation in PIRs, they should receive tailored information about the aim and purpose of the encounter. As the patients had individual views on when and how the PIR should be conducted, they should influence the planning for the PIR. The time point for the PIR should be flexibly based on the patients' mental health condition and preferences. Further, extension of the patient's power network through advocacy by peers, user consultants, contact nurse or other trusted persons may support the patient in the PIR (Levy & Payne, 2006; Ridley et al., 2018).

The PIR form in the services should be critically assessed, by (1) paying attention to the patients' motivation and capacity to take some responsibility for preventing new restraint events and (2) adding a concluding question about whether the patient needs to talk about something they have not mentioned in the PIR.

More studies are however essential to acquire knowledge of how to support patients' active participation in PIRs.

## 8 | RELEVANCE STATEMENT

There is international consensus about the importance of restraint reduction in mental health services, as the use of restraints has negative consequences for all involved. Different strategies have been implemented aiming at restraint reduction. In this paper, we explore patients' experiences of one of those strategies, post-incident reviews (PIRs) including patients and care providers after restraint events. The results add crucial insight into patients' perspectives regarding participation in PIRs, which are scarcely explored in previous studies. The findings extend the knowledge about PIRs as a useful procedure. Pitfalls are however identified that must be considered both on the individual and institutional levels.

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### CONFLICT OF INTEREST

The authors declare that they have no competing interests.

### AUTHOR CONTRIBUTIONS

A relationship was established among the authors prior to study commencement. UH, HS and RN conceived and planned the study. UH and HS developed the guide for the semi-structured interviews. UH conducted the interviews. RN and HS gave advice regarding the research questions explored and later provided constructive feedback regarding the interpretation of the results. UH wrote the first manuscript draft. All authors provided feedback on the draft manuscript and approved the final version.

### ETHICS APPROVAL

All participants provided written informed consent to participate prior to inclusion. The study was evaluated by the Regional Committee for Medical and Health Research Ethics (REK South-East, project number 2013/2359) and approved by the National Data Protection Official for Research (NSD October 15, 2014, project number 39122).

### DATA AVAILABILITY STATEMENT

Research data are not shared. The transcripts from the interviews are confidential and cannot be shared as this was not described when presenting the project to ethical committees. Consequently, the participants in the study were assured that the given information will be kept confidential.

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