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‘STREET LEVEL BRICOLAGE:

HOW INDIVIDUALS FIND PRAGMATIC WAYS TO CARE WITHIN THE CONTEXT OF RESPONDING TO BEHAVIOURS OF CONCERN’

THE LIVED EXPERIENCES OF STAFF WORKING WITHIN DOMESTIC & FORENSIC SETTINGS

A thesis submitted in fulfilment of the requirements for a

PhD in Social Policy

by L. P. Hollins

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[1] Serre, C. (1994). Le Bricolage, France: Glénat.

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Abstract

Individuals working in caring and supporting roles are required to respond to behaviours of concern. Various problem solving, diversionary and distractionary strategies can quickly and unexpectedly give way to a need for far more urgent and active interventions, up to an including the use of force or physical restraint. Such actions are widely castigated, with the currently national policy position requiring organisations to take steps to reduce, if not eliminate, their use. Whilst much research focuses on the strategies and approaches that underpin such reductions little is known about the day-to-day pragmatics of physical responses. Whilst it is recognised that complexity and uncertainty abound within events requiring staff intervention, little is known about how such situations are practically made sense of by staff. Staff from two different settings were recruited to explore their experiences. Four worked in a private dwelling as personal assistants funded to support a single person, and a further four from a large regional forensic inpatient service which catered to multiple individuals. Each was interviewed, and the findings analysed by drawing on IPA methodology (Smith *et al., 2021,* 2009). Individual Personal Experiential Themes were first identified, and then Group Experiential Themes compared. Street Level Bureaucracy (Lipsky, 1980) combined with 'Primary Task' (Rice, 1963), and 'Care Ethics' (Gilligan, 1982) provided the conceptual tools to explore the experiences of participants, whilst 'Bricolage' (Levi-Strauss, 1962), 'Mature Care' (Pettersen, 2012), 'Self-Regulation' (Vohs & Baumeister, 2004) and 'Resilience' (APA, 2018) subsequently provided the means to describe the morally infused physical adaptivity which was found in both cohorts. The findings suggest that this is different to physical restraint as currently defined and widely understood. It was often personally authored and can be recognised as caring. This has implications for local policy development, training and practice leadership.

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Chapter 1: Introduction

Context

Within UK health and social care settings, physical restraint has long been used by staff facing 'challenging' behaviours presented by adults with Learning Disabilities (Fitton & Jones, 2018; BILD, 2014; Hawkins *et al*., 2005). Whilst its use can be lawful, the ethics of it have long been questioned (Sturmey, 2009a; BILD 2009; BILD, 2004). The political will to address concerns was largely absent until the Winterbourne View scandal, where the physical abuse of service users was captured on film by an undercover BBC reporter (Dept. of Health, 2012). The Government then called for care providers to commit to the reduction of all types of restrictive interventions [including physical restraint]. Norman Lamb, the then Minister for Care and Support, stated:

> '…restrictive interventions have not always been used only as a last resort in health and care. They have even been used to inflict pain, humiliate, or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this' (DoH, 2014 p.5).

The legacy of Winterbourne, and something which has been compounded by further scandals, is that physical abuse and physical restraint have sometimes been unhelpfully conflated, and the focus very much on *not* restraining. This inadvertently makes any conversation about restraining, and in particular restraining *well*, difficult.

Researcher's Motivation

The original impetus for this study came from my personal experiences and observations, which led me to conclude that the physical restraint techniques which were routinely taught to staff were not retained or applied as prescribed. This was based on incidents I had been involved in and witnessed, as well as feedback from staff returning for refresher training. My vantage point was one of having been involved in such training for over 25 years, delivering courses aimed at preparing various workers to 'prevent and manage challenging behaviour', as well as being involved in martial arts training. It was common to see people struggle to reproduce techniques as prescribed, and to hear about responses that were 'make do' versions of the prescribed physicality. The training itself involved cascading information, and techniques which were deemed to be reliable and effective. Much of which came down from 'experts', who seemed to dwell comfortably within certainty.

Over time I had many conversations as I tried to understand why techniques dissembled, or more pointedly why particular types of physicality might surface in the response space. Originally, I felt there was some sort of gendered dynamic in play [ultimately gender as a construct was edged out following an early external review]. As my research started, I also began to question the certainty I had acquired over time through what might be described as cultural osmosis; I had been told these techniques worked quite emphatically, so they must do. If they didn't, the applicant must be doing something wrong. In losing the certainty I needed to be prepared to question everything, including myself. Even so I could not completely divest myself of myself. It will become apparent that my pre-existing frames of reference, particularly those linked to martial arts, surfaced from time to time as I made sense of the experiences of others. I am very transparent where this occurred, and reflexive. To be very clear, I have no wish to promote my way of knowing and understanding, rather I have honestly declared my process of sensemaking so readers can take account of it.

Study Aim & Research Questions

The aim was to explore staff experiences to gain a better understanding of what takes place within the physical responses to behaviours of concern, thus determining something of the nature of the translation of policy into practice. Whilst the national policy goal is to reduce or eliminate restraint, it is still widely used. This inquiry set out to access staff perspectives to better understand exactly how they experience physicality within their responses, to make a constructive contribution to necessary but difficult policy and practice discussions. To do the following research questions were answered:

> **RQ1**: How do staff experience the events that constitute a 'response' to behaviours of concern: their own thoughts, feelings, reactions and responses, and the context within which this all takes place?
>
> **RQ2**: In what ways do the practices disclosed within participant accounts align with those expected responses identified within guidance, such as policy documents and staff training programmes?
>
> **RQ3**: What conclusions (if any) can be drawn about these practices and the presence or function of the organisational primary task?

The selected methodology is expanded upon in detail in Chapter 4.

Scope

The study will focus on the lived experiences of staff responding to escalating or escalated behaviour ['behaviours of concern' henceforth]. Those working in learning disability settings were chosen because restraint is recognised as being common within them (Fitton & Jones, 2018).

Structure and Contents

Chapter two provides an overview of the relevant contextual literature. It examines aspects of the widely recognised three-tier public health-type approach to managing behaviours of concern, including interventions aimed at heading off distress and arousal, the use of calming de-escalation strategies and finally physical restraint techniques. The review reveals a paucity of evidence in support of reactive strategies. The growing body of 'risk' literature reveals restraint [or the use of force] can be painful as well as physically and psychologically harmful, and on occasion fatal (Aiken *et al.*, 2011). There is also a small body of literature that raises questions as to whether the physical fidelity of authorised techniques is maintained when they are translated from the static and largely predictable training environment into the dynamic and complex practice environment (Dickens *et al.*, 2009; Rogers *et al.*, 2006), as well as a recognition of 'field modification '(Paterson, 2007), where techniques are adapted in practice. At the time the literature review was being undertaken, the death in the United States of George Floyd at the hands of Police officers seems to have raised the public consciousness of the nature of restraint, with the knee on his neck captured by citizen journalists on mobile phones, being scrutinised around the globe. It seemed that an official technique in routine usage was being field-modified. A conversation around the role and function of modification seemed timely.

The literature review touches on 'restraint reduction' from a policy perspective. The public policy impetus to reduce recorded restraint within Mental Health/Learning Disability settings was consolidated by the publication of the 'Positive and Proactive Care' document (DoH, 2014) and foreshadowed in the Mental Health Act 1983: Code of Practice (DoH, 2015a). The literature also speaks to how staff experiences have added to wider understandings around restraint in different ways. It

has revealed disquiet (Cusack *et al*., 2018; Wilson *et al*., 2017), as well as how remaining present and attuned can inform the caring ways in which physicality is expressed (Bailey, 2015).

Chapter three provides an overview of those theories and approaches used to make sense of the findings. Many were considered as the research question was refined over time, but three were determined to be useful. The first, 'Street Level Bureaucracy' (Lipsky, 1980), provides a way of locating the lived experiences of staff involved in this study as it recognises policies are often implemented, and more pointedly interpreted and negotiated, from the bottom up, rather than the top down. A second body of theory relates to the 'Primary Task' (Rice, 1963), which allows one to understand an organisation's reason to exist, and to understand how staff members enact this. Finally Care Ethics (Pettersen, 2012; Tronto, 1993; Noddings, 1984; Gilligan, 1982; Ruddick, 1980) provides a standpoint that offers a way of understanding how staff relate to, and act towards, those enacting behaviours of concern.

Chapter four outlines the research methodology. The two participant cohorts that were recruited are introduced, those working in a domestic home and a forensic unit respectively. The research design that flows from the research questions, involves the use of audio diaries, semi-structured interviews, and the utilisation of a data collection and analysis process belonging to the Interpretative Phenomenological Analysis (IPA) methodology (Smith *et al.*, 2021, 2009). Chapter five examines the findings across the home cohort [setting one], providing a set of Group Experiential Themes [GET] (Smith *et al.*, 2021, 2009). The supporting case studies that serve this analysis are available in the Appendix. Chapter six replicates this analysis for the hospital cohort [setting two], with chapter seven then examines convergences and divergences across the two groups.

Chapter eight provides a discussion of the findings. In negotiating the complexity and uncertainty of responding to behaviours of concern, both sets of participants revealed a highly individualised, pragmatic physical containment methods during the early stages of their responses. This sometimes shifted to a closer approximation to approved methods in the concluding stages. It is suggested that 'mature care' (Pettersen, 2012) offers a way of understanding what happens in this space practically and ethically. It is in this messy space that staff become bricoleurs (Levi-Strauss, 1962), creative pragmatists who bring both their private and professional selves to bear in the formulation of a fitting response. In so doing, resilience (Foster *et al*., 2023) infused by 'Self-Regulation' (Vohs & Baumeister, 2004) were identified as key traits, allowing staff to keep going carefully when the going gets physically and mentally tough. This is a practice I have referred to as 'Street Level Bricolage'.

Whilst the study is a very small exploratory one, the findings and conclusions provide some grounds for questioning some of the orthodoxies present within the prevailing discourse, as well as training and policy narratives. Chapter nine provides a series of recommendations for future research. Chapter ten ends with a series of personal reflections. It elaborates upon the challenges as well as the thoughts and feelings experienced along the way, as well as speaking to the resultant personal and professional growth.

Chapter 2: Literature Review

Search Strategy

This chapter provides an overview of the literature addressed to the contextual issues relevant to a consideration of staff responses to behaviours of concern, with particular regard to physical restraint. In reviewing the literature, the starting search terms were 'physical intervention' OR 'physical restraint' AND 'learning disabilities'. Initial searches included restraint use in mental health services, on the basis that such services support individuals with a Learning Disability[2]. The ScienceDirect, Medline (ProQuest), PsycINFO, IngentaConnect, ERIC, EThOS, SCIE databases were used, as well as the SUPrimo, Google Scholar and Google search engines. Peer-reviewed journal articles, national guidelines and doctoral theses were all considered on a case-by-case basis. The review was iterative, using a snowball strategy of reference and citation tracking (Greenhalgh & Peacock, 2005). As the search widened, sources beyond the UK were acknowledged, as was the work of scholars from a widening range of backgrounds found to speak to pertinent issues. The initial searches covered literature published since 1980, when restraint use within UK health settings was first formalised (Bonner *et al.*, 2002), however iterative searches [and reading] resulted in the inclusion of earlier literature when relevant topics were identified. Literature expanded to include that relating to training, risk, restraint reduction and elimination, and the practical translation of techniques into the practice setting.

[2] *According to NHS Digital, 'All activity relating to patients who receive assessments and treatment from Mental Health Services is within the scope of the Mental Health Services Data Set, where the patient has, or are thought to have A mental health condition and/or need for support with their mental wellbeing and/or a Learning Disability and/or Autism or any other neurodevelopmental condition'.*

The Learning Disability Context

The Dept. of Health (2001) defines a Learning Disability [LD] as the 'significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood' (p.14). The root causes include genetic factors, infections *before* birth, brain injury or damage *at* birth, as well as brain infections or brain damage *after* birth, but there are many individuals for whom the cause is unclear or unknown (BILD, 2011). The term 'Learning Disabilities' is retained throughout this document because most of the UK literature has historically used it, although this is beginning to change. This shift in terminology spans the last 150 years, '…from 'idiots' in the 1880's, through to 'mad', 'feeble minded' and 'imbecile' in the early 1900's. It was not until 1948, with the formation of the NHS that the term 'mental handicap' was first used when a distinction was made between 'mental handicap' and 'mental health'' (BILD, 2011 p.2). Outside of the UK the term 'intellectual disability' is often used (BILD, 2011). There is now an increasing use of the term 'Intellectual and Developmental Disabilities' in recognition that lifelong disabilities can manifest in intellectual or physical forms, or both (NICHHD, 2016).

The more severe the intellectual impairment the greater the likelihood that life chances will be curtailed (Public Health England, 2015). In terms of physical health, obesity is twice as common in learning disabled people aged 18-35, and between 20% and 33% of adults known to Councils with social service responsibilities also having autism (Emerson & Baines, 2010). Robertson *et al.* (2015) estimate that approximately one in five people with LD are likely to have epilepsy. Hughes-McCormack *et al.* (2017) discovered that of those with LD, 12.8% children, 23.4% adults and 27.2% older adults lived with concurrent mental health conditions compared with 0.3%, 5.3% and 4.5% of the general population respectively. In terms of mortality the median age at death is around 25 years younger

than for those without LD (Emerson *et al.*, 2012), with the three most common causes of death being circulatory disease (22.9%), respiratory disease (17.1%) and cancer (13.1%) (Public Health England, 2016). Diagnosis alone is sufficient to place an individual at heightened risk of physical abuse within care settings (Cambridge, 1999; Cambridge, 1998) and violent assault in public spaces (Hughes *et al.*, 2012). When Valuing People (DoH, 2001) was published, the government recognised, '…almost all encounter prejudice, bullying, insensitive treatment and discrimination at some time in their lives' (p.1).

It took an undercover BBC reporter exposing the abuse taking place within a single long-stay hospital called Winterbourne View, to prompt government action to tackle the abuse of people with learning disabilities. At the heart of the abuse exposed was the physical mistreatment of individual patients, and the exploitation of power through physical force. During the subsequent prosecution of staff, the Prosecutor described '…inhumane, cruel and hate-fuelled treatment of patients. So-called restraint techniques were used to inflict pain, humiliate patients, and bully them into compliance with the demands of their carers' (Guardian, 2012). The scandal led to the publication of policy guidelines aimed at reducing the use of restrictive interventions, including physical restraint (DoH, 2014). It should be noted that this focused on formal service provision, and not the support provided by families or within domestic settings.

Behaviours Requiring Staff Intervention

Some form of staff intervention to attenuate escalation is required when a person's behaviour is likely to cause harm. The use of the term violence to describe such behaviour has historically been used in mental health settings (NICE, 2010, Richter & Whittington, 2006). Intuitively one knows what violence

looks like, however it is ‘‘a slippery term which covers a huge and frequently changing range of heterogeneous physical and emotional behaviours…, situations and victim-offender relationships’’ (Levi & Maguire, 2002 p.796). Reference to victims and offenders speaks to the common framing of violence as inherently wrong or bad, or as criminal, leaving those guilty of it (offenders) liable to prosecution and punishment, including their removal from society. The World Health Organisation (2002) define violence as:

> The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation (p.5)

By contrast, the Health and Safety Executive define violence as ‘Any incident in which a person is abused, threatened or assaulted in circumstances relating to their work’ (HSE, 2006). The European Commission offers an expanded definition: ‘Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health’ (WHO, 2020). The physical harms are often readily visible, in the reddening of the skin, bruising and bleeding. Visible but often less acknowledged is the attendant suffering seen in grimaces of pain and heard in distressed verbalisations. Often unacknowledged are the invisible emotional and psychological impacts. These belong to a family of harms that often live on longer than the physiologically fixed time damaged tissues take to repair, and pain signals take to subside (Marieb, 2006). According to UK health and safety law, violent (or hazardous) behaviour requires elimination, mitigation, or control (HSE, 2006). The traditional focus has been on protecting staff from harm. Training forms a core part of any organisational response (HSE, 2006), including the use of personal defence (Mott *et al.*, 2012) and restraint techniques (RRN, 2020) to escape from, or contain the behaviour. Whilst service users can present a hazard to staff,

staff in turn can present a hazard to those they care for when using force to restrain them (Aiken *et al.*, 2011). This will be returned to. Within social care spaces more generally, the term 'Challenging Behaviour' is commonly used (NICE, 2015a&b, RCP *et al.*, 2007). It has been defined as:

> Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities (Emerson, 1995, p 233)

Reference to 'cultural abnormality' and the safety risks associated has led to the term 'challenging' to become informally synonymous with difficult and demanding individuals, suggesting that such 'behaviours' are a fundamentally part of their identity (Chan *et al.,* 2012). The term is still widely used, with critics continuing to argue that it gives rise to stereotyping and diagnostic overshadowing (Chan *et al.*, 2012), where an understanding of true causation is lost to a more immediate, superficial determination linked to its physical form, and its close appearance to 'violence'. It is argued that this can result in a disconnection by staff and a reduction in the number of social interactions (Hastings & Remington, 1994).

There have been numerous attempts to re-frame such behaviours, as being indicative of a need for urgent help or support rather than risk mitigation. This includes the use of technical language 'maladaptive externalised behaviours' (McDonnell, 2010 p.156) as well as more imaginative or humanising language, including 'exotic communication' (Ephraim, 1998), and 'expressive communication' (Chiang, 2008). There has also been reference to 'behaviours that challenge' (RCP, 2007), 'behavioural distress' (BPS, 2013) and latterly 'behaviours of concern' (RRN, 2020).

The term 'Behaviours of Concern' is gaining traction and has been adopted for this study. The term shifts the focus from risk to distress, with support being the most important response.

> A behaviour of concern is any behaviour which causes stress, worry, risk of or actual harm to the person, their carer's, staff, family members or those around them. The behaviour deserves consideration and investigation as it is an obstacle to achieving the best quality of life for the person (DBMAS, 2012 p.5).

It is noteworthy that the language used within the policy and practice literature is variable. In Positive and Proactive Care (DoH, 2014), reference is made to challenging behaviour, behaviours that challenge, behaviours of concern, disturbed behaviour, aggression, violent behaviour, and violence, whilst within the Mental Health Act Code of Practice (DoH, 2015) reference can be found to challenging behaviour, disturbed behaviour, behavioural disturbance, dangerous, threatening, or destructive behaviour, behaviour that is violent or dangerous, as well as aggression and violence.

The Policy Context

Whilst policy implementation is further expanded upon in the Theory Chapter, the sub-strand that this study is concerned with comes to prominence within Chapter 26 of the MHA CoP (DoH, 2015), Chapter 6 of the Mental Capacity Act Code of Practice (Department for Constitutional Affairs, 2007) and Positive & Proactive Care (DoH, 2014). Further to this, good practice, in respect to responding to behaviours of concern is captured in various supplemental guidance documents, including those produced by the National Institute of Health and Care Excellence (NICE, 2015a&b).

Staff responses to such behaviours occur within an organisational context. This study includes two settings providing support to adults with LD: an NHS commissioned forensic service and a wraparound homecare team funded by the local authority administered personal budget. Within these spaces, localised second-tier policies are implemented. These provide a bridge from overarching public policy imperatives and relevant legal frameworks, into localised procedures and practice expectations. Staff training is central to the operationalisation of local policy. The conglomeration of practices, procedures, principles, strategies, and techniques implemented at a policy level in the localised practice space will be described in this study collectively as the 'organisational response policy'.

The language relating to physical interventions has remained largely unchanged for decades, something which will be expanded upon later. This leaves one to conclude that there has been little appetite to revise our understanding of how people physically interact during periods of crisis, and that perhaps the drive to eliminate such practices has stymied the development of language in this area. As a result, the policy messaging around the act of restraint is confusing. Staff have a lawful right to be safe at work and are within their rights to use force to keep themselves safe. They are simultaneously obliged to discharge their legal and professional duty to keep those in their care safe from harm. This may potentially require physical action. Force and restraint are therefore legally and operationally within policy scope, but public policy messaging asserts that staff should not restrain service users, and that restrictive interventions should be reduced if not eliminated. Organisations can have both 'restraint' and 'restraint reduction' policies. Paradoxically, the answer to whether staff should restrain those in their care can be yes and no at the same time.

Constructs Used to Conceptualise Policy Actions

The training flowing from local policy is designed to ensure that staff respond in safe, effective, and lawful ways to the behaviours of the people they care for (McSherry & Maker, 2021; Hughes, 2009; NIMHE, 2004; Murphy *et al.*, 2001; Harris *et al.*,1996). In preparation to intervene, staff need to clearly conceptualise the interventions open to them, as well as when and how they should be used. To do this there is often a tendency to group interventions hierarchically using the public health-type model. The public health model (Holland *et al.,* 2023) has some parallels with the medical model (Zaks, 2023), in focusing on an avoidable negative state, located within or around the individual, with the remedy being specified, implemented, or facilitated by suitably knowledgeable and skilled professionals. This negative state can include ignorance or misunderstanding, as revealed through the poor-quality decisions and actions which result in a health decline or a wellbeing potential that is not reached (Public Health England, 2017). The Public Health model lends itself to a pyramidal visual for strategic communication purposes, with a broad base comprising primary [foundational] interventions designed to prevent illness or ill health from developing. Secondary interventions are then aimed at early detection and symptom amelioration occupying the middle strata whilst tertiary interventions which sets out to arrest the progress of disease and reduce the incidence of chronic incapacity occupying the apex (Boyce *et al.*, 2010).

The tiered Public Health Model has also been used to frame policy towards the management of the risk of violence across the world (WHO, 2002) and within the UK (Faculty of Public Health, 2016) as well as within Health and Social care settings (Paterson *et al.*, 2005). The diagrams below illustrate different uses within the context of managing the risk of violence [Fig 2.1 & 2.2]

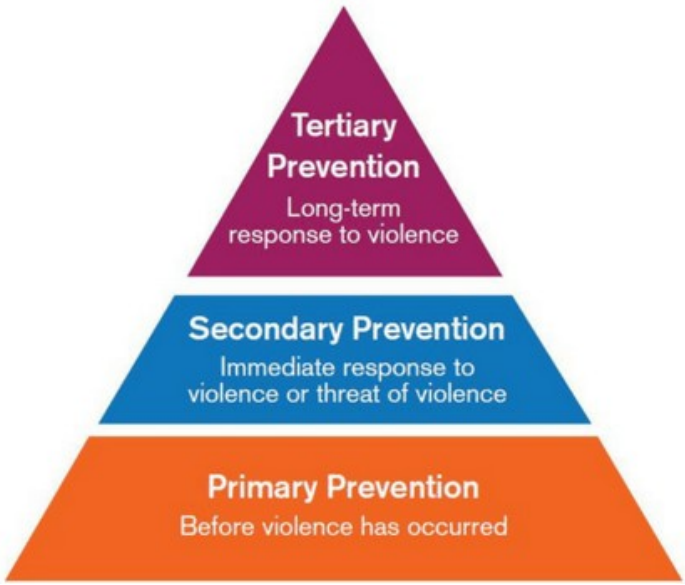


Fig 2.1: The Public Health Model Covering interventions aimed at preventing male violence and abuse against women and girls (White Ribbon, 2019).

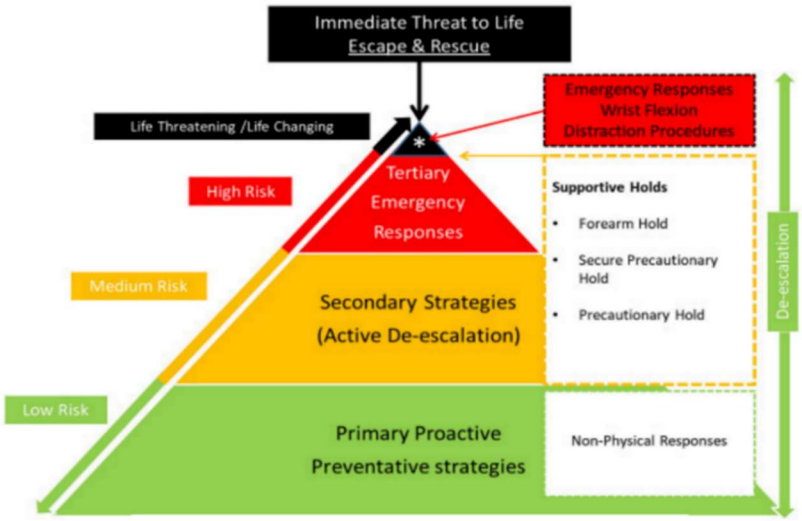


Fig 2.2: The model used by West London NHS PMVA Dept. (Taylor, 2020 p.20).

Training is recognised as not being a panacea in and of itself, and that a total organisational response is likely to be far more effective. Despite this, training that has been structured thematically and sequentially upon the model is often a part of the standard practical solution (Paterson *et al.*, 2005). The three-tier model is present within Positive and Proactive Care (DoH, 2014), has been formally integrated into the new Restraint Reduction Network (RRN) training standards (RRN, 2020), and referenced by NHS England, and the CQC (RRN, 2020b). The curricula specification within the RRN Training Standards refers to primary, secondary, and tertiary requirements, with tiered levels being incorporated into a table read left to right (Fig 2.3).

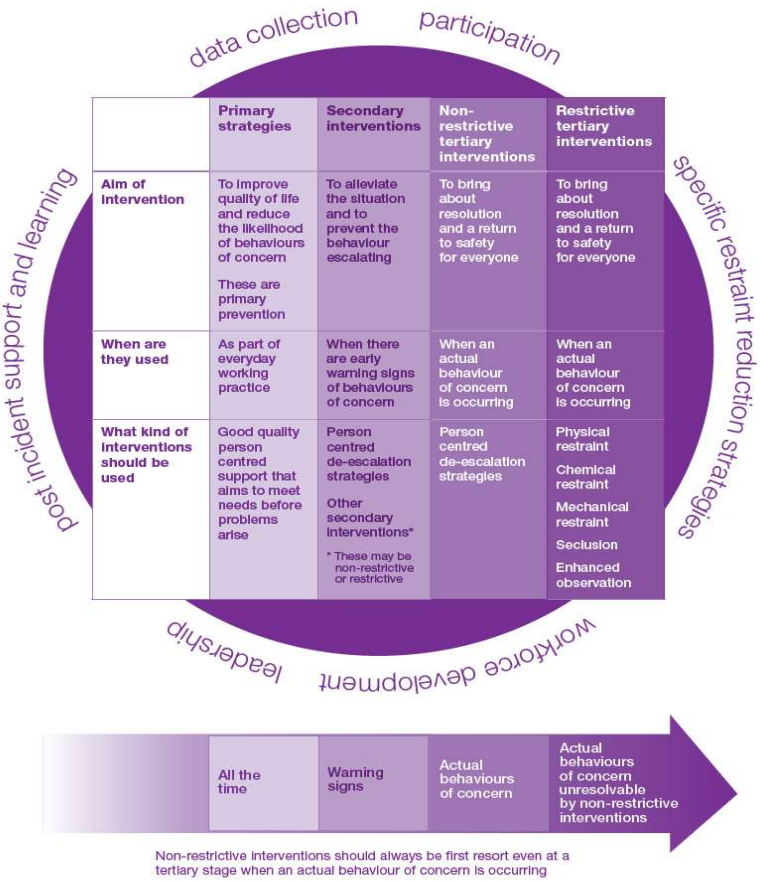


Fig 2.3: RRN Minimisation Matrix (RRN, 2020 p.59).

Primary preventative work focuses on '…strategies [that] aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern arising' (RRN, 2020 p.171). The focus then shifts to secondary reactive interventions, where 'strategies focus on the recognition of an individual's early behavioural signs (physical, emotional, communicative) which can indicate an increase in behavioural disturbance. Strategies are developed to identify how to respond to a person's behaviours or support the person to self-manage. Secondary strategies are likely to include approaches to de-escalation' (RRN, 2020 p.172). Finally tertiary level protective strategies are deployed, where 'strategies are used when an actual behaviour of concern is presenting, with the primary aim to bring the incident to an end in a timely and safe manner, with due regard to the individual's rights and dignity' (RRN, 2020 p.173). When efforts at exploring lower-level interventions fail, the 'step up' to the next level is deemed to be logical, and justifiable. Each incremental step involves the exploration of ever more complex strategies, often requiring further legal justification, and as they increase to physical intervention, more likely to result in adverse outcomes equal to or greater than those it is designed to mitigate. Thus, staff need to demonstrate the ability to dynamically assess and balance risks in situ. Restraint risks will be explored later.

Another visual device used in both training and policy spaces to both conceptualise the trajectory of an incident, and map out opportunities for interventions, is the 'Assault Cycle' (Kaplan & Wheeler, 1983) and latterly the Breakwell Assault Cycle (1997). This five-stage cycle tracks the rise and fall of emotions and behaviours: trigger, escalation, crisis, recovery, and post crisis. At each stage the intervention requirement changes, and staff are expected to adapt as required (Fig 2.4)

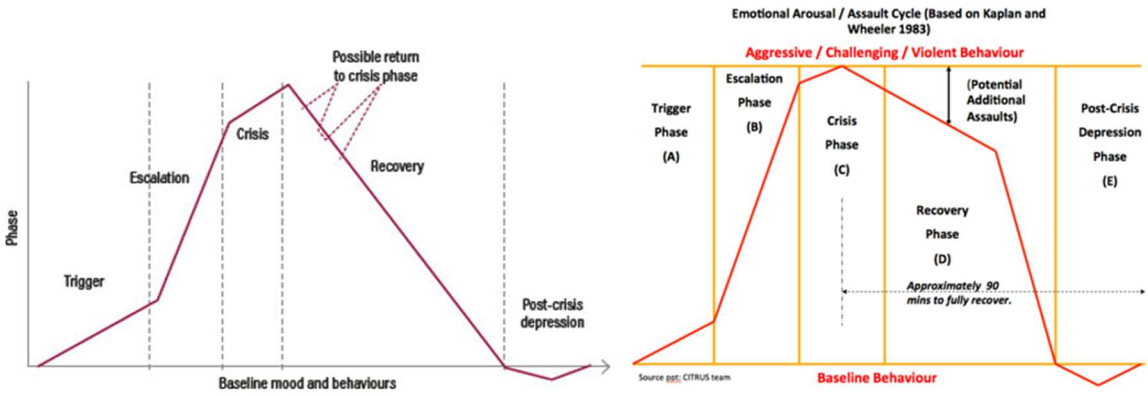


Fig 2.4: The Assault Cycle (Hallet, 2015; Citrus, 2015).

At face value such models offer a way of making some sense in advance of what is to come. A counter claim can be made that they offer a somewhat reductive representation, by focusing solely on the patient and inferring a certain ordered and predictable sequencing. This is certainly the case with the more Americanised use of force continua serving criminal justice communities (Ciminelli, 2014; Police Executive Research Forum, 2020). It is the apparent rooting of such models in a scientific tradition, inferring a predictable cause and effect which is the basis of criticism. The public health model and assault cycle are useful and complimentary visual devices but premised on particular epistemologies. The largely biomedical knowledge often underpinning structured visual representation models is constructed through empirical research based on a positivist approach (Al-Azri, 2012), whilst the lived experiences of physically responding to others in distress [the focus of this research] are not founded solely on predictable physiological and pathophysiological processes but rather are determined by a complex and changing array of individual psychological situational and social influences. My research seeks to bridge the gap in understanding.

Primary Level Policy Interventions: Preventative Measures

Primary level interventions seek to avert the potential for behaviours of concern to develop. Such interventions can be aimed at improving quality of life or providing greater autonomy, and they can be seen to be implemented within individual care planning activities (CBF, 2023). Behaviour analysis methods, such as ABC [Antecedent, Behaviour & Consequence] (Dyer, 2013) or STAR [Setting Events, Trigger, Actions & Responses] (Zarkowska & Clements, 1994) can used to understand how and why particular behaviours occur and thereafter personalise interventions. Various models have been offered up as good conceptual fits for such a preventative approach. They include 'Positive Behavioural Support' (Allen, 2009) and 'Trauma Informed Care' (Classen & Clark, 2017), as well as 'Capable Environments' (McGill *et al.*, 2020). The latter is premised on the observation that behaviours of concern increase within environments where there is a lack of meaningful engagement and poor-quality social support (DoH, 2007). The environment extends beyond the physical one to include social and cultural aspects. For a person to flourish, the environment needs to meet their needs: 'Capable environments are those that support a person effectively and provide the optimal setting to support positive interactions and opportunities' (BPS & RCP, 2015 p.198).

Secondary Level Policy Interventions: De-escalation

Secondary level interventions are 'activities aimed at detecting and treating pre-symptomatic disease' (Kings Fund, 2010 p.6). In the context of this study, these involve the early response to the development of behaviours of concern indicating a deviation from that person's individual baseline. Responses often involve resort to non-physical interventions such as de-escalation, distraction, or diversion. De-escalation, as the main secondary intervention appears to be a straightforward proposition: an individual takes steps to resolve a state of rising tension in the other. NICE (2015)

define de-escalation as 'The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression' (p.70). However, it can be a deceptively complicated undertaking, within a complex, changing, and unpredictable situation. Following their concept analysis, involving a review of n=79 studies, Hallet and Dickens (2017) offered a more expansive theoretical definition of de-escalation, 'a collective term for a range of interwoven staff interventions, comprising verbal and non-verbal communication, self-regulation, assessment, and actions, whilst maintaining the safety of staff and patients' [p.10).

Having been put forward as the key form of secondary violence prevention, it is somewhat surprising to discover that there is little evidence to substantiate the use of de-escalation (Spencer *et al*., 2018; Hallett & Dickens, 2017). There is little in the literature to show which aspects of de-escalation are most effective, nor how people become effective de-escalators (Price & Baker*,* 2012). Leach *et al.* (2019) reported on the paucity of evidence underpinning the de-escalation training programmes used in UK NHS healthcare settings, noting a wide variation in both the duration and intensity of training programmes. Courses durations range from 45-minute micro education sessions (Leach *et al*., 2019) to 24 hours of one-to-one support (Spencer *et al*., 2018), with the structure of sessions including focus groups convened to reflect on specific assaults (Gillespie *et al*., 2014), as well as the more traditional didactic lectures (Ramacciati *et al.*, 2016). Reference to training intensity speaks to the contrast between sessions involving the passive dissemination of information in contrast to those sessions involving active scenario training or role plays where the staff member is required to dynamically problem solve in the face of simulated aggression (Mott *et al.*, 2012).

Leach *et al.* (2019) found that de-escalation training didn't prevent violent or aggressive incidents but offered some guidance with managing the risks arising. The mechanism by which this occurred was by increasing staff knowledge and confidence. Many evaluations of training outcomes comprise self-

assessed knowledge and confidence gains, with very few studies providing objective evidence of conclusive knowledge gains (Ramacciati *et al.*, 2016, Peterson & Densley, 2018). Self-reporting is inherently biased, as people tend towards making positive claims about growth and development (Wassell, 2009). Where knowledge and confidence gains are measured, unvalidated instruments are often used, and measurement limited to performance in artificial training scenarios (Price *et al*., 2015). Leach *et al*. (2019) also found the evidence was inconclusive as to the effectiveness of de-escalation training in reducing injuries to staff. Any such claims, linked to specific training sessions must be considered with caution. This because de-escalation training is often only one component of a much larger organisational strategy, and evaluations sensitive enough to disaggregate the effects of de-escalation training from other programme components are not currently reported within the literature (Price *et al.,* 2015).

Tertiary Level Policy Interventions: Physical Restraint

In the public health context, tertiary level interventions are those aimed at averting harms (Kings Fund, 2010). Within the context of this study, they include staff physicality such as the use of force and the application of restraint techniques. In health and social care settings in England, physical restraint and physical intervention can be considered synonymous terms, whilst in other areas such as residential childcare in Scotland they refer to qualitatively different things (Davidson *et al.*, 2005). Physical intervention is defined by NICE (2015a) as 'a skilled hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned' (p.16). In the LD literature, the definition put forward by Harris *et al.* (2008) is widely used, 'any method of responding to challenging behaviour which involves some degree of direct physical force to limit or restrict movement or mobility' (p.2). More recently the

Department of Health have returned to the term 'physical restraint' referring to 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person' (2014, p.14).

Physical restraint involves the manual application of force to physically stabilise a person whose behaviour directly or indirectly jeopardises someone's safety. In analysing how such techniques work, Leadbetter (1995) provides four bio-mechanical mechanisms: the immobilisation of the subject by weight or strength, the restriction of movement of the long bones by some sort of hold or lock, maintaining the subject in an unbalanced position and the use of reasonable force. The mechanistic nature of restraint comes as no surprise, originating as it did from unarmed forms of combat which relay on body mechanics. The very early 'Control and Restraint' (C&R) training was derived from various Japanese Martial Arts including Aikido and Jiu Jitsu (Tarbuck, 1992). First developed for the Prison Service in the early 1980's (Lewis, 2002) it migrated across to the Special Hospitals in around 1985 (Wright, 1999). In time the term C&R has become redundant as organisations sought to brand and market their own restraint training systems. Whilst the number is impossible to calculate there are reports of 'approximately 650-700 providers of some sort of restraint training' (IRAP, 2014 p.43). It is noteworthy that the term physical restraint [and physical intervention] refers to biomechanically mediated actions which do not extend in their influence beyond merely constraining movement and mobility. There is no reference to calming, soothing, comforting or caring within commonly used restraint definitions. In this sense they are a discrete intervention targeted at the external aspects of the behaviours, and not the underlying emotions such as anger, fear, confusion, distress or pain driving them (NHS Protect, 2013). These are resolved by other interventions, the methods of de-escalation spoken to previously. The conceptual separation should be noted. Physical restraint, largely because of its reliance on force and its close topographic resemblance in the eyes of some to physical violence, has been cast as an undesirable action which represents the failure of person-centred care

planning (Bauers & Dzikiti, 2023), or a 'treatment failure' (Ashcraft *et al.*, 2012 p.416), posing a significant risk, 'there is no such thing as 'entirely safe' restraint' (Smallridge & Williamson, 2008 p.5). These potential risks of restraint comprise one of the driving forces of restraint reduction at national policy level (DoH, 2014).

Restraint training is premised on knowledgeable, skilled, and experienced trainers developing staff competencies in the application of precisely configured techniques (RRN, 2020). Techniques taught on training courses are framed as the officially mandated responses to escalated behaviours, and as a result are often considered officially 'approved' or 'authorised'. Staff are expected to maintain the integrity or fidelity of these techniques as they are translated from the training into the working environment. The requirement to develop such competency is required by the new restraint training standards launched in England, with training providers expected to identify '…any issues that may compromise the fidelity of the technique between the taught version in the classroom and its application in practice' (RRN, 2020 p.40). See 'Complexity & Pragmatism' below.

The Risks Associated with Physical Restraint

A growing body of research providing service user perspectives indicates that physical restraint is often perceived as a hostile experience. Sequeira and Halstead (2001) reviewed records and undertook semi-structured interviews of adults with LD (n=82) who were exposed to physical restraint (n=3767) over a three-year period in a long stay UK hospital. Reports of physical pain and mental distress were recurring themes, as was the perception that techniques were used by staff to punish and control, which gave rise to feelings of anger and the urge to express further aggression. Fish and Culshaw (2005) interviewed staff (n=16) and service users with a LD (n=9) using an open unstructured

format, which revealed that recipients felt physical restraint was used as a punishment and made them feel frustrated and aggressive. They were also reported as re-traumatising, with one respondent reporting how she goes 'ballistic' if restrained by male staff members as it triggers memories of serious sexual assault (Fish and Culshaw, 2005).

MacDonald *et al.* (2011) conducted semi structured interviews with learning disabled individuals (n=8) who had experienced or witnessed physical restraint. Interviewees (n=7 male, n=1 female) lived in their own flats with regular visits from support staff or had individual support packages ensuring 24-hour one-to-one support. In addition to pain and mental distress they found that the experience of restraint was indistinguishable from abuse, and indistinct from general violence within the environments [where service users sometimes attacked each other]. Such interviews reveal much but conflate abuse and restraint, with accounts reliant on recall, sometimes of events years past. Hawkins *et al.* (2005) improved the methodology and interviewed staff/service user dyads (n=8) within one week of their mutual involvement in a restraint. The final sample comprised eight pairs, from six community residential homes operated by four different service providers. Pain and discomfort were again reported. Significantly, the restraint system did not include techniques designed to cause pain. The researchers concluded that the process of being restrained gave rise to the adverse subjective experiences. This was something that staff did not seem attuned to, as the service user experiences were more negative than the staff had believed they would be. Hawkins *et al.* (2005) suggest that staff need to recognise that by taking physical control of a situation, even in the name of safety, they are removing opportunities for a service user to assert self-control through self-calming and time out and that the experience may be physical and/or psychologically painful.

Adults with LD are at increased risk of physical harm from restraint techniques because they are more likely to be restrained (Emerson, 2002; Emerson *et al.*, 2000) and are more likely to have health issues

placing them at risk of adverse outcomes (Aiken *et al.*, 2011). Poor problem solving and reduced capacity to cognitively engage with emotional regulation are likely to increase the likelihood of fight or flight responses within the context of a stressful encounter (Schuengel & Janssen, 2006). Other risk factors include poor body awareness, depressed pain responses and limited communication skills (Emerson *et al.*, 2011) as well as obesity (DRC, 2006), heart disease and poor cardiovascular fitness due to reduced levels of physical activity (Emerson *et al.*, 2011). The risks associated with physical restraint have been captured by Paterson *et al.* (2003) who reported the restraint-related deaths of individuals with a LD: Freda Latham, Zoe Fairley, and Michael Craig. They are no more recent figures, with no reference to restraint deaths in the most recent LeDeR Annual Report Learning from Lives and Deaths: People with a Learning Disability and Autistic People (White *et al.*, 2023). This is perhaps not unexpected as deaths pinpointing restraint as a cause or contributory factor in deaths is not straightforward as Police have also found (IOPC, 2024).

Research papers covering the impacts of restraint rarely provide detailed information on the techniques referenced within the text, settling for the general application of undefined techniques (Sequeira & Halstead, 2001), sometimes to specific systems but not individual techniques (Hawkins *et al.*, 2005; Fish & Culshaw, 2005; MacDonald *et al.*, 2011). This means the exact configuration of the technique is unclear, as is its fidelity to its original specification. Within published service user narratives, the most common practice seems to be of referring fleetingly to the intervention they believe constituted restraint before expanding in detail on the impact of its use. This gives rise to broad descriptions such as someone who was 'holding you', 'holding someone back' and 'taking control' (Jones & Stenfert-Kroese, 2007 p.52) which leaves one unable to determine whether the applications were defensible or not, a close approximation to the officially authorised technique, or whether the physical force behind that application was the damaging component as opposed to the technique or authorised response itself. Whilst staff actions, technical and forceful, are implicated in causing

distress and injury, we simply do not understand the enough about the nature of the physicality involved in such interactions. We need to move beyond abstracted conceptualisations to refine or improve practice.

One exception to the tendency to not report techniques in technical detail is a small body of experimental research concerned with the risks associated with defined interventions. Such investigations typically take the form of laboratory experiments, including illustrative photographs of the investigatory procedure. Even then, the visuals are of carefully posed photographs of ideal techniques, applied under conditions of non-resistance. Research that falls into this category include works by Barnett (Barnett *et al.*, 2018; Barnett *et al.*, 2016, Barnett *et al.*, 2012a & 12b) and Parkes (Parkes *et al.*, 2015; Parkes *et al.*, 2011; Parkes & Carson, 2008). Into this category one might also add safety alerts such as those put out by the National Health and Safety Function (2015) covering high risk techniques, along with training manuals produced by training providers (Mandt, 2010). It should be noted that when techniques are contentious there is a practice of redacting these manuals when they enter the public domain (NOMS, 2014).

The Evidence Supporting Restraint Training

The practice of providing health and social care staff with restraint training has been likened to a '…large scale but wholly unregulated and uncontrolled experiment' (Duxbury & Paterson, 2005 p. 15), with the evidence for its effectiveness sparse. In the UK, any evidence of efficacy is often offered by the training vendors as part of their marketing:

> Some organisations seem to have evolved a rather defensive cult mentality, refusing to entertain the possibility that any of their techniques can be improved, and resenting any questioning of the edicts of 'guru' trainers. A too common feature has been reluctance on the part of those selling training to acknowledge any difficulty with it, blaming instead the clients who try to operate their techniques. Some seem reluctant to expose their techniques to outside scrutiny, refusing to publish exactly what sort of training they offer, until a financial commitment has been made (Allen, 1998, p.13).

Allen (2001) examined the literature on restraint training in LD settings, because 'scant attention' (p.6) had been paid to the topic. Several papers were identified (n=45) including quasi-experimental studies (n=30) [of which only one included a random allocation of subjects to experimental and control groups], non-quantitative studies (n=6), and unpublished reports on training outcomes (n=9). There were no comparison studies so none of the 70 training systems acknowledged were evaluated against competing systems. Several different methods of measuring training success were used, including direct ones purporting to gauge participant knowledge, confidence, and competence as well as indirect ones such as rates of reported challenging behaviour, the incidence of reactive strategy use and injury rates. McDonnell (2009) and Allen (2001) highlight that restraint training is a 'behaviour management strategy' and not a 'behaviour change strategy' and therefore claims to reduce rates of challenging behaviour are unlikely to be substantiated. Also, self-reported measures of confidence ('I believe I have the ability to restrain someone') and competence ('I am effective at using restraint techniques') seem not to be aligned with the larger goal of preventing potentially aversive or harmful interventions. Allen (2001) concluded that whilst some of the outcomes were both desirable and possible, training could not guarantee them, and on occasions seemed to increase the likelihood of challenging behaviours, and restraint.

The Royal College of Psychiatrists (2005) published an occasional paper covering the management of imminent violence within LD settings, which examined (n=96) papers. Only six studies covered training in restraint, and the summary findings concluded: 'control and restraint techniques resulted in the quick and effective relocation of violent and obstructive inmates' (p.20); there was 'an increase in staff confidence in dealing with aggression' (p.21); and that when more staff were trained in C&R violence levels reduced. The findings largely related to psychiatric and criminal justice settings, and restraints were largely viewed as successful when they served the best interests of staff, and not that any underlying distress had been identified or meaningfully resolved.

In the systematic literature review by McDonnell *et al.* (2008a) various papers (n=98) were identified, but only those with control or comparison groups were reviewed (n=14). The presence of such a meagre number of studies was described by this research team as 'a damning statistic in any field of applied research' (p.13). Conclusions could also not be drawn as courses covered disparate educational elements, used different training methods, and resorted to a wide range of different outcome measures whose validity was unexplored. An absence of any follow up studies also made it difficult to draw conclusions. McDonnell *et al.* (2008a) noted that no programme involved service user input in development or implementation. This has been addressed in part by the RRN Training Standards which oblige training providers to include the voice of lived experience in course development and content (RRN, 2020). More generally McDonnell *et al.* (2008a) called for higher quality evidence, namely Randomised Control Trials, with Allen (2011) also concluding that 'despite the huge emphasis that training in physical interventions is given in the UK, data on its effectiveness is conspicuously absent' (p.14). McDonnell *et al.* (2023) revisited this issue and found little had changed.

It is worth noting the component of training which notionally readies people to deal with the unknown is referred to in various ways, trouble drills (Bleetman, 2011), scenario training or role plays (Cushion, 2022, 2020) and simulations (Krull *et al.*, 2019). Historically elements of such training have been criticised, due in large part to early control and restraint trainers seeking to create high fidelity to real word incidents: unpredictable, loud, and physically contested events which have been associated with high levels of anxiety and delegate injuries, as well as the suggestion that the forceful responses it engendered were then carried over into the practice setting (Stubbs *et al*, 2009; Lee *et al*, 2001; Dowson *et al*, 1999). Better designed scenarios which focus on problem solving rather than force refinement are now being explored (Cushion, 2022, 2020).

Restraint Use in Institutional Learning Disability Settings

The use of force in the form of physical restraint techniques in LD settings has long been custom and practice (BILD, 2009; 2004). In the event challenging behaviour reaches crisis, physical restraint 'may be regarded as more or less inevitable' (Harris, 1996 p.100). That such 'challenging' behaviour occurs within LD settings is widely acknowledged. The National Institute for Health and Care Excellence report prevalence rates are around 5–15% in educational, health or social care contexts (NICE, 2015a). It is more common amongst teenagers and those in their early 20s (NICE, 2015a), and amongst those with communication difficulties, co-existing diagnoses such as a mental health diagnosis, dementia, autism, and some form of sensory impairments or processing disorder (Cooper *et al.*, 2009a, Cooper *et al.*, 2009b). There is no consensus on the percentage of the population who experience physical restraint, as figures show: 36% (Lowe *et al.*, 2005), 45% (Sturmey, 2009b) 50% (Deveau & McGill, 2009), 53% (Robertson *et al.*, 2005) and 57% (Emerson, 2002). McGill *et al.* (2009) found an even higher incidence; their postal survey of staff (n=100) revealed a prevalence rate of 78% of those in their care (n=268).

Allen (2001) observed that underreporting, and the use of unauthorised techniques, was likely to obscure the true extent of its use.

The immediate nationwide inspection of LD settings triggered by the Winterbourne View scandal revealed an over-reliance on the use of restraint (DoH, 2014, CQC, 2012). The tendency to conflate the behaviour with the person, and both with danger (Dagnan *et al.*, 1998) is one factor that encultures the use of restraint. There is also the possibility that the risk narrative itself is maintained using terminology such as violence. Harris and Leather (2012) surveyed social care staff (n=363) and found 93% reported having been verbally abused, 71% threatened or intimidated and 56% physically assaulted. Brockman and McLean (2000) found 37% of social service managers, residential and home care workers (n=1031) had been physically attacked. The has led to individuals with LD being labelled as 'most at risk' of causing harm (Skills for Care, 2013 p.xii) and bearing responsibility for abuse and violence in 73% of reported instances (Skills for Care, 2013). Irrespective of the rationale for use, restraint seems a daily occurrence in formal care settings. Figures from the 40 mental health providers revealed patients were restrained on average across the commissioned services once every ten minutes (NHS Digital, 2018).

Restraint Use in Family or Domestic Learning Disability Settings

A substantial number of people with a LD are cared for and supported in the home setting (Elford *et al.*, 2009, Emerson *et al.*, 2001), where families, parents in particular, face the dilemma of how to respond safely to escalated behaviours. These behaviours include aggression sufficient to cause serious injuries to family members, serious or severe self-injury as well as the destruction of property (Allen *et al.*, 2006). Up to half of the people presenting such behaviour are reported as living in their

family home (Emerson *et al.*, 2001) and up to 87.5% percent of parents (n=72) responding to a survey stated they have had physically intercede in escalated behaviours to protect their child (Allen *et al.*, 2006).

The literature relating to this area of practice is sparse, often relates specifically to children under 16, and includes those having experienced trauma (Moffit *et al.*, 2013). As a result, the literature often becomes continuous with that covering broader child to parent violence (Selwyn *&* Meakins, 2016). One reason for this seems to be that the domestic setting is not a regulated space. It may be supervised by social workers, and the family may receive support from various health care professionals, but it is not under the day-to-day oversight of a regulatory entity such as the CQC (2019c). Historically there has been a reluctance to provide parents with training in physical intervention skills (Newbold, 2017; Elford *et al.*, 2009). The consequence of this is that parents have unmet support needs (Hewitt *et al.*, 2016) and are 'often left to fend for themselves' (Allen *et al*, 2006 p.1). As a result, many spontaneously create, or improvise 'restraint' techniques (Elford *et al.*, 2009; Adams & Allen, 2001), sometimes having sought ad-hoc training from friends and family members who have picked up skills on training courses in unrelated work and hobbyist spaces.

The family home, and familial dynamic seem to result in a different form of thinking and construction of behaviour management techniques. Newbold (2017) in her personal blog, charting her experience as a parent, challenges the word 'restraint', and suggests it doesn't fit with a parent's lived experience:

> …restraint as a word is very emotive and can conjure up images of big burly blokes pinning a child to the ground, and sometimes by using that word parents are giving completely the wrong impression of what they are actually doing. Sometimes it's a parent's role to prevent

> our children doing something, and most parents have physically held on tightly to a small child near traffic to keep them safe. If by 'restraint' what you really mean is 'I had to hold him back to stop him kicking his brother' it's probably better if you explain exactly what you did and why, and don't actually use the word 'restraint' in case it wrongly rings alarm bells in others.

Elsewhere in the family-oriented space, restraint has been described as '…a 'very fine line', drawn in an attempt to strike a balance between right and wrong, safety and danger, humanity and dehumanising, and helping and harming' (Elford *et al.*, 2009 p.75). The same authors found that families felt the context was different in the domestic setting; longstanding relationships, accumulated trust, and a familiarity with physical contact and touch set their interactions apart from those of healthcare professionals. The working relationship between parents and professionals has itself been characterised as complex, with Elford *et al*. (2009) reporting that parents felt scrutinised and judged by healthcare professionals, something which in part seems to be accounted for by the differing governance arrangements in place. A highly structured, risk-averse organisation (Preece, 2014; Allen *et al.*, 2006; Green & Wray, 1999) governed by a '…bureaucracy of policies' (Elford *et al.*, 2009 p.81), stands in stark contrast to a parent or parents who often operate through the prism of unconditional love, with little or no formal restrictions on decisions. In practice a deep understanding of their child, their moods and behaviours has been reported as a special insider knowledge that can be used to prevent or preclude restraint (Elford *et al.*, 2009).

Restraint Reduction and Minimisation

Strategic policy goals in relation to restraint have changed from restraining well to restraining less (BILD, 2017). Restraint reduction can be defined as 'Assessment, planning and review measures

designed to reduce the number of times restraint techniques are used within defined settings, or in relation to a defined population or a specific individual' (RRN, 2020 p.171). Significant reductions in the use of restraint have flowed from total organisational approaches, with highly visible and clearly focused leadership (Duxbury & Paterson, 2005; McDonnell, 2010, Huckshorn, 2005), augmented by robust feedback systems (McDonnell, 2010). Such initiatives are focused on culture change (RRN, 2020; Paterson *et al.*, 2013). There are several well-established approaches including the '6 Core Strategies' (Huckshorn, 2005), comprising leadership toward organisational change, the use of data to inform practices, the development of the workforce, the implementation of seclusion/restraint prevention tools, as well as the full inclusion of service users and families in all activities and the use of rigorous formal debriefing. Derivatives of this have been implemented in the UK, including 'ResTrain Yourself'. Another approach is 'No Force First', which was also originally developed in the USA by Recovery Innovations Crisis Centres and has been advanced in England. It comprises executive level commitment, peer support at ward level, the redefinition of relationships between staff and service users as one of 'risk-sharing partnership' rather than 'risk management control', the use of positive 'recovery focused' and optimistic language, trauma informed care, the definition of the use of restraint and seclusion as a 'treatment failure', critically reviewing incidents on that basis, and the wider use of data (Merseycare, 2015).

Since the publication of 'Positive and Proactive Care' (DoH, 2014) formal restraint reduction efforts have been reported through various outcome measures including the number and percentage of patients restrained, and discrete restraint episodes (Huckshorn, 2005), the cumulative time of restraints, and any increase or decrease in restraint use (Lewis *et al.*, 2009), the cumulative duration against patient time spent on a ward (Putkonen *et al.*, 2013) and the mean number of restraints per shift (Bowers *et al.*, 2006). For audit purposes, outcomes are typically reported at organisation, service or unit level rather than in relation to specified individuals. What is often not captured is the change,

or reduction, taking place within the context of an individual case where intensive, and individualised care planning and relational working leads to notable reductions in restraint use.

There is now a developing distinction between measures aimed at restraint reduction, reducing the overall number of times restraint techniques are used, and the less commonly used term 'restraint minimisation' defined as 'Assessment, planning and review measures aimed at reducing the intensity and duration of any physical restraint techniques that are used within defined settings, or in relation to a defined population or a specific individual' (RRN, 2020 p.171). Given that excessive force and its prolonged application are risk factors (Aiken *et al.*, 2011), restraint intensity seems to be the logical target of research. It is also congruent with the concept of specifying the least restrictive intervention (CQC, 2019, DoH, 2014). To date, however, little research has explored this specific strand of restraint reduction.

Restraint Abolition and Eradication

The concluding report by the UN Committee on the Rights of Persons with Disabilities, recommends healthcare providers 'Adopt appropriate measures to eradicate the use of restraint for reasons related to disability' (2017, p.7). In this statement one can discern a tension which more broadly divides the perspectives of commentators into those of abolitionists and those of reductionists. The term 'eradicate' (UNCRPD, 2017) and 'eliminate' (PRERG, 2022), suggest an ambition to bring about an end to physical restraint, the inference being it can and will cease to be. This transcends the more pragmatic goal of 'reducing' and 'minimising' (RRN, 2020), which seems to accept that at least some restraint use is likely necessary.

When one explores the abolitionist perspective, beyond simply stating that restraint would be unnecessary if an individual's needs were met there seems to be an underlying antipathy towards the act of restraint. This position might be characterised as an ideological one, manifesting as it does in a determination that restraint is simply wrong or bad, and that whilst it is legal it should be cast out of practice. This position has manifested in various calls for the prohibition of restraint, or of specific forms of restraint (MIND, 2013; Millfield's Charter, 2006). The UN Special Rapporteur on Torture, also called for a ban on the use of restraint in health care settings:

> Any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psycho-logical or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions (UNHCR, 2013 p.14-15).

In a subsequent report by the Human Rights Council (2017), it states:

> In the view of the Special Rapporteur, the absolute prohibition of torture and other cruel, inhuman or degrading treatment or punishment may well constitute the most fundamental achievement of mankind, and any tolerance, complacency or acquiescence in such practices, however exceptional and well argued, will inevitably lead down a slippery slope towards complete arbitrariness and brute force, a disgrace for all of humanity (p.5).

In the UK, Duxbury (2015) posits that the use of restraint may be 'indefensible' given the paucity of evidence to support its use:

> Despite the growing evidence that physical restraint is potentially counter-therapeutic, traumatic, unnecessary and can be life threatening, nurses continue to rely upon this practice (p.98).

Limiting, Obscuring and Contaminating Terminology?

The terminology which speaks to the physical actions of staff, unlike that which speaks to the behaviours being responded to, remains largely unchanged. References to physical restraint have now endured since the 1800's (Haw & Yorston, 2004). Current definitions [see 'Tertiary Level Interventions'] refer to actions taken to restrict an individual's movement and mobility (DoH, 2014). The limited broadening of the terminology includes 'Physical Intervention' (Harris *et al.*, 1996), 'Restrictive Physical Intervention' (DCSF, 2002), and 'Manual Restraint' (Stewart *et al.*, 2009). All of these retain the descriptive focus on the form, and its physically restrictive functionality. This continues to confine restraint to being framed as a physically forceful, biomechanically focused intervention focused on mitigating the behaviour rather than addressing the person presenting it.

Discontent with terminology has resulted in the use of terms like 'Safe Holding', and 'Therapeutic Holding' (Hollins, 2017), which confer a particular quality upon the intervention, in these two instances its safety and therapeutic value. These in turn have been framed as euphemistic attempts to try and hide the coercive and dangerous reality of physical restraint. The RRN (2021) have been explicit when talking of restraint:

> The nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as ‘embrace’, ‘prompt’, ‘guide’ or even referred to erroneously under euphemisms such as ‘physical support’, ‘manual handling’ or as a ‘first aid technique’ (p.120).

The Fabian Society (2013) interrogated the use of the term ‘Seated Double Embrace’, which was implicated in the death of Gareth Myatt within a Secure Training Centre. The term ‘embrace’ infers some sense of willing participation, as a transitive verb ‘to take up especially readily or gladly’ and noun, ‘a close encircling with the arms and pressure to the chest especially as a sign of affection’ (Merriam-Webster, 2024). What is masked here is any suggestion of force, and the asymmetrical power relations within the application [Myatt was outnumbered by staff] and the setting [a secure setting for children and young persons, staffed by adults]. One might conclude that the titration of terminology has been commandeered by training retailers, rather than policy makers.

There seems to have been little exploration of the nature of the physical interactivity between staff and those presenting behaviours of concern and whether it offers benefits, such as anxiety relieving connectivity, relief of touch starvation, or trust building. The enmity towards physical restraint has perhaps stymied such research. An example of research that has been undertaken is that of Bailey (2015), who’s hermeneutic inquiry into adult acute mental health nurses’ experience of physical restraint procedures spoke to the lived moral and care inconsistencies of nurses, and of their preferences for reaching out to different parts of the patient’s body during a restraint with an ambition to confer some form of non-hostile intimacy in the contact. Bailey (2015) spoke of a complex sequence of touches including forced, gentle, protective, and compassionate touches.

Another way in which the exploration of restraint has been restricted is by commentators drawing on the language of contamination (Hughes, 1971). Godin (2000) describes work with persons who are troublesome or dangerous as 'a dirty business' (p.1396), with Cusack (2020) characterising restraint as 'dirty work'. A moral taint is evident in many descriptions of physical restraint, where it has been variously described as 'frightening and hugely disempowering for anyone, let alone someone in a highly distressed state' (MIND, 2013 p.3), '…an extreme response [that] can be humiliating, cause severe distress and at worst it can lead to injury and even death' (MIND, 2013 p.3), a 'necessary evil' (Wilson *et al.*, 2017 p.500) and something that in certain circumstances can be construed as 'Malicious and abusive' (RCN, 2008 p.3). Elsewhere in the UK, restraint has been characterised as a form of violence (McSherry, 2017). Implicit in the description of such acts is the condemnation of the actor, he or she who is doing that thing unto others. In addition to the ethical challenges of investigating restraint, the exploration of the topic can be construed as advocacy of that which seems morally difficult to countenance. The examination of restraint is largely confined to the discursive domain, occasionally augmented by undercover and citizen journalist footage of adverse events. It does not feel as if as researchers, we are yet to examine the matter in its everyday actuality or totality.

Complexity and Pragmatism in the Practice Space

It is recognised that there can be a divergence between policy and practice (Anderson *et al.*, 2023; Hollnagel *et al.*, 2015). NHS England (2023) recognise that 'The NHS and social care is a complex adaptive system. This means high levels of interdependence and connectivity, competing and changing demands, unpredictability, uncertainty, myriad relationships – as well as the need to work with emergence'. They further state:

> A complex situation is when you cannot predict with certainty the result of actions, there is no cause and effect, the same actions may produce a different effect each time. Complexity

> is characterised by unpredictability and interconnectivity, the need for flexibility and adaptation and is underpinned by relationships. The result for leaders and staff is the need to be able to work with constant change and emergence and the challenges such a system produces (NHS England, 2023).

Price & Baker (2012) speak clearly to the messy reality that is practice in this area:

> The causes of violence are multifactorial and unique to each individual situation and nursing interventions in response to aggression should reflect that. The need for creativity, flexibility, and interventions that are tailored to meet the specific needs of each patient is stressed within the literature. Furthermore, in situations that are highly stressful and anxiety-provoking for staff members, it might be more useful to be conscious of the need for more general self-awareness, rather than attempting to recall a set of rigid rules (p.317).

Therefore, it seems reasonable to conclude that responses to behaviours of concern will take place amid complexity. Fig 2.5 provides a representative illustration of the behaviours and responses study participants experienced. It has been created by using descriptive notes identified in the preliminary stage of data analysis. It is here that the confluence of events, many unexpected, can serve to destabilise any certainty and predictability, requiring urgent situational adaptation, leading to the 'emergence' mentioned. There is a recognition that authorised physical interventions do not maintain the whole, pristine form seen in the training environment (Koerner *et al.*, 2021), with challenges in developing and retaining competence in physical skills noted (Dickens *et al.*, 2009; Rogers *et al.*, 2006). The literature acknowledges the notion technique creep, in the idea of 'Field Modification' (Paterson,

2007). This occurs when component parts of a technique are omitted or adapted, or other parts added. This may occur consciously or unconsciously, although it is difficult to say as research is lacking.

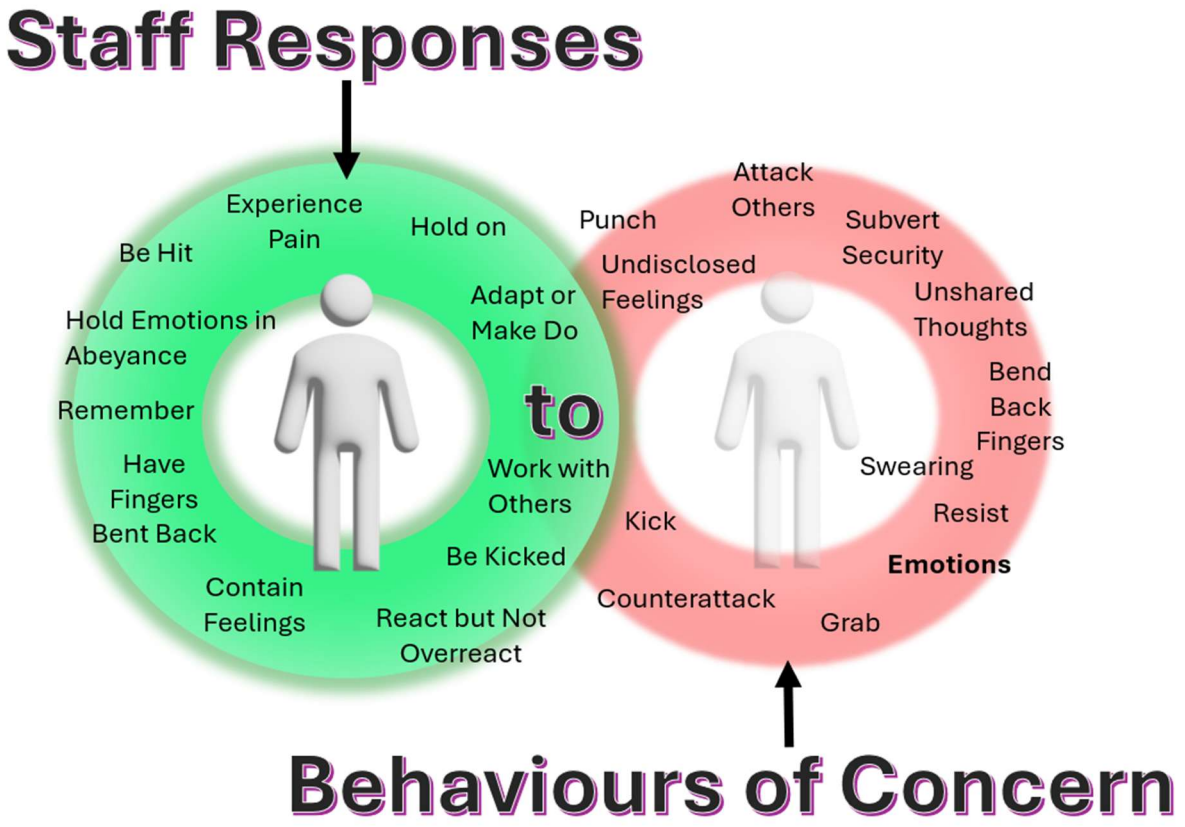


Fig 2.5: Illustrative Complexity (see analytical chapters for elaboration).

The literature suggests that applying physical restraint itself can be an uncomfortable, dangerous, and morally difficult experience (Cusack *et al*., 2018; Wilson *et al*., 2017). Kodua *et al*. (2023a, 2023b) undertook a systematic review of the literature which resulted in the review of 19 studies (n=19). They arrived at one overarching interpretive theme: 'unpleasant but necessary', which in turn was underwritten by five subthemes: 'maintaining safety triumphs all', 'emotional distress', the 'significance of coping', 'feeling conflicted' and 'depletion'. Verdana *et al.* (2018) interviewed psychiatric nurses (n=29) and found that physical restraint was considered unpleasant, challenging, risky, and frequently associated with situational dilemmas and conflicts. In their systematic review and thematic synthesis of qualitative papers (n=21) Butterworth *et al.* (2022) found that staff experiences

of restrictive practices were overwhelmingly negative and carried with their implementation harmful physical and psychological consequences for them. This all points towards the mentally complex situations into which staff members are thrown when committing to responses involving force. The paucity of research around negotiating physical complexity may be rooted in the challenges of ethically getting to such physicality in vivo.

In Summary

Staff, as part of their duty of care, are required to take action to resolve behaviours of concern and reduce the potential for harm. The definitions describing the various components of such responses are contested, and the research supporting the efficacy of their use extremely limited. For various understandable reasons restraint is both difficult to talk about and explore. As a result, it is unclear how staff orientate within situations in which they become involved in finding pragmatic solutions to risks of serious, imminent harm. By exploring the lived experiences of staff, this study seeks to better understand how individuals make sense of complex situations to negotiate the implementation of their response strategies. The aim being to explore staff experiences to gain a better understanding of what takes place within the physical responses to behaviours of concern, thus determining something of the nature of the translation of policy into practice.

Chapter 3. A Sensitising Framework

Overview

The aim of this chapter is to set out the framework that has been constructed to help sense to be made of the lived experiences of participants. It is constituted from Street Level Bureaucracy (Lipsky, 1980), Care Ethics (Pettersen, 2012; Tronto, 1993; Noddings, 1984; Gilligan, 1983; Ruddick, 1980) and Primary Task (Lawrence, 1977; Rice, 1963). This chapter will first provide an overview of the policy context, before exploring the individual framework components in more detail.

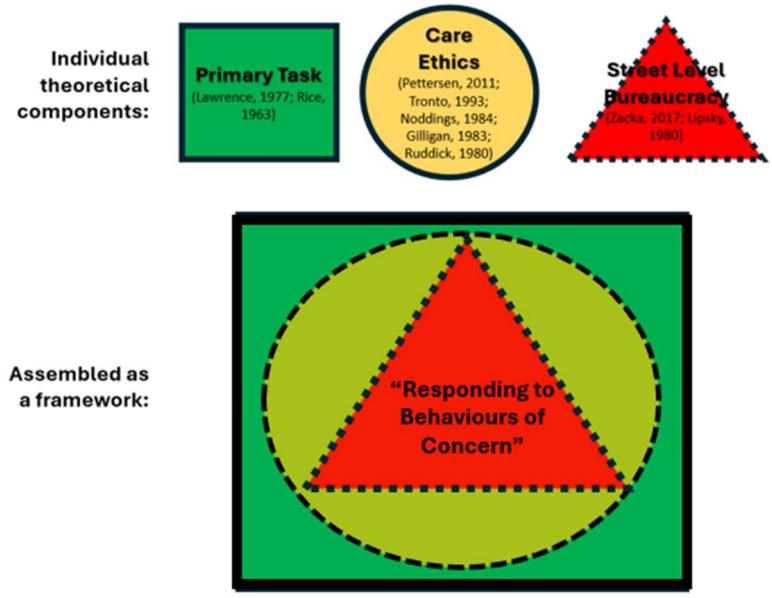


Fig 3.1: Explanatory Theory: Individual components and assembled framework.

Fig 3.1 provides a sense of how they interrelate. Street Level Bureaucracy (Lipsky, 1980) provides a means to talk about the translation of policy into practice, and the role that staff play in this. Care Ethics (Pettersen, 2012, 2008; Tronto, 1993; Noddings, 1984; Gilligan, 1983; Ruddick, 1980) provide a way of examining the contents of those actions. Finally, Primary Task (Lawrence, 1977; Rice, 1963)

provides a way of examining the functioning of the organisation, by examining how those within it enact and experience their pursuit of that mission. The dotted border lines symbolising the integration of theories constituting the framework, with all components combining as one.

Street Level Bureaucracy

The Term 'Bureaucrat'

The relevance of the local context in policy-related decision making, and the role of the individual agent (both established in the previous chapter) make 'Street Level Bureaucracy' (Lipsky, 1980) a valid choice for this study. Whilst remaining true to the literature, the term 'bureaucrat' does not immediately resonate with the roles of study participants. Bureaucrats are often portrayed as officious or overwhelmed [Fig 3.2], with paperwork central to their mode of working. Paperwork, whilst present, is ancillary to lived experiences of participants, who are involved in a very hands-on form of work. The term bureaucrat will sometimes be used, in other instances the term staff, support worker and nurse should be considered synonymous.

This image has been removed from the public version of the thesis for copyright reasons.

Fig 3.2: The officious bureaucrat and the overwhelmed bureaucrat.

This study is concerned with exploring how one aspect of policy is implemented. Such implementation can be understood as being Top Down or Bottom Up (Evans, 2011). Top-Down policy theorists (Simon, 1955; Weber, 1947; Taylor, 1911) believe policy to be a more-or-less fixed entity, which maintains its integrity as it passes down through levels of bureaucracy. Weber's seminal work on bureaucracies in turn also giving us the ideas and terminology that pervade exploration of such structures. In contrast Bottom-Up theorists believe policy is effectively determined at the point of implementation. This is necessary because work is often undertaken within complex operational contexts (Evans, 2011).

What is a Policy?

According to Evans (2020) 'Policy itself is a portmanteau term, referring to things as varied as, say, a detailed prescription, a strategic plan of action, or the indication of a broad aim' (p.3). Elsewhere, when politicians engage with the notion of policy it can represent a statement of a position or a stance (Hill, 2013), a broad-brush commitment, an intention to do 'something', or even used symbolically, as a rallying call, without regard to the practicality involved in any subsequent realisation (Hill, 2013). Policy in this sense is often speculative or rhetorical in nature, 'As politicians know only too well, but social scientists too often forget, public policy is made of language. Whether in written or oral form, argumentation is central to all stages of the policy process' (Pawson *et al*., 2003, p. 53).

Richards and Smith (2002) suggest that policy is a general term used to describe a formal decision or plan of action adopted by an actor, to achieve a particular goal. According to Evans (2011) policy is synonymous with the provision of a service, something that is implemented within a flexible set of parameters, including instances where policy constitutes *the* service, where policy *is* practice. An example would be the issuing of permits or licenses (Evans, 2011). Elsewhere policy provides a

framework for strategic decision-making within the context of the service provided. In this instance competing demands or conflicting priorities are resolved by considered judgements as to how best to balance service provision in the prevailing circumstances. The policy agent is provided with the latitude to make choices or choose from recognised options. A Police Officer encounters a person who has broken the law but discovered to be 'off their meds'. Here they must decide whether to process the person as an offender through the criminal justice system, or as a patient through the mental health system (Evans, 2011). Finally, there are instances where policy's role is to provide members of the public with the service to which they are entitled, it provides the logic for the provision. In this type of service, policy scaffolds the 'street level bureaucrats' exercise of a far more expansive form of discretional decision-making which constitutes policy implementation. A nurse may be faced with a patient presented serious risk of harm, where decision making may be dependent on the interpretation of a complex set of circumstances, and where the actual response is defined by the situation (Evans, 2011). Colebatch (1998) offers a useful perspective, describing policy as comprising:

> Diverse activities by different bodies [which] are drawn together into stable and predictable patterns of action which (as often as not) come to be labelled 'policy' (p.5)

This refers to a body of practice being labelled as policy. This could equally speak to practice where no formal policy exists, or where ad-hoc practice redefines the boundaries of an existing, underdeveloped, or insufficiently coherent policy. Here policy arises from decisions made in that space where existing policy fails to provide the required clarity, and pragmatism can be required. By way of illustration, Page (2015a) looked at holding practices used to help children and adults stay still during the administration of treatments, preventing treatment interference. The specialist restrictive physical interventions used in such circumstances are commonly referred to as 'clinical' or 'therapeutic' holds. Page (2015a) found that 'the practice of therapeutic holding was often covert and

not considered to be part of the treatment per se, which has led to concealment and a reticence to discuss practices openly'. Here a practice was enacted which informally began to constitute a policy that did not formally exist (Page & McDonnell, 2015, Page *et al.*, 2015a&b).

Top-Down Policy Implementation

Brodkin (2016) refers to the 'compliance model' (p.326), where high level administrators seek 'to achieve control through formal rules and regulations, monitoring, rewards, and penalties, even persuasion and exhortation, standard instruments of the 'old' public administration' (Brodkin, 2007 p.2). This is premised on 'command and control' assumptions wherein bureaucrats strive to meet policy goals by drawing on technical competency, and by consciously excluding any moral or political element of judgement (Zacka, 2017). According to this model, the organisation should be the one to provide the answer through its crafted systems and processes, 'we should not be looking for morality inside individual bureaucrats' (Zacka, 2017 p.36).

Much of the early thinking underwriting the 'compliance' model can be found in the writings of Taylor (1911), Weber (1947) and Simon (1955), who posited that organisations were rational systems. This theory envisioned bureaucrats, at point of implementation, as no more than conduits, without need for discretion. The assumption is that the drafting of policy and the accompanying standardised operating procedures preclude any such need, being so tightly drawn that discretion was superfluous. Zacka (2017) describes a range of administrative structures that effectively serve as such bureaucratic fetters: 'Hierarchy' which involves the careful parsing out of responsibility, limiting the extent to which it can be devolved down to lower level bureaucrats; 'Discipline and Control' arrangements which prevent bureaucrats from transgressing the limits of their fixed role and responsibilities; 'Fixed

Jurisdictional Boundaries' involving the disaggregation of tasks, keeping certain ones under the auspices of particular specialists and finally 'Impersonal Rules and Procedures', the prescriptive operating procedures that minimise any exercise of discretion.

Technical Discretion

As an advocate of rational systems, Simon (1976) distinguished between judgements relating to 'states of the world' or matters of fact, and judgements relating to 'values', amounting to beliefs that guide or motivate attitudes or actions. The closer to the street, the less that 'value' judgements are permitted or encouraged by design. This encouragement of fact-based judgements can be subsumed under the exercise of 'Technical Discretion' (Zacka, 2017), which can be reduced to three types of judgement:

- A Subsumptive Judgement. In making this type of judgement the bureaucrat is discerning whether the case before them relates to, or is covered by, the policy they have identified. This judgement involves recognising and understanding the difference between a case to which policy applies, and one to which it does not. It involves a consideration of 'facts' in evidence and can lead to decisions being set aside as out of scope (Zacka, 2017).

- An Interpretative Judgement. The task is to determine exactly what aspect of policy is relevant at the decision point, then how it relates to this category of person or event. Part of this involves the exclusion of policies and aspects of policies that do not relate. The bureaucrat needs to be clear about policy before they can process the case before them. The rules governing this presume a common understanding of policy by all implementing it, and a shared approach to discernment and decision making (Zacka, 2017).

- An Expert Judgement. To realise the policy goal there is some latitude [albeit it minimal and mediated by the administrative structures previously mentioned] afforded to the bureaucrat, as to how to process the case before them. This latitude typically extends to a choice between approved solutions. Whilst this is discretion, the system continues to limit or control it (Zacka, 2017).

A system built around 'technical discretion' has much to offer in the way of reassurance to policy makers, and those with governance functions. Realised in its pure form, the bureaucrat deals with matters of fact rather than value, serving to mitigate against the infiltration of concerning eventualities such as personal agendas. This strengthens accountability and makes implementation of policy auditable (Evans, 2011). Deviation from the process, or any breach of rules governing technical discretion, will be readily visible and thus allow for 'Discipline and Control' measures to come into effect. The operation of 'technical discretion' has its limitations, namely that the policy needs to be amenable to practical simplification (Zacka, 2017).

Bottom-Up Policy Implementation

Lipsky (1980) developed 'Street-Level Bureaucracy' after concluding that policy was often incomplete, or imprecise and that it was not possible to implement policy as prescribed, given that this often involved meeting complex or complicated human need, needs which are experienced individually, and sometimes emotionally by those unconstrained by the same rules as the bureaucrat. Street Level Bureaucracy theory contends that the decisions and actions of bureaucrats effectively *become* the policies of the agency they represent (Lipsky, 1980).

Lipsky's theory speaks to those who serve as the face of policy, public servants, or policy agents that work on the ground, at 'street level' (Lipsky, 1980) or on the 'street corner' (Muir, 1977). Examples include social workers, teachers, police officers, health service workers, nurses, doctors, counsellors, and caseworkers (Erasmus, 2015, Brodkin, 2007), those 'ostensibly at the bottom of the policy hierarchy' (Brodkin, 2007 p.2). This study focuses on the experiences of such individuals.

The interpretative work undertaken by 'Street Level Bureaucrats' was not held by Lipsky to invariably result in positive, or effective policy delivery. The discretion available is recognised as supporting innovative practice, however Lipsky criticised what he saw as a tendency on the part of bureaucrats to develop approaches to their work that were 'often biased in ways unintended by agencies whose policies are being implemented or are antithetical to some of their objectives' (p. 84). The operation of latitude can therefore be seen as being helpful in expanding the reach, or in personalising the realisation of policy, only where the refinement or adaptation of practices meets a particular need or solves a unique problem in the spirit of the organising policy. It can also be seen as resulting in a reduction in policy reach or impact when bureaucrats make decisions and take actions in ways that are designed to protect them from the personal cost of implementing policy. Such protectionism is not inevitable but understandable in those spaces where staff face pressure and experience anxiety. This alerts us to both the challenges presented by the goodness of fit of policy, as well as the cost of implementation to the bureaucrat.

The Working Context

The context in which street level bureaucrats operate has been found to have implications for how work is done (Zacka, 2017; Lipsky, 1980). This has relevance because study participants come from

distinct settings, each with their own contextual idiosyncrasies. Policy is often implemented with 'Inadequate resources' (Erasmus, 2015), including too few staff. This in turn may be compounded by 'vague or conflicting organisational expectations' (Erasmus, 2015), where the policy goals are not clear enough and further complicated by 'Ambiguous, contradictory, or unattainable role expectations' (Camillo, 2017). Real world nuance can also confuse, such as when a 'bad' outcome, can paradoxically be a 'good' outcome. For example, an emotionally charged service user damages a chair, but staff are satisfied that this is good because the distress was not revealed through self or other-directed violence. It is important to point out that policy is often implemented into a space populated by 'non-voluntary clientele' (Camillo, 2017) or 'captive clients' (Erasmus, 2015). These include individuals in custody or healthcare in-patients and reflect the conditions of the study sites in this thesis (see chapters 4 onwards). Within this context there can be power imbalances, where policy may be resisted and revealed in the 'existence of clear physical and/or psychological threats' (Camillo, 2017), which can be anxiety provoking or otherwise destabilising for staff. Furthermore, there is often no regularity to policy-sensitive encounters. One might suggest that if every physical response to behaviours of concern could be planned, staff would have at least time to prepare and offset concerns or anxieties, but the need for such interventions cannot be scheduled or always anticipated. Zacka (2017) spoke of interactions as the 'ordinary non-routine' and the 'extraordinary non-routine', with the latter being emergency-like, where the loss of something important was at stake. Notably, in spaces where staff are regularly responding to behaviours of concern the 'extraordinary non-routine' can seem to become the norm.

Resort to Coping Strategies

In response to the contextual challenges, Street-Level Bureaucrats can develop an array of reductions and simplifications to allow them to gain greater control over their workload and to mitigate the stress

arising. This includes 'rationing the services' (Erasmus, 2015) to regulate demand, including selecting clients likely to provide good outcomes. It can also mean ignoring or delaying, providing a minimal service to maximise volume of processed cases, and in some instances applying psychological pressure to discourage individuals from expressing a demand. An expansion of this is 'controlling clients' in order that they might co-operate or comply (Erasmus, 2015). This involves manipulating the space in which interactions take place to communicate power, signalling to clients how they should act within it. It can also include strategies designed to punish clients who do not conform to expectations (Erasmus, 2015). Bureaucrats also engage in 'managing and conserving resources' (Erasmus, 2015) wherein they seek to protect themselves by conserving resources and regulating their work time and activities. Examples include building 'slack time' to preserve their capacity to respond to unpredictable situations and restructuring engagements to enable clients to be processed by phone, letter, or video call. This is especially likely if hostile or negative interactions are foreseen. Staff may also devolve or delegate responsibility to others, or 'managing the consequences of practice' (Erasmus, 2015). If other strategies have failed, and clients prove to be particularly difficult, bureaucrats may refer individuals to specialised workers or specialised units. Such practices may be a legitimate exercise of technical discretion (Zacka, 2017) or be self-serving and protect staff from increased or unsustainable cognitive demands, hostility or even violence. Manifestations of the exercise of such discretion encompass the strategic, such as referrals to other units, passing over to designated response teams, and more subtly to colleagues with or without them being explicitly told.

Non-Technical Discretion

As has been discussed, Policy can be implemented in line with the 'compliance model' (Brodkin, 2016) where the discretion for those at street level is narrow and technical, where facts will clearly take precedence over values at point of implementation. However, in Street Level Bureaucracy (Lipsky,

1980), there is recognition that policy can be found to be 'vague, imprecise or incoherent' (Evans, 2020 p.2), meaning that something beyond technical discretion is required: 'non-technical discretion' (Zacka, 2017). For Lipsky, this expanded discretion manifested in spaces where top-down control efforts fell short and where 'complex tasks for which elaboration of rules, guidelines, or instructions cannot circumscribe the alternative' (Evans, 2011). Responding to behaviours of concern would seem to be a clear example.

Zacka (2017) argued that non-technical discretion flows from the authorised exercise of power, and whilst externally constrained by the law, it was simultaneously mediated by the bureaucrat's sense of what was reasonable and possible. For Zacka this included what was morally right, with it being incumbent on individual bureaucrats to account for their actions. In so doing they should be actively resisting easy, or unthinking choices. Zacka (2017) argues that non-technical discretion represents a normative position, a necessity arising out of the complex circumstances faced by the bureaucrat. He expands on this complexity by recourse to 'goal ambiguity', 'conflicting goals', 'limited resources', 'fuzzy boundaries', 'uncertainty', 'soft evidence', 'unpredictability', 'entangled ends', and 'information asymmetry'. Some of these are conceptually related to those factors which give rise to the pressures on bureaucrats, and which engender reductions and simplifications (Erasmus, 2015; Lipsky, 1980). Zacka (2017) posits that they give rise to the development of three 'pathologies' which function as coping strategies [more on these shortly].

The notion of 'Goal Ambiguity' refers to the clarity and coherence of policy goals, and the discretion necessary to interpret and negotiate them in practice. An example given by Zacka (2017) is that of Police goals around 'Law Enforcement' and 'Maintaining Order'. Whilst law enforcement lends itself to clear practice remits, the maintenance of order is more nebulous. What is order? In the US, this ambiguity led Police officers to emphasise those aspects of their job that were most easily

standardised and recorded to the detriment of equally important but more complicated tasks involved in mediating family and barroom conflicts (Wilson, 1989). Zacka also spoke of 'Conflicting Goals', where policy ambitions which are in opposition can generate conflict. Within mental health nursing, for example, the conflicting need to provide care and assert control have long been recognised (Breeze & Repper, 1998). Within the context of responding to behaviours of concern one can fail to restrain someone who subsequently causes damage or harm. In failing to restrain, staff are paradoxically positively contributing towards the policy goal of restraint reduction, whilst simultaneously instrumental in allowing harm.

Zacka highlights 'Limited Resources' as a significant factor for consideration. At the time of writing, reduced budgets, and increased expectations are facts of working life (CQC, 2023). Resources are more than money, property or equipment. Physical and psychological resources can include time, energy, attention and empathy, as well as compassion, patience, resilience and creativity (Conradson, 2003). A reduction in such resources has the clear potential to erode the quality of staff members responses to behaviours of concern.

Bureaucrats have the authority to, and are expected to, draw a line. That is, they are required know where the boundaries are, and the suitability or not of the proposed course of action. This introduces the possibility of 'Fuzzy Boundaries'. In the 'compliance model' (Brodkin, 2016) this is supposedly a matter of fact, the demarcation being clear and unambiguous. In real-world scenarios it can be a matter of value. Zacka gives examples of policy definitions of disability, and the conditions under which people qualify for benefits or not, and how that state of disability can be drawn in different ways. Elsewhere, Åkerström (2002) spoke to a particular form of embodied boundary-work taking place under the auspices of healthcare policy, where care workers supporting adults with dementia elaborated on how aggressive acts were constructed to avoid representing them as 'violence'.

Defining them as 'violence' would push the person in need outside the notional boundary for continuing care, into a space where control measures flowing from behaviour management policies would be applied. How staff recognise, name and deal with such behaviour is central to this study.

The role of 'Uncertainty' is also considered. When making a policy-based decision the bureaucrat evaluates an array of evidence, or 'factual premises' (Zacka, 2017 p.56). Uncertainty may refer to what is unknown, or unprovable and as such requires the bureaucrat to exercise discretion. Different answers will signpost different actions, and the degree of certainty may determine the urgency of a response. Zacka (2017) highlights the role of situational heuristics, or 'rules of thumb', to which the individual often resorts when seeking to resolve such a demand. These are fast and readily accessible rules for responding to types of situational challenge (Tversky & Kahneman, 1975). They are often deployed on the basis that 'on balance of probability' this action will be useful. But useful to whom? Zacka (2017) argues that we should be judicious in resorting to heuristics as they 'often serve as a refuge for implicit biases, and idiosyncratic preferences' (p.56). Again, one can readily argue that practices which otherwise might be necessary and proportionate can be counterproductive when one realises how and why they are being used. Here the absence of universally shared certainty operates as a destabilising force. Bureaucrats may be unable to draw emphatic inferences from what Zacka (2017) characterises as 'Soft Evidence'. To mitigate this there may be fixed solutions, favoured by those with allegiance to the 'compliance model' (Brodkin, 2016). But, one size often does not fit all.

Another relevant issue according to Zacka, are 'Entangled Ends'. Brodkin (2016) makes a distinction between the choice of 'means', such as the choice of discretion in respect to process options, and the choice of ends such as discretion over the outcome that is settled for. But, policy implementation becomes messy, as 'means' become entangled with 'ends'. Imagine a member of staff who is dealing with someone heading for crisis. They have discretion over both 'means' and 'ends', to pursue a co-

regulatory strategy by persisting with de-escalation resulting in opportunities for reflection, or to seek quick resolution through restraint, and the expedited placement of them in a seclusion space where they can self-regulate and reflect. Which is right? Or best? Finally, 'Information Asymmetry' speaks to the partial or periodical disconnect between the senior administrators [managers] and the street-level bureaucrats [frontline staff]. It is within this disconnect that information becomes asymmetrically distributed, and non-technical discretion is required.

Dispositions and Pathologies

Brodkin (2007) reminds us that 'bureaucratic discretion has variously been blamed for being too broad and too narrow, too lax and too rigid' (p.1), and that at both ends of the continuum can lie peril. Zacka (2017) explored the idea of different dispositions being embodied by bureaucrats. He argues these dispositions can give rise to adaptive worldviews which act as protective mechanisms, to this end he posited the 'three pathologies'. To make sense of this, Zacka introduces us to the 'mode of appraisal' [or 'local disposition'], 'moral disposition' [or 'enduring disposition'] and 'role conception', which will be separately considered [Fig.3.3]

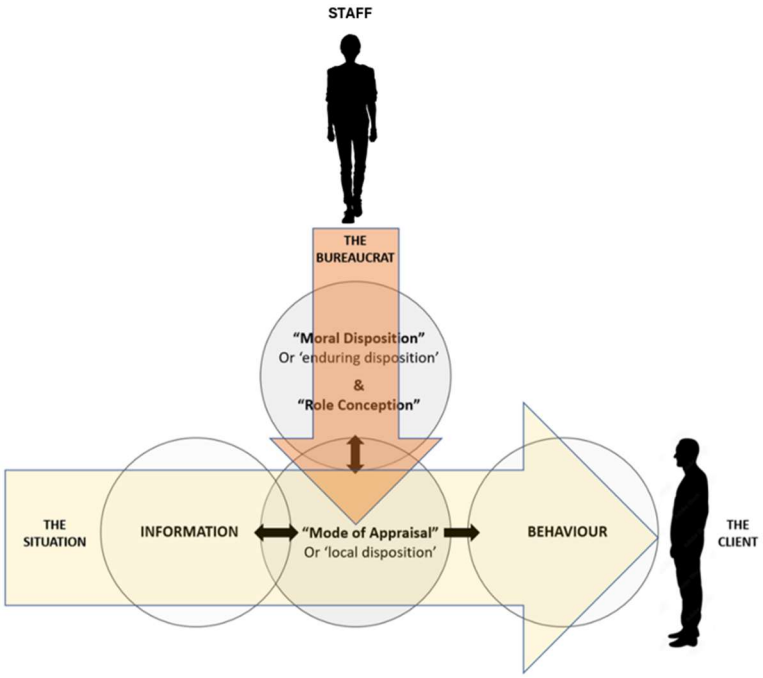


Fig 3.3: Conceptual Overview of Dispositions (Zacka, 2017)

Within the horizontal arrow one can see the 'situation' in which the 'bureaucrat' will become involved. This involvement is represented by the vertical arrow bisecting the horizontal one. The 'situation' has 'information' available to the bureaucrat, the processing of which leads to some form of situational behaviour that notionally embodies policy at the point of implementation. According to Zacka (2017) a bureaucrat's moral disposition represents something that can be thought of as a standpoint, position, or perspective. Fig 3.4 shows this disposition comprises three linked components: 'a hermeneutic grid', 'a mode of affective attunement' and 'a normative sensibility' (Zacka, 2017) all of which speak to how one sees or understands *things* in a particular way. This gives rise to a particular way of emotionally engaging with that *thing* [warmly, and sympathetically or otherwise] which in turn impacts on how the person proceeds, the decisions they make, and ultimately actions they might take.

A hermeneutic grid	A way of perceiving or interpreting a given person or situation
A mode of affective attunement	The extent to which one is moved by, or emotionally engaged with, events
A normative sensibility	The resultant way of "weighing" factors, which is likely to manifest in certain particulars being assigned greater salience or credence

Fig 3.4: The constituent parts of a 'Disposition' (Zacka, 2017)

These three components can be thought of as scaffolding distinct dispositions, or 'harmonious psychological ensembles' (Zacka, 2017 p.86). Each have their own internal coherence. The three key dispositions [or pathologies] that Zacka (2017) identifies as moral modes of engagement are the 'Indifferent', 'Caregiver', and 'Enforcer'. They offer a way to discern and name individual tendencies and offer a shorthand to a particular mode of analysis, and subsequent engagement. They do not however represent the only, absolute and categorical ways of *being* within policy implementation. They are set out side-by-side in Fig 3.5. The 'Indifferent' describes a dispositional mode wherein the bureaucrat does not connect with the person and superficially serves the policy implementation process. The 'Caregiver' by contrast is a disposition that seeks the best for the individual person, cognisant of their unique situation and circumstances, whilst the 'Enforcer' protects the integrity of the policy above all else. In this instance the notion of resourcing includes the mind and body of the bureaucrat. The notion of 'role conception' which refers to the identity they adopt, provides a sense of continuity to what they do, as well as a link with policy.

	The INDIFFERENT	The CAREGIVER	The ENFORCER
A hermeneutic grid	A way of extracting information that is administratively relevant	On the lookout for signs of strain and distress	Expects that the client will transgress or take advantage
A mode of affective attunement	An emotionally neutral response	A tendency to be moved, and experience feelings of sympathy	A guarded perspective, characterised by a suspicious outlook
A normative sensibility	A concern with handling matters efficiently	A concern with meeting the specific needs of the specific individual	A pre-occupation with preventing and punishing perceived transgressions

Fig 3.5: The three dispositions (Zacka, 2017)

To return to Fig 3.3, the 'Conceptual overview of a Dispositions', it is important to recognise that dispositions can reveal themselves in both a smaller, situational form as a 'mode of appraisal' [or 'local disposition'], as well as a larger, more fixed, or abiding form of 'moral disposition' [or 'enduring disposition']. The situational form or 'mode of appraisal' [or 'local disposition'] is fluid rather than fixed. A bureaucrat who starts with the local disposition aligned to the 'Indifferent' might shift to a disposition aligned to being a 'Caregiver', or by contrast one initially aligned to the 'Caregiver' becomes an 'Enforcer'. Contexts may change over time. The nature and extent of the information the bureaucrat is in possession of, and the diverse nature and impact of the ongoing experience may change. If the information changes, so might the bureaucrat's disposition. It should be recognised that in addition to situation-dependent 'Modes of Appraisal' there can be the situation-independent 'Moral Dispositions'. Such dispositional inclinations could be rooted in personality or founded on accumulated tacit knowledge, 'a non-linguistic, non-numerical form of knowledge that is highly personal and context specific and deeply rooted in individual experiences, ideas, values and emotions' (Gourlay, 2002 p.2).

One can see in Fig 3.3 how the information received within the context of the situation passes through the prism of the bureaucrat. His or her 'mode of appraisal' is clear in the central portion of the diagram, meaning that the bureaucrat themselves is part of the interpretive process; their inherent values and worldviews are part of what happens next. Zacka (2017) gives examples that illustrate how some individuals do not bring any extraneous values into the sense making process. This may be because they adopt the disposition of the 'Indifferent' as a protective mode of being, insulating them from the costs attached to dealing with the person or situation. It may also be that the bureaucrat has yet to develop a strong personal perspective. One thinks of a student coming into a work setting with only limited theoretical knowledge and real-world experience.

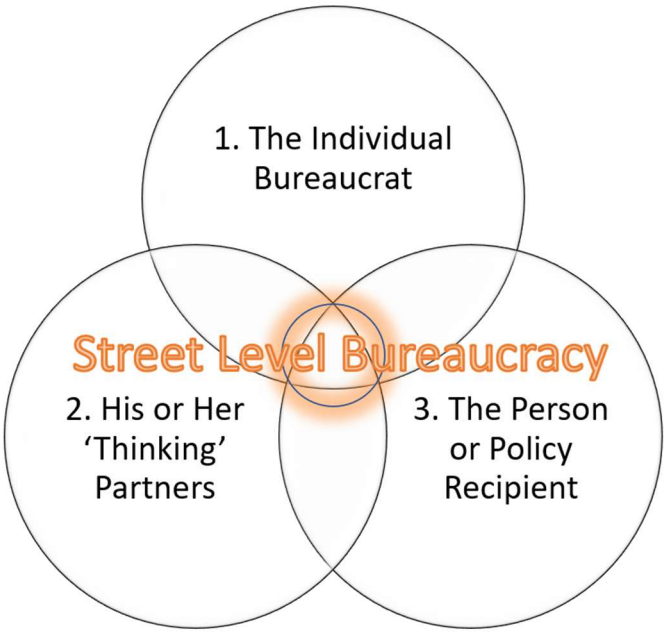


Fig 3.6: Street Level Bureaucracy – The broader response context (Zacka, 2017)

Non-Technical Discretion then can be thought of as being a feature of Street Level Bureaucracy. The enduring dispositions of individuals account in no small part for how people can express themselves within policy decisions and actions. There are at least two other developmental forces that one needs to acknowledge [Fig 3.6], namely the bureaucrats' peers or 'Thinking Partners' and the client or policy

recipient themselves (Zacka, 2017 p.79). The notion of 'thinking partners' accounts for a variety of influences, ranging from that of a mentor or supervisor through to trusted colleagues who can be used as sounding boards for interpretation and formulation of possible responses. In exploring participants lived experiences the broader response context is expected to reveal the nature and extent to which 'Thinking Partners' figure in responses, and the extent to which staff understandings of care influence how they interpret and attempt to implement any restraint policy.

The Specific Policy Context

The policy levers, ideas, concepts and terminology that relate to this very specialist area of practice were discussed in the literature review. The practice of restraint [and its policy guidance] is located conceptually within the broader and preeminent restraint reduction policy. They take a strategic, top-down formulation, which is optimally integrated as a total organisational change mechanism (RRN, 2022; Paterson, 2010). Whilst responses to a relatively fixed schedule of broad types of events can be outlined, and staff notionally directed to meet various legal obligations including those relating to upholding human rights, discharging the attendant duty of care and the obligation to act proportionately, the exact nature of those responses involves interpretive work. Here the ideas, techniques and strategies contained within training programmes present them with an array of tools. The exact nature of the bottom-up interpretive work that takes place is unknown and so the Street Level Bureaucracy lens has been selected to facilitate a more detailed exploration of the phenomenon. Care Ethics and Primary Task have also been integrated into the sensitising framework to permit examination of the individual and organisational aspects of staff members responses.

Care Ethics

Due to its multi-faceted nature, scholars have failed to reach consensus on any singular meaning of care. 'Care can be construed as a sense of concern or as a practical task such as nursing the sick; it can also be perceived as women's unpaid domestic work, an innate female disposition, a suppressed moral value capable of challenging patriarchy, a private or a civic virtue, a gender-neutral political concept, a citizenship issue, the outcome of a welfare state, or as paternalism in disguise' (Pettersen, 2012 p. 367). Before focusing on the moral or ethical function of care, the reasons for caring will be briefly explored.

Why Should We Care?

In his examination of care, Engster (2005) cites Robert Goodin's vulnerability model, wherein because of our proximity to others we can help or hurt them; they are vulnerable to our actions or inactions. As a result of this vulnerability, we have a moral obligation not to hurt them (a negative duty) and an obligation to help (a positive duty). This obligation can extend to any 'other', such as a stranger in need, when they are similarly vulnerable to us. So, according to Goodin, when conscious of this vulnerability we are obliged to care.

Another explanation is the 'dependency' model, put forward by others, including Kittay (2001). Building on Goodin's vulnerability model it suggests there is an obligation to pay back into a society for the care we receive when in a state of need. Everyone will have experienced a state of dependency. As a child we would have been dependent on our parents, at times of ill health we depend on others including healthcare professionals, and as we age this dependency returns. As we have depended on

others, so will others depend on us. This also highlights the functioning and operation of relationships that are needed to sustain us all.

Engster (2005) offered a modified model of obligation, 'the principle of consistent dependency' (p.64). It was developed in the wake of criticism that autonomy is often taken as a starting point, when there may be individuals without full agency. This revised theory founded the obligations upon common dependency rather than the acts accrued through autonomous agency resulting in societal credit, thus storing up a right to claim care because of first having provided to others. Engster (2005) asserts that all human beings require care to survive, function and flourish. From this it follows that individuals who value their existence, recognise care as a necessary good and one required when it is needed. Based upon this it is contended that all individuals may be said to assert a right to be cared for when in need, meaning that they can expect care when they cannot reasonably survive, function or flourish by themselves. It is notable that some individuals may not make explicit claims for care due to being non-capacitous. In practical terms, best interests' frameworks provide a way for such claims to be processed legally.

Care As an Ethic (Care Ethics)

Caring actions can be seen as ethical, whether they come from a place of goodness as a virtue (Arries, 2005), are good in and of themselves [a deontological endeavour], or they produce consequences that are more favourable than unfavourable [a byproduct of consequentialist reasoning] (Tseng & Wang, 2021). The recognition that human relationships provide a space within which morally important actions take place led to the development of an 'ethic of care' [now 'care ethics']. Whilst the act of caring has always been considered a natural expression of what it is to be human, the development

of a formalised 'Ethic of Care' provides a lens to examine the act of responding to behaviours of concern. The pioneers of this new form of ethicism were Sara Ruddick and Virginia Held.

Sara Ruddick and Virginia Held: Maternal Practices

Held (2006) has gone on record to state: 'I locate the beginnings of the ethics of care with a pioneering essay called ''Maternal Thinking'' by philosopher Sara Ruddick published in 1980' (p.26). Ruddick was intellectually absorbed by the notion of 'mothering' and 'maternalism' and saw maternal practices as flowing from the conscious decisions made by 'maternal persons'. It is important to note that Ruddick believed such individuals could be female or male. Such practices were aimed at meeting the safety and well-being needs of the child involving activity on three levels; preserving the life of the child, promoting the growth of the child, and providing the child with the training needed to develop appropriate social responsibility (Ruddick, 1980). Part of this philosophy was a strong stance against violence.

Held (2006) also argued the mother/child relationship was something that could be taken as the prototypical model of moral relations and should be put forward as the basis for all other relations in society. This was not universally embraced with the claim that the mother-child dyad was an overly romanticised notion leading to the development of a selfless and ultimately burdensome mentality (Shefer *et al.*, 2006). More broadly, there was also a criticism of latent ethnocentrism levelled by Lugones and Spelman (1983) who said, 'it is only possible for a woman who does not feel highly vulnerable with respect to other parts of her identity, such as race, class, ethnicity, religion, sexual alliance, etc., to conceive of her voice simply or essentially as a 'woman's voice'' (p.476).

Nel Noddings: Natural Caring & Ethical Caring

Noddings (1984) was critical of the rationalistic principles that turned ethical thinking into a form of 'mathematics', asserting that traditionally ethics had been discussed in 'the language of the father' (1984, p.1). By contrast she valorised the role of a 'feminine spirit' in moral reasoning but was clear that men as well as women could conceivably possess the traits allied with the feminine psyche and world view (Noddings, 1984). In Common with Ruddick and Held, Noddings saw the maternal perspective as central to the development of care. Noddings believed care was an intrinsic part of human life, which commenced the moment the child was born. She asserted that a rising state of dependency was the 'original condition' (Noddings, 2002, p. 151), and further argued that 'natural' caring was intuitive impulse. For Noddings (2002) caring was driven by a combination of the human affective response and the imprinted memories of being cared-for, resulting in 'a form of caring that does not require an ethical effort to motivate it', although, 'it may require considerable physical and mental effort in responding to needs' (2002 p.2).

Noddings clearly did not believe abstract rules were sufficient to guide moral behaviour (Johnston, 2008). Indeed, she asserted that, 'When we look clear eyed at the world today, we see it wracked with fighting, killing, vandalism and psychic pain of all sorts. One of the saddest features of this picture of violence is that the deeds are often done in the name of principle' (Noddings, 1984, p.1). Noddings believed that reasoned or 'ethical care' came only after 'natural care' had first been provided,

> Like a mother responding to the cry of her infant, we must receive the situation of the other as if it were our own. To do so requires emptying ourselves of attention to our own situation, at least for the moment, to make room to take in the existential condition of the other. For the moment, and whatever our situation, her need becomes our need (Bergman, 2004 p.151).

According to Noddings, ethical caring is distinct from natural caring in the sense that it is the right thing to do under the circumstances, and not just the obvious or easy response. Once ethical caring is provided, and needs met, the individual may return to a natural caring state until such time as ethical caring is once again needed. The guidance she offered was, 'Always act so as to establish, maintain, or enhance caring relations' (Noddings, 1995, p. 188).

For Noddings a relational ontology was fundamental to being human. When elaborating on the act of caring and the importance of the relationship, Noddings (1984) described a caring relationship comprising the 'one-caring' and the other being the 'cared-for'. She offered description of the caring process, starting firstly with mental engrossment in which the 'one-caring' chooses to direct their attention onto another (The term 'engrossment' later became 'attention'). This permits a motivational displacement whereby the one-caring clears their mind to make the mental space required to address and meet the needs and goals of the cared-for individual. Thereafter an affective responsiveness, a form of insight and an appreciation of the world of the 'cared-for' individual, develops before the decision is made to respond and help the other (Noddings, 1984). Noddings (1984) believed a degree of reciprocity was intrinsic to the process of caring, that the 'cared-for' party had an obligation to connect with the other in a morally, meaningful manner. For her caring is an act that is received by the recipient, and that 'acknowledgement of the contribution of recipients of care may be the very heart of the care theory, and thus recognises moral interdependence' (Noddings, 2002, p. 87–88). Noddings (2002) suggested that the obligation to care diminishes as individuals become more distal. In practical terms the relationship with, and understanding of, an individual reduces broadly in line with the ability to make considered contextual judgment. This led Noddings to posit that it is impossible to provide care for everyone.

Nodding was not without her critics. The diminishing obligation to care for others was seen as anathema by those theorists and writers who endorsed a universal obligation to care (Birsh, 2014). Noddings was also subject to criticism for drawing on a maternal perspective that re-enforced the idea of essentialism and otherness (Hoagland, 1990) which in turn re-enforced the traditional role of the female as subordinate or subservient. This was characterised as a service mentality or a slave morality (Puka, 1990). Hoagland (1990) criticised Noddings' broader use of unequal relationships as a model for understanding the concept of caring, arguing that such relationships, embodied by the mother/child or teacher/pupil dynamic, make one party dominant which provides them with power-over the dependent other. According to Hoagland (1990) this is morally unsound and such relationships should be seen as transitory arrangements and not as morally sustainable configurations. Card (1990) also criticised Noddings for the absence of any explicit reference to Justice. Noddings responded by offering a distinction between 'caring-about' and 'caring-for':

> The key, central to care theory, is this: caring-about (or, perhaps a sense of justice) must be seen as instrumental in establishing the conditions under which caring-for can take place. Although the preferred form of caring is caring-for, caring-about can help in establishing, maintaining, and enhancing it. Those who care about others in the justice sense must keep in mind that the objective is to ensure that caring actually takes place. Caring-about is empty if it does not culminate in caring relations (Noddings 2002, p. 23-4)

Carol Gilligan: A Different Voice

Carol Gilligan published 'In a different voice' in 1982, after she became disillusioned with the work of her mentor Psychologist Lawrence Kohlberg. This because, by using his criteria to judge moral

development, the average young adult female scored a full stage lower than any male counterpart (Gilligan, 1993). Gilligan believed that a women's moral development wasn't less developed, simply at variance. Gilligan believed that women operated an 'ethic of care' founded on relationships and responsibilities, which was qualitatively different to the men in Kohlberg's cohort who presented with an 'ethic of justice' that stressed the observation of rules and the recognition of rights (Gilligan, 1993). It wasn't that this ethic was superior, just that it was different, hence the title of her publication: 'A different voice'.

Gilligan proceeded with research that was built around an analysis of real-life moral challenges, rather the hypothetical dilemmas used by Kohlberg. A Supreme Court ruling that legalised abortion presented just such an opportunity to study women's choices when facing moral dilemmas (Gilligan, 1993). Gilligan concluded that those interviewed discussed their deliberations and ultimate choices within a care orientation rather than one framed by justice. Rather than decisions originating from a place of self-interest, they were seen as being defined in a collective sense, taking account of the interests of other parties (Gilligan, 1993). Gilligan went on to conclude that moral development for women meant learning how to integrate and balance the demands of others with one's own concerns, in a way that men didn't naturally seem to.

According to Gilligan (1982), moral maturity was something an individual reached they were able to take their own and others' interests into account. This gave rise to the concept of 'mature care', which involved balancing reason with emotions. Whilst Kohlberg focused strongly on moral reasoning at the exclusion of any emotional response, Gilligan recognised the need to reconcile the two. She saw emotions as a powerful means to connect with others, but which needed to be attenuated by the application of contextualised rational thought. Gilligan distinguished between 'empathy' and 'co-feeling'. She saw empathy as a process by which an individual identified the emotion another was

displaying, whilst co-feeling was the ability to experience feelings that are not one's own. According to Gilligan (1982), to 'co-feel' was to participate in an attitude of engagement rather than an act of judgement. Pettersen (2008) described how this distinction fitted into Gilligan's overall ethic of care elegantly:

> Co-feeling is the ability to participate in the feelings of others, through the act of 'affective imagination' without (con)fusing self with others on the one hand, or, on the other, merely observing the others' feelings from a distance. The capability to uphold integrity, and, at the same time not revert to egocentrism, is a feature of moral maturity in Gilligan's developmental theory (p.57)

The relational ontology upon which the ethic of care is built is different to those supporting orthodox ethical outlooks. Historically, ethical agents making decisions were held to be independent of the reality they were contemplating. The relational proximity to those being considered was deemed immaterial, as principles and rules took primacy in moral calculations. Gilligan's contribution to moral deliberation was to recognise the importance of connection and interdependence. At the heart of Gilligan's ethic is the idea that care comes from, and is explored through, the medium of relationships, something not rooted in sex differences but in differentiated upbringings. According to Griffin (1991):

> Gilligan is convinced that gender differences in identity are grounded in early childhood experiences with the person who provides primary physical and emotional nurture, usually the infant's mother. Early in life, girls discover that they are like their mothers. Growing up means relinquishing freedom of self-expression in order to protect others and preserve relationships. Boys' first psychic task is to understand that they aren't (and never will be) like

> their mothers. Maturity means renouncing relationships in order to protect freedom and self-expression. The result is an adult population of men who see themselves as separate from others and of women who think in terms of connectedness (p.3)

The incorporation of emotions when formulating caring actions drew criticism. Gastmans (1999) warned that an 'emotivist concept of care that would reduce caring involvement to some form of sentimentality' (p.217). When talking about care within a nursing context, Gastmans (1999) asserted that care was a 'future-orientated project' and so needs to be thought of as a bigger, longer-term engagement that requires non-sentimental formulation. Such criticisms seem to lean into an either/or position, whilst Gilligan seem to have called for a carefully balanced perspective, the best of both worlds.

Joan Tronto: The Political Context

Tronto (1993) was interested developing an ethic of care with wider scope for practical real-world use, one that that enabled a more equitable distribution of power throughout society. To this end she was drawn to examine how the separation of morality and politics could be overcome, contending all moral arguments had political contexts. Tronto defined care as a 'species activity that includes everything we do to maintain, contain, and repair our world so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment' (Fisher and Tronto, 1990). Tronto conceived of a moral power to be located within caring and called for society to elevate care from a disposition to a social practice, from a private to a public endeavour, 'for a society to be judged as a morally admirable society, it must, among other things, adequately provide for care of its members and its territory' (1990 p. 126).

Like Gilligan, Tronto (1993) was uncomfortable with the idea that there is an essential, gendered view of morality. 'We need to stop talking about 'woman's morality' and start talking instead about a care ethic that's includes the values traditionally associated with women' (1993, p.3). Tronto (1993) also addressed what she calls the 'false dichotomy' between care and justice. She stated that there was an assumption that the two are mutually incompatible because they originate from two different meta-ethical starting points, 'an argument that presumes that care is particular, and that justice is universal' (p.166). Tronto delineates between what she calls obligation-based ethics and responsibility-based ethics. The former is synonymous with utilitarianism, deontological perspectives and Beauchamp and Childress's principalism, with human beings seen as separate entities, though the latter involves the moral agent existing within a relationship with others (Edwards, 2009). Obligation ethics are seen by Tronto as being characterised by what amounts to a two-stage engagement process; what are my obligations and thereafter how do I continue ethically? By contrast in responsibility-based ethics the person is already in a relationship with whoever is need of care and obligated to the person. The question becomes only: how do I act ethically? In Tronto's words, 'The moral question an ethic of care takes as central is not – What if anything do I (we) owe to others? but rather – How can I (we) best meet my (our) caring responsibilities' (1993, p.137).

Tove Pettersen and 'Mature Care'

Like Tronto (1993) and Gilligan (1982) before her, Pettersen (2008) does not see care as an exclusively gendered phenomenon, but something that anyone so minded could participate in. A key aspect of her work involves the expansion of Gilligan's 'mature care' (1982), which she describes as exemplifying two core values: The universal condemnation of exploitation and hurt, and the universal commitment to human flourishing. Pettersen (2011) sees the condemnation of exploitation and hurt as akin to the principle of non-maleficence, and the commitment to human flourishing with the principle of

beneficence but highlights critical differences. Non-maleficence can be understood to stand for refraining from making decisions or taking actions that may result in harm being inflicted on others. Pettersen (2011) believes the ethic of care calls for more, requiring that the individual be active in averting or mitigating harm. It is therefore an expanded requirement. Beneficence by contrast compels the adherent to do good. Pettersen (2011) points out that there seems to be no limitation on the obligation to produce good, and so often seen embodied in altruistic care. Such an obligation can come at a physical, emotional, and psychological cost to the carer. It is something that needs to be curtailed if self-sacrifice and all its attendant costs are to be avoided. As a counterpoint to the expansion of non-maleficence the principle of beneficence needs to be restricted to prevent systematic self-sacrifice by surrendering to the interest of others, 'This expanded idea of care exposes caring to be a relational process in which both the carer and caree participate. To prevent inflicting harm and/or to promote flourishing, these aims of caring must hold true for both the carer and the caree' (Pettersen, 2011, p.55).

Pettersen and Hem (2011) suggest that in some instances putting oneself in the position of others and understanding their perspective is to recognise the care-receivers 'epistemological narrowness', the fact that they may not have the cognitive flexibility required to adjust or refine their understanding of their own need, and to recognise the goodness of fit of the care received. They may even reject the care. Examples offered by Pettersen and Hem (2011) included the effects of mania, depression, psychosis, or drug addiction. Mature care necessitates the development of imagination and creativity to overcome such barriers. Need does not subside or disappear if the offer of care is rejected, or the individual is non-responsive. Pettersen and Hem (2011) suggest the mature response in such circumstances could involve widening the scope of care or otherwise directing some form of caring act towards some other relevant *thing* in the immediate vicinity. Attention could be shifted to the individual's immediate environment, or into some other supportive tasks. Either would constitute a

significant expression of care and carry with them the potential to register within the intended care-receiver.

In response to a rejection of care, the immediate tactful termination of efforts may provide time and space to reflect. Such a termination would not typically be permanent, as alternate approaches may follow on. It is in this space that an adjacent idea has resonance. Compassionate interference (Verkerk, 1999) speaks to providing care despite resistance. This resistance is qualitatively different to fully understanding and rejecting care through reasoning. Rather, it is what can develop when the ability to embrace care is itself blocked by misunderstanding or mistrust. Interventions in such circumstances have been described as paternalistic, but compassionate interference is distinct in that the need itself is identified through the interactivity scaffolded by a relationship of respect, rather than being singly or individually determined by a detached care-giver. The individual in need is often uncertain as to how to let others help, often due to poor relationship experiences or prior abusive treatment by figures of authority. To fail to carefully explore possibilities for caring would likely pave the way to symbolic care that does not meet need but satisfies the detached ego needs of the carer or even result in a neglect of care as they step back. In so doing they may be re-enforcing the corrupted sense of what relationships are to that individual.

The balancing of Justice and Care is also examined by Pettersen. Her pragmatic solution, like Tronto's, is rooted in the relational ontology. According to Pettersen (2008) a third way can be found because of the access the care-giver has to contextual information, and because of actual communication rather than the mental gymnastics required of problem-solving models rooted purely in the theoretical processing of abstracted principles. Pettersen contends that a care-giver's situational knowing and judgement is more nuanced than a decision guided by pre-established ranking schema. 'The third way is an approach to moral challenges not characterised by acting spontaneously out of

the sympathy or by relying entirely on pre-established principles, but the deliberation on how to prevent hurt and promote flourishing based on general as well as contextual knowledge of the actors' (Pettersen, 2008 p.108).

From the mature care perspective, the care-giver also has rights that need to be recognised. Pettersen (2012) draws upon Aristotle's treatise on the virtue of friendship that posits reciprocity and mutual goodwill between individuals are central to the healthy functioning of a friendship. A friendship can be characterised as a broadly symmetrical relationship, although in practice there may be asymmetrical shifts as the needs of those in the dyad change over time. Asymmetrical relationships, such as those often operating in a caring context, can be negotiated through the balancing function of mature care. According to Pettersen (2012) this can be conceptualised as intermediate position, or 'golden mean'. This central position is one that that demarcates the zone between too little concern or care for others, or egoism and an overriding concern for the self, and too much concern for others as embodied in the notion of altruism. Such thinking creates the opportunity to reflect upon the needs and rights of the carer within the context of responding to behaviours of concern, as well as the cared for party. The relationship as a structure provides a useful context in which to consider how such matters are balanced. Reciprocity is at the heart of mature care and described by Pettersen as the exchange of 'knowledge, information, and emotions in order to achieve the goal in the right way' (2012, p.382). Pettersen (2012) further states that being:

> Being mature means to be able to integrate both reason and emotion into our moral judgement. If you feel repulsed by caring for someone, one should be aware of, and reflect on, this emotion—but not necessarily act on it. Both reason and emotions have to be listened to before acting. That is also to be mature. In my view, either to always act on emotion, or to

> never take emotions into account, is to be equally immature (Cited in Jarymowicz, 2016, p.123)

Some critics question the notion that the care-giver should be seen as important as the care-receiver. Nordhaug and Nortvedt (2011) contend that the notion of balancing the needs and interests of the care-giver against those of the care-receiver is fundamentally at odds with a professional caring perspective, because such care is provided ‘‘in asymmetrical relationships in which professionals’ concern should be directed towards patients and not vice versa’’ (p.210). Nordhaug and Nortvedt (2011) further assert that the concept of reciprocity is given undue prominence. They venture that there is an implicit suggestion in Pettersen’s theorising that both parties in a caring relationship are potentially able to act in a caring way towards each other, whereas it is much more likely to be one way relationship in the real world. Finally, they caution against taking Pettersen at her word when she says, ‘within the care perspective, however, determining what is morally right and wrong is not first and foremost a matter of consulting a set of rules; the focal point is the effect on those involved’ (2008, p.92). Their concern is that adherents to a mature care perspective may not feel the need to follow policies and procedures or give enough consideration to guiding principles. This criticism seems to have face validity but would likely be mitigated to some extent by commitments to accountability and transparency which underpin professional caring practice. It is possible to understand caring practices as purely technical acts that flow down from care-orientated organisational policies. This is perhaps an impoverished way of conceptualising how and why care is realised in the way it is. Street Level Bureaucracy (Lipsky, 1980) provides the means to examine the actuality of practice and explore how this is assembled from bottom up by involved individuals. To understand the deep-rooted commitment to caring, it is useful to turn to a consideration of the organisations primary task.

The Primary Task

An organisation's 'Primary Task' can be defined simply as the task which it must perform to survive (Hayden & Molenkamp, 2003; Rice, 1963). It might otherwise be described as its defining function, ultimate purpose, or raison d'etre (Palmer, 2002). From the point of view of effective organisational performance, this task needs to be clearly defined (Whitwell, 2020). Examples of 'Primary Task' types in residential childcare settings include 'caring', 'therapeutics', and 'custody' (Macleod, 2010), and building on Whitwell's point Macleod adds, 'a common means of defining and sharing the task of a residential childcare setting is the Mission Statement or Statement of Purpose'. Policies which operationalise an organisation's mission can be seen as the means of achieving the ends that the organisation aspires to, and that an organisations performance and achievement is beholden on its staff's ability to act in accordance with the primary task.

It is an over-simplification to suggest that an organisation has only one primary task, but an organisation requires a stable system in place to cater to differentiated sub-tasks and ensure a coherent level of distributed performance accordant with the overarching task (Grubb Institute, 2014). The requisite leadership and resulting management activity flows from having congruent mental models across the group (Grubb Institute, 2014). MacLeod continues by stating, 'Where the organisation has a lack of clarity in its task definition, or there are competing and conflicting definitions, there is likely to be increased interpersonal and intergroup conflict' (p.3).

The Tavistock Institute of Human Relations [as was] and Leicester University under the leadership of A. K. Rice, pioneered the use of group relations conferences to explore the tensions inherent in group life within organisations (Bradbury, 2021). Incongruence with their organisation's primary task is

where tensions are held to be evident, giving rise to the incongruence in its realisation. Lawrence (1977) and Menzies Lyth (1974), amongst other Tavistock consultants, observed that these disconnects with the primary task often arose from anxieties and confusions around boundaries. When left unresolved these had the potential to lead to an array of expressions of disequilibrium in anti-task activities, as the resulting unconscious defence mechanisms destabilised their thinking and behaviour. This could manifest in staff feeling isolated, unattended to, under-appreciated, unsupported, alienated, and lost (Bradbury, 2021). Such maladaptive responses will be returned to shortly.

Defining the 'Primary Task' therefore becomes an important challenge for any organisation wishing to identify and explore these destabilising dynamics. Lawrence (1977) led the early Tavistock work analysing and remedying maladaptive group dynamics. These investigations often revealed that the 'Primary Task' an enterprise was engaged in could be at considerable variance to the 'Primary Task' it was established to fulfil. Lawrence (1997) suggested the value in exploring what the organisation was *actually* engaged in, was to determine the actuality of what he called the 'normative', the 'existential' and the 'phenomenal' aspects of the 'Primary Task'.

According to Lawrence (1977), 'The normative Primary Task is the task that people in an organisation ought to pursue', the one that is congruent with its stated mission. Thereafter, 'the existential Primary Task which they believe they are carrying out' is what allowed the consultant to discern 'the many and various motives for, and meaning of, the work for whose individuals engaged in doing it' (Bradbury, 2021 p.5). Finally, 'The phenomenal Primary Task [is that] which it is hypothesised they [staff] are engaged in and of which they may not be consciously aware' (p.23). Bradbury (2021) summarises these three levels of 'primary Task' thus, 'The normative task is the one on the tin. The existential task stands for the many and various motives for and meaning of the work for whose individuals engaged

in doing it. The phenomenal task is the 'as if' task; that is, the task that can be inferred from the way people behave and the organisation functions, but which may be unconscious'. He then offers the example: 'The school may behave 'as if' it was a young offender unit' (p.23).

Key to its analytical power is the implicit recognition that 'Primary Task' performance can be affected by the unconscious. An organisation needs a collaborative culture to be optimally effective, which in turn requires effective relationships and conscious collaborative connections. According to Freud, the unconscious mind is conceived of as a reservoir of feelings, thoughts, urges, and memories that exist outside of conscious awareness (Baumeister & Bargh, 2014). Its contents are considered to include the unacceptable or unpleasant, such as phantasies of death, finitude, and loss, as well as feelings pain, anxiety, and fear (Bradbury, 2021; Baumeister & Bargh, 2014). Bradbury (2021) articulates the danger of these unresolved issues, 'left unattended to, unconscious processes precipitate the precise opposite of the needed engagement, collaboration, partnership working, integration and increased staff motivation' (p.1).

Left unresolved, the unconscious enables its own defences designed to keep the arising anxiety under control, including 'denial' and 'projection' amongst others. Denial manifests when the unconscious suppresses certain uncomfortable thoughts and feelings, preventing them from entering one's consciousness (Hall & Pick, 2017) and 'projection' where the individual ascribes their feelings to someone else, locating that which is unbearable within the other (APA, 2023). Menzies-Lyth (1988), in her seminal review of institutional functioning, highlighted the potential tension between the institution's 'Primary Task' and the anxieties provoked within staff arising from challenges in meeting that task. The focus was a general hospital, where the primary task of nurses was caring for the sick and dying (Menzies, 1960). The nurse's role involved bearing witness to suffering and death. These experiences were intensely emotional, with increased anxiety levels within staff, engendering feelings

which ran from pity and guilt to hatred and resentment. Menzies saw this as giving rise to psychodynamic coping responses which functioned to defend both the individual and organisation. This had the net result of subverting working practices which then become what Menzies (1960) described as 'Anti-Task', practices whose main (unconscious) function is to defend against undesirable feelings and that can lead to the caring agent becoming uncaring and even coercive. The consequences of avoiding, denying, and trying to repress the attendant anxieties was the de-personalisation of the client, resulting in the reduction of the staff-patient relationship through imposed prescriptive rules and procedurally dominated practice (Menzies-Lyth, 1988; Menzies, 1960). The unconscious attenuation of the accumulating feelings through such distancing strategies dehumanises the recipient of care, reducing them to an incidental feature of the work task. Thus, the primary task is fundamentally destabilised.

The Primary Task (Lawrence, 1977; Rice, 1963) functions as both a descriptive and an analytical device. This dual function provides an opportunity to discern any deviation from an organisation's *reason to be* and permit its exploration. It is also noteworthy that any deviation is invariably linked to the lived experience of staff fulfilling the primary task within a real-world environment which includes political, personal, physical and mental challenges conspiring against the implementation of that organisation's self-defining work. Within the context of this study, it allows the exploration of an important policy sub-task, and critically those thoughts and feelings within staff, which may speak to congruence or incongruence, and ethical integrity.

In Summary

The ambition of any research is to better understand elements of the world in which we live. The *thing* that is the focus of this study is the experiences of staff responding to behaviours of concern. The framework that has been assembled is designed to help make sense of the findings. In this study the 'Primary Task' (Lawrence, 1977; Rice, 1963) of the organisations recruited are forms of caring (Tronto, 1993). The general expectation is that the Primary Task will be embodied by, and operationalised through, staff actions. Whether or how this can be discerned within responses to behaviours of concern, is something this study seeks to better understand. The potential role of staff in shaping policy at the point of implementation is explored drawing on 'Street Level Bureaucracy' (Lipsky, 1980). It is clear through the foregoing consideration of Lipsky and other scholars that staff can take refuge from the complexity and difficult that situations bring by leaning into a range of pathologised standpoints, standpoints that have the potential to tip a team into a mode of working that amounts to being anti-task. Care Ethics (Pettersen, 2012; Gilligan, 1982) can reveal modes of engagement that transcend those characterising top-down, command-and-control type organisational directives that exemplify legalistically orientated policy. How the Street Level Bureaucrat copes with uncertainty and complexity can revealing, especially when understood beyond considerations of policy implementation. As such, this framework offers an important new way of understanding the physicality deployed within responses to behaviours of concern. In this instance I have used it to examine a formal, alongside a less formal space, this suggests it may have potential utility in other adjacent spaces such as formal social care, and physical healthcare provision. The next chapter provides an overview of the research methodology that enabled this crucial exploration.

Chapter 4: Methodology and Methods

The Research Question

The aim of this research is to explore staff experiences to gain a better understanding of what takes place within the physical responses to behaviours of concern, thus determining something of the nature of the translation of policy into practice. This research sets out to answer the following questions:

> **RQ1**: How do staff experience the events that constitute a 'response' to behaviours of concern: their own thoughts, feelings, reactions and responses, and the context within which this all takes place?
>
> **RQ2**: In what ways do the practices disclosed within participant accounts align with those expected responses identified within guidance, such as policy documents and staff training programmes?
>
> **RQ3**: What conclusions (if any) can be drawn about these practices and the presence or function of the organisational primary task?

The central focus of this study is on the last resort physicality undertaken by staff, which can be necessary within the context of responses to behaviours of concern. It is because, so little is known about the physicality deployed in response to behaviours of concern, as revealed in the literature review, that this study was undertaken.

The Importance of Appropriate Methods

A high value is currently placed on understanding individuals lived experiences of restrictive interventions (Griffin *et al*, 2025; Bennetts et al, 2024; CQC, 2024), with the lived experiences of recipients being pre-eminent. As applicants of the force being deployed, I felt the lived experiences of staff were distinct and potentially revealing, with phenomenological methods facilitating access to such experiences (Smith *et al.*, 2021, 2009). I also felt it was important to adopt an approach wherein my presence could be disclosed and managed through reflexive engagement. In my day job I have a professional interest in physical restraint, and I actively lobbied to do this research. It would be dishonest to claim that my personal or professional self could be wholly excluded from this study, so the declaration of my presence felt ethically important too. I chose the Interpretative Phenomenological Analysis (IPA) methodology for these reasons. It also permitted these insights to be compared across cohorts (Larkin *et al.*, 2019), for first tier research questions to be supplemented by second tier ones and for engagement with relevant existing bodies of theory (Smith *et al.*, 2021, 2009).

The Supporting Worldview

Good research should operate under a coherent philosophical worldview (Creswell, 2014; Creswell & Piano, 2011) or 'Paradigm' (Kuhn, 1970). Determining which is most appropriate involves establishing whether it is congruent with the intended inquiry, and thus to essential claims relating to ontology [the nature of reality], epistemology [how we know what we know], and methodology [the process of inquiry] (Doyle *et al.*, 2009). Morgan (2007) argues that the term paradigm is used differentially. Firstly, by lay individuals to denote a superficially coherent perspective on the world, then in a more restricted fashion by like-minded researchers with shared ideas about the nature of questions and

answers in a specific field. Most commonly he asserts it is used as a way of aggregating methods around epistemological perspectives in the form of quantitative and qualitative approaches. The worldview taken in this study is qualitative, drawing on a 'soft realist' or 'minimal hermeneutic realist' ontology (Larkin *et al.*, 2006; Kochan, 2017; Dreyfus, 1995) using an interpretative epistemology. The ontological position is one where 'what is *real* is not dependent on us, but the exact meaning and nature of reality *is*' (Larkin *et al.,* 2006 p.6). All around is therefore real, but only by engaging with it, does it become *our* individual lived reality. The interpretivist epistemology therefore foregrounds the meaning-making power existing within social interactions, specifically how such interactions are perceived by individuals. From my perspective as a researcher, staff responses as one key aspect of an interaction that has the potential to be of great interest to those charged with reducing ((DoH, 2015a; DoH, 2014), and more pertinently minimising restraint (RRN, 2021A).

Interpretative Phenomenological Analysis (IPA)

Phenomenology is both a philosophical orientation, and a form of inquiry, concerned with understanding the human 'experience' (Cassidy *et al.*, 2011). In the latter form it has been described as an approach to qualitative, experiential, and psychological research, used to access the perspective of someone who has the lived experience of a particular phenomenon, in order that others might know it. IPA is a relatively new methodology, developed by Smith et al. (1996), and has been informed by three key strands of the philosophy of knowledge: phenomenology, hermeneutics and idiography [Fig 4.1].

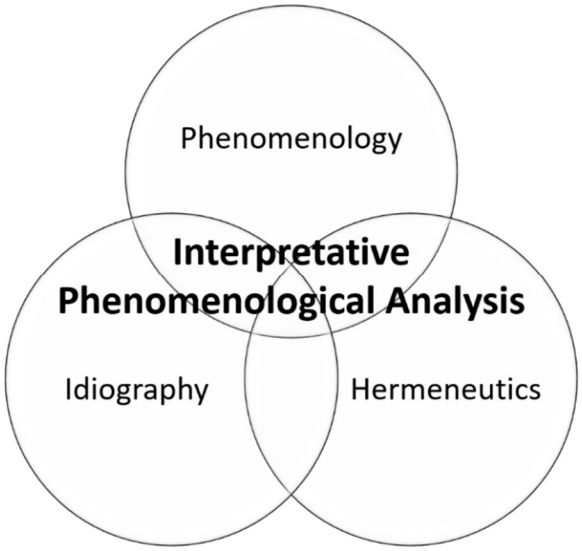


Fig 4.1: Overview of IPA (Smith, 1996).

Phenomenology

Edmund Husserl (1859-1938) pioneered 'Descriptive Phenomenology' [then 'Transcendental Phenomenology'], which focused on the structure of individual experiences (Rodriquez & Smith, 2018). According to Husserl, it involved a conscious step away from the 'natural attitude', or non-reflective immersion in the everyday, lived world, '…when we are fully engaged in conscious activity we focus exclusively on the specific thing, thoughts, values, goals or means involved, but not on the psychical experience as such' (Husserl, 1927, in Smith *et al.*, 2009, p.12-13). The process of excluding extraneous thought is variously referred to by different phenomenologists as 'bracketing' or engaging in 'epoche' (Brooks *et al.*, 2015). To achieve what Husserl termed a 'phenomenological attitude' one must engage:

> Through reflection… (where) we grasp the corresponding subjective experiences in which we become 'conscious' of them, in which in the broadest sense they 'appear'. For this reason, they are called 'phenomena' and their most general essential character is to exist as the

> ‘consciousness of’, ‘appearance of’ the specific things, thoughts, judged states of affairs, grounds, conclusions, plans, decisions, hopes and so forth. (Husserl, 1927, ibid)

Despite rejecting the subject/object division posited by Descartes, Larkin *et al.* (2006) argue that Husserl inadvertently propagated it by focusing on human consciousness, effectively demarcating it as a separate and distinct subjective domain. Husserl’s student Martin Heidegger (1889-1976) swept away this division by deepening the ontological claims through ‘Interpretative Phenomenology’ (Rodriquez & Smith, 2018). Whilst Husserl focused on the epistemology of ‘knowing’, Heidegger was chiefly concerned with the ontology of ‘being’. For Heidegger the human being is an integral and inseparable part of the world in which individuals exist, ‘Heidegger makes the human individual a part of reality, rather than an ego dualistically separated from the world, thereby reconciling relativism and realism (or objectivism)’ (Rennie, 1999 p.6). The term Heidegger uses to capture this ontological state is ‘Dasein’, translated from German as ‘there being’ or ‘being there’ (Larkin *et al.*, 2006). This enabled him to expand upon an assertion, first made by Husserl, that ‘Intentional Directedness’ is fundamental to human activity. Whilst Husserl contended that it was a purely mental activity, Heidegger asserted it was part of ‘being’ (Rodriquez & Smith, 2018, Cassidy *et al*, 2011),

> We cannot occasionally jump out of an isolated subjective sphere to impose meaning on a world of otherwise meaningless objects, because we are always-already ‘out there’ in a meaningful world (and such meaningfulness is a fundamental part of its constitution). In short, we are a fundamental part of a meaningful world (and hence we can only be properly understood as a function of our various involvements with that world), and the meaningful world is also a fundamental part of us (such that it can only be properly disclosed and understood as a function of our involvements with it) (Larkin *et al*., 2006 p.106)

Ontologically Heidegger lays claim to the aforementioned 'minimal hermeneutic realism' (Larkin *et al.*, 2006; Kochan, 2017; Dreyfus, 1995). IPA research sets out to understand a person (or people) as they exist within *their* unique context, and as they live *their* unique lives (Smith *et al.*, 2021, 2009; Kochan, 2017), or in Heideggerian terms *their* Dasein (Larkin *et al.*, 2006). According to Riemer and Johnston (2012), 'Dasein is the 'being' of humans.. …Equipment is the being of entities encountered by Dasein in use' and 'Objects are entities that are encountered by Dasein through attention and breakdown' (p.7). This breakdown is useful, as it captures a shift in the ontological status of the entity, when the 'thing' in question, which is otherwise 'ready-to-hand' (invisible to the conscious mind) becomes 'unready-at-hand', therefore requiring some form of reflective attention or conscious engagement to align its way of being to serve the individual's current or future orientated mode of existence. Riemer and Johnston (2012) have written extensively on the appropriation of IT which might be considered 'equipment' by Heidegger; these 'things' provide a means to an existential end, as would a spanner, a key or a restraint technique. This use of this technology therefore shifts from technology 'as-designed', to technology 'in-practice' or 'in-use' (Riemer & Johnston, 2012, Orlikowski, 2000). This represents both a dynamic utilisation of the 'equipment' at hand, and the defining of reality within the unique context of the individuals as-being-lived experience.

Idiography

Whilst Husserl contemplated his own personal experience, other forms of phenomenology such as IPA have shifted towards engaging with other peoples lived experiences (Shinebourne, 2011). The term 'idiographic' comes from the Greek 'idios' meaning 'own' or 'private' (McLeod, 2019). The exploration of a given phenomenon using IPA is accessed through the person's account, being concerned with *their* unique perception, and understanding of objects and/or events (Smith, 2004). This focus on the individual is key to acquiring a depth of understanding, 'Thus, the very detail of the individual also

brings us closer to significant aspects of a shared humanity, and the *particular* case can therefore be described as containing an 'essence'…' (Smith, 2004 p.43). For this reason, the case study is favoured by IPA researchers (Cassidy *et al.,* 2011; Smith *et al.*, 2009). A distinction should be made between the case study as a research strategy with its own methodological tradition (Priya, 2021) and as a method of data collection subordinate to the chosen methodology as it is with IPA. Within the context of this inquiry every individual was treated as a separate case. The singularity of this method avoids a tendency towards conclusions founded on aggregated data which '…decontextualize(s), disconnect(s) and fragments meaning…' (Weaver, 2013 p.92). The case study is a powerful way to understand the experience of a particular phenomenon at the level of the individual (Yin, 2009, Eisenhardt, 1989, Stake, 1995), 'A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (Yin, 2009 p.18). It permits an in-depth exploration of attitudes, perceptions, understandings of unique context and the identification of those causes and factors which determine the outcome of a particular situation (Robson, 2011). It is described as the ideal method to use when a 'how' or 'why' question is being asked about a set of events over which the researcher has no control (Gray, 2018), and can be used for exploratory, descriptive, or explanatory purposes (Yin, 2009). Cross-case analysis provides opportunity to consider convergence and divergence within experiences (Smith, 2004). IPA case studies have been used to access the lived experiences of carers', health professionals', and patient's as well as the experience of psychological distress (Smith, 2011). IPA is being used increasingly in health, psychology, and counselling research projects (Hefferon & Gil-Roderiguez, 2011) but is underused within social work research (Loo, 2012). At the time of writing there were 68 research articles drawing on IPA returned in a search of *Qualitative Social Work* from 2015 to 2025.

Hermeneutics (Interpretation)

The journey of interpretation starts with the raw text in which the lived experience is recorded (Smith, 2014). The researcher must negotiate what Cassidy *et al.* (2011) refer to as 'layers of resistance' as they analyse the narrative. A superficial review of the text offers a purely descriptive account and first-order analysis, providing a summary account but no interpretative insight (Larkin *et al.*, 2006). For the IPA researcher the participant is describing 'what it is like', but through second order analysis 'what it means' can be revealed (Larkin *et al.*, 2006). As the analysis advances, the phenomenon being scrutinised never fully discloses itself, and interpretative work is required to gain an understanding of its meaning (Cassidy *et al.*, 2011). Within IPA, getting to this knowing involves a structured approach. Ricouer (1970) referred to the hermeneutics of 'recollection or restoration of meaning' and the 'hermeneutics of suspicion'. The latter is more strongly aligned to a critical engagement with the text, whilst the IPA approach to analysis is centred within a hermeneutic of understanding combining empathy *and* questioning (Larkin *et al.*, 2006; Smith, 2004) [Fig 4.2].

Fig 4.2: The Hermeneutics of IPA (Smith *et al*, 2021, 2009; Ricoeur, 1970).

In further formulating IPA 's hermeneutic perspective Smith drew upon the works of Schleiermacher, Gadamer and Heidegger (Cassidy *et al.*, 2011; Larkin *et al.*, 2006; Smith, 1996). Schleiermacher posited that understanding, based on both a linguistic and psychological interpretation, could extend

meaning-making above and beyond the captured claims, and reveal things that the person themselves was unaware (Larkin *et al.*, 2006). Gadamer reminds the researcher that is it their own lived experience that both facilitates access to the text, and potentially limits its interpretation, so they must remain alive and mindful to themselves as they engage. The researcher must focus on the meaning *as given* by the participants irrespective of whether they agree or reject it on a personal level (Finlay, 2014). In his own descriptive phenomenological work Husserl determined that the researcher must be bracketed out of any analysis whilst Heidegger's perspective was that reality is inherently connective and that '…we are embedded in the world of language and social relationships and that we cannot escape…' (Tuffour, 2017 p.3). In IPA, the researcher is acknowledged as being integral to the exploration, and whilst the participant is viewed as the experiential expert, the researcher is acknowledged to be part of the interpretation of those experiences. This interdependent engagement has been referred to as 'the double hermeneutic', wherein the researcher is making sense of the participant's world as the participant is making sense of their own personal and social world (Smith & Osborn, 2008; Smith, 2004). Therefore, the researcher is required to be reflexive, with their biography acknowledged as existing within the analysis (Peat *et al.*, 2019). To this end, I compiled a biography comprising a summary of work roles (Appendix 26) and a disclosure of personal and professional engagements with physical force and restraint (Appendix 27) as well as list of assumptions and expectations collated before the fieldwork was undertaken (Appendix 29). To mitigate against any fore-knowing or pre-existing patterns of thinking biasing the findings, I kept a reflective diary, which captured those occasions when I discerned tensions or confusions that needed to be made sense of. This included how such thoughts and feelings impacted me personally and professionally (Appendix 28). To illustrated this, I am including two partial excerpts:

- Diary Excerpt Title: 'Confidence Revisited': 'Restraint. I thought I knew this stuff. But others might see it differently? The things that pre-occupy me [i.e., Masculinity, Violence, Martial Arts] have made me foreground the role and function of force as a tool or a means to an end. It is, but at the same time it isn't for others, at least not in the same way as for me. Its bigger

somehow. I'm not sure what I'm saying, but I am less certain than I was. That seems good, but also embarrassing and troubling to me.'

- Diary Excerpt Title: 'Systemising & Organising': 'I systemise and organise – but is this a strength or a weakness in the research context? I think I try to systemise and organise situations, turn them into black and white, logical entities… Is this a response to trauma? A way of re-asserting control? A way of somehow intellectually triumphing over some proxy threat? Or is it not about triumph but about feeling safe and in control? Either way the act can take precedence at the cost of nuance and context'

Research Design

The figure below provides a visual overview of the research design. It is read top down, starting with panels outlining the sampling and recruitments stages, before those relating to the data collection and analysis. Each stage will now be elaborated upon.

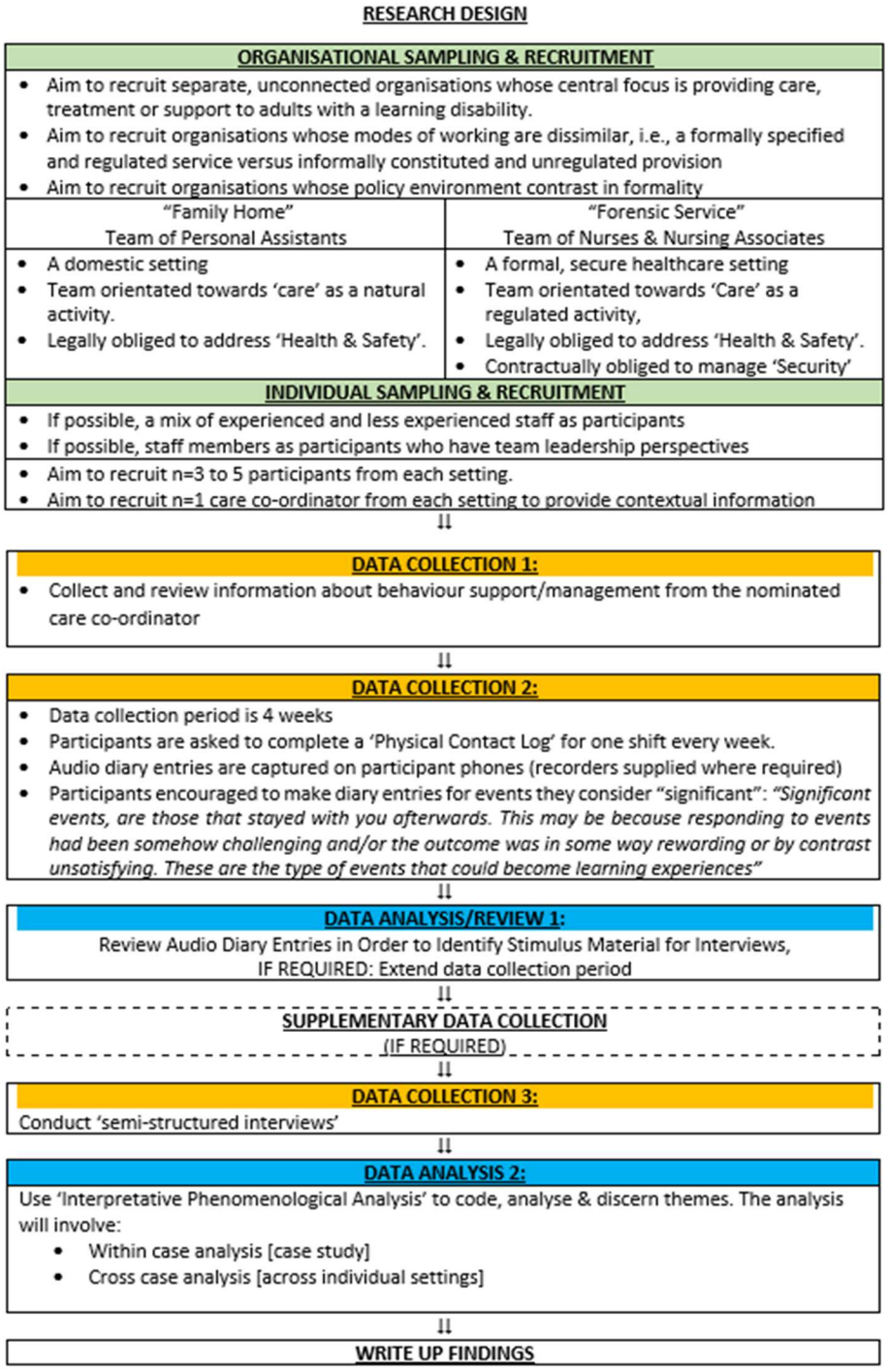


Fig 4.3: Overview of research design**.**

Sampling and Recruitment

Sampling involves selecting a group of people from a larger population to take part in a study, whilst recruitment speaks explicitly to the process of engaging potential participants (Gray, 2018). As can be seen from the design above, at organisational level, sampling involved encouraging organisations, whose primary task (Rice, 1958) centred around the provision of care, support &/or treatment to individuals with LD who had a history of presenting behaviours of concern, with staff being expected to respond to such behaviours. I used my professional networks to identify organisations meeting these criteria. Recruitment letters (Appendix 3) provided an overview of the study, potential risks, and parameters of consent. These were sent to organisational gatekeepers [the 'Manager' or 'Care-Coordinator'], along with participant introduction and information sheets (Appendices 4-8). The recruitment of the first organisation was relatively straightforward, whilst the second required its participation to be approved by an internal research committee.

The organisations recruited were different, ensuring a breadth of perspectives. The difference was in how they were constituted, and the extent to which formal commissioning and policy implementation determined the nature of the provision. The first was a family home [setting one], where a wraparound team of Personal Assistants[3] provided support to a single individual. The second [setting two] was a secure forensic setting where staff provided support and treatment to individuals detained under the Mental Health Act. Appendices 31-33 provide more contextual organisational information. The recruitment process involved obtaining the consent of those who served as 'Manager' and 'Care-Coordinator'. Thereafter they were invited to share the participant information with staff meeting the inclusion criteria. I remained available to answer questions relating to the practicalities and protections in place. In setting one the entire team were recruited due to the team size, whilst in

[3] Personal Assistant met the criteria of employed staff. This excluded support being provided purely by family members.

setting two, a much larger and more complex organisation, the participants self-selected. Both can be considered forms of convenience sampling (Gray, 2018), whilst structurally the cohort in setting two were informally stratified.

Recruiting and Sampling with IPA in Mind

Within IPA, participants need to be recruited on the basis that they can grant the researcher access to personal experiences, providing a perspective or understanding of a very particular phenomenon (Smith *et al.*, 2021, 2009). IPA focuses on depth rather than breadth of understanding, so works with small samples (Peat *et al.*, 2019). The number of participants may be as few as one or as many as fifteen (Pietkiewicz & Smith, 2014). Smith and Osborn (2008) point out that most studies settle upon between 5 and 10 participants, whilst Smith (2004) advocates for the value of the single case with the in-depth insight it brings being 'sorely neglected' (p.42). In this case the target recruitment sample was 3 to 5 per setting. This permitted scope for dropouts and offered a contingency down to single participants. The number of participants recruited ended up being the same for each organisation (n=4).

Gathering, Reviewing and Collating Contextual Information

I established contact with the respective 'Manager' and 'Care-Coordinator', to gather information on the arrangements in place to guide staff in their responses to behaviours of concern in advance of the field work to ensure I had the best understanding of the distinct working contexts. The process involved a short fact-finding conversation with the nominated gatekeeper via TEAMS, with the information being contemporaneously recorded in the 'Fact Find' (Appendix 13). This was followed up

by a review of any information and materials provided. I recontacted the gatekeeper to verify understanding. The summary of this was used to prepare for participant interviews.

Data Collection Methods

Participant Information Forms

My contextual understanding was enhanced by gathering background/demographic information from individual participants (Appendix 14). The information included the person's current job role, and previous caring or support roles (either formal employment or informal caring roles). The participant was also invited to provide information about relevant work-based training they had undertaken as well as any other training that they had found useful to them.

Physical Contact Logs

Participants were asked to complete a 'Physical Contact Log' (Appendix 16) for one shift every week (n=4 for the data collection period). This was designed to gather a snapshot of the physicality undertaken by the individual and give a sense of the volume and diversity of such contacts. A five-tier taxonomy was used to capture this (Fig 4.4), which was based on an observation checklist developed by Tanner (2017). The intention was not to analyse this data, but to provide an indication of the diversity of contact in interactions at individual level with a view to informing later interviews.

Task Orientated	*Involves the use of contact when **used functionally in attending to a person's physical care needs** e.g. activities of daily living, washing and personal grooming.*
Expressive Task Orientated	*Involves the use of contact **to proactively convey warmth and/or affection**. Includes 'playful', 'energising/vitalising', 'comforting', 'reassuring' or, 'celebratory' touch',*
Person Centred	*Involves the use of reactive touch, as described in the expressive category, **to meet a perceived need** for love, comfort, attachment, occupation, identity or inclusion*
Person Centred Safety	*Involves 'contact' that stops, prevents, restricts and controls aspects of escalated behaviours of concern in order to prevent the person harming **themselves**.*
Safety Of Others	*Involves 'contact' that stops, prevents, restricts and controls aspects of escalated behaviours of concern in order to prevent the person harming **others**.*

Fig 4.4: Contact taxonomy (Based on Tanner, 2017)**.**

Participant Diaries

In respect to physical contact, I selected a particular form of participant diary as a suitable and convenient data collection tool. According to Farrelly (2011), diaries offer an opportunity to make sense of events as people take time to reflect when recording them. In making entries one brings events to mind and directs one's consciousness towards them as they reflect on-action in a more expanded way than they might have previously done in-action (Schon, 1983). Outside of the research domain, diaries are largely repositories for private reflections, typically not intended for public review or analysis. In the research context the structure of entries can be pre-defined to capture events in a way that serves the inquiry, as such they become 'researcher-driven diaries' (Farrelly, 2011).

The frequency or conditions under which diary entries are gathered can vary. According to Bolger *et al.* (2003) entries can be interval-contingent, signal-contingent or event –contingent. The first refers to entries that are required at regular, pre-determined time points, the second at a frequency

determined or indicated by the researcher (often by email, text, or call). Event-contingent entries are determined by an anticipated but unpredictable eventuality, such as when escalated behaviours occur and require some form of response. Farrelly (2011) suggests that diaries completed on this basis provide a heightened degree of ecological validity.

To maximise the use of event-based researcher-driven diaries, Bolger *et al*. (2003) emphasise the need for clarity on triggering events and stipulations on reporting conventions (Corti, 1993). Elsewhere researchers have found a lack of consistency in participant responses when generic instructions are given without specific prompts (Monrouxe, 2009) which reduces reliability (Marino *et al*., 2004). Within the 'Diary Entry Guidelines' (Appendix 17), recording criteria was specified, as well as a sense of the time required and level of detail. See also below.

The Use Audio Diaries

It has been argued that diaries, and the analysis of their contents offer '…a unique window on human phenomenology' (Bolger *et al*., 2003 p. 610). Despite being an extremely cost-effective method, pen and paper-based versions have been reported onerous, leading to missed or cursory entries which degrade data validity (Lida *et al*., 2012). A pragmatic solution is to use audio diaries. Despite the ubiquitous presence of recording equipment built into mobile phones, such diaries are reported to be an under-used research method (Williamson *et al*., 2015; Crozier & Casell, 2015). Williamson *et al*. (2015) noted audio diarists found the equipment simple to use, with narration preferable to traditional longhand. Some participants did express concerns over rambling or being repetitive in their answers, although it did not stop them completing entries. Elsewhere Crozier and Casell (2015) pinpointed the ability of audio diaries to be deployed quickly after an event in order capture immediate sense making

in periods of change and flux. Their particular focus was in '…exploring the stress experiences… …to examine the interplay between a range of challenging circumstances and their psychological impact' (p.397). The delay between event and subsequent interview is one example in which thoughts and feelings associated with the immediate experience could conceivably dissipate as other events imposed themselves. The ability of participants to review, delete and re-record entries also ensures the diarist feels a sense of control over their disclosures (Williamson *et al*., 2015). There was also a sense of the diary as a reflective device underpinning personal development, echoed in comments by those who found its use to be cathartic, therapeutic and educational. Diaries tend to be supplemented by additional data gathering methods such as interviews (Williamson *et al*., 2015).

Selecting A Digital Audio Recording Device

Several devices were considered. This included a digital recording device (Appendix 22), a password protected portable recording device (Appendix 23) and inbuilt smartphone functionality (Appendix 24 & 25). It was decided inbuilt smartphone functionality was suitable, and sufficient for the recording, and offered the means to send audio files directly to the researcher if required via WhatsApp. In the event restrictions linked to security policy in setting two precluded the use of personal mobile phones and recording devices. As a result, a protocol was devised whereby each participant would be able to make diary entries via TEAMS. Technical challenges in implementing this were ultimately insurmountable, and so diary entries were not collected at setting two.

It was made clear in the orientation session for research participants that only those events that the participant felt were 'significant' needed to be recorded. This was defined as follows:

> Significant events are those that stayed with you afterwards, in the form of lingering thoughts and feelings. This may be because responding to events had been somehow challenging and/or the outcome was in some way rewarding or by contrast unsatisfying. These are the type of events that could become learning experiences.

What is significant for one person may not be for another. To understand how people experience events, and how some register more so than others it is useful to consider the difference between 'The Experiencing Self' and 'The Remembering Self' (Kahneman, 2011). The 'Experiencing Self' is the one that experiences emotion 'in the moment' as an event plays out, while the 'Remembering Self' is responsible for curating the enduring memory of the experience afterwards. The 'Experiencing Self' is that part of the brain which cognitively, affectively, and behaviourally responds to life as it materialises around us, whilst the 'Remembering Self' is concerned with reflecting on what has been lived through (Kahneman & Riis, 2005).

What 'significance' is understood to mean to individual participants is unknown. It can be conjectured that recollections of responses to behaviours of concern in the immediate aftermath will register less because of *what* happened [the factual structure and sequence of events], and more because of *how* it made the person feel. Events that are emotionally valent seem likely to register strongly with the Experiencing Self, including positive emotions such as excitement or happiness, or negative ones such as anxiety, anger, or fear (Russell, 2003). Individuals in this study were empowered to make their own

choices as to what events are significant and thereafter capture events of their choosing in their audio diaries.

To capture their unique reasoning, participants were asked to describe in their own words why the event had been recorded. Reflections were then prompted by questions that were designed to elicit data which captured key elements of their lived experiences, namely the reason for intervening, as well as the non-physical and physical strategies explored within the individual response. Finally, the participants were invited to reflect briefly on the impact to the relationship between themselves and the patient, service user or supported person (see 'Diary Entry Guidelines'). Whilst diaries were not used in setting two, the invitation to reflect on significant events was used in both settings when it came to interview wherein singular events were explored.

Semi - Structured interviews

The last form of data collection that I chose was a semi-structured interview. An interview in the broadest sense can be defined as 'a verbal exchange in which one person, the interviewer, attempts to acquire information from, and gain an understanding of, another person, the interviewee' (Gray, 2018 p.378). Despite their ubiquity as a research method Darke *et al.* (1998) advise they should only be used to obtain information that cannot be collected by other means. An interview is the right choice when the research objectives are about understanding peoples lived experiences, where there is a need for highly personalised data and likely to be a need to press and probe for additional information (Gray, 2018). This is why they are the most common method for collecting data in IPA studies (Peat *et al.*, 2019). Giving due consideration to the time and location of the interview is important, and key to providing a safe and supportive environment in which disclosure can take place (Smith *et al.,* 2009).

In this case the subject matter would be personal and sensitive, so I needed to ensure that a psychologically safe space (Edmondson, 1999) was created on an individualised basis. In practice the interviews were set up a time convenient to the interviewee, and as far as it was practical to do so a convenient place.

The broad phases of an interview are, orientation, information gathering and interview closing (Baskarada, 2014). Putting the interviewee at their ease can increase both their willingness, and ability, to talk (Baskarada, 2014). Further to establishing ground rules such as the avoidance of names or identifying information, I advised each interviewee that there are no right or wrong answers, only their accounts of their experience (Smith *et al.*, 2021, 2009). Smith *et al.* (2021, 2009) also suggest that the initial question should give the participant chance to provide a descriptive episode or overview of an experience. This is to make them comfortable with speaking and subtly dismantle any misconceptions or apprehensions about the interrogative nature of the interview. Over its course the questions should effectively funnel down from the general to the specific as rapport increases and the interviewer brings the phenomenon to the forefront of the interviewees conscious mind (Baskarada, 2014).

The interview schedule should have between six and ten open questions, augmented by prompts designed to elicit as expansive and detailed account as possible (Smith *et al.*, 2021, 2009). Interview questions should be open, and to come at the research question 'sideways', meaning the research question itself should not be asked outright, rather through a series of questions the answers providing the researcher with the opportunity to find answers (Smith *et al.*, 2021, 2009). When asking questions, the interviewer can make use of skilful prompts to elicit deeper reflection: Can you tell me more about that? Tell me what you were thinking? How did you feel? Smith *et al.* (2021, 2009) also talk about asking the interviewee to 'expose the obvious', which prevents the researcher from making

presumptions during the analysis phase. For example, in setting one Emma was talking about responding to behaviour and stated incidentally 'I'm an emotional person'. Here I pressed for expansion; 'When you said you were an emotional person, are you talking about a tendency to feel upset, angry or..?' In this case it uncovered feelings about being judged by the service manager, which uncovered a relational aspect to responding. The schedule for this inquiry comprised three main questions, with accompanying prompts (Appendix 18).

Silence and time to reflect on questions is also important. The novice interviewer can struggle with both and deny the interviewee critical processing and reflection time that might yield richer and more insightful answers (Smith *et al.*, 2021, 2009). Early I my interviewing I noticed that I did not always allow for time for reflection. I felt the interview was expected to have a forward momentum, and pausing lost that. Making the realisation I was seeking a deeper understanding from participants helped me to recognise the value of providing processing and reflection time. The interviewer should always be listening in an intent fashion but presenting a relaxed mode. In listening mode, they will hear the spoken words but should also be attentive to the body language of the interviewee. Any discomfort observed should cause the interviewer to respond appropriately, perhaps giving the recipient time and space to compose themselves, by rephrasing or refocusing the question (potentially even away from the sensitising subject) or even evaluating the decision to continue (Smith *et al.*, 2021, 2009). Paterson *et al.* (2018) indicated their research into restraint was halted by the re-traumatising experience of talking about restraint amongst survivors of domestic abuse. Therefore, guidelines were put in place and submitted as part of the ethics application (Appendix 20). In practice I also enquired as to the whether interviewees had been adversely affected by checking in when the interview concluded. When interviewing Emma in Setting One, a disclosure was made in respect to undeclared historical events which had relevance to her in the here and now. I did not press for details but needed thereafter to be aware beneath the surface of her account were events that had been awoken and

thus I needed to be mindful to ensure that I responded appropriately if distress was discerned. In the event it did not break through, but this did not take away from a need to be ready to respond with care.

Establishing a rapport is key to accessing honest answers. In practice this involves being personable and reflecting back terms and language used by the interviewee [including the vernacular] as well as participating in moments of light relief. The rapport should not be allowed to subvert the interview goals and processes. I sought out a respectful sharing of power which I felt increased the participants' comfort and sense of personal control. I felt this was key to enabling candid disclosure. Smith *et al.* (2009) provide a useful qualification on the interview itself asserting that the understandings accessed within in the bounds of the interview should not be held to be 'the truth', definitive and unassailable, rather but should be understood as being 'meaning-full' (p.66) [see reflexivity below].

I also recognised that as the interviewer I was a potential source of bias (Gray, 2018). Investigating a topic that to me was so close to home meant I had preloaded conceptions of what I expected. I sought to put these on the record 'Researcher Expectations' [Appendix 29] – reflection on my assumptions will be returned to later. In respect to bias how might be revealed, the semi-structured interview allows interviewer to control the follow-up questions, the focus, the structure; open or closed, the framing, and the time afforded to allowing the participant to reflect and answer. Such control of the flow of communication introduces the potential for both conscious and unconscious bias to develop (Chenail, 2011).

The Interviews, n=4 for each setting, were completed over TEAMS, with the participants selecting the most convenient time and place. This included the home setting, and private rooms in the work setting.

Data Analysis Methods

One reason IPA has seen a growth in use is that a framework for analysis is provided (Hefferon & Gil-Rodriguez, 2011). The framework is flexible and provides the researcher with scope to diversify in their approach by applying '...flexible thinking, processes of reduction, expansion, revision, creativity and innovation' (Smith *et al.*, 2009 p.81). It facilitates sensitive but coherent movement from developing a description of the experience to an interpretation of it. I felt that the practical elements of the responses were key to understanding the experience, and to learn from them, so they were noted.

IPA analysis involves a step-by-step approach which has been outlined by Smith *et al.* (2009) and enriched by Peat *et al.* (2019). According to Smith *et al.* (2009), transcription for IPA purposes should be at the semantic level, capturing spoken words, false starts, significant pauses, as well as laughter and other relevant communications, but one does not need the more detailed transcription including the prosodic features of spoken words required for formal conversation analysis [see reflections on transcriptions below].

When rereading the transcript and listening to the audio I sought to immerse myself in the participant's world. Smith *et al.* (2009) counsel against the 'quick and dirty' reading that is often a habituated practice amongst researchers who routinely trawl through vast and varying tracts of information. The advice is to slow down. Any ideas or connections that do spring to mind can be

informally recorded in a notebook and returned to when the time is right. The focus at this stage is on the text in and of itself. There comes a time after the text has been absorbed when more formalised noting begins. Whilst the ultimate interpretation is mine, and is subjective, I did not arrive at it by taking an unconstrained approach. My methodological coherence provided rigour, and the evidence of my process provided here [and in the appendices] offers the opportunity to interrogate how I have arrived at my findings and conclusion. The following provides a breakdown of the process I followed.

1. Starting with line-by-line Analysis and Exploratory Notes

The analysis commenced with preliminary, exploratory notations following line-by-line reading. This ensured an in-depth consideration of the whole text and provided an opportunity to ensure the analysis was built up from a consideration of the most granular level of detail. Smith & Nizza (2022) refer to 'Descriptive Notes' (p.36), such as reference to 'objects, events, locations', practices and principles', 'Linguistic Notes' (p.36)such as 'shifts from the first to second person, false starts, laughter, 'protected pauses, particular words and emotional/emotive language' (p.36), as well as 'Conceptual Notes' (p.37)which take the form of questions.

The analysis for this study was undertaken using NVivo [Appendix 34 'Using NVivo for IPA Analysis']. My preliminary notes were captured in the codebooks that accompanied the analysis of individual transcripts [Appendix 35].

2. A Commitment to Engaging Reflexively with the Text

The developing sense-making process needs to be as free as possible from preconceptions and prejudices, requiring self-awareness. There are various modes of untainted, pre-reflective engagement including 'Epoche', 'Bracketing' and 'Bridling'. According to Gearing (2004) 'Epoche' is an epistemological position that prevents 'constructivist meanings'. Bednall (2006) reports epoche as an-ongoing analytic process, integrated into the whole research project, from its inception. He suggests 'bracketing', by contrast, occurs at those interpretative moments when a researcher holds the identified phenomena for inspection. Husserl (2001) referred to 'Bracketing' as the suspension of judgment about the natural world, with Oxford Reference (2023) defining it as 'the process of thinking away the natural interpretation of an experience in order to concentrate on its intrinsic nature or phenomenology'. Dahlberg *et al.* (2008) suggest that the act of *bridling* is the demonstrable ability to slow down and reflect on the process of understanding, in order that the researcher does not understand carelessly.

Smith *et al.* (2009), like Heidegger, take the position that one cannot completely divest oneself of their history, memories, or values. Therefore, when one engages with and interprets the experience of others, they bring themselves to bear on the process. It is incumbent on the researcher to remain self-aware, and to interrogate how they make sense of what is before them. Wilkinson (1988) identifies three forms of reflexivity which can inform qualitative research: 'personal', 'professional', and 'disciplinary':

1. Personal Reflexivity: 'Aspects of reflexivity [that] refer to the researchers own identity' (p.494)
2. Functional Reflexivity: Asks how the form of our research (such as choice of methods; way of interpreting results) has been shaped by our values, life circumstances, role in society, and/or

ideology, and what part does the form of our research play in creating our concepts and constructing our knowledge.

3. Disciplinary Reflexivity: 'The requirement for a discipline or sub-discipline, to explain its own form and influence' (p.495). A scientist and an artist may engage with experiences in different ways to produce outputs recognised by others within the same disciplinary group.

From my personal perspective as a longstanding trainer [martial arts and restraint], deviations from technique are seen as performance errors, or mistakes in replication. I needed to hold such thinking in check, and to consider the physicality being described not as technically wrong, or the result of a mistake. It had to be understood as that person's way of responding to the practical complexity that they were amid. Consider the following exchange with Lisa in setting two:

> Interviewer: So, in that sense then, are the techniques you're taught any use at all? Or no use at all?
>
> Lisa: [laughs] Moving on! [laughs more]
>
> Interviewer: I read between the lines on that one...
>
> Lisa: Yes. I suspect you've got a flavour of the answer anyway.

This was my first interview, and in addition to realising at point of transcription that I had not immediately taken the opportunity to 'expose the obvious' (Smith *et al*., 2021), my reading was that this could reveal a fundamental disinterest in training, a flippant regard for techniques or a fogging of the answer to mask incompetency. Fortunately, as the issue was returned to, both directly and obliquely I came to recognise that techniques as precisely specified and performed in the training environment did not work in the practice environment. Beneath Lisas idiosyncratic answer lay more

expansive and nuanced experience, which it could be argued, revealed a policy or training deficit rather than a staff one.

3. Capturing Initial Thoughts within Preliminary Experiential Statements

During the second stage of analysis those preliminary notes which the I determined had some form of discernible resonance with others were brought together under a subsuming and coherent whole, which Smith & Nizza [2022] refer to as an 'Experiential Statement' [formerly 'Emergent Themes']. These linkages are captured in the codebooks accompanying the analysis of each individual case [Appendix 35]. During my supervisions these were share and discussed.

4. The Subsequent Development of Personal Experiential Themes [PET]

This stage of analysis involves the clustering, or distillation, of the 'Experiential Statements' into 'Personal Experiential Themes' [PETs]. These linkages are captured in the individual codebooks [Appendix 35]. Interpretation, like reflexivity, is an ongoing and interactive process. Smith & Nizza (2022) remind us that 'Exploratory Notes' (p.32), 'Experiential Statements' (p.38) and 'Personal Experiential Themes' (p.45) are not immutable, and may be revised, refined, and updated throughout the analysis. This can involve separating, combining, refining, and reducing each component in line with the growing understanding of the text [see 'Hermeneutic Circle']. Verbatim extracts are often used to evidence areas of analytical interest, tensions within the analysis, idiosyncratic or outlying findings and analytical conclusions (Smith *et al*., 2009).

PETs represent the end of the individual-level analysis. At this point I would start again and analyse the next transcript. The next transcript is analysed on its own terms, with those themes identified in the preceding case are not carried over into the analysis. Once again, my ability to be reflexive was central to the integrity of the analysis. I used my reflexive diary to make my reflexivity transparent [see also point 7].

The PETs are contained in the Case Studies (Cassidy *et al.,* 2011; Smith *et al.*, 2009) which form the basis of this study. These are located within the Appendix [Appendices 38-45], where one can see the idiographic nature of the analysis within them. Locating them in the appendix both protected the permitted word count (University of Strathclyde, 2024) and was in keeping with IPA convention, re-affirmed by IPA practitioners within a professional IPA forum (ipaqualitative@groups.io, 2024). Finally, and most personally, it permitted transparency. To my mind it was important to share this analysis with readers.

5. The Identification of Convergences & Divergences: Group Experiential Themes [GET]

After I analysed the individual cases, I took the opportunity to compare themes across the group. Some were strongly noted, such as having to undertake some sort of practical field modification of techniques (Paterson, 2007) – more later. Whilst others were more tentatively noted, such as reference to tension in working relationships. Something that was exclusively noted in Setting One, and most notably within the accounts of two staff members accounts of their experiences. I completed the collation of these findings by using a manually populated cross-case analysis table (Cloutier & Ravasi, 2021), which involved me moving away from NVivo to tables created in word [see 'The Use of NVivo' below]. I revisited the individual chapters and original coding tables, before using the new word

table used to support the cross-case referencing was populated. Some of the individual 'Experiential Statements' were supplemented by my notes [in effect more strategic forms of 'Exploratory Notes'] which flowed from the analysis within each unique chapter. These in effect became consolidated versions of the initial 'Experiential Statements' and were listed in columns under individual participant names. Then I conceptually linked and organised them into thematic clusters, to become Group Experiential Themes [GET] [Appendix 36].

The two GET are located within the main body of the thesis [chapters 5 and 6] and represent the substantive within-group analysis. These are accompanied by chapter 7 which takes the form of a cross-group analysis. It is within this third chapter that convergences and divergences between study participant groups are considered, and the point at which the analytical work may have resonance with readers. Smith *et al*. (2009) suggest that IPA can 'tell us something about people's involvement in and orientation towards the world' (p.47). This analysis draws from several individual experiences of the same phenomenon. It was important to state that even in their similarities, no definitive claims can be made as to the inevitability of the experiences of others.

6. The 'Hermeneutic Circle'

Throughout the analysis I engaged within the 'Hermeneutic Circle'. This refers to the idea that interpretation of any single part of a text is undertaken with cognisance of the contents of its whole (Smith, 2007):

> Of course, one has to balance this with a large dose of pragmatism; the final interpretation may never be reached as the circle could theoretically go on forever. Thus, the skill is in

> deciding when to come out of the circle and commit oneself to speaking or writing, to deciding that one has an interpretation that is good enough (Smith, 2007 p.5)

This speaks to both deep engagement with the totality of the text, the ability to metaphorically step 'in' to consider small details and then step 'out' to see them and understand them in the context of the bigger picture.

7. The Use of a Personal Reflexive Diary

As the analytical journey continues, so does the tendency to self-reflect and think about the authenticity and integrity of the interpretations and links being made. My reflexive diary [see Appendix 28] provided a place to record what otherwise might have been transient thoughts. In recording them and not losing them to any incidental shift in cognitive focus, I could dwell in them and seek to understand their importance. I found reflexivity to be essential. Starting this level of research so late in my life, after thirty years immersed in use of force training [martial arts and restraint], meant that certain patterns of thinking had become inured. This presented a risk that the data I acquired could be subconsciously sorted by me, precluding any opportunity for contextualised sense to be made. Without reflexivity I came to realise that this study would lose its integrity and be reduced to my own singular experiences and perspective. The verb *realise* is important here, as it speaks to the bringing into one's possession that which was formerly not possessed (OED, 2024). Reflecting on my own outlook and behaviours I can see how perilously close I was to failing to recognise my own shortcomings, which some might characterise as a form of incompetence that often afflicts individuals making claims to be subject matter experts (Kruger & Dunning, 1999). I offered an example that speaks to this in the section on Hermeneutics in the previous chapter; 'Diary Excerpt

Title: ‘Confidence Revisited’, it pinpoints when my confidence in my subject matter expertise fell away. There are further reflexive commentary examples in Appendix 28.

8. The Use of Supervision Structures

Regular discussions were undertaken with research supervisors who were able to both review and critique draft output, as well as discuss issues arising. One of their key goals was to ensure that personal responsibility was assumed for producing an analysis that was both clear and unambiguous, as well as being evidenced by excerpts from the text. My supervisors also stimulated reflective and reflexive practice. All supervisions were noted on the NEPTUNE system.

9. The Identification of the Researchers Voice

Research supervision led me to a decision to adopt a style of writing up in this and the analytical chapters [5 to 7] which allowed my voice to be detected, as distinct from the voice of others. When speaking to personal interpretation, I used the first person. This permits the reader to reflect on the analysis and be cognisant of my presence. I included key aspects of my background to enable readers to make their own interpretations of my readings and findings [Appendices 26, 27 & 29].

10. The use of Language within the Subsequent Write Up of the Analysis

The interpretations that are offered come in a variety of forms, including those I determined to be strongly felt or held, and those that felt more tenuous. Throughout the analysis, care has been taken

to use a carefully considered array of adjectives. I signalled my interpretation with language such as 'my sense is that X speaks to Y', or when I had a stronger sense of the interpretation 'it is possible to conclude A from statement B'. I avoided the use of terms such as 'undeniably,' 'absolutely' or 'beyond dispute'. On occasions statements may be something like 'one reading is C, but I tend to feel that rather than this D speaks to this'. Here I acknowledge that an alternate reading had occurred but was discounted based on the totality of evidence under consideration [see 'The Hermeneutic Circle'].

The Use of NVivo

NVivo software was selected to facilitate the IPA analysis, rather than code manually as per the personal preference of Smith *et al* (2009). This amounts to the setting aside of the preferred approach of the originators of IPA. Such a choice is not prohibited but needs justification, and explanation. I had never used NVivo before, so did not arrive with any preconceived ideas as to how it should be used, or with any habits in relation to its use. I personally found the prospect of manual analysis quite daunting. It seemed to me there was something quite fragile about it, comprising as it does many separate pieces of paper that are organised and reorganised freehand. For me NVivo was the antidote to this fragility, with hundreds of separate notes instantly saveable. It also offered portability, allowing the coding and analysis to continue unabated in a host of locations [I spent significant periods of time away from home]. The use of NVivo also permitted multiple versions of individual attempts at coding and analysis. Lisa's transcript was coded 8 times as I familiarised myself with the IPA process.

NVivo itself is recognised as having an intuitive user interface, whose functionality is supported by a significant data storage, search, and retrieval capacity (Smyth, 2008). The benefits of it include being able to test tentative relationships with the data at any point, save and track differentiated analyses as well as saving search results (Smyth, 2008). To me NVivo provided a means to perform rudimentary

coding tasks, allowing me to formally record an interest in a word or section of data, with space being provided in the accompanying pop-up box to both make notes on the selected section and to name or label it. NVivo also allowed me to go on to link this 'code' with other selected sections of the text and assign the linked items [hierarchical and non-hierarchical] unique identifying labels. I could also just as easily unlink and re-link items. The thinking that drives the coding and analysis are my sole responsibility, NVivo simply provided the tools to operationalise the thinking: NVivo will only do what I, the researcher, makes it do. Obviously, the corollary of this is that it will not recognise analytical errors, i.e., unfounded interpretations, or linkages without strong enough foundations.

As has been described, NVivo allows for selected text to be conceptually tethered to a descriptive label, which it refers to as a 'New Code'. The term 'code' at this stage perhaps creates an impression of a developed understanding of some 'thing' within the data. At this stage in my analysis, that 'thing' might have only been a word, or a phrase, or the abrupt end to a statement, and the thinking around it not fully developed. In identifying it, I was simply marking something for further consideration. NVivo provides the facility to attach a 'Name' field and provide an accompanying description field, a space that was used to record developing thoughts that related to the object. See Fig. 4.5. At this stage there was no limit to the number of codes that could be added. Unless, and until some form of hierarchy was attached, all new codes existed at the same level. They were yet to be sorted and prioritised.

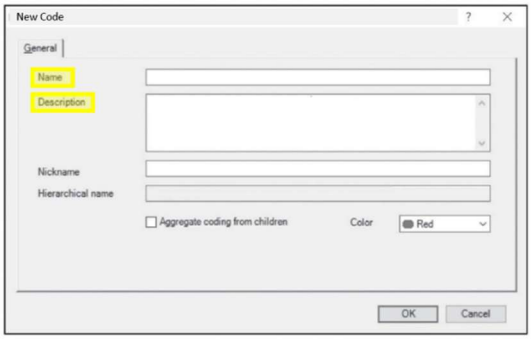


Fig. 4.5: A 'New Code' box provided by NVivo

To create a 'New Code' in NVivo was to simply register an interest in a piece of text, and to enter it into the software system. Whereas to 'code' using IPA is to designate a piece of the text to which some form of attention is being directed, and ultimately some form of interpretation is taking place. These are separate components of the same process, one practical, the other cognitive. The cognitive work can involve further interpreting already coded data and assembling coherent and resonant text in blocks of increasing size. As stated, IPA provides an array of terms to specifically designate their level: 'Exploratory Notes', 'Experiential Statements' and 'Personal Experiential Themes'. The latter of which are essentially coherent clusters of 'Experiential Statements', which provides some sense of how the researcher reading of the text is systematically constructed. Fig 4.6 shows the NVivo functionality alongside the interpretative levels within IPA.

Code Action using NVivo	Type of Code within NVivo	Level/Hierarchy
Creating a new 'Code'	**'Exploratory Notes'**	Low
Creating a new 'Code'	**'Experiential Statements'**	Medium
Creating a new 'Code'	**'Personal Experiential Themes'**	High

Fig. 4.6 Coding Functionality and Level of IPA interpretation

As explained, I was new to NVivo and sought to leverage its functionality to meet the requirements of the analytical process as defined within the IPA literature (Smith *et al,* 2009). For me there came a point within the assembly of GET when a form of manual coding seemed to be the most pragmatic way to compare the individual findings. It may have been possible within NVivo, however I elected to undertake it manually. This may well have also been linked to an increase in confidence on my part. I was a significant way through the analytical process, and NVivo was holding everything in place. The tabletop working I now employed could easily be restarted, with a new print off. I used transcripts, and copies of coding tables. These were used to populate paper and pen tables I had created. Text was highlighted, sections cut out and moved around the tabletop. They were then stuck in place when

their location was finalised, and then this was typed up into a note I could save. This manual mode of working complemented what had been accomplished within NVivo. This combination of computer-based and practical hands-on coding felt optimal to me, although others may attend to the task in different ways.

Data Collection, Storage and Security

The participants were given the option of submitting 'Physical Contact Logs' and 'Audio Diary Entries' on an ad-hoc basis or waiting until the data collection period had elapsed before handing over all files. For reasons already outlined, only setting one participants returned 'Physical Contact Logs' and 'Audio Diary Entries.

Data was uploaded to the OneDrive at the first opportunity, at which point copies residing within WhatsApp messages, and in other formats [such as scanned copies of the 'Physical Contact Logs'] were permanently deleted/destroyed. In practical terms this was often within 60 minutes of receipt. For the duration of the data collection period my phone back-up storage was switched off so that no unencrypted storage could inadvertently take place.

Interviews were all completed via TEAMS and recordings were uploaded to the OneDrive. No data was retained on any handheld devices, phones, laptops, desktops, memory sticks or other data storage drives or alternate storage platforms or cloud spaces.

The data files were saved using non-descript file names [for example H1-PCL-22]. All participants were assigned pseudonyms to protect their identity. The names of patients or supported individuals,

referred to in interviews, were similarly anonymised. The exception to the pseudo-anonymisation rule was the decision within accounts collected from setting one to use the terms Mum and Dad to denote Sara's parents. The word Mum was the descriptor that Sara's mother used to describe herself, along with all participants in setting one. Likewise, all participants referred to Sara's father as Dad. Terminology is important, and commentators have been critical of such terms. Goddard (2021) suggested the terms Mum and Dad can be perceived as disempowering or patronising, as they fail to recognise the innate humanity and unique identity of individuals. Elsewhere, there have been moves within public bodies to increase the inclusivity of language, with terms such as Mum and Dad being replaced by non-gendered, non-relational terms such as grown-ups, caregivers, or guardians, to avoid inadvertent discrimination against non-traditional families (Stringer, 2022; Wadsworth, 2021). Such careful handling of terms is wholly understandable within residential childcare and educational settings, as well as within critically sensitised explorations of relationships in such environs. In this study, a decision was made to carry the identifiers Mum and Dad over into the transcriptions. When used, they conveyed something about the person and their perceived parental role, and protected the anonymity of the parents, differentiating them from participants for whom names were used.

Analysis took place using only a password protected computer, with only myself able to view/review the data files. Analysis took place in private surroundings and never in public spaces (libraries or cafeterias). After any analytical work, the files were closed and remained in the OneDrive. No copies were made or transferred onto any handheld devices, phones, laptops, desktops, memory sticks or other data storage drives or alternate storage platforms or cloud spaces. Only fully pseudo-anonymised documents were ever printed.

Quality and Validity

Within IPA it is recognised that the researcher can never truly access the lived reality of participants, only interpret the experiences they are provided with. Therefore, a commitment to ensuring that this process is as valid as possible is necessary. Hammersley (1987) defines validity as, 'An account is valid or true if it represents accurately those features of the phenomena, that it is intended to describe, explain or theorise.' (p.69). The steps taken to ensure the rigour of the analytical process, as outlined above, play their role. Furthermore, guidelines produced by Yardley (2000) and Elliott *et al.* (1999) have been acknowledged by IPA researchers as providing a robust framework for ensuring quality (Shinebourne, 2011, Smith *et al.*, 2021, 2009). They cover 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and finally 'impact and importance' [Fig 4.8].

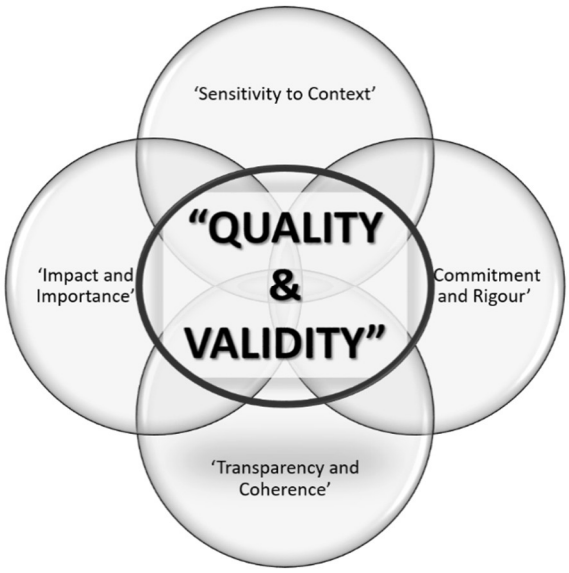


Fig 4.8: Quality and Validity within Qualitative Research.

Sensitivity to Context

A commitment to observing a sensitivity to context can be evidenced in various ways (Yardley, 2000). Firstly, sensitive handling of the literature review is important (Shinebourne, 2011). To me this speaks to *what* I read, and *how* I read it as well as whether I included it in my literature review. In assembling the literature review I sought to provide a broad summary of what is known about restraint and responding to behaviours of concern within disability settings. In my day job I sometimes find myself dealing with what I might characterise as pro-restrainers, and at other times anti-restrainers. My own, private opinion is that there should be much less restraint, but that to get restraint *right* we need to talk about it. I am alarmed by those pro-restrainers who seem to advocate for force and am also sometimes frustrated by the intransigence of the anti-restrainers. I am somewhere in the middle and sought to present a balanced literature review that supported a useful study.

I also carefully considered the sensitivity with which participants were engaged with, listened to and left. To this end I developed captured in a set of emotional safety guidelines (Appendix 20). The initial familiarisation along with the open dialogue maintained with participants across the research span, was designed to engender an environment in which people could be themselves, speak freely and openly, and in so doing offered some mitigation against the Hawthorne effect (Hammersley, 1987), wherein people can find themselves trying to tell you want they think you want to hear.

I approached the presentation of data with similar sensitivity. Smith *et al.* (2009) require that analysis '…will always have a considerable number of verbatim extracts from the participants' material to support the argument being made, thus giving participants a voice in the project and allowing the reader to check the interpretations being made' (p.180-181). Through all the analytical chapters,

verbatim accounts were used to illustrate and support interpretations. In the final review it was recommended that I pare back the number of quotes in the case studies. This was done, and I added a rationale for those that I kept in [see appendices 38-45]. Sensitivity was further and finally demonstrated by providing tentative rather than definitive readings of the findings, with coherent links being made to any relevant literature (Shinebourne, 2011). It should be noted that, respondent validation or member checking (Brooks *et al.*, 2015) is seen as being less appropriate in IPA (Larkin & Thompson, 2011) than in other qualitative methodologies. This because accounts given by participants in their natural attitude are interpreted by researchers in a phenomenological attitude, resulting in deeper and differentiated perspectives of the lifeworld under scrutiny (Brooks *et al.*, 2015, Finlay, 2014). According to Larkin & Thompson (2011), 'the combined effects of amalgamation of accounts, interpretation by the researcher and the passage of time, can make member-checking counter-productive' (p.112), with interpretations that are not congruent with participants own reading of themselves or their actions. The finalised thesis will, however, be made available to all who participated.

Commitment and Rigor

Commitment and rigor require prolonged, focused, and thoughtful immersion in the data (Shinebourne, 2011, Smith *et al.*, 2021, 2009). The commitment to the data is evidenced in a diligent and intelligent analysis which seeks to ensure the researcher focuses on 'how things are understood', as opposed to stagnating in a descriptive account of 'what happened' (Larkin & Thompson, 2011), 'Rigour in IPA 'refers to the thoroughness of the study, for example in terms of the appropriateness of the sample to the question in hand, the quality of the interview and the completeness of the analysis' (Smith *et al*., 2009, p.181). I set out how I undertook the analysis and part of the process involved

dwelling within the data, as well as reflecting on what I was doing. One such reflection related to the effects of fatigue when transcribing interviews was captured in my diary:

> Diary Excerpt Title: 'The Ethics of Transcription': 'Transcription is an arduous process. It seems to go on forever. I find myself checking the time stamp with increasing frequency as the process endures. What seems like a significant period of time typing up passes by, but when I check progress, only 90 seconds of interview has been transcribed. I find myself taking short cuts i.e., not checking what I had heard was what I have typed, and perhaps more egregiously contemplating the omission of tracts of data which in my fatigued state feel extraneous. I am actually doing this when suddenly the gravity of the actions pierces the fatigue and registers. I realise I urgently need to pull myself out of this malaise. I take a break and henceforth recognise the value of taking breaks. [I get tired more than once]. It doesn't help that I am not good at taking breaks, I always feel compelled to 'do' things, but here I can see I would be sabotaging myself and degrading my work if I carried on in this vein.'

Transparency and Coherence

Transparency and coherence refer to the clarity afforded to both the design and implementation of the research process (Yardley, 2000). I made research decisions throughout the study which were taken with reference to the relevant literature and the ongoing moderation of the research supervisors to whom I regularly reported. This was something which was captured in supervision. I designed a clear study protocol detailing the methods of data gathering and analysis procedures that allowed third parties to review and critique (Gray, 2018). The process of my interpretation was made transparent by including numerous and extensive samples of the transcript that are supported by

contextual detail (Larkin & Thompson, 2011). As previously stated, a very personal part of the process was a reflective research diary that I used to keep contemporaneous records of thoughts and feelings as the various stages of research design and implementation were negotiated. Positive and negative experiences were logged in the diary as well as reflections on them (Appendix 28). The full disclosure of confounding data was a part of the being transparent, revealing those findings that did not resonate across the cohort (Weaver, 2013).

Impact and Importance

I think determinations as to 'impact and importance' of my research is the responsibility of others to make. My role is to expedite that evaluation, by making make it accessible. I will submit precis to relevant journals and seek opportunities to share my findings through relevant conferences. By promulgating my work, I will invariably be required to explain and clarify or even defend. All of which will further inform evaluations by others and feed my own reflective journey.

Other Potential Approaches to this Study?

There are various other qualitative research approaches that may have suitable for this study. One is Grounded Theory [GT] (Glaser & Strauss,1967). GT provides a systematic method for developing a theory directly from data. Like IPA, Grounded GT "provides a frame for qualitative inquiry and guidelines for conducting it" (Charmaz, 2009, p. 127), which undoubtedly aids researchers, however it is its commitment to setting aside the existing literature that has drawn criticism (Bryant & Charmaz, 2007). The expectation is that a theory of the phenomena at hand will rise from the data, making any findings in the existing literature of second order importance. If the approach taken follows a purist's interpretation of GT, there should be no strong sense of the knowledge gap to be filled, nor expectations. In the field of inquiry that I was working within, the literature and the discourse

surrounding policy and practices were *the* reason I chose to mount the inquiry and central to making sense of the findings. Others have however sought to utilise GT. Lawrence *et al* (2025) recently reported completing a GT study which explored decision-making as it related to the seclusion process, from initiation to termination. The result is described as a "Model of the Seclusion Decision-Making Process" (p.227) and was driven by a gap identified in the literature, which seems to reaffirm that in doing GT it is difficult to truly start from a position of unknowing. Furthermore, in its meticulous and detailed approach have been described and experienced as an "exhaustive Process" (Hussein, 2014 p.5). For these reasons I chose not to utilise GT, although a theory of response physicality is a very intriguing possibility.

Another possible approach is offered by Thematic Analysis (Braun & Clarke, 2006). Described by its originators as an appropriate and powerful method to use when seeking to understand any set of experiences, thoughts, or behaviours (Braun and Clarke 2012). Indeed, Braun and Clarke (2006) have argued that it should be the first method of qualitative analysis that prospective researchers learn. The key to its effectiveness as an approach, seems to be in using it in such a way as to serve the research project. Coding can be for what are described as semantic, manifest or surface meanings, or for latent, implicit or hidden meanings (Braun and Clarke 2012). Thereafter, it can be used for inductive [as was the case with this study], as well as deductive analysis (Kiger & Varpio, 2020). Its chief use seems to be in inductive application wherein the phenomena of interest are analysed holistically across a data set (Braun & Clarke 2012). This was something I wanted to avoid, as I felt that to lose individuality to an aggregated whole was to lose something important, indeed the essence of my inquiry as I saw it. This is not to say that individual analysis could not be undertaken on a case-by-case basis. As with all quality research approaches the work required to make it effective is the responsibility of the researcher. Kiger & Varpio (2020) point out that the description of findings or the mere listing of data extracts or paraphrased responses does not constitute a thematic analysis,

analysis itself is required. Again, this seems to hold true across all qualitative research. TA has been used within the context of the workspace and staff activities that I am interested in, namely where staff come to apply restrictions on patients. Griffin *et al* (2025) explored a particular aspect of the restrictive interactions between staff and patients, namely the relationship between restrictive practices and psychological safety. They highlighted that some staff do not look beyond the behaviour being presented, and that the immediate environment in which a response needs to be mounted, is chaotic. Both of which can engender anxiety and uncertainty. This certainly has resonance with the findings of this study, but IPA with its commitment to phenomenology, idiography, and hermeneutics allows the researcher, me in this case, to get beneath this surface reality to reveal how people make sense of such challenging experiences and move through them. Whilst I think TA has great utility, I feel my commitment to getting to the lived experiences of individuals was served well by IPA.

Chapter 5. Group Experiential Themes, Setting One

Setting One

Setting One is a family home. Three Personal Assistants, Lisa, Emma and Russell, and Donna the team leader, provide support to an adult female with a Learning Disability: Sara. Saras mother, referred to by the participants, and thus in this thesis, as 'Mum' is the service manager, overseeing as well as working alongside the team. Donna has worked in the service for several years. Russell had also previously worked there, at a time when behaviours of concern were at higher levels. Both Lisa and Emma are relatively new to the service. Whilst seen as providing a vital service, the role of Support workers is not currently professionalised.

In this chapter I will explore the findings at group level. To do this I have already analysed everyone's individual account of their experiences. I have referred to these as case studies, and the write up of each can be found in Appendices 38-41. Therefore, in this chapter, I will touch upon similarities and differences as they exist at the level of this cohort [n=4]. I identified several 'Group Experiential Themes' (GET) [See Fig 5.1], alongside which I have highlighted the research questions [RQ], to which each theme most directly speaks.

GROUP EXPERIENTIAL THEMES	RQ1	RQ2	RQ3
1. Relationships can hold things together or pull things apart.	■		
2. Mum is present within both policy and practice.	■	■	
3. Autonomy is negotiated, Not Inflicted.	■	■	
4. There is always a complex array of emotions present.	■		
5. The individuals inevitably use themselves as a resource.	■		
6. Some training helps and some training doesn't.	■	■	
7. We are judged whether our actions are witnessed or not			■

Fig 5.1: Setting One GET, and links to RQ.

Relationships Can Hold Things Together or Pull Things Apart

All the research participants revealed something about the importance and role of relationships. Donna spoke explicitly to the trust that flowed from her relationship with Sara:

> I think trust is probably a really big one. I think if she trusts you and you've built up a really good relationship with her, then I think you are probably able to achieve more because she knows where she stands with you [128-129]

Lisa, by contrast spoke of the relationship the team have with Saras father, which appeared to have destabilising effects:

> He comes in cocks everything up for everyone else, and her. And then buggers off again, quite frankly. And then come back again a week later and does it all again. And yet he is the one who doesn't get hammered. Who doesn't get sworn at. He isn't the one that get pinched, and all that. Because he's giving in to her every time. So, I get quite angry [315-319]

There seemed to be a range of different types of relationships present within the service, as well as underpinning the responses to behaviours of concern presented by Sara. I thought of these as constituting an invisible relational web. The diagram below [Fig. 5.2] provides an overview. The number of relationships in the diagram should not be seen as exhaustive but gives some idea of how numerous and varied they were. What seemed to reveal itself was the absence of reference to certain relationships, and the presence of some dysfunction in others [green indicating their functional presence, amber indicating reference to a relationship that had a degree of dysfunctionality, and red denoting no reference]. In the case studies [Appendices 38-41] the dysfunctions revealed themselves as tensions and disagreements between parties that served to reduce the amount and quality, of collaborative communication. Most notably Russell disagreed with strategic decisions made by Mum, which ultimately resulted in his departure from the service. The other notable tension was between the team members and Saras father who they all felt did not follow the agreed support plan. Notwithstanding these, the relationships in the main were revealed as valuable and helpful. It is worth noting that when one looks at the web below, the relationships with Sara, and with Mum in her practice leadership role, are positive. This latter role was exemplified by her guiding situational reposes to behaviours of concern and supporting staff members in making sense of events. This will be explored later.

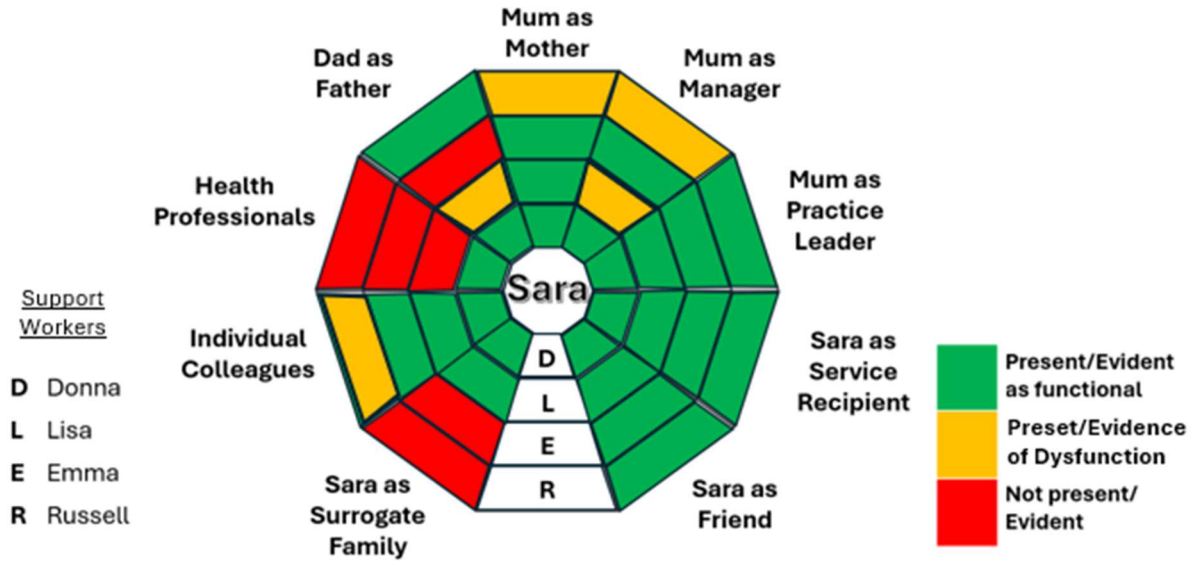


Fig 5.2: Sara's relational network.

When considering these relationships surrounding Sara, I was reminded of a multi-disciplinary team (MDT), 'a group of health and care staff who are members of different organisations and professions, that work together to make decisions regarding the treatment of individual patients and service users' (NHSE-TD, 2022). The individual with multi-dimensional needs is attended to by qualified and/or experienced practitioners, whose inputs are organised and sequenced through some form of governing structure. Whilst the MDT speaks most obviously to the co-ordination of specialisms, the relational network *here* seems to speak to the connections and communications that facilitated the support required to meet general needs, as well as titrating situational support when behaviours of concern manifested, as other themes will show. This is captured in the Relationship-Based Care model (Koloroutis, 2004) [Fig 5.3]. Rather than focus solely on the patient/practitioner alliance, or therapeutic relationship, Koloroutis focuses on three interrelating relationships: One's relationship with oneself, with one's colleagues, and finally with the patient/person being supported [& their

families], with the caring relationship with ones-self being foundational to the other types of relationship.

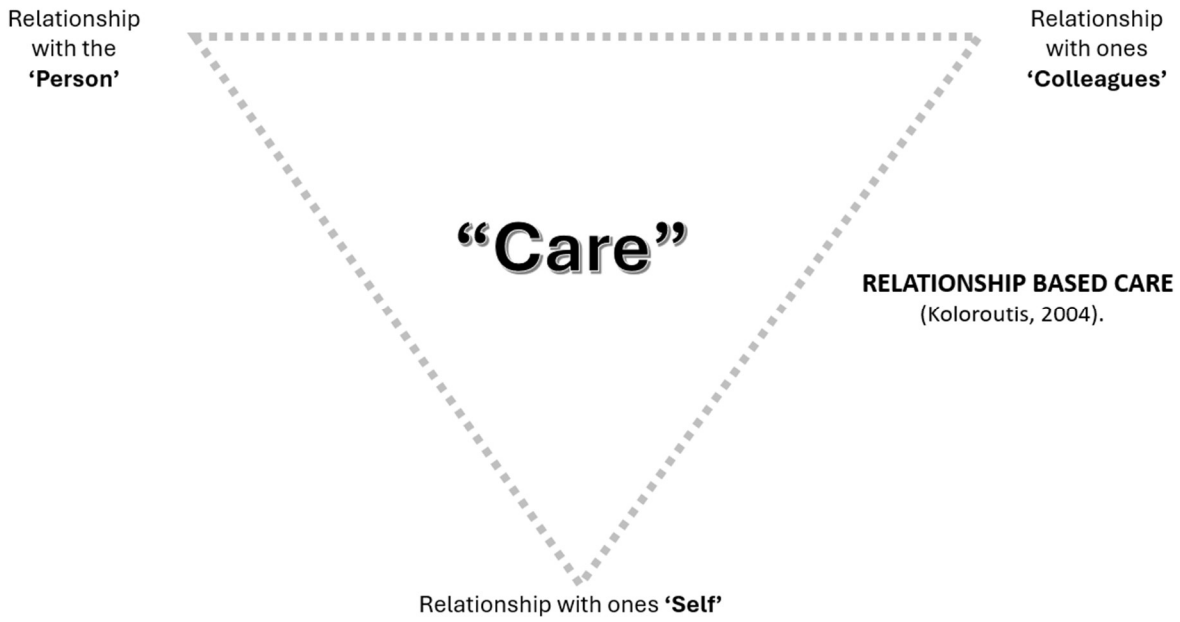


Fig 5.3: The Relationship-Based Care model (Koloroutis, 2004).

Through my analysis, I concluded that participants' relationships with themselves were important [See 'The Individual Inevitably Uses Themselves as a Resource']. This was revealed in a self-awareness and a self-regulation that enabled individuals to tap into experiential resources during and after events:

> Lisa: I get myself really quite emotionally wrapped up, and sometimes I think maybe I shouldn't [97]
>
> Emma: I'm like "Pull yourself together Emma, just ignore it. You're here to do what you've got to do and then you go home" [174]

> Russell: In these heightened episodes that we've had. On reflection it does cross your mind 'I wonder what would have happened if it had carried on? And we hadn't got her into the room' [707-708]

Koloroutis (2004) placed an emphasis on the development of a self-caring relationship, achieved through the cultivation of self-attunement, self-clarity, and self-compassion (Koloroutis, 2014), where one attuned to oneself, and sought the clarity required to ensure a compassionate perspective on what was necessary to look after oneself. In this study the emphasis seemed to be on how high-stakes interactions were managed: how 'I' related to 'me' before 'thee'. The ability to holds one's emotions in check in order to make nuanced decisions and take careful actions (Hallet & Dickens, 2017) seems central to this, as does the ability to keep going and remain 'on task'. This seemed important because all participants found themselves involved in complex and risky interactions, and spoke of being exposed to harmful behaviours, something that added to an already wide range of difficult-to-bear emotions which they had to process at pace. Both concepts will be packed more fully in the theme ['There Is Always a Complex Array of Emotions Present'].

> Russell: It's the unknown, you don't know how this scenario is going to play out. You don't know how much she is going to hurt you [712]

Within the context of this self-relationship, the relationship between the personal and the professional aspects of the self was revealed in the data [see 'The Individual Inevitably Uses Themselves as A Resource]. My feeling was that more seems expected of the professional self in terms of how deportment, interaction and expression is moderated, especially within regulated professions,

as opposed to the personal self that is less constrained. As indicated, a later theme will also explore the presence of, and the dealing with, emotions presence within the whole self.

Relational Coordination Theory [RCT] (Gittell, 2011) offers another relevant perspective. RCT makes visible the social processes within human interactions that underpin the more technical aspects of coordinating complex team working. The theory holds that the interprofessional working taking place is optimised by communication focused on problem solving that is timely, accurate and frequent. It also speaks to how relationships between professionals or practitioners are underpinned by shared goals, shared knowledge, and mutual respect. Donna encapsulated the complexity surrounding the achievement by the team of goals set by Mum, with mum leading the way in communicating 'how to' move forwards in the moment:

> Donna: There's obviously more that Mum can get away with than I can get away with. Yes, I know that there I things that I can push her into do that Lisa can't. But definitely Mum is the one that's says 'Come on, we are going out and we are going to do this' [95-101]

This is very much resonant with how staff spoke of the ways they related to one another and grew through each other, and especially through their relationship with Mum [apart from Russell] – Mums unique role will be expanded upon in the next theme. It seemed to me that the relationships and communications within them were an integral part of team responses and seemed central to the realisation of the Primary Task (Lawrence, 1977; Rice, 1963).

If these relationships did indeed support the primary task, what of their driving force? A caring disposition would seem to be vital in their formulation, something which is usually innate within the

person (Pettersen, 2012). This is likely to reveal itself through actions that register as kind, helpful or well meaning, which garner both trust and regard. Not doing something, an inaction, could also be construed as caring: waiting, not exercising one's power, or giving someone the time they need to do something on their own terms. If someone, through their personal *being,* was inclined towards a caring *doing* in a professional context, it would seem that a conscious act of titration would be required to curtail its expression. This because there comes a point when enough is enough. Any more might be unwelcome, disabling or be seen and felt as serving the interests of the carer's ego rather that the individual in need (Pettersen, 2012). In the next theme the notion of going as a far as to expose oneself to harm whilst caring is touched upon as it was exemplified by Mum.

In the absence of an innate caring disposition the individual would need to recognise the need for some form of care, before a conscious act of will is used to bring appropriate actions into existence. A caring disposition is therefore distinct from a caring act (Tronto, 1993). As a physiotherapist I did caring things. This is not to say they always originated from a caring inclination; they were tasks I was obliged to attend to. Such actions then, can therefore be devoid of care but seem caring to the recipient. The cynical practitioner could conceivably effectively feign a caring inclination. The relationships, and accrued benefits derived, could be founded on an illusory regard for the other. However, having spent a great deal of time considering participant experiences, I feel that the relationships between Donna, Lisa, Emma and Sara revealed something about the presence of an authentic, often approaching familial, caring disposition, which underwrote how they responded to Sara. This developed within the somewhat loosely bounded relationships that were the result of Mum not instituting any formal boundaries; staff were friends and not workers. More about the relationship with mum is unpacked in the next theme. By contrast, with Russell there is at least an aspect of caring that was seen by him as a work task, and a sense that Mum somehow failed to provide an infrastructure for his more impersonal, technically framed mode of working. This is not to say that the work had not resulted in

Russell reappraising what it was to be learning disabled through his relational proximity to Sara, and to develop vestiges of regard. However, how he related, and how his relationships facilitated caring seemed qualitatively different to the other relationships in the house. The way he described them was less personal, with reference to how he audited people [he was formally an auditor]. Both forms of relationship seemed to work, but the informal nature of theirs seemed to free Donna, Lisa and Emma to be unconstrained in their expression of care and embrace of positive emotions. Emma stated, 'You know, when she's lovely, she bloody lovely'. This informality, and delimited possibilities flowing from it, did not seem to be part of how Russell experienced caring and responding. In conclusion relationships seem to support practice, the day-to-day as well as responses to behaviours of concern. It was noted that Mums' presence was significant, which will now be further elaborated upon.

Mum Is Present Within Both Policy and Practice

All the participants referred to Sara's mother ['Mum'], and agreed that Mum could achieve more with Sara, often more efficiently than they could. This is perhaps unsurprising. Donna sums this up when she describes Mum as 'Sara's knowledge book'. Importantly this knowledge seems to have been shared with participants through their various relational connections with her. The includes how to best to support Sara as well as how to respond to behaviours of concern. Formal, approved responses are outlined in the 'Positive Behaviour Support Plan' and cascaded through the scheduled training. Mum, however, remained able to interpret and refine responses 'on the hoof' [more shortly], meaning she assumes something of a 'Practice Leadership' role (Mansell *et al.*, 2004).

In their accounts, Donna and Lisa most clearly spoke to the store that was placed in Mum as a policy resource, and a practice leader, although they did not use such terms. Donna speaks obliquely to Practice Leadership, commenting on Mums positions and knowledge, 'I suppose with Mum because she's mum and manager she's known Sara for 29 years. She knows Sara inside and out'. There was a sense that Emma did too, but that she was still building her confidence and competence, and that the relationship with Mum which scaffolded this was not yet fully formed. Russell stood as the outlier, with his relationship with Mum under tension. What was revealed by him were decisions and actions by others that seemed to run counter to what he felt was right or necessary. One of the barriers to buy-in from Russell was what he saw as Mums' conflicted position, because of her familial proximity to very intense events.

> This is no disrespect with Mum. There is a huge conflict of interest with her, a manager and a mother for starters. [77-78]

Russell spoke of this at length, [captured in his PET - see Appendix 41], with the issue clearly significant enough to him to ultimately merit his departure [I interviewed him on his last day]. His criticism emerged following comments on the presence of too many feelings in the workplace. Like relationships, feelings will also be explored in a later theme. That everything seems to be so enmeshed says something about the complexity involved in the work taking place, and something which seemed to unsettle Russell to the point of resigning, but which Mum and others were able to live with, and function within.

Despite his criticisms, Russell did offer a vivid example of Mum's role in the policy space, and on this occasion his agreement with her. He described an intense experience which involved working

alongside Mum, when it was deemed that for safety's sake Sara needed to be moved into the Blue Room [the purpose-built seclusion area]. Mum was instrumental in validating the ad-hoc physicality assembled in the moment, 'Mum would say 'Quick! Just get her in and get the door shut!' She would agree, she couldn't do anything other than agree'. It showed how staff were required to face up to the demands of an unforeseen situation, where emotions are running high, and time was of the essence. In these moments formal policy and training did not offer clarity or certainty. It was not possible to specify in advance, and be ready to apply, physical responses which fitted the situational demand with precision. In their experiences of physically responding, all participants spoke to having to improvise to find a safe and effective physical response utilising acceptable force, that avoided any lasting physical or psychological harm to Sara, and which they seemed to imply would be deemed righteous by Mum. When talking of dealing with difficult situations Lisa states:

> I would do my best to model my behaviour on mums' behaviour [438-439]

Mum's tacit or conjectured approval seemed to me to be the arbiter of acceptable performance, and as their actions needed to be intrinsically right rather than simply legal. This was a mothers' daughter being restrained and relocated under her direct authority and supervision, as such Mum was proximal in a way parents aren't in hospitals and care homes. The sense I got was that any physical response was expected to be careful as a consequence. As a result, I saw Mum was both a visible stake-holder, who spoke to and modelled the standard of care that was expected, as well as being present in spirit when incidents arose, after effectively franchising staff to use such ethical force in her absence.

So, whilst there were official documents and plans, policy seemed to be a set of parameters, or an ability to know what would be considered right, which was retained by each participant. As previously

indicated, these parameters appeared to have been developed and curated with Mum, through her relationships with staff members. The cultivation of this knowing took place through group team meetings and one-to-one discussions, as well as by Mum working alongside individuals. These understandings in turn governed the interpretation necessary in practice by staff. That staff responses are assembled 'in the moment' speaks to the pragmatism, which is a central feature of bricolage (Levi-Strauss, 1962), the ability to adapt on the hoof. This is a key concept and will be expanded upon in a later theme. Alongside this, participant accounts revealed Mum also seemed to model a form resilience (Foster et al., 2023) and kept going when events became complex and difficult. Donna spoke of how Mum appeared to keep going in all her roles, without a clear support mechanism, despite being there to provide support to staff:

> I almost feel like Mum has been through a lot of shit, and she often doesn't get the support she needs to get [493]

This notion of keeping going 'through a lot of shit' seems to include continuing through physically harmful behaviour according to Lisa:

> A few weeks ago, Mum had an incident. Which was documented, where Sara beat her black and blue actually. Mum was bruised. Well, she's still got bruises

To be clear, my reference to keeping going and demonstrating resilience does not mean Mum had any expectation that staff continued to the point of harm. Of course, harm to any party involved in a physical intervention is a real possibility, but perhaps as a mother, Mum herself processed risk differently. The issue of how far to go will be returned to later. To keep going and continue to stay

true to the Primary Task (Rice, 1963) and provide Sara with the support she needs when she needs it, is perhaps better understood as standing in contrast to withdrawing and ceasing to care as fully as required or resorting to a maladaptive response (Menzies, 1960). Within the context of their caring role participants did intervene in various ways. This was something that involved a practical and at times physical negotiation of Saras autonomy, an aspect of their practice experience that constitutes the next theme.

Autonomy Is Negotiated, Not Inflicted

All the participants spoke of 'pushing' Sara to do things that she didn't want to. Donna spoke of how she could push Sara more than Lisa but not as much as Mum:

> There's obviously more that Mum can get away with than I can get away with. Yes, I know that there I things that I can push her into do that Lisa can't. But definitely Mum is the one that's says, 'Come on, we are going out and we are going to do this' OK Mum! But if I was doing that it would be "I don't think so, not today! [95-102]

In the context spoken to above, the 'pushing' referred to was of Sara into life experiences and activities that were deemed to be likely to expand her agency and her own resilience, and by extension a mastery and control over the quality of her life. If this resultant freedom led to less frustration and boredom, one might make a tentative claim that the pushing averted behaviours of concern and thus served a distal restraint reduction function. The holding, and 'pushing' [or indeed pulling] that might take place within a physical response are similarly infringements of Saras autonomy but are likewise made in her best interests. In such instances they are to avert harm. The infringement of another's

right to exist as an autonomous individual is one of the foundational objections to the use of restrictive interventions (EHRC, 2019). Such infringements, even when legally justified, have been problematised, often with staff being condemned by virtue of being complicit in the restriction (Wilson *et al.*, 2017, MIND, 2013). In participant experiences, during periods when behaviours escalated, autonomy was something to be negotiated and titrated rather than existing in an unassailable state. This 'pushing', the physical as well as the non-physical, for me was resonant with the 'Compassionate Interference' (Verkerk, 1999) that was introduced in the theory chapter which involves actions (and inactions) being justified through the operation of a relational ontology. It speaks to a world in which the interdependence with others is part of what makes 'us' us, and that if we would take actions in our own best interests we would or should equally take them on behalf of others. Verkerks' thinking was stimulated by the experience of a Dutch nurse who had been working with drug addicts living on the street [sic – now 'person with substance use disorder', 'who is unhoused or houseless'], who consistently refused care. The situation with Sara to me seems to be one where she rejected care. In the context of day-to-day support when she rejected all reasoned appeals to participate in developmental activities, and those others where she presented with behaviours of concern, and as a result required careful attenuation of those behaviours but was resistant to it. In both instances, my reading of participant experiences was that they found it morally difficult to settle for inaction or being passive observers. It seemed like this would have been tantamount to abrogating their duty to care implicit in their legal duties and Primary Task (Rice, 1963).

Whilst critics labelled the imposition of the unwanted care as paternalism by another name (Silvers, 1995), Verkerk (1999) argued that autonomy can be understood as more than 'agency, independence and rationality' (ibid p.360), with the prevailing interpretation premised fundamentally on issues of 'capacity'. Verkerk (1999) states, 'The idea of the self as 'disembedded and disembodied' that has

played a prominent role in moral and political theory, is also rejected in the care perspective' (ibid, p.363), she goes on to say:

> In the care perspective a relational account of moral agency and an idea of interdependency as characteristic of human existence are emphasised... The self is relational in the sense that one of the fundamental ways in which a person conceives of himself and thinks about the world around him is in terms of relationships in which he is involved', [so] '…instead of defining autonomy in opposition to social relationships, autonomy is *made possible* by our social relationships… (ibid p.364, italics my emphasis).

Such interference, according to Verkerk (1999), involved doing unto others that which the individuals themselves had demurred, including treatment referrals, and the replacement of wet and unhygienic bedding for clean replacements. In this study context, removing someone's liberty in the interests of safety, or imposing a restriction through some form of restraint can equally be put forward as a form of compassionate intervention [it is of course recognised that the identical act, underwritten by a different framing or motivation could be wholly anathema to the care of an individual or the functioning of a respectful relationship]. According to Verkerk, when taking an action on behalf of someone, they are essentially doing things *with* the other rather than *to* them, due the shared situational reality, and shared recognition that we all need care. Donna spoke of having to hold Sara for her to have a covid jab. Sara was both physiologically vulnerable to its effects and psychologically scared of hospitals after having had a traumatic period in a long stay LD hospital. For Donna her interference was necessary for the good of Sara, but uncomfortable for her:

> It really upsets me. I really don't like doing it. But I think, like for instance the covid one, obviously it does upset me, and I don't like having to do it, and I don't like seeing her in that situation, but actually it was beneficial for her to have it done. You know she would probably be very poorly if she was to get covid. She might have to go into hospital, and that would be an absolute nightmare because she hates hospitals [624-628]

As can be seen in Donna's comments above, and was borne out by other participants, none of these decisions to interfere with Sara's freedom and freedom of expression were taken lightly. It was noticeable that there was no reference whatsoever to any legal basis for such interventions. Phrases like 'in line with the mental capacity act', 'as justified by common law' or 'as was my right under the criminal law act' were never used. There always seemed to be an implicit caring driving force behind the actions, it was part of their caring role. The actions were described in detail within the individual case studies and did not appear to me to amount to unnecessary forceful interventions. These were actions taken to keep both parties safe. All members of the team had been struck or attacked in some way by Sara, but these painful and often injurious actions did not appear to have resulted in any resentment towards Sara or in any damage to their relationship. They sought to do good for her, and to her.

> Emma: But sometimes it gets to that point, where I have no choice but to call somebody else. Because, you know, she's hurting. Do you know? I'm black and blue at the minute. You know, when she's lovely, she bloody lovely [66-68]

In line with findings in the previous theme, I felt participant accounts indicated that this relationally mediated balancing act has an ethical rather than legal core to it. Pettersen (2012) spoke of finding

the ‘Golden Mean’. In those moments of pushing Sara to grow, as well as moments responding to her behaviour, relationships, actions, impacts and outcomes were all in a state of disequilibrium and needing to be balanced and rebalanced until something approaching a harmonious conclusion was reached. The organising principles posited by Pettersen (2011) seem to speak to how pragmatically this equilibrium was sought, namely the universal condemnation of exploitation and hurt, and the universal commitment to human flourishing. These principles will echo throughout other themes. What seemed clear to me was that participants interfered from a place of care. The emotional aspects of interacting, and intervening is Sara’s world were noted and constitute the next theme.

There Is Always a Complex Array of Emotions Present

I found that there was an emotional dimension to the experiences of all participants. At a time when they were making decisions about how to respond to behaviours of concern, all participants spoke of experiencing a wide range of emotions [Fig 5.4].

DONNA	Revealed feeling 'frustration', 'upset' at witnessing self-induced suffering, feeling 'pride' in accomplishment and calmness in the face of attempts to 'scare', finding some situations and circumstances 'difficult', feeling really 'annoyed' or 'pissed off'
LISA	Talked of feeling 'heightened' when involved in incidents, 'anger' 'frustration', 'pain', 'upset', 'sadness', 'happiness' and 'love', feeling 'wonderful' when Sara shows affection and feeling like 'crying' when witnessing a seclusion, witnessing things characterised as 'horrible'
EMMA	Disclosing being 'upset', 'hurt', 'uncomfortable' as well as a dip in mood due to a tense atmosphere, and unnamed feelings following perceived admonishment, and because of being misunderstood, feelings associated with rumination as well as more positive feelings associated with work accomplishments
RUSSELL	A sense of having 'bonded', 'shock', being physically 'hurt', 'fear' of getting hurt, a feeling of being 'vulnerable' to harm, feelings of 'guilt' at having to use force to restrain, 'frustration' at Mum, feeling 'sorry' for Mum, feelings of accomplishment, some unnamed feelings approaching low level apprehension in anticipation of an escalation in Sara behaviour, finding perceived criticism, and chastisement 'difficult', being something approaching 'frustrated' or even 'exasperated' with policies or practices he doesn't agree with, confusion or incomprehension in relation to Saras infatuation, pride or satisfaction in accomplishment.

Fig 5.4: Those emotions present within individual participant experiences.

It became evident that feelings and emotions materialised in various locations. Before, during and after responses, including when the participants were exposed to what I felt constituted violence:

> Donna: She can kick you in the head whilst she's standing up [632]

> Lisa: But once she starts throwing punches and kicking and physically getting out of control, the Blue Room, you've got to put her in there for the safety of herself and others [655-657]

> Emma: 'So she turned round and got her fingers and went like that [shows pinching], and I'm literally black on the back of my arm' [points to triceps area] [237-238]

Russell: She can kick, bite, scratch, headbutt you name it. She's got the full armoury [221-222]

Unsurprisingly when exposed to such behaviours there was talk of pain, anger and frustration, of feeling heightened', as well as the cascade of adrenalin, all often associated with actions incongruent with situational caring goals, namely fight or flight behaviours (McDonnell *et al.*, 2008). Despite the presence of potentially destabilising feelings and emotions, the participants seemed to be able to continue functioning in a balanced manner which could be considered caring.

It makes sese to unpack the self-regulation that has been previously alluded to a little further (Vohs & Baumeister, 2004). It is described as 'the self's capacity for altering its behaviours' (ibid p.115) defined thereafter as 'the capacity of organisms (here, human beings) to override and alter their responses. It is the process by which people attempt to constrain unwanted urges in order to gain control of the incipient response' (p.116). Such a capability greatly increases an individual's adaptability, enabling them to adjust their actions to various social and situational demands. Within the account of participants, I was drawn to the act of individuals holding their own feelings when exposed to overwhelming, frightening and threatening behaviours, before regulating their physical response. They seemed able to supress any desire to vent in the moment, or pursue some primal, unthinking form of redress driven by feelings of injustice. If Koloroutis (2014) identified constructive ways to relate to oneself, I think the notion of self-regulation, in this very urgent and intense context, speaks to averting a potentially very destructive form of relating to others. This relatedness, combining 'Self-Regulation' (Vohs & Baumeister, 2004) and a resilience (Foster et al., 2023) that permits the individual to remain on task, specifically the primary task (Rice, 1962) adapting to demands is further now added to the earlier visual [Fig 5.3 & 5.5].

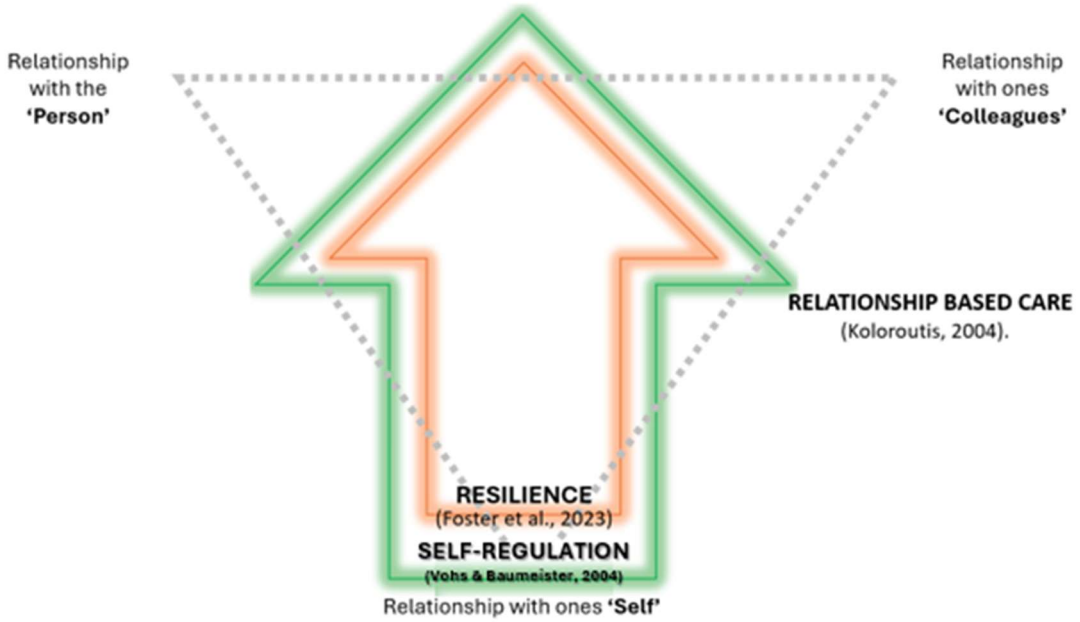


Fig 5.4: Resilience and Self-Regulation define the relationship with self, and through that with others.

Historically the presence of emotionality within decision making has been seen as problematic. The Enlightenment saw the application of reason and logic elevated above the practice of making sense of things emotionally, the thinking 'self' valued above the feeling 'self' (Smith, 2009). For centuries irrationality and emotionality were cast as decidedly female attributes, and as such a destabilising force, to be constrained or excluded by the power of masculine reason (Ruddick, 1989). The primacy given to reason has shaped many professions including health and social care, where individuals were encouraged to divest their professional selves of seemingly incompatible personal components. This has meant that the qualities of detachment, objectivity and of 'professional distance' have been prioritised and valued, whilst emotional involvement is often construed as unprofessional, and likely to compromise professional conduct. Indeed, within care work professional status and standing has been historically located within technical competency specifications, and practice standards that are rationally structured within a highly top-down bureaucratic delivery infrastructure (Ingram & Smith, 2018).

As the theory chapter reveals, a robust challenge to the exclusion of emotions from the sensemaking and decision-making process has been made by a growing number of care ethicists (Pettersen, 2008; Tronto, 1993; Noddings, 1984; Gilligan, 1983; Ruddick, 1980). Emotions, when considered in context and through the application of rational thought, can tell us much about our current selves and others along with the situation we find ourselves in, information that is vital in formulating the most appropriate response. Care Ethics acknowledges that emotions and feelings can have a role to play in providing valuable insight and direction. This is not to say that one should rely solely on them exclusively, or that they are infallible. Donna feeling 'pissed off', Lisa 'Frustrated', Emma 'Upset' and Russell 'Shock[ed]' are components of a larger and complex experience, and not the singular driving force. It is more accurate to say that care ethicists acknowledge that emotions are an inevitable feature of human interactions and can enhance rather than inevitably contaminate decision making. The presence of such emotions in and of themselves is saying something about the demands the event is placing on the individual, and that urgent action is required to ensure the ethical integrity of the progress they may through the situation. Participants in setting one described instances where they held unhelpful emotions in check and titrated their responses with care. Ruddick's (1980) 'Maternal Thinking', an early strand of care ethics, has resonance here. Confortini and Ruane (2013) refined the notion, describing three key stages through which an individual moves to arrive at a place of resolution. First living with dissonance, then creatively overcoming disconnects between the interests of the self and the other, before finally bridging practical goals for surviving the present with more idealistic goals for best practices in the future' (p.73). Being able to live in dissonance seems fundamental to working through complex situations, where there will often be difficult to bear emotions, as well as chaotic or unexpected elements to the presenting challenge or dilemma that one must work through this to overcome the disconnects. Lisa described how she consciously resorted to reason when she found herself becoming emotional. This was with the context of being exposed to Saras painful/harmful behaviour:

> Now when we get emotionally upset, we can somewhat keep it under control. We can think our way through it. We can reason. And therefore, most of the time you can bring yourself down [89-90]

Rather than be halted in one's tracks, or diverted into an over-emotional response, participants described holding destabilising emotions in abeyance, pressing ahead with what was represented as a balanced response. This stands in contrast to emotions being allowed to alter the form and function of the response. The ethical contents of interactions are also considered in later [see 'Autonomy Is Negotiated, Not Inflicted'].

It should be noted that various other approaches to dealing with such emotions appear in the literature. These range from the attenuation of broad-spectrum stresses (McDonnell *et al*, 2008, McDonnell *et al.*, 2002), through tension reduction and cognitive reframing (Singh *et al.*, 2016, Singh *et al.*, 2009), to the conscious presentation of more congruent emotions and actions (Hochschild, 1983). Versions of these approaches have been integrated into a variety of training programmes that prepare staff and parents to respond to behaviours of concern; these include concepts such as 'mindfulness' (Singh *et al.*, 2016), 'low arousal' (McDonnell *et al.*, 2008) and 'non-violent resistance' (Jakob, 2011). Whilst the attenuation of difficult emotions was central to making physical sense of what are often difficult or even dangerous situations, any success seemed to be contingent upon the right actions flowing at the right time from the staff member. It was in this space that the unique capacities and capabilities of each person became central. This will now be elaborated on.

The Individual Inevitably Uses Themselves as A Resource

All the participants revealed that in the novel situations they found themselves in, the urgent demands they faced made them alone the arbiter of their actions. As a result, they brought their whole *selves*, in varying degrees, to the task at hand. For example, Lisa brought in a maternal perspective which illustrated how she perceived Saras situation and her potential as well as a warm parental regard:

> I've got a daughter her age. Actually, Sara is five months younger... And she's married, she's been married four and a half years now. And has a good job. And her husband has a good job as well. And I look at her, and I look at her situation, and I think 'wow!" - How different it can be when you've got a chromosome that's perfectly OK, as her friend and her carer, I do get very emotionally involved. I probably shouldn't [99-103]

In addition to how they engaged broad-spectrum caring/support activities, participant personalities, and life experiences amongst other things, seemed to shape how, during periods when behaviour was escalating, responses were assembled. The table below [Fig 5.5] provides a non-exhaustive summary of the components of the individual participants selves that were gleaned from interviews.

	PERSONAL INDENTITY [REVEALED IN LIVED EXPERIENCE NARRATIVE]	PROFESSIONAL INDENTITY [REVEALED IN LIVED EXPERIENCE NARRATIVE]
DONNA	• 'Mother' • 'Brownies & Guides Leader'	• Support worker in other services • Long standing member of Sara's support team • A senior member of Sara's team
LISA	• 'Mother' • 'Grandmother' • 'Niece' of individual with LD	• Sales assistant [with reference to customer service, rude customers] • Current member of Sara's support team
EMMA	• Self-described as 'sensitive' as result of an undisclosed prior event • Recently bereaved [and thus sharing a common experience with Mum]	• Bar staff [with reference to rude customers] • Current member of Sara's team, who had previously worked in the team
RUSSELL	• No personal disclosure	• Support worker • Role in industry [specifically reference to a familiarity with systems and processes, and an auditing mindset] • A departing member of Sara's support team, who had previously worked in the team

Fig 5.5: The component individual parts of the responding whole.

I found that the individual's relationship with themselves was important in moments of response (Koloroutis, 2004) and involved both allowing or inviting in their personal self, with all it has to offer, whilst simultaneously constraining or excluding unhelpful emotional responses (Vohs & Baumeister, 2004) that run counter to the primary task (Rice, 1963). The personal components brought to bear by participants, seemed to me to be aspects of the participant selves which were disclosed which were synonymous with providing pastoral care, the roles of 'Mother', 'Grandmother' and 'Brownie Leader'. The 'Mother', and 'Grandmother' identities seemed to me to account for the presence of 'Storgia', the love between parents and children (Clingan, 2021) which gives rise to nurturing and actions approximating to compassionate interference (Verkerk, 1999), intervening in the life of an-other out of care. Whilst a parent also has a legal duty to make decisions on their child's behalf, the 'Brownie Leader' serves in loco parentis and is required to make decisions in a child's best interest. Whilst Sara

is an adult and not a child, there was talk of her child-like worldview, something which speaks to her learning disability and mental capacity. Whilst running the risk of underpinning a paternalist approach, it can equally be interpreted as a lens for making visible the responsibilities towards someone who may experience periods of vulnerability through fluctuating mental capacity. The family-esque structure and sensibility of the service was noted by Dona, Lisa and Emma whilst Russell describes how his professional working experience has changed him and perhaps narrowed the divide between himself and the learning disabled, 'you feel like you are in their club.', a technical rather than familial affiliation. Russell also stands apart from other members of the team in how he threads references to previous role-based competencies through his narrative, 'Its that observation side of me, that auditing. I virtually audit people.' Such references underpin several wider statements which amount to him calling for the further systemisation and proceduralising of working practices. This perspective is not without value, and an argument could easily be made that such thinking should be brought to bear in the design, implementation, and review of any type of service. What can be said is that such thinking is distinct from what other members of the team seemed to draw upon in general, and certainly within the response space. That he is the only male member of the team might be used to draw tentative conclusions about a masculine perspective, and the operation of a detached self (Noddings, 1983).

Donna, Lisa, and Russell all spoke to constructing ad-hoc responses, by using what was intuitively ready-to-hand during the spontaneous assemblage of the physical components of the response. Russell described how situation and circumstance forced him to adapt his physical response:

> It doesn't matter what training you've had, on that occasion, when it's like that. Its very restricted. It's a little hallway, as wide as a door. You've got a doorway there, and a doorway in front of you. And another door on the right. It's just in a hall. You've got no room to move

> out. You can't get out of her way. All the doors around you, apart from the seclusion room, are locked. You have no room, nowhere to escape to. You have no room to escape. If you went running down the corridor, she would run after you and kick the shit out of you. You have got nowhere to go. This was the trouble. The key thing was the only door that was open was the door we had to get her through. As best we could, by any means we could. And that's what we done [628-636]

As alluded to earlier, this situational adaptation seemed to me to amount to a form of 'Bricolage', a term originally used by Levi-Strauss (1962) to describe how new narratives or stories were assembled from a patchwork of old or existing ones. The concept extends to practical or pragmatic actions, which involve reorganising and repurposing objects in a new way, or within a new context (Maniago, 2018; Gobbi, 2005; Bechky & Okhuysen, 2011). The example often given is spare car parts being used to create a new car. In essence bricolage is the skill of using whatever is at hand and recombining those things to create something new and useful. The concept of bricolage has begun to find its way into the research, education, and nursing literature (Broom, 2009) which involved traversing between different knowledge domains, referred to as 'border crossings' (p.1050). Elsewhere, Maniago (2018) focused on nursing practice, again within the physical healthcare domain, and stated 'Bricoleur nurses draw on the 'shards and fragments' of the situation-at-hand to resolve the needs of the individual patient for whom they care' (p.2). It seems participant accounts spoke to the assembly of responses arising from a combination of explicit and tacit knowledge (Bergheim, 2019; Smith, 2001) accumulated through prior experiences, vested in values, and attitudes as well as determined by individuals' unique psychological and physical resources. All four participants use what was available to them, to implement their interpretation of policy in in the practice domain. Their resources seemed derived from their various life roles and experiences. Their accounts participants revealed that they fused different techniques [from different training courses] and completely contrived functional physicality when circumstances conspired against approved techniques [Russell previously spoke to how

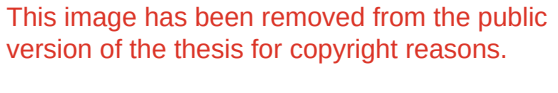
circumstances dictated responses]. Bricolage therefore seems to be very important to acknowledge when seeking to understand how responses manifest, how staff adapt to demands and uncertainty as well as how staff stay true to the primary task. But what of the training participants had received to ready them for such eventualities? The next theme reveals more.

Some Training Helps and Some Training Doesn't

In preparation to serve their role, implement local policies and respond to behaviours of concern, all participants completed specialist restraint training. Individual comments on the function and value of training were noted during interviews. None were critical of the trainer, rather they described struggling with the translation of approved/authorised techniques from the training environment to practice setting or criterion environment (Staller *et al*., 2021). All participants spoke to a common experience of finding that techniques could not be reproduced in a textbook fashion because conditions necessary for the perfect reproduction never materialised. Russell spoke earlier to how environmental condition shaped his physicality, and here Donna spoke to 'doing what you can' despite having attended several training courses:

> I don't ever think there is such a thing as a perfect hold. I think you can go to all the training courses in the world. I've done I don't know how many different physical intervention training [courses] in my time. I think in the moment you have some of what you've learnt in your head, but I think in the moment you're doing what you can to keep Sara safe and yourself safe [602-605]

First aid has *some* conceptual parallels with restraint. It is often deployed in emergency and less-than-ideal circumstances. Indeed, within the context of military activity, there is the notion of 'battlefield first aid' and 'combat medicine' (Hodgetts *et al.*, 1999) within which improvisation and adaptation are features of the action oriented technical skillset (ICRC, 2006). The images below [Fig 5.6] show specific examples of adaptations involving equipment in the first aid context. In the restraint context, where the use of techniques and procedures is so freighted with negative connotations, there seems to be a significant emphasis on assuaging these concerns at the strategic level by approving idealised interventions whose likely impact can be quantified in advance. A practice of risk assessing techniques in their notional form prior to being approved for use within an organisation has developed (RRN, 2019). The implicit assumption seems to be that such techniques will maintain their topography and thus their power to reduce harm once they are implemented.



A latex glove being utilised as an improvised chest seal to an open wound [source]

A barrier being repurposed as a stretcher at the Manchester Arena Bombing [source]

Fig 5.6: Exemplars of first aid modifications.

As previously stated, as a result of being thrown into to an unpredictable situation, staff invariably had to become bricoleurs (Levi-Strauss, 1962). The participants seemed to accomplish this by drawing on an array of training memories [all participants had received training in more than one system], personal values bases and previous experiences. Staff ranged in age from late 20's to 60's, with three females and one male. It would not be disrespectful to say that none were physically imposing or

seemed disposed towards 'the physicality' that is so commonly associated with some young adolescent men, police officers, prison officers or security guards. If participants' physicality was a raw ingredient in their bricolage, it would seem likely to be used sparingly because of its paucity.

In his essay on Strategy, von Moltke, wrote 'One cannot be at all sure that any operational plan will survive the first encounter with the main body of the enemy' (p.291-292). To be very clear there is no enemy here, and whilst using a military quote in a caring context seems incongruous, the essence of the point being made holds true: that the best intentions, the best laid plans, or the most carefully considered procedures or techniques are invariably thwarted by the complexity, unpredictability or resistance that is encountered from independently minded third parties, especially when in opposition. The capacity of Donna, Lisa, Emma and Russell to keep going and maintain the caring integrity of actions seems to speak to their ability to regulate themselves (Vohs & Baumeister, 2004) and proceed with an adaptive resilience (Foster *et al*., 2023) wherein the individual remains wedded to 'seeking positive solutions and outcomes' (ibid, p.871) despite the situational stresses and challenges. In many ways this spontaneous adaptability, as delineated here, could be seen as anathema to restraint reduction or restraint minimisation (RRN, 2019), for to keep going with physicality would seem to be all too readily framed as promoting restraint. All participants seemed to feel judged for participating in restraint, something that will now be unpacked, and unpicked.

We are judged whether our actions are witnessed or not

I became aware that participant accounts of physicality were often appended by descriptions of things that did not happen. Often this was the harm that was not caused, such as when Donna states that her intervention was 'Just something to keep her arm still. Obviously not hurting her in any way'. Unsolicited, Russell also states, 'I've never hurt and would never want to hurt Sara'. In this statement

he seems to be rising above any single event to make a proclamation pertaining to every physical encounter he has ever had with Sara. The second half of the statement speaks explicitly to the absence of any intention on his part to cause hurt. I have read this as him making what amounts to a plea of not guilty, even though he has not been directly accused of anything. He is saying not only did I never hurt her, but I never wanted to. The act and the intent are both publicly declared to be free of any hurtful content. Lisa also spoke from a collective standpoint, 'Obviously no one wants to hurt her'. This again speaks most directly to the absence of intent. Lisa went a little further, stating that herself, Mum and others are the ones who are hurt and harmed:

> We are actually the ones that pick up the most bruises, we are the ones that are hurt. Because we've been trying to sort her out before it becomes a Blue Room incident [703-704]

When the wider discourse seems to characterise physical restraint as indefensible, unnecessary or inexcusable (Duxbury, 2015; UNHCR, 2013; MIND, 2013; Millfield's Charter, 2006), this seems to me to pass a silent judgement on those involved. That staff are somehow deficient in their practice, or somehow wrongheaded in their thinking if they restrain. I felt participants were expecting their actions to be judged. Emma, who did not talk extensively about restraint still spoke to the importance of working within areas covered by 'cameras', and writing things down so 'you can justify why you did what'. To me, Emma and the others are engaging defensively caveating their accounts, seemingly in anticipation of judgement.

In full disclosure as I completed my thesis, I was aware of commentators who felt staff were unfairly cast as being too ready to restrain or use force. This discourse does not appear to have surfaced in the literature to date but is none-the-less *out there* in my personal experience. It seems to me to speak to

a feeling that the righteous condemnation of the few involved in the “overuse and abuse of restraint” (MIND, 2011 p.5) has been uncritically extrapolated to the many. To me this seemed part of a wider debate that characterised the rights of service users and the public, including staff as existing on a pendulum (Thalamos, 2025) that swung back and forth, favouring one cohort and then the other over time. I had not anticipated that a sense of judgement would permeate the lived experience of participants in the way it did. I expected to hear about it in vocal debates but not found it embedded quietly in experiences. To me participants communicated a sense of judgement obliquely, rather than directly. I interpreted the appending of comments with ‘but I didn’t’ or ‘we wouldn’t’ as something that was proffered to attenuate the anticipated and understandable concerns of others as much as anything. It was a careful disclosure that served to reassure whilst revealing something about their deeper feelings.

The Presence of Learning Disabilities within the Groups’ Experiences – Setting One

Sara’s learning disability surfaces in all the participants accounts. References to its explicit existence are limited but still telling. Donna seemed to be frustrated with the fact that in other settings she had worked, there wasn’t the presence of specialist knowledge around LD, ‘She [Mum] knows Sara inside and out. She’s like Sara’s knowledge book. Whereas when you go into a residential home, the managers only just qualified, they’ve had no experience with adults with learning disabilities, and they don’t know what the hell they are doing’. She speaks to who she personally has become through her immersion, ‘I think seeing people with learning disabilities and seeing it as the norm’ which seems to speak to a dismantling of what Galtung (1990) describes as the self/other gradient that exists between us and that which is deemed other. The message seems to be we are one and the same.

As opposed to having worked with persons with LD, Lisa speaks from a standpoint of having been related to someone who has Cretinism. In her words, 'Its never freaked me out. I've never thought of them as being weird or whatever. Having Uncle Joe gave me a good grounding in that'. In much the same way as Donna, Lisa seems at ease, but the use of the words 'Freaked' and 'weird' seem to reveal an awareness of the boundary between the rest of society, and those with LD. In expressing this she reaches for words that would ordinarily be used against people with LD, to identify them as different, to denigrate and distance those of us who are 'normal' versus those of us who are not. She also uses the term 'special needs', which seems to have come into usage in a well-meaning way within education settings but has become a label to denigrate. This is not to say that Lisa is the wrong side of the invisible line between those who are 'in' with persons with LD, working respectfully and collaboratively alongside such individuals, and those who are 'out'-side, staring in. Within the 'out' space there are those who stereotype and discriminate consciously, those who adopt a 'live and let live' mantra whilst sometimes retaining unconscious biases, and finally those who march in to the 'in'-ner space seeking to do good to 'them', serving their own need through some form of saviour complex (Stevens, 2006). I think Lisa is 'in', and without prejudice, but is expressing herself using the language that she has found herself surrounded by 'out' there in wider society. To this list one could also add cretinism, which is now itself obsolete, and has given way to the term congenital hypothyroidism (Stoppler, 2023).

Emma found herself with Sara in a 'club …for people with learning disabilities', and there is no reference to any others present. Rather the focus is on a moment when Sara gravitates towards her. That Sara has LD seems to be of no relevance whatsoever, but that she smiles and makes all the hard work worthwhile seems to implicitly acknowledge that supporting a person with LD is not easy, but that beneath the challenges there is a warm, funny, and positively affecting person with whom she expresses an enormous regard for. That these challenges seem to be so separable, and readily

consignable to the past, and that the power of the affectivity registers so strongly seems to speak to a connection that transcends the presence of LD, and all that a label may bring.

Russell does not seem to share the same way of relating to Sara and her LD as his colleagues, but that is not to say that he has no regard for her, or that his approach to support is any less conscientious. Rather he seems to take a rational approach to framing the challenges he faces. He reached for several generalisations, as part of his sensemaking, 'You can't say no to anyone with a Learning Dis, No is a No word. It doesn't exist in their dictionary' and 'Well Sara, like all people with a learning disability, has got a great fear of anything medical. Whether it be a dentist, doctor, nurse, anything' [342-343]. These do not seem to be hostile or immediately harmful assertions; they are closer in nature to reductions that serve to turn features [real or not] of Saras LD into extraneous variables to be methodically mitigated against within his calculations and determinations. Russell consistently appeared to approach challenges, including behaviours of concern, with a rationalist perspective, seeing problems as clear and predictable events which should succumb to logic.

In conclusion, it seems for Donna, Lisa and Emma, LD features as a label that is superfluous to requirements. It makes no difference to their role and responsibilities. For these participants the humanity within the individual transcends and function of such a label. Sara can be related to without a label interfering in any way. That such labels, or seemingly unchallengeable truths, feature in Russell's response says perhaps more about his thought processes than any discriminatory outlook. Used clumsily they can only get in the way, investing a person with characteristics that may never be proven to exist, or more pointedly never understood for what they are, which would seem to be central to providing person-centred support.

Chapter 6. Group Experiential Themes, Setting Two

Setting Two

Setting two was a regional forensic unit where a mixture of Nurses and Nurse Associates, both professional roles requiring registration with the Nursing and Midwifery Council, work alongside healthcare assistants. The participants, Sabrina and Charlie, John and Jill, Nurses and Nurse Associates respectively, all work with numerous patients currently held under section because they are deemed to pose a risk to themselves or others. Sabrina and Charlie also had roles as team leaders and as such a degree of seniority. As a specialist commissioned mental health inpatient service, the unit is overseen by the CQC and must comply with legal requirements specified in the Mental Health Act, and Mental Health Units (Use of Force) Act, amongst others. The participants, and the service, are therefore under a great deal of scrutiny, and unsurprisingly have a significant policy infrastructure in place. In this chapter, the experiences of the participants are explored, with similarities and differences being commented on within the GET. The RQ they speak most directly to are indicated [See Fig 6.1].

GROUP EXPERIENTIAL THEMES	RQ1	RQ2	RQ3
1. With Great Power Comes Great Responsibility	■	■	
2. Relationships and Trust are Central to Making Progress	■		
3. I Bring Multiple Selves to My Role and My Responses in the Face of Complexity	■		
4. Taking Risk Can Be a Part of Making Progress.	■	■	
5. Things Will Be Messy, During and After	■		
6. We Must Reflect, Rebuild, and Redefine Irrespective of any Judgement			■

Fig 6.1: Setting 2 GET, and links to RQ.

With Great Power Comes Great Responsibility

Jill, Sabrina, John, and Charlie all spoke to the power they had. As agents operating on behalf of the confining system, all participants were positioned to exert 'power-over' their patients (Pansardi, 2012), however each appeared to me to take steps to differentiate themselves from the system, although all used physical force in response to behaviours of concern to establish control, which will be explored later. Their lived experiences were distinct [see Appendices 42-45 for individual case studies]. Jill spoke as a staff member, whilst Charlie as a team leader, with Sabrina speaking to how her position of power alleviated some of her anxiety and John speaking to how patients can be poorly served by the power imbalance. The power asymmetry acknowledged seems to be most clearly experienced by Jill and John. In role terms they are the juniors, which leads me to consider whether the power vested in the roles they assumed was still being processed and understood. John spoke of the injustice he felt when insufficient numbers of staff meant that patients could not be unlocked as per procedure. This giving rise to opportunities to make progress being lost:

> If the staff aren't there, then we can't open them [up]. It's sort of like an injustice really, because we're there to assess them to move them onto other wards. We're there to gauge, because they're an unknown quantity really when they come in [30-32]

John seemed sensitised to what the patients were losing out on, and the opportunity he himself had lost that would have been used to assess patients. It wasn't just *one of those things*, it rose for him to the level of an injustice, a violation of the rights of the patients. The power located within the system was experienced differently by Jill, who was concerned by the asymmetrical distribution of information, and how it made the patients more vulnerable:

> You're always going have that where you know a bit more [about them], and that's where they're quite vulnerable because you know them, but they don't know you. So, I do think you need to give them that little bit of 'you' [755-757]

John's feelings of 'injustice' and Jill's sense of being in a position of greater knowing seemed to me to indicate that both were aware of how the power imbalances inherent in the system invariably led to the patient being placed at a disadvantage. My conclusion was that they were still coming to terms with being agents of that system. By contrast, Sabrina and Charlie, in their leadership roles, had greater power to intervene in the lives of others, a position which they seemed to be at ease with and which they were able to utilise positively:

> Charlie: I think that because I am in a role where I make decisions, and decisions around people's care, that sometimes helps that relationship, and that person might see you as somebody who can give them something and fulfil a need [54-56]

Sabrina spoke to the power she had in a leadership role to deploy staff where they were mostly likely to use their unique experiences and resources to avert disturbances between patients:

> Quite a lot of the time the patients argue among each other. So, it's literally about balancing who goes where, what staff are with who. It's just all yeah, maybe a bit messy [39-40]

To me, Charlie and Sabrina were both minded to acting in the best interests of patients and also sought to encourage the same outlook in the cohorts they led. In interview, Charlie was found to actively

challenge the attitudes and outlooks of others, so he appears to be challenging the way the system operates from within. This implications of his willingness to not default to restrictive practices is captured in the following:

> If a patient needs seclusion today, that will come down to me and my decision. Say that I decided not to seclude that patient and they went on to seriously harm staff. People would then quite possibly attribute blame to me, if that patient had been presented as agitated and I didn't manage that [149-152]

He seemed to me to be saying that to default to seclusion would be an easy choice, and one that would be likely to meet with approval from colleagues, yet he intimates that sometimes the right decision might be to not seclude. A decision which could backfire if someone was harmed as a result. In such circumstances he would be the clear, single point of failure, and would be blamed for not using the power at his disposal properly. Sabrina also spoke to the power present within the system in a different way. She spoke of the 'beauty' of the secure environment:

> I think though the beauty of a secure service is that you've got a lot of physical security… It's the most restrictive environment that you can ever be in really, so those restrictions can sort of aid us to keep everybody safe. I used to work in a low secure environment, and I would say my anxiety was a lot higher, because you don't have the same restrictions that you can apply. Obviously, you don't live by restrictions, but they are something that you can do. They personally for me take away a lot of my anxiety [52-57]

In this she seemed to me to be speaking first and foremost to the psychological sense of safety that it afforded her, through the procedural and physical boundaries, and their role in reducing her anxiety.

Feeling safe seems a basic human need, and the statement suggests that the comfort drawn by Sabrina from the existence of physical and procedural security measures, provided her with the opportunity to engage with and do right by patients; restrictions therefore can be enabling.

Something else power-related that intrigued me about two of the participants is what I shall refer to as the warrior paradox. This is the tension between the fact that John and Charlie are both immersed in martial cultures but who see control and coercion as anathema to their personal codes. To me they assumed a responsibility for partitioning off a part of themselves when becoming engaged in a response. The paradox being that the warrior capability that they both so assiduously sought to develop could not be realised to its full extent within situations where they faced risk to themselves: the power they personally possessed was not released. Consider the two contrasting statements made by Charlie:

> I suppose, like, you know, the focus of my training now is on Brazilian jujitsu, which is a grappling art. You start off standing, but you try and take them to the floor and submit people. You know with chokes or joint manipulation on the floor [315-318]

> You know, really a lot of the job is managing their behaviour. Trying to deescalate the stress before it reaches crisis point and then if it does reach crisis point, obviously managing that, in a least restrictive way [18-20]

The first speaks to an imperative to submit people using highly painful, potentially damaging and even deadly tactics a capability that he strives to acquire, whilst the latter focuses on de-escalation, stress reduction and least restrictive physical intervention. His and Johns backgrounds in martial arts are elaborated upon in their respective case studies. Both have spent considerable time cultivating the

mental, and developing the physical, attributes required to dominate and defeat others. Yet neither spoke within their experiences of any desire or opportunity to assert their dominance or prove their capability when being attacked and injured by a patient in their professional capacities. This resonated with me as I have a background in martial arts [see appendices 26 & 27]. It is also something I have brought with me into both training and operational roles. The mistake would have been for me to make assumptions in relation to their experiences, based on my own. This was exemplified by a consideration of the *clinch* which was referred to by both. It is a boxing technique/tactic [Johns's art] and a Muay Thai one [Charlie's other art] but does not feature in Ju Jitsu [my art]. They therefore have a tool that I am aware of but have no experience of using. According to Hatmaker (2006) 'the clinch isn't exciting viewing' (p.7), which contrasts its appearance and function with the more exciting and dynamic techniques available to the combat sports practitioner. This would be to overlook that in its relative passivity and stillness it provides a practical platform and strategic opportunity for transition, into offensive or defensive actions, supplemented in this instance by protective and de-escalatory possibilities. Having never explored the clinch I almost missed its utility, which I would have done were it not for reflective and reflexive consideration of what it meant to participants. This responsible titration of practical power was therefore noted as something they were able to bring to situations, and this paradox will be returned to later.

This image has been removed from the public version of the thesis for copyright reasons.

Fig 6.2: Exemplars of Clinches': L-R: Wrestling, Wing-Chun, Boxing & Muay Thai

What participants revealed seems to me to speak to a mindedness to the perils of accruing or asserting power and revealed something of a corrective or balancing approach: a mindful titration of power. To me this shows they seek to find ways to relate and respond with care, in a very controlled world in which care could be readily sacrificed to power. This feels important. The individuals are actively seeking to find ways of *doing* that are congruent with their caring *being*. Much work in supporting the titration of power took place within the context of relationships, which are now explored.

Relationships and Trust are Central to Making Progress.

Every participant in setting two revealed how the experience of spending time with patients and building trust was a feature of both working clinically with them, and of responding to behaviours of concern. According to Sabrina:

> I think the 'Relational Security' part of it, and the 'relationship' is more significant than… obviously you need to be trained in your restraint. But I think the 'relationship' side of it is much more significant because that patient has a level of trust in you that you're going keep them safe, that you're going to make the right choice for them, and they will respond to you [160-164]

It is recognised that a therapeutic relationship in a forensic setting can ensure an inclusive approach to managing needs and risks (Markham, 2021; Timmons, 2010), even though the structural and systemic focus is on security rather than a primary regard for agency or autonomy (Markham, 2021). The patient typically arrives as an unknown *other*, any relationship starting with some form of pre-read or handover provided by other *others*. A negative appraisal by whom, unless offset by

independent attempts to connect and build trust, can have detrimental effects, including negative beliefs around identity and worth (Markham, 2021; Martin & Ryan, 2011). Jill's use of information was expanded on by John whose comment was similarly reflected by the others when he spoke of breaking such a cycle:

> It's all about perception, really, how you perceive someone to be. So, I might see things differently to what you perceive. We've all got different pockets for information, haven't we? We're all unique, so is that makes it difficult [106-109]

He seems to be saying that we all have our own mind which we bring to the negotiation of a relationship, which is something that requires conscious effort. To differentiate yourself as an individual from an institution vested with such power seems to involve a personal choice to relinquish some of the power, to create a *sense* of parity. The relationship presents that opportunity. In common with setting one, the network of relationships operating in this setting could also be understood using the Relationship-Based Care model (Koloroutis, 2004), with the internal relationship with the self being equally important, along with the problem-solving dynamics of RCT (Gittell, 2011).

All participants clearly indicated that spending time with the patient was of critical importance. It provided a conduit through which care could be meaningfully channelled. According to Charlie:

> So, like, if they don't trust me as their named nurse, or have that level of trust that has been built through the relationship, it's harder to achieve a positive outcome for them. But yeah, you know, a lot of the time relationship building, spending time with patient and maybe doing activities with them [37-42]

This in turn led to what participants described as successes which provided a sense of personal achievement and professional accomplishment, the reward for realising the primary task that was spoken to by MacLeod (2010). Sabrina states, 'I think we do it literally, continuously, every day on here, and it's about the relationships, and keeping people busy and stuff'. Here she was speaking explicitly to using relationships to avert situations requiring restraint. A common feature of the experiences were decisions made to stay with the patient during difficult, even dangerous times. The sense gained was such actions can have lasting impacts. Jill revealed 'we've got a patient who has a colostomy bag, and quite often, if he's in seclusion, he'll throw that colostomy bag around the seclusion room, and it absolutely smells vile'. This is something that would readily elicit disgust or horror and underpin a withdrawal or detachment, but instead she reveals stays with him. In a further example provided by Jill, there was a self-ligating patient, where her non-interventionist stance [not physically intervening or forcefully removing the ligature] was based on knowing the patient and believing he was not intent on harm:

> If he's going to tie that sock around his neck, then let him do it and nine times out of ten, it's so loose. This is going to sound really awful, but you probably would leave him about 10 minutes now. Just say like 'I'm just going to leave you because you just being silly. I'm not coming in there' and know that I'm not coming in. He'll actually take the sock off himself [531-535].

This might be something that could easily have been judged by others as indifference, policy deviation or even negligence. But this would be to define an event by superficial appearance and not knowing the full content or context. John and Charlie both described being physically attacked and electing to continue to work with the patients, rather than to reduce or circumscribe the support available to them. That such relationships endure despite events that could easily reduce them or lead to their

rupture seems to speak to a broad-spectrum non-judgemental, adaptive resilience (Foster *et al*., 2023; Srivastava, 2011), a will to keep going and keep finding ways to care. As the stakes rise, the ability to regulate their situationally derived emotions (Vohs & Baumeister, 2004) also seems key [covered in later themes].

John and Jill spoke of pushing patients, using the trust that had been built up within relationships, to press patients into action. I understood this pressing or pushing, based on their explanations, as a form of assertive encouragement in the face of a perceived or expressed unwillingness to engage in a task [something also seen in setting one]. As previously stated, I understood this pushing as having a moral dimension, of being done by one for the good of the other, as compassionate interference (Verkerk, 1999). I began to understand pushing, interference and physical interventions as having the same ethical genus, as all being part of the work involved in supporting, caring and treating people. To dwell upon them as discrete tasks, and to consider them in isolation seems to be to strip way critical context and lose sight of how they are part of a coherent whole. John's experience covered the resistance he encountering to actions: 'But sometimes when they are in a state of distress, they just sometimes push those who are closest away' [133-134]. In staying with the patient and pressing ahead, again resilience seems to be in evidence:

> So yeah, I do find, because there are frequent incidents and stuff, and it's not all smooth sailing and happy times, it's. [pause] You are faced with a lot more challenges and it's just about trying to persevere [135-136]

Jill also talked of pushing:

> I would sort of, I'd like to say I'd make him do things that maybe he didn't initially want to do because he was a bit scared, but he does really want to do so. I'd like 'no come on, I'll come with you. I'll come and do it with you'. And then, you know, and get him involved in stuff [102-104]

Even though Sabrina and Charlie did not talk about such pushing explicitly, or of such perseverance, it did not feel like this was because it did not happen. Both spoke to their leadership roles, Sabrina of shaping practice and Charlie of promoting positive risk taking, which led me to surmise that such pushing would likely be in their practice repertoires. Perhaps they did not think about it in the same way as their junior colleagues. In a space where coercion is rightly called out and the notion of compliance is being outmoded, the ethics of 'pushing' is perhaps more actively and consciously considered by less experienced practitioners. As a result, it was perhaps closer to the forefront of their minds. As their practice wisdom (Klein & Bloom, 1995) accumulates, perhaps it is taken in one's stride and ceases to be something that one is so consciously minded to. The impression I arrived at was that John and Jill are still consciously negotiating such practice challenges, whilst Sabrina and Charlie are able intuit in the moment or draw on tacit knowing, to process and progress unconsciously, until such time as events [such as interviews] prompt conscious reflection. Such interference in the form of pushing to realise care also seems foundational to physical interventions that support care, as was found to be the case in setting one. This will be returned to. What each participant brought to their responses will now be explored.

I Bring Multiple Selves to My Role and My Responses in the Face of Complexity

At a practice leadership level Sabrina and Charlie seemed to use their unique selves to influence others Charlie described himself as an 'independent thinker' who believed in proactively shaping practice: 'I think that in big institutions like this, people get very stuck in managing risk with restrictions rather than thinking, 'oh, we can actually manage risk by taking a risk' if that makes sense', whilst Sabrina through her connective sensibility used group reflection to shape practice, 'I always say, 'right, let's all have 10 minutes. Let's all talk about it''. In both cases the leadership being demonstrated but in different ways, based on their unique selves.

What also became very clear, much like in setting one, was that each participant revealed something of themselves in how they responded to behaviours of concern. For example, Jill brought aspects of her most intimate past experiences into their practice. A patient was distressed by recent change:

> On one of the wards I worked with a patient that had a catheter fitted, which is very traumatic for her with her history. I empathised with her and said, 'I fully understand you're not comfortable, you don't want males fitting it, you don't want it in, you want to pull it out'. I said 'I understand its uncomfortable. I've had one myself before.

Albeit fitted for a clinical purpose, this remains a bodily trespass. Such an intimate incursion has the potential to awaken past physical or sexual traumas (Cusack *et al*., 2019). This was something that appeared to be implied by Jill. That Jill was alert to her patient's discomfort and was willing and able to share her experience of enduring a similar procedure meant that in that moment she transcended

her professional role boundary. She seems to have sought to commune with the patient through the personal experience of pain, powerlessness, and vulnerability.

Charlie also brought a private self with him into the professional role. The disclosure that he had restrained his own cousin, by using force. This to quash his self-injurious behaviour and in so doing bearing witness not only to his cousin's distress and injury, but to his aunt's distress as well:

> I was always used to managing his risk, which was never towards me but was always towards himself. And I would see my auntie, who was always in a panic, and you know, she would have been in hysterics because he was out in the in the garden head banging [565-567]

A teenager at the time, this was likely taking place during a formative period of his life, as well as amounting to an extra-ordinary responsibility. This very personal knowing of living alongside someone with autism, and direct experience of responding carefully to behaviours of concern is not something that is likely to be discarded or forgotten.

John and Charlies' identities as warriors or martial artists were explored in detail in their case studies [see Appendices 44 & 45]. Without doubt this aspect of their individual selves came very strongly to the fore in those moments that they spent within the physical aspects of their responses [see 'Things Will Be Messy, During and After']. Neither brought their whole warrior self into the work setting, as neither spoke in a manner that revealed a desire to win, beat, or triumph over any other.

Based on the foregoing it seems hard to make an assertion that there is a singular type of 'fully trained and qualified health professional', who when employed by an organisation will complete work tasks and respond to developing crises in uniform and expected ways. It may be possible to produce widgets through standardised production process [Russell in setting one had a background in industrial production], but human beings cannot be moulded precisely. Furthermore, there is no endpoint to developing attitudes or competence, and as has been seen, people continue to grow and develop inside and outside of work concurrently. That an individual will make sense of events and make decisions based on their interpretations from the bottom up speaks directly to 'Street Level Bureaucracy' (Lipsky, 1980), only here the interactions take place when both parties are physically and psychologically vulnerable. The sense I gained through reflecting on the experiences of participants, was the importance of the *whole* individual to how policy became defined in practice. That risk was often a part of their wider working as well as focal responses to behaviours of concern was acknowledged by all and forms the core of the next theme.

Taking Risk Can Be a Part of Making Progress

> We risk assess them like on constantly all day, every day, and because everybody's access to various items changes. So, you're just constantly watching, you're constantly eyeballing things, making sure people are where they're meant to be. Me and making sure everyone's safe [Sabrina, 27-30]

All participants spoke to risk. Risk is an inescapable feature of working in a Forensic Service (Greenwood & Braham, 2018; Dickens *et al.*, 2013). Individuals within them often have histories of harmful behaviour, and varying degrees of willingness and ability to regulate themselves. Their

physical confinement, and the requirement for them to submit to various non-negotiable risk-management based procedures are matters that understandably give rise to a wellspring of difficult thoughts and feelings which can be destabilising in and of themselves. All four participants spoke of involvement in physical restraints, with two of them, Charlie and John, directly revealing that that had been physically attacked. John was admitted to the medical bay and took time off work to recover from his injuries. Sabrina also made an indirect reference to having been attacked when she said, 'if I've been hurt in an incident, I just need a few minutes to have a drink, have a cup of tea, whatever, to gather my thoughts and then you can mentally process it a bit easier'. Events, particularly those where staff members have been hurt, would seem to hold the potential to cause people to become risk adverse, or invite defensiveness (Andersen *et al.*, 2023). Risk aversion can be thought of as a form of withdrawal, with anxious staff stepping back and withdrawing to the margins of core service provision. Less involvement, and less interaction with an individual perceived to represent a risk is a form of risk control. This can be conceived of as a lurch to the back foot, which can have the effect of increasing harmful behaviour. The notion of an extinction burst offers one explanation for why a non-response might inadvertently increase behaviours and their intensity (Shahan, 2022). Another form of defensiveness could involve staff going on the front foot. It might be more accurately described as counter-offensiveness, rooted in a desire to protect oneself. This can be seen in the imposition of increased restrictions, the increase in the numbers of staff orbiting risky individuals or risky tasks [such as 'unlocks'] and in the overwhelming use of force when 'managing' patients. Arguably many of the restraint-related scandals (BBC, 2018; DoH, 2014, CQC, 2012) have taken place in settings where service recipients have been othered (Thomas-Olalde & Velho, 2011), and there have been no meaningful or effective-enough safeguards governing the use of force. In contrast to this, what stood out in setting two was the nature and the extent of the positive risk taking. Charlie spoke about his approach to working with a patient who had been involved in an incident involving a weapon.

> I would describe him as a patient who wasn't much liked by the staff, based on the incident that led to him getting placed in segregation which was quite a serious one that involved a weapon. And you know, trying to explain to people that, that he is less likely to, well, that was my opinion, that he was less likely to attack people if he had more time out of his room. I suppose it was a bit counterintuitive because he would have more time to plan an attack or to, you know, to attack somebody. I suppose it to comes down to me getting to know the patient. You know that I had worked with him for two years at that point [127-133]

As a result, the patient would likely be considered dangerous or 'high risk', but Charlie had found himself arguing for increased liberty rather than increased restriction. Sabrina spoke to the active, real-time awareness and acceptance of risk involved in facilitating the coming and going of patients within the least restrictive environment. She described her mental balancing of risks as 'human chess'. This allusion to chess is interesting. It speaks to both immense concentration and a mental preparedness for multiple contingencies. According to chess grandmaster, Garry Kasparov, 'chess teaches you to play by the rules and take responsibility for your actions, how to problem solve in an uncertain environment'. That he himself graduated from chess to politics and human rights advocacy adds resonance to his words, 'The brute force of calculation isn't enough—human intuition is an integral part of successful decision making. Chess provides an ideal field for this experiment' (Beard, 2015). Jill also seemed prepared to take a chance. A vivid example of which was the risk taken with the self-ligating patient. Here she refrained from intervening, instead she remained an observer and waited the patient out until he removed the sock from his neck. By Jill's own account such action by the patient in the presence of other staff could easily has resulted in a restraint, whilst the ligature was removed. By contrast were she to have got it wrong he could have harmed himself. Sabrina's 'balancing' and Kasparov's call to offset brute force of calculation with intuition both seem to have resonance with how Jill engaged with her patient.

As previously mentioned, John was struck by the injustice of those confinements of patients rooted in workforce shortages, 'We're there to gauge… because they're an unknown quantity really when they come in'. He seems to be saying there is a need for staff to be available to interact with, to get to know and to understand patients in order that they might be supported in a meaningful way. Whilst he might not be speaking explicitly to the risk of harm, he is saying that staff can be complicit in a system that reduces opportunities to deliver care, and for therapeutic relationships to develop due to resource constraints. By seeing this as an 'injustice' John seems to be both explicitly advocating for the rights of the patient and implicitly suggesting that he is not risk averse.

Working with risk in such a highly regulated setting, can readily become a technical affair. Validated risk assessment tools, measurement scales and multicomponent strategies abound (Ogonah *et al*., 2023), and whilst these are mandated and arguably essential components of a protective infrastructure, interactions within all but the most highly controlled encounters rely in the end on human beings in all their uniqueness and potential fallibility to make decisions and take actions. It seemed to me after contemplating participant experiences in depth, that whilst interactions with risk will never be untethered from such legal and technical provisions, there will always be a pragmatic element to decisions taken on a day-to-day basis, revealed in the balancing actions by staff. Such balancing becomes an ever more critical imperative as the stakes rise. Markham (2020) reports on the dearth of research into how patients view the risk assessment and risk management processes implemented in forensic settings: it remains something largely done to them. From the accounts of participants there is a strong sense of it being something done *with* patients in mind. At the heart of staff responses in these moments are decisions and actions which are highly contextualised. The discretion spoken to by Lipsky (1980) was differentiated by Zacka (2017) with reference to its technical and non-technical manifestations. Discretion was originally understood as the 'ability to perceive and

understand; moral discernment, ability to distinguish right from wrong' (OED, 2024b), with discernment being 'the power to make distinctions' (OED, 2024b). This evaluative, mode of thinking might be thought of as ultimately deconstructive or separationist in nature, given that the thinker is expected to arrive at distinct options or possibilities with regards to options for progress, of which one will be selected. Within the context of the participants' experiences, the time available seems to have precluded such evaluative, linear thinking [at least in the early stages of a response], with the *doing* being assembled at pace. Charlie commented on the sudden and confusing nature of responding:

> You do things you don't know you're doing until you've done them [633-634]

This mental mode of engagement seems to span the unconscious through to the conscious, meaning instinctive and intuitive elements of a response occur alongside more reasoned actions as things slow down [see 'Physicality' in Chapter 7]. I felt this mode of engagement could be fairly described as mature-care-in-action (Pettersen, 2012) and seemed constructive or connective in a way that discretionary thinking is often not. Unlike the discretion usually exercised in the spaces of street level bureaucracy, where the bureaucrat considers the options open for the processing of the other's needs and what will be done *to* them by the organisation, here the mental engagement can be thought of as navigating *with* the other through a relatedness. The condemnation of exploitation and hurt, and the commitment to human flourishing (Pettersen, 2012) relate to equally to both parties, indicating the recognition of a common humanity. Moving forward through the demands placed upon them was never straightforward. The attendant messiness and how it was negotiated forms the next theme.

Things Will Be Messy, During and After.

> The actual like incident or restraint itself, sometimes it can be scary sometimes. You are just you just full of adrenaline and you just you just think 'Oh my God!' [Sabrina, 131-133]

Policy is in place to guide practice, (Richards & Smith, 2002) and training is provided to ensure staff can meet the demands on them posed by behaviours of concern (DoHSC, 2021b). The experiences of all four participants show that unpredictability and uncertainty are common features within events in which they physically responded to behaviours of concern. Elsewhere in the literature covering law enforcement use of force training (Koerner *et al.*, 2021), as well as sport (Correia *et al.*, 2018) the need to adapt because of the non-linear actions and contested interactions is recognised.

This messiness seems predictably unpredictable. All participants described working with longstanding patients, who acted in unexpected ways, despite any forgoing care and support or progress that had been made. Examples include John and Charlie being punched, Jill chasing a patient who suddenly ran to attack another patient, and Sabrina having her colleague assaulted. All the participant responses comprising attempts to quell acts of violence and mitigate harmful actions [addressing the 'external' component of the behaviour] and as far as is practically possible attenuating the underlying thoughts and feelings [the 'internal' state of being, or unseen component of the behaviour] (DoH, 2014). In the examples given staff members were suddenly responding to unforeseen events, and no sooner had they orientated to them, then things were changing. The requirement was for the rapid assembly of a response that was simultaneously ethically and legally defensible, as well as effective.

Charlie: ‘So, we managed to get this patient to the ground, sort of, and he landed in supine with one of his arms in between my legs’ [271-272]

John: ‘Me and the patient were tussling. I was trying to hold him to stop him hitting me because he continued to try and punch me’ [414-416]

Jill: ‘I ended up holding on to somebody else's legs, and then somebody else had hold of my legs, and then we managed to sort of sort the situation out’ [268-269]

From participant accounts it was clear that staff members found a way through. John and Charlie, through the training they engaged in outside of work, having developed a greater familiarity with their own bodies, and its possibilities made their own way. The difference in the event involving Jill being that the word ‘we’ seems to speak to a collective resolution, one that seems to be comprised of involving others to first disentangle bodies then re-assert some form of functional physical containment. All involved worked with what was to hand, making them bricoleurs (Levi-Strauss, 1962).

This led me to reflect on the ways in which one’s private or personal self can be revealed through one’s professional self. Could bricoleurs operate at different levels? Perhaps, novice and expert, as per Benner (2004). Of course, individuals might not always progress from one level to another but nevertheless be adapting based on their unique self and own resources. At the expert end of such an imagined continuum, currently unrecognised forms of explicit and tacit knowledge (Bergheim, 2019; Smith, 2001) and adaptive physicality would need to be recognised. Given my background the surfacing of this specialist form of bricolage (Levi-Strauss, 1962) immediately put me in mind of some

of the philosophies and practices within the martial arts world. Kenpo Karate provides a useful illustration of how the development of martial arts themselves is a work of bricolage. Kenpo is a form of American karate that was synthesised from Japanese and Okinawan forms of karate and judo (Crudelli, 2008) and simultaneously influenced by Chinese martial arts and martial artists including directly by Bruce Lee who was himself developing his own hybrid form of martial artistry Jeet Kune Do (Parker, 1982). Kenpo karate in its codified and promulgated form encourages participants to identify and tailor aspects of the art that suits their unique needs and strengths (Parker, 1975). It is also still developing and changing under the governance of new gatekeepers since its founder Ed Parkers died. It is effectively a framework defined by bricolage, used to promote further bricolage.

All participants spoke to the many and varied emotions that materialised. John acknowledged on occasion being 'anxious', with the potential to feel 'scared' and 'fearful' on the cusp of incidents, whilst Jill spoke of colleagues providing an emotionally stabilising presence during restraint, her emotions being vicariously assuaged. She also spoke to the impact of the job, and in particular dealing with behaviours of concern, on her emotional responses over time, 'I don't let things get to me as much as what I probably would have done before. I sort of take things that you know at face value quite a lot. It does harden you up'. She did not appear to be decrying this change, merely noting it. She also spoke of confusion being a part of coming to terms with what might have just happened. Sabrina spoke most directly to those emotions present within others rooted within events, and which percolated through to verbal expression after, and her role in responding to them. Her practice of calling for '10 minute' chat suggests she sees processing emotions as an important facet of her response and makes clear that things can be messy during and after. Charlie disclosed the 'anger' that some patients provoked in the moment, albeit an emotion that indicated he managed so that it did not infiltrate his response. Charlie also spoke of slipping into periods of 'emotional detachment' during incidents. Unlike Sabrina, Charlie was reluctant to process with just anyone, 'I'll talk to mates. I won't talk to a randomer, or

somebody who's done defusion training and works on a different ward and doesn't know the patient'. This could be read as a form of defensive practice, a mechanism for preserving a 'closed culture' (CQC, 2019), where a complex and messy admission to a disconnected outsider could lead to uncomfortable questions. It would also preserve the established trust between parties. Another reading is that the act of keeping disclosures to a select few may protect a radically innovative culture, where risks are taken at the edge of what is permitted by policy, and where those who have been there and understand, recognise such practice as coming from a place of virtue even if it is messy [see next section on reflecting, rebuilding, and redefining oneself]

Of course, the practice of venting can by its very nature be equally messy, dirty and unedifying to the lay ear and is thus often a guarded practice. It was interpreted that venting may play a part of Charlie's reluctance to talk through complex, sensitive and challenging aspects of a response with someone who does not know the patient or unfamiliar with them or their behaviours. This highlights both the challenges faced by staff, and the weight of responsibility placed on any subsequent interpreter, myself included [as researcher]. I have elaborated here on how I understood what could readily be characterised by others as negative emotions, and rogue practice. This because I have chosen to apply the hermeneutics of understanding (Larkin *et al.*, 2006; Smith, 2004), itself premised on considering the participants' experience in its totality. In this sense I am choosing to consider events holistically, rather than as atomised parts. To me it feels easy and potentially dangerous to isolate a disclosure, word or action and read it distinctly differently to how it might be considered in context.

I found that participants' accounts revealed that the work of assembling a response, and subsequently processing the event is undeniably messy. Within the critical response phase, participants appeared to collectively and connectively push through and carry and on. The notion that they would be prepared to abandon patients or to punish those who were perceived to be hostile was never

discerned. Whilst I could foresee a need to withdraw from the immediate vicinity on the grounds of safety, this was never spoken to either. Rather, a way to resolve the situation which included restraining the person was present within all their accounts. Rather than dwell in any seeming loss of control within developing incidents, all parties continued to move forward pragmatically, which ultimately allowed them to re-orientate within the emergent solution. Sometimes this was a collective endeavour [Jill & Sabrina] other times an individual one [John & Charlie]. The way that participants spoke of navigating their way through the complex and shifting emotional landscape re-affirmed the importance of 'Self-Regulation' (Vohs & Baumeister, 2004) and the role of resilience (Foster *et al*., 2023; Rooney, 2017), in creating conditions for individuals to improvised within their responses. This said much about their abilities as bricoleurs (Levi-Strauss, 1962). For Charlie and John, the physicality required appeared to be supported by their external training and experiences. For Jill and Sabrina, it appeared to be supported by the intervention of colleagues wherein the team helped them to find the right place in their own interventions and re-established the opportunity to draw on their relational resources to re-connect, calm, and de-escalate. The processing of their responses was revealed by participants and will now be explored.

We Must Reflect, Rebuild, and Redefine, Irrespective of any Judgement.

The setting two cohort revealed how they brought their unique selves to their responses. It is perhaps more accurate to say that each staff member brought their unique 'current' self to the response, current because I felt that as regulated professionals, ad through their disclosures, they were always changing, growing, and developing. When sharing their experiences, all the participants spoke to the various ways in which they sought to both process and make sense of their actions and decisions with a view to validating effective practice, modifying future practice, developing wider perspectives, and realising their fullest personal and professional potential. John was clear:

> Speak after. It's massive. Reflections. That's the only way that you're going to improve and get better. Be open to feedback [770-771]

The experiences shared by participants spoke to team working, and practical interdependence. This was something that seemed to be premised on everyone working within acknowledged parameters, that there were shared notions of how to work and how to deal with risk. John expands:

> So, you want to look out for each other. Because if we don't do it right then, it's obviously not going to be nice for the patients. You could get even worse reaction, because you might not use your de-escalation effectively because you might be too scared, and you might over-react. You might escalate your reaction and go for a physical restraint when you could have spoken to someone or spoken to the patient. If that makes sense. I think its massive. Especially new starters. They do need supervision and debriefing and stuff like this because it's not normal [783-788]

Effective de-escalation, and how not over-react physically are capabilities that seem to be refined over time, through cycles of responding and reflecting together over time. This, for me, amounted to actions taken by individuals to find their way back after finding their way through; back to their new changed self, back to their old team with their new shared experiences and back to those relationships with their patients which will also likely change too. In response to the question 'Do you think that the way in which you respond to someone, including restraining someone, can build trust or strengthen a relationship, Sabrina stated 'I do see a therapeutic value in in restraint'. In this statement I believe she is saying that how one goes about restraint communicates a great deal to the person being restrained,

rather than the restraint being able to attenuate their illness. If the staff member is careful, and respectful this has the power to strengthen the relationship and increase trust, which may lead to more productive future interactions, bringing them back to a new relationship with all its possibilities.

All four participants spoke of the sense of accomplishment they experienced when they were successful in caring, in terms of providing the broader support which helped pave the patient way to recovery. Responding to behaviours of concern was a part of this, and integral to their role. It was not separate and unrelated. One does not set aside one's explicit responsibilities and values, respond to events in a state of divestment, only then to return a resume a professional role. They are one and the same, part of the same job. When asked to attach names to the feelings or emotions generated by their broader successes, Jill said 'Happy. Excited. Fulfilled', John replied 'I'd say quite proud to be fair. Proud of the whole team. For persevering, for like trying to optimize their chances really, and reduce their risk. It's that it's very pleasing, very pleasing', and Sabrina articulated herself thus, 'you feel like a sense of pride, and you feel like a sense of, like, accomplishment that, you know, my input has influenced this, and my input has had a positive effect on a person's life'. The sense I gained when considering the totality of participant experience was that progress meant fewer behaviours of concern, and so less likelihood of physical intervention or other restriction, Charlie exemplifies this:

> The most rewarding thing that I've done in my time here, involved a patient in long term segregation on four staff unlock, with four men round him at arm's length and. And in six months, once I took over has his named nurse, he came off segregation and had no staff. He went from assaulting people every couple of weeks and having around 15 hours out of his bedroom a month, to being able to come out, you know, at all times [79-83]

Here Charlie spoke less explicitly in terms of any emotional dividend, rather he focuses on the practical consequences of his success for the patient. Although it was not something that was consciously probed, there was a sense that whilst success was important to each of the participants, it was not a destination in and of itself simply part of the journey. From the patient perspective spontaneous acts of violence can result in guilt, remorse, or even shame very quickly after any momentary disequilibrium has revealed itself in hostile behaviour (Tangney *et al.*, 2011). Charlie spoke to such an incident where a patient started to cry and called for a hug. The moment passed without Charlie providing the hug, likely a combination of the formal safety rules, and perhaps Charlie's own guardedness, but the point to note is that the patient appeared to be affected by his own behaviour, this was not something done unto him by others, it was effectively *oriunda sui*; done unto oneself. The repairs to relationships in such a setting will never be easy and quick. Staff as well as patients can ruminate. The recovery journey itself is a tenuous one, and the therapeutic relationship and trust stored up in it would be jeopardised by the sort of uncaring or actively hostile restraint that is exemplified in the anti-restraint discourse. For practitioners who strive to work productively, and who seem to genuinely treasure progress, and success why would they abandon their Primary Task (Rice, 1963) when they patient needs care and protection the most?

The innate desire to provide care seems also to have shaped how participants reflected. John spoke at some length about how he questioned himself when he was attacked, 'what I should have done? or is there anything it's down to?'. These questions seem to suggest John felt he may have in some way failed the patient. It was following a period of convalescence he mused, 'It's not a normal thing to be assaulted, is it?'. To me these words are striking, because for most of us, the prospect of an assault is both an unlikely eventuality, and a deep fear. Short of any physical injury, the damage to one's own self-image can be a psychological wound in and of itself. It is to recognise one's human frailty. Janoff-Bulman (1992) spoke of the adverse effects of events such as violent attack, which can

shatter our fundamental assumption that the world is a fair and just place and that we get what we rightly deserve, positing that this often resulted in paradoxical and maladaptive responses such as growing doubt and self-blame, even self-loathing, not to mention counter hostility. In this precise location the balancing function of mature care [Pettersen, 2012) has a role to play. The impression I formed was that John retained an open mind, and did move forward through such thinking, scaffolded by the feedback from trusted colleagues, and did not slip into resentment, blame or limiting self-doubt:

> Feedback. Yeah, that that definitely helps because you know it's sort of solidifies what you were thinking. Because obviously, I'm not going go out there and act in a way which I think I shouldn't, but if there was something that I might missed, it would have been nice to know [705-707]

Amidst the disclosures around localised, personalised reflection and sensemaking I also noticed statements that did not seem to relate to what had happened, rather to the opposite. Like those of participants in setting one, the accounts often related explicitly to what did not happen. Charlie described a situation with a patient being held against a wall, which he immediately qualified, 'I don't want to say push him up against the wall, like driven to the wall'. It seemed necessary to him that he qualify what he had not done or did not do. Likewise, John stated 'You can't run [and] rugby tackle someone'. Jill described the impact of her response by reference to that which it would not have, 'knowing that for myself I'm not going to hurt you', and Sabrina spoke of the right approach being 'firm but not too direct as such'. The fact that all spoke to aspects of their responses that did not occur, seemed to me to suggest they anticipated I might have expected them to be over forceful. My sense was that they were speaking to a much wider audience, comprising 'others', unnamed and unknown.

These *others* might have included me, my supervisors, the setting gatekeeper and others who might read the finalised thesis. That such defensive descriptions were present in all accounts is notable.

John stated, 'Obviously we're under a lot of scrutiny'. For Charlie it was the judgment that flowed not so much from scrutiny [or at least clear-headed scrutiny], rather an unconnected contemplation of a conjectured reality, where restraint was deemed wrong by default. This was most evident when he spoke of his disagreement with colleagues at university:

> I'm talking about restraint and the majority of that room said they agreed with that the use of restraint is just barbaric and you shouldn't restrain somebody in this and that. I just couldn't believe it. You know what I mean? Like, I just thought, do you know what, you just live under a rock, because you know, you should see my reality [668-672]

He was not saying 'I didn't do X or Y', rather he was saying I restrain people because there is a legitimate need, not just for the sake of it or for some nefarious purpose. My sense, gleaned through reflecting deeply on their individual experiences, was of a group of individuals working hard through uncertainty, and adversity to attenuate periodic disequilibrium, and to mitigate inequality within relationships that have inherent power differentials built into them, with a view to getting back to a mixture of relative normality and to facilitate those therapeutic interventions designed to support recovery and personal empowerment. If that is the meaning to their work, then the difficult, dangerous, and dynamic interactions are what need to be carefully negotiated to make that progress. It was something they had to work through, as best they could; to continue to serve their higher caring purpose or primary task (Rice, 1963) within the context of the relationships and interactions they had with members of the cohort they served.

The Presence of Learning Disabilities within the Groups' Experiences – Setting Two

The team within setting two are principally caring for, supporting, and treating individuals with mental health diagnoses. As has been previously indicated, the presence of a learning disability [LD] is subsumed within the technical definitions used in the Mental Health Act and the service specifications of commissioners. Time was taken in recruitment to ensure that participants were working with individuals with LD, and in interviews the focus was on their experiences with such individuals. Once again, an awareness of, and a regard for, the needs of individuals with LD was implicit within all the accounts. The explicit mindedness of participants towards LD was also occasionally discerned.

> Jill: I think the way you talk to [patients with a LD] would be a lot clearer, a lot more open. You would probably talk a bit slower, and then you'd ask them if they understood and probably repeat back what you're going to say just they understand [402-404]

John seems to recognise that on a given day, a patient might not be able to articulate their feelings, which in turn might reveal itself through escalating behaviours. He talked of taking a 'step back', and of trying to give communication a chance. In stepping back, he appeared to be instituting some time and space to facilitate self-regulation or at least find the processing easier, with fewer demands and less at stake. Charlie spoke about his caring relationship with his cousin [with Autism, as opposed to LD], and the physical interventions he made when he was self-harming. When his account returned to the workplace, he drew a parallel between how he made sense of, and reacted to, behaviour presented by two very different patients, one with a mental health diagnosis, and the other with LD. A turn of phrase he used to describe the behaviour presented by the patient with LD, was that there was 'no heart' to it. My reading here is that Charlie seems to see some behaviours as planned or

intentionally used to target a staff member, with some intrinsic hope of causing harm to them. In the other incident, in the absence of such intent, Charlie reports being willing to endure what amounts to repeated assaults from a patient with LD. This leads me to tentatively conclude that he is saying that when he perceives the presence of hostile intent, it can invest behaviour with particular properties. It can feel different when one determines that it was supposed to hurt. Conversely, when there is no intent, some of its impact is reduced. In Charlie's account, he seems to be saying that in his mind, because of the evident the dysregulation of the patient due to his LD, the behaviours were not personal. This might be characterised as a form of empathy. It also might be understood as an informal type of 'reasonable adjustment'. That *perspective taking is needed to* maintain the integrity of the relationship in that moment, and to focus on doing right, without being overcome by any anger or resentment.

Jill brought LD to the fore when speaking about her approach to managing restraint. She spoke of needing to talk more clearly, and check understanding more frequently [see above]. In this adaptation there is evidence she considers the processing differentials that may exist between a staff member, and patient. She indicates that she takes time to make her communications fit for purpose and seems to indicate that she takes her patient with her on the journey through restraint, rather than imposing it on them and expecting them to independently make sense of events. For Sabrina there was also an indication that LD implicitly figures in the working practices, within the context of restraint. Sabrina says, 'Obviously, it's never going to be nice to be the person who's being restrained. So, I think I always make a point of saying to the person what's going to happen'. Like Charlie, there is an empathic connection and a recognition that within the context of a restraint the not knowing can somehow add to the experience of disorientation and distress, and like Jill she takes time to relate to and connect with that person in that moment of crisis. All in all, accounts seem to suggest that for participants in this study the recognition and knowing of LD is part of the fabric of their responses.

Having explored the experiences of staff working within two very different settings, I will next go on to examine these alongside one another to establish commonalities or convergences between them as well as ay differences or divergences. Whilst the services are distinct from one another, both require staff members to respond to behaviours of concern in a safe, effective and lawful manner

Chapter 7. Convergence & Divergence Across Groups

Key Elements Within Identified Themes

This chapter will analyse the similarities and differences between the experiences of participants across study sites. These are represented by eight elements. Fig 7.1 offers a visual summary of these elements, and their presence within the foregoing setting-specific themes. These elements are parts of the experience, without which the experiences considered would not have been *those* experiences. In Phenomenology, eidetic reduction (Pietkiewicz & Smith, 2014) involves identifying the essence of the phenomena by removing all extraneous elements until all that is left are its fundamental components. Once anything further is removed from the experience it ceases to be that specific *thing*. To be clear, I am not asserting that the structure of this chapter comprises the fundamental components of *all* responses to behaviours of concern, rather that these to me were representative of the key elements of the experiences that I interpreted and analysed. To my mind a contemplation of the totality of the experiences of Donna, Lisa, Emma, Russell, Lisa, Sabrina, John and Charlie would be incomplete without attention being given to Individuality, Relationships, Feelings & Emotions, Violence, Physicality, Balancing, Sensemaking and Judgement. In this chapter each element provides an opportunity to say something about these aspects of participants experiences.

		Individuality	Relationships	Feelings & Emotions	Violence	Physicality	Balancing	Sensemaking	Judgement
Setting One	Mum is present within both policy and practice.		■					■	
	Relationships can hold things together or pull things apart.		■	■					
	There is always a complex array of emotions present.			■	■				
	The individuals inevitably use themselves as a resource.	■							
	Autonomy is something that is negotiated.		■			■	■		
	Some training helps and some training doesn't.					■			
	We are judged whether our actions are witnessed or not					■			■
Setting Two	With Great Power Comes Great Responsibility		■	■				■	
	Building Relationships & Trust Is Central to Making Progress in This Complex Space		■					■	
	We Bring Multiple Selves to My Role, and My Responses.	■				■		■	
	Taking Risk Can Be a Part of Making Progress.		■			■	■	■	
	Who Knows What Will Happen Next, But It Will Be Messy.			■	■	■		■	
	We Must Reflect, Rebuild, & Redefine Irrespective of any Judgement	■		■	■			■	■

Fig 7.1: Summary of Converging and Diverging Elements from GET Chapters

The diagram below [Fig: 7.2] provides a representative structure of the participant experiences. It builds on a visual structure that started to be assembled in Chapter five. It seems clear that who the staff member is as an individual, determines how they assemble their response. The framework as laid out in chapter three has been used to identify key elements of what Leigh-Osroosh described as 'the phenomenological house' (2021 p.1817). Within this house of experience one can find the essence of the response, or what will be referred to in this chapter as 'Street Level Bricolage'. I will now examine the individual elements that constitute this structure.

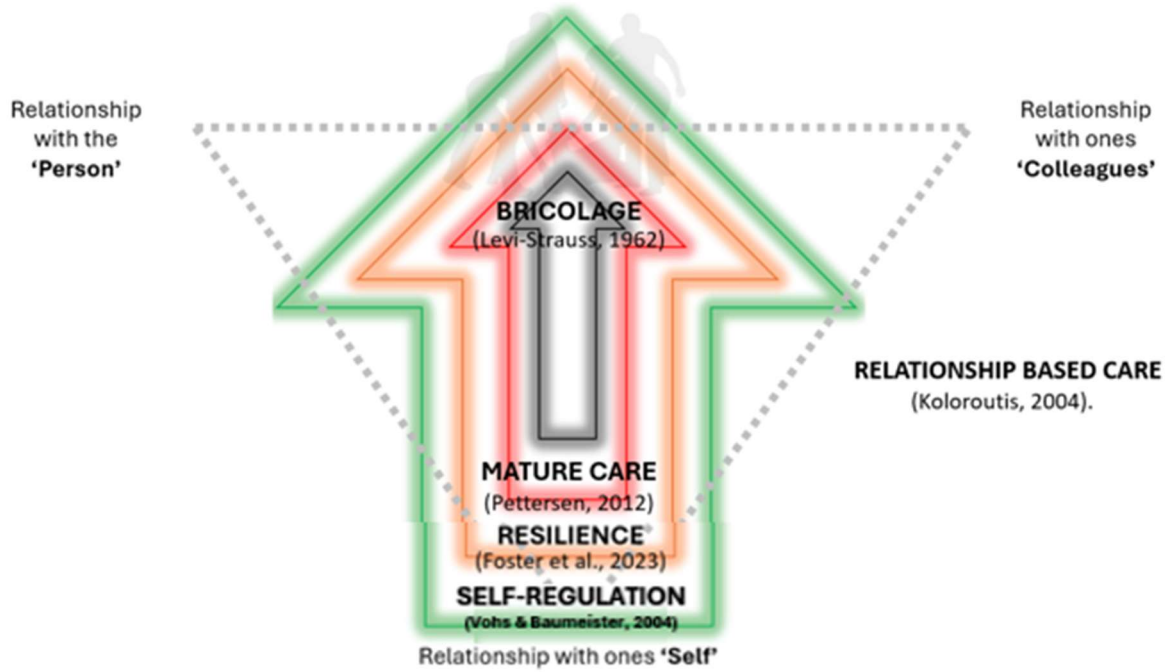


Fig 7.2: A Structural Representation of Participants' Experiences.

Individuality

Within a study that foregrounds idiopathic data collection and analysis (Smith *et al*., 2009) it is unsurprising that the individual looms large, IPA however allowed me to look deeper into responses rather than just acknowledge the presence of an expanded version of field modification (Paterson, 2007), something that is recognised but not necessarily fully understood. To me the individual experiences, revealing *who* the participants were said something important about *how* they responded to behaviours of concern, and how they adapted when negotiating that response. They seemed to synthesise a combination of the individuals' physical capability, concrete knowledge, instinct, and intuition to produce *their* unique response. A great deal was clearly at stake, and to meet the demands of the situation each participant needed to bring their most competent and attuned self

to deal with the 'unready-at-hand' (Riemer and Johnston, 2012). Fig. 7.3 conveys something of the individual variability amongst participants. The diagram captures some of those parts of the self that were implicated in accounts of their participant's practice. The use of white and grey allows a personal/professional distinction to be made between the various aspects. This is not to divide the components, simply to distinguish them.

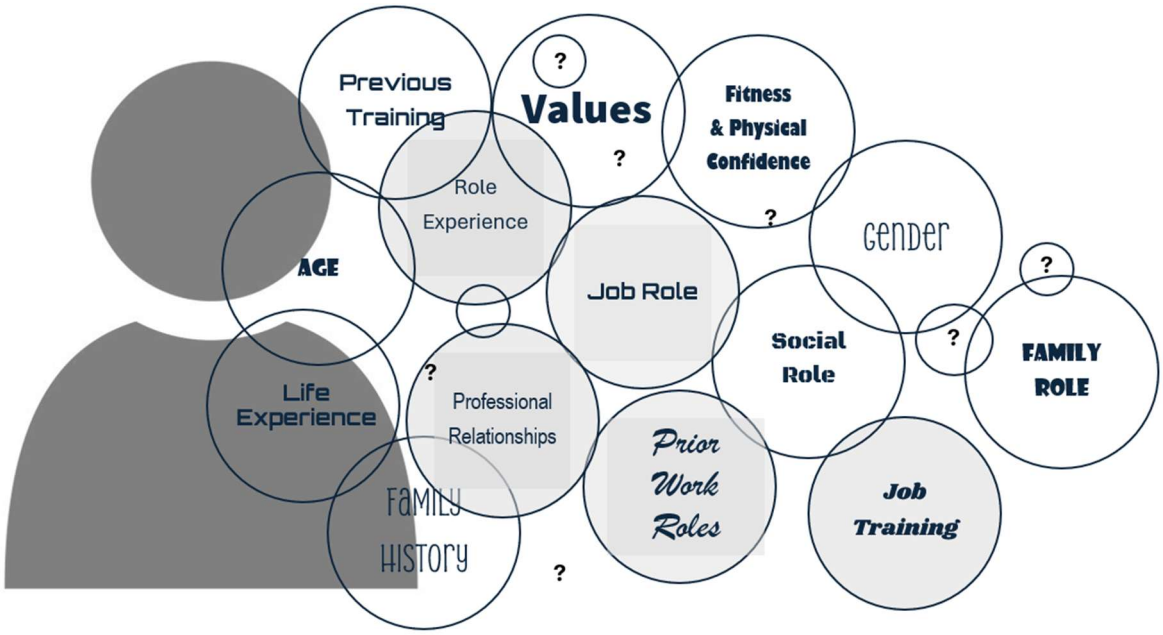


Fig 7.3: Aspects of Individuality: Professional [grey] and Private/Personal [white]

Across the two cohorts, the participant experiences also revealed something about the rigidity and inflexibility of the tools provided to them through their preparatory training [see 'Physicality below]. Donna in setting one had previously said, 'I think in the moment you have some of what you've learnt in your head, but I think in the moment you're doing what you can'. Jill from setting two seems to concur, indicating that training does have some value, although you must find your own way to restrain a patient:

> It's like you're driving test. You can learn to drive, but you don't ever learn to drive until you actually go and do it. So, you know, when you do your MVA, and things like that, it never goes that way. It's not that straightforward. But by the time you've done your first restraint, it kind

> of gets that. What would the word be? You'd be a bit scared to get involved to begin with, but then it sort of takes that away. Once you've had your first restraint, and I think once you've done one or two, that's when you're kind of learning. You know how to do what, you know what's required of you, and how things work and how to sort of deal with the situation [641-647]

To me this says something about the limited transferability of policy, resulting in a pragmatic need for formal directives being informally interpreted from the bottom up (Lipsky, 1980). Second order policies in general seem to be concerned with the *what and when* more so than the *how* of physical responses, other than to name authorised techniques. It was in this negotiation of individual responses that I felt that mature care (Pettersen, 2012) allowed them to find a balanced solution [see 'Balancing']. Many of the resources drawn upon were not acquired or developed within any formal induction or training, rather they were the legacy of individual life experiences. So, their individuality as expressed with their responses was singularly them. Their individual *being*, became their unique *doing*. Individuals found themselves in situations where the risk of harm to themselves was real and live, and they quite simply had to find a way to respond. Charlie spoke of his spontaneously assembled 'clinch' manoeuvre:

> This came completely out of the blue, and I would say it was rather effective; it didn't hurt him you know. If I had tried to take hold of an arm that at that stage, I probably would have got more hurt, you know. You know more injuries than what I did get [302-305]

It is also important to consider the presence of an attack dynamic [see 'Violence' below], because it provided the stimulus for key elements of the follow-on response. The national policy preference is

for planned restraints (DoH, 2014), where resources are marshalled, and contingencies considered before any agreed plan is put into action at an agreed time. When someone is attacked there is typically no fully developed plan, other than resort immediately to so-called breakaways. Charlie, John, Russell and Lisa were all attacked when in one-to-one situations, whilst Jill and Sabrina responded to a sudden attack of another person, and Emma was confronted on her own. Participants had no choice but to dig deep within themselves for effective solutions. It is this act of balancing and of blending components of the self which was revealed in what they did [see 'Balancing' and 'Physicality']. As has already been noted the participants came from different types of service and were all very different as individuals. On a general level the setting two cohort were younger, and professionally qualified. But still what seemed to define them in the moment of response was who they were personally and privately, not the formal role identity they assumed at work. It was their points of unique personal and private differences located within social role, family history, life experience, prior training, age, fitness, physical confidence, values and style of thinking that seemed to me to lead to who they were in those moments. It was also noted that professional relationships were important, as was prior response-related experiences in the work setting.

Individuality seemed key to the bottom-up, situational policy interpretation. Fig 7.2 offered a very visual representation of the structure of participant responses. At the centre is the practical interface between bodies, where the physical aspects of Street Level Bricolage are revealed [see 'Physicality']. These actions seem to be a manifestation of 'Mature Care' (Pettersen, 2012) which can be thought of as the organising mode of mental engagement, scaffolded as has been highlighted by resilience (Foster *et al*, 2023) and bridled by 'Self-Regulation' (Vohs & Baumeister, 2004). The rest of this chapter touches upon those elements of the individual experiences that led me to my conclusions. I think that it is important to say that whilst this chapter is laid out in ordered sections, the elements are not separate and distinct. The reader will become aware of signposts linking sections, and interpretations

that may resonate as they move through the text. To me they blur and blend into one another, defying ready compartmentalisation.

Relationships

Relationships were in evidence across both settings, but their function, form and dynamics seemed to differ. In setting one relationships functioned to hold the collective together to provide support to Sara. A sense of the 'we' was spoken to by Lisa, Donna and Emma, although less strongly, by Russell. The emotional connective fibres of the core relationships between the staff and Mum seemed to outnumber the purely rational ones, which appeared difficult for Russell to accept. It seemed to clash with the rationality that appeared to bring him comfort and certainty. The relationships in setting one were characterised by inter-team communications, phone calls and texts which took place outside out-of-hours. Russell revealed this at the same time he pushed against it:

> She will phone you up and talk about this and send pictures of that. She'll send videos of this, "Oh Sara is doing this". You don't feel like you are ever away from the job [795-797]

To him this communication broke a rule, that work, and specifically the mental attendance to the role, should only take place within contracted hours. It is difficult to argue against this. Therefore, his rejection of this expanded relationality channelled at times and through media outside of work, yet work-related, is not criticised. Rather, in a service with its a familial-like structure and functioning, it comes as no surprise to me that individuals wholly immersed in the *project*, did not limit their thinking, feeling and communicating to prescribed times. Therefore, the substance of those responses sought out in RQ1, and the integrity of the policy framework central to RQ2 can be said to be in part defined

by distributed conversations, taking place within professional *and* personal time and having the quality of both. In these communications there appeared to be an ever-developing set of thoughts and feelings which scaffolded the task at hand. In the following excerpt Lisa shifts from the 'I' of her personal experience, to the 'we' of finding understanding and a way forwards:

> Other times, I think to myself "Oh shit! What's going to happen now?". So then sometimes I get apprehensive. Because I think, 'what happened?'. And then we pick the bones out of it and think, "Ah right, that's what happened [326-328].

In the practice space itself, during formal working hours, relationality supported a host of functions. Within the direct relationship with Sara there was a sense that trust was built, and knowing gained. Both seem to be two-way activities, but as I did not speak to Sara her reciprocity is speculation on my part. Russell also spoke to critical intra-incident policy direction given by Mum [see 'Physicality' below], but otherwise less was spoken to this immediate functional aspect of the relationships within experiences described by participants in setting one. But the connectivity seems to re-emerge after events had taken place [see 'Sensemaking' below]

In setting two there was also a sense that relationships also mattered to the work, and to responses. In this space the study participants were not part of a singular team in the same way as those in setting one. However, relationships with colleagues were spoken to, and characterised as extremely important and as functioning to quite literally avert restraint, as well as being key to the safe and effective management of physical restraint [although out of work communications were not referred to]. Sabrina spoke of the continuing conversations with colleagues that helped to avert restraints:

> I think we do it literally, continuously, every day on here, and it's about the relationships keeping people busy and stuff. So, if you were to sit on a chair and not move all day, then you would have incidents all day, every day, you know? [419-421]

The avoidance of restraint [which is unlikely to be recorded as such] speaks to the spirit of the broader policy framework within which the responses under consideration in RQ2 are defined, whilst the management of restraint speaks to most directly to RQ1, specifically that responses had both an individual as well as a collective, relationally supported and enabled dimension. The participants in setting two held professional roles in a regulated service, wherein restraint reduction is a formal national policy goal (DoH, 2014). It is something they are publicly measured against (NHS Digital, 2018) and therefore a formal feature of their professional job role, the performance of their role and any deviation from expected practice is monitored organisationally and regulated professionally (NMC, 2018). Working towards this goal seems central to who they are, and to the implementation of their Primary Task (Rice, 1963), the accomplishment of which involved working with like-minded individuals, Jill spoke to her colleagues 'who worked very much like me', whilst John spoke to the collective, integrated whole team when he said, 'In health care we're always trying to improve'. In finding the sense of defined purpose, and confidence in its pursuit amongst the setting two cohort I tentatively attribute this to being a corollary of professionalisation, whilst in setting one that professionalism is worn more lightly, with affection and regard being more strongly in evidence. They are different drivers of practice, but both permitted individuality [see 'Individuality' above] to surface within their relationships and actions.

In setting one, I discerned an array of contested or dysfunctional relationships. Russell openly expressed disagreement and frustration with others, chiefly Mum:

> It doesn't work. Too many conflicts, too many angles to work at. When you really think about it, it can't work can it? It can't... Sort of feelings dictate too much when you are a mother as well, and you can't manage in a systematic and consistent approach if you've also got your mothers hat on [103-106]

In addition to this, all the team seemed also to have a fractious relationship with Sara's father, Lisa offers this explicit summary:

> He comes in cocks everything up for everyone else, and her. And then buggers off again, quite frankly. And then come back again a week later and does it all again. And yet he is the one who doesn't get hammered. Who doesn't get sworn at. He isn't the one that get pinched [321-324]

This was important because it was his deviation from the agreed support regime which was reported to lead to disequilibrium within Sara which was expressed through behaviours requiring resort to physical intervention, which led to staff injury. Relationships therefore seem key to implementing the support necessary to meet the restraint reduction components of policies referenced in RQ2, which had a direct impact of the experiences which were the focus of RQ1. Such dysfunction was not evident within the experiences of participants in setting two, however it was intimated by Charlie that some staff had more restrictive mindsets, and Jill indicated the actions of team members can have a negative impact. For her the psychiatrist's decision to change medication led to a breakthrough of behaviours that she was required to respond to, which in turn required her to contemplate whether to restrain or not, thus introducing an ethical challenge into her relationship with a patient.

Relationships can be conceptualised with resort to Noddings (2002) and her use of 'circles' and 'chains' to illustrate the scope of her ethic of care. She conceived of the caring obligation as an ever-expanding series of concentric circles, with the obligation and understanding of the individual to be cared-for being strongest closer to the centre of the circle. She used the 'chain' to illustrate that when someone enters an individual's moral world, connections where then forged with them, and through them with others via relationships. Noddings (2002) suggested that the obligation to care becomes increasingly diminished as individuals become more distal. In practical terms the relationship with, and understanding of, an individual reduces broadly in line with the level of interactivity shared with them. Participant experiences suggested that the knowing of the person whose behaviour was being responded to did matter. It came through strongly in setting one, with a relatedness to Sara by Donna, Lisa and Emma which that approached the familial. In setting two Charlie was untroubled by the person whose behaviour had 'no heart', [read as no *intent* to cause harm], this knowing came through their relational connection. Separately Jill held off from restraining a ligating patient because of her deep knowing of him.

It is also possible to integrate some of the thinking found in the Street Level Bureaucracy literature, Zacka's (2017), 'Thinking Partners' being used to speak to the role of partners [or relationships with such partners] in the realising of individual thinking [and feeling] which ultimately transcends non-technical discretion (Zacka, 2017) within the context of individualised responses. In setting one Mum could be considered a strategic Thinking Partner (Zacka, 2017), and her presence seemed to me to be as the living embodiment of policy. Here exchanges between her and team members took place at pace amidst the chaos, and at a more measured pace within reviews of events and developmental discussions. Her thinking was distributed amongst team members through her role as a practice leader and through the conversations which were valued so highly by Donna, Lisa and Emma [see 'Sensemaking' below].

> Lisa: Mum is very good at talking things through with you. And then you can see the error. What you did, and then you think 'Oh!' And it can be the tiniest of things that you might not normally think you know. Then it's yeah [423-425]

In setting two, it was Sabrina and Charlie who seemed instrumental in shaping colleagues' attitudes, understandings and practice through their relational connections, functioning as de-facto Thinking Partners (Zacka, 2017).

> Sabrina: the staff team that I work with, that we all have quite a good level of trust with each other and so we can pick up on each other. Someone's not great, or someone needs a bit more support. We can very much pick up on that. We'll walk off together. We've talked about it, and everybody feels... I suppose they're not thinking about work when they go home [93-97]

> Charlie: If there's ever something that really bothers me, whether it be challenging behaviour or issues with management, I'll talk to mates. I won't talk to a randomer, or somebody who's done defusion training and works on a different ward and doesn't know the patient. I'll talk to somebody who knows the patient and the situation [554-557]

Both approaches seem informal, with Charlie being more guarded in the selection of those involved in the processing of experiences after the fact. My conclusion is that Thinking Partners can function in different ways [see 'Sensemaking' below]. One of the key matters for discussion within such forums being feelings and emotions which will be considered next.

Feelings and Emotions

All participants spoke of emotionally tumultuous experiences, before, during and after their responses, but which were fundamentally linked to them. All spoke of anxiety upon becoming involved in events that required some action on their part was a universal experience, participants also spoke of the pain caused by attacks and the injuries sustained by themselves and colleagues. Participants also seemed to carry away with them a form of anxiety, or increased awareness, which kept them alert to the prospect of future involvement in harmful events. Russell and Emma both spoke to this, whilst all participants in setting two acknowledged such feelings as part of the risk of working within a forensic setting. Russell articulated this most clearly:

> She's never in green. There's no green. Theres's green, red and amber in this world we live in, there's a shade of green but not a green... But its predominantly amber, because anything can happen at any moment and this is what makes the job so difficult [154-156]

Emma was also anxious about getting things wrong, whilst Russell was angry and frustrated at Mum and the underdeveloped system as he saw it. In setting two, feelings of frustration, and anger were also in evidence, arising from similar situations. Charlie revealed the anger he felt when subjected to a malicious complaint about his response to an event. Johns' confusion and bewilderment followed him home after an attack as he struggled to process the why of it all.

> You're sort of like sat at home really. And for a couple of days, you're thinking about it all the time, it like 'is there anything that I should have done differently?' and 'Why did it happen to me?' [675-676]

All participants experienced a degree of confusion in amongst the chaotic physicality, where violent patient/service user behaviours were met with incoming staff responses. What was notable in both settings was the extent to which all participants held such feelings in abeyance when responding. They were able to relegate them, and whilst they may not have entirely dissipated, they did not infiltrate and taint the physicality within their individual responses.

> Sabrina [Setting Two]: if you yourself are feeling anxious, or you let the patient see that you're stressed, then all hell breaks loose [24-25]

> Donna [Setting One]: Say she comes up to my face. She comes up on her tiptoes and tries to make herself big. Like I wouldn't move. I would probably stay where I was. And not flinch or move backwards, because it's almost like she has gained control of me. And then she's gained [control of] the situation [232-235]

This situational sublimation of unhelpful feelings and emotions seems to be derived from a conscious exercise of will; and act of 'Self-Regulation' (Vohs & Baumeister, 2004). This seems to me to speak to the intentional foregrounding of a care-full attitude and the prioritisation of care-full actions. The former again is in line with the tenets of care ethics (Pettersen, 2012; Gilligan, 1982) [see 'Balancing' below], enabling the latter: situationally negotiated physicality or Bricolage (Levi-Strauss, 1962) [see 'Physicality' below]. All of which as previously discussed seem to be key to this very specialist form of Street Level Bureaucracy (Lipsky, 1980) that I am referring to as 'Street Level Bricolage'. I will now turn to the nature of the behaviour experienced by participants.

Violence

This study set out explicitly to explore the lived experiences of responding to behaviours of concern (DBMAS, 2012). This would include behaviours that have been referred to as having a challenging component (NICE, 2015a&b, RCP *et al*., 2007). This family of terms all confer a communicative core to the behaviour, and a suggestion that distress and need are revealed by its manifestation. Perhaps the clearest example of this was the self-ligating patient supported by Jill in setting two. The *need* in this instance was possibly for physical contact, the alleviation of distress, boredom or frustration, or perhaps the satiation of a hunger for meaningful interaction. Sometimes such self-injurious behaviours can be very seriously damaging to the patient (CBF, 2023; Nawaz *et al*, 2021), so it is readily conceded that behaviours of concern can be harmful. The descriptions offered by all the participants provided insights into the answers to RQ1 and RQ2, but it was noteworthy that the behaviours all chose to reflect upon involved what could accurately be described as violence. The contents of the behaviours included punches [John, Charlie], kicks [Russell], scratches and pinches [Emma], fingers being bent back [Lisa] and attacks on other patients [Jill and Sabrina]. The latter two, along with Donna, John and Charlie, also encountered forceful resistance to what in all instances appeared to amount to a necessary physical intervention. This is not to claim that all behaviours of concern are violent, rather that the behaviours which participants deemed significant and stayed with them, were.

It could be argued that violence is a form of communication. An example given by Russell in setting one involved Sara indicating that she did not want to go out, and when this was not heeded a member of staff was struck. Whilst it may now be an outmoded distinction, such an act could be characterised as a manifestation of instrumental aggression (Bushman & Anderson, 2001), the message being 'I told you; I do not want to go out'. However, when Emma was in the hot tub with Sara, one minute laughing and enjoying a fun experience, the next having her fingers suddenly grabbed and bent backwards

there appeared to be no obvious communicative functionality. Sara was not reported to have been noticeably distressed or angry and so based on what I was told it is difficult to readily identify what need was not being met. The assertion that 'behaviour that challenges often indicates an unmet need' (NICE, 2015 p.38) is a useful precept. It prevents expressions of behaviour being routinely categorised as violence, and it also stimulates investigation and curiosity in equal measure, which offer the hope of better understanding and a revision of support. Whether there can be violence that is justifiable is not the focus of the inquiry, but the experience of responding to it and how exposure to it makes people feel is of relevance. In the context of my analysis, irrespective of whether any clear rationale can ever be discerned, the immediate experience of participants was one of attack and of exposure to potentially harmful behaviours, of violence. This study involves exploring a phenomenon from the perspective of the participant [or staff member]. If one accepts the legitimacy of the lived experiences of staff, then there was not one of encountering behaviours of concern in the more benign sense that is currently posited [Fig 7.5 – see below]. In the diagram, the Title 'Behaviours of Concern?', underwritten by 'No. Violence!' inserted in red. This is used to symbolise that the study participants experiences contrasted with the accepted current framing of those difficult to manage behaviours that can be encountered. Violence stands in contrast to terms such as 'behaviours of concern' and 'behaviours that challenge', which both suggest that the fundamental meaning of the behaviour is best read from the perspective of the person presenting the behaviour; they are expressing their unmet need in their own way. This has an ancillary function of de-stigmatising the person. By seeking to understand the behaviour as serving such a function, alternative readings of it as inappropriate or problematic are minimised. There is no reason to abandon the pursuit to understand behaviours expressed by supported or cared for individuals. Such explorations can underwrite the formulation of meaningful planned care, as well as provide critical information that is vital to the forging of professional relationships through which such care is channelled (Soklaridis *et al.*, 2016). What this does not preclude however is a recognition that the staff experience is separate and distinct. The

understandings that I have arrived at, in answer to RQ1, after reflecting on the reflections of all participants is that violence is *their* personal experience to name, articulate and process.

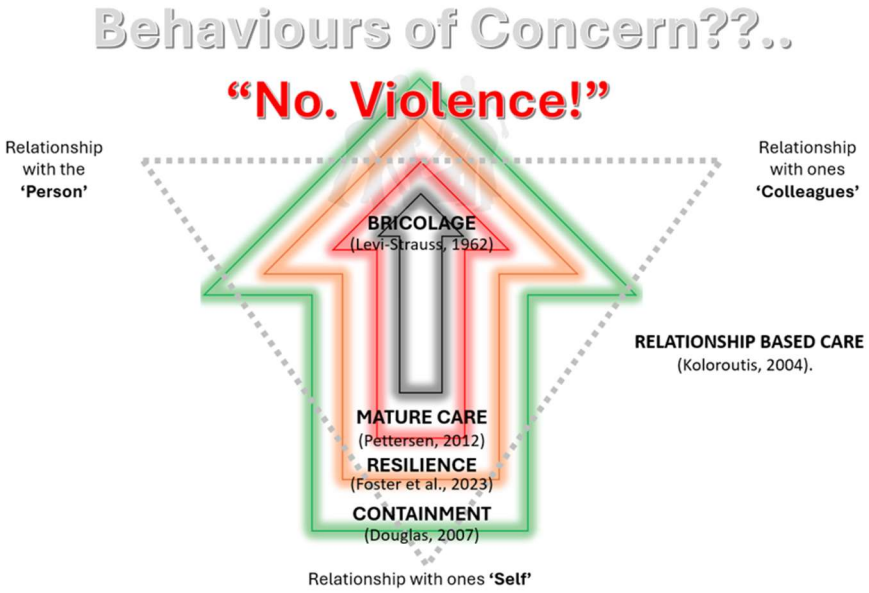


Fig 7.5: The experience of study participants was of violence

Physicality

Participants in both settings revealed how their responses deviated from the idealised forms referred to within policy and covered in training.

> Russell [Setting One]: We had the training. Tim did the training. It was OK. He showed us these techniques. We were there for a couple of days. He showed us a few moves. Now? I forgotten them all [456-458]

> Donna [Setting One]: (describing a common situation that training fails to prepare staff for): The first-person releases, and she's already grabbed back hold of you! How then are you

meant to come out of that room with out her grabbing back hold of you... There's never ever been any concrete answer about what we're meant to do. I've asked in every single training [session] and nobody has ever come up with a solution [483-486]

Sabrina [Setting Two]: (describing her need to adapt beyond the authorised techniques): You just grab hold of something until it's safe. So that's why I had had these two [head and arm], until another staff member arrived. Then you can sort of fix yourself. In the immediate moment you'll just grab on [258-260]

John [Setting Two]: When you're doing it in a training facility in them exercises it doesn't replicate, nowhere near to when you face with someone who literally wants to like, rip your head off and do some damage to you. So, you do sort of think 'How am I going to react?' [279-281]

Events themselves were more complex and dynamic than visually represented within commonly used illustrative assault cycles (Breakwell, 1997; Kaplan & Wheeler, 1983), and there also appeared to be no clear, singular, reason to physically intervene, as the need for physicality kept changing. Fig 7.6 provides an overview of the reasons why physical action was taken by participants, revealing change within individual events.

		WHY?							
		Self-Defence or Self Protection, in the event of an Attack by Person	Restraint To Prevent an Attack/ Continuing Attack by Person	Intervene and Apply Self Protection or [Other-Defence] to Stop Attack on 3rd Party	Restraint To Prevent Attack/ Continuing Attack on 3rd Party	Restraint For a Clinical Reason	Restraint For Policy Purpose e.g., Seclusion	Restraint To Prevent Self-Injury	Force to Counter Resistance and/or Attempts to Escape Restraint
WHO?	DONNA	Secondary to the Restraint >>>>				To facilitate a covid jab			<<< Secondary to the Restraint
	LISA	Her fingers bent back in hot tub							
	EMMA	Escape from kitchen when confronted							
	RUSSELL	A kick to the groin in the bedroom							
	JILL	Secondary to the Restraint >>>>		One patient attacks another>>	Necessitating restraint>>>				<<< Secondary to the Restraint
	SABRINA	Secondary to the Restraint >>>>		One patient attacks another>>	Necessitating restraint>>>				<<< Secondary to the Restraint
	JOHN	When hit by the superman punch >>>	Necessitating restraint>>>				>>> Resulting in seclusion		<<< Secondary to the Restraint
	CHARLIE	When receiving multiple punches to face >>>	Necessitating restraint>>>				>>> Resulting in a return to his room		<<< Secondary to the Restraint

Fig 7.6: A summary of reasons/functions behind the use of force

Each row summarises a single incident spoken to in the case studies, with the dark green blocks indicating the initial function of the physical intervention. The exception to this is the amber block which refers to Emma, who ducked under and arm and fled the kitchen, thus actively avoiding any engagement in direct physical interactivity. The secondary subsequent responses are denoted by lighter green blocks, which reveal something of the diversity of functionality within single events. Linked to this, the behaviours being mitigated through physical responses were found to change their nature and focus:

i. The initial presenting behaviour, which in this study was mostly in the form of attack but included non-compliance[4] during the facilitation of a covid jab.

ii. Subsequent resistance to the staff intervention

iii. Counter-attack directed at the staff member.

[4] It is conceded that the term 'non-compliance' is loaded. The act was the rejection of treatment approved through a best interests panel. It could therefore be described as a refusal, objection to, decline of or veto.

Further to this, within participant experiences of responding to 'behaviours of concern', three distinct manifestations of physical responses were identified, exemplars of which were present within the foregoing quotes above:

i. An initial unthinking, instinctive component of the response, often manifesting in taking hold, and thereafter holding on to a person/their limbs to dampen down the potential for harm.

ii. An intuitive, thinking response, where hybrid techniques are assembled in the moments after any initial instinctive response.

iii. An approved technique/procedure, arrived at after colleagues become involved, where brief pauses allow thinking and refocusing to take place.

This type iii response was seen exclusively in setting two, where restraints involved longer formalised procedures, which seem to have provided greater opportunities for staff to approximate and effectively re-integrate within a policy-aligned process. By contrast in setting one, responses often remained in the form of a hybrid intuitive response [type ii], which allowed staff to move Sara out of one room, and into another ['The Blue Room'].

One final observation as to the nature of the physicality was that because of exposure to the violence [as the initial presenting behaviour, but also present within counterattacks], the responses of all participants necessarily incorporated self-defensive components. Except for Emma, this involved the direct application of force. In Emma's case, her actions are self-defensive but are more accurately characterised as flight or disengagement. The focus of the experiences for all participants up until the point of attack had been engagement in some form of caring task or supportive endeavour, directed

towards meeting the needs of the other. This then transitioned suddenly into an urgent need to defend themselves, before segueing into physicality more closely resembling physical restraint. The significant aspect of all the participants' experiences was their ability to hold in abeyance any unbridled physicality while at the same time, difficult emotions were manifesting [see 'Feelings & Emotions'] and automatic physiological cascades electrically and chemically primed their bodies for defensive action (Marieb, 2006).

> Russell [Setting One]: I had a whole mixed bag of emotions. Obviously, your heart is pounding because there is a heightened state of anxiety for yourself as well as her. It's the unknown, you don't know how this scenario is going to play out [716-718]

> Sabrina [Setting Two]: You are just you just full of adrenaline and you just you just think 'Oh my God!' [129]

The curtailing or suppression of expressed physicality is notable in respect to John and Charlie, both of whom possessed capabilities as martial artists. The perceived capability and inclination of martial artists towards rendering harm is something often captured in lay references to the possession of 'deadly hands' (Romeo, 2017 p.23), a trope now ironically capitalised on by an enterprising retailer who has set up the International Registry of Lethal Hands (2024).

What I found across both groups were individuals, who seemed to be seeking to dynamically negotiate a good-enough physical containment strategy. The use of the word dynamic is apt here, as it speaks to the ad-hoc and changing structure of the response:

Lisa [Setting One]: In reality you've just got to grab a bit and go [590-591]

Donna [Setting One]: I think I use a mixture of all the different holds that I've always been taught [724]

Emma [Setting One]: (on applying taught techniques in the practice setting) Its doesn't work like that all the time [414]

Russell [Setting One]: When I went in, she was just lying there. Chatting away. Then "No! Russell!" and she kicked out [to his groin], and that was that. But overall, what training I've had doesn't really prepare you [465-467]

Sabrina [Setting Two]: You just grab hold of something until it's safe [258]

Jill [Setting Two]: Doing whatever we needed to do to get him apart, I'll be quite honest. Nobody was hurt in the restraint anyway. Then the idea, after you've got them apart, is to pin the limb on a patient. So as long as you pinned a limb, it didn't really matter [330-332]

Charlie [Setting Two]: He ran at me; he punched me maybe three or four times. I sort of instantly [pauses] My arms were sort of inside and over his shoulders near his neck. I wouldn't say my hands around his neck. I was sort of closing in and trying to stop these punches [267-269]

> John [Setting Two]: You, just you have to grab what you can really. Obviously, there's no striking. So, I wouldn't strike back or anything like that. It would be more of, like a wrestle. That's how I'd describe it [508-509]

In addition, as has been stated, the reasons for using force, appeared to change within the context of an incident very quickly, possibly below the level of conscious perception. On occasions the participants found that their actions were difficult to define and even describe, with Charlie saying, 'you do things you don't know you're doing until you've done it', revealing the instinctive or intuitive element to their assembly. At face value it may seem somewhat paradoxical to be certain about what you did not do [i.e., hurt someone] but uncertain about what you did do [i.e., the precise structure and sequencing of the physicality]. The possibility of that participants were psychologically defending themselves in some of their accounts of course cannot be excluded. At the same time some things are not readily explicable, and this is also important to consider when seeking to understand experiences of responding to behaviours of concern. Here it is useful to draw upon the work of Polanyi (1967) who spoke to two forms of awareness, the first 'Focal Awareness' being that which is concerned with knowing the '*what'* of doing. This can otherwise be described as explicit knowledge (Smith, 2001). The second is 'Subsidiary Awareness', which is concerned with the '*how'* of doing. This second form is implicit and embodied, often called tacit knowledge (Smith, 2001; Polanyi, 1967). This can involve a degree of somatic awareness, comprising bodily feelings, perceptions and sensations (Bergheim, 2019) that register and inform to do-er but which do not readily translate to a clear form of words, that if passed over to another could enable them to replicate the task precisely. Bergheim (2019) asserts that such knowing is likely to figure within the work of Street Level Bureaucrats, which would seem to nestle comfortably alongside the notion of non-technical discretion (Zacka, 2017) and here more pointedly mature care (Pettersen, 2012), ultimately being realised in a specialist form of Bricolage (Levi-Strauss, 1962): Street Level Bricolage.

In his book, the Savage Mind, Levi-Strauss (1962) compared the bricoleur to the engineer. He suggested the Bricoleur would be able to 'make do' with whatever materials and tools were to hand, whereas the engineer would need to plan, and procure a precise array of tools and resources. The bricoleur demonstrated a freedom and creativity that enabled them to resolve problems as they emerged, with whatever was available. To me this was what the participants had described doing. A defining characteristic of this specialist form of bricolage, as I came to understand it, was the time pressure individuals were working under. There was little or no time to think; they had to act before harm was caused. Further to this, the resources which they drew on were not physical artefacts located in the immediate vicinity. Rather, they were resources held in the form of personal knowledge and capability nestling within their physical and psychological being. In this context, age, strength, agility, fitness, co-ordination and reaction times (Andrade *et al*., 2019; Trew & Everett, 2005) seemed likely to define at least some aspect of the response. Here, I am leaning into the notion of Bricolage as central to the assembly of some form of novel, physical product. Whilst consideration of Nursing bricolage to date has tended to focus on the assemblage of knowledge (Warne & McAndrew, 2009) therefore one of the unique contributions offered by this thesis is its particular practical application. Interestingly Bui *et al* (2023) suggest that within mental health nursing 'Bricolage might be a part of 'resilient practice' which involves nurses' use of cognitive, behavioural, and emotional strategies to effectively manage challenging interpersonal interactions to provide optimal care' (p.1741). So, the notion of resilience (Foster *et al*, 2023) and mature care (Pettersen, 2012) can also be readily integrated [see Fig. 7.2/7.5 above].

When asked to reflect on their individual physicality, participants across both settings made no reference at all to *its* congruence with policy, or whether *they* followed policy, or whether they adhered to training. Comments about training and its utility in preparing them to respond physically only came to the fore when I asked explicit questions. This leads me to the tentative conclusion that

when they responded they did so in large based on their own innate sense of right or wrong, safe and effective. Of course, the impact of training messaging and the integration of cultural norms cannot be set aside, but the suddenness and pace at which responses were required, leaving very little time for high level cognition, necessitating all the concomitant adaptivity made me conclude that the organising principle was *the* person; *their* unique selves. At one end of what might be characterised as the continuum of responses represented within the accounts of participants is Emma, in her [conjectured] psychological fragility, revealing her aversion to physicality in a spontaneous ducking and running. Somewhere in the middle are Jill and Sabrina, committing to restraint without hesitation and then working through a combination of attempts to physically contain the patients, moving through a phase where they restrained each other in error, through ad-hoc sub-technique forms of restraint before finally arriving at an authorised hold. At the far end of this notional continuum there were John and Charlie, both confident amidst their spontaneously improvised physical responses. Both described assembling responses that worked, but neither described immediately resembling formal holds. Despite this, what they did they described as working effectively in preventing harm and being arrived at very quickly.

It seemed to me that Care Ethics (Gilligan, 1982) were manifested in relation to physicality in two important ways. In the first instance, within the decision not to intervene: their un-physicality. In setting one Emma ducked and ran, whilst Russell walked away after being kicked. In setting two Charlie argued for non-seclusion, Jill held off from restraining the self-ligating patient and John walked rather than physically guided a patient to seclusion [a patient who subsequently attacked him]. My reading is that the participants were acknowledging the patients' humanity, and their feelings and needs, at a time when resort to the law could easily have been used to deny such private, personal and existential needs. The situations could easily have been reduced in their complexity and framed as situations where the matter of risk was foregrounded, which would have readily legitimised some form of force. The second occasion in setting two where I felt that Care Ethics (Gilligan, 1982) and more pointedly

Mature Care (Petterson, 2012) was in evidence was within the actual application of force. Its titration appeared to me to be being made in respect to the known person, and not the perceived risk or externalised components of behaviour. All participants seemed to me to be care-full in the decision making and actions revealed through their experiences.

> Donna [Setting One]: I just don't like it. But I know that I've got to do it because it will keep her safe and it's going to keep us safe [599]

> Lisa [Setting One]: (on how she restrains Sara with care): Nobody ever sets out to hurt anybody in their care. They don't [699]

> Emma [Setting One]: You don't her <u>that</u> tight... I don't grab hold of her... because that's not the way I was taught... I'd rather do it properly than get myself in the S.H.I.T. [476-478]

> Russell [Setting One]: Not only towards Sara, but all the other peoples I've worked with other people with challenging behaviour, you've got that duty of care towards them [740-742]

> Jill [Setting Two]: Actually, when you think about it, people in general in real life annoy other people. We're not perfect as human beings, but it's about managing that. We can manage that. Whereas he couldn't manage that, you know his first thought was he's doing my head in and I'm gonna bop him one [laughs], whereas we sort of like, we'll walk away and have a bit of the moan. Whereas we manage it differently and that's about him understanding the way he should have managed it rather than the way he did manage it [422-427]

> Sabrina [Setting Two]: Obviously, it's never going to be nice to be the person who's being restrained. So, I think I always make a point of saying to the person what's going to happen… Because I think that little bit of reassurance can bring their emotional state down, and you've got more chance of them working with you [272-277]
>
> John [Setting Two]: (on doing the right thing requiring effort) Because as well as keeping yourself and your staff safe, it's about keeping the other patients safe and that patient there safe as well. So, in a sense it is tough [250-252]
>
> Charlie [Setting Two]: (on adapting his physicality to keep all involved safe] My background and what I do in my personal time, you know, helps me an awful lot. I feel comfortable adapting and being able to do something to keep myself and others safe [516-518]

In moments of personal reflection, I remember occasions when I used force, and what resonates was an upsurge in my aggression at point of force application. I would apply all the force I had at my disposal to overwhelm the other in order that I might take control, and then down-regulate my force[5]. I had assumed many pursued some form of variation of this surge strategy. However, it was absent from all accounts. This feels important to me. It seems to reveal an ethical core to what is often framed as a legally-mandated task. The participants in this study were clearly working as Street Level Bureaucrats (Lipsky, 1980) making sense of things from the bottom up. It seemed to be about

[5] I consciously refer here to aggression, and not violence. In describing how I felt in contrast to what I discerned from participants I needed to exercise reflexivity and not project my experiences onto others. In this disclosure I was describing aggression as something located within the forcefulness used, whilst I personally would see violence in this context as actions primarily taken to channel that aggression/force into actions that would carry a high likelihood of causing pain or harm. In the same way one might channel aggression into pushing an inert car or lifting a heavy box, as distinct from smashing the car or the box. The line between the two is blurred, but I wanted to be clear that I was reflecting on the strategy of leveraging the power available in the force or physical energy released within responses.

participants doing what was necessary and right in the moment, to keep the possibilities for progress, and growth or recovery intact. I understood this as ethical working.

Balancing

Despite using force, participants revealed an ambition to avert harm, revealing them to balance 'control' with 'care'. Charlie and Sabrina did use the term 'least restrictive' whilst others [Emma, Russell, Lisa, Donna & Jill] spoke of being mindful not to cause harm, with John commenting on not using harmful techniques such as strikes. I have already suggested that in some instances comments in this regard communicate something about their caring sensibility, and well as communicating something about judgement [see 'Judgment' further on]. The force used was literally in their hands, and their descriptions spoke to their commitment to a titration of it. Therefore, I felt that the force described by participants had an ethical dimension. As responders they needed to remain safe in order get a job done, wherein the interests of both parties need to be considered when titrating. Something that is in line with 'mature care' (Pettersen, 2012). My impression was that this balancing seems to cut across the whole response and not be confined to individual aspects or single techniques. This should perhaps come as no surprise, as the notion of striking an acceptable balance is present within the very fabric of care provision. Organisations commissioned to provide caring services face economic and workforce pressures which force trade-offs and comprises at every level (Kings Fund, 2020). At the street level, individuals interact with service recipients, with the delivery of care at this level being founded on people and personal relationships. The key to forming and utilising successful relationships involves finding a way to ensure the needs of both parties are respectfully served.

The study participants' balancing responses can also be interpreted as a form of boundary working, a concept used by Jacobs (1986), to refer to 'The boundary between what is me and what is not me, between self and not self' (Briant & Freshwater, 2006, citing Jacobs, 1986 p.206). This seems to take place where the physical as well as the mental components of the self and meet with those of the other, within the context of some form of temporary, antagonistic state of being. The presence of physical antagonism, even physical hostility was clearly in evidence:

> Russell [Setting One]: I've been the key de-escalator. Sometimes it's worked. Sometimes I've got a kick in the balls [735-736]

> Emma [Setting One]: If I'm completely honest, she bloody hurt me. She really got her fingers in there and it definitely made me wince [239-40]

> John [Setting Two]: And then the patient leapt off the door and just Superman punched me [425-426]

> Charlie [Setting Two]: As soon as I went out the office door and told him that, he ran at me, he punched me maybe three or four times [466-467]

What marks these events out is that an attack seems to be the precursor to the subsequent restraint. In such moments it is possible to see how the assaulted staff member might seek to assert non-negotiated control, dominate or even punish rather than to find ways to express one's actions in caring ways. The potentially imbalanced 'me' that may be hijacked by heightened emotions, anger or adrenalin [see Feelings & Emotions'] seemed to make way for the more balanced 'we' under the auspices of some form of self-regulatory inhibition (Vohs & Baumeister, 2004). As was elaborated

upon in the theory chapter, caring actions that are founded on the singular rights of the caring agent are what Pettersen (2012) has described as egotistic, whilst those concerned only with the rights of the recipient [or 'other'] are labelled altruistic. Both can be incommensurate with the consistency care organisations seek to provide, as well as being psychologically unhealthy for all involved. The represent the extremes. The egotistic carer foregrounds their needs. This can be witnessed in the carer who cares performatively, in order that their actions might register in some way with others, thus embodying what is sometimes described as a saviour complex (Davis, 1988). There is also the individual who prioritises their own self-care, which degrades their ability to participate fully in the care of others, an inclination which when taken to the extreme has been described by nurses as 'indulgent' (Baker, 2022). By contrast the altruistic carer abrogates any self-interest and sacrifices their own rights and needs in service of the needs and rights of the other. Recently, awareness has grown around 'pathological altruism' where altruism in extremis compromises patient care and practitioner health (Sajjad *et al*., 2021). There is therefore a balance to be struck, what Pettersen (2012) referred to as a golden mean. This draws upon the thinking of Aristotle (1908), who argued that a virtue was the mean between two vices.

The various policies, such as they were, made it clear that restraint was not the answer, rather an emergency measure which must be handled with care, hence a need to balance actions. In setting one it was Mum principally who looked on to see if this is happening, whilst in setting two the number of incidents must be publicly declared (NHS digital, 2018) as well as coming under local scrutiny. To my mind the wider anti-restraint discourse undoubtedly has the power to make staff reflect more deeply about the necessity and nature of restraint, or more specifically to think about whether it is really needed. However, in the context of the narrative around balancing I would suggest that it succeeds in elevating the rights of patients and responsibilities of staff but does little to amplify the rights of staff or responsibilities of patients. At a strategic level this represents an imbalance.

Mature care (Pettersen, 2012) integrates the mental and physical needs of both parties, which need to be balanced against one another, and a golden mean found. This must include a need to avoid pain and injury. As part of this process the physical selves of staff need to find equilibrium with the physical selves of the patient or service user. The harmful potential of grabs, holds, punches, pushes, pressure, kicks and containing physicality need to be offset, and thereafter reduced. In this reduction the mental needs and once again prioritised and served. John made an incidental comment:

> You can't run [and] rugby tackle someone, obviously because that's just bizarre! [laughs] [310-311]

The fact that John appended his statement with 'that's just bizarre!' and laughter seemed to me that he was making an unstated point: don't be ridiculous that could never be countenanced in any circumstances. There is a clear unspoken recognition of a prohibition on certain actions. No such constraint exists within the context of a violent event occurring outside of the work setting. I think its existence is significant. It seems to suggest that there are certain raw, unrefined and instinctive forms of physicality that are beyond immediate consideration. Whilst such physicality may have been mentally set aside prior to any use of force event, the point where the implicit resolve required to hold such physicality in abeyance would seem to be most likely be tested at the point of attack [as revealed above].

These ideas are summarised in Fig 7.7, where all three forms of care identified by (Pettersen, 2012). In the depiction of altruistic and egotistic care, the single arrows signify a very singular direction of travel to an end point state that serves the carers or cared for person's needs. In the final image, depicting mature care, the unidirectional arrow is replaced by a spiral one that repeatedly transects

all four quadrants. It passes through the mental and physical needs of both parties, symbolising how both parties' needs are considered as care is formulated. The pragmatics of that balancing are individually mediated and involve attenuating the 'Feelings and Emotions' as well as the 'Physicality' which were both previously spoken to.

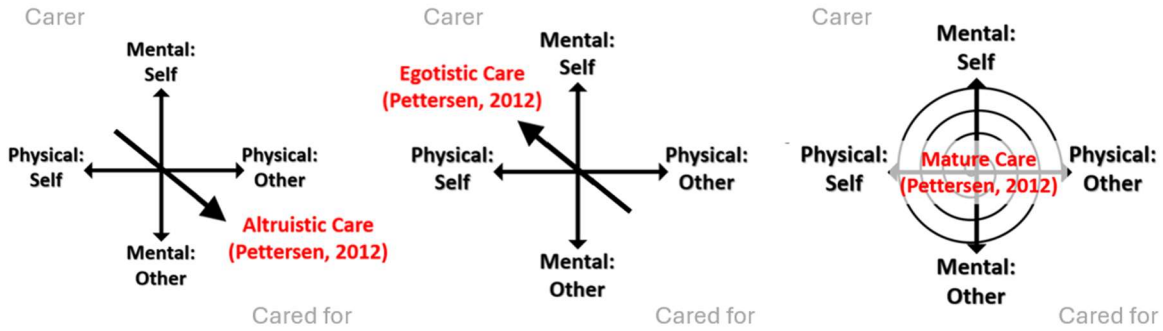


Fig 7.7: Visual representations of the three forms of care described by Pettersen (2012)

Sensemaking

The preceding chapter spoke to balancing responses. This would seem to me to be something that follows on from this. Sensemaking is a term used to refer to the process of 'structuring the unknown' (Waterman, 1990, p. 41). This is accomplished by placing that unknown *thing* into some form of organising framework which permits the sense-maker 'to comprehend, understand, explain, attribute, extrapolate, and predict' (Starbuck & Milliken, 1988, p. 51). Unlike the balancing that was previously mentioned, sensemaking as spoken to here takes place after the event as opposed to within it. There is no time I the moment. It is the act of sensemaking that allows us to take complexity and bring some form of intelligibility to it, enabling to us to move forward more confidently via the sense that it makes or brings (Weick *et al*., 2005). In practical terms this seems to have been attended to by study

participants through a mixture of personal reflection, group processing and sometimes one-to-one discussions.

> Emma [Setting One]: Just chatting about the event. How everybody feels. You know... What we could have done differently? What went good? What we think could've caused the incident? You know, different things [579-580]

> Jill [Setting Two]: You're probably quite elated at the time, because you sort of just come out of a restraint, your adrenaline's going to probably quite elated. But I think sometimes as well, if you've got quite a lot of questions that you feel in your head need answering. It's probably just feeling like a little bit confused, maybe and then you and then it. Once you've spoken about it, you probably sort of calmed down and feel a lot more relaxed and able to carry on [625-629]

The finding across both groups was that this was a desirable component of the overall task, although workforce pressures, and to a lesser extent the trust placed in thinking partners (Zacka, 2017), conspired against accessing structured opportunities to do so. In setting one staffing issued precluded Emma and Russell getting the opportunities they wanted, and in setting two John spoke for those he felt were unable to speak to just anyone [a 'randomer']. One may ask why such processing seems necessary. A partial answer is articulated by John when he said what he experienced was not 'normal'. Elsewhere in setting two Charlie said he left work having lived through the 'surreal' and on working in a new service within the unit Sabrina said, 'It was a normal day for them. But for me I thought 'Oh shit! This is quite bad'. In setting one Russell alludes to the abnormality of his workload, 'anything can happen at any moment, and this is what makes the job so difficult'. My sense was that this held true for all participants. Facing hostility, encountering violence, and being forceful towards others, are not

ordinary experiences, and certainly not desirable ones. Elsewhere, workers stack shelves, provide hospitality, cut hair and prepare food. All these, by comparison, are safe and mundane work tasks [and represent what the participants in setting one did before becoming support workers]. As far as I could tell all those in setting two were career healthcare professionals. But this does not preclude them from having normal lives outside of work. To my mind all participants had a sense of normal against which un-normal or ab-normal experiences could be compared. As a result, all the participants spoke to some form of sensemaking that took place after events. As they returned from the ab-normality of what had taken place within their responses, to where they existed day-to-day, their relative comfort zone.

Within the participant experiences, the opportunity to make sense of things [most notably through some form of conversation] was available and engaged with in different ways. Russell stated he saw a the time to process or collectively reflect as something as a value adjunct, and a defining feature of a well-structured system of care but indicated he did not get access to one, 'There's no trending, no... "Well, what do you think then Russell?". We don't sit and talk'. Emma appeared to need one to process her experiences but was not getting enough opportunities to do so due to staffing shortages at the time of the data collection, 'at the moment there's not enough time to do that'. Donna, John, Jill and Sabrina all used the opportunities they got to sort through their experiences and understand what happened. Sabrina indeed championed them. Charlie recognised the value, but to him it was the quality and integrity of what was on offer that mattered most. The reason for this was that things were said, and he felt judgment could be drawn if people did not understand the experiences, and they themselves were not able to orientate within the abnormality. He referred to candid expressions of feelings made to him by a colleague, 'what the fuck? How am I going to do this?', and the use of humour to offload, 'off the back of scarier, or more serious incidents'.

One of the requirements of sensemaking would seem to me to be that people are honest about what happened to them. To talk through what they did and did not do. What they thought and felt, in all its raw and unfiltered uniqueness. Accounts of all participant experiences included a great deal of information about what happened and how it made them feel. What held true across both cohorts was that the discussion of these experiences was not something that people could talk about in abstracted terms. Accounts were rich, and descriptive and personal. Words mattered. Exemplar excerpts from the case studies, include Lisa in setting one, 'She just went loopy. She really went off on one. There was punching. There was pinching', and John in setting two, 'when you face with someone who literally wants to like, rip your head off' [266]. Such verbal intensity seems to me to be important in the expression of a personal truth, to convey the strength of attendant feeling. In this sense it seems to have something akin to a venting function. I am however minded to the current sensitivities around language. It is conceded that such phraseology could be construed by others as victim blaming, revealing unconscious bias, acting as an antecedent to the horn effect (HTHC School of Public Health, 2022), or even as a form of 'epistemic violence' (Siva, 1988). I cannot preclude such possibilities. I also feel that in moments of high emotion the language servicing the situational expression can get away from us. People are only human. My sense is that amongst some very well-intentioned commentators that such language is indicative of indifference towards those in their care, making them less cared for 'others' (Akbulut & Razum, 2022). My reading of participant experiences did not bear this out, although such third-party judgements did seem to be experienced by participants [see next section].

Judgement

Testament to the judgment of others was most clearly voiced by Charlie, in setting two. In his PET 'I believe We Are Wrongly Judged', he chose to forcefully reject the judgements of commentators, when speaking of his experiences discussing restraint with fellow university students. As previously stated,

the determination that restraint was 'barbaric' seemed implicitly condemnatory of staff, further tainting those already considered to have failed in person-centred care planning (Bauers & Dzikiti, 2023) and being somehow derelict in providing the treatment which ultimately necessitated restraint (Knox & Holloman, 2012). The feeling that judgments are made by those who are not present, along with the pre-condemnation of actions yet to be taken has been discussed in preceding chapters. There was convergence on this matter across settings, with a defensiveness discerned with the unsolicited comments that were appended to descriptions of the responses [covered above in the section on 'Physicality']. To my mind, having analysed all the accounts, is that the proffered caveats are driven by the matter of indivisibility, which is implicit within the generalised judgement located within the anti-restraint discourse. Quite simply, the person who responds physically is indivisible from the act of physicality. In much the same way, the *doing* of CPR is indivisible from the *being* of the rescuer. Restraint has no independent existence, it is assembled or brought into being by the doing of the individual. To applaud the act of resuscitation is to applaud the resuscitator. Therefore, to condemn the act of restraint is to condemn the restrainer. My impression is that participants in their defensive descriptions were seeking to mitigate the judgement that was anticipated from outsiders.

Much is therefore at stake in the interpretation of events. The interpreter may, as I have tried to do, set out to apply the hermeneutics of *understanding* (Larkin *et al.*, 2006; Smith, 2004) but equally may resort to the hermeneutics of *suspicion* (Ricouer, 1970). The point Charlie seems to have been making, which was lightly echoed in the accounts of other participants, was that the practice of restraint is something that invites critical interpretation and invariably judgment, with the restraint in question being seen or unseen. To my mind scrutiny is only right and proper, and all actions should be judged, with staff being held accountable for any improper or unnecessary use of force. But this is something to be done on a case-by-case basis. What seemed to be underwriting participant discomfort and defensiveness was that judgements were rendered sight unseen, and accounts unheard. There was in

effect the operation of a pre-judgement, that restraint was inevitably and invariably bad or evil (Wilson *et al.*, 2017, Perkins *et al.*, 2012; Ockwell, 2007), along with calls to eliminate it, which to me seem overly simplistic, and make staff who do have to restrain somehow complicit in that *thing* which to the minds of many should simply become an un-thing. This study findings offer a new insight into the complexity of staff sensemaking and responses. These actions, taken in difficult circumstances, amounted to defining policy-in-action (Lipsky, 1980), aspects of which have been touched upon throughout this chapter.

Conclusion

There seemed to me greater formality embedded in setting two, with more highly developed systems and processes in place, as well as a professionalised and regulated workforce. Despite this and the obvious differences between settings, the experiences of both cohorts were remarkably similar. All the foregoing elements were present in both spaces; relationships were key, mixed emotions surged as situations escalated, unhelpful thoughts and feelings were held in abeyance as was any aberrant physicality whilst the participants sought to assert some form of pragmatic control over a complex and unpredictable manifestation of behaviour, that often-constituted violence. The physicality in both settings diverged in various ways from the techniques that were authorised. Looking back at the cross-setting analyses what comes through is the very human aspects of responses. People's distinct individuality seemed central to how responses were formulated, with a form of pragmatic balancing central to this. In the wake of dealing with situations that sit outside of the norm, all participants spoke to a need to make sense of their experiences, which included naming clearly and honestly what had happened.

Chapter 8: Discussion & Conclusions

The Study Research Questions

The foregoing analytical chapters have sought to answer the previously stated research questions:

> **RQ1**: How do staff experience the events that constitute a 'response' to behaviours of concern: their own thoughts, feelings, reactions and responses, and the context within which this all takes place?
>
> **RQ2**: In what ways do the practices disclosed within participant accounts align with those expected responses identified within guidance, such as policy documents and staff training programmes?
>
> **RQ3**: What conclusions (if any) can be drawn about these practices and the presence or function of the organisational primary task?

Arriving at a Sense of meaning & Understanding

Street Level Bureaucracy (Lipsky, 1980), Care Ethics (Gilligan, 1982) and Primary Task (Rice, 1963) were used to create a sensitising framework allowing the lived experiences of study participants to be explored. This framework can be seen in Fig 8.1, with the issues identified for discussion appearing on the frameworks' canvas. These cohered at three levels, the discursive, the organisational and the individual.

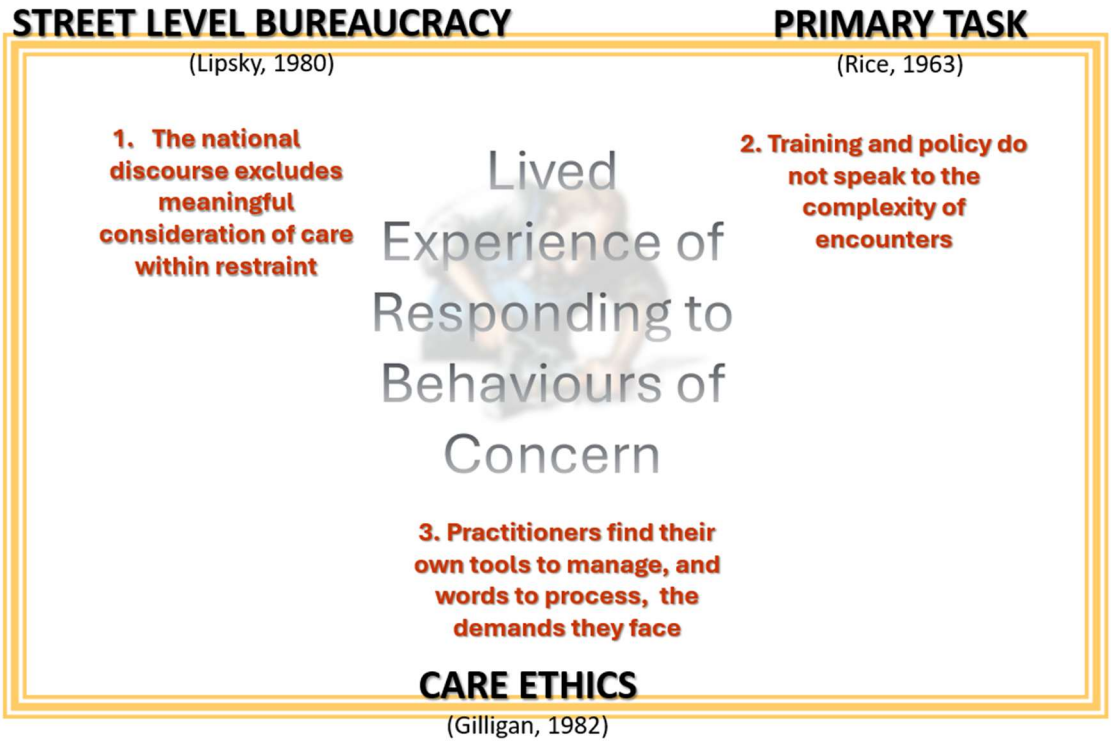


Fig 8.1: The sensitising framework and those areas for discussion

Within the national restraint discourse an anti-restraint strand (EHRC, 2019; UN CRPD, 2017; Duxbury, 2015), which often merges within the restraint reduction is discernible. The study findings suggested to me that this seems to inadvertently conspire against the recognition of care within restraint. This was discerned within comments made by all participants whose experiences also suggested that organisational policy, and training, did not speak to the complexity of the events they faced. The sudden, disorienting and often violent nature of incidents required individuals to quickly self-author responses which attempted to balance care with control. Participants spoke to their individual need to process experiences and make sense of events that were outside of the norm. Without an opportunity to do this, the words to express thoughts, feelings and actions, and the freedom to do so without judgement, personal and professional growth seemed precarious. In arriving at the essence of the participants' experiences a range of concepts spoke directly to what I had found, with 'Bricolage' (Levi-Strauss, 1962), 'Mature Care' (Pettersen, 2012) 'Self-Regulation' (Vohs & Baumeister, 2004) and

'Resilience' (Foster *et al.*, 2023) combining to create what I am referring to as 'Street Level Bricolage' [Fig 8.2].

Fig 8.2: The essence of the response experiences located within 'Street Level Bricolage'

The national discourse excludes meaningful consideration of care within restraint

Within the participant experiences, the findings seems to speak most directly to RQ3: 'What conclusions (if any) can be drawn about these practices and the presence or function of the organisational primary task?'. Responding to behaviours of concern brought staff members into direct contact with the person whose needs they served. The resulting interactions threw up an array of practical challenges and ethical dilemmas. The individual commitment to the Primary Task (Rice, 1963) appears to have imbued responses with care in such moments.

Primary Task: Often Undeclared but Fundamental in Practice

The notion of 'Primary Task' (Rice, 1963) as discussed in the theory chapter, speaks to an organisation's 'reason to be', with Lawrence (1977) providing a framework that can used to identify those psychodynamic variables which conspire to undermine the attainment of the task (Menzies-Lyth, 1974; Menzies, 1960), which can aid this discussion. The study settings appear to be governed by similar primary tasks, which I have formulated by drawing on shared information and study data:

- **Setting One:** Providing an opportunity for a normal life to a single supported person at home
- **Setting Two:** Providing an evidence-based programme of treatment to a variety of patients held under the MHA

Both are care-oriented, with the second seeming to me to be more medicalised through the treatments offered, although like the support provided in setting one, mediated through relationships that take time and effort to develop. As expected, there is no explicit reference to a primary task in any of the key policy-related texts made available [see appendix 13], however the contents of participants' experiences revealed something about the presence of an overarching mission that is summed up in the articulation of primary tasks, above. Whilst local, second order response policies were present in both settings, these seemed to be more technically or rationally oriented (Whan, 1986) meaning they are primarily focused on techniques and procedures founded on workers' processes of reasoning, whilst participant responses were found to be more practically and morally orientated (Ruch, 2005; 2002), something that places formal theoretical knowledge alongside personal, tacit, and intuitive ways of knowing, permitting them to be synthesised or integrated. This is something acknowledged in the practice space (Ruch, 2005). I believe it is significant that

participants revealed that they were required to, and could work simultaneously with different forms of knowledge, often very suddenly and when the stakes were high. They very quickly found ways to respond to concerning behaviours that were not explicitly covered by policy or training, in ways that upheld the Primary Task (Rice, 1963).

Discourse Creates Doubt

The impression I formed was that participants committed to trying to do right by others in moments of crisis. Accompanying this was a sense that such actions, and the declaration of participation in such events, was difficult. The act that they were participating in [and the *experience* I was exploring] seemed to have been rendered un-good or un-caring by the prevailing anti-restraint discourse. Participants spoke in ways that indicated to me that they felt scrutinised, with one explicitly stating that they felt unfairly judged by individuals who are not present and did not share the *same* lived experiences. This discourse, as an abstracted conversation, by its very nature is often speaking to restraints in an abstracted form or which haven't occurred or been witnessed, frequently relying on exceptional past cases to define expectations, that restraint is invariably 'frightening', 'disempowering' and '…an extreme response [that] can be humiliating, cause severe distress and at worst it can lead to injury and even death' (MIND, 2013 p.3). Of course there will be uncaring, coercive and harmful staff actions, but I do not think every single one is destined to be so. I would argue that the thoughts and feelings arising from these judgements have a direct impact on how staff feel and preclude any open and meaningful discussion around the actuality of what is taking place thousands of times a month across the country (NHS digital, 2018). These difficulties, presented within individual case study analyses and foregoing chapters, are summarised below [Fig 8.3 & 8.4], using Lawrence's (1977) framework to illustrate the impact on staff for discussion purposes. The two tables contain the

normative, existential and phenomenological readings of the primary task in each setting, which I will elaborate upon.

	SETTING ONE
OVERALL PRIMARY TASK (Rice, 1962)	'Providing an opportunity for a normal life for a single supported person at home'
Normative domain (Lawrence, 1977) of specialist sub-task: responding to behaviours of concern	**Keep Sara safe, support best interest procedures, and avoid any harms**
Existential domain (Lawrence, 1977) of specialist sub-task: responding to behaviours of concern	**Use of force on a friend, family member and a mother's child**
Phenomenal domain (Lawrence, 1977) of specialist sub-task: responding to behaviours of concern	**Engage in reluctant and upsetting but necessary action. Just get it done and quick**

Fig 8.3: Primary tasks for setting one, in respect to responding to behaviours of concern.

	SETTING TWO
OVERALL PRIMARY TASK (Rice, 1962)	'Providing an evidence-based programme of treatment to a variety of patients held under the MHA'
Normative domain (Lawrence, 1977) of specialist sub-task: responding to behaviours of concern	**Upholding National and Organisational Policy, Keep everyone safe**
Existential domain (Lawrence, 1977) of specialist sub-task: responding to behaviours of concern	**A treatment failure and publicly visible coercive act**
Phenomenal domain (Lawrence, 1977) of specialist sub-task: responding to behaviours of concern	**A professional and balanced response, necessary but ethical**

Fig 8.4: Primary tasks for setting two, in respect to responding to behaviours of concern.

If an organisation is constituted to care, in those circumstances where users of its services are in distress and/or presenting with concerning behaviours, care should logically come to the fore. In such circumstances arguably more care is required, not less. To my mind, what Lawrence's (1977) layers of the primary task allow to be revealed is the uncertainty present within participants' attendance to this specialist sub-task. As one reads down through the table above, these summary rendering of setting specific types of primary task seem to speak increasingly to a subtext which centres on what staff feel

they are not allowed to do, thus denying the acknowledgement of those actions within which care can exist.

The first aspect of the primary task is the normative aspect, the element most congruent with the organisation's stated mission (Lawrence, 1977). In the case of setting one this would be its funded purpose [locally defined] and setting two its commissioned function [nationally defined]. Both examples of this normative sub-domain clearly lean into an aspiration to care, but I am using somewhat perfunctory language to articulate them. This represents a guardedness on the part of staff, which was discerned within all accounts. It speaks to a caution in making any public disclosure implicating them in the act of restraint. Whilst a staff member might reveal participation in tasks construed as physically dirty [bagging soiled bedding, attending to intimate care, taking blood and such like] (Hughes, 1951) the *morally* dirty task of restraint felt to me like it is was reluctantly revealed.

The existential aspect of the primary task arises from 'the many and various motives for, and meaning of, the work for whose individuals engaged in doing it' (Bradbury, 2021 p.5). When talking to this aspect of the primary task, participants seemed keenly aware of the anti-restraint discourse. In the table, the task descriptions are infused with a growing sense of discomfort, and a sense of guilt over failure. This reflects how, in their accounts, participants seem to have absorbed the circulating rhetoric which I understood as their burden. In the tone of these descriptions, one may be minded to a defendant making a public disclosure that is self-incriminating. Whilst no legal evaluation was undertaken, a sense of guilt seemed to prevail. Jaspers (1947) identified four forms of guilt. The criminal and political forms speak to the consequences of breaking the law and of failures at state level respectively. *Moral guilt* spoke to transgressions of personal conscience, where we break our own individual codes. It is perhaps the guilt in its final form, *metaphysical guilt,* which has relevance here. This, according to Jaspers (1947), arises from transgressing the universal solidarity between

human beings which exists beyond the limitation of self, family, or nation. Whilst Human Rights law seeks to legislate this inviolate responsibility towards others, it is suggested that those who care, feel *with* and *for* others, and do so without need for legal compulsion. As a result of care within restraint being discursively denied, staff seem to be left conflicted. What they do in good faith is now tainted and cast as wrong, giving rise to the possibility of feeling guilt.

Finally, the phenomenal aspect of the primary task is one that can be inferred from the behaviour of those within the organisation, revealing the 'what' that staff do (Lawrence, 1977). While I can only draw on what a small number of participants [n=8] have to say about this phenomenon, a sense of caring mission was apparent in their experiences. As a result, the phenomenal components of the primary task have been described in such a way as to provide a sense of caveated engagement. This speaks to a form of doubt that the national discourse seems to have instilled, flowing from the forgoing caution and guilt. However, what the condemnatory discourse cannot do is prevent staff from *having* to respond to situations where harm *is* being caused/imminent, and action *is* required. The study participants provided accounts of their experiences of striving to do the right thing, and of doing so from both a personal and professional place of care. I recognise that this study involved me as someone who was not present during events imposing *my* interpretation of *their* experiences. The two important caveats are that I have arrived at my determinations following a very rigorous and transparent process, and that I am clear that my claims are tentative rather than immutable.

There is no certainty to the efficacy or safety of restraint (Aiken *et al*, 2011). It seems however to be further destabilised by denying it as a caring task. Were this to be acknowledged, a legitimate goal would therefore be to find ways and means to make it more caring. It has been said that the age of restraining *well* has yielded to restraining *less* (BILD, 2017). Less, of course, should remain the prime and enduring ambition. My opinion, however, is that less will likely never become zero. As restraints

diminish, it could be reasonably argued that what will remain are those deployed in the face of the most extreme manifestations of behaviour leading to the most complex restraints. Therefore, the contents of restraints must surely remain something that organisations must strive to improve upon and minimise (RRN, 2021). The reference to restraining *well* can perhaps be interpreted as code for *safely*. It was posited at a time when restraint related deaths were very much public health concerns being widely scrutinised (South London Coroners Court, 2017; Norfolk, Suffolk & Cambridgeshire Strategic health Authority, 2003). To my mind there seems to be something that lies between 'safely' and 'less', but which does not amount to therapeutic. Claims to any therapeutic value to restraint have been rightfully opposed (BILD, 2017). The relationships curated allowed for therapeutic working to take place, but the restraint itself does not directly serve any therapeutic goals. Rather it was something that needed to be attended to carefully to preserve future therapeutic possibilities. What participants appeared to be endeavouring to do was their best to restrain with care, in a way that preserves such future possibilities. My sense is that forceful interference that is ethical, only takes place when it was necessary [lessening its incidence] and must be safe to all.

There are injurious and fatal restraints, but these are distinct from those which are not. Undifferentiated blanket statements appear to have resulted in a widely accepted truisms, that restraint is invariably bad or injurious, and those restraining are complicit in some degree to bad or injurious actions. Such statements are more readily made when the interventions are framed as paternalistic or coercive, however Chieze *at el.* (2021) suggest that concepts such as relational autonomy, put forward within care ethics (Gilligan, 1982), allow for such definitive characterisations to be revisited and revised. Elsewhere, were one to make tenuous or unfounded generalisations in relation to a defined cohort of people (albeit by implication), which resulted in them experiencing unfounded adverse judgment and potential castigation, one might be accused of othering (Akbulut & Razum, 2022). Rather than assert this, I am simply suggesting that such public or professional

discourses can have real world consequences. According to Baumeister *et al.* (2001) 'Bad impressions and bad stereotypes are quicker to form and more resistant to disconfirmation than good ones' (p.323). This perhaps explains why the worst-case restraint scenarios such as George Floyd, Seni Lewis and Rocky Bennett are used to exemplify restraint within the anti-restraint discourse.

A Need to Name My Experience and Be Heard in My Own Right

The words used by participants seemed to be an important aspect of unpacking their lived experiences. The term 'Behaviours of Concern' did not seem to serve them. Ideological concerns over the power of words such as aggression and violence, along with more trauma informed perspectives, have led to such terms being slowly outmoded. Understandable as this is, it seems to deny the lived reality of staff and the tools to describe *their* experiences. Participants tended towards explicitly naming the behaviours they encountered: having fingers bent back, being kicked in the groin, experiencing 'punches to the face', 'attacks', and witnessing 'self-injury'. This naming seemed necessary to share their experiences and process their impacts. Talking about a punch to the face and the anger it caused was not for Charlie to malign a patient but to allow him to explore his actions and inactions. To assert that Sara kicked him in the groin allowed Russell to reflect on strategy and the role of colleagues. In both instances calling the behaviour what it *was*, did not seem to me to be an attempt to reduce the individual to a singular piece of behaviour or to dehumanise them. The terms violence [Lisa, Russell, Charlie, John] and aggression [Russell, Charlie, Sabrina, Jill & John] were used to describe behaviour participants faced. In and of itself the use of such language does not seem to inevitably create a slippery slope wherein culture and practice degrade. Such a claim would seem to infer that the use of particular words or language is causal to moral and practice decline. I readily accept that a culture that places little or no value on the service recipients may well be marked by language which reveals indifference or low regard. There were exceptions in setting one that involved loose language,

however examining them with the context of their whole accounts and greater experience, I felt able to exclude them as anomalies, as not representing any fundamentally toxic mindset or revealing a detrimental pattern of thinking that tainted practice. [6]

The Whorlton Hall scandal (BBC, 2019a), reveals something about the power of words and language. Support workers were filmed referring to the service being the 'House of Mongs', as well as verbally goading patients, and explicitly threatening them with violence. In a further instance a staff member made repeated references to balloons, which the patient was known to be fearful of (Julian, 2024). Here the language and words seem to be selected very specifically to reveal active disdain and evoke feelings of fear and distress in patients for the purpose of staff entertainment. This language speaks to how they are symptoms of a corrupted culture (Paterson *et al*., 2013). There seems, in the use of these words, to be a combination of intent to harm and indifference towards those in their care. I wholly recognise the power of words and am not dismissive of the importance to be mindful of them. I have mentioned and am also briefly reminded of a protracted discussion with my supervisors about the use of the name Mum. I chose to use it as it honoured the word choice of all participants and Mum herself in setting one. Yet, it is recognised as being a word that for others can cause a level of offence (see Method chapter). In some instances, words can be selected because they are accurate descriptors, and should not be read as markers of indifference, or that they are used to convey an unpalatable agenda. Of course, such an assertion can never be made categorically, and it is only right that words are checked and challenged. In this instance I believe they provide the means for staff to name accurately what it is they have experienced. If the critical judgement on the use of language

[6] Russell said, ''You can have a dog for five years, but you can never trust it. It can always bite you'. This was a clumsy way of indicating that Sara would always be capable of harming staff. I discuss in his analysis chapter. Lisa referred to witnessing 'evil' behaviour. This was an historic reference to seeing Sara seriously injure her mum. That such inelegant asides took place in setting one perhaps reveals something about a setting where roles are yet to be professionalised, and where individuals often arrive from other distinctly different occupations wherein language is not so critically examined. Outside of these remarks both participants demonstrated a warm regard for Sara and spoke of actions commensurate with elevating her rights.

takes place at the expense of a consideration of what happened and attempts to find ways to care, crucial opportunities to learn, grow and improve may be lost.

Training and policy do not speak to the complexity of encounters

To me this spoke most directly to RQ2: 'In what ways do the practices disclosed within participant accounts align with those expected responses identified within guidance such as policy documents and staff training programmes?', but also to RQ1 [see discussion point 3]. Responding to behaviours of concern is a complex, and emotional endeavour. Staff have reported being troubled by the act of physical intervention (Kodua *et al.*, 2023; Cusack *et al.*, 2018; Wilson *et al.*, 2017) and to recognising the potential for harm (Kodua *et al.*, 2023). Along with growing calls to eradicate (UNCRPD, 2017) and eliminate restraint (PRERG, 2022), staff are now becoming increasingly familiar with the notion of restraint reduction (Doh, 2oH, 2015, 2014, MIND, 2013). As a result, it has become increasingly difficult to talk about restraint techniques, particularly as a potentially positive intervention used to avert harm. They do exist, meaning something is required to attenuate the anxiety their presence evokes. Steps to attenuate such anxieties include authorising precisely defined techniques, which have been scrutinised, risk assessed ahead of use by 'clinicians', and then second reviewed by others 'with significant experience…' (RRN, 2021 p.43), however what I have discovered as part of this study is that such prescriptiveness seems illusory. What participants experiences spoke to was their need to refine and redefine physicality, as the prescribed techniques were often forgotten or difficult to immediately operationalise.

Local policy and training [the organisational response policy], were introduced in the theory chapter. They are ostensibly top-down texts, premised on an implicit assumption that the techniques will hold their integrity at the point of implementation. As was explained, the implementation of such texts is founded on an array of 'Discipline and Control' arrangements', governed by the application of 'Technical Discretion' (Zacka, 2017). All of this seems to characterise the practice in an unrealistically prescriptive, and perhaps more hopeful than honest way. This study has shown that the policy implementation space is effectively a street level bureaucracy (Lipsky, 1980), where interpretation is made from the bottom up, through Street Level Bricolage. That there would be field modification (Paterson, 2007) was my expectation coming into this study [see Appendix 29]. However, I think my prior assumptions, meant I was expecting participants to lean into the legally delegated authority that allowed them to determine what reasonable force was required in the circumstances (CPS, 2022) and surge strategies as was my experience. I think that simply seeing this bottom-up implementation as a corollary of reasonable force was much too simplistic and reductive. Reasonable force is the amount required to nullify the threat being posed, with the *other* in the equation being limited to their capacity to cause harm. The responses disclosed by participants reflected that the person presenting behaviours of concern was treated as a whole person and not just reduced to their harmful parts; they were cared for. The study participants' accounts reflected their attempts to find a way through the temporary, external aspects of behaviour to connect with the totality of the individual.

All but one participant spoke of using force. The imposition of physical control appears to be an unwanted aspect of the job; 'necessary *control*', rather than 'necessary *evil*' (Wilson *et al.*, 2017 p.500, Perkins *et al.*, 2012 p.43 and Ockwell, 2007 p.48). It was used by participants to prevent self-injury [Sara picking an open wound] but mainly to prevent other-directed harm [aimed at another patient in

setting two, and staff in both settings]. These responses involved staff members imposing pragmatic forms of restrictive physical intervention (DoH, 2014), holding arms and legs to limit the individual's ability to cause harm. The participants were clear that their use of force was to protect and keep safe. This included the protection of the individual whose behaviour necessitated the intervention [e.g., Donna], the patients immediately affected by the behaviour being intervened in [e.g., Sabrina and Jill], as well as those making the intervention [e.g., John and Charlie], the initial subjects of violence. As the seconds passed, the instinctive initial dampening actions of the personal self, appeared to give way to a more intuitive response, as the professional started re-emerging. Participants spoke of finding themselves engaged in a hybrid form of holding, based on individual knowing. This often bore a resemblance to a more formalised hold but did not amount to one. This seems to be a form of field modification (Paterson, 2007) wherein a close approximation to an approved or known hold is used to 'make do' in the circumstances.

Active de-escalation seemed to commence after the initial physicality had found pragmatic coherence. This may only have taken seconds but was a distinct stage when a dialogue seemed unfeasible, so intense were the efforts to stabilise the situation. Having damped down the harmful potential, time and space seem to have been created within which staff had more capacity to invest in assembling a functional and potentially mutually beneficial dialogue. Control, such as it was, was careful and necessary to enable core care to continue. It is therefore argued that such responses meet the definition of care provided by Tronto (2010) 'a species of activity that includes everything we do to maintain, contain, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment' (p.3)[7].

[7] Physical restraint [or the use of force] as described in participant accounts has been interpreted as an act of care. Accounts have revealed it as a physical expression by the individual staff member of their organisations Primary Task. More prosaically, in the NHS Digital dictionary (2024) 'Physical Restraint' as an exemplar of a 'Restrictive Intervention' is defined as 'Care Activity', which itself defined as 'The provision of an individual instance of care to a PATIENT given by one or more CARE PROFESSIONALS'. Were one to stay with technical definitions, its function, to prevent harm and to facilitate treatment could conceivably see it characterised as a health intervention. According to the International Classification of Health Interventions (ICHI) 'A health intervention is an act performed for, with or on behalf of a person or a population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions' (Klaic *et al*, 2022 p.3).

In contemplating this care-in-action, I found myself thinking about force itself, something which is part of every restraint. Compassionate Interference (Verkerk, 1999) offered a way to frame relationally negotiated autonomy, meaning that third-party interference was not inevitably wrong. It could be just and even said to expand an individual's autonomy as well as keeping those involved safe. I came to think of this as reducing the certainty with which restraint is understood as invariably bad or morally wrong. In thinking about force within the context of caring actions, I again reflected on the implementation of first aid principles. Here various manual procedures are vital to the preservation of life. Whilst typically applied consensually, they can be applied non-consensually to inert, confused and even combative casualties, with resistive behaviours rooted in pain, intoxication, traumatic head injury, infection and such like (Tindall, 1990; Wang *et al.*, 2021). The manoeuvres themselves include the manual assessment of the body mediated through touch, squeezing and exploring body contours, the head tilt and chin lift, the recovery and shock positions, the repositioning of limbs, application of bandages and use of tourniquets (Minna *et al.*, 2022) as well as casualty removal procedures (ICRC, 2006). These applications all involve some form of titrated force, often amid the moments when the recipient is overwhelmed. Here force and control, as within restraint, is a temporary practical interference in the lives of others for the purposes of preserving their future right to assert singular autonomy [Fig 8.4]. In assembling this argument, I am aware of the risk of leaning into euphemism or doublespeak (Wasserman & Hausrath, 2005), a practice in the restraint training space which has been critically exposed (Fabian Society, 2013; Paterson *et al.*, 2009). First aid should never be a cover for unnecessary force. Force however can clearly be required in first aid, necessary to affirm life: it can be caring[8]. Without the taint of being morally wrong, first aid brings into clearer view the potential mingling of care and force in some situations.

[8] April 2025. A family friend went into anaphylactic shock following the consumption of food containing undeclared peanut oil. She found herself unable to administer her epi-pen due to fear of needles. Despite declining respiratory function, she attempted to prevent a first aider from doing so. The first aider overrode these objections and successfully 'stabbed' her with the 'needle', thus averting a life-threatening event. On reflection the friend admits desperately wanting to administer the medication, but that fear stopped her. She and her family are effusive in their praise for the first aider, who in their opinion 'did the right thing'.

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Fig. 8.5 Forceful physicality within first aid: A zookeeper pulls colleague to safety when he is bitten by a lion, a Police officer uses the Heimlich manoeuvre on a choking casualty, a passenger is pulled from under a moving train, and a soldier carries a wounded colleague.

Self Defence Does Not Always Equate to a Form of Counterattack

In respect to force, six participants spoke to experiences of responding to direct and unexpected violence. The function of naming the behaviour as such has been previously discussed, however the need to respond to violence does not seem to me to be fully, formally recognised within the wider national policy landscape. The number of restraints in NHS commissioned services are publicly visible via NHS Digital (2018), whilst those in the home are not. Those publicly declared physical restraints are not accompanied by the reasons why. There is a danger then that events are read as restraints solely in response to behaviours of concern [behaviour expressing an unmet need] and the potential for any to be responses to violence [and as such being hostile behaviours bearing an intent to cause harm] is made invisible. Force being used on people expressing a need seems perverse, and wrong, and indication of how words can gerrymander meaning. The result is that the legitimacy of staff responses that involve physical restraint (when those responses are indeed legitimate) is lost to negative framing. I accept that the force-based actions of staff across the country, and across different sectors will be of varying levels of legitimacy and quality. At worst these *can* be abusive, unnecessary, injurious, ad potentially assaults. The point being made here is in relation to lawful and necessary physicality that I believe represents the bulk of what takes place day-to-day. I am aware that in stating this I may be criticised for making an unsubstantiated claim. To which I can only say it is the impression

I formed after speaking to study participants, and after speaking to practitioners over the years on numerous courses.

What is significant is that all participants spoke of incorporating some form of self-defensive component into their actions as they worked towards their immediate, situational goal. The notion of self-defence can be problematic, with the use of self-interested force being seen as tantamount to violence by staff (McSherry, 2017). Like the first aid mentioned above, self-defence is a notion that can be semantically deployed to provide camouflage for unnecessary force. Within the context of care provision, the safety of the person in receipt of services is seen as paramount. The stated aim of 'Putting Patients First', is echoed in the NHS constitution, 'The patient will be at the heart of everything the NHS does' (DHSC, 2021a). The legacy of fatal restraints has also resulted in staff being compelled to actively avert harm. Against this backdrop, staff can perceive their interests are relegated to a form of second-order importance. The experiences of study participants suggests that staff need to be safe to respond well.

Participant descriptions indicated that in the very early moments of a violent encounter; staff do not immediately and exclusively prioritise the interests of service users. The instinctive damping down of behaviour is as much *self*-defensive as it is *other*-protective. What could be described as 'self-care' (O'Malley *et al.*, 2023) is recognised within the 'mature care' framework (Pettersen, 2012; 2011) and provides scope to shift a broader discussion around how ethical force might be distinct from legal force [see previous chapter on 'Balancing', and more later]. This is a *very* nuanced point that runs counter to current calls to foreground service recipients' rights (EHRC, 2019). As a result, it is foreseen that any suggestion that staff be permitted to prioritise their safety, or put their rights first, will be seen as amounting to the devaluation of service recipients, of legitimising coercion and removing important safeguards. This is emphatically not the finding, nor the point being made, rather it is

highlighting something that *has been discerned;* the moving away from the dichotomous thinking centred around patient safety *versus* worker safety. This is something that the mature care perspective (Pettersen, 2012) can hold and allow to be processed as ethical decisions are made.

More than Restraint, as Currently defined

Caring actions and interactions need to be carefully calibrated. The power amassed in caring settings, psychiatric ones in particular, has long been recognised, and conscious effort is required to offset the inherent asymmetries (Bacha *et al*., 2020). Latterly there is growing talk of *concordance*, amounting actions taken following 'agreement between patient and health professional reached after a negotiation' (De las Cuevas *et al*, 2012 p.1-2). This seems to have advanced the rather more one-sided notion of *compliance*, defined as 'the extent to which the patient's behaviour matches the prescriber's recommendations' (Chakrabarti, 2014 p.30). Whilst compulsion according to Szmukler (2015), 'is a reasonably straightforward notion: the use of force, one hopes always governed by law, to make a person accept treatment that has been refused' (p.259). The broader notion of coercion, along with notions of compliance, concordance and compulsion, are terms that seem to be used with precision and imprecision in equal measure. As intimated, the mental health system in its totality is often described as coercive (Council of Europe, 2019), and singular actions taken by staff members have also described as coercive (MIND, 2013). Richter (2024) offers some welcome clarity, by placing the notion of coercion in a very particular therapeutic context, 'From an ethical perspective, the aim of measures taken against a person's will is to improve the health of the person concerned' (p.3). This makes a distinction between those actions taken to preserve safety in the here and now such as those self-defensive or other protective in nature, and those implemented to facilitate a therapeutic intervention. Both can involve some initial form of physicality in response to the presenting behaviours of concern. They can both take place when there is an actively harmful component to the behaviour

being presented, but the nature of those interventions which scaffold therapeutic projects such as NG feeding, or the administration of medication, depart from those deployed solely to prevent situational harm being realised, becoming extended and expanded to achieve therapeutic aims. There is of course a third form of physical intervention, that which deployed for its own sake, which constitutes an assault even if the applicant tries to camouflage it under the guise of necessity.

This study involved the exploration of several experiences containing an array of physical interventions, including self-defensive components. My reading has been that the participants, within the experiences they shared, did not cease to care. Nor did they fail to actively attenuate the force to minimise discomfort and distress, before relinquishing it [It is conceded that in both settings some responses involved a transition into a seclusion setting thus expanding the restriction]. The key distinction I am making is between the response in its totality, and an element of it, namely the use of force. A scalpel penetrates the skin, and a hand grasping the patients head to oxygenate them [Fig, 8.6], are both acts of force. The former, considered in isolation, is a far more violent act and certainly more dangerous. But both are small parts of much larger tasks, which in their totality might readily be understood as caring.

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Fig. 8.6: Cutting and grabbing/holding as components of greater caring responses.

The hermeneutic circle (Smith *et al*., 2009) suggests our understanding of any whole text is based on our understanding of its individual parts, as well as our understanding of how each individual part relates to the greater whole. This underwrites IPA and seems to have resonance here. To disaggregate the responses, and consider force elements in isolation, is to free the interpreter up to dwell on isolated, decontextualised elements of actions, which would seem to delimit the way in which they come to be understood. Boeckh (1968) has posited 'vicious' interpretation wherein meaning is arrived at, intentionally or unintentionally, through the importation of what amounts to non-reflexive subjectivity, through the integration of bias or prejudice. Prejudice is often presented as being deleterious to understanding, but according to Gadamer (2013) the presence of prejudice only means a judgment has been made before all the conditions necessary for a definitive evaluation are yet to be met, making it neither positive nor negative. To me, this echoes in many of the restraint related debates. Prone restraint is held to be dangerous and to be cast out of practice (MIND, 2013), but there is no consensus on how to define it (Sethi *et al*, 2018). The use of use of pain-based techniques are deemed to have no place in a civilised service (RRN, 2021), yet the most frequently cited sensation reported by service users, when held by staff trained to use a 'non-pain compliance approach to physical intervention' (Hawkins *et al*, 2005 p.19) was pain. To me 'vicious' interpretations (Boeckh, 1968) are more likely when restraint is referred to in reductive ways. When Wilson *et al* (2017), Perkins *et al* (2012), Griffiths (2014) [concerned with the restraint of children], and Smith (2005) [concerned with the restraint of children] all refer the homogenous entity labelled 'restraint' as a 'necessary evil' such an interpretation might seem to have been made. Irrespective of whether there is nuance deeper within any text or dialogue, the public headlines seem to suggest that those making assertions believe there are no further conditions necessary to advance their evaluation. It would seem to me that to reduce any danger and pain associated with what has been revealed to be adaptive physicality, we first need to acknowledge and define the existence of what can be just physicality.

Within what is an evolving holding strategy, the staff members seemed to be inter-relating with the physical and mental aspects of the person before them, drawing on their own mental and physical resources to do so [as per 'Balancing', Chapter 7]. Considering this, the current definitions of restraint, as covered in the literature review, seem lacking. The focus is solely on physical actions, with the person being restrained unacknowledged in any meaningful sense, instead being reduced to aspects of movement and mobility. In short to their behaviour alone. A more expansive and respectful conceptualisation of physical restraint may help examine past events as well as inform future interactions in a constructive way. An example of what a more expansive conceptualisation may look like is offered for illustrative purposes[9]. Restraint *could* be defined as:

> The use of proportionate physical and non-physical strategies by individuals in caring or support roles to limit or facilitate the movement of any part/s of a persons' body, to achieve a lawful objective, such as a defined policy-based action, or to prevent serious and imminent harm, with due regard for the physical and psychological safety of all parties involved during and after any application which ends with the return of the persons autonomy at the earliest practical opportunity

This definition departs from the current ones in several ways. In the first instance it registers the presence of both physical and non-physical components. A restraint will invariably be infused with some sort of communicative exchanges between the parties, which would be expected to transition into a wholly non-physical interaction over the course of the restraint. Also, the reference to strategies is broader than just techniques and so permits whatever combination of contact, structured physicality and naked force which comprise the physical element. Then there is a reference to the

[9] Developed informally by myself following a very late reading of Muluneh *et al*. (2024).

functionality of the combined strategies, as being to 'limit' or 'facilitate' movement. In practical terms movement can still be governed by the restrictive nature of the physicality being applied, and would include the facilitation of voluntary movement, which there may be, which would be expected to increase as the intervention progresses, and agency is returned. The definition then refers to the intervention being implemented under the auspices of the law and/or policy. This reference to the necessary authority differentiates what is taking place, from indefensible physicality such as assault or abuse. Considering the study findings, I think ethics too has a place here [see next section]. This definition also explicitly makes a reference to the safety of both parties, and their physical and psychological safety. This may be implied or assumed to exist within current definitions, but it is not explicit. When restraint is considered in such totality a form of holism is introduced, where individual practical, physical, social, psychological, emotional, legal, and ethical components cannot be fully understood without reference to each other. As earlier stated, to focus on physical force is to interrogate one aspect entirely out of context. The lived experience of study participants strongly suggests a need to consider and understand the totality of responses. Finally, agency is returned, this is part of any strategy although is not stated within current definitions.

Ethical Rather Than Legal Force?

In respect to any physical response, the question asked by managers is likely to be, 'was the force legal?'. In this study, care has been discerned. Participants described responding to ordinary people; the consensus in setting one being that Sara was lovely in setting one, with Jill appearing to speak for the setting two cohort when she said, 'we're all human, aren't we?'. These were people who immediately prior to the event were being provided with support or treatment within the context of a respectful relational connection. The 'other' was not the 'intruder' (Foster & Leigh, 2016 p.403), 'marauder', (Wiseman, 1997 p.44), 'Mugger' (ibid, p.44) or 'Rapist' (ibid, p.150) of the avowedly

legalistically influenced self-defence literature. It seems to me that the forceful balancing of the participant's physicality with that presented by the other individual, assumed an ethical rather than solely legalistic quality. As a result, the evaluative question conceivably should become, 'was the force ethical?'. I suggest that an ethical intervention is likely to be legal, but not necessarily vice versa.

Within the notion of legal force, the focus is on the act, and its reasonableness or proportionality within the context of the threat faced. It is fundamentally a divisive act, where one person [the self-defender] differentiates themselves from another [the attacker]. It is argued that ethical force differs in that the relationship within which the act takes place is fundamental to the delivery of meaningful care [Fig 8.7]. The act is therefore unifying, wherein the staff member eschews those crude, unrefined or intentionally damaging actions, which in their deployment would likely damage the vital relationship.

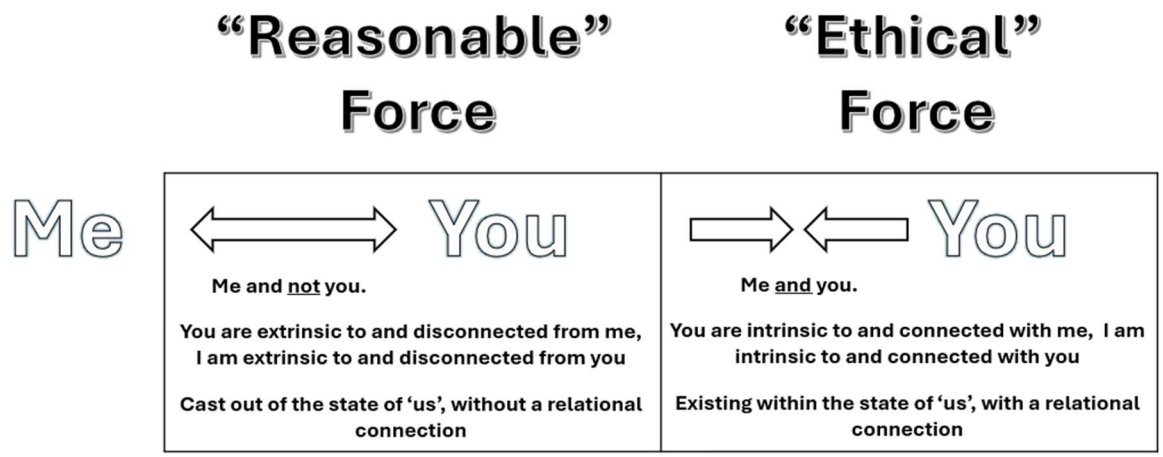

Fig 8.7: Reasonable vs. Ethical Force.

As previously discussed, the development of an ongoing dialogue is not central to restraint as currently defined, nor legal force, neither is the swift implementation of post-force support or relational repair. The archetypal householder that the CPS (2022) refer to in their self-defence guidelines is unlikely to

need to interact with the burglar that they have forcibly repelled. Theirs is a temporary and enforced relatedness. By contrast the individual held physically and emotionally by staff in the therapeutic milieu is someone to whom staff want and need to continue to relate, thus needing to move beyond any antagonistic interactions.

Lipsky (1980) spoke of the need for discretion, in recognition of the fact that street level bureaucrats made policy from the bottom up, as dictated by the demands they faced, and determined by the resources available to them. This was not always to the benefit of the policy recipient. It is clearly possible to find examples of street level bureaucrats who have resorted to blanket forms of overwhelming force to gain immediate control. The Police responses to striking miners (IPCC, 2015), bouncers suppressing confrontational customers (Winlow *et al.*, 2001) and custodial officers imposing regimes of control and discipline in youth custody settings (Price, 2021). In such instances the use of violent force rapidly established power-over the other. The violent force is done unto others without consideration, titration or any regard for the person, before being passed off as reasonable. For participants in this study, the use of force seemed subordinate to a greater caring goal or primary task. This required individuals to remain present within the unfolding moments of the event, and move beyond non-technical discretion (Zacka, 2017) to mature care (Pettersen, 2012).

In conclusion, the physicality recounted by participants seemed less legalistically constructed than expected (no participant referenced reasonable or proportionate force). The participants revealed how the techniques provided through workforce training were of limited value and instead resorted to instinctive [having no fidelity to pre-specified techniques] and intuitive responses [with partial fidelity to pre-specified techniques]. It is possible to think about actions being mediated through the notion of ethical force. This transcends the current concept of restraint, tethered as it is to legalistic notions of force, and more expansive than any single technique. Whilst techniques can be useful when

realised, making them synonymous with restraint seems to be a reductive convention, limiting the consideration of a critically important topic.

Official Techniques Are Only Part of the Solution

Technique is a term that has been widely used within this thesis. It can be said to refer to a skilled way of doing something, using methods, skills, or procedures to achieve a desired result, typically implying a level of proficiency or expertise (Kontokanis, 2024). It is derived from the Greek 'technikos meaning 'of art, or skilled in art' (Kim, 2024). In its current usage across scientific, educational, and engineering settings the emphasis on precision seems to be foregrounded. In the teaching of restraint techniques such precision can be implied from the both the way techniques are visually portrayed in manuals (Mandt, 2010), and the commonly stated training aim of ensuring delegates are able to replicate individual techniques (RRN, 2021). However, if one revisits its etymological root, reference to art stands in contrast to the science inferred within the notion of precision. As previously described, the state of being 'ready-to-hand' occurs when we engage with that which is invisible to the conscious mind (Riemer and Johnston, 2012). Only when we encounter that *thing* which leaves us 'unready-at-hand', is our consciousness engaged. Responding to behaviours of concern would seem to necessitate such a state of *being,* and a need to *do* something. How this manifests is in the hands of staff member and is wholly reliant on a form of creativity defined by them, their experiences and resources. This would seem to me to take staff actions beyond the rote application of a mere technique and allow it to become a creative act. The ability to engage in such creative synthesis is not something that is meaningfully explored within current restraint training (RRN, 2021). Such assemblage is defined by the person, and the resources they have at their unique disposal in that moment [see final theme].

In setting one, Sara's mother was reported earlier to have uttered, 'Quick! Just get her in and get the door shut'. This exhortation freed staff to do what they needed to do 'in the moment', which transcended the techniques taught in training. It provides a clear illustration of the recognition of the need to be free to adapt to a dynamically evolving event, and to exercise creativity. Charlie's and John's martial artistry were clear examples of how the personal self was manifested within responses. I believe it also challenges any blanket assertion as to the unsuitability or incongruence of martial arts training. The takeaway is that how people respond is ultimately determined by who they are, and the context they find themselves in. This raises significant questions about the meaningful place of standardised training and regulatory frameworks in protecting patients/clients and workers and addressing poor practice. Much of what has been covered within this section of the discussion has relevance and resonance with the final section. Perhaps this speaks to the holism of the findings, that it is difficult to completely isolate those things that were a part of the overall whole under scrutiny.

Practitioners find their own tools to manage, and words to process the demands they face

To my mind, this speaks most directly to RQ1: 'How do staff experience the events that constitute a 'response' to behaviours of concern: their own thoughts, feelings, reactions and responses, and the context within which this all takes place?'. This study was initially driven by my curiosity in relation to what I was seeing as a longstanding trainer: that delegates were unable to reproduce techniques in the refresher training environment and would often disclose that prescribed physical techniques lost their form they were translated into the practice setting. Responses seemed not a matter of simply replicating techniques or following scripts. This exploration set out to find out something about how such responses were negotiated from the bottom up, something that was essential to understand if both staff responders and those they are required to respond to are to be well served.

The Inevitability of Feelings

The restraint literature speaks to the presence of feelings in at least two distinct ways. Firstly, in how feelings, often induced by stress, create distance, corrupt cultures and increase the use of force (Paterson *et al.*, 2011, 2013); and secondly in how staff are troubled by restraint (Kodua *et al.*, 2023; Cusack *et al.*, 2018; Wilson *et al.*, 2017). Participants revealed many feelings and emotions which did not seem to readily align with the primary task at hand. In setting one, Donna spoke of 'intense' situations and facing behaviour intended to 'scare', Lisa of witnessing 'evil' behaviour, and behaviour which made her 'angry'; Emma of talking to Sara when she 'grabbed hold of my shirt and went to rip it'; whilst Russell said, 'The biggest fear is you are going to get hurt, isn't it?'. In setting two, Jill spoke to being 'definitely scared' and 'confused'. John described a situation 'when someone starts swinging punches at you and you can't think', Charlie of being ran at and punched without warning, whilst Sabrina spoke of the ear-piercing sounds made by patients as being disturbing and draining.

Participants spoke of having to quickly assemble a response, such was the urgency, but in so doing of setting aside, or holding in abeyance, those feelings and emotions which had the potential to destabilise their actions. It could be conjectured that these accounts were simply the result of the careful curation. However, such self-regulation (Vohs & Baumeister, 2004) is already recognised. The literature is replete with examples and explanations, including 'rational detachment' (Meissel & Salthouse, 2016), the ability to live in dissonance (Confortini & Ruane, 2014), to undertake motivational displacement (Noddings, 2009), to work in, and with, incongruent emotions (Hochschild, 2003), as well as the ability to tolerate distress (Linehan, 2014). The care ethicist would assert that fundamentally these emotions are messages that need to be processed and responded to, an act of relating constructively with the self. As a result, the individual embodying the response is then able to find balanced ways to care amidst messy emotionality *and* physicality.

A Recognition of Street Level Bricolage

The core of the participant experiences constituted a practice I have referred to as 'Street Level Bricolage'. Fig 8.8 encapsulates the ideas that demarcate this practice of defining a specialist form of policy from the bottom-up.

Fig 8.8: Street Level Bricolage, bottom-up policy definition.

Study participants revealed a form of adaptive resilience when responding to 'behaviours of concern'. Resilience in this sense was not about keeping going irrespective of the impact, seen in the form of the 'bulldozer' approach (Björkdahl *et al.*, 2010). Rather, resilience here speaks to the importance of a particular mindset within fraught circumstances, and how it scaffolded an adaptive response at a time when others may be expressing themselves maladaptively. Resilience or 'grace under pressure' (Foster *et al*, 2023 p.866) seems crucial and a necessary adjunct to the aforementioned self-regulation, that is alive within the thinking associated with negotiating mature care (Pettersen, 2012) which is

necessary facilitate the situational bricolage (Levi-Strauss, 1962). This outlook, or enduring resolve, seems to be coupled with the physical energy necessary to keep the physicality within an ethical range; neither too much [egotistical], nor too little [altruistic]. Talk of too little force may seem counterintuitive, but one must consider the consequences of failing to contain harmful behaviour. In could constitute a dereliction of one's duty of care if that person subsequently hurt themselves or others. Sometimes less is more, but on occasions it can be insufficient.

The Street Level Bureaucracy scholarship does not speak to the resources that enable the practical implementation of policy actions. Rather it names the strategies staff employ to attenuate the demands placed on them (Zacka, 2017; Lipsky, 1980). Policies which prescribe actions, and limit implementation to a decision [option A or B?] leave the street level actor to find a way through the situations they encounter. Such assemblages have been previously described as comprising the ''shards and fragments' of the situation-at-hand' (Maniago, 2018 p.2) and are likely include memories of historically successful strategies and actions, advice and insights shared by colleagues, as well as some mix of instinct (Mott *et al.*, 2012; Cobb & Pincus, 2003) and intuition (Melin-Johansson *et al.*, 2017), seemingly tempered by ones intrinsic values. In this study there were also references to workplace training undertaken in previous roles, training undertaken outside of work, and aspects of the individual's personal life experiences which determine the physical capability available to the unique individual.

I have already referenced how bricolage can be said to be part of the fabric of some martial arts systems. Martial arts systems, and the training practices flowing from them, contrary to the lay impression that they are systems of codified violence (Croom, 2009), are usually infused with some form of ethical code. To illustrate this, I will turn to Ju-Jitsu as it offers me a means open the discussion and simultaneously makes transparent a part of my personal history that informs my perceptions, my

interpretations and my understandings. In my estimation this does not impoverish readers who do not have such a background in martial arts, rather I hope it can offer a perspective with the potential to stimulate thought.

Ju is a term that refers to a concept, 'to be gentle', 'to give way', 'to yield', 'to blend', or 'to move out of harm's way' (NHMAD, 2009). Jitsu then is the 'art or technique' that operationalises the concept (NHMAD, 2009; Kano, 2005), thus Ju-Jitsu [also Ju Jutsu, Ju Jitsu, and Jiu Jitsu] is the art of overcoming those in opposition by yielding or pliancy. Whilst its toolbox does contain various blocks, strikes, throws, chokes, pressure points and joint locks, they are not advocated for blanket usage. If one strips back its utility, the core philosophy is the balancing of forces to resolve the potential for harm. One does not need to exploit that force to the point of pain or harm. In fact, traditional Ju-Jutsu is founded on the precepts of a love of life, society, and nature, and seeks to harness the development of 'the courage to be reasonable, achieving dynamic balance at its centre' (Cynarski & Jong-Hoon, 2021 p.36). The force deployed within the context of martial arts, irrespective of its form, is not therefore designed solely to achieve a destructive end.

An example of the ethical utility and technical advantage offered by this art, can be found in its adoption and deployment by Suffragettes in the early 20th century. Traditionally 'suffragettes had relied on bats and makeshift weapons hidden in their hats or garters' (O'Hagan, 2021). In resorting to such violence, they risked harm to themselves and others. In many respects they were replicating a practical and hegemonic form of the masculinity that was complicit in curtailing their freedoms (ibid, 2021). They turned to Edith Garrud, who pioneeringly ran a School of Ju-Jutsu in London. She made it abundantly clear that Ju-Jutsu should never be used to provoke violence or to unlawfully attack somebody; it was solely necessary to protect oneself when faced with external aggression (ibid, 2021). At a little under five feet tall, Garrud contended that in practicing what she characterised as the 'soft

art', size did not matter. It relied on an understanding of the attendant weaknesses in the aggression that was encountered, which could be deflected, contained or dissipated with the skilful use of minimal force (ibid, 2021).

Training in a martial art, like the restraint training undertaken by all participants, is founded on acquiring a mastery of prescribed techniques and principles, as well as boosting one's endogenous ability to respond to unexpected or un-cued events (Johnstone & Marí-Beffa, 2018). In Ju-Jitsu, competent performance results in the awarding of a coloured belt, in restraint training a certificate, typically valid for a year (RRNN, 2019). A subtle difference within the training structure, is the integration of what in Japanese is referred to as kata and kumite. Kata is the precise, non-contested practice of the technique or series of manoeuvres, whilst kumite involves finding ways to apply one's knowledge and the skills in whole or part when exposed to unpredicted attacks (Doria *et al*, 2009). This can also be called 'sparring' in striking arts [John's boxing, and Charlies Muay Thai] or 'having a roll' in Brazilian Ju-Jitsu [also practised by Charlie]. Here one becomes inured to the physical distraction that incoming physicality causes, choosing rather to focus on the opportunities that arise to problem solve and progress through to a more advantageous position. This will involve applying adapted and modified techniques, to either achieve one's objective or to provide a bridging physicality into some other strategy or technique. To return to the participants experiences, I saw parallels with Ju-Jitsu. What I felt they were engaged in was far more nuanced than simply applying brute force. There was an ethical core to the assemblage of their adaptive physicality. I have previously described balancing care with control and holding onto the physical chaos whilst staying true to the primary task. I have suggested that how this is done, through mature care, which was defined by who the individual is, and what they personally and privately bring to the moment.

In those moments when the personal self was at the forefront of the response, accounts revealed actions stopping short of the violence associated with the hardwired protective instinct (Mott *et al*., 2012; Cobb & Pincus, 2003). The physicality in these fleeting seconds amounted to holding and stabilising the person. The staff member seemed to be attempting to literally hold the behaviour in their hands, as they orientated on the moment, before moving through it, to connect with the person through their relational resources. This feels important and seems to indicate something about the individual that constrains the response at a time when instinct might be to counterattack or retaliate. In the following moments more developed holding strategies begin to form [most notably in setting two]. Whilst the physical manifestation of the personal self was revealed most vividly through John and Charlies hybrid martial artistry, Donna, Emma, Jill, Sabrina and Russell all spoke of transitioning into hybrid forms of holding rooted in their personal knowing, prior training and personal capabilities. The personal and private individual was defining the professional and organisational response in the initial moments and early minutes of incidents. Perhaps another way to frame this is that two defining identities were involved in what was happening.

The Revision of the Self

John's previously discussed statement, 'it's not normal, is it?', which seemed to speak to the experiences of all participants, lead one to contemplate how participants re-established normality. There seemed no immediate regard for them, by their 'attackers' [used here descriptively and not ideologically], in the moments of violence. In responding, staff seemed to be trying to first briefly self-care, then other-care at a time when the person before them did not want, or was unable, to accept that care. This incongruity left staff like Emma [setting one] troubled, and John [setting two] with feelings of guilt. Participants in both settings spoke to the value they perceived in the process of

making sense of experiences *after* the event, despite differentiated experiences in accessing those opportunities.

These processing-cum-consolidation sessions can be seen as spaces in which the *messiness* is tidied up, and the *dirt* is metaphorically removed, in order that a new and wiser self may emerge. These sessions seem to be facilitated with, and shared by, colleagues who worked alongside them. The inference was that those who understood the actuality of events were unlikely to confer judgement. To be effective these sessions needed to be places where staff could speak candidly about the behaviour and voice their true feelings. Whilst often ad-hoc, having no formal structure, and squeezed in around other work demands, they seemed to function as places of sensemaking which simultaneously allow staff to offload, to intellectually resolve difficult feelings, and commence the consolidation of their practice. Implicit in this is the suggestion that staff members remain open to growth and are not destined to become blunted or burned out (Sequeira & Halstead, 2004). There is also a paradox, in that processing events and consolidating practice might mean that staff potentially become better at responding physically, running counter to national policy messaging that staff should be become better at not restraining. This would especially be the case if the sole focus of that processing was the physical techniques. It seems possible that staff continue to grow, tacitly developing practice beyond any technical and legal competency sought or validated through formal training sessions. Existing policies, both national and local, in relegating and limiting considerations of PMVA-esque training to initial courses and annual refreshers, seem to propagate the notion that how staff respond is developed solely within formalised training and development programmes, and therefore do not acknowledge the developmental function of these often-invisible sessions. It is likely that within these informal developmental spaces that the personal *and* professional selves are redefined.

Conclusions

As a result of this study much has become at least a little more clearly understood to me. Physical responses to behaviours of concern have been found to be more than just pre-defined techniques. Responses were predicated on explicit and tacit knowledge (Bergheim, 2019; Smith, 2001), with the personal knowing located within staff member coming to the fore. I also discerned a relational component to how they worked, prefiguring responses, present within their actuality, and continuing after the event where sensemaking seemed to be best facilitated by those known and trusted by responding individuals. This processing seemed to require language which spoke candidly to what happened, rather than in abstracted terms. The term 'behaviours of concern', seems to obscure violence, and go at least some way to denying its existence. The term restraint was also found limiting, denying the opportunity to acknowledge the totality of its components. The force used within responses is posited as ethical, representing a higher practice benchmark than simply reasonable or proportionate. The responses considered in their totality seemed to me to meet the definition of care, with the protection of the individual from harm and the preservation of their opportunity to recover or flourish their ultimate function. Staff also found ways to keep safe without resorting to unchecked self-defence. All of this was understood within the concept of mature care (Pettersen, 2012). The need to recognise the caring aspects of staff responses is crucial, as the work of caring professional and the primary task appear to have been diminished by the prevailing anti-restraint discourse.

In terms of my own expectation, I had originally felt that some form of gendered dynamic would be in play, and that a clear masculine form of restraint would emerge, perhaps built on competitiveness, strength and aggression. I found something different, with *who* people are being more important that what chromosomes they carried. Whilst sex and gender may still prove to be relevant variables, I think they will only provide a tangential insight into what happens during moments of crisis that caring staff

continue to face daily (NHS Digital, 2018). The emergence of the personal and private self, along with the ideas of street level bureaucracy (Lipsky, 1980), bricolage (Levi-Strauss, 1962), 'Self-Regulation' (Vohs & Baumeister, 2004), resilience (Foster et al., 2023) and mature care (Pettersen, 2012), or what I have described collectively as 'Street Level Bricolage' offer a construct that needs and deserves more exploration.

In Closing

In completing this thesis and arriving at my own personal sense of what was happening within the experiences of the study participants, I read and re-read their accounts. I considered the answers to individual questions within the context of their whole experiences, thus completing the 'Hermeneutic Circle' (Smith, 2007). Where there were outliers, alternate readings, or uncertainties, I have highlighted these in the respective case studies and analytical chapters. I am content that the experiences represented are credible (Stahl & King, 2020). The condemnation faced by staff who restrain made honest disclosure by participants a brave decision. To have declared involvement in restraint, and to have been open about it not always going to plan, is something that could readily be misrepresented, which to my mind would obscure the ambition to find useful knowledge. It is my hope that those occupied with the practice challenges spoken to in this study will find at least some of the findings and conclusions sufficiently resonant to be taken seriously, and for any uncertainties arising to be worthy of further consideration, reflection, or investigation.

Chapter 9: Looking Back and Looking Forwards: Recommendations & Limitations

This Doctoral study journey, like others before it, set out to find something more about the as yet unknown. As such it is not a final destination. I will now reflect briefly on the research questions before elaborating upon further research that I think is necessary to further and deepen understanding.

Revisiting & Reflecting on the Research Questions

In respect to RQ1, I think this research, through the interpretation of eight individual experiences, has revealed much about the constitution of an individual's response to behaviours of concern. In answering the question, I believe I was able to provide an answer that transcended the limited written records that typically exemplify the organisational record, and thus its memory of such events. I was able to go beyond simply registering the occurrence of some form of action and gained valuable insights into a complex social interaction that is often problematised rather than explored. Despite only being a very, small scale study, the answers to RQ1, when considered in totality with the answers to RQ2 and RQ3, suggest that there appears to be some significant disconnects between policy and practice that themselves require further study to achieve a deeper appreciation of their existence.

Using the semi-structured interview as a data collection method (Gray, 2018), I discerned affective contradictions as well as tensions, and sensemaking challenges along with an urgent practical need to construct a response from the resources available to the individual, to meet the demands of the unique situation at hand. My sense was that *who* the person the participant [as a staff member] was

encountering, along with that individual's role as a patient/service user, mattered to them as a they assembled their physical responses. It meant they were not simply responding to an abstract problem or threat, they were responding to someone they recognised as in need of care and support. More than this, the answers to RQ1 revealed *who* they as individuals were themselves determined *how* they responded, rather than the assembly or production of their response being governed wholly by policy or training. It seemed clear to me from my interpretation of the participants experiences, that each was driven by a sense of duty and responsibility mediated through their unique minds and bodies. All eight were truly street level bureaucrats defining policy-in-action from the bottom up (Lipsky, 1980).

The interview as a data collection method is not without its shortcomings. Its effectiveness is predicated on the interviewer's communication skills, ability to formulate suitably evocative questions, and to listen intently whilst simultaneously retaining the acuity necessary to further probe or prompt as required (Cohen *et al*., 2007). The unique semi-structured route taken through the interview in and of itself means no two interviews will be identical data gathering opportunities. Irrespective of this, the interview will only succeed if the interviewee can be encouraged to talk freely, for it to be made easy for interviewees to respond (Clough & Nutbrown, 2007). For me this was key, as the use of physical force seems to have become a tainted activity and acquired a moral dirtiness (Hughes, 1951) that seems to currently define it and its exploration. This meant that honesty and transparency were things that could not be taken for granted. Thankfully, I found that practical mistakes, operational failings and negative feelings were all disclosed, leading me to conclude that the method and its execution was largely successful. If I were to conduct this study again, I would seek to augment the collection of verbal data with visual data. Visual data would potentially allow for the actuality of events to be seen by both interviewer and interviewee, and this serve as stimulus material during the interview. To do this I would seek to use either existing CCTV or body camera footage of

incidents, or potentially use footage gathered by myself as a non-participant observer [formal electronic surveillance in domestic settings seems likely to be rare]. I recognise however that such data collection would be ethically challenging. This having been said, there is an irony on the fact that many of the physical abuse scandals that have raised concerns resulting in government action (Dept. of Health, 2014) have been driven by video footage (Dept. of Health, 2012), albeit that which was gathered covertly. I think that it is also important for me to add that I recognise that my personal interviewing technique is something that I will need to continue to develop. Reflecting now I recognise more deeply than perhaps I did at the time that an interviewer is not a passive participant in the process, and that levels of rapport, and interest in the answers, can fluctuate between interviews. The key I feel, to me at least, is to be more minded to the nature of my contemporaneous presence and attentiveness, the latter at a micro- or interaction-by-interaction level. In this study I interviewed participants only once. I think, that returning to explore facets of the individual experiences is something I would contemplate were I to do the study again and dig more deeply into them. Looking back, I also think the Physical Contact Logs that were prescribed were of negligible value. In the final analysis, only half were completed and even then, this was sparse and perfunctory. They were intended to capture something about the volume and nature of an individual's utilisation of physicality as a communication strategy on a day-to-day basis, and whilst of negligible value within the context of this study, I do think that in and of itself they could be used to reveal much and be worthy of revisiting as an isolated project.

The answers to RQ2 spoke to the experience of disjuncture between training-based experiences of reproducing the authorised physical responses (RRN, 2021), and the practice realities of seeking to replicate them. This was revealed to be the case in both settings. The participants accounts revealed that the disconnection seemed to have arisen from a combination of factors. Firstly, the policy expectations in both settings were brief, idealised and decontextualised written directives. The

translation of text into physical action requires words on a page to become a dynamic and adaptive interplay of thoughts, feelings and co-ordinated body movements. Here the weakness of the top-down model of policy implementation becomes evident (Brodkin (2016). As the answers to RQ3 revealed, whilst the spirit of the reported responses was determined to have remained congruent with the spirit of the local policy [and thus the primary task (Rice, 1963), the contents of the responses were individually self-authored, as the individuals became specialist bricoleurs (Levi-Strauss, 1962). The answers to RQ2 revealed that the sudden manifestation of violence, the individual's location and position, their relative isolation, the absence of time to plan and prepare with colleagues, as well as their unique physical and psychological makeups conspired against them being able to synchronise immediately, or wholly, with the physicality they had been taught. Participants revealed that they were left with no choice but to respond as they saw fit to do so. More specifically in a way that they felt was right and proper, and as they were able to do so which seemed to be based on their own, unique, individual capabilities and values. This make me think that in the training space trainers need to explore the assembly of physical responses in a more multifaceted way in order that this aspect of the response is considered in all its ethical and practical complexity.

I observed the training completed by both participant cohorts, although this was not a data collection point. Even so, I felt I was able to hold their essence in mind when talking about them. To provide some context, Appendix 31 has something to say about the systems that currently define the restraint training marketplace. The Rocky Bennett Inquiry (NSCNHA, 2003) called for "A national system of training in restraint and control" (p.67), wherein techniques were centrally approved. A timeframe of twelve months was set. That this did not happen was remarked upon several years later by Independent Advisory Panel on Deaths in Custody (2011), who reaffirmed their opinion that there was still a need for it. Today, it remains the case that whilst the various training programmes available are in some ways very similar [they are certified against the same training standards, requiring the same

topics to the covered], they are in other ways very different, with different techniques, procedures and approaches to physicality permitted and allowed to progress without central governance. As I will suggest in the recommendation chapter, I think a more in-depth analysis of the way trainers prepare staff to translate, or more accurately to integrate, attitudes, and knowledge as well as make sense of the skills and force demanded by unique events needs further research. In the international law enforcement space, research on how to ready staff for such practical and pragmatic negotiations is already taking place (Rajakarunaet *et al*, 2017). This is possibly because organisations operating in this space operate under a primary task (Rice, 1963) that does not explicitly foreground care and thus necessitate a contemplation of the complexities involved in foregrounding it within the use of force. Under the rubric of 'law enforcement', apprehension, arrest, detainment and even the facilitation of punishment are seen as markers of some success. Of course, there is nuance to this, which itself deserved further elaboration in some form of comparative study. To return to my reflections, I think that a longitudinal study which examined the development of the ability and understandings of new staff in respect to the matter of physically responding to behaviours of concern, would be valuable. A study with data collection points prior to initial training, after the training, then after their first responses in the practice setting, before finally a follow-up sometime later when they have become both experienced and encultured in practice ways would have the potential to be highly revealing, and reveal something about the growth of what seems a specialist form of tacit knowledge (Gourlay, 2002) and situational sense-making (Starbuck & Milliken, 1988). The recommendations in a later chapter will further expand on future research possibilities.

In my reading of things, despite training being closer to the practice space, policy maintains its primacy in the hierarchy of governing mechanisms. Policies are typically mandated to ensure patient as well as staff safety (HSE, 2003), maintain legal and regulatory compliance (CQC, 2024), provide guidance for decision-making (Evans, 2011), and promote fairness and equality (EHRC, 2019), thus setting out to

improve the overall quality of care and efficiency of service delivery. It seems to me that the training that accompanies the facet of service delivery that I have concerned myself with has not been served well historically by the government and the various ancillary arms-length bodies who retain the power and authority to specify training content. As far back as 1977 COHSE the health service union complained that the first official guidance issued by the Department of Health and Social Security on what was described as the management of patient violence [DHSS Health Circular (76)11] was insufficient and thus continued to leave staff to fend for themselves, "the advice contained therein was far too generalised and of little help in practice" with the conclusion that, "the DHSS and employing authorities do not want to be specific because of 'liberal' criticism and prefer to let violent incidents 'take care of themselves'" (Davies, 1978 p.187). Only relatively recently have a first generation of national training standards been developed and mandated for mental health in-patient settings [setting 2], which themselves are being revised and iterated at the time of writing.

As stated, it is unrealistic to expect that a top-down policy document would be able to speak to every eventuality likely to be faced by staff, but what such policies do is devolve a form of technical discretion (Zacka, 2017). Regarding any requisite physicality, deferral is typically made to legally permissible force as an organising framework, often caveated within policies by a list of actions that may well be lawful but are not organisationally sanctioned, such as strikes or the targeting of no-go areas such as the groin, eyes or throat. This default to law is entirely understandable, [as is the caveating] when one considers the prominence of the law as a regulating mechanism in caring spaces, where individual staff members actions are constrained or dictated by various bodies of law, including the Mental Health Act, Mental Capacity Act 2005, Human Rights Act 1998, and Equality Act 2010 amongst others. It seems paradoxical that the accountability required of such a legal framework, can inadvertently relegate the prominence of any ethical contemplations of what constitutes the right type of response and the right sort of force. As has been argued the difference between ethical and

lawful force may be subtle and nuanced, but an ethical perspective ensures the subject of the response is not abstracted or reduced to a factor or indeed object for legal consideration. The policy infrastructures of the respective participant organisations have been summarised in Appendices 31 & 32. Participants were not explicitly questioned as to their understanding of them, nor were they asked for their individual ethical perspectives. Meanings were imputed through considerable interpretative work (Larkin *et al.*, 2006; Smith, 2004) on my part. If the matter of how staff respond is to be more fully explored and understood in its multi-dimensional complexity perhaps such questions could have been included in interviews such as the ones I conducted, although I remain content that the oblique line of questioning that I took did serve the IPA methodology (Smith *et al., 2021,* 2009) and was revealing.

Looking at the findings, I believe this study was able to determine the presence and impact of the primary task (Rice, 1963), thus answering RQ3. The organisations participating were constituted to care, and the staff participants employed and trained to care as need dictated. Such a '*reason to be*' seems to me something that can be discerned from, and determined, by a multiplicity of interrelating mechanisms of influence: legal requirements, commissioning specifications, operating policies, recruitment practices, job descriptions, practise leadership, the language and terminologies that are locally recognised, the prevailing cultures, as well as the openness and responsiveness of individuals to reflection and more formal reviews, investigations and inspections. Despite participants being likely to be influenced day-to-day [at least in part] by such mechanisms of influence, when faced with unexpected and unforeseen demands, such as was encountered by study participants, they seemed to be guided in large part by who *they* were as unique people. People who have been shaped and continue to exist outside of the primary task. As I reflect now, I think it might also be possible to think of the primary task as potentially having catalytic qualities, allowing individuals to bring their unique intrinsic goodness or strengths to bear in their work role. Of course, this would need to be in line with the organisational goals, however they are articulated or embedded. This would accrue additional power to positively exert an influence were there to be coherence across any team that was working

together within the context of any response [or delivery of care more broadly]. Irrespective of whether this conjecture is founded, it was the individuality of the participants and its role in shaping how they attended to the task at hand that came through strongly in this study, and which revealed a primary task-in-action.

Within the context of this study, my own discernment of a primary task operating within each of the recruited organisations was arrived at by drawing inferences from the type of services being operated, the nature of provision described by participants, the spirit of the policies provided and in largest part by the accounts of participants, when they shared experiences of making sense of the unexpected and complex situations they were *thrown* into, to respectfully leverage a Heideggeran term (Larkin *et al*., 2006). Looking back now, if I were to more fully explore whether the primary task was realised, I would perhaps need to determine whether those in receipt of the responses felt like the care that I had discerned was received, as intended. I could determine this in different ways, which would amount to the inclusion of their presence as part of the fundamental design. Some form of Person/Patient-Reported Outcome Measure or Person/Patient-Reported Experience Measures could have been used to get to relevant facets of an individual's experiences (Benson, 2021). A post incident interview with them, perhaps located within any debrief might also have provided revealing insights from their experiences. I have been clear that this research was focused wholly on the lived experience of staff, but it is important to recognise that any interactions within the context of the local primary task, particularly those that involve physicality and are in some way resisted or contested, are dialectical and involve agents of the service provider as well as the service receiver. As a researcher with an inquiring mind, as well as a sense that research questions need to be answered ethically, and appropriate research questions raised. Bailey (2015) has shed some light on this, but in my recommendations, I make an explicit suggestion for future research.

Policy Research Recommendations

I suggest that current definition of restraint need to be refined. An alternate was provided:

> The use of proportionate physical and non-physical strategies by individuals in caring or support roles to limit or facilitate the movement of any part/s of a persons' body, to achieve a lawful objective, such as a defined policy-based action, or to prevent serious and imminent harm, with due regard for the physical and psychological safety of all parties involved during and after any application which ends with the return of the persons autonomy at the earliest practical opportunity

It was offered as a starting point for further discussion which would arrive at a definition that could enable more nuanced analytical work within both the practice and research spaces. To do this the various components of such complex responses need to be identified and named, and their functions more clearly understood. It is readily acknowledged that definitions have legal, political, and practical implications, and as such revision has a myriad of consequences. Despite this I believe that a revision that would allow the actuality of restraint to be more accurately understood would serve both staff and service users/patients. The 'Forced Touch' uncovered by Bailey (2015) has already opened the door to reveal the differentiated physicality utilised in the restraint space, and its communicative rather than solely controlling function. In arriving at a definition, there may also be an opportunity to dismantle some of the oversimplistic representations of restraint as purely a biomechanical and restrictive intervention.

The use of language as it pertains to 'behaviour' also seems to need revision. If all behaviour has a communicative function, what does this suggest when service recipients attack and hurt staff? This is not to call for a regression to a staff-centric framing of behaviour as invariably violent, but that a harmful element can be present. The term 'behaviours of concern, with the *potential* for harm has been offered up as an evenly balanced starting point for discussion amongst practitioners and service users.

Questions need to be asked and answered by researchers if greater understanding is to be achieved. One such question might be: "Physical restraint and the use of Force: To what extent do the lived experiences of patients and staff members concur with current definitions as used in organisational policy documents?"

Practice Research Recommendations

Much qualitative research on the restraint experiences of staff seems to have been focused on isolating the negative or adverse psychological components (Kodua *et al.*, 2023; Cusack *et al*., 2018; Wilson *et al*., 2017). This because explorations seem to have lent into critically sensitised readings of the practice. If one were to ask individuals what the most difficult aspects of parenting have been, answers may include the loss of self, a curtailment of personal freedoms, an accumulation of psychological and emotional fatigue, and perhaps a sense of being judged by others. All intuitively feel valid, however, none are taken to represent the totality of parenting. Instead, considerable work is ongoing, aimed at defining and understanding what constitutes *good enough* parenting (Eve *et al.*, 2014) and how people can be supported to exemplify it. In the restraint context a great deal of qualitative research evidence is seems to be principally used to augment calls for it to be reduced or

eliminated. More research to isolate the physically caring practices that are integral to the responses to 'behaviours of concern', needs to be undertaken, as it is conjectured that many staff will feel that this is what they are striving to implement amid the situational chaos. Such research would notably inform the underdeveloped body of restraint minimisation literature (RRN, 2021A).

More focal examinations of how staff assemble their responses is also required. The experiences of staff members balancing care with control is an area where more can be learned about the manifestation of the form bricolage (Levi-Strauss, 1962) brought to the forefront in this study. That elements of the physicality are spontaneously developed should be further examined. Are such field modifications (Paterson, 2007) based on personal experiences, resonances with familial events, or out of work training? Or does length of service, sex, or psychological characteristics define how such assemblage is attended to? Are there any common manifestations of such assemblages? To what extend does the relationship with the individual being responded to inform it? What do martial arts have to offer? Or other types of training that increase people's sense of mastery over their body and over situations involving physical and psychological altercations. Given the proliferation of different physical skills systems, and a recognition that this can lead to incongruities between how differently trained staff come together in an incident, it would make eminent sense to explore how teams adapt to each other in addition to exploring how individuals themselves adapt to the messy and dynamic event they find themselves within. Research is essential if we are to understand this better and use this knowledge to improve the safety of all involved in what are common occurrences.

Separately it may be useful to explore the extent to which staff feel reluctant or are limited in expressing themselves or exploring events. Does the widespread problematisation of restraint curtail potentially important conversations, and who suffers as a result?

An examination of the self-defence component within responses could be revealing. One might conjecture that as and when staff members prioritise their own safety, they may experience guilt or be more conscious than ever of the moral judgement hanging over them. At least two participants had the know-how and means to forcefully counterattack when defending themselves but did not. Such titration of a response warrants more scrutiny. The concept of 'mature care' (Pettersen, 2012; 2011; 2008) has provided the conceptual tools to examine the function and value of this balancing act.

How responses are shaped from inside the reflective space would benefit from examination. Beyond processing thoughts and feelings, how are future physical interventions shaped after the event? How does reflection shape the next physical response? Sportspersons routinely use failures and successes of their physical performances to consolidate and enhance their approaches to their next physical challenges (Ellis *et al.*, 2014). Are there lessons to be learnt from research in this space?

There is no current training programme underwriting good practice in respect to the very specialist type of practice leadership required in and around restraint-related events. Something that is designed to ensure nominated individuals can work alongside staff to find, and model, the safest and most ethical ways to physically intervene would be valuable, as would recognised this area of practice as a specialism. The closest qualification at present seems to me to be the 'Enhancing the Safety and Wellbeing of Persons in Care and Custody' qualification available at Certificate, Diploma and Masters' levels (QMUL, 2023a; 2023b; 2023c). Whilst this is not a practice related qualification, it does implicitly recognise that restraint occurs, restraint-based interventions need to be visible, and that organisations as well as individuals need to be accountable for their use. A qualification that grapples

with the ethical and practical complexities could serve as a compliment to the equally important restraint reduction qualifications to expand the work serving the safety of all.

The challenges of finding a way through what can be complex encounters need to be better understood by asking research questions such as: “What are the pragmatic parameters of field modification within the context of responding physically to behaviours of concern?”, “How are people constrained or freed in their performance of physical responses to behaviours of concern by their own unique minds and bodies?” and “Can care be discerned by service users within the use of force?”

Training Research Recommendations

All the recommendations above will ultimately lead to revised understandings and new approaches that will be cascaded down through training courses. It therefore makes sense to consider the efficacy of training methods. An exploration of those components within training sessions which prepare individuals to translate information [policy, principles, and guidelines] into real world practice, and the extent to which it readies them to adapt and improvise in face of the unique demands of a situation could be valuable. This exploration would likely touch on simulation and scenario training, seeking to identify the optimal method for preparing staff to navigate the practical complexity, as well as the extent to which it prepares staff to apply legal or by contrast ethical force.

I have personally seen much informal innovation within the training environment, however, to formalise profession-wide progress, more research needs to be undertaken. I think a great deal of useful knowledge could be accrued by asking research questions such as: “In what ways can staff training really prepare staff to respond physically to behaviours of concern?” and “Is a practical

understanding of the use of force in response to behaviours of concern most fully developed in the training or practice space?"

In Closing

In all these areas, the use of visual data should be explored. Whilst video still has the potential to capture partial or ambiguous footage (Jewitt, 2012), its role as stimulus material and its value as the subject of qualification and quantification would seem to be invaluable. In closing, this study has been small, but important. By exploring the experiences of individuals, it has allowed a researcher to get close to what it feels like to respond to situations that are very common in care settings, but which to date have, for various noted reasons, been both misrepresented and characterised in limiting ways. Research is notionally the pursuit of some form of accurate representation of a particular facet of a reality. The role of the researcher is to offer those findings, discussions, and conclusions to members of any concerned or interested cohort, in order that they in turn might consider expand upon the understandings. It is hoped that this is what will now happen.

Limitations

This has been but one minor qualitative study, whose foundations have been the lived experiences of eight people. Any claim to categorical certainty or broad-spectrum generalisability would be unsubstantiated as qualitative research does not allow statistical extrapolation from a sample to a population. The experiences of participants have been taken at face value. Within any sharing of experience there is clearly the possibility that recall, and presentation can be reduced by intentional

and unintentional bias (Wassell, 2009), with the self-selecting nature of the sample likely to have had some impact on who volunteered to participate (Olsen, 2008).

Chapter 10: Personal Reflections

Personal Change Over Time

This study journey forced me to look more deeply within myself than ever before. When I started, with a background in restraint training, martial arts and first-hand experience of using force, maybe subconsciously I felt I was a subject matter 'expert'. I was one of many, mainly men, who have made a career out of informing, advising and training others on the use of force.

It took some early checking and challenging by my supervisors for me to realise I was often confusing my opinions with the lived experience of others and what might be happening out *there*. This underwrote a failure to be self-reflexive and engage in critical-enough thinking. I had expected people to assemble their own ad-hoc physical responses, and in the first interview this was upheld: I was right! This led to a conversational dynamic infiltrating the interview, as I listened selectively and effectively chatted with my interviewee when I should have been pressing them to reveal deeper dimensions to their experiences. I had probably, unconsciously always made such errors, giving me what I always expected, providing illusory competence and confidence. This was ultimately a self-defeating cycle of validation that I only became aware of because of the reflexivity demands of his thesis.

It was my supervisors who pressed me. Always politely and supportively. They gently tugged at loose ends in my assertions, positing other possible explanations and theories, and exposing my missteps by simply asking questions that I could not easily answer. My thinking, my writing and what might be termed my intellectual product continued to be pressed along the way. Always kindly. This led to private bouts of frustration and once or twice a loss of confidence in who I was. My supervisors were

however always there to metaphorically hold me as I made sense of all these things and feelings. As I approach the end of this journey, irrespective of whether I succeed or not what I can honestly say is that it is a different me that is approaching the finishing line because of that skilled supervision: Less certain, exercising greater attention to detail, as well as being more questioning, reflective and reflexive. To anyone contemplating a doctoral journey, you will almost certainly experience uncomfortable and overwhelming feelings along the way. I would say dig down through the discomfort and find their root. You will likely discover matters requiring deep and honest reflection, which will offer opportunities for personal and professional growth.

The Use of IPA

The more deeply I learned to reflect on how this research was conducted the greater the value I saw in IPA. In honesty its selection was more luck than judgement. In time I came to realise how it let me into the lived experiences of participants, and to get a sense of what was happening for them as individuals. I think that the lived experience of staff in relation to the practice/phenomenon in question is important to recognise, and to me at least feels like it should count as much as any other form of lived experience in caring spaces. However, as stated above to understand it as well as its value, I needed to set aside my preconceptions and patterns of thinking to leverage its potential. The diary excerpts in chapter three, and reflexive comments along the way hopefully reveal something of my journey to the open-mindedness.

IPA is a relatively new research methodology, because of it not being understood in depth by Students and Research Supervisors alike it has been suggested that it has been seen as 'the easy option' for qualitative research (Hefferon & Gil-Rodriguez, 2011). Having now attempted to do IPA I would concur with Larkins *et al* (2006) that 'IPA is not an easy option', (p.103) and is actually 'easy to do badly, and difficult to do well' (p.103). I found it to require considerable time and attention. A tension for me was

between endeavouring to do IPA properly, and getting to the data that I believed would provide me with access to new and informative understandings of restraint. It was a long and frustrating process. I had to temper my urge to 'get the job done ASAP'. I learned to allow myself to slow down, to both dwell within the data and allow myself the time necessary for connections to be made.

This allowed more than just the physicality to register. The experiences captured more than just applying force It revealed the attendant emotionality, its necessary regulation, the presence of resilience and adaptivity as well as the need to process events in the knowledge that restraint was largely seen as wrong or dangerous. Yes, participants revealed something of the structure of the physical aspects of the events but there was more I would have missed had I not set aside my old thinking. I choose to note the physical structure of the force, something that for IPA purists that might have transcended the core aim of IPA to capture the essence of the mental experience. To my mind reference to the physicality is a useful compliment to, rather than a detraction from, those experiences that IPA sets out to access and represent. Upon reflection this component of responses may have been more fruitfully explored through some other form of phenomenology which focuses on embodiment of experiences.

My Presence Within the Interpretation

IPA recognises the presence of the researcher within the interpretative process, something that must be subject to disclosure (Smith *et al*, 2009) [Appendices 26 & 27] and the operation of regulating mechanisms such as ongoing reflexivity [Chapter 3]. I think the opportunity to be transparent was essential for me, after all I arrived with decades of particular types of experience, and it would not be accurate or honest to suggest I could completely divest myself of it. Within the text I made several martial arts mediated observations and comments, for example homing in on to the martial arts training undertaken by John and Charlie, with some elaboration on Ju-Jitsu. There had been no

expectation of discovering their backgrounds and involvement, but it became clear once it was revealed that it strongly registered with a part of me. It is a world I have been immersed in and continue to be. Perhaps someone who was not as familiar with restraint training, violence and martial arts may not have understood things or represented them in the way I did. On this basis I suggest I am not hiding my 'self'. I believe I have openly, honestly and transparently revealed my unique interpretive presence. I believe my very particular personal background and mode of thinking are used, much like an expanded vocabulary, to articulate the sense I have made of the text. This I offer up to others to draw their own conclusions.

In respect to honouring the data and interpreting it in a balanced way I return to the assiduous supervision I received, and all its checking and challenging. I had two research supervisors reviewing each chapter. Each provided an independent critique of my thinking and resultant writing. Another form of sense check was my own. All my output became increasingly subject to deeper review and reflection. There were occasions when I revisited early work and had no recollection of writing particular tracts. In some instances, I was very pleased with pieces of this work, the lines of thinking seemed clear and coherent, and sometimes the turn of phrase I found would be very pleasing to my mind's eye and ear. On other occasions I was disappointed at what now seemed like clunky, or clearly biased work. The good news, for me at least, was that I became better at identifying underdeveloped writing and thinking for what it was. I feel that early in my period of study I would have been much less able to do this and been more defensive. I have come to see defensiveness now, as ultimately working against my best interests. Those interests are related to personal and professional growth, and to producing a thesis that has at least some value to others.

The Use of Researcher Directed Audio Diaries.

The strategy of gathering researcher directed audio diary clips using WhatsApp to aid the holding in mind of specific events and provide stimulus materials for subsequent interviews was a mixed success. In the event only one setting used them. This was due in the main to security concerns at setting two, in relation to personal mobile phones and thereafter password protected recorders. A further pragmatic alternative was explored, involving the use of TEAMS to capture audio reports but in the end, this was set aside due to a combination a scarcity of available and accessible hardware on site, incompatibility between NHS and University of Strathclyde software, and finally the study was quite simply running out of time.

I think the diary entries themselves helped me to orientate on the setting, to get a sense of the staff's role, and the team dynamics, as well and getting to know the sort of person I was dealing with. I drew some tentative conclusions from the length, frequency, and nature of the entries. Lisa was very talkative whilst Emma seemed more measured, Donna efficient and Russell matter of fact. I think, although cannot prove, that these one-sided disclosures served to underpin the development of a rapport between participants and myself.

I transcribed these diary entries, but never formally coded or analysed them. In practice they provided a source of useful information which helped me familiarise with settings and individuals in the lead up to the interviews. That this information was not available to me for setting two can only impoverish my understanding the service, and familiarity with the participants. Despite not having this information, I do believe I was able to develop a suitable and sufficient rapport with participants in setting two, which positively served the data collection.

The Completion of Physical Contact Logs

Once again, largely due to security restrictions, no physical contact logs were completed by participants working in setting two. By contrast the logs were completed by participants in setting one. Having reviewed them I was left unconvinced that they captured all the contacts made during a shift. My sense in reading them was of them being populated at the close of shift, by recalling all the main contacts over the course of the day. This is not a criticism of the participants. Rather it is a flaw in the data collection design. To have picked up and made notations on a sheet of paper over a busy 12-hour shift was likely unrealistic. The initial design expectation was that the physical contact logs would say something about the individual's style of physically interactivity, and their readiness to make contact outside of restraint. High levels of touch or holding may say something about the individual, which may have been informative. In the event, neither the logs nor excerpts from the diaries were used as stimulus material during interviews. It leaves me to ponder what is the optimum amount of data collection that a researcher has a right to expect? At both sites the workforce was depleted, and staff were being required to work a combination of more shifts, and with lower numbers of staff. The job is a complex one in optimal conditions, and a researcher is ethically bound not to burden staff. On balance I feel that the loss of the physical contact logs did not diminish the pursuit of knowledge.

The Interview Process

I found interviews difficult to do well. I was initially pleased to develop an organic rapport. Whilst very useful, I found that it had two distinct downsides. In the first instance, I found the extent to which I remained present and focused could fluctuate. In the first interview when I heard about ad-hoc physicality my focus on the interviewee was fleetingly interrupted, as my [bracketed] expectations were met. Thereafter, in the last two interviews, when the subject of martial arts came up quite

unexpectedly, I found my attention was drawn at the fleeting expense of focusing on the experience itself. Through a combination of post interview reflection, supervision and wider reading (Nathan, 2021) I developed my own self-awareness and a deeper appreciation of the art of the interview. The other consequence of developing a rapport, and perhaps more pointedly of being me, was the reluctance to press when I discerned discomfort. I described Emma as a Wounded Healer in my PET-level analytic work, following her disclosure of an adverse experience, I chose to not press her on it. I felt it was her experience and not obviously related to work or the phenomenon under scrutiny. On reflection it could have been relevant and possibly have had some resonance. At the very least I could have asked whether she was comfortable to talk about its relationship to the issue at hand. If I to face a similar situation in future I would likely consider ways to mine the experience through oblique questioning.

The Use of NVivo

Qualitative analysts often speak of the freedom and unbounded opportunities to make sense of the data that manual coding offers. A world of possibilities is presented by deconstructing the data, reducing it to piles of notes and excerpts which can carefully and artfully be move around a tabletop [or wall] to create readings and curate structures of coherence which are invisible to the naked eye, or inaudible to the naked ear. Whilst I recognise and respect all the foregoing to me it represented a form of chaos that was anxiety provoking. It felt like there are an almost infinite number of ways where sense can be lost. Some may argue that the decision to go digital rather than analogue may have impoverished my analysis. All I can say is that I designed the analysis with reference to key texts in the field, I dwelt within data at every level, from the smallest piece to the largest theme. I believe NVivo served the project and was the right choice for me. Others of course have the right to make their own choices.

The Analysis of Local Policy

There was no ambition to formally evaluate policy documents, or to compare them across settings. Rather there was an aim to say something about the resonance of practice to the policy. In practice a policy comparison would have been difficult, as there was no formal policy in place at setting one. Instead, practice was guided by a combination of the details contained in the support plan, by taking direction from Mum [in her role as both manager and mother] and by working alongside Mum [in her role as support worker]. By contrast setting two was very well served by what might be characterised as a policy eco-system; policies, support plans, risk management plans, as well as the direction of team leaders/charges nurses [such as Sabrina and Charlie], and a longer staff training programme.

Being an Outsider.

I imagine it is not uncommon for researchers find themselves wondering whether participants would or have been totally honest with them. When Charlie in setting two asserted that he would not countenance talking to a 'randomer' he led me into thinking about how in the context of this study it might be difficult. Of course, I can never know the extent of the honesty I encountered, or the fidelity of individual's accounts to their actual lived experiences. My sense is that there was enough honesty to conclude the accounts had validity. There were disclosures of irritation and disagreement between participants in setting one, as well as disclosure of the negative emotions and feelings encountered. Furthermore, three out of four participants in this setting spoke to difficulties in applying the appropriate technique, which was in essence a policy deviation. In setting two there were once again candid disclosures of strong emotions, of similar struggles with techniques across all four members of the cohort, and reports of failures and difficulties in getting things right. Accounts and actualities are clearly two very different things, with much potentially conspiring against the twain meeting. I think about this, and those things, now more than I ever did.

Delays and Interruptions

In those instances when the Audio diary was used by participants in setting one, I was unclear when the recordings were made: on shift [in a quiet moment], at the end of shift, the end of the day or at some later date. It was also not clear whether recordings were made on site, or off site. The delay in making diary entries could conceivably mean that individual recollections and perceptions become shaped or influenced by intervening events. A delay could also lead to the forgetting, inadvertent mixing, conflating, and melding of disparate events. The tendency towards some form of self-serving post hoc rationalisation is always a possibility with or without delays or disruptions, as is the Hawthorne effect with participants tending towards telling the researcher what they think they want to hear. Encouraging participants to time and date events against recordings may reveal something about the refractory period, or a stipulation that it should be completed on the same day may prevent too much time passing between the events.

Later in the study, three interviews were temporarily halted when other staff members entered rooms unannounced. The freedom to speak may have been temporarily reduced, and the possibility exists that such interruptions may have curtailed the intensity of emotions, or distracted the person and led to smaller, less intense thoughts, feelings or emotions being lost. An interruption may easily break a chain of thought, disrupt a developing line of sensemaking. Ideally, I would have been to control the interview space, but covid and the use of TEAMS technology precluded this at the time.

The Presence of Adults with Learning Disabilities Within Experiences

I focused on staff who responded to behaviours of concern presented by adults with learning disabilities because there was an increased likelihood of responses to such behaviours, within staff working with such a cohort, and within those responses there was a likelihood of some physicality

being required. This probably reflected a greater familiarity on my part with those services, through training experience and my employment. On reflection and having looked at the national MH restrictive intervention dataset such prescriptiveness was probably not necessary. Fundamentally the exploration was of the staff experiences, not service user experience and not of staff perceptions of service user experiences. I acknowledge peoples' LD was leant into lightly and it is conceded that other researchers may have framed the inquiry differently and reached into this aspect of the experience more deeply.

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Appendices

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Appendix 1: Ethics Application Confirmation

SUBJECT LINE: Approval: UEC21/23 Steckley/MacIntyre/Hollins: Responding to Behaviours of Concern: The Experiences of Staff

Thu 18/03/2021 10:10

To: Lee Hollins; Laura Steckley; Gillian MacIntyre

Dear Lee

ETHICAL AND SPONSORSHIP APPROVAL

UEC21/23 Steckley/MacIntyre/Hollins: Responding to Behaviours of Concern: The Experiences of Staff

I can confirm that the University Ethics Committee (UEC) has approved this protocol and appropriate insurance cover and sponsorship have now also been confirmed.

I remind you that the UEC must be informed of any changes you plan to make to the research project, so that it has the opportunity to consider them. Any change of staffing within the research team should be reported to UEC.

The UEC also expects you to report back on the progress and outcome of your project, with an account of anything which may prompt ethical questions for any similar future project and with anything else that you feel the Committee should know.

Any adverse event that occurs during an investigation must be reported as quickly as possible to UEC and, within the required time frame, to any appropriate external agency.

The University agrees to act as sponsor of the above mentioned project subject to the following conditions:

1. That the project obtains/has and continues to have University/Departmental Ethics Committee approval.
2. That the project is carried out according to the project protocol.
3. That the project continues to be covered by the University's insurance cover.
4. That the Director of Research and Knowledge Exchange Services is immediately notified of any change to the project protocol or circumstances which may affect the University's risk assessment of the project.
5. That the project starts within 12 months of the date of this letter.

As sponsor of the project the University has responsibilities under the Scottish Executive's Research Governance Framework for Health and Community Care. You should ensure you are aware of those responsibilities and that the project is carried out according to the Research Governance Framework.

On behalf of the Committee, I wish you success with this project.

Kind regards
Angelique

Angelique Laverty
University Ethics Committee Manager
Research & Knowledge Exchange Services (RKES)
University of Strathclyde
Room 3.01, Graham Hills Building
50 George Street
Glasgow
G1 1QE

ethics@strath.ac.uk

Appendix 2: Inclusion/Exclusion Criteria For Study Participants

Study Participants

These comprise individuals working within an LD support context: 'Staff Members' working within formal/corporate settings, A Long Stay Hospital setting, a Residential Care Home setting, and a Supported Living Setting, as well as 'PA's' working within private domestic settings.

- Staff Members: Individuals working within formal LD settings.
- PA's/Team Members: Members of wraparound services for people with moderate to severe LD living at home

Target number: n=3-5 from each setting to be interviewed

Age (range) 18 and over

Inclusion criteria for Study Participants:

Individuals:

- who work in settings providing support to individuals with moderate to severe LD; and
- who are sometimes or frequently required to respond to escalated behaviour; and
- who are over the age of 18.

Exclusion criteria for Study Participants:

No exclusion criteria

Appendix 3: Introduction Letter: Institution Level Recruitment

University of Strathclyde
Humanities & Social Sciences

Dear XXXX/To Whom It May Concern

Responding to Behaviours of Concern: The Experiences of Staff – A Qualitative Research Study

My Name is Lee Hollins and I am a PhD student based at University of Strathclyde.

My doctoral research, which has received ethical approval[1], aims to find out more about the human experience at the heart of responding to behaviours of concern (sometimes referred to as challenging behaviour or behaviours that challenge) within settings where individuals with a learning disability are supported.

I am interested in how staff make sense of what are often complex, dynamic and fast changing situations. I am particularly interested in those responses which, in addition to the use of verbal and non-verbal communication strategies, include some form of physicality, but which don't amount to the full application of formal or authorised restraint techniques. I am interesting in the use of touch and physical holding as well as the use of partial restraint techniques as people seek to avoid the use of full restraint techniques.

I hope to use the information from this research to inform policy and practice in the area of relational working and restraint minimisation.

Study participants need to be aged 18 and over, and to have a likelihood of being involved in responding to behaviours of concern in their work with a person or people with a moderate to severe learning disability.

I would like to recruit 3 to 5 members of your team.

If you decide to support this research and allow members of your team to participate I will:

- Interview yourself in order to obtain a clear sense of what your service or team are constituted to achieve, and to familiarise myself with your guidelines on responding to behaviours of concern
- Meet with you and your staff who choose to participate using Zoom or other form of remote communication, at a time of your convenience, in order to deliver a short orientation session, and complete consent forms
- Thereafter, ask individuals to collect data for a period of approximately 4 weeks. This would involve:
  - Completing anonymised physical contact logs (1 per week)
  - Compiling an anonymised audio diary, capturing personal reflections on significant events in relation to their responses to behaviours of concern
- Conclude by interviewing staff participants using a semi-structured interview format

I have included with this letter an information sheet that gives further details about this study.

I will telephone you in the very near future to discuss whether you might be interested in the study. If, however, you want to make contact in the meantime my contact details are **lee.hollins@strath.ac.uk**

Thank you.

Yours sincerely,

Lee Hollins, PGCert Health Research, BSc Physiotherapy
School of Social Work & Social Policy,
University of Strathclyde, Glasgow
PhD Research Supervisors: Dr Laura Steckley & Dr Gillian MacIntyre

[1]*Ethical Approval was granted by the University Ethics Committee at the University of Strathclyde on 18/03/21 [UEC21/23]*

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Appendix 4: Introduction Letter: Participant Level: Hospital Setting - Manager

University of Strathclyde
Humanities & Social Sciences

Nominated representative name

Recorded address here

Date here

Responding to Behaviours of Concern: The Experiences of Staff – A Qualitative Research Study

Re: Institutional Contextual Profile

Dear XXXX

My doctoral research, which has received ethical approval[1], aims to find out more about the human experience at the heart of responding to behaviours of concern (sometimes referred to as challenging behaviour or behaviours that challenge) within settings where individuals with learning disability are supported.

The institution in which you work has indicated that they are will to support the research, which means I can now make you aware of the research and invite you to consider taking part.

As part of the preparatory work, and in line with the preliminary information provided, I would like to arrange an opportunity to discuss and clarify the primary aims of your hospital/service.

This is something that may be captured in documentary form such as a 'Mission Statement', or can be elaborated on in discussion.

I would also like to establish what arrangements are in place to guide staff when they respond to behaviours of concern. The sorts of information I am looking for are any policies or procedures in place and details of any guidelines or training the staff receive. I have included a sheet outlining the questions I will be asking.

If you are able to contact me and indicate a convenient time the discussion should not take more than 15-30 minutes.

Participation is entirely voluntary, and it is essential that if you do consent to take part that your consent is fully informed.

I have attached an 'Information Sheet for Study Participants' tells you what you need to know to make an informed decision. It also outlines how you can get further information.

Thank you.

Yours sincerely,

Lee Hollins, PGCert Health Research, BSc Physiotherapy
School of Social Work & Social Policy
University of Strathclyde, Glasgow
PhD Research Supervisors: Dr Laura Steckley & Dr Gillian MacIntyre

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University of Strathclyde
Humanities & Social Sciences

Re: Institutional Contextual Profile

Dear XXXX

My doctoral research, which has received ethical approval[1], aims to find out more about the human experience at the heart of responding to behaviours of concern (sometimes referred to as challenging behaviour or behaviours that challenge) within settings where individuals with learning disability are supported.

The institution in which you work has indicated that they are will to support the research, which means I can now make you aware of the research and invite you to consider taking part.

As part of the preparatory work, and in line with the preliminary information provided, I would like to arrange an opportunity to discuss and clarify the primary aims of the wraparound team involved in providing care and/or support.

This needn't be something that is captured in documentary, and can be something that is elaborated on in discussion.

I would also like to establish what arrangements are in place to guide staff when they respond to behaviours of concern. The sorts of information I am looking for are any policies or procedures in place and details of any guidelines or training the staff receive. I have included a sheet outlining the questions I will be asking.

If you are able to contact me and indicate a convenient time the discussion should not take more than 15-30 minutes.

Participation is entirely voluntary, and it is essential that if you do consent to take part that your consent is fully informed.

I have attached an 'Information Sheet for Study Participants' tells you what you need to know to make an informed decision. It also outlines how you can get further information.

If you are able to contact me and indicate a convenient time the discussion should not take more than 15-30 minutes.

Thank you.

Yours sincerely,

Lee Hollins, PGCert Health Research, BSc Physiotherapy
School of Social Work & Social Policy
University of Strathclyde, Glasgow
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Appendix 6: Introduction Letter: Participant Level: Staff

University of Strathclyde
Humanities & Social Sciences

Dear XXXX/To Whom It May Concern

Responding to Behaviours of Concern: The Experiences of Staff – A Qualitative Research Study

My Name is Lee Hollins and I am a PhD student based at University of Strathclyde.

My doctoral research, which has received ethical approval[1], aims to find out more about the human experience at the heart of responding to behaviours of concern (sometimes referred to as challenging behaviour or behaviours that challenge) within settings where individuals with learning disability are supported.

The institution in which you work has indicated that they are will to support the research, which means I can now make you aware of the research and invite you to consider taking part.

Participation is entirely voluntary, and it is essential that if you do consent to take part that your consent is fully informed.

I have attached an 'Information Sheet for Study Participants' tells you what you need to know to make an informed decision. It also outlines how you can get further information.

Thank you.

Yours sincerely,

Lee Hollins, PGCert Health Research, BSc Physiotherapy
School of Social Work & Social Policy
University of Strathclyde, Glasgow
PhD Research Supervisors: Dr Laura Steckley & Dr Gillian MacIntyre
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Appendix 7: Information Sheet – For Managers Or Care Co-Ordinators

INFORMATION SHEET FOR MANAGERS OR CARE CO-ORDINATORS

Name of department: School of Social Work & Social Policy

Title of the study: Responding to Behaviours of Concern: The Experiences of Staff

Introduction

My name is Lee Hollins; I am a Doctoral student completing my PhD at the University of Strathclyde.

You have been given this information sheet because your place of work has indicated a willingness to support the research by sharing this information with you. It is, however, down to you personally whether or not you participate. The information below is designed to help with that decision

What Is the Purpose of This Research?

My research seeks to better understand staff members' experiences of responding to 'Behaviours of Concern' as they take place within settings where individual(s) with moderate or severe learning disabilities are being cared for or supported. in this study I am using the term 'Behaviours of Concern', but you may be more familiar with terms like 'Challenging Behaviour' or 'Behaviours that Challenge'

I am interested in speaking with staff who work in hospital settings and family settings in order to discover how people make sense of what are often complex, dynamic and fast changing situations. I am particularly interested in those responses which in addition to the use of verbal and non-verbal communication strategies include some form of physicality, but which doesn't amount to the full application of formal or authorised restraint techniques. I am interesting things like the use of touch and physical holding as well as the use of partial restraint techniques as people seek to avoid the use of a full restraint. My aim is for the findings of this study to inform current efforts to minimise physical restraint and other restrictive practices.

To be clear, physical restraint is not the focus of the study, and so I will not be asking about the techniques themselves, or in evaluating your competence to apply particular techniques. I want to explore and better understand how staff think and feel as they try to navigate their way through situations which may escalate to a physical restraint.

Do You Have to Take Part?

Your decision to participate in this research must be entirely voluntary.

If you decide to participate, you have the right to withdraw without any consequence, and your decision will not affect your employment.

What Will You Do in The Project?

Should you decide to participate in this study, I will ask you about the purpose or function of the team or service from which potential study participants are drawn. I am also looking for information about what arrangements are in place to guide staff when they respond to behaviours of concern. The sorts of information I am looking for are any policies or procedures in place and details of any guidelines or training the staff receive.

In order to gather this information, I will arrange a short interview which will be undertaken in a mutually agreed setting. This could be by phone, or via a video platform such as zoom. Or it could be in person if a suitable private space is available and meeting in person becomes sanctioned again by my university's ethics committee.

The interview will take approximately 15 minutes, and involve me asking a series of questions. I will record the answers and then read them back to you at the end to ensure I have accurately recorded them. If there are any documents to share we will arrange for a subsequent transfer to take place.

Why Have You Been Invited to Take Part?

You have been invited to take part in this research because you manage a team or service that support an individual/individuals with a moderate or severe learning disability who it is recognised does present with behaviours of concern that do, on occasion, that require some sort of response in order to keep them (or others) safe from harm.

What Are the Potential Risks to You in Taking Part?

The research itself will not require you to do anything that you wouldn't already do, other than to provide information about your service/team. Therefore, it will not add to, or remove anything from, what might be described as your crisis management toolbox (i.e. the knowledge and skills that you apply when responding to behaviours of concern).

It should also be noted that participation may offer benefits. The reflective practice that is central to this study, might be supported by our interview, may help you to develop insights that could potentially enhance your practice.

The management of data is covered more fully below, but as the researcher/interviewer, the only circumstances in which I would have to pass any information onto others (i.e. my supervisors and safeguarding teams) would be if you disclosed serious, imminent harm in the information your shared. Otherwise all information that you provide remains confidential, and is managed and disposed of in accordance with University GDPR policy.

What Information Is Being Collected in The Project?

As previously described I will be asking for information about the purpose or function of your team/service and the behaviour management arrangements in place.

Who Will Have Access to The Information?

Only my research supervisors, Dr Laura Steckley and Dr Gillian MacIntyre from the University of Strathclyde, and I will have access to the full information you provide to me.

When I share my findings in my PhD thesis, in articles and at conferences, you and the organisation you work for will remain completely anonymous. I will use quotations from the information participants share, but will take care not to include details that identify the speaker.

No specific geographic information will be included.

No means of identifying your place of work will be used beyond a 'Hospital Setting' or a 'Family Setting'.

Where Will the Information Be Stored and How Long Will It Be Kept for?

All information will be managed in accordance with University of Strathclyde GDPR policy. Information is available HERE and HERE

Data collected during the study will be uploaded to an encrypted online storage space: OneDrive.

This space will only be accessible through a password protected computer used by the researcher, and his supervisors

No files with any identifying information will be stored on any computer or any external storage device i.e. a memory stick or external hard drive

Anonymised copies will be retained by the researcher, in order that they might be analysed as part of follow up research.

Please also read the accompanying copy of the University of Strathclyde's Privacy Notice for Research Participants

What Happens Next?

IF YOU DO NOT WANT TO PARTICIPATE

If you have no interest in this study you are not required to do anything.

Many thanks for taking the time to read this participation information sheet.

IF YOU ARE POTENTIALLY INTERESTED IN PARTICIPATING

If you want any further information before you make a decision you can either:

- Pass any questions or raise any concerns with the nominated contact/gatekeeper who will obtain clarification on your behalf, and feed back to you, or
- Contact me directly. My contact details are at the end of this information sheet.

Please note that such an expression of interest does not constitute any commitment to the study, or consent in any form.

Researcher contact details:
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Supervisor contact details:
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E: Laura.L.Steckley@strath.ac.uk

[1]*Ethical Approval was granted by the University Ethics Committee at the University of Strathclyde on 18/03/21 [UEC21/23]*

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
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Appendix 8: Information Sheet – For Staff Who Provide Direct Care

INFORMATION SHEET FOR STAFF WHO PROVIDE DIRECT CARE

Name of department: School of Social Work & Social Policy

Title of the study: Responding to Behaviours of Concern: The Experiences of Staff

Introduction

My name is Lee Hollins; I am a Doctoral student completing my PhD at the University of Strathclyde.

You have been given this information sheet because your place of work has indicated a willingness to support the research by sharing this information with you. It is, however, down to you personally whether or not you participate. The information below is designed to help with that decision

What Is the Purpose of This Research?

My research seeks to better understand staff members' experiences of responding to 'Behaviours of Concern' as they take place within settings where individual(s) with moderate or severe learning disabilities are being cared for or supported. in this study I am using the term 'Behaviours of Concern', but you may be more familiar with terms like 'Challenging Behaviour' or 'Behaviours that Challenge'

I am interested in speaking with staff who work in hospital settings and family settings in order to discover how people make sense of what are often complex, dynamic and fast changing situations. I am particularly interested in those responses which in addition to the use of verbal and non-verbal communication strategies include some form of physicality, but which doesn't amount to the full application of formal or authorised restraint techniques. I am interesting things like the use of touch and physical holding as well as the use of partial restraint techniques as people seek to avoid the use of a full restraint. My aim is for the findings of this study to inform current efforts to minimise physical restraint and other restrictive practices.

To be clear, physical restraint is not the focus of the study, and so I will not be asking about the techniques themselves, or in evaluating your competence to apply particular techniques. I want to explore and better understand how staff think and feel as they try to navigate their way through situations which may escalate to a physical restraint.

Do You Have to Take Part?

Your decision (as an individual supporting a person/people with a moderate to severe learning disability) to participate in this research must be entirely voluntary.

If you decide to participate, you have the right to withdraw without any consequence at all, and your decision will not affect your employment.

What Will You Do in The Project?

You will be asked to carry on with your day-to-day activities and attend to your routine duties. You will not be required to do anything different when at work, only to gather data and share your experiences.

You will be invited to a short '**Orientation Session**' that will outline how data will be collected. This may take place in person, or over Zoom depending on Covid restrictions at the time. It will take around 1 hour.

At this time, you will be asked to complete a short '**Participant Personal Information Form**', which gather information about your current job role, previous roles (in care or support settings) as well as any relevant training you may have completed.

Subject to completing the orientation session and consenting to take place in the study you will be invited to collect data. This will involve completing a '**Physical Contact Log**' once a week for 4 weeks, Individual logs, which are forms which will be provided, may take around 15-20 minutes in total to complete.

You will also be asked to complete a series of '**Audio Diary**' entries. – You will be invited to complete a diary entry in the wake of each response to a behaviour of concern that you feel is significant in some way. You can record as many, or as few. as you wish. The goal is to ensure as far as possible your entries provide an insight into the types of responses you are involved in. The diary entries will be captured by using the recording feature present on most mobile phones, or in the event this isn't practical or possible, a discrete digital recorder will be provided. You will be given a set of guidelines outlining what information is required, and individual entries should take between 5 and 10 minutes to complete.

Finally, there will be follow-up interviews which will be recorded and typed up for analysis. The intention is to conduct interviews in person in a safe and confidential setting. However due to Covid restrictions, an option will be retained to complete these by phone, or over Zoom (or other suitable video platform) Interviews should take between 30 and 60 minutes to complete, with breaks provided where required.

The follow up one-to-one '**Interview**' will be confidential, and completed in a private space where we may review some of your diary recordings and contact logs. I will also ask you some questions to get a better understanding of your experience. I will ask you to: describe the situation as you saw it, to identify the challenges you faced in responding to the behaviour, to explain how you decided how to respond, to speak about what you remember feeling, and also discuss any other factors that may have informed your thinking and actions.

I am not looking for specific 'right' answers. The aim of the research is to better understand the experiences of the people who choose to take part.

I am looking for people who are willing to participate in all three parts of this study (doing the physical contact log, recording audio reflections and doing a follow-up interview), but if you decide to withdraw at any point, this decision will be respected. There is no requirement to justify your decision, and there will be no consequence for withdrawing (see the accompanying flowchart)

Why Have You Been Invited to Take Part?

You have been invited to take part in this research because you support an individual with a moderate or severe learning disability who it is recognised does present with behaviours of concern that do, on occasion, require some sort of response in order to keep them (or others) safe from harm.

What Are the Potential Risks to You in Taking Part?

The research itself will not require you to do anything that you wouldn't already do. Therefore, it will not add to, or remove anything from, what might be described as your crisis management toolbox (i.e. the knowledge and skills that you apply when responding to behaviours of concern).

Recording your immediate reflections on an incident involving behaviours of concern and discussing such events within the context of a follow up interview both have the potential to be uncomfortable. As the interviewer, I will always aim to ensure the subject is dealt with sensitively, but as has been stated already, if you change your mind and want to stop participating in the study you have a right to withdraw without any reason or any negative consequence. You also don't have to answer any questions you don't want to.

It should also be noted that participation may offer benefits. The reflective practice that is central to this study may help you to develop insights that could potentially enhance your practice.

The management of data is covered more fully below, but as the researcher/interviewer, the only circumstances in which I would have to pass any information onto others (i.e. my research supervisors, with whom I would discuss any appropriate actions which could include notifying an appropriate contact within the participant institution) would be if you disclosed serious, imminent harm in the information your shared. Otherwise all information that you provide remains confidential, and is managed and disposed of in accordance with University GDPR policy.

What Information Is Being Collected in The Project?

The '**Participant Personal Information Form**' will be used to gather general demographic information about all participants, e.g. job role, previous roles (in care or support settings) as well as any relevant training.

The '**Physical Contact Logs**' will be used to note the different types of physical contact you make during a given shift e.g. touch, hold, restrain etc.

The '**Audio Diaries**' are designed to capture your reflections on your experiences of responding to behaviours of concern. This is achieved by answering pre-set questions that ask you to describe what you did and why, long with your thoughts and feelings about how responses impact on relationships.

The '**Interviews**' will focus on specific events and seek to examine a small number of responses in greater detail.

In the event you withdraw from the study, but consent to your data being used it will be anonymised and treated in the same way as other data. You will have the right to withdraw the data up until it has been fully anonymised and written up into the final thesis

Who Will Have Access to The Information?

Only my research supervisors, Dr Laura Steckley and Dr Gillian MacIntyre from the University of Strathclyde, and I will have access to the full information you provide to me.

When I share my findings in my PhD thesis, in articles and at conferences, you will remain completely anonymous. I will use quotations from the information participants share, but will take care not to include details that identify the speaker.

Demographic information will be very general in nature, such as: "*There are 5 staff members (Female =3, Male = 2); the average time spent working with adults with learning disabilities is 7.2 years (range: 3.1 years to 12.2 years)*".

No specific geographic information will be included.

No means of identifying your place of work will be used beyond a 'Hospital Setting' or a 'Family Setting'.

Quotes will have randomly generated pseudonyms, e.g., 'Jack' or 'Jill' and information contained in research outputs will include qualitative data (i.e. words or quotes), e.g. 'Jill' said "physical restraint is a last resort", or 'Jack' said "Restraint can be scary for everyone, so you need to do it carefully.").

Where Will the Information Be Stored and How Long Will It Be Kept for?

All information will be managed in accordance with University of Strathclyde GDPR policy. Information is available HERE and HERE

Data collected during the study will be uploaded to an encrypted online storage space: OneDrive. At this point any copies of recordings held on other devices such as the researchers phone (WhatsApp) and the researcher's computer (Zoom recordings) will be permanently deleted.

This space will only be accessible through a password protected computer used by the researcher, and his supervisors.

No files with any identifying information will be stored on any computer or any external storage device i.e. a memory stick or external hard drive.

Recordings will be held on the OneDrive for the duration of the study, in order that the researcher can re-listen as required. When the final analysis is complete the recordings will be permanently deleted.

Anonymised transcriptions will be retained by the researcher, in order that they might be analysed as part of follow up research.

Please also read the accompanying copy of the University of Strathclyde's Privacy Notice for Research Participants.

What Happens Next?

IF YOU DO NOT WANT TO PARTICIPATE

If you have no interest in this study you are not required to do anything.

Many thanks for taking the time to read this participation information sheet.

IF YOU ARE POTENTIALLY INTERESTED IN PARTICIPATING

If you want any further information before you make a decision you can either:

- Pass any questions or raise any concerns with the nominated contact/gatekeeper who will obtain clarification on your behalf, and feed back to you, or
- Contact me directly. My contact details are at the end of this information sheet.

Please note that such an expression of interest does not constitute any commitment to the study, or consent in any form.

I will be running a 'Participant Orientation Session' in the near future which will explain what is involved in more detail. At the end of the orientation session you will be provided with a consent form and asked to complete it if you are interested in participating. If, at that point, you need a bit more time to consider the information before you decide, that will be okay. In the event that you do decide to participate during this period I will make arrangements to collect your completed consent form.

Researcher contact details:
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School of Social Work & Social Policy
University of Strathclyde, Glasgow
E: lee.hollins@strath.ac.uk

Supervisor contact details:
Dr Laura Steckley, Senior Lecturer
School of Social Work & Social Policy/CELCIS
T: 0141 444 8654
E: Laura.L.Steckley@strath.ac.uk

[1]*Ethical Approval was granted by the University Ethics Committee at the University of Strathclyde on 18/03/21 [UEC21/23]*

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

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Appendix 9: Participant Consent Form – Manager or Co-Ordinator

Consent Form for Managers or Care Co-ordinators

Name of department: School of Social Work & Social Policy

Title of the study: Responding to Behaviours of Concern: The Experiences of Staff[1]

- I confirm that I have read and understood the 'Participant Information Sheet' for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the 'Privacy Notice for Participants in Research Projects' and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any without having to give a reason and without any consequences
- I understand that prior to the anonymisation of data I have the right to withdraw, and request my data be withdrawn and permanently deleted
- I understand that if I withdraw after the data is anonymised, it may still be included.
- I understand that anonymised data (i.e. data that does not identify me personally) cannot be withdrawn once it has been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project
- I consent to the data that I provide and/or collect during the study period to be used for the purposes of research, including primary analysis (this research project) and secondary analysis (follow up research related to this research project)

(PRINT NAME)	
Signature of Participant:	Date:

[1]*Ethical Approval was granted by the University Ethics Committee at the University of Strathclyde on 18/03/21 [UEC21/23]*

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Appendix 10: Participant Consent Form – Staff Who Provide Direct Care

Consent Form for Staff Who Provide Direct Care

Name of department: School of Social Work & Social Policy

Title of the study: Responding to Behaviours of Concern: The Experiences of Staff[1]

- I confirm that I have read and understood the 'Participant Information Sheet' for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the 'Privacy Notice for Participants in Research Projects' and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any without having to give a reason and without any consequences
- I understand that prior to the anonymisation of data I have the right to withdraw, and request my data be withdrawn and permanently deleted
- I understand that if I withdraw after the data is anonymised, it may still be included.
- I understand that anonymised data (i.e. data that does not identify me personally) cannot be withdrawn once it has been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project
- I consent to being recorded as part of the project, this includes audio diary entries and interviews which may be recorded in person, over the phone or via Zoom (or other video platform)
- I consent to the data that I provide and/or collect during the study period to be used for the purposes of research, including primary analysis (this research project) and secondary analysis (follow up research related to this research project)

(PRINT NAME)	
Signature of Participant:	Date:

[1]*Ethical Approval was granted by the University Ethics Committee at the University of Strathclyde on 18/03/21 [UEC21/23]*

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Appendix 11: Recruitment Protocols

Describe the method of recruitment (see section B4 of the Code of Practice)

The researcher will directly recruit a long stay hospital setting and use a gatekeeper to obtain access to interested families.

Organisations registered with the CQC are publicly visible, and therefore somewhat easier to identify and approach. Families by contrast are private and publicly invisible, therefore a gatekeeper was used to mediate access, therefore ensuring that if a family declined to participate their privacy would be maintained and the researcher would never know who they were.

RECRUITMENT OF ORGANISATIONS

1. The researcher will formally approach organisations meeting the criteria using an introductory letter, along with the 'Participant Information Sheet'.
2. This will be followed up within 28 days to establish interest. If an organisational representative has questions or wants clarification at any point of process, they have the option to contact the researcher directly at any point.
3. In the event organisations decline to participate, the researcher will have no further contact and will delete any contact information that he might have, such as email addresses and phone numbers.
4. If the organisation is willing to participate, the researcher will make arrangements to a participant orientation session and ensure consent forms are completed prior to the data collection period starting.
5. In the event individuals within the organisation decline to participate or withdraw any information relating to them will be permanently destroyed

RECRUITMENT OF FAMILIES USING AN EXTERNAL GATEKEEPER

Potential gatekeepers will be identified. These may be co-ordinators of support groups, charity representatives, healthcare professionals or other providing families with support services.

By acting as a critical friend to the families, he/she can keep preliminary contacts confidential to ensure the families do not in any way feel obligated to participate in the research process, and also provide a degree of support/clarification.

1. The 'Participant Information Sheet' will be made available.
2. Families who are provided with information about the research and who are not interested are able to notify the gatekeeper without the researcher ever knowing their identity.
3. If a family has questions or wants clarification on any point of process, they have the option to relay those questions through the gatekeeper or to contact the researcher directly. This is entirely their choice.
4. If families are interested in participating, the researcher will make arrangements to attend a convenient location and provide an overview of the process. This could be facilitated via some form of virtual communication channel [i.e., TEAMS or Zoom], or a confidential, private physical setting away from busy / noisy work areas, such as a University meeting room, or even the home setting subject to the family's approval.

5. The families have the option to request that the gatekeeper is in attendance to ensure that the information is provided without any inducement such as payment or any undue pressure such as stressing the importance of the research.
6. Time will then be provided for reflection and consideration. This will be agreed between parties, but likely to amount to between 7 and 28 days. The researcher will remain contactable to attend to any follow up questions. The researcher will not be party to any discussions taking place between the gatekeeper and the interested parties.
7. In the event families decline to participate, the researcher will have no further contact and will delete any contact information that he might have, such as email addresses and phone numbers.
8. If the family is still involving the gatekeeper at this point, the gatekeeper will then notify the researcher whether a family was willing to participate in the study. Otherwise, the family will inform the researcher directly. Either way, at this point the researcher will deliver a participant orientation session and provide consent forms that will be collected prior to the data collection period starting.
9. In the event individuals within the family setting decline to participate or withdraw any information relating to them will be permanently destroyed

Appendix 12: Participant Orientation Workshop

The session will run for between 30 and 60 minutes and be delivered by the researcher.

1. The aim of the research project: what it is and what it isn't.
2. The role and responsibilities of the researcher & participants.
3. An introduction to the 'Participant Information Form'.
4. An introduction to the 'Physical Contact Log'.
5. An introduction to the 'Researcher Driven Audio Diary'.
6. An introduction to the 'Interviews'.
7. Consent
8. Any other questions?

Appendix 13: Organisational Fact Find

I will be asking you a series of **questions** in order to get a clear sense of the mission or purpose of your institution/of having the wrap around service [I will delete accordingly] (This is sometimes referred to as the 'PRIMARY TASK'). This will include questions designed to get a better understanding of how staff/team members are expected to respond to behaviours of concern

I will make a note of your **answer/s**. I will also ask for, and list any **documents** provided in support of your answers, e.g., policy documents. Please note that there is not an expectation that everything will be in documentary form.

When the interview is complete I read back what I have noted, and will ask you to **confirm** I have accurately recorded your answers. This discussion will not be recorded. Finally, I will ask you to forward any documents discussed which will allow me to complete the compilation of contextual information.

MISSION OR PRIMARY TASK
QUESTION: A PRIMARY TASK has been described as an institutions prime function, its reason to be, or what it needs to do to 'survive'. Can you describe in your own words exactly what it is that you do?
PROMPT e.g., mission statement or quality strategy **ANSWER**:
EVIDENCE?

PROACTIVE MEASURES
QUESTION: What arrangements do you have in place to **prevent** behaviours of concern?
PROMPT e.g., policies/procedures, training, risk assessments, support/crisis plans? Consultation? Co-production work? Reviews etc. **ANSWER**:
EVIDENCE?

REACTIVE MEASURES
QUESTION: How do you **manage** behaviours of concern when they occur? Including any requirement to impose a temporary restriction, hold, restrain, or use some physical act of containment
PROMPT e.g., policies/procedures, training, risk assessments, support/crisis plans? Consultation? Co-production work? Reviews etc. **ANSWER**:
EVIDENCE?

RECOVERY MEASURES
QUESTION: How do you ensure everyone is OK, and lessons are learnt where and when appropriate?
PROMPT: Responses to behaviour recorded? Debriefs of all involved? Incident reviews, support plan reviews. Supervision sessions etc. *PROMPT:* What specific arrangements are in place to support staff who may become distressed by work related events? **ANSWER**:
EVIDENCE?

SUPPLEMENTAL QUESTION
QUESTION: Do you have a policy on touch or physical contact? Inc. physical affection. if so, what does it consist of?
PROMPT e.g., guidelines, training, supervision **ANSWER**:
EVIDENCE?

Appendix 14: Respondent Background Information Form

NAME:

AGE:

SEX: Male/Female

HIGHEST EDUCATIONAL ATTAINMENT:

- ☐ No formal qualifications
- ☐ GCSE/National 5 (N5) qualifications/O Level/CSE/SCE
- ☐ A Level/**Scottish Higher and Advanced Higher**
- ☐ Vocational qualifications (inc. The Care Certificate)
- ☐ Undergraduate Degree
- ☐ Post Graduate Degree

CURRENT ROLE/JOB TITLE:

HOW LONG HAVE YOU BEEN IN THIS SPECIFIC ROLE (*approximately*):

HAVE YOU HAD ANY PREVIOUS <u>FORMAL</u> CARING/SUPPORT ROLES? e.g., *support worker, nurse. List <u>all</u> of the separate roles you have filled.*

HAVE YOU HAD ANY SIGNIFICANT INFORMAL CARING/SUPPORT ROLES OUTSIDE OF WORK? *e.g. as a carer for a family member. List <u>all</u> of the separate roles you have filled.*

CAN YOU LIST ANY TRAINING YOU HAVE UNDERTAKEN IN THIS <u>CURRENT ROLE</u> THAT RELATES TO THE PREVENTION &/OR RESPONSES TO BEHAVIOURS OF CONCERN? *Try to remember the course name as best you can, and list as many as you can remember.*

CAN YOU LIST ANY TRAINING YOU HAVE UNDERTAKEN <u>PREVIOUSLY OR ELSEWHERE</u> THAT YOU BELIEVE HAS PROVIDED KNOWLEDGE OR SKILL WHICH CAN BE USEFUL TO YOU WHEN RESPONDING TO BEHAVIOURS OF CONCERN IN YOUR CURRENT ROLE? *Try to remember the name as best you can, and list as many as you can remember*:

Appendix 15: Physical Contact Purpose Criteria

The classification of physical contact used in the 'Physical Contact Log' is based on a five-point scale developed by Tanner (2017) for use in touch observation.

Tanners Original 'Touch' Taxonomy

Task Orientated	*Involves the use of touch that attends to a person's physical care needs but with the exclusion of any type of person-centred touching.*
Expressive Task Orientated	*Involves touch that expresses a kind, caring, loving, warm and/or affectionate relationship. This experience of touch includes 'procedural touch', 'orienting touch', 'diagnostic touch', 'investigative touch' and 'directive touch' combined with one or more of the following types of touch: 'affectionate touch', 'playful touch', 'energising/vitalising touch', 'empathic touch', 'comforting touch', 'reassuring touch', 'celebratory touch', 'touch to further intimacy', 'touch that contains overwhelming feelings', 'socially stereotyped touch', 'touch to provide warmth', 'healing touch' and 'touch mediated by shared object/activity'.*
Person Centred	*Involves touch that meets a need for love, comfort, attachment, occupation, identity or inclusion. Occurring outside care tasks this experience of touch includes 'affectionate touch', 'playful touch', 'energising/vitalising touch', 'empathic touch', 'comforting touch', 'reassuring touch', 'celebratory touch', 'touch to further intimacy', 'touch that contains overwhelming feelings', 'socially stereotyped touch', 'touch to provide warmth', 'healing touch' and 'touch mediated by shared object/activity'.*
Negative protective touch	*Involves touch that stops, prevents, restricts and controls what people can or cannot do on the basis that a carer knows what is best for the person.*
Negative restrictive touch	*Involves touch that resists people's rights and freedom of action/expression and/or results in physical injury or emotional distress*

Considering it being a self-report instrument, rather than an observation tool the final two categories were restructured to fit.

The Modified 'Contact' Taxonomy

Task Orientated	*As above (refer to 'contact' not 'touch'; a term with broader scope inc. holding etc.)*
Expressive Task Orientated	*As above (refer to 'contact' not 'touch'; a term with broader scope inc. holding etc.)*
Person Centred	*As above (refer to 'contact' not 'touch'; a term with broader scope inc. holding etc.)*
Person Centred Safety	*Involves 'contact' that stops, prevents, restricts and controls aspects of escalated behaviour in order to prevent the person harming **themselves**.*
Safety Of Others	*Involves 'contact' that stops, prevents, restricts and controls aspects of escalated behaviour in order to prevent the person harming **others**.*

Appendix 16: Physical Contact Log

ID:	
Shift length:	
Number of persons you are involved in supporting?	

People often use physical contact including touch) in a variety of legitimate and helpful ways. You are being asked log any contact you make using the following 5 categories:

1. Task Orientated	*Involves the use of contact when **used functionally in attending to a person's physical care needs** e.g. activities of daily living, washing and personal grooming.*
2. Expressive Task Orientated	*Involves the use of contact **to proactively convey warm and/or affection**. Includes 'playful', 'energising/vitalising', 'comforting', 'reassuring' or, 'celebratory' touch',*
3. Person Centred	*Involves the use of reactive touch, as described in the expressive category, **to meet a perceived need** for love, comfort, attachment, occupation, identity, or inclusion*
4. Person Centred Safety	*Involves 'contact' that stops, prevents, restricts, and controls aspects of escalated behaviours of concern in order to prevent the person harming **themselves**.*
5. Safety Of Others	*Involves 'contact' that stops, prevents, restricts, and controls aspects of escalated behaviours of concern in order to prevent the person harming **others**.*

Describe Contact	**Contact purpose? Indicate what types of contact you used within the context of this event**				
State the nature of the physical contact, and the form/s it took e.g. • *'Washing Hair: Wipe water/soap out of eyes, plus hand on shoulder to reduce anxiety when soap started stinging'.* • *'Intervene to stop argument escalating: Squeeze people's hand to get their attention, then gently pull on that hand to turn person away from conflict and finally place an arm around shoulders to walk away'.* *REMEMEBER DON'T INCLUDE ANY NAMES*	1. Task oriented 2. Expressive Task Orientated 3. Person Centred 4. Person Centred Safety 5. Safety of Others CIRCLE BELOW, AS MANY AS APPROPRIATE				
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
DO NOT USE THIS SECTION	**1**	**2**	**3**	**4**	**5**

Appendix 17: Audio Diary Guidelines

Thank you for agreeing to take part in this research. Where possible, please record your reflections on your experiences of responding to behaviours of concern as regularly as possible over the next month. Recordings will be made using in-built functionality on mobile phones, or using a recording device supplied by the researcher if you don't have a phone or the required functionality. The researcher will check this with you during the orientation session. I will plan to collect recordings (if required) and to check everything is OK, otherwise you should send them using a number that will be provided via WhatsApp as soon as is practically possible/convenient. NOTE: WhatsApp operates 'end-to-end encryption' which ensures only you and the researcher can read or listen to what is sent, and nobody in between, not even WhatsApp., can access them.

Excerpts for this diary entries will be used in later interviews. Whilst I will select some I wish to discuss, you are also encouraged to identify those that are particularly significant to you. For this reason, you may retain the recordings to personally review prior to the follow up interviews. Other than this, once I confirm receipt of the file you are free to retain or delete the file as you see fit.

It is important that you try to record your experience as soon after it happens as is practically possible, in that events are fresh in your mind. It is recognised however that there may be practical challenges in some settings and situations, such as immediate workload and access to your phone (or recording device). Participation in this research should not interfere with your work role, so if it's not possible to make recordings until the end of shift it is better to make them then than not at all. You should record your reflections on those events that you deem to be significant, however trivial you think they may seem to others. An event can be significant because it went well, or not so well. A useful definition you may wish to refer to is:

> *Significant events are those that stayed with you afterwards, in the form of lingering thoughts and feelings. This may be because responding to events had been somehow challenging and/or the outcome was in some way rewarding or by contrast unsatisfying. These are the type of events that could become learning experiences.*

Every time you make an entry, please cover the five parts outlined overleaf. Each contains some illustrative examples to guide you, however, remember it's <u>your</u> diary entry so you use the words that make most sense to you. You may make single continuous recordings each time or stop/start as you reflect on the sections outlined below. It is expected that a typical diary entry will take somewhere up to 10 minutes, but the length of entries is entirely up to you.

It is crucial that personal information is protected, and that the identity of individuals involved in those events you capture in your audio diary are not disclosed. You should therefore not include the names of supported persons/patients (P) or of colleagues (C) working in support with you. You may choose to adopt a convention such as referring to 'P', and 'C1' and 'C2'. You should also avoid using any other identifying information such as locations or the name of units or wards.

MAKING AN AUDIO DIARY ENTRY – A QUICK GUIDE

THERE ARE FOUR MAIN PARTS TO AN AUDIO DIARY ENTRY. SIMPLY ANSER THE QUESTIONS BELOW IN YOUR OWN WORDS.

VOICE NOTE PART 1: What was the date of event?

- *You might say, 'The date today is Friday July 17th….'*

VOICE NOTE PART 2: Why do you think that you needed to take action in response to the behaviour on this occasion?

- *You might say something like, 'I felt I needed to do something because I saw ABC, &/or heard XYZ..' &/or 'I was concerned about 123…'*

VOICE NOTEPART 3A: What NON-PHYSICAL strategies did you explore?

Try to include ALL the things you remember that you might have done, no matter how small or fleeting.

- *You might say something like, 'I tried various things. These included 1, 2, 3, 4, 5, 6 etc. etc…..'*

VOICE NOTE PART 3B: What PHYSICAL strategies did you explore?

Describe the nature of any physical contact and/or physical strategies you tried/used.
If any type of holding/restraint technique was used give its name or describe it.
Try to say something also about any challenges/difficulties in implementing any physical containment strategy. It doesn't matter if you tried something, and it didn't work.

- *You might say something like, 'In terms of physical strategies. I tried A, B, C, D, E, etc. etc…'*
- *&/or 'Applying HOLD X was not easy, because… so I tried…..'*
- What about this occurrence has stayed with you? What have been some of the thoughts and feelings that have come up for you about the occurrence afterwards?

VOICE NOTE PART 4: What impact do you think your response had on the ongoing relationship?

- You might say something like, 'I do think/don't think my relationship with this person has been effected in the short/medium term because….'
- You might say something like, 'After the event, I did X, Y, Z… '
- Remember to maintain confidentiality and avoid people's names.

Please feel add anything else that you think is important at the end of the recording. This may include a short voice note at the end to indicate that you would like to discuss this entry in the follow up interview.

PLEASE REMEMBER TO AVOID INCLUDING ANY NAMES OR IDENTIFYING INFORMATION

Appendix 18: Semi-Structured Interview Structure

RESEARCHER: 'Thank you agreeing to take part in this research. As we discussed during the orientation session, it will involve answering a series of questions as fully as you feel able to. As we move through the process, we may refer back to your audio diary entries, your contact log and your personal information sheet, so that we can get the most out of discussions around specific events. It's important to stress that I am not looking to evaluate your practice. I am simply here to learn more about your experience of responding to complex and challenging situations. You have previously indicated that you do consent to participating in this study. Is this still the case?' (ANSWER) 'I will also remind you that in order to ensure confidentiality is maintained you should avoid using names of individuals, and any obvious identifying information', 'Let's start by confirming you have worked in this role for 'X' months/years, and with previous employment in this role you have 'Y' years' experience'

TOPIC 1 –THE PARTICIPANTS LIVED EXPERIENCE OF A CARING/SUPPORT ROLE

- **Q.1A**: Can you describe the most rewarding aspects of your current role? PROMPT: Why?
- **Q.1B**: Can you describe the most challenging aspects of your current role? PROMPT: Why?
- **Q. 1C**: Having described both challenging and rewarding aspects of your work, can you define or describe your overall WORK ROLE/TASK in your own words?

TOPIC 2 – THE PARTICIPANTS LIVED EXPERIENCE OF 'BEHAVIOURS OF CONCERN'

RESEARCHER: 'Your diary indicates you have been involved in responding to various behaviours presented by individuals you care for/support.

- **Q.2A**: Tell me about the behaviours you have been involved in responding to? [Researcher shows the participant some specimen terms]. PROMPT: Tell me more about …
- **Q.2B**: In general terms how does it make you feel when you realise that [use the participants CHOSEN DESCRIPTIVE WORD] are developing/escalating?

TOPIC 3 –THE PARTICIPANTS EXPERIENCE OF RESPONDING TO 'BEHAVIOURS OF CONCERN' 'REFLECTION' 'IN-ACTION'

RESEARCHER: 'Focusing on some of the specific situations that you have captured in your contact log and audio diary'

Q.3A: Can you tell me more about the NON- PHYSICAL STRATEGIES and PHYSICAL STRATEGIES you explored?

Q> Can you tell me more about what you refer to as STRATEGY 'XXX'? [refer to those identified in the participant's contact log & diary entries and ask the following questions of each strategy that is explored – Orientating the participant first by presenting the relevant 'Contact Log' entry or playing the appropriate 'Audio Diary' excerpt]

PROMPTS:

- *What were you responding to? (PROMPT expansion): The risk to you? The risk to the supported person? The behaviour itself? The person? Something else?*
- *How did the situation make you feel? Were you aware of your feelings? How did you deal with your feelings at the time?*
- *What were your thought processes as you made sense of the situation? (PROMPT expansion): What was your rationale or reasoning for applying XXX? Have you made different sense of it since the event?*
- *How did you judge the effectiveness or ineffectiveness of XXX? (PROMPT expansion): What did you see, hear, feel or sense that led you to draw a conclusion?*
- *In that moment, did you get the impression that XXX was accepted or rejected by the person themselves? (PROMPT expansion): How did you arrive at that impression? Was that a reason to END the encounter? OR CHANGE your intervention strategy?*

- *In this particular situation you were [on your own]/ [with others] What difference did this make to how you felt about what was happening?*
- *FINALLY: In your mind, where did XXX come from?*

TOPIC 4 – THE PARTICIPANTS LIVED EXPERIENCE OF 'REFLECTION' 'ON-ACTION'

RESEARCHER: 'We are going to talk now about your experience of looking back and reflecting on situations you have been involved in'

- **Q.4A**: When you look back, in what ways do you think the way you respond to behaviours of concern influences the relationship you have with that person going forward? Can you explain/expand/describe…
- **Q.4B**: When you look back have on your responses, are there any that have resulted in you making changes to your practice? PROMPT: Do you distinguish between what worked and what didn't? PROMPT: Do you reflect on such things as an individual, or are their opportunities to feedback and/or reflect as a team/organisation? Can you explain/expand/ describe… PROMPT: Do you ever get any opportunity to discuss or address the feelings and emotions that are generated by dealing with such difficult and complex situations? Can you explain/expand/ describe…

RESEARCHER: 'That's all the questions I have. Are there any significant interventions that I haven't covered, that you think should be discussed? [discuss]. Is there anything else you would like to add that will help me too understand your experience of responding to situations? Any questions? Thank you for your time. I will share the findings with you…. DATE/TIMELINE'

Appendix 19: Behaviour Descriptions

‘Escalated Behaviour’	‘Non-Compliant Behaviour’	‘Risky Behaviour’
‘Challenging Behaviour’	‘Behaviours of Concern’	‘Disruptive Behaviour’
‘Violent Behaviour’	‘Destructive Behaviour’	‘Unsafe Behaviour’
‘Oppositional Behaviour’	‘Attention Seeking Behaviour’	‘Aggressive Behaviour’
‘Dangerous behaviour’	‘Anti-Social Behaviour’	‘Inappropriate Behaviour’
‘Distressed Behaviour’	‘Pain Based Behaviour’	‘Self-Injurious Behaviour’

Appendix 20: Guidelines On Interviewee Emotional Safety

This research project will involve interviews that will seek to understand how people make sense of the behaviour that presented itself, and how they decided what form of physical response was most appropriate.

In undertaking this process there is the possibility that an individual might find it uncomfortable or even distressing, especially if it brings previous experiences back to the forefront of people's minds. In order to manage this risk, the following guidance is provided.

1. Ensure all participants are fully informed about potential risks.

Prior to participation in the research study, it is important that potential participants are made aware of the scope of the research project.

They will be provided with an information sheet outlining what is involved in the project. This includes the following statement:

'*Recording your immediate reflections on involvement in an incident involving escalated behaviour and discussing such events within the context of a follow up interview has the potential to be uncomfortable. The interviewer will always aim to ensure the subject is dealt with sensitively, but as has been stated already, if you change your mind and want to stop participating in the study you have a right to withdraw without any reason or any negative consequence'.*

If anyone does decide to end the interview/discontinue their participation in the research the researcher will remind them/signpost any organisational support structures.

If the researcher is unsettled or distressed by events he discusses, he has the right to convene an ad-hoc/emergency supervision to discuss his feelings/experiences with his supervisors.

2. Stay aware and monitor for signs of distress

Individuals who may need assistance include those showing signs of distress, including individuals who stop responding to questions, become tearful or start to cry, become withdrawn or 'shut down', are irritable or angry or express concerns or regrets about their actions.

3. Maintain a Calm Presence

People will take their cue from how others are reacting. By remaining calm and responding in a measured and non-judgemental manner the message is that it is safe and that any emotional discomfort will pass.

4. Remove source of distress (stop the interview)

The focus now must be to provide the time and space for individuals to re-orientate on the present, and the here and now. This can be facilitated in part by suspending or terminating the interview. Closing any laptop or file displaying any images, and terminating the line of questions.

5. Provide Safety and Comfort

- Give the person a few moments before you speak
- Indicate that you will be available if they need you
- Remain calm, quiet, and present, rather than trying to talk directly to the person, as this may contribute to cognitive/emotional overload.
- Just remain available, while giving him/her a few minutes to relax and re-orientate
- This is often enough for the person to feel safe, secure and present once again

6. IF THE DISTRESS IS TRANSIENT: Ask if the person wishes to continue with the interview

The person may wish to continue with the interview, or formally end it.

As a researcher your ethical responsibility is to the person and you must never try to encourage the person to carry on. The decision must be their own, and made of their own violation.

7. IF THE PERSON AGREES TO CONTINUE: Complete the interview.

Thank the person at the end, and make it clear that if they want to further discuss the matters that have arisen, they are free to get back in contact

The researcher will also remind participants/signpost any organisational support structures.

8. IF ANY DISTRESS IS ENDURING: Provide choice: Connection with Social Supports

In the unlikely event the distress is significant, and the interview is terminated the goal now becomes directing the persons towards establishing brief or ongoing contacts with supportive persons or other sources of support, including family members, friends, and/or organisational or community resources.

Discuss the options they have for seeking help and encourage them to contact the relevant support services.

If they refuse to get help and you believe the distress is an indicator of an underlying crisis, best practice would be to re-affirm sources of support such as those outlined.

The cessation of the interview will however remain confidential.

RESEARCHER FOLLOW UP

If any interview is terminated and/or someone withdraws because of the distress encountered the researcher must inform their research supervisor on the day of the interview and discuss an action plan. This may include the scheduling of an ad-hoc supervision meeting to more formally discuss matters arising.

If the researcher experiences distress as a result of what has been observed they must raise it with their research supervisor on the day of the experience and discuss an action plan. This may include the scheduling of an ad-hoc supervision meeting to more formally discuss matters arising.

INFORMATION ABOUT LOCAL SUPPORT ARRANGEMENTS

Thank you for taking part in this research study.

It has involved calling to mind and discussing events that have taken place in the work setting.

Reflecting on those behaviours of concern that you may have faced, and the ways in which you might have responded to them could conceivably lead to feelings of discomfort and even distress. Especially if it has brought previous negative experiences back to the forefront of your mind.

Such responses are normal responses to extraordinary events, and there is a great deal of support available that can help you to resolve such feelings.

YOUR LOCAL GP

Your local GP can be contacted by phone or email and is in a position to provide or signpost local support services.

NHS SUPPORT

The NHS have a webpage with a list of resourceshttps://www.nhs.uk/conditions/stress-anxiety-depression/understanding-stress/

If you need help urgently, but it's not an emergency 111 can tell you the right place to get help if you need to see someone. Go to 111.nhs.uk or call: 111.

SAMARITANS

Confidential support for people experiencing feelings of distress or despair.

Phone: 116 123 (free 24-hour helpline)

Website: www.samaritans.org.uk

SUPPORT AVAILABLE VIA YOUR WORK SETTING

This section will be populated with local information at the point key operational information is gathered to populate the contextual profile (Appendix E)

Reference/Source:

National Child Traumatic Stress Network and the National Center for PTSD (2006) Psychological First Aid Field Operations Guide

Appendix 21: Guidelines On Data Protection & Management

1. The researcher is committed to ensuring all files will be uploaded into a password protected storage space as soon as is reasonably practical after receiving them. This will be in a password-protected OneDrive storage application, where it will be held in accordance UK Data Protection Regulations.
2. This will involve the transfer of files from their source location to the researcher's computer to the secure storage area.
3. This process may involve files being converted to a digitally storable format. This may involve scanning paper documents into the computer, and permanently destroying the original.
4. Copies of any files which may have temporarily been stored on devices owned, operated, or provided by the researcher will be permanently deleted once they have been transferred.
5. Up until the point of upload files may be temporarily held on devices under the direct supervision of the researcher. When devices are being used to temporarily hold such data they will be retained at all times by the researcher.
6. The password to his computer will be retained by the researcher, and not shared or written down.
7. The password to the Strathclyde storage area will be retained by the researcher, and not shared or written down.
8. The data will be uploaded to the storage location as soon as possible, which in practice is likely to mean before the day is over.
9. The researcher will not retain any copies of any files on his own computer, or on any storage device once the files have been transferred to the secure storage space.
10. All review and editing of files will take place on password protected equipment and in private spaces.
11. The research supervisors will be granted access to files as required to fulfil their supervisory and quality assurance roles. They will observe the same data management protocols and restrictions on storage as the researcher.
12. No copies of any audio will be made or shared, with the exception of any clips that could become part of a formal criminal investigation if unlawful actions are disclosed.
13. Any audio reviewed by the researcher that are not taken forward to the interview stage will be permanently deleted as soon as practically possible.
14. It is anticipated that a small number of audio clips will be extracted from the diaries to use as stimulus material during interviews. The audio clips available to the researcher for the purposes of the interview will remain in the secure storage space, and be played directly from there.
15. Note that once transcripts have been effectively anonymised it is then effectively no longer private information. Therefore, the use of any excerpts or from the research for the purposes of supporting the final thesis, any published article of dissemination of findings through professional conferences will not be subject to additional consent.

Appendix 22: Recording Device Specification: 'Digital Voice Recorder'

DESCRIPTION: Sony ICD-PX240 High-Quality MP3 Mono Digital Voice Recorder with 4 GB Internal Memory and Long Battery Life

PRICE: £34.99

Product Description

- Built-in memory: 4GB
- PC connectivity: Yes
- Built-in microphone: Monaural
- Recording format: MP3
- Playback format: MP3
- Battery type: AAA x2
- Maximum files (total): 495
- Maximum files per folder: 99
- Battery type (provided): Dry battery (alkaline, size AAA)
- Low-cut filter: Yes
- Add/overwrite recording: Yes
- VOR: Yes
- Recording monitor: Yes
- Battery life for recording MP3 8 kbps (monaural): 32 hours
- Battery life for recording MP3 48 kbps (monaural): 27 hours
- Battery life for recording MP3 128 kbps: 23 hours
- Battery life for recording MP3 192 kbps: 21 hours
- Frequency response MP3 8 kbps (monaural): 75-3,000 Hz
- Frequency response MP3 48 kbps (monaural): 75-10,000 Hz
- Frequency response MP3 128 kbps: 75-15,000 Hz
- Frequency response MP3 192 kbps: 75-15,000 Hz
- Digital pitch control (speed control): Yes
- Noise cut: Yes
- Easy search: Yes
- Alarm playback: Yes
- Erase: Yes
- Protect: Yes

Box Contains

- Quick Start Guide
- Stereo Microphone with Shirt-Clip
- Dry Battery x 2

SOURCE: https://www.amazon.co.uk/Sony-ICD-PX240-High-Quality-Recorder-Internal-Black/dp/B00IZEJFPE/ref=sr_1_1?dchild=1&keywords=Sony+UX-533&qid=1593928819&s=electronics&sr=1-1

Appendix 23: Recording Device Specification: 'Password Protected Recorder'

DESCRIPTION: Speak-IT Premier Password Protected 8 GB Digital Voice Recorder

PRICE: £58.80 incl. VAT

An affordable password-protected voice recorder from Speak-IT

Make your recordings on-the-go and remain confident that your ultra-portable recording device is password protect to secure your device and personal data. The Speak-IT Premier Password Protected Voice Recorder gas exceptional audio quality and connects to your PC for quick and easy file transfer. Equipped with dual stereo microphones for HD recording, the microphone sensitivity control allows you to adjust the input level of recorded audio to suit your environment. This device supports Wav file format.

- Superior recording quality with two HD sensitive microphones
- Recording folders A/B/C/D (save up to 999 files in each folder)
- 360 Stereo Recording
- AGC intelligent dynamic noise reduction
- Extra-long standby - 320 hours' battery life in standby mode
- Built-in 8GB USB flash drive
- Store up to 280 hours of audio
- One key recording - slide switch up to 'Rec' to commence
- A/B repeat function
- Fast forward and rewind during playback
- Play MP3 music/audio files
- Built-in loudspeaker
- LCD display screen
- PIN/password protection for device security
- Files password protected when transferred to a PC
- Easy file transfer via USB cable (included)

Box Contains

- Speak-IT Premier Digital Audio Voice Recorder with Password Protection
- Earphones
- Telephone Recording Adapter
- Micro USB Cable
- User manual

SOURCE: https://speechproducts.co.uk/collections/view-all-philips-digital-recorders/products/speak-it-premier-password-protected-8-gb-digital-voice-recorder

Appendix 24: Smartphone Functionality

The mobile phone is ubiquitous. A smartphone is a mobile phone combines characteristics of an ordinary phone with computer functionality (Gill, Kamath, & Gill 2012). Within the context of a Doctoral cohort that with a growing racial and gender mix that faced significant financial contrast Matlala and Matlala (2018) describe how smartphones were used in their research as a cost-effective alternative to purchasing Dictaphones or purpose built recording devices. They outline the describes its multi-tasking applications.

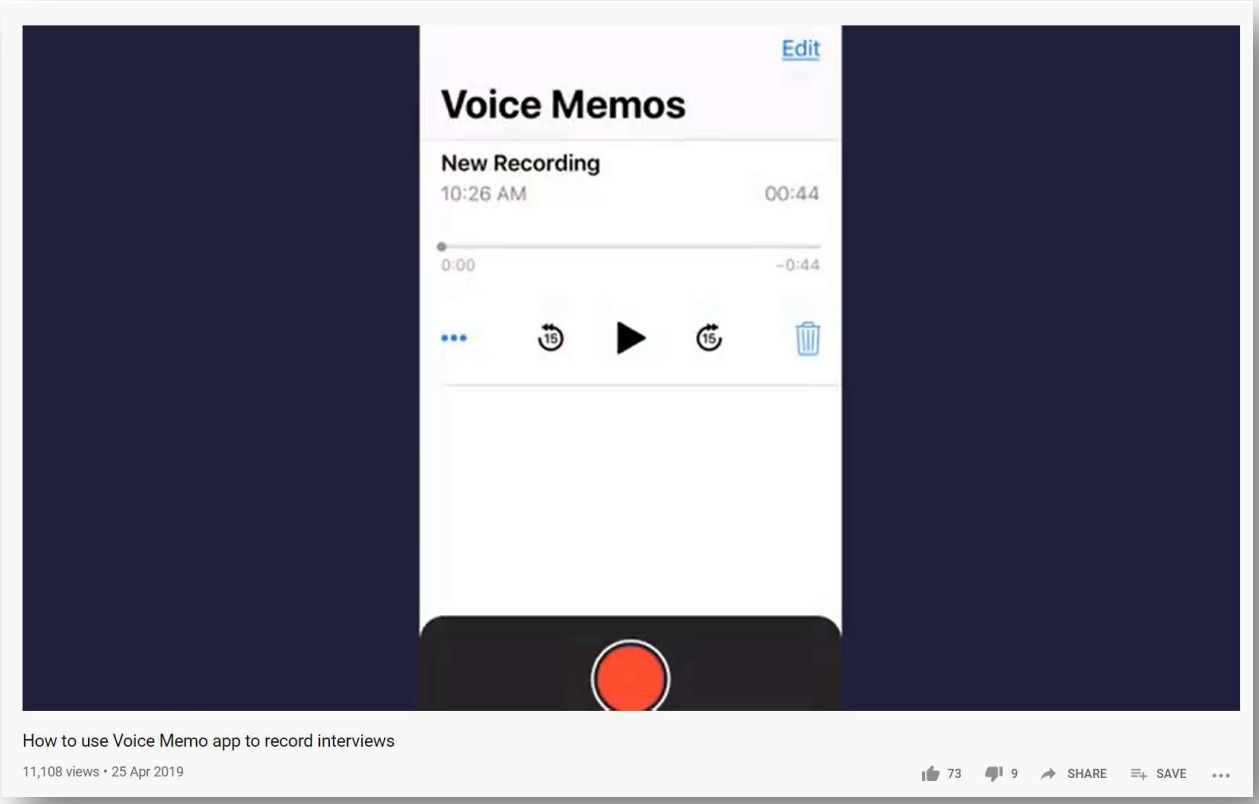
Smartphone Application	**Research Utility**	**Use in research**
Short Message Service (SMS) Text message Multimedia Messaging Service (MMS)	Data Collection	To remind participants about appointments for data collection
Airplane mode, Flight mode	Data Collection Data Analysis	To prevent interference from calls and messages during interviews and recording
Voice recorder Voice memo	Data Collection Data Analysis	To record interviews and voice memos and then store the voice recordings to use when needed
Audio jack, Connector,	Data Collection Data Analysis	To connect headphones during listening of voice recordings
Wi-Fi (Wireless Local Area Network) Internet browser	Data Collection Data Analysis Reporting of Findings	To connect to the internet and surf the World Wide Web (www) in search of relevant literature to provide background and support findings and search for tools to facilitate data analysis

The first author's doctoral research comprised n=25 semi-structured interviews lasting between 30 and 60 minutes, all of which were captured on his smartphone. Matlala and Matlala (2018) also report smartphones being used to collect data in education and health care research.

Appendix 25: YouTube: ‘How To Use Voice Memo App To Record Diary Entries’

This short video provided a quick overview of how to use the voice memo app on an Apple I-Phone.

During the induction session the functionality of participant’s smartphones was explored.



https://www.youtube.com/watch?v=mlWHI1hjfB4

Appendix 26: Researcher Profile

Lee Hollins *BSc (Hons) Physiotherapy, PGCert Health Research*

Lead Assessor BILD-ACT

My current work as **Lead Assessor** for BILD-ACT involves examining the suitability and implementation of a brand-new set of national training standards governing the use of restrictive intervention (including physical restraint) across health, social care and educational settings. I am currently involved in the pilot phase working with organisations providing care and support across various settings right up to and including high secure hospital settings.

Since the mid 1990's I have been involved in designing and delivering training programmes designed to provide staff with the knowledge and skills they need to safely and sensitively manage behaviours deemed to be 'of concern' (in practice these have ranged from socially challenging behaviours through to overt and calculated acts of criminal violence, depending on the setting). These training programmes have been designed for a wide range of groups ranging from parents and support workers, nursing and other clinical staff, local authority employees, housing association staff, pub, club and bar staff as well as various types of security staff.

As a qualified physiotherapist I have a particular interest in the safety of all forms of physical intervention. In practice this involves working to integrate research findings into practical strategies. Such work is at the heart of restraint reduction and restraint minimisation. I have written extensively on this topic and have been published across a range of academic journals. Articles have examined the assessment of risk, **using physiotherapist to assess the suitability of physical intervention skills as well as the risks arising from the use of unaccountable trainers/tutors (**see below).

I have examined physical interventions and the management of risk many settings. To this end I completed a review for the Home Office Immigration and Nationalisation Directorate; 'The role of the security guard: An examination of the potential for exposure to violence'. This led to me being tasked with creating staff response guidelines for the security team at the Home Office Immigration and Nationalisation Directorate.

Prior to involvement in such strategic projects, I have had direct experience of security management in various licensed retail settings as well as being on the team that took operational charge of the stewarding at the Notting Hill Carnival.

In autumn 2017, I won the coveted John Anderson Research Award at Strathclyde University. It was the first time that a researcher working within the School of Social Work & Social Policy had won the prestigious award. The prize was the funding of My PhD which is examining how the process of providing safe physical containment/holding experiences is mediated by gender. This research will be focused on adults with Learning Disabilities.

<u>Publications</u>

Hollins, L.P. (2018) Martial Arts, Disruptive Innovation and the Future of Physical Interventions? *Learning Disability Practice*, 21 (1) pp.20-25

Hollins, L.P. (2017) The NICE 10-minute physical restraint rule: A discussion of the relative risks. *Journal of Psychiatric and Mental Health Nursing*. 24 (9-10) pp.719-726

Hollins, L.P. (2017) The Reality of Physical Restraint: An Online Survey for Adoptive Parents: 'A Cry for Help'. Findings of a co-project with the Open Nest adoption support charity. pp.1-15

Hollins, L.P. (2016) Physical interventions: hiding in plain sight. *Learning Disability Practice*. 19 (10) pp. 35-38

Stubbs, B. and **Hollins, L.P**. (2011) Are Physical Intervention Techniques likely to cause pain or injury when applied to manage the severely aggressive older adult?: A Survey of physiotherapist's expert views in the UK, *Journal of Clinical Nursing*, 20 (4) pp. 855-857

Hollins, L. P. and Stubbs, B. (2011) The shoulder: taking the strain during restraint, *Journal of Psychiatric and Mental Health Nursing*, 18, pp. 177–184

Hollins, L. P. and Stubbs, B. (2011) 'Managing the risks associated with physical intervention: a discussion paper', *The British Journal of Forensic Practice*, Vol. 13 (4), pp.257 – 263

Hollins, L. **P**. (2010) **Proposing a common sense approach to assessing the risks posed by physical intervention techniques.** *Journal of Psychiatric and Mental Health Nursing*. 17 (3) pp.216-221

Hollins, L. P. (2010) Managing the risks of physical intervention: developing a more inclusive approach. *Journal of Psychiatric and Mental Health Nursing,* 17(4) pp.369-76

Hollins, L. P. (2010) **Using a physiotherapist to assess the suitability of physical intervention skills.** ***Learning Disability Practice*** **13 (3)** pp. 26-28

Hollins, L. P. and Paterson, B. (2009) Physical intervention Trainers; the case for greater accountability. *Journal of Psychiatric and Mental Health Nursing.* 16 pp. 376-381

Appendix 27: Researcher Personal Reflexivity Statement

From earliest memories I can recall living in a home that was routinely filled of violence, and the threat of violence. My father, who was brought up in the care system, used violence as a means of securing a certain status or standing founded on fear.

As a result of deep reflection during this inquiry, of violence, and power revealed through relational dynamics, I can now see more clearly how both my personal life, and my professional life were shaped by this relationship by violence; The fear of it initially and most strongly, and then the desire to engage with it and triumph over it. This journey through violence, involved many hours a week spent in the dojo to master the physical techniques. It also involved time spent working in a security role 'on the doors'. It was in this space that the tension between being good at violence and being good at restraint was perhaps initially indivisible for me. Subsequent work as a trainer has allowed me to consider and begin to explore power, risk and the function of any use of force. My conclusion was that power, status and violence were intertwined, and that its utility is so great that violence in one form or another is enmeshed in the very fabric of society. Manifestations can be seen in hospitals, care settings, prisons, police stations, pubs, clubs, bars, schools, homes and the streets which interconnect us all.

Perhaps endeavouring to try to find some redress to violence is a way of exorcising demons. Certainly, my life has been filled with violence and symbolic violence. In my late teens I became interested in 'Ju-Jitsu' and began to study it. Looking back now I realise my interest in it was in part driven by my fascination with the ebb and flow of the various techniques, especially the 'Grappling Skills', whose physical 'systemising' became an intellectual as well as a physical pursuit. I can also now see it was also driven by my desire to develop a physical competence in self-defence which I perhaps saw as a pre-requisite for being a successful 'man'. Most importantly I recognise now that my attempt to master this 'unarmed combat' system was to win the approval of my father, who was a powerful, violent and feared man.

After gaining my black belt I began to run ju-jitsu clubs. I also ran public 'Self-Defence' classes giving people access to the simplest and most powerful techniques that they could use to escape danger. About this time some of my students, who were involved in the security industry, invited me to join their ranks and work alongside them in pubs, clubs and bars as a doorman. They said it would be an opportunity to see how effective techniques are in real world conditions they said. And it was. Over the course of time, I got involved in training door supervisors as well. These I taught a narrow range of skills that enabled them to break up fights, to evict people from venues and/or detain them until the police arrived. These were mainly 'Restraint Techniques'.

The night-time economy seems to bring out the worst in people, and in particular men. Whilst at work I bore witness to the needless violence. This was sometimes a drunken overreaction to a perceived sleight, or just to make the perpetrator feel tough, to feed their need to feel powerful and project an image of being 'hard'. Bearing witness to people being hurt affected me, and caused me to question both my job role, and the violent masculinity that it exposed me to. I used to contend that those immersed is such events for long periods of time eventually saw their own souls darken. I didn't want to suffer this fate.

It was about this time, that I began working for a professional training company. Here I worked with former 'Control and Restraint' instructors to create training programmes which excluded all the harmful and coercive elements associated with the C&R philosophy. I learnt how critical it was to specify the right 'Physical Intervention Skills' when working in settings where vulnerable adults were being supported. Week in and week out I delivered training designed to enable staff to respond sensitively to challenging behaviours. I estimate I trained between 500 and a 1000 staff a year for at

least a couple of decades, as well as having formulated many bespoke person-centred, fully risk-assessed 'Safe Holding Plans'.

I qualified as a Physiotherapist along the way and went on to get my Post Graduate Certificate in Health Research. I trained in various clinical settings; elderly, respiratory, amputee and intensive care but ultimately decided against clinical practice. The knowledge and skill I gained was however invaluable in analysing physical techniques and exploring the implications of their use in terms of the risks they present. I have since had several academic articles published in peer reviewed journals.

My work expanded to include the management of physically challenging behaviours presented by children and young persons within adoptive families and foster care settings. The need to sensitively formulate plans for a population who have often been exposed to abuse, and neglect necessitates a trauma informed approach, as well as the development of strategies which permit safe emotional containment by parents and carers in times of crisis; these have been labelled forms of 'Therapeutic Holding'.

I won the John Anderson Research Award at Strathclyde University. It was the first time that a researcher working within the School of Social Work & Social Policy had won the prestigious award. My initial plan was to examine how the process of physical restraint was mediated by gender. The initial plan was to examine whether the use of force and techniques was influenced by masculine and feminine perspectives. The backdrop to this is the examination of power and how gendered structures of oppression operate across society.

Sylvia Walby defined the 'Patriarchy' as the 'system of social structures and practices in which men dominate, oppress, and exploit women'. I can now see that my journey into this topic, of exploring physical force, of examining power imbalances and gender differences, began. It was because of my relationship with my father. He passed away just before I started my Doctoral studies. He was finally sober and spent his final years struggling with a host of ailments including liver failure, Parkinson's and Dementia. I had made peace with him before his passing and have come to realise he was who he was because of a difficult childhood and his time in the care system. But I also now see why I am who I am. As I now reflect, I believe am a decent and caring person who empathises with those who are vulnerable and scared. I always strive professionally to identify the safest and most ethical ways of managing physically challenging behaviours. Dignity and kindness are everything. I realise I have him to thank for that.

Appendix 28: Researcher Personal Diary (Excerpt)

23/09/2021	First audio diary entry	• I have received my first audio diary entry. • Really pleased with the reflectivity and openness • Of course, I fear the Hawthorne effect [?] people giving me favourable or flattering perspectives, but I think the interviews will provide an opportunity to go deep and get unvarnished answers. • The entry spoke of completing a hold. I wonder if there was any other physicality? I need to dig during the interview – this has just reminded me to open up a case file where I can make these notes which I can pick up on later.
23/09/2021	First audio diary entry - Researcher acknowledgement	• The audio was accompanied by a text WhatsApp message checking to see if the audio was ok • I felt compelled to respond, because to ignore it would be rude, and could lose participant goodwill [relationship] • This having been said I needed to be careful to ensure that the response was study neutral – that is I didn't want to influence what appears in future entries – e.g., 'I really like the description of restraint you provided' – which may cue an increased attention to this specific facet of their lived experience or type of event • Instead, I said 'Just to confirm I received the message, the recording came through really clear. Thanks for following the diary structure, looking forward to receiving future entries. Speak soon. Thanks again' • I think that this is a form of relational working that I need to think more about i.e., encouraging and prompting participants but staying outside of giving any steer on the data collection or any favoured type of detail
05/10/21	Physical contact logs received	• The physical research diary entries outline the scant nature of the physical contact logs received. • This is once again disappointing. • Why did it happen? • Either my instruction wasn't clear enough • That scant entries are a by-product of people being busy and quickly backfilling the paperwork after the fact • Perhaps peoples are convincing one another that it just needs to be kept simple and straight forward – a message I would have tried to give out, but would not have meant quite this simple and straight forward. • Whatever the cause I must try to salvage the situation. My strategy is two-fold: 1. I have sent short audio messages which hope serves a number of functions: bring the research to mind, validate their involvement [by showing polite gratitude] and giving some light direction as to what is expected [without the suggestion that what has been received is less than I expected 2. As with the audio diaries I feel that there is a different and unexpected type of data in their. Still relevant but not in the clear, unambiguous form I expected. I do think I am moving away from the mechanics of crisis management to the exploring the frame of mind/ emotional intelligence/ frame of engagement that underpins caring interventivity. It is not just the selection of techniques and tactics in the moment that define the response it is those things much further upstream that determine it. I think that relationships are a part of this

05/10/21	Relationships?	• I have looked at the structure of therapeutic relationships. I have come across the stages, the required knowledge, and capacities, but what I'm not clear about is whether you have to like a person? Or whether 'you can fake that until you make that?' • I came across a small entry in a Guardian obituary to Lord Longford: '*..in the late 1980s, he was contacted by the solicitor for a young Dutchman, convicted of a drugs offence, sent to Albany prison on the Isle of Wight, suffering from Aids and cut off by his family. Longford was the only person to visit this dying man, a gesture repeated in countless episodes that never made headlines but which brought succour and relief..*' • What does it take to care for someone you don't know? In the case above, someone you do know has done wrong? And potentially caused harm to others • I think Lord Longford's faith may have something to do with this, but such unconditional positive regard can't be solely a by-product of faith? [I'm also reminded of Ruddick's 'Mothers' and of Confortini & Rouane's 'living with dissonance'. • Do support workers or nurses like the people they care for and support? Does this make a difference to how they respond to them in periods of crisis? If so, can this be manufactured or stimulated in others??
	Delays, dropouts and disruptions	• The delay in recruiting site 2 is beginning to cause anxiety. I would be a really great site to work with but what with covid, and operational priorities I have approached a fall-back site. Again, I am encountering the spectre of covid, and the primacy of operational priorities. Perhaps supporting external research is of secondary importance? And people do seem to worry that the research is going to be critical. Certainly, this was a question that was raised by site 2. My response is that I am trying to understand the experience, and not evaluate practice. Time will tell. • The lesson here, I think, is that I need to be able to provide reassurance up front and highlight possible benefits. Research, it seems, needs to be 'sold' to perspective supporters
18/02/22	Interview reflections: site 1	• An interview can be defined as 'a conversation with a purpose'. • I have now undertaken 4 out of 5 of the interviews scheduled for site 1. • I have now come to think of an interview as a 'one sided conversation with a purpose'. • If I converse freely, I run the risk of shaping the interviewees perspective, or sense of what answers I might expect. Or worse still of my personal perspective. • I recognise the need to take responsibility for regulating the extent of my input; verbal and non-verbal. This can mean holding back, and can mean waiting. It's a skill and I am aware I need to continually hold the goal of the interview in mind, and to keep myself [Lee] out of the exchange. It must be undertaken by the researcher [who happens to be Lee]
18/02/22	Interview reflections: Site 1	• I interviewed two people who swore when answering nothing hostile, 'I'm pissed off', 'Its bloody unfair' and 'I got kicked in the balls' • I found myself when relating back, echoing their language 'So when you get pissed off..' That type of thing. • It instinctively feels like the formality of the interview has been lost. By lost I think I mean that the language is informal and doesn't immediately feel like language I would uses as the interviewer. I think that would be the context in

		which the unspoken professional contract between myself and the research participant might be breached. • 09/04/22 – I've come back to this and think that I need to talk to people in a language they understand and feel comfortable with. My policy seems to be let the interviewee to set the limits – and tentatively reflect it back where echoing it is necessary for a line of inquiry. I have listened since to the content of the speech of those around me and recognise that in casual conversation its endemic. Maybe I am being too sensitive as part of inhabiting what I perceive to be the professional researcher persona I need to reside within.

Appendix 29: Researcher Expectations

September 2020

- Physical intervention will be messy. Whilst some final holds might end up resembling an authorised one the journey to the hold will be chaotic and require field adaptation
- Other holds or holding configurations will be spontaneously developed, but potentially be distributed across/amongst carers/family/team members.
- Personal experiences and prior applications of force/restraint will be more powerful educational events than formal training events, policy etc.
- The application will be supplemented by other subtler, soothing (rather than restraining) physicality's such as touch, and non-physicality's such as eye contact and vocalisations which may be more powerful than any physical hold in and of itself – this may be considered relational practice
- Staff will feel conflicted about the use of force; it will be characterised as a necessary evil
- Family members will more strongly recognise the protective value of physically intervening, therefore demonstrating a more pragmatic, less emotional perspective than staff in relation to the use of physicality/restraint – provided that any physicality/restraint is used as a last resort and utilising minimal force for the minimum amount of time [pure interventions]
- Staff and family alike will be adversely emotionally affected by any distress revealed by the supported individual, this may be differentiated with family members have a guilt component linked to their genetic relationship to the person.
- The caring sensibility will transgress boundaries ordinarily demarcated by codes of practice. E.g. touch will be acceptable, friendship will manifest. Even love?
- Staff will reflect individually and collectively and shift physicality's and broader responses to a truly person-centred approach.
- In the event pain or distress is caused, or 'physical interventions' otherwise fail there will be a tendency towards openly discussing and learning in a way that might not so readily occur within corporate or congregated/group living arrangements.

Appendix 30: Restraint Training Systems

Description of restraint training

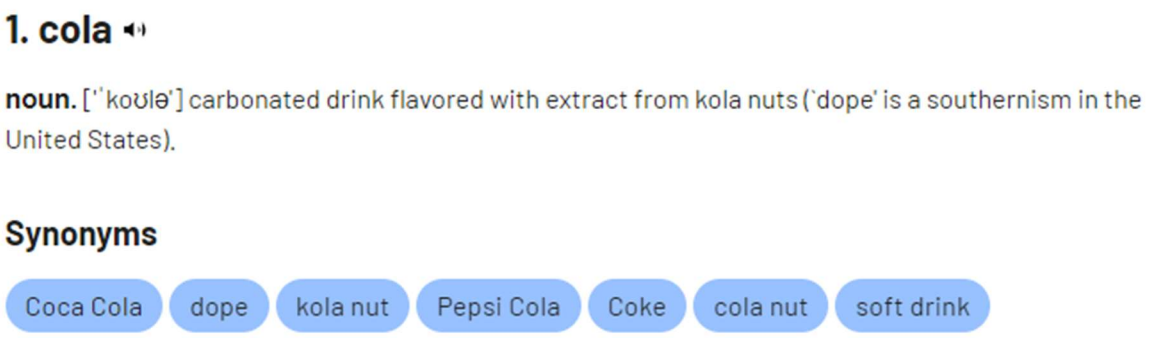
Organisations offer what is often referred to, or could be classed as, **PMVA** training to the staff.

The term PMVA refers to 'Prevention and Management of Violence and Aggression' training. It is a general, umbrella term used to describe training that includes instruction in the use of various Physical Intervention [or Physical Restraint] techniques, with varying levels of accompanying theory training.

There are variants of this umbrella term, such as:

- **MVA** [Management of Violence & Aggression, or Managing Violence & Aggression Training]
- **PMAV** [Professional Management of Aggression and Violence] and
- **TMVA** (Therapeutic Management of Violence and Aggression).

In some instances, individual training organisations have coined the term as a way of differentiating their training. However, as a result of this type of training in effective being a commodity in a marketplace there has been a tendency for vendors to use titles and terms in order to position their product as a purchasable entity. Such generic labelling is not uncommon is other contexts [see below]



Historically reference was made to the term Control & Restraint [C&R] following the introduction of a system of this name in the prison service. The term became synonymous with restraint training and was used as a generic label. Once it began to all from favour, alternative labels were explored for a time e.g., or Care & Responsibility training.

Brands of restraint training

There are also different branded training systems. Examples of which are:

- GSA,
- PSVR and
- Safety Interventions [previously known as MAPA].
- RESPECT

There are also training providers whose physical skills systems are often referred to by use of the company name e.g., NAPPI, Proact SCIPR, Studio III, TCI, PRICE and CALM.

These systems may have very different underlying approaches, put different emphasis on the role of physical techniques and include different techniques, but could still be categorised as being a PMVA type offering.

Appendix 31: Home Policy Covering Responses to Behaviours Of Concern

There seems to be no **First Order Policy** that is dedicated to those responses to behaviours of concern in the family space. Presumably this is because the state doesn't mandate the practices of private citizens in their home. However, the fact that the provision of additional support is funded by the government through the 'personal Budget' mechanism means that the home does become a place of work, and individuals providing care and support become employees or 'Personal Assistants'.

Policy, such as it is, at the second order level seems to be comprised of an amalgam of strategies and practices which come under the oversight of the Care Coordinator appointed by the funding commissioner. In this unique space one can see the influence of common law, health and safety legislation as well as the overflow into it of best practice from more formally regulated caring spaces.

To be clear there is no central service level policy, that **proceduralise** staff responses to 'behaviours of concern'. Caring and supportive practices, including responses to behaviours of concern comes under the most immediate oversight of MUM on a day-to-day basis. The Senior Support Worker acts up as a managerial proxy if MUM isn't available or is off site.

Basic support is outlined in a document entitled 'My Support Plan' which covers physical health, eating and drinking, mental health, emotional support, relationships, personal safety and access to the community etc. Further to this, behaviour support [which includes reactive behaviour management] is outlined within a personalised 'Positive Behaviour Support Plan' which covers triggers, early warning signs, strategies to prevent SARA getting upset as well as those strategies for managing any risks arising. This is augmented by a 'Quick Guide Positive Behaviour Support Plan' providing a readily accessible aide -memoire. These are developed in conjunction with, and reviewed by, the aforementioned 'Care Co-Ordinator'.

The knowledge and skills required to implement the agreed support, including responding to behaviours of concern, are developed by a combination of formal training sessions [including a behaviour support/management programme delivered by the 'Care Co-Ordinator'] and working alongside MUM [or the Senior] with individual, personalised understandings being further enhanced through scheduled team meetings and informal post incident or issue-related conversations.

Support activities are logged in the 'Daily Support Record', with incidents arising being more expansively recorded in the 'Supervised Seclusion Form' which includes those instances when SARA is moved into the BLUE ROOM (more shortly). Any injuries arising from the use of physical actions/interventions are noted in a separate 'Body Map'.

The BLUE ROOM is a lockable room which is used solely to provide a safe, low stimulus space for the supported person [SARA] to self-regulate within, in the event that she 'goes into incident'. Technically it amounts to a seclusion area. Seclusion being a practice that has been defined as involving 'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving' (Department of Health, 2015 p.103). It has been described to the researcher as being without any formal furniture, but with soft, padded surfaces. Its entrance is covered by CCTV which records 24/7. Its use has been scrutinised and approved by a 'Best Interests' panel. It has a procedure with its own governance arrangements, hence a dedicated 'Supervised Seclusion Form'.

Appendix 32: Hospital Policy Covering Responses To Behaviours Of Concern

The **Second Order Policy**, which flows from to national **First Order Policy** documents is an organisational level policy, that **proceduralise** responses to 'behaviours of concern'.

This centrally relevant policy is one of many, and as such is augmented by a number of related policies covering care planning, the formulation of advance statements, seclusion and long-term segregation, the use of restraint devices, rapid tranquilisation, lone working and exposure to blood borne viruses amongst others.

There is a very clear, upfront commitment to:

- Preventing, minimising, and managing aggressive and violent behaviour in a safe and ethical manner
- The safe and professional management of aggressive and violent incidents consistent with a duty of care to ensure life, safety and health of the patient and staff, showing respect for the individual and their unique needs, ensuring that all patients are treated justly and fairly, and that their Human Rights are respected and met. 'Respect for the patient's autonomy within the parameters of safety including advance statements related to restrictive and other interventions and their alternatives'.

There is a commitment to ensuring the professional management of aggressive and violent incidents is in line with:

- The European Convention on Human Rights
- The Human Rights Act 1998
- The Equality Act 2010
- The Mental Health Act 1983: Code of Practice (DoH, 2015)
- The Health and Safety at Work Act 1974
- The Criminal Law Act 1967 3(1)
- Common Law: 'Cases of Necessity'
- The Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice (2008) and
- The Mental Health Units (Use of Force) Act 2018
- Violence and aggression: short-term management in mental health, health, and community settings (NICE, 2015)
- NICE - Endorsed Resource – Positive and Safe – Violence reduction and management programme – Instructors Manual
- Restraint Reduction Network (RRN) Training and Trainer Standards
- Department of Health - Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health (DoH), 2014)

It is made clear the document has been consulted on organisation wide.

As can be seen, behaviours of concern are nor referred to as such, and are referred to indirectly as:

- The Disturbed Patient
- Behavioural Disturbance
- Aggressive and Violent Incidents
- Violence and Aggression

There is a reference to strategies designed to optimise the personal safety of staff.

Managers are responsible for ensuring staff undertake MVA training, and staff are responsible for attending.

There is a commitment to, and an outlining of, **'Primary Preventative Strategies'**, which include de-escalation and the use of low stimulus environments.

There is reference to **PBS plans** and **Risk Management Plans**. The former focusing on identifying more proactive than reactive strategies designed to enhance quality of life, and enable the person to develop new skills and more effective ways of getting their needs met. The latter is linked to the PBS Plan, but identifies individualised strategies aimed at predicting, preventing, and managing violent and aggressive behaviour. This is augmented by information on risk recognition.

The completed risk management plan must consider, trauma histories, physical health issues, personal statements and a hierarchy of staff interventions must be considered and incorporated into the patient's individualised risk management plan, and the risk assessment should also take account of any cultural needs. Where possible, patients should be involved in the development and review of their individualised risk management plan.

The risk management plan should provide clear directions on the use of pre-emptive and/or reactive strategies including the use of physical restraint if this is necessary to manage the patient's behaviour. The patient's risk management plans and personal statements should be reviewed with the patient monthly and amended accordingly if necessary

There are then **'Secondary Interventions'** which are low level physical interventions designed to limit the persons immediate ability to cause harm as well as move them to a secondary area, such as a low stimulus environment in order that they might self-regulate or be co-regulated.

'Tertiary Interventions' are described as the most restrictive interventions, and are specifically intended for those exceptional circumstances where the level of risk to others requires staff to exert a maximum level of control over a patient's limb movement and mobility to prevent physical harm to others. It is made clear that such holds should not be routinely applied and should only be used in situations where the use of secondary interventions is assessed to be ineffective (unsafe) in containing the patient's behaviour and/or minimising the risk of harm to others, and that the decision to use tertiary strategies should always be based on necessity, proportionality and reasonableness

These responses to such are presented hierarchical, and it is made clear that certain responses are limited to certain sites or services.

The policy goes on to highlight staff responsibilities for managing risk within incidents, recording their actions, engaging with/providing post incident support to those involved, and participating in posit incident reviews for both staff and patients with 'a view to learning lessons and future prevention'.

In terms of operationalising the policy, or translating its aims into practice on a patient by patient, incident by incident, intervention by intervention, the following is stated:

- All staff are responsible for their own safety and the safety of others
- Knowledge of environmental and situational factors which may lead to violent behaviour may assist staff to manage a violent incident and prevent its escalation.
- staff must always have regard for the human rights of all patients, including both the disturbed patient and the other patients and staff on the ward.

- Recognising the signs of an escalating situation is a prompt to initiating attempts at de-escalation. However, in these instances staff should always assess whether it is safe to approach the situation and attempt de-escalation.
- Staff should never approach a potentially violent situation on their own without the support and knowledge of colleagues and should avoid isolating themselves with patients.
- When faced with a violent situation staff should be aware of the patient's personal space and should adopt a non-confrontational protective stance. A side on approach, with the member of staff's hands being continually visible should be adopted. The use of hand and arm movements should be slow and deliberate with palms outward towards the patient in a non-threatening gesture
- Staff should avoid raising their voice or speaking over the patient.
- The use of active listening skills is a key strategy in managing potentially violent situations. Staff should utilise these skills to explore the underlying thoughts and feelings of the patient, with the primary focus that the patient should always be treated with dignity and respect
- Knowledge of the patient is a crucial aspect of successful de-escalation and staff should utilise relevant clinical and personal information, including existing positive relationships the patient has with others to structure de-escalation approaches. Individualised de-escalation approaches should be recorded in the individual's positive behavioural support plan and/or the patient's risk management plan.
- Where communication difficulties exist, staff should make every attempt to overcome the difficulties based on their knowledge of the patient's needs.
- Where the patient's presentation escalates to a point where physical restraint is required, staff should continue to communicate with the patient with a focus on establishing a rapport, demonstrating concern, helping the patient to relax, reducing the patient's level of agitation, and providing instructions
- Patients identified to be at risk of presenting with violent and aggressive behaviour should be supported to utilise individualised coping strategies which might prevent or minimise their violent and aggressive behaviour.
- When an escalating situation requires the use of secondary or tertiary strategies, the nurse-in-charge should, where appropriate, assemble a number of staff (depending on the nature of the incident) who are PMVA trained.
- If the situation allows, all staff involved should receive a briefing about the individual and incident. If the incident is in progress, staff must support their colleagues in the management of the incident.
- The gender, size, age, strength, ethnicity, culture, health issues and potential trauma triggers of the patient must be taken into consideration when assembling and briefing the PMVA team.
- One member of staff should assume control of the incident.
- Any use of force must be necessary to prevent harm to the person or to others, be a proportionate response to that harm and be concordant with the principle of least restriction (e.g., be the least restrictive option).
- All MVA techniques must be carried out in accordance with the MVA training syllabus.

Appendix 33: Side By Side Comparison of Settings

1. Location/Service	• Home/ Family	• Forensic/Secure Service
2. Setting	• Social Care	• Healthcare
3. Type	• Personal Budget	• Public service
4. CQC Reg	• NO	• YES
5. Function of the service	• To support individuals with a learning disability to develop independence, and to live an active and fulfilling life.	• The treatment of patients who are a serious risk to others. • Patients have likely been either charged or convicted of a criminal offence. • Patients who require physical security to prevent them from escaping.
6. Number of People	• One - Daughter	• Many - Patients
7. National policy on responses to behaviours of concern	• N/A	• Positive & Proactive Care • Mental Health Act Code of practice 1983 (2015), Department of Health, The Stationary Office, London
8. Legal Framework	• Mental Capacity Act • The Health & Safety at Work Act • The Management of Health and Safety at Work Regulations 1999 • Common Law • The Criminal Law Act	• The Human Rights Act • The Mental Health Units Use of Force Act • Mental Health Act • Mental Capacity Act • The Health & Safety at Work Act • The Management of Health and Safety at Work Regulations 1999 • Common Law • The Criminal Law Act
9. Practice Framework	• Locally defined. • Largely developed by working side the supported person's mother	• Nominated charge nurses. • Professional Qualification • NMC Registration • NHS Constitution/NHS Values • Code of Conduct for Healthcare Support Workers & Adult Social Care Workers in England • RRN training standards
10. Best practice guidance available	• Key messages about Positive Behaviour Support (Bild, PBC Academy, Health Education England, The Challenging Behaviour Foundation & Skills for Care) • Well matched & Skilled Staff: A Pamphlet for Commissioners of Services for Adults with Learning Disabilities Who Display Challenging Behaviour (The Challenging Behaviour Foundation) • The Challenging Behaviour Charter (The Challenging Behaviour Foundation) • At a glance 37. Challenging behaviour: a guide for family carers on getting the right support for adults. (Social Care Institute for Excellence). • NICE Quality Standard Learning Disability: behaviour that challenges. • Royal College of Psychiatrists, British Psychological Society, Royal College of Speech, and Language Therapists (2007) Challenging Behaviour: A Unified Approach (CR144). Royal College of Psychiatrists	• NICE NG10: Violence and aggression: short-term management in mental health, health, and community settings (2015) • NICE NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015) • Towards Safer Services (RRN, 2022) • Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions (2019) • Positive and Proactive Workforce (2014) • SEE- THINK – ACT (Quality Network for Forensic Mental Health Services, 2023) • NHS Security Management Service (2005) Promoting Safer and Therapeutic Services. Implementing the National Syllabus in Mental Health and Learning • NIMHE (2004) Mental Health Policy Implementation Guide 'Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Service user Settings'.
11. Local 2nd tier policy	• See below.	• Preventing, Minimising and Managing Aggressive and Violent Behaviour {main Policy] • The Use of Advance Statements

		• The Use of Advance Care Planning • The Use of the Safety Pod • The Use of Rapid Tranquilisation • The Use of Seclusion & Longer-Term Segregation • The Use of Mechanical Restraint Devices • The Post-Incident Support Procedure • [this list is not exhaustive]
12. Support, inc. Behaviour Management [in place within the organisation]	• Overseen by a Care Co-ordinator • My Support Plan • Positive Behaviour Support Plan • Quick Guide Positive Behaviour Support Plan • Training Sessions • Daily Support Record • Supervised Seclusion Form • Body Map • Team meetings	• Positive Behaviour Support plans [& regular review] • Risk management plan [& regular review] • Safety huddles • Incident reports & Body map • Incident defusions/reviews. • Personal reflection
13. Training in primary preventative measures	• YES – Training Provider RRN certified	• YES – RRN Certified Training
14. Training in de-escalation [secondary]	• YES – Training Provider RRN certified	• YES – RRN Certified Training
15. Training in Breakaways [secondary]	• YES – Training Provider RRN certified	• YES – RRN Certified Training
16. Training in Standing & Seated Holds [Tertiary]	• YES – Training Provider RRN certified	• YES – RRN Certified Training
17. Training in Teamwork [Tertiary]	• NO	• YES – RRN Certified Training

Appendix 34: **Removed [text now in main body of thesis]**

Appendix 35: Code Book Excerpts [John]

Name	Description
Z1 ENTERING A RIGID WORLD	
1 ITS A VERY RESTRICTED WORLD	
1 It all starts with an UNLOCK	So then we'd unlock.
2 ONLY the non seg patients get access to communal areas	Because on the assessment side, the patients aren't in segregation so they have access to the communal areas throughout a day.
3 THEN we sort breakfast	Then from then, we'll get medication out with first round, sort breakfast
4 Then we sort medication	Then from then, we'll get medication out with first round
5 The SYSTEM responds to INDIVIDUAL risk. But SLOWLY	INTERVIEWER: So I guess the system down-rates the risk level. But you must see in an individual patient, changes over time. I don't k I'm guessing here, but how they cope with stressful situations or you know... JOHN: Yeah.
6 On PAPER this is the end of the line	On paper, they are like, you don't get any further than that, like within forensics. You're in the Anytown Forensic Service and you've got high-level restrictions imposed on you.
2 WE LIVE AND EXIST WITHIN THESE RESTRICTIONS	
1 You are rightlly under scrutiny	Obviously, we're under a lot of scrutiny. Because we've got to handle it in a way which is professional and keep your own emotions in s really.
2 With Patients in SEG we try yo FACILITATE activities	But then on the flip side, on the intensive care side of a ward, we've got patients in segregation. So, if I was on that side, would be getti them up. Trying to facilitate them in some sessions and activities as they're limited to what they can do throughout the day.
3 Staffing levels mean sometimes we cant provide access to the communal areas	However, if the staff aren't there, then we can't open them.
4 Staffing levels determine whether we can do this too	Obviously judging on staffing as well.
5 Staffing levels make a difference to me	Normally on my ward we should have about 13 staff. At the minute we run on about 9. Which is quite a significant difference.
6 Ifeel its an injustice AND it prevents us assessing patients	It's sort of like an injustice really, because we're there to assess them to move them on other wards.
7 We are understaffed the ABNORMAL is THE Normal	Normally on my ward we should have about 13 staff. At the minute we run on about 9. Which is quite a significant difference.

Z3 NAVIGATING THE COMPLEXITY AND MESS	
1 THERE MORE TO CHALLENGING BEHAVIOURS THAN VIOLENCE	
av HOSTILITY	I'd say, being faced with hostility. That's probably one of the biggest. Not just physical, but verbal as well.
av1 SUBVERTING SECURITY	Having to deal with security. People trying to subvert security measures That's quite difficult.
av2 Patients can cause concern by being ELATED	Each patient, each individual will have different risks associated. So, in instance we might see a patient who is becoming quite elated.
av3 a LOW MOOD and WITHDRAWAL can be a behaviour of concer	But then you can have someone who's low in mood, like not saying anything, and that can be a behaviour of concern.
av4 SHOUTING and PROFANITY can be a behaviour of concern	Shouting. Using like profanity. Body language can be one. Either quite guarded or and aggressive stance. Eye contact. Staring. There loads.
av5 BODY LANGUAGE and EYE CONTACT can be a behaviour of concern	Shouting. Using like profanity. Body language can be one. Either quite guarded or and aggressive stance. Eye contact. Staring. There loads.
av6 BREAKING RULES can be a behaviour of concern	INTERVIEWER: Yes, so we got a set of rules and it's trying to bend or break those rules. JOHN: Yeah, yeah. It means the rules, they' blanket restrictions essentially because they're done across the whole of the Anytown Forensic Service. So, if a patient is trying to go another patient's room, that's like subverting security as well. Or trading, that can be subverting security.
av7 TRADING can be a behaviour of concern	INTERVIEWER Yes, so we got a set of rules and it's trying to bend or break those rules. JOHN Yeah, yeah. It means the rules, they'r blanket restrictions essentially because they're done across the whole of the Anytown Forensic Service. So, if a patient is trying to go another patient's room, that's like subverting security as well. Or trading, that can be subverting security.
2 THE ART OF RELATING AND CONNECTING IS UNIQUE & TENUOUS	
1 our patients have usually been MANAGED elsewhere	because a lot of the patients that we have, they've come from other medium secure units, where they're being isolated for months like year really. Because they can't be managed there or perceived not to be managed there.
2 This means we need to start by building social foundations	And then they come to us and we're having to build up that interaction socially as well. So, it's a big challenge for them, but that just re gets the foundations going for recovery.

Name	Description
3 They may struggle to express or COMMUNICATE	There might be more hostile behaviour or something, because they not might be able to communicate in a way which we can.
4 YOU dont want to be TOO.. You need to step back	So, it's about trying to gauge... So how you deal with it, really. You don't want to be too... You want to take a step back, and try and all them to communicate, or understand where they're coming from.
5 SO a normal day starts with a handover	So, on a on a day-to-day, if I start from beginning. From like when we come in, I'll probably get on the ward about half, seven. Do a hai
6 Handovers are useful BUT	I'd say yeah, the handover is useful. Especially if you've not been on for a few days. Because you do see patterns in behaviours. I thin gives you that base for that day. But
7 BUT you need to judge people for yourself	It's sort of judge them again, like reassess them in the morning when you see the patient. You get a feel for it.
8 BUT you have to be wary of the judgements of others	I might be on one side of the ward and then someone might come to me and say 'so-and-so' is not doing so well. Then you'll go across then you can make an assessment and be like, 'Oh well, that seemed fine to me' or you know...
9 You nee to SEE people and get a FEEL for them	It's sort of judge them again, like reassess them in the morning when you see the patient. You get a feel for it.
A10 People can be two different types of person	So for me... Well, we have patients who one minute there might be quite agitated, and then the next minute they'll be like quite cooper and calm. So, it can fluctuate throughout the day.
a11 Different people read different people in different ways	INTERVIEWER: What you seem to be saying is that different staff members read people can vary. JOHN: Yeah.
a12 We all have different INFORMATION	Going back to what you said, it's all about perception, really how you, how you perceive someone to be. So, I might see things differen what you perceive. We've all got different pockets for information, haven't we? We're all unique, so is that makes it difficult.
a13 we all PERCEIVE differently	Going back to what you said, it's all about perception, really how you, how you perceive someone to be. So, I might see things differen what you perceive. We've all got different pockets for information, haven't we? We're all unique, so is that makes it difficult.
a14 every relationship is different	INTERVIEWER: Maybe, I don't know, but maybe, the fundamental relationship is different? You know, you might get on better with so patients than others. Do you think that's the sort of thing that comes into play? JOHN: Yeah, definitely, definitely.
a15 MY definition of a therapeutic relationship IS	My own definition would be, 'A relationship between a staff member and a patient, which is formed to have positive care outcomes'. Th what I would probably put it as.
a16 a therapeutic relationship needs to defy EXPECTATIOS & HISTORY	It's about trying to alter their misconceptions isn't it? That's why I speak about therapeutic relationships a lot, because it's about showir not every relationship will have a negative outcome and not everyone's going to leave or abandon and or mistreat you. That's a massi thing, because a lot of patients do have trauma. Which can be the reasons for the mental health decline. So, it plays a massive part.
a16 My therapeutic relationships are MINE ALONE	And I think that's why it's key to gain therapeutic relationships and try to, not force them, try to promote them more because you can. Obviously, you can liaise more with patients and get a better understanding of their needs.

Name	Description
a17 for ME it all starts with finding COMMON GROUND	I think, initially it's about... I'll try and find a common ground. So, a lot of the time it can be on sports or something. If it's not sports, you and find another hobby and you can get someone talking more then.
a18 common ground gives way to DISCLOSURE and TRUST	So, I think once that common interest is found then you can start to progress more. They might come to you if they're feeling low, they open up to you more because they've got that common interest with you, or they know that you're easy to talk to and open and willing engage really.
a19 SOMETHING to lose vs NOTHING to Lose	INTERVIEWER: So you can bring their successes back into your interactions, and then that kind of gives an opportunity for them to se progress for what it is and reflect on, how well they are moving forward. JOHN: Yeah, definitely. At that point then they've got somethir lose.
a19 TRUST is a two way thing	As soon as they've started to find that trust, it's all off of trust. But it works in both ways, really. Because if you as a staff member, if you trusting of that patient then how are they going to be trusting of you? It does really work in both in both ways.
a20 You start building and progressing from there	But it progresses when obviously they can see that you're... They can trust in you, so can come and tell you that our worries and their struggles, and if you offer resolutions and can help them and they feel better on it. Then it's just going to develop massively from there
a21 for me you need to be honest with patients	For me, I perceive that if you straight with them all the time, and you ride the rough with the smooth
a22 If they need a hand YOU reach out	If they need a hand, you reach out, and you try to encourage them to speak openly to you. I think that builds the foundations,
a23 Patients can push way those that are closest	Because on the flip side, patients will also sometimes push away who's closest to them.
a24 holding on to a little of something is a BIG responsibility	At that point then they've got something to lose. Sometimes if someone thinks they're in the dumps. At the bottom of a low, like within t mental health as well. Some feel like they've got nothing to lose. So, they continue to act and behave in a certain manner. Whereas wi patient can see that they're progressing and they're getting closer and are getting less restrictions and stuff and feel like they've got something to lose then. Which is a bit of responsibility, isn't it really.
a25 You can give someone EVERYTHING but progress is not guaranteed	You can give someone everything, like the best treatment possible and the best care. And two patients may react differently to it.

Appendix 36: Example Of Sheet Used For Manually Coding GET

	DONNA	LISA	EMMA	RUSSELL	JILL	SABRINA	CHARLIE	JOHN
TRUST	Time spent/invested	Time and empathy	Time listening and learning	Can't trust a dog. it can bite	SHOWING YOU ARE PRESENT FOR PATIENTS	Time and care	Time and consideration Trauma aware	Time and empathic mindedness
PUSHING				Its black and white			Colleagues	Pushed away
NEGATIVE AFFECT			Black & Blue		Hold in	Poker face		The edge – combat stillness
RESILIENCE	APA	Rides bumps in road	Drink and smoke as release = feels stress??					
BRICOLAGE	Other training Old techniques Hybrid	Grab a bit and go	Duck under arm but avoided physical engagement	DIY-type pragmatism	Instinct Mess order	Instinct Mess order	Martial arts Clinch Confidence and awareness	Martial arts Clinch Control of self Ease with self
PERSONAL/PROFESSIONAL	Mum, Brownie Leader. Friend of mum.	Uncle, mum, grandmother. Friend of mum	Wounded healer	Auditor	Catheter		Thai Boxing, jiu Jitsu	Boxing
"WE"/US	Team leader Friend and family	Part of family Familial sensibility	Personal motivation for professional role	ANTI-WE	Same as me = colleague	Team Leader	Team leader	Family connection

Appendix 37: Glossary Of Key Terms

The following have been clustered thematically.

Certain/ty: A belief is *psychologically* certain when the subject who has it is supremely convinced of its truth. Certainty in this sense is similar to *incorrigibility*, which is the property a belief has of being such that the subject is incapable of giving it up. A second kind of certainty is *epistemic*. Roughly characterized, a belief is certain in this sense when it has the highest possible epistemic status. Epistemic certainty is often accompanied by psychological certainty, but it need not be. A third form of certainty is moral certainty. Descartes says that 'moral certainty is certainty which is sufficient to regulate our behaviour, or which measures up to the certainty we have on matters relating to the conduct of life which we never normally doubt, though we know that it is possible, absolutely speaking, that they may be false' (Reed, 2022)

Complex: A complex situation is when you can't predict with certainty the result of action, there is no cause and effect, the same actions may produce a different effect each time. (Plsek & Greenhalgh, 2001)

Complexity: Described as 'a dynamic and constantly emerging set of processes and objects that not only interact with each other but come to be defined by those interactions' (Cohn *et al*, 2013).

Complicated: A complicated situation requires experience and may involve many people and steps but there is predictability and certainty that if the steps are followed the desired result will be achieved (NHSE, 2023)

Messy Reality: Characterised by the kinds of adjustment, adaptations, variations, trade-offs, compromises, and workarounds that are hard to prescribe and hard to see from afar, but can become accepted and unremarkable from the inside. Mostly, such variability is deliberate, but sometimes is unintended. As such, this archetype will be familiar to almost everyone. (Shorrock, 2017)

Work-As-Done: Work that is characteristic of this archetype may or may not be disclosed by those who do the work. It is not necessarily secret (as is more characteristic of taboo). The key point is more that work-as-done is not as prescribed, and probably not as-imagined or known by others. This archetype is common and applies to much specialist activity in most sectors, e.g., healthcare (Shorrock, 2017)

Dirty Work: Work that can be physically distasteful, morally 'dirty,' or socially and personally disreputable. Hughes (1971) argued that work becomes 'dirty,' when it 'in some way goes against the more heroic of our moral conceptions'.

Fuzzy Logic: Is used when one provides logical reasoning with vague or imprecise statements like 'Peter is young (rich, tall, hungry, etc.)'. It refers to a family of many-valued logics, where the truth-values are interpreted as degrees of truth, The truth-value of a logically compound proposition, like 'Charles is tall and Chris is rich', is determined by the truth-value of its components. In other words, like in classical logic, one imposes truth-functionality (Zadeh, 1965).

Moral Distress: Defined as 'the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action' (BMA, 2021 p.2).

Tacit Knowledge: can be defined as 'a non-linguistic, non-numerical form of knowledge that is highly personal and context specific and deeply rooted in individual experiences, ideas, values and emotions' (Gourlay, 2002 p.2).

Empathy: Defined as 'the unique capacity of the human being to feel the experiences, needs, aspirations, frustrations, sorrows, joys, anxieties, hurt, or hunger of others as if they were his/her own'

Institution: 'a complex of positions, roles, norms and values lodged in particular types of social structures and organising relatively stable patterns of human activity with respect to fundamental problems in producing life-sustaining resources, in reproducing individuals, and in sustaining viable societal structures within a given environment' (Turner, 1997 p.6).

Primary Task: This can be defined simply as the task which the institution must perform to survive (Rice, 1963).

Lawrence (1977) qualified this by referring to the 'normative', 'existential' and 'phenomenal' forms of primary task. The 'normative' task is the one that is congruent with its stated mission, whist the 'existential' task embodies 'the many and various motives for, and meaning of, the work for whose individuals engaged in doing it', finally the 'phenomenal' task is that which can be inferred from the behaviour of those within the organisation. This recognises that primary task performance can be affected by the unconscious.

Policy: 'Policy itself is a portmanteau term. It refers to things as varied as, say, a detailed prescription, a strategic plan of action, or the indication of a broad aim' (Evans, 2020 p.3). Elsewhere, ''Policy' is a general term used to describe a formal decision or plan of action adopted by an actor … to achieve a particular goal … 'Public policy' is a more specific term applied to a formal decision or a plan of action that has been taken by, or has involved, a state organisation' (Richards & Smith, 2002 p.1).

Street Level Bureaucracy: The day-to-day implementation of government policies, typically enacted via statute or regulation, by frontline public servants, often on a case-by-case basis and in contact with the public and employing discretion (Camillo, 2017 p.1)

Practice Wisdom: Can be defined as 'a personal and value-driven system of knowledge that emerges out of the transaction between the phenomenological experience of the client situation and the use of scientific information' (Klein & Bloom, 1995 p.799)

Resilience: Defined as 'the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands' (APA, 2018)

Reflection: Can be defined as 'serious and careful thought' (Cambridge Dictionary, 2023)

Reflective Learning: Has been defined as the 'Process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self and which results in a changed conceptual perspective' (Boyd and Fales, 1983, p.100).

Relational Security: Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and

care. Relational security is not simply about having 'a good relationship' with a patient. (DoH, 2023, 2015, 2010)

Risk: A 'a situation or event in which something of human value (including humans themselves) has been put at stake and where the outcome is uncertain' (Rosa, 1998, 2003).

Risk Work: Defined as 'working practices framed by concepts of risk' (Gale *et al*, 2016 p.1047-48).

Technical/Rationale: An approach to something, can be characterised as a rationale, objective, codified or authorised one; where '…instrumentality is …underpinned by a technocratic form of consciousness' (Whan, 1986)

Practical/Moral: An approach to something can be described as involving '…practical wisdom, and relates to how knowledge is applied, in a way which mediates between the universal and the particular' (Whan, 1986)

Care: Defined as 'a species of activity that includes everything we do to maintain, contain, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment' (Tronto, 1993 p.103).

Coercion: Can be defined as 'Any action or practice undertaken which is inconsistent with the wishes of the person in question, i.e., undertaken without the person's informed consent' (RRN, 2020 p.169)

Physical Intervention: Defined as 'a skilled hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned' (NICE, 2005a p.16).

Physical Intervention: In LD settings has been defined as 'any method of responding to challenging behaviour which involves some degree of direct physical force to limit or restrict movement or mobility' (Harris *et al*, 2008 p.2).

Physical Restraint: Defined as 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person' (DoH, 2014, p.14).

Techniques: *[relating to physical restraint] provide a concrete way of carrying out a particular task, in this instance that of physical restraint. This is achieved using certain physical 'actions' e.g., holding an arm, or leg, or head in a specific way. Typically undertaken by a single member of staff e.g., an arm hold [Hollins]*

Procedures: *[relating to physical restraint] comprise 'a series of actions [i.e., 'techniques'] that are carried out in a certain order or manner to achieve the defined goal or to realise a particular strategy e.g., facilitate the safe and controlled movement of a person into a segregation area. Typically undertaken by a group of staff [Hollins]*

A restraint technique is said to be ***Fragile*** *'…if a small adjustment (movement or pressure) to the procedure (intentionally or unintentionally) is likely to result in in intentional or unintentional injury, or severe pain to the individual' (Martin et al, 2008).*

*The literature acknowledges the notion technique creep, in the concept of '**Field Modification**' (Paterson, 2007), which occurs when component parts of a technique are omitted or adapted, or other parts added. This may occur consciously or unconsciously, it is difficult to say as research is lacking.*

*Bailey (2015) has examined the role of what she describes as '**Forced Touch**' within physical restraint in mental health settings. This refers to informal, unofficial, sub-restraint physicality deployed by staff aimed at calming and facilitating co-regulation, rather than physically controlling the individual.*

Use of Force: According the Mental Health Units Use of Force Act 2018, 'Use of force includes physical, mechanical, or chemical restraint of a patient, or the isolation of a patient (which includes seclusion and segregation). The act defines the different types of force as:

- Physical restraint: the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient's body. This would include holding a patient to give them a depot injection.
- Mechanical restraint: the use of a device which is intended to prevent, restrict, or subdue movement of any part of the patient's body, and is for the primary purpose of behavioural control.
- Chemical restraint: the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body. This includes the use of rapid tranquillisation (DoHSC, 2021 p,7)

Restraint Reduction: Can be defined as 'Assessment, planning and review measures designed to reduce the number of times restraint techniques are used within defined settings, or in relation to a defined population or a specific individual' (RRN, 2020 p.171).

Restraint Minimisation: Can be defined as 'Assessment, planning and review measures aimed at reducing the intensity and duration of any physical restraint techniques that are used within defined settings, or in relation to a defined population or a specific individual' (RRN, 2020 p.171).

De-Escalation: De-escalation techniques consist of a variety of psychosocial techniques aimed at reducing violent and/or disruptive behaviour (NICE 2005). They are intended to reduce/eliminate the risk of violence during the escalation phase, through the use of verbal and non-verbal communication skills (CRAG 1996).

Hallet and Dickens (2017) provide a more expansive theoretical definition of de-escalation as 'a collective term for a range of interwoven staff interventions, comprising verbal and non-verbal communication, self-regulation, assessment, and actions, whilst maintaining the safety of staff and patients' [p.10).

Challenging Behaviour: '*Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.*' - (Emerson, 1995)

Behaviours That Challenge: *'Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion.'* (RCP *et al*, 2007)

Behaviours of Concern: Behaviours of concern are words that describe a kind of behaviour. They are behaviours people do that may be a problem for them or others. Behaviours of concern can be when someone does things that hurt themselves, other people, or things. Behaviours of concern are sometimes called challenging behaviours (SCOPE, 2009).

In the dementia context in Australia, 'A behaviour of concern is any behaviour which causes stress, worry, risk of or actual harm to the person, their carer's, staff, family members or those around them. The behaviour deserves consideration and investigation as it is an obstacle to achieving the best quality of life for the person…' (Dementia Behaviour Management Advisory Services, 2012 p.5).

Pain-Based Behaviour: For example, impulsive outbursts, aggression, running away, self-injury, defiance, an inability to regulate emotions and trauma re-enactment (Anglin, 2003)

Distressed Behaviour: Among the behaviours which might be considered indications of distress are self-denigrating statements, complaints about anything other than the person being addressed, and nonverbal displays of sadness. Such behaviour appears to be a cardinal feature of the social behaviour of depressed people and people who are experiencing chronic pain. It may prove to be typical ofpeople who are experiencing any chronically aversive event (Biglan, 1991)

Behavioural Distress: Alternatives to antipsychotic medication: Psychological approaches in managing psychological and behavioural distress in people with dementia (British Psychological Society, 2013)

Help-Seeking Behaviour or Health Seeking' Behaviours: *In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern (*Cornally & McCarthy, 2011).

Expressive Communication: It was found that children with autism may use what may be perceived at face value to be problematic behaviour, such as self-injury, tantrums and aggression to communicate in order to gain access to an item or escape a demand (Chiang, 2008)

Exotic Communication: As is often the case when terms are used to define a group of individuals, they acquire pejorative meaning over time, so new labels are created to replace problematic terms. Ephraim (1998) offered a different way of looking at things and suggested there is no such thing as CB, instead there is 'exotic communication'; the effect of a behaviour may be heard, but the message may not be listened to or understood. People who display CB are described as 'the pained the unheard and the unloved' (Ephraim, 1998, p. 210).

Violence: Defined as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation' (WHO, 2020)

Work-Related Violence: 'Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health' (WHO, 2020).

Work Related Violence: '*Incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health*' (Wynne *et al*, 1997).

Closed Cultures: Defined as ‘a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm’ (CQC (2020)

Compassion: Defined as: ‘Being moved by another's suffering and wanting to help’ (Lazarus, 1991 p. 289).

Elsewhere as: ‘the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help’ (Goetz et al. p. 351).

Also, as ‘An orientation of mind that recognises pain and the universality of pain in human experience and the capacity to meet that pain with kindness, empathy, equanimity and patience’ (Feldman & Kuyken, 2011, p. 145).

Appendix 38: Setting One, Case Study: Donna

The Use of Quotations

The following case studies include several direct quotes from participants. IPA as a methodology keeps the number included to a minimum to foreground the researcher's analysis and sense making (Smith *et al*, 2009). I have sought to attend to this central sense making diligently, following the procedure outlined in the method chapter, but feel that quotations can provide evidence to support the analysis and enrich the experience the readers experience. My interpretation is my best effort, but I can make no claim to it being definitive. As a result of reading the following case studies, readers in turn will arrive at their own interpretations and understandings of parts and of the whole. These will be rendered through the prism of their own knowledge, background, and experiences. The 'the double hermeneutic', (Smith *et al*, 2009) informally becomes the triple hermeneutic, becomes something of an infinite hermeneutic as excerpts, are potentially then integrated in subsequent writings and research in an unknown number of ways. Whilst I concede I have curated the quotes, I feel I have done so fairly, allowing the essence of participant experiences to be heard. In conclusion, my hope is that these case studies and the quotes can be used as an adjunct to the analysis within the main body of the thesis.

Introducing Donna

Donna is the Senior Personal Assistant working within the service supporting Sara. She has been with the service for seven years, having previously worked there for two years as a support worker. Her description of her role reveals an organisational hierarchy with Mum at the top, Donna's participation in managerial/supervisory tasks and a working relationship with Mum not shared by others. Donna acts as her proxy when she is absent. This relationship is central to understanding Donna's experience of responding to behaviours of concern, which seem to be characterised as part of the support

provided. One reason for this conclusion is that nowhere in Donna's answers is there any use of the terminology or concepts present within the literature: 'primary-', 'secondary-' and 'tertiary interventions', 'dynamic risk assessment', 'escalation' and 'de-escalation', 'physical intervention', 'restrictive interventions', 'physical restraint' or reference to defined techniques. The only technical language she uses is 'seclusion', with the Blue Room being referenced. My sense is that because this procedure is scrutinised and subject to an external 'best interests' review, it is a formal 'thing, and as a result is named when reference is made to it. In accounts given by other staff, reference is made to whether it was done carefully, rather than whether it met any technical criterion.

Donna uses the term 'Incident', which seems to be an overarching term used when Saras behaviour requires some form of physical intervention, which Donna describes as 'helping', 'holding' and 'going hands on'. Holding conveys what is happening but does little to denote the nature of the physical contact or any forcefulness. It sounds gentle whilst terms like grabbing, detaining, or restraining all sound harsher and less controlled. Going 'hands on' carries with it a sense of force being applied but seems to limit that force to one's 'hands', as if they are momentarily detached for just long enough to attend to an uncomfortable task, before returning to be re-integrated with the carer.

Looking at Donna's lived experience, three key themes were identified:

1. Through My Experience and Commitment, I Serve the Goal
2. Through Mum I Engage with Complexity
3. Through Reflection I Grow Internally.

These 'Personal Experiential Themes' [PET] were based on 12 'Experiential Statements', arising from 120 'Exploratory Notes' [Fig 38.1].

Through My Experience and Commitment, I Serve the Goal
• My experience and responsibility are important. • I want the best for Sara. • You need to invest in Sara to support her.
Through Mum I Engage with Complexity
• Mum is ever present. • I wish dad wasn't present in the way he is. • Crisis interactions are complex I need two heads. • The way it is. • The way it was. • Holding is always messy. • The covid jab.
Through Reflection I Grow Internally
• Debriefing is essential to learning and making sense. • Training has a place but limited value.

Fig 38.1: Donna's 'Personal Experiential Themes'.

Through My Experience and Commitment, I Serve the Goal

Donna previously spoke to the variety of tasks, and responsibilities she assumed. When asked to qualify them she described managerial or administrative tasks. The sense I got was of quiet pride and professional accomplishment, and perhaps a passing allusion the trusted status she has. This is not to suggest that she is asserting that care only exists in these tasks. It simply reminds us that care itself is a multi-layered task and needs organisation and leadership if it is to be wholly and effectively implemented. When she states that her role is ensuring 'everybody else is doing what they are meant to be doing', this suggests that there is a recognised performance standard to which other team members must adhere. As the next theme suggests, Mum's way of supporting Sara defines a performance standard that is relational and responsive, 'with' Sara rather than 'to' her. When asked to identify her working goal, Donna says, 'I just want her to live the best, fulfilled life that she can. Yeah' [35]

This ‘fulfillment’ is unspecified and so has a nebulous quality. I understood this as something not pre-ordained or imposed on Sara, but rather something she was involved in defining. The exclamatory ‘yeah’ seems to serve both the explicit satisfaction that the preceding statement was accurate, and that in and of itself the goal is guided by Sara. As and when Sara becomes distressed, this indicates that her situational needs are not being met, or that ‘something’ she is currently experiencing is somehow unwelcome. As a result, the nature of the support being provided needs to change. Implicit in this reading, based on the interpretation of Donnas’ experience, is that the PA’s [or Mum] do not down caring ‘tools’ and pick up restrictive ‘tools’ to quash the behaviours; rather they adapt with Sara ‘in mind’ and care differently to strive for her ‘fulfillment’.

This way of working, and of responding to Sara’s changing needs, seems to be rooted in knowing Sara. Donna described her previous caring experiences. Here she reflected on working with five different people at once in one setting and characterising it as a ‘nightmare’. In addition to the workload, Donna is perhaps referring to the enormous investment required to get to know different people in all their uniqueness and be able to be a different person for each of them. One can see how easily staff who are overwhelmed by such a mental and physical, workload. In the absence of supervision and support, they might revert to the safety of very impersonal, transactional care, with the individual becoming ‘the guy in room four’ or ‘the new chap with downs’. This depersonalisation was spoken to by Menzies (1960) in her seminal case study covering the functioning of social systems as defences against anxiety in a hospital setting.

Donna spoke about the sense of accomplishment that flowed from the support she provided to Sara in the current setting, and of feeling proud. Pride is a powerful emotion and often associated with visible accomplishment such as a university graduation. Its far more powerful than satisfaction, and perhaps because of its potentially intoxicating nature one is reminded that pride often precedes some

form of catastrophic failure, going as it does before a fall. The pride expressed by Donna seems modest and private, and only revealed when I pressed for an answer. It did not seem limited to egotistical self-accomplishment, rather it referred to a shared success. Donna was a 'part' of this, and Sara 'really really achieved' and that this was present within how Sara 'feels' and 'how far she has come'. Her pride is largely in Sara's achievement and the journey *she* has made.

Donna uses the word 'mixture' periodically which seems to indicate how on occasions things can be messy, uncertain, or unclear, but this is something that is accepted and lived with. This subject will be returned to. For now, Donna spoke to the need to forge a relationship with Sara, to care well for her. She suggests that trust is central to this. Trust was built over time, and developed through persistence, required a willingness to remain alongside Sara within a respectful and responsive relationship: She also refers to persistence in the face of failure or difficulty was also highlighted. She described how in trying to nurture autonomy, behaviours of concern were routinely experienced. Rather than dampening resolve, the team along with Donna persisted, and incrementally behaviours reduced.

Donna speaks of one 'incident' involving the ripping and divesting of clothing when being encouraged to leave the house. Rather than interpretating this as an emphatic 'No', there seems to me to be a sense that the fundamental goal of imposing the demand [getting Sara out of the house] was seen as in Sara's best interests, and as such was caring and nurtured independence and autonomy. It seems Sara's behaviour was not understood as an unwillingness to grow, or that autonomy was unwelcome. Rather than Sara was so overwhelmed by the task that she needed support with it. This seems to suggest that behaviours of concern are understood within the context of the moment they occur, and that staff actions are determined by the fundamental commitment to caring and that pressing ahead is to move through a difficulty in caring rather than coercing. This persistence through difficult and challenging circumstances speaks to Donna's resilience, which can be defined as 'the process and

outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands' (APA, 2018). This also reveals an ability to 'bounce back' (Tugade & Fredrickson, 2004) from exposure to difficult events and the ability to positively adapt when moving forwards through them. It is this latter ability that is most prominent in these moments.

The relationship that scaffolded the care provided seemed hard for Donna to define. Donna is a 'friend' according to Sara [Personal Assistant's are called 'friends of Sara'], which was a conscious choice by Mum to distance Sara from the difficult and damaging professional relationships she experienced whilst a patient in a long stay hospital. But is she a 'friend' as the term is more widely understood? It would be hard to argue that people who have spent nine years sharing time and space, would not develop an affinity with each other. For her part Donna says she feels like she is 'almost part of the family', making the boundaries between Sara and Donna ever more complex. Given that love can exist within such relationships, the complexity increases. Love itself is complex and comes in many forms. The consideration here is not of 'Eros', or the form of love that is central to attraction, passion, and sex (Clingan, 2021). Rather 'Philia' or the love between friends, based on equality, and loyalty or 'Storgia', the love between parents and children, or between siblings (Clingan, 2021). To be clear this is not spoken of explicitly by Donna, rather it is the potential implication of a relationship that exceeds a formal, professional configuration and is more closely characterised as one shared by friends or family members. The sense I have is of Donna working within an institution that has been modelled on the family by Mum, and that Mum assumes a responsibility for supervising the many relationships.

Through Mum I Engage with Complexity

Donna talked of Mum and Dad's joint aspirations for Sara, which since the dissolution of their relationship were now largely driven by Mum. This speaks to a familial drive to ensure Sara's needs are met. It suggests that to Donna's mind, since Mum has assumed overall responsibility, things have improved. The use of the terms 'push' and 'pushing' as well as 'more' echo where Donna herself was 'pushing' to encourage Sara to leave the house. One can see that this pushing too has a familial resonance, with how a parent [Mother or Father] would push their child to complete homework or participate in sport with the intention of expanding their horizons and increasing their personal resources. Such interventions, and the ethics of such interference will be returned and discussed more fully. It seems clear that Donna channels Mum's approach, whilst recognising that she cannot achieve everything that Mum can.

Donna is asked what Mum brings that is different to other managers. To Donna, it is the deep understanding borne of a lifelong relationship. Mum along with her 'knowledge' [explicit] and accompanying 'wisdom' [implicit] can define the care that Sara needs, the inference being a mum 'knows' her child like no one else. This means that providing support is not something based on training, it is based on knowing. In her role as the 'Senior' PA, Donna is cascading Mum's philosophy to other team members. There is a sense that this comes from the strong bond, and effective working relationship that Donna has developed with Mum over the years.

The final PET will pick up on the relationship between Donna and Mum and reveal how the connection continues to be central to Donna being able to address the difficult feelings arising from the job she does. It seems clear that Donna's role means that she finds herself in situations where complexity abounds, where sense needs to be made of uncertain or unpredictable situations, where decisions

need to be made, and where actions taken. Earlier attention was drawn to Donna using the word 'mixture' to speak to the variability she encounters. She also uses the word 'sometimes' within many answers:

> I think as soon as she lays hands on, I think that's it. I'm going to use the word 'attack you' because that is what its like. As soon as she starts attacking you that the moment when actually we need to do something about it because sometimes when she's in her little rant she kind of works her way through it and it stops, and then other times it just goes the other way [261-267]

> You've got to try and find the right balance and sometimes that doesn't work [303]

The word 'sometimes' is an adverb referring to frequency which can be used to mean 'occasionally', or 'now and then'. Its use could be construed as an easy catch-all term used when the speaker does not care to search for a more specific answer, or in the context of an interview such as this one, as a more conscious choice, affording the participant a protective vagueness, meaning they do not have to over commit, or provide a concrete answer. That having been said, my sense is that 'sometimes' in Donna's answer is concrete, and as is noted it is often used within the context of answers relating to responses to behaviours of concern. In this reading of its use, Donna seems to be saying 'what I do all depends on Sara'. This is re-enforced when she said 'Sometimes I think with Sara it all comes with experience. Obviously, I've got the advantage in that I've known her for a very very long time' [279-280].

A good example of Donna working alongside Mum, of dealing with complexity and of embodying Mum's philosophy of 'pushing' Sara through an uncomfortable experience was when a covid jab was

required. The following four excerpts capture what happened when Donna drove Sara and Mum to a vaccination centre and ended up having to join Mum in physically holding Sara to facilitate the injection. The excerpts reveal the physical, psychological, and emotional dimensions to what is ostensibly an act of care:

> Its difficult. In that situation, me and Mum will be like 'We're just going to try and help you. We don't want the silly bug, and we're just trying to help you.' So, I think she knows we are trying to help her, and that's the reason why we are doing it [168-170]

> Obviously Saras trying to hurt and scratching and being rude. And then obviously me and Mum went either side so that she could have her injection. Well, I was stood out of the bus and Mum was on one side of her. I was on the outside trying to hold Sara, so the injection didn't move while it was in her arm [509-512]

> It really upsets me. I really don't like doing it. But I think, like for instance the covid one, obviously it does upset me, and I don't like having to do it, and I don't like seeing her in that situation, but actually it was beneficial for her to have it done. You know she would probably be very poorly if she was to get covid. She might have to go into hospital, and that would be an absolute nightmare because she hates hospitals. But if we were in an incident inside it does really upset me, and I can feel my adrenalin going. And yeah, because I don't like seeing her hurt people. I don't like it. I just don't like it. But I know that I've got to do it because it will keep her safe and its going to keep us safe [593-599]

The sense I got from these statements was of engaging in difficult and troubling situations, and of balancing and rebalancing actions for a Sara's greater good. For Donna physical interventions are not a welcome or exciting prospect in the way that it has been found be with staff groups such as police officers (Baldwin *et al.*, 2019). Donna became upset when Sara became upset. This seems suggestive of empathising or co-feeling (Clark, 1980), despite which Donna carried on. This then seems to reveal a need to be able to determine very quickly the 'right' response and get them both through the [shared] distress to the other side, where things can be returned to normal. Again, this seems to embody resilience (APA, 2018). When exploring the wider matter of the emotions present within the context of such turbulent events, Donna was asked 'What is the experience of trying to set the anger to one side for just long enough to do the right thing?' [358-359]. In her reply she spoke to appearing to split herself in two, distancing the personal from the professional if unhelpful thoughts or feelings arise, 'I think I've almost got a Sara head on when I'm at her house. If that makes sense [361-365]

This answer speaks to the capacity to 'Self-Regulate' (Vohs & Baumeister, 2004) as well as to Donna's personal and professional selves and the tension between them. In assuming a work role staff typically agree to placing parts of their personal selves in abeyance. The role they assume is defined by a job description and the performance standards captured in policy documents and care plans, and cascaded through training sessions, supervision, and on-the-spot mentorship. It's within these latter spaces that concepts and principles, boundaries and interpretation are explored, refined, and developed. On a mundane level, within the context of care work there is a need to professionally engage with activities such as food preparation and the facilitation of excursions. Responses to behaviours of concern are more complex matters. As Donna alludes to, such behaviours in the private home setting may have a disciplinary component that does not translate into a service setting. If a staff member is 'attacked', 'hurt' or 'injured' this can seem to transcend professional boundaries, with the individual who has been scratched, punched, or kicked often feeling that they are in danger, and

retaining the right to defend themselves. The notion of self-defence itself is complex, and can, amid the heighted emotions present, mutate into a form of rough retributive justice. Irrespective of this potential self-protection is a legal right to which Donna has a genuine claim. To put this to one side, my reading here is that Donna recognises the need to differentiate her responses and metaphorically grows a separate 'mind': 'I've almost got a Sara head'. This seems to speak to the recognition of formality entrenched in the role description, and guidelines previously touched upon, but the aspiration to care and all the resources it requires seem to transcend such boundaries. Donna is a mother outside of the work setting, striving to do the best for her child as Sara's mother is in the work setting.

Within the context of responding to behaviours of concern, Donna reported difficulty in assembling a prescribed physical hold. The following exchange speaks to necessity of holding, the chaotic nature of such events, and how the resulting physicality is often assembled instinctively or spontaneously. To return to the covid vaccination:

> DONNA: I instinctively held her arm because I knew from previous that she wasn't going to sit still
>
> INTERVIEWER: How do you hold her arm? What do you do? Do you have a perfect technique that you've been taught on a course?
>
> DONNA: Just something to keep her arm still. Obviously not hurting her in any way. But yeah.
>
> INTERVIEWER: I'm interested in how easy it is to put a perfect hold on?
>
> DONNA: I don't ever think there is such a thing as a perfect hold. I think you can go to all the training courses in the world. I've done I don't know how many different physical intervention training [courses] in my time. I think in the moment you have some of what you've learnt in

> your head, but I think in the moment you're doing what you can to keep Sara safe and yourself safe. Obviously, you don't hurt her in any way because you wouldn't want to do that. But I think you just do what you can, and you hold her arm like you're meant to hold her arm, but you might have your arm under her arm like you are meant to have, but actually with the other hand you might be doing something completely different to what it is you are meant to be doing [602-609]

The holding took place on the back seat of a people carrier [a vehicle]. This represents the reality of the awkward or restricted environments in which staff are required to work [Russell spoke of working in a confined corridor that limited his physical options]. Donna intimates that the techniques taught on training courses do not translate into the messy world in which staff find themselves. This notwithstanding she must do *something*, which both works and does not hurt Sara. This is a significant responsibility, as well as one that needs to be urgently met. This seems to speak to a particular mental and physical agility, whose end 'product' is a safe, lawful, ethical, and effective intervention. I was left wondering whether this spontaneous assemblage is an innate capability, has roots in the formal training provided or is built up through experience and reflection. This will be returned when exploring the experiences of other participants across both settings, as will the reference to the self-defence component within the response.

Through Reflection I Grow Internally.

Donna described how events played through her mind in the aftermath. It seems clear that responding to some of the behaviours Sara presents can be difficult, dangerous, and stressful. Donna identifies adrenalin as something that infiltrates this process and makes it difficult. It seems reasonable to conclude that this difficulty could extend to clarity of thought. When one is trying to make sense of

events that is currently transpiring one needs to be able to move into the experience and focus on elements, whilst also moving out and considering actions within the context of the bigger policy framework. If this is thwarted one might spend time after the event experiencing disappointment, fear, and guilt. Donna speaks to her reflectivity, and I find it interesting that she finds the that processing is enhanced by writing things down. By fixing it like this, perhaps it makes it easier to focus on or process. This seems to serve many purposes; presenting a focused opportunity to resolve the difficult emotions that arise and addressing patterns of thinking that might lead to self-doubt, or self-reproach. The practice also seems to have developmental function, wherein personal, and professional capacities and competencies may be consolidated. The personal self participates in this as understanding what care is, and how to find ways to be caring amid complexity and challenge is a holistic endeavour.

The development of doubt and guilt is something that Donna concedes is possible, and which she finds can be addressed in the reflective/processing space. It seems paradoxical that one can do things in another's best interests [facilitating the covid jab] yet the resultant emotions can crowd out lines of reasoned sensemaking. Perhaps this speaks in part to the power of emotions, as well as Donnas clear sensitivity and aversion to witnessing distress in Sara. The feeling of having been complicit in causing the distress would seem to put the recipient of the feelings in an invidious position: to stand by and see suffering would be to cause distress, but to avert that distress by intervening elicits a similar set of feelings. Donna seems to take steps to actively manage the discomfort she experiences, and articulates the value of unpacking events, as well as the utility of 'time out', 'I quite often talk it through with Mum. Sometimes I subside it and say to Mum, 'I'm just going to go outside for five minutes. And sort the animals out' [393-394]

Stepping away from a stressful event, can offer distraction as one encounters a new or different environment. There can also be an element of wilful diversion, as one loses oneself in a fresh task. If the nature of that tasks [such as cleaning out the animals] places a lower cognitive demand on the individual, when one's mind gets the chance to rest. The resolution of difficult emotions is also something that Donna seems to find essential to be able to move forwards, unencumbered. Mum allows her to speak freely, and vent. She says, 'I think its really important [pause] because otherwise they just build up and they build up, and there's going to be an explosion at some point isn't there? And obvious we don't really want that explosion' [412-420]

The close relationship with Mum is clearly important to Donna. Without the trust and mutual respect existing between them, Donna would not be able to unburden, and more pointedly not be able to do so in the way she does, expressing things that are critical or unflattering about Sara. Perhaps within the multi-occupancy service where she previously worked, where there were no familial connections, such venting might have been easier. That having been said, what would not exist in such a situation would be the opportunity to make sense of those emotions, and to move forward with someone in possession of the intimate 'knowledge book' possessed by Mum. Such receptivity isn't guaranteed. It is entirely possible that a mother or father may balk at perceived criticism of their child, a position that would conceivably stifle the possibilities that the reflective/processing space can offer. Donna speaks to the intensity of her feelings by describing the potential outcome as an 'explosion', providing a sense that a significant amount is at stake. This post-incident processing, and its developmental component, seem to speak to resilience in the form 'bounce back' (Tugade & Fredrickson, 2004) or adjustment and restructuring of the self in preparation for the next adverse event.

It is also worth noting that Donna reports feeling for Mum and recognises the need to provide her with support after events, or when things become complicated, 'Mum can be upset sometimes. That's

when I find it a bit difficult sometimes' [492-493]. This answer reveals a great deal about Mum and Donna. That Mum appears to be bearing a host of burdens, the result of her myriad roles, seems to be something that Donna feels for, whilst Russell is critical [more in a later chapter]. Donna could quite easily stick her 'head in the sand' and avoid acknowledging the burden that Mum is carrying. This would perhaps make Donna's life easier but run counter to her nature. The sense of 'all being in it together' seems to mean that Donna also acknowledges the validity and resonance of her colleagues' experiences, that when shared, they too can provide insights and knowledge that could be useful to her, 'Because you might not have necessarily got it right. By everyone sitting down and talking about it there could have been something that you'd missed' [470-71].

The need for staff to continue to refine and develop the service they deliver is also an ongoing endeavour. The knowledge and wisdom required by Donna to continue to provide Sara with 'the best, fulfilled life' [35] she can, through the inevitable ups and downs, is not something that can be bottled or xeroxed and passed on to others. It is a unique state of knowing and understanding, acquired through contextualised, ethically informed 'doing'. As Donna has stated, 'there's obviously more that Mum can get away with than I can get away with'. There is likely more that Donna can do through her relationship with Mum than colleagues, but perhaps they themselves have unique connections that serve them in this network of support which surrounds Sara.

Appendix 39: Setting One, Case Study: Lisa

Introducing Lisa

Lisa is a PA who has been working for Sara for three years, having previously worked in a supermarket. Early in the interview she described her role thus, 'The title is 'Personal Assistant', and it is exactly what it says on the tin'. When gathering contextual information, a small number of 'Daily Support Records' were shared. Quite by chance an event that Lisa subsequently self-selected to expand upon in her interview was captured. The incident was recorded in written form as follows:

> 4.35pm Sara has had to get out of the hot tub because Sara started pinching, scratching, [and] squeezing hands. Mum was on hand and there was a swap.

Entries relating to challenging events were marked to be easily pinpointed by the 'Care Co-ordinator' when reviewing records. The mark was an illustrative emoji: ☹ . This serendipitously acquired data was illuminating, as it highlighted what can be the reductive nature of recording and reporting systems. The individual lived experience of that event, which was subsequently explored during the interview, was captured in twenty-eight words and an emoji.

After analysis four 'Personal Experiential Themes' (PET) were identified:

1. You are always connected somehow.
2. Feelings of all types are always present. You use the good ones.
3. It's about finding, or making, a kind way, through to the other side.
4. You only really know after the fact.

These were founded on 15 'Experiential Statements' [Fig 39.1], based on 86 'Exploratory Notes'.

"You are always connected somehow"
• Together with mums help we set out to help sara thrive. • It feels like a family affair. • We act in saras best interest's dad works against them. He's not a team player. • My uncle, my daughter and my grandson come to mind.
"Feelings of all types are always present. You use the good ones"
• The rewards are many and powerful. • The job has so many emotional dimensions good and bad. • Honestly... Anger abounds. • So, what I get out of all this
"It's about finding, or making, a kind way, through to the other side"
• Making decisions and doing the right thing is complex takes effort and skill. • She presents with behaviours that need us to do something. • Getting it right is an art not a science and unique to each one of us. • I was relaxing one minute sharing a nice experience then... • The last resort is getting physical and getting sara into the blue room
"You only really know after the fact".
• Getting to know her in all her complexity never stops. • It's been a journey through to my current knowing not easy

Fig 39.1: Lisas 'Personal Experiential Themes'.

Lisa's account provides insight into what it took to provide support to Sara. When describing her responses to behaviours of concern, these were not characterised as extra or emergency tasks. Rather they came across as part of the ebb and flow of day-to-day support, with part of Lisa's role being to respond to Sara's changing needs. Sometimes, events or fluctuations in mood or behaviour were expected or anticipated, and at other times they materialised suddenly and unexpectedly. Some responses were spontaneously determined by Lisa and done to Sara, whilst on other occasions they were negotiated 'with' Sara. In using the term negotiation, the hope is a sense of the dialogic is conveyed, wherein two independent individuals commune to determine what happens next. A notable exception to this two-way interactivity would be the physical relocation to the Blue Room, done *to* Sara in what was determined to be her 'best Interests'. I formed the impression that Lisa's professional practice was often closely aligned to a parental sensibility, manifesting in boundary setting and actions taken to negate or minimise the impact of Sara's behaviour. Lisa was a mother and grandmother, which seemed to inform her perspectives and understandings, she spoke of not 'giving

in to her every demand', which conjured up the parental sensibility that infused her work and her relationship with Sara.

You Are Always Connected, Somehow.

To Lisa there seemed to be a strong sense of a collective endeavour, reliant on a range of connections through which different types of *relating* took place. These connections included working with Sara, Mum, Donna and colleagues, along with Sara's Dad, who together represent Sara's supportive ecosystem. An early comment suggested to me that she found her way into her role and the knowing required, through connecting [or not] with others. At this point she seems to be making a distinction between difficult people [in her old job] and difficult situations [in her new job]. The way she spoke captured Lisa's shift from working with the whole public, to working for a single person. The description implies that this brought her into a new type of relationship with a different type of person, that person being someone who was not *'normal'.* Rather than being used to create distance and establish Sara as 'other', the use of the term 'normal' was directed principally at the members of the public she previously served. It seems to be used to suggest that the facility to behave intentionally badly was too often the province of the intellectually unimpaired, the inference being that the possession of higher cognitive faculties permitted conscious hostility and intentional unkindness, and because Sara did not have that same capability, she offered a purer relationship. Lisa returns to this theme later when talking about her uncle, and grandson. Lisa's uncle had cretinism, and her 3-year-old grandson a naïve view of the world. That Lisa also discloses getting things wrong and failing in her new role [the consequence of which was Sara going 'into incident'] was linked to a relationship that she did not yet have, and needed to form, if she was to get to 'know' Sara and do her job well.

As she sought to move forward there was a sense of Lisa drawing upon the new range of relationships and using them as 'resources' to build competence and resilience. This involved an array of often ad-

hoc, interactions with her doing things, feeling things, and thinking things, which came together to define Lisa's knowing and practice. This developing connectivity, along with the practice of relating to others seems to suggest that very few decisions or actions were Lisa's to be taken in personal or professional isolation. One exception was those actions immediately required to escape from potentially harmful situations.

On some occasions individuals Lisa interacted with left traces of themselves behind, including experiences with her uncle and grandson. In other instances, those co-involved in the provision of day-to-day support, such as Mum and her co-workers shaped her thinking, Lisa was therefore never responding completely on her own cognisance. She consistently represented connecting mentally, emotionally, or practically to others, and in some instances in some combination of the three. The proliferation of the term 'we' was noticeable which spoke to the connectivity and interdependence that appeared central to support work, as well as to responding to challenges.

On a typical shift, at least two staff were working, with Mum sometimes present. At the end of every shift a handover ensured that incoming staff were briefed on the day's events, Sara's current mood, details of any incidents. The rota meant that there were regular opportunities to work alongside others in the team. This meant there was always a network of individuals on hand to learn from, and to collaborate with. It was interesting to note how Lisa often spoke from a team perspective, implying a felt connection and cohesion, of individuals working in concert, towards a common, shared purpose. She even spoke of 'we', when questions were directed specifically at her, '*We encourage her as much as we can to be independent*' [26]

This linguistic tendency towards the collective was noticeable when talking about providing support, as well as when responding to Sara in periods of crisis, 'You have to look out for each other. And we all go to each others aid if there is a problem' [398-399], captured most vividly:

> We want it to be that she doesn't get to full incident... We want it to be that she can calm down without having to be put in the room. That's what we want. That's what we want. [739-741]

The connectivity experienced by Lisa seems to transcend mere presence and the performance of a practical task in response to need. It reveals a form of co-existence or interrelation with Sara. The prefix- 'inter' means among, in the midst or between, and is integral to notions of inter-vention, inter-action, inter-relating and inter-dependence. As one moves through these selected this inter-connection is revealed through Lisa's empathic connection to Sara:

> Now when we get emotionally upset, we can somewhat keep it under control. We can think our way through it. We can reason. And therefore, most of the time you can bring yourself down. But when she gets emotionally upset, she can't reason, not really. She doesn't know what to do about it [89-92]

It is worth noting that the emotional connection Lisa formed within the work environment, did not end at the door, or at the close of shift. It endured, beyond the physical and temporal bounds of work. When talking of 'it' she is referring to the connection, and all that comes with it. Here Lisa spoke of being out shopping for her grandson and becoming aware that unconsciously she was registering things that Sara would like, 'You see she's instantly in my thoughts. With my grandson' [115]. Returning to the more practical, visible connections, Lisa clearly spoke of other team members, but Mum in particular, as playing a significant role in shaping her practice, 'Mum has got a way of being able to get her to do things pretty much on the first time of asking' [21-22], 'So. I would do my best to model my behaviour on Mums behaviour' [430-431]. To my mind, relationships within a professional context are often strongly bounded, but when one looks at Lisa's account of her experiences, the boundaries seem to blur:

> Mum is Mum. And although we are her Personal Assistants, we are her carers, we are her friends. And you have a different relationship with friends don't you, than you do with your mum. And it would be wrong for us to try and take over the role as Mum. Which we couldn't do. We couldn't do that [33-36]

The term 'Personal Assistant' is a role label used within the context of the funding mechanism, the 'Direct Payments' or 'Personal Budget' (SCOPE, 2023). The term 'Carer' is most often used to describe an unpaid role, often one assumed by family members. When one has 'Friends', this normally speaks to a form of connection that exists and functions beyond professional transactions. A friend might be thought of as someone you know, like, and trust, with whom you enjoy spending time. It is a stronger form of interpersonal bond than that shared with a passing 'acquaintance'. Lisa's relationship with Sara was characterised by her as a carer [33, 103, 793], a friend [34, 102, 473] and family member [44, 46]:

> We do see ourselves as extended family really. I don't entirely see it as just a job. It's not. I mean I would be there for half the wages. You know. I would be there for no wages. So, we are her kind of extended family. As such. You know [44-46]

A carer, friend, and family member seem to me to be founded on differing types of bonds. A friend can be characterised by the existence of shared interests, acts of disclosure, the accumulation of trust, interdependence, and the sharing of affection (Policarpo, 2015). Familial bonds run as deeply if not deeper, and it is possible to suggest that such relationships increase the intrinsic vulnerability of both parties to each other. This because the protective instincts one relies upon in functional or disposable relationships are set aside, and strong emotions such as affection and are more freely expressed. A carer can operate within an entirely transactional context, although have the potential for the

aforementioned vulnerabilities to develop if boundaries are not instituted. From my perspective, relational boundaries for Lisa seem fluid. The professional blends with the personal, and the personal with the private. The investment Lisa makes in the role seemed to come from a personal place, interrelating as a friend or even proxy-family member, where emotions are not excluded, indeed were welcomed. Demarcations between such roles are recognised as being important, 'Professional boundaries are a set of rules which protect patients and staff from harm. Staff must understand they are in a position of power within this relationship, and this must not be abused' (CNTW, 2020 p.2). In the absence of such delineation the sense of role may be lost, complacency develop, along with a host of feelings reserved for the private realm, jealousy and resentment as well as attraction and entitlement. In such a homely setting, in which the service so closely resembles a family dynamic, boundaries are perhaps likely to become blurred, even if ultimately, they are not broken.

It should be noted that in Lisa's experience, relational boundaries appear to blur for Sara too. The fact-find revealed that Sara has tended to experience periods of fixation, or obsession with individual staff members. Both Lisa and Russell have experienced this, which manifested in high levels of demand for attention being placed on them. This in turn was reported to reduce team efficacy as demands become unequally distributed, tiring the subject of the fixation, so intense does their workload become. The ability to relate with Sara, however, was stated by Mum to be an important recruitment criterion, with interviews of new staff often involving them being introduced to Sara with Mum observing to see if rapport was forthcoming.

It was clear from Lisa's account that not all connections were comfortable, or useful. The notable example was that with Sara's father. Having separated from Sara's Mum, he went from a constant presence in Sara's life to one that routinely enters and exits. Lisa's experience [as well as that of colleagues] spoke to the way this father/daughter relationship often sent destabilising ripples through Sara's life, and then through the professional lives of staff. Having dropped Sara back after spending

time with her, these ripples often materialised in practical challenges, rising frustrations, and in dysregulation which Lisa and her colleagues were required to deal with. The discord between Mum and Dad led to staff siding strongly and protectively with mum, which in turn simultaneously weakened the necessary relationship with Dad, giving rise to powerful feelings. She spoke of experiencing 'anger', rising from a combination of his periodic presence in Saras life, versus Mums' constancy and of his absence of structure leading to Sara returning from time with him feeling unsettled. Lisa felt Dad left Sara feeling bored and frustrated, feelings that would ultimately be revealed and displaced upon her return home. In addition to this she believed Dad did not place necessary demands on Sara [or 'push' her], encouraging her to move out of her limited comfort zone to increase her opportunities for social engagement and increase her personal and interpersonal competencies. From Lisa's perspective this stored up problems for the team, he 'doesn't get hammered. Who doesn't get sworn at. He isn't the one that get pinched, and all that. Because he's giving in to her every time. So, I get quite angry' [315-319]. For Lisa, relational boundaries seemed fluid, and shifted easily from the personal to the professional, and back again. This included those emotional aspects were present.

Feelings of all types are always present. You use the good ones.

Lisa's account speaks of many emotions being experienced. The examples reveal the range of named emotions reported by Lisa (Fig 39.2):

#1	Interviewer: "*It sounds like. You're understandably **angry** with the situation....*" Lisa: "*I am. I am. It shouldn't be the case*" [348-351]
#2	"*You can't spend 26 years and not know. I'm sorry, but you can't. Which is why I get so **frustrated**. In that sense*" [346-347]
#3	"*It's a 'Golden Moment' because in a moment like that you sort of look at her and think 'Yeah. You're not bad really, are you?" [Laughs].. "I **love** you..". And you feel special*" [72-73]
#4	"*And it was... [exhales] **horrible**" [428]*
#5	"*It did. It really hurt…" i.e., **physical pain** [553]*
#6	"*…after the adrenalin has come down, you feel really quite.. [pause] You have a sense of **upset**. Well, I do anyway*" [87-88]
#7	"*Nobody wants her in the Blue Room. It's always a **sad** moment when she's had to go in.. Nobody likes it. It's horrible*" [741-742]
#8	"*I am much **happier** working there. With all the slings and arrows of outrageous fortune slung at me, and things. I would never want to go*." [496-497]

Fig 39.2: Emotions and feelings reported by Lisa.

Whilst this is not offered up as a quantitative analysis, most emotions could be categorised as negative. There are also examples of indeterminate emotional responses. The following excerpt refers to the feelings generated when Lisa compares Sara's life opportunities with those of her own daughter who is nearly the same age:

> I get myself really quite emotionally wrapped up, and sometimes I think maybe I shouldn't. Maybe I should be stepping back a bit. [pause] I've got a daughter her age. Actually, Sara is five months younger... And she's married, she's been married four and a half years now. And has a good job. And her husband has a good job as well. And I look at her, and I look at her situation, and I think 'wow!' - How different it can be when you've got a chromosome that's perfectly OK, as her friend and her carer, I do get very emotionally involved. I probably shouldn't [97-103]

The emotions present within this excerpt are not named, so I can only speculate what they might be. It does not seem unreasonable to suggest this may include hope, pride, sadness, and frustration. The final reference to emotional involvement seems less to do with the tendency towards experiencing what have been characterised as negative emotions, and more to do with the strength of the positive regard Lisa appears to have for Sara. Lisa mentions her own daughter, and that she also thinks about Sara outside of work, where she also thinks of her at the same time as her grandson. That Sara stays with Lisa, and that this commitment transcends the superficial, immediate array of emotions rooted in periods of conflict, tension and challenge, seem to indicate a deep regard and connection.

When Lisa's account moves to how she responds to the demands placed on her by Sara, she concedes that a wider wellspring of emotions can reveal themselves, 'I get quite angry. Internally. And occasionally I will get a bit shouty towards Sara. If she's been really evil to her mum' [319-320]. The use of the term 'evil' is jarring. It is a word that imputes bad character, and speaks to indifference, and in extremis it speaks to the intent, active pursuit and satisfaction in causing harm to others. What would constitute 'evil' within a loving Mother/Daughter relationship? Lisa went on to give the following account:

> A few weeks ago, Mum had an incident. Which was documented, where Sara beat her black and blue actually. Mum was bruised. Well, she's still got bruises. Sara completely flipped over an item of clothing actually. Just completely flipped [385-387]

Lisa reveals there are times when anger predominates, leading to her venting, and getting 'a bit shouty towards Sara' [320]. In contrast, being able to identify those emotions present within another can help sensemaking and the formulation of a response. Lisa takes us through an experience, where she demonstrates her awareness of Sara's internal state:

> It was PMT week, and it was a particularly bad week. So, she was very emotional. Anyway. She just went loopy. She really went off on one. There was punching. There was pinching. And whatever else. Then she dashed out of her room, and went into the small toilet, shut the door, and wrecked the towel holder. [256-260]

In another instance Lisa brings herself into the moment, how she felt, and her reliance on the application of reason to attenuate rather than deny the impact of her own emotions:

> To be able to do it properly, I think, you have to have some kind of emotional investment. Because, when she has her moments, obviously she is emotionally upset. …Now when we get emotionally upset, we can somewhat keep it under control. We can think our way through it. We can reason. And therefore, most of the time you can bring yourself down. But when she gets emotionally upset, she can't reason, not really. She doesn't know what to do about it. Apart from go into incident. She ends up in a room. And you think to yourself, 'that is really quite horrible'. I remember the first time I ever saw her in incident. I nearly cried [pause] Because it was absolutely horrible to see. And I kind of put myself in her place sometimes. And think to myself, 'If that were me' [84-95]

Lisa seems to travel with Sara as she grows and changes, a journey and companionship that is rewarding for her. She never talks about Sara as 'other', an object solely of her professional attentions, or someone whose transgressions require remedy. She talks of someone in distress, struggling with normal and natural emotional reactions to a situation she does not understand or have mastery over. This leads to a need for Lisa to set aside difficult emotions, to make decisions and take actions designed to restore emotional and behavioural equilibrium. Returning Sara to a place where she can be supported to thrive.

It's About Finding, Or Making, A Kind Way, Through to The Other Side.

There was a sense from what Lisa said, that when responding to behaviours of concern she was doing what she felt was best for Sara at the time, based on what made sense to her in the moment. In such positions it is not uncommon to see staff lose sight of the person they are supporting, as they become little more than a risk or a hazard that needs to be managed. Lisa articulates the fine line that needs to be negotiated when force comes into play:

> Obviously, no one wants to hurt her, but if she picks up an odd bruise due to conflict, due to battle. Then that's a fraction of what we've probably picked up. And nobody ever sets out to hurt anybody in their care. They don't [697-699]

This seems to acknowledge that in that interface between herself and Sara, when force is used, where resistance and counterattack are experienced, there is the potential for harm on both sides. Whilst this short passage seems to make clear and obvious sense, and to indicate a clear commitment to avoiding any harms, the resort to force is routinely condemned. This possibility of causing harm within the context of such responses has the potential to be framed in various ways: as an inevitability of physical restraint [thus undermining the ethical imperative to care], as an infringement of the individual's human rights [not be exposed to cruel and degrading treatment] and as a gateway to abuse [when such restraint becomes a measure of first resort rather than last resort]. There was no evidence to suggest that Lisa engaged with such philosophical deliberations, and simply pragmatically accepts that necessary restraint and any inadvertent harms are an inevitable price to be paid for serving the greater good and doing right by Sara.

Whilst Sara's 'Positive Behaviour Support Plan' guides staff actions, and training provides them with model responses, neither categorically define in advance what will happen. The navigation and

negotiation of those uncertain and unpredictable events meant that Lisa's personal, relationally mediated sense of what was required as well as her instinct loomed large in the formulation of her responses. The following comments relate specifically to the event captured in the log as described as comprising twenty-eight words, and an emoji:

INTERVIEWER: Can I just take you back to one of your audio diary entries? I think it's a day when I think you were in the graded, and you went into the hot tub. On the entry she [Sara] had decided to pinch you, and you said, 'she was really strong' and it 'really hurt.

LISA: It did. It really hurt' For some reason, and genuinely I haven't got a clue what that was about, she was fine. Got in. She was fine. The day had been fine. From what I can remember. We went in and had the hot tub. And she just decided to just go for me! [448-555]

INTERVIEWER: I'm interested in, in that moment of getting out of reach or getting out of the way, you do have to peel her hands off, or push her arms out of the way, or do anything to give you a chance.

LISA: Yes. Sometimes you do. Sometimes you have to do that. And other times, if she's letting you go. If she's managed to let you go and then you kind of like are able to move. But sometimes if she's on one she will follow you. and you can't get away [559-570]

LISA: It's instinct. Its complete instinct because she doesn't conform to the Physical Skills Training. She doesn't. It's as simple as that. You know it's like wrestling jelly sometimes. You know. Because she has EDS[10], and because she's extremely

[10] Ehler Danlos Syndrome. Ligamentous laxity permitting hyper-mobilisation of certain joints.

flexible. You know you can move out of the way, but she can still manage to get you. I mean all you can do is have an essence of it but [pause] In reality you've just got to grab a bit and go. And try and get away.

INTERVIEWER: And that would be [pause] Correct me if I'm wrong here, peeling her hand off maybe, pushing her arms away, is there anything else you would do in that instinct moment? Would you ever push her? Or pull her? Or?

LISA: If she had her hands on me, I would do my best to get her hands off, by whatever means possible. You know. I mean I never physically [pause] If she's on one [pause] I never physically touch her. She comes after me.

INTERVIEWER: So, in that sense then, are the techniques you're taught any use at all? Or no use at all?

LISA: [laughs] Moving on! [laughs more] [578-611]

Lisa's account reveals she experienced sudden, intense pain because of an unprovoked attack. She reveals hastily contrived actions which serve her situational goal of getting away. In terms of the structure of her response, it seems to have been physically constructed from those resources that were available and ready-to-hand; the action of pulling away, standing up and running [This DIY sensibility will be returned to in later chapters]. In terms of the nature of the response, taking action to escape, or get away, clearly contrasts with restraining. In choosing restraint, one would have sought to 'close down' the capability to 'attack' and used physically containing manoeuvres to nullify the potential for Sara to continue to inflict pain and cause potential harm. A third option would have been to retaliate. Such a response could have been underwritten by some form of greater, overpowering evolutionary drive, to invalidate or vanquish someone who by their actions have presented as a threat or enemy (de Becker, 2000). Such responses would seem to come easier when someone is in the thrall of heightened emotions such as anger. That Lisa did not counterattack seems to say something, either

about Lisa's inherent nature, value base, and physical capability, and perhaps ultimately her connection to and regard for Sara.

In answering questions Lisa begins to speak more broadly about the subject of restraint, rather than dwelling within the incident in question. Whether this was to avoid contemplating the actions she had taken, or to make a broader point about the inevitability of being involved in such actions is unclear. That she then speaks to the insufficiency of training perhaps leads one to conclude that physicality is invariably messy. In her account Lisa had found herself involved with Sara when she suddenly went 'into incident'. Here an urgent, and arguably primal need to extricate herself from a harmful situation became her prime goal. This she did by resorting to her 'instinct' as she found the training failed her. Despite her experiencing intense emotions and expressing her feelings, ''Will you bloody well leave me alone!'. 'Get off me! What have I done?' and just 'Stop!'', these did not appear to permeate or shape the response. In the face of active hostility, and despite experiencing pain and the potential for injury, Lisa seems to have kept righteous anger and an instinct for survival from overtaking her response. This seems to speak, at least in part, to some sort of commitment to a particular type of being in that moment and in the response to Sara. It seems to me that some form of 'Self-Regulation' (Vohs & Baumeister, 2004) and resilience, of 'adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility…' (APA, 2018) which served to ensure Lisa remained true to her supportive and caring goals. She found, or more accurately made, a way through a situation, which allowed her to retain her caring integrity, something which echoes the grace under pressure spoken to by Foster *et al*. (2023).

You Only Really Know After the Fact.

We make sense of information, complete calculations and consider options as we make sense of what is happening to us. Any resultant actions are then modified or adapted in the wake of their success or

failure. Often this is hurried thinking, close to or even sometimes beneath the threshold of conscious awareness. The term 'Instinct' [579] was used by Lisa. Further to the sense of striving to do right, of committing to do good and endeavouring to find a way through which served Sara's best interests, it seemed clear from Lisa's account that the nature of any true success did not become apparent, or any learning did not take place until after the event concluded, when Sara had returned to a place of emotional and behavioural stability, and a state of safety and comfort. Whilst reflection might be considered serious and careful thought directed at some '*thing'*, reflective learning is defined as the 'Process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self and which results in a changed conceptual perspective' (Boyd and Fales, 1983, p.100).

The efficacy of any response and whether the emotions experienced were justified is only truly engaged with through reflection. How the next fluctuation or escalation in behaviour could be averted, or would be dealt with, seems for Lisa to be collaboratively determined in conversation with others, and particularly Mum, 'Mum is very good at talking things through with you' [423]

Recent events had resulted in a significant reduction in the size of the team. The knock-on effect was that there was little time for the highly valued opportunities to process, until more staff were recruited. For Lisa, the absence of that opportunity to review her practice, and to consolidate her knowledge led to self-doubt:

> Well, it was difficult for me, because I didn't know if I was coming or going. I didn't know if what I was doing was Right. I was doubting myself. I was thinking 'Am I any good at this?' or 'Am I getting it?', or 'Am I suitable?' or 'Should I even be here?'. I would talk these things through with Mum. Mum was brilliant [437-439]

Lisa then had transitioned from a regimented and procedurally mediated role in a retail environment to a far more dynamic role that required an ability to find a way through the undeniable challenges presented by fluctuations in Sara's emotions and behaviours, including attack. The ability to do this seemed to be predicated on a strong shared mission, and the ability to embrace complexity, and tolerate what might be characterised as dissonance or uncertainty, and certainly destabilising emotions. This revealed a form of resilience or positive adaptation that extended to the post-event sensemaking. Lisa's values and her sense of a collective presence seemed to facilitate the dynamic adaption required. Holding all this together was an amalgam of relationships. That those relationships were honest and allowed for the expression and processing of heightened emotions and uncertainty seemed integral to success within each unique response to behaviours of concern.

Appendix 40: Setting One, Case Study: Emma

Introducing Emma

Emma is Personal Assistant, working for a second time within the service. She revealed a peripatetic career path, as a hairdresser, bar worker, and carer/support worker. When asked to describe her current role, she used the word 'we'. To me this spoke to her seeing caring as a communal endeavour, with Emma and colleagues working *with* Mum and Sara. There was an explicit recognition of Sara's autonomy and her innate capability ready to be realised in her references to 'assistance' and of 'encouragement', with the qualifier 'if' describing the graduated and contextualised nature of the support provided. Emma observes, 'You can have a laugh and a joke and things like that, but she's a lot more switched on than people think she is' [37-38], suggesting she does not underestimate Sara's intelligence. When describing how she would encourage Sara to engage in an activity that she had been seeking to avoid, Emma said she would say ''Come on cheeky. We've got to do a game now' [62-63]. As will be explored further on, such encouragement can come up against refusal or resistance, necessitating a more assertive approach, or what is referred to in the first PET as a 'care-full challenge'. I was reminded of the 'graded assistance' hierarchy located within the 'active support' framework (Jones *et al.*, 2012), wherein the help given is 'just enough' to enable the supported person to accomplish a particular task themselves. Looking at the interview in its totality, the notion of 'encouragement' seems to involve imposing demands such as cleaning teeth and getting dressed, as well as imposing restrictions [such as injunctions to stop ripping one's clothes], navigating the fine line between encouraging and imposing.

When taken as a whole, Emma's interview suggests to me a strong sense of her being someone for whom the ability to care for someone professionally was important personally. As the first PET is

unpacked Emma makes a key disclosure 'I've got quite a lot of history, personally'. This is not elaborated upon, but after reflecting on the decision to reveal it, coupled with a consideration of her interview in its totality, it *seemed to me* to speak to someone that was important to her sense of who she was. I was minded to those who are driven to caring by having seen or known or experienced something akin to 'uncaring' treatment. This can be referred to as being a 'Wounded Healer', a term credited to Jung (2013/1946), which captures the idea that a person assumes a caring role [the analyst in Jung's writing] because they themselves are 'wounded'.

The Personal Experiential Themes [PET] that capture Emma's lived experience are:

1. I care-fully challenge.
2. Caring can be a struggle and even hurt but be rewarding.
3. Despite this, physicality escapes me.
4. My mind needs support.
5. Experience is my teacher.

Fig 40.1 shows the 11 'Experiential Statements', arising from 84 'Exploratory Notes'.

I care-fully challenge
• I support but I don't over support. • Reading the mood is complex but essential to care. • My own sensitivity and vulnerability make me who I am in a caring context
Caring can be a struggle and even hurt but be rewarding
• Sometimes I have to metaphorically push or pull SARA in order to care. • Sometimes the price of doing what's best for her is pain. • For me personally the reward transcends the pain
Despite this physicality escapes me
• There are all sorts of understandable behaviours of concern. • I'm reluctant to get physical - it's not ME
My mind needs support.
• My mind Travels with my body through Her Behaviours
Experience is my teacher
• Training Isn't Real Life - Life is real life - Real life is training. • I'm always looking backwards to look forwards

Fig 40.1: Emma's 'Personal Experiential Themes'.

I Care-Fully Challenge.

Emma used the word 'encouragement' in her job role description, which seems worthy of deeper consideration. Emma makes it clear that there is a distinction between doing things for Sara and encouraging her to do things for herself. My impression is that the decision to refrain from doing certain things for Sara does not arise from inherent laziness. Neither is it a punitive form of teaching. Rather it seems that Emma communicates a sense that Sara's autonomy depends on her doing things for herself, increasing her experience of freedom. In which case Emma's practice of imposing a demand, or declining to do something on Sara's behalf, could be construed as caring and designed to promote growth. Rather than allowing her to be cast in the disabled role of a permanent child, reliant on able bodied adults [carers and parents] to minister to her needs, she is challenged to do things for herself. The challenge for Emma is to strike the right balance and is something that will be returned to in the next PET. Her answers revealed something to me about how the preparedness to challenge comes into being. As a nurturing intervention aimed at increasing freedoms, I can see it has role in

protecting the supported persons autonomy. Doing things 'with' someone can become doing things 'for' someone, can become doing things 'to' someone. Along this slippery slope, choice is reduced and often ultimately disregarded. In such circumstances caring becomes a depersonalised, unthinking, unfeeling, transactional affair (Reader & Gillespie, 2013). By contrast, Emma spoke to the need to 'read' Sara as part of both forging a productive relationship and providing support. At this point I began to discern an underlying ambition promote Sara's personal freedom.

Having disclosed that she had 'quite a lot of personal history', weight was added to this disclosure when she conceded that she takes 'everything to heart' [128]. I interpreted this to mean that she was sensitised to the words or actions or others, and that when they are internalised, manifesting as unsetting feelings. What this history comprised was not something that I felt was appropriate to press her on, so left her to finish her description of bringing it to the attention of Mum, 'Once you've read it put it in the bin. Burn it. I don't care what you do with it. But you'll realise I am the person I am for a very good reason' [130-132].

Later she refers to her emotionality and characterises it as problematic in her eyes as it means she is a 'woos', and 'not hard in any shape or form' [165-167]. Positioning sensitivity and emotionality as burdens would reaffirm the narrative that an idealised member of society should be strong, and independent and rational (Scott, 2000). Emma's account reveals she tries to do right by Sara, but not in a way that is reliant on any overt strength or externally tangible conviction. She also indicates that she goes over and above what is expected and does not necessarily receive acknowledgement for this. She speaks of wanting connection, and of it being an intrinsic reward. In her account, she returns to her personal philosophy of holding firm to care. This reveals a paradox, she is sensitive and vulnerable, but at the same time she is strong and pushes on through whatever Sara throws at her [see next section]. This again to me would seem to be a manifestation of some form of resilience (APA, 2028).

To return to the 'wounded healer' (Jung, 1946) this notion captures a psychological perspective wherein seemingly mutually exclusive and contradictory opposites can be simultaneously held onto: the damage done unto the individual who was once overwhelmed by adversity, and the ability now to overcome adversity in the service of others, driven by that that damage done. To return to an earlier sense that she was seeking to preserve and promote Sara's freedom. Perhaps this is because freedom was something she herself had experienced being curtailed. If this was the case, she could be seen and understood to be vicariously experiencing freedom through her care for Sara.

Caring Can Be a Struggle, And Caring Can Hurt but It Can Also Be Rewarding.

Emma reveals the working relationship can be fragile, contingent on Sara's mood and behaviour, which can include physical hostility. This notwithstanding Emma still communicates a positive regard for Sara, which seems to speak to a caring that transcends the challenges. These challenges manifest in the harm done to her by Sara, 'Sometimes I do get the odd more scratch than others, but you know my job title is not to be there and do everything for her' [24-25]. At the time of the interview she said, 'I'm black and blue at the minute. You know, when she's lovely, she bloody lovely. Bless her' [67-68]. Emma reveals that on multiple occasions she incurs a physical price for caring for Sara and nurturing her growth. The act of supporting Sara the 'person', seems on occasions to involve a need to work through the 'behaviours' and to keep going despite any pain or disappointment. As suggested, this speaks to resilience (Foster *et al.*, 2023).

Looking at the behaviours Emma encountered, one reading could be that they are defensive or protective actions [by Sara], taken to repel what is perceived to be a trespass upon her person. This type of behaviour being something that can be construed as an attack or act of violence. A alternate reading is that the behaviour has a communicative function. In the absence of being able to articulate

their needs and wants, a learning-disabled individual may use such behaviour as a form of physical language (NICE, 2015). A modified version of this perspective is that of pain-based behaviour. Anglin (2002) coined this term in the field of residential childcare to counter the growing use of labels such as troubled, challenging, misbehaving and acting out. It spoke to the behaviour witnessed or experienced having its roots in psychosocial pain, and being an instrumental release of that pain. The sense gained here is that the there are occasions when Saras behaviours of concern embody her discomfort, frustration or confusion, and that Emma is metaphorically reaching through the behaviour to connect with Sara to resolve that distress, frustration, or confusion. When kicked, or scratched whilst reaching out, as Emma described, this could be characterised as a form of personal sacrifice on her part, the price paid when caring for Sara in crisis. There is no obligation to endure this, so it might be more accurately described as a form collateral damage.

By striking, grabbing, and pinching, Sara clearly causes Emma pain and injury. In contrast to the Emma's willingness to endure the pain when there may has been no ill intent, she did also speak of occasions when there was a feeling that the behaviours were deployed for the sole purpose of causing pain, or fear or harm:

> INTERVIEWER: Do you think she realises that she's hurt you?
>
> EMMA: Yes. I do honestly. And I don't know if other people agree with that. But I think she's quite calculating and manipulative. Earlier I said you can sometimes see that look in her face, and I'm like; she's testing to see what she's going to do next. And I've worked with other people like that. And I didn't realise it at the time, but I know now, as he was sat there, and I thought he was all lovely, he was actually planning in his head how he was going to kick the living you-know-what out of me. But obviously I didn't know that at the time. But with Sara, I

> don't know. Sometimes I think if she can't get her own way she will sometimes try and hurt to get her way [282-291]

It is difficult to imagine tolerating pain and setting it aside for a greater good. It becomes particularly difficult to understand, when on occasions that harm is perceived to be inflicted with intent. One might endure such experiences if one was able to see beyond such 'attacks', and past those moods and patterns of thinking that motivate the 'attacker'. It is possible to think of them as rooted in some form of displaced rage, or as some form of cathartic discharge where pent-up emotions are released. There is no evidence whether such conjecture has any grounds, but what is in evidence within Emma's account is that despite the above, Sara is deeply felt to be 'lovely, she bloody lovely'.

Despite This Physicality Escapes Me.

Something that came through strongly was Emma's aversion to physicality. She spoke of adopting various strategies that, whilst principally designed to reduce rising tension or distress, they seem to me in large part to be about minimising the need for any physical intervention. This is because Emma continued to focus on such approaches even when the questions were ostensibly about physical responses. There also seemed to be a reluctance to talk about physicality head on, and Emma would often digress. However, she did speak about an incident when Sara grabbed her clothing in the kitchen, and was pulling at it:

> I was in the kitchen, and by the sink, I was stood there think 'I hope this doesn't go seriously negatively because I can't get out' I'm by the sink, and she's in front of me, and I've got no way out [laughs]. Luckily whilst she took her eyes off me for a moment, I literally dodged past

her and got out into the hallway. Because I thought, I'm in front of a camera then. There're no cameras in the kitchen. At least when I was in the hallway there was cameras. So, when you write everything down you can justify why you did what, and you know 352-357]

This brief account seems to reveal a series of underlying anxieties. She expresses concern that it could go 'seriously negatively', and that she might possibly not be able to get out. It feels to me that she is further leaning into the notion that she is a 'woos', and 'not hard in any shape or form' [165-167]. My sense is that she would not see 'hardness' or 'toughness' as appropriate in that moment, I do not believe she would want to act in a way that jeopardised the safety of Sara. I think what she is speaking to in that moment are the feelings of vulnerability, and inadequacy that her own life experience has left behind. I think she is speaking to personal feelings in isolation, rather than in context. She then spoke of the 'luck' she had when an opportunity for escape arose, of concerns around the absence of cameras in the kitchen, and the need to complete an incident report to justify her [minimal] actions. One can conjecture that a video recording would provide proof after the fact that she did the right things. The reference to writing things down and justifying what she did also seems to lend weight to this reading. What she did not do is as important as what she did do. She did not launch into a breakaway technique when initially grabbed. This did not transform into a holding technique. Physical encounters can on occasion result in Sara being transported to the Blue Room. This did not happen. Such a measured response could be considered skilful. However, the sense gleaned from talking to Emma is that it was strongly governed by her values and in part by her aversion to physicality.

She went on to reveal that last time she worked there 'she would have been in her Blue Room all day every day' [371-372], and that was one of the reasons that she felt that Sara was in a 'better place' [370] now. Through talking with Sara's mother, I established Sara had experienced a very difficult time within a long stay hospital, and that Mum and the team of PAs have been working hard to help Sara

recover from her experiences. It is conjectured that the earlier, more challenging period of service that Emma speaks of was during that time when the legacy of her poor experience was being worked through. With hindsight, supplemental questions could have shone light on why Emma had previously left the service, and whether Sara's adverse experiences linked to the high levels of physical intervention at the time were a factor.

My Mind Needs Support.

It seems clear Emma values connection, and that the connection is central to how she cares. By unpicking the relationship, a light is shone on how Emma lets Sara into her mind, and what this does to her. She indicates that the team describe themselves as Sara's Friends, and that through her role Friendship, and presumably feelings have developed, 'I am her support worker, but I'm her friend. My only concern is her' [525-527]. The reference to concern is then expanded upon, and how it seems to give rise to a state of heightened psychological arousal, 'You know I go home, and my brain doesn't turn off. Its still ticking, wondering what's she's up to' [528-529]. This is positioned by her as somewhat unusual, 'Some staff members aren't like that. But I've been like that. Always' [529-530]. If she was revealing her vulnerability earlier in stating she was a 'woos', I think here the statement reveals something of the hypersensitivity that has arisen from her life experiences, and how she has come to demonstrate the traits of a 'wounded healer' (Jung, 1946).

Emma seems to reveal concern around how her actions are perceived. This echoes the anxieties expressed around the need for cameras to record her actions. Here she states 'I'm worried about the public if anything were to go belly up. And my colleagues'. It is possible to read this in different ways. As a concern for the integrity of the service, and a desire not to give anyone ['the public'] any reason to raise a criticism or complaint. Sara is often out in public spaces, and presumably may display

behaviours of concern whilst out, which of course would necessitate a response by staff members. These messy realities can be misconstrued by the public. That Emma also includes colleagues leads me to read this as perhaps an insecurity revealing itself. Drawing any substantive conclusions form the presence of these traits would be interpretative over-reach. However, the fact that Emma values the opportunity to process and seems to want to continue to learn comes as no surprise.

The team were depleted at the time of data collection, and it was conceded that often, whilst seen as extremely valuable, opportunities to process were not possible. Their current absence aside, Emma revealed something of the psychological and emotional impacts which were attached to providing support and responding to behaviours of concern. Emma seems not to be able to 'switch off' when she leaves work and speaks of how smoking and drinking could function as coping mechanisms. There seems a tangible need by Emma to dissipate the accumulated stress, with making sense of things being a significant part of this. Perhaps, as a wounded healer and being sensitised to feeling the pain of others and needs to relieve herself of this burden. To this end a talking things through was seen as providing a chance to decompress and rebalance mentally, 'It makes me feel a lot more comfortable. in myself, when I haven't got those thoughts ticking away in my head [602-603]

Those things 'ticking away' in Emma's head seemed to involve all manner of concerns. It is recognised that exposure to aggressive or violent behaviour can engender fears that resurface within subsequent incidents, including the fear of being harmed. Fear itself is a valuable emotion, but one which can take root in unwelcome spaces. It can degrade one's personal and professional abilities, as well as one's sense of invulnerability (Janoff-Bulman, 1992). Such changes can be fuelled by experiences where things have not gone to plan, strategies have failed, and the hostility is perceived to be personal. We know that Emma faced difficult situations, with Sara being 'horrible' [327], 'a bit of a devil' [518] and experiencing pain and injury at her hands, 'If I'm completely honest, she bloody hurt me' [239]. As the

next section will show, she values learning, and processing events in a supportive way, both of which help her to consolidate her experiences and grow in confidence.

Experience Is My Teacher.

Very early in the interview Emma spoke about learning. Rather than it being something routine or inconsequential, she spoke actively of the role of training in her development and her capacity to do her job to the best of her ability. How she learned seemed in part to be linked to her dyslexia. Emma seems to come across as both wanting to learn and being willing to learn. Inherent within this an openness to 'change', and desire to do things differently or better. Emma seems to be sold on the value of training but still asserts that first and foremost she does not want to be in a situation where physicality is required, 'I prefer not to put myself in that situation [443]. Further to communicating her unease around physical interventions, and of actively avoiding them, she also talks needing to be able to justify why she did what she did. To this end, the efficacy of physical skills training was enquired about. She acknowledged that techniques for different situations were taught, but 'It doesn't work like that all the time [412].

Emma's answer seems to reveal something personal, and something practical. To have been able to assert that techniques don't work, I can only conclude that she has tried to use them, and failed. Perhaps this was during her earlier tenure when the behaviours were more intense, and more frequent. Irrespective, it is the fact that she does not want to talk about physicality that registers with me. My sense is that being placed inside a violent encounter, is perhaps to place Emma in the most difficult of all situations for her to handle or process. A place where whatever historical events have left her feeling vulnerable become very close to the surface of the experience. Moving past such events is key to maintaining feelings of safety. Being willing to come close to such uncomfortable

experiences, seems to me to say something about the power of Emma's desire to care for others. It perhaps says something about the origins of the urge to care, that would be interesting to explore further in another study.

The practicality that Emma's comment touches upon relates to the transferability of the knowledge and skills developed during training, and the way techniques themselves are packaged. Emma indicated, 'It doesn't work like that all the time'. This seems to suggest that what she has learnt in the classroom did not 'fit' the reality she faces. This may be rooted in the custom and practice of teaching a standardised menu of techniques, against a very fixed range of attacks which do not capture either the true diversity of potential attacks or their dynamic nature. It may also speak to the fact that precise, sequenced patterns of physicality are not retained or recalled by everyone. It would be speculative to suggest that dyspraxia accompanied Emma's dyslexia, but an assertion that has a firmer anecdotal footing is that trainers teaching breakaways and restraint techniques routinely encounter individuals who struggle with reproducing techniques. Emma has an aversion to physicality, which may also impact on her retention. This interpretation is linked to the elements of physicality, which of course will usually only comprise a small, often fleeting part of any overall response. To respond to the behaviours presented by another, such as Sara, a staff member like Emma needs to make sense of what is happening, to address any feelings or emotions that are stirred in that moment and be able to select and if necessary, adapt strategies to meet the situational goals, which include the interests of both Sara and Emma. In part due to dyslexia, she identifies questioning as an effective practice to develop her underpinning understandings. Her approach to her job seems characterised by a desire to care coupled with a willingness to learn and grow. She is reluctant to get involved in any physicality, which seems to be rooted in an empathic connection arising out of the vulnerability and sensitivity that she personally brings with her into the role. She comes across as someone who would not

proclaim she knows emphatically what she is doing, or that she gets it right every time. Rather she appears to be someone who always tries hard to do her best by Sara, and to avoid causing harm.

Appendix 41: Setting One, Case Study: Russell

Introducing Russell

Russell is a PA, in his second term within the service. At the time of the interview, he was the only male member of the team. He turned to care work after a career in industry, working in large scale industrial production. He revealed nothing of his own family, only that his partner also works in care. Early in the interview he describes his role, 'Primarily as a support, and somebody who can relate and relay things with Sara, understanding her fully. And try to make her life, with all her obvious difficulties, a better and more fulfilling one'. The subjunctive clause 'with all her obvious difficulties' seems to speak to Sara's diagnosis, and the implicit assertion that this is something that inevitably conspires against her progress or success. Further to this, the use of the word 'more' rather than 'the most' *could* be taken to suggest that some sort of acceptable rate of failure is built into the pursuit of the 'production goal'. Russell's technically oriented mindset will be returned to.

I identified four 'Personal Experiential Themes' [PET] in Russell's account:

1. I know what to do, and what should happen – its logical
2. But it's all so complex and complicated.
3. The physicality is trial and error, not training
4. I need systems and certainty. I can't cope without

These were based on 13 'Experiential Statements' [Fig 41.1], arising from 54 'Exploratory Notes'.

I Know What to Do, and What Should Happen – Its Logical
• I came with significant experience of care, and the world. • I provide a service to Sara. • My Job is Sara and Sara alone. • I believe my success is quantifiable. • I am fully aware that Sara presents Challenging Behaviour • The service I provide involves dealing with risk
But It's All So Complex and Complicated
• It can be Incidents within incidents
The Physicality Is Trial and Error, Not Training
• The training 'as is' certainly doesn't prepare you. • The physicality required is mostly made up in the moment. • I got kicked recently and you do what you have to do
I Need Systems and Certainty. I Can't Cope Without
• Turning Off isn't always easy. • I reflect, But WE don't. I'm on my own. • So it is that my time here now is over

Fig 41.1: Russell's 'Personal Experiential Themes'.

The interview with Russell took place on his last day of service. He had decided to leave to pursue other opportunities. As was made clear, his exit had been hastened by the frustration he felt with how the service was run, which seemed to arise from what he saw as Mum's conflicted role as mother *and* manager, and the absence of a coherent management system supporting the service delivery. Russell's' recollections were offered in a very matter of fact way, with his answers being punctuated with expressions of exasperation, as well as the use of the phrase, 'isn't it?'. This phrase seemed to be used to communicate a variety of sentiments, including 'it's obvious' suggesting that his conclusion is logical, therefore incontestable, and as a result 'you agree, don't you?'. The latter function seemed to be subtly manoeuvring me into agreeing with the statement without critiquing it:

> My core job is sara. Not Mum. Or her sister. Or her dogs. Sara. Sara is my primary purpose and reason I'm there. And sometimes lost in the mists of it all. Which is a shame because that's what I'm paid to do isn't it? [198-200].

I Know What to Do, and What Should Happen – Its Logical

Russell's spoke about knowing the job and being clear about managing the demands likely to arise. He had experience of working in care, having worked within various care providers. Sara's service represented the smallest, and least formally structured that he had worked within. Having worked with her previously [his reason for leaving is unknown], he was able to comment on where he felt Sara was now:

> She's moved on, and she seems most of the time seems to be settled, whereas when I worked with her before we had just as many incidents and bad days as we had good. She was a very very challenging, very difficult, which made working with her very challenging as well [39-41]

His diverse care working experience, and familiarity with Sara, seemed to account at least in part for his understanding of the role he fulfilled. Here he referred to the service he provided with the qualifying clause highlighting 'all her obvious difficulties'. To me his choice of words seemed to serve an analytical and planning function. He indicated that relatively speaking her disability is less than that of others he has worked with, and that you can 'see' that she wants to do unspecified things with her life. One reading of this statement, is that having identified a gap between where Sara is now, and where she could be, Russell felt enfranchised to do what he thought was in Sara's best interests. I would not want to overstate this and suggest Russell in any way misused such practice latitude. The title of this theme was structured around two organising principles: 'I' and 'Logic', with the 'I', placing Russell somewhere close to the centre of the inevitable decision-making process, and the expectation that things will develop logically. An adjunct to this is the way that Russell conceptualises the job at hand, 'My core job is Sara. Not Mum. Or her sister. Or her dogs. Sara. Sara is my primary purpose and reason I'm there. And sometimes lost in the mists of it all' [197-199]. This speaks to both his rational

and rigid conceptualisation of the job, and a further sentiment that will be picked up in the second PET, and the sense of being overwhelmed by the complexity of the demands placed on him. I would not go so far as to suggest that he is asserting an entitlement to a role defined on his terms, but the potential at least, that his rational and logical approach to the job does not fit with the more complex and unpredictable reality he encounters, and the service appears to lack the reassuring systems and processes he is used to. He talked about the impact he had made, which to me seemed to allude to the centrality of his influence, and the apparent value of his method/approach. A claim to working success is fair, and supports a contention that the job, as understood, is being fulfilled.

Before examining this rational perspective, it should be noted that during this period of service he became subject to Sara's known tendency towards fixating on staff members. In describing this he uses the term 'bonding', which often carries positive connotations. Russell has, in his own words, been the 'good cop' [41-42, 296 & 293] during this tenure. However, within the context of his work this 'bonding' has brought clear challenges. Russell's favoured status has meant that other staff have routinely offloaded tasks to him, often difficult tasks which increase his frustrations. In one instance the readiness with which his colleagues saw fit to utilise his connection placed him in a position where he was kicked by Sara. In listening to his description of the event the sense I gained was that he was more aggrieved at being put upon by colleagues than being kicked. Roles and responsibilities were perhaps being redrawn by colleagues to arrive at a situational solution. One reading of this might be that the system allowed him to be used as a resource which reduces his sense of his own agency, or more cynically that in being so deployed he was offered up to take what might be seen as an inevitable fall. My sense is that a system designed by Russell, would not allow that to happen.

Russell's rationality surfaces when he analyses the successes or failures of other staff when responding to Sara's behaviours of concern. This tension will be explored in the next PET. For now, it further

suggests that rationality is central to this worldview. Russell had much to say on the management of risk. That Sara presented a variety of challenging behaviours was readily acknowledged: her propensity to 'pick' [225, 227, 345, 347 & 348] and 'rip' skin, [228] 'rip' clothes [865, 866 & 867], that 'She has kicked at walls and doors' [259, 532] caused 'damage' [260, 282, ', 'kicked' staff [267, 268, 291, 312, 389, 398, 413, 420, 441, 462, 465, 618, 624, 704, 731, 758, 770], 'lashing out' [615] and 'beaten' [251] Mum 'black and blue' [252]. This led to the following statement:

> She's never in green. There's no green. There's green, red and amber in this world we live in, there's a shade of green but not a green. But its predominantly amber, because anything can happen at any moment, and this is what makes the job so difficult [150-152]

Russell speaks to what he experiences as the ever-present potential for behaviours of concern, which could escalate and require intervention. He does this by drawing on a commonly used colour coding system. It aligns closely with the three-tiered public health model referred to in the literature review. The affirmative nature of the statement seems to bake in a degree of expectation, that Sara will inevitably behave this way. Whilst one should never be so naïve as to assume that there will be no risk, to live in expectation that Sara will invariably present a danger risks characterising her as a potential hazard and as a result depleting the hope of positive possibilities within the context of the working relationship. I am not asserting with unassailable conviction that this is how I think Russell thinks, but that framing behaviour in such a way, can lead to conflating the person with the behaviour (Chan *et al.,* 2012), and that this in turn can legitimise physical intervention. It is one of the slippery slopes that seem to be present within the restraint discourse. Others centre around safety, legality and morality, and their gradual erosion.

Russell reveals that memories of earlier experiences with Sara still inform his perspective. I had a sense that he felt he was still vulnerable to both attacks, and to harm:

> This period of employment hasn't been as bad as the first. But those memories of the first period I worked with Mum are very vivid in my mind. You know. Being headbutted, nearly broke my nose, punched and the rest of it. They are very very clear. When you see, even Sara today, you get flashbacks [519-521]

> You get yourself in a heightened state I suppose. Because there's that concern that you're going to get seriously injured. You know? You've seen the lumps she knocks out of her mother. There is that self-preservation that kicks in. That's the first thing. you know if you move away you give her more space to work within. So, it is [pause] It's fearful. There's no doubts about that. It's not nice to think you're going to work and potentially you're going to be hurt, is it? [511-513]

This led to a statement that was both revealing, and jarring:

> This is the trouble. And I don't mean to refer to her as anything other than an adorable girl really, but you know, they say 'You can have a dog for five years, but you can never trust it'. It can always bite you. And I don't want you to take that in the wrong context. Sara can always hurt you. [395-397]

The use of the analogy centring on the potential of being bitten appears to draw on the 'dangerous dog' narrative, whereby some breeds, despite attempts to domesticate them, retain their wolven characteristics. What is lost in this is that some dogs can bite out of fear or frustration, because they are in pain or want to be left alone, rather than indicating a penchant for aggression (AMVA, 2023).

To be very clear, my impression is not that Russell is characterising Sara an animal, or in any way sub-human. However, by drawing a parallel with a dog, Russell seems in a word to have positioned Sara as an unpredictable and dangerous entity, a source of risk, and potential harm. (HSE, 2003) This determination seems likely to be rooted in his past experiences, and what he sees as her ability to hurt. To me the point was made in the vernacular, and whilst it may be seen as an inelegant or clumsy turn of phrase it speaks to a genuine underlying feeling or experience [e.g., patents/mum and dad, 'they f*** you up', James, 2002; Larkin, 1971].

Whilst such events may be emotionally intense and unpredictable, it felt to me that he believed order can be imposed on such situations by the application of reason or logic. This implies that he feels there is an underlying cause and effect mechanism, that should ensure the unsettled or distressed person will respond in a predictable way to a particular intervention. This seemed to lead to an oversimplification of a complex situation to make it more manageable, and easier to process mentally. Such mental processing can protect a person from the need to deal with difficult emotions. It is possible to conclude that Russell has found that the role requires a large amount of emotional labour (Hochschild, 1983) and necessitated that he set to one side the rational or logical mode of thinking that he used to great effect in industry. The resultant incongruence and the toll it exacted, perhaps contributed to him leaving the service. I am left thinking that the resilience (Foster *et al*, 2023) and ability to positively adapt to situational demands seen in his colleagues appeared to be absent.

But It's All So Complex and Complicated

In a support role, work tasks can range from the mundane to the intense, such as responding to behaviours of concern. These tasks rely on different types of thinking, and different speeds of thought. Ensuring that any pending or current actions are congruent with the caring role is a significant

challenge. Russell revealed fleeting disdain for some of the mundane tasks, 'you've got to clean ducks, chickens, pick up dog's mess. You name it you do it! I'm not kidding' [178-179]. Such tasks may be seen as nothing to do with providing support. They could however be seen as helping Sara to care for her animals and in so doing communicating something important to her about exercising care and responsibility. Russell also expressed dissatisfaction with the more complex and complicated work tasks, and how his job role seems to lose coherence. Something that was captured succinctly when he said, 'You don't do 'the job' you have to buy into 'The Family'' [80-81]. The prefix 'But' in the PET title provides a conceptual bridge between it and the first PET, revealing a contrast between the way Russell thinks it should be, and the way he experiences it. This is something echoed later in the interview when he said 'That's why I want out. I can't hack it. Its too much. Its not a job. Its more. Its too big' [572]. This will be picked up again in the final PET.

Returning to Russell's dissatisfaction with work related tasks and the inherent complexity, an incident he recounted reveals much. It was captured within the 'Experiential Statement' 'It can be incidents within incidents' and comprised twenty-two 'Exploratory Notes' [Fig 41.2].

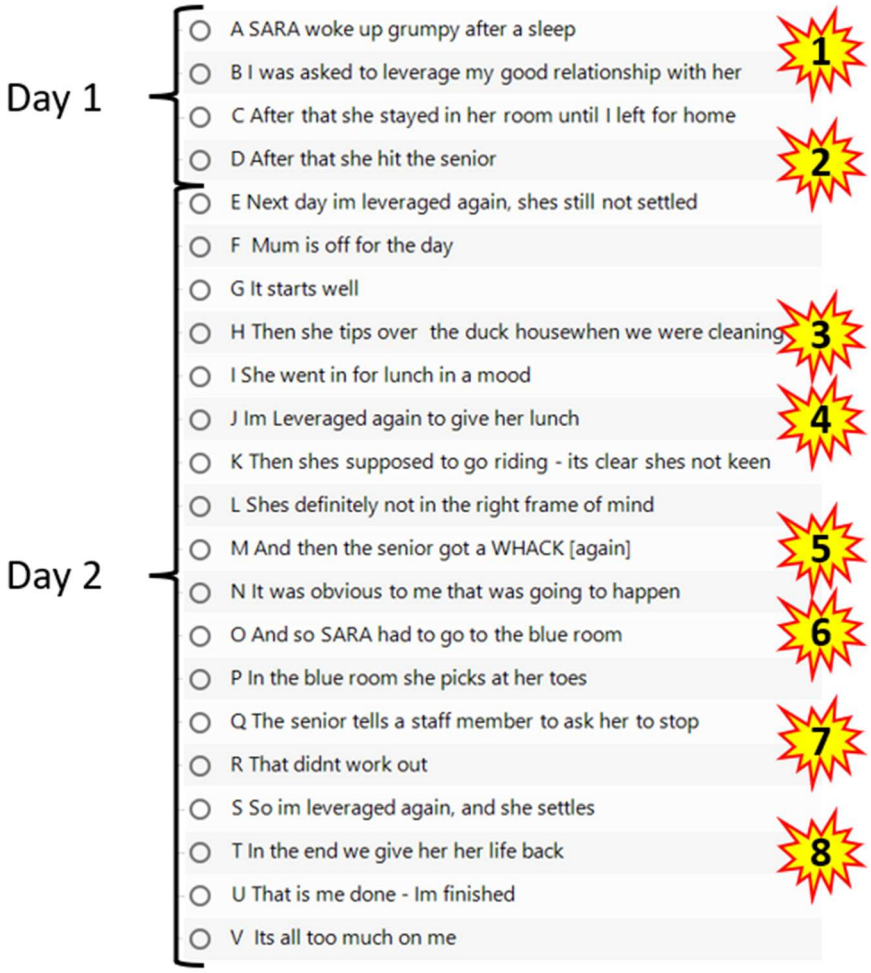


Fig 41.2: Exploratory notes underpinning the experiential statement 'It can be incidents within incidents'.

The following are some key excerpts from Russell's recollection of this protracted event:

1. I was asked to go in this morning because they'd had a terrible night with her, up and down. She'd hit the night staff, and she'd hit the senior. And it continued this morning [293-295]

2. You know, I'm the good cop at the moment. These are bad cops. Which I can fully understand. You know, I've seen this in other services where a change of face. You know. You can't always be the favoured one, because they will become an obsession.

But as Mum said, you can use that rapport to an advantage at times. So, I went in. A smile on the face, and the rest of it. And all was well, and we went outside. It all started as she upturned this ducks house [295-300]

3. So, I wound up giving her dinner. Which again I don't mind. This is the annoying part. They moan that I'm the favoured one, but I'm left to do it all the same. You know? I can't win! [301-303]

4. Then we were supposed to take her out riding. So, we get her ready about half one, quarter to two to go riding. It was clear to me personally that as soon as you mention it, you can tell whether Sara is keen or not, and if she's not keen. Bear in mind her mothers been away over 24 hours, she's spoken to her a couple of times on the phone. And she's already in a heightened mood because her mother [303-307]

5. So, Sara was already anxious. So, me, I would have said its riding today, and as soon as you could see that sort of tension in her, it's a no. But the senior says, 'Lets get your clothes and your boots' Oh dear! This is going to end badly. And of course, the senior turned round and said, 'Come on Sara, let get you dressed' Whack! She got a smack. With that another kick out, and she said 'Right! That's it you're not going riding!'. Well of course she isn't going riding! She got what she wanted didn't she? [308-313]

6. So, she got what she wanted. She took her off to her seclusion room, slammed the door and that was that [315-316]

7. So, my perception of it was that she doesn't want to go riding. So, she's reacted to make sure first off, that aint happening. The next thing was she knew her mother was on the way home. So why would she want to go out when she thinks her mothers [returning] [325-327]

8. Yes, the horse riding was booked in. And I could fully understand why Mum had done it. Because keeping Sara in the house all day is not a good thing either. But you've got to take each day, and each incident as it is. I could understand why Sara was in a heightened state of anxiety because of the situation with her mother, and she just didn't want to go out [331-334]

9. She had her nighty on, which is what she wears all day round the house unless she is going out, so she'll put clothes on. The clothes were in the seclusion room, because that's where she gets dressed. Well, they got shredded [335-338]

10. She was in that room for half an hour I suppose. She sat on her little seat in the corner, and watching her on the monitor, and up with her foot and she started going at one of her toes. So, the senior said to one of the staff 'Oh, open the door and tell Sara not to do it' [338-342]

11. Any way I opened the door and said 'Right Sara. We had a lovely day yesterday walking about. If you keep picking that toe like that, you'll have a sore foot. And you won't be able to wear shoes without having a bit of pain' [347-350]

12. Anyway, she put her foot down and we started chattering away, and I just kept the door open. I said, 'I'm going to go' and she said 'No, don't go Russell. Don't shut the door' So, I stayed [353-355]

13. 'I'm not going to shut the door because I'm not going to go anywhere' I said. Happy days. I'm going to stay here. So, I stayed, in the doorway. Chattering way to her. Counted her down. 5-4-3-2-1. 'There, out you pop my dear' [359-361]

14. It was about half past two I suppose. She came out, and eventually, 'Can I have this.' and 'can I have that'. So gradually, depending on what she's like, you start introducing bits of her life that you've taken away [363-365]

15. So that was unlocked, and we let her in there, and gradually I finished at three. At which time there were three members of staff there, and she was heading back towards amber. She could have gone back, but she was no longer in crisis as such. We'd had the incident, she'd come out of it, and she knew her mother was imminent. She'd got away with not having to go out [368-372]

16. She's got bits of her life back. Still got the same staff she can't stand the sight of. But I said 'I'm off Sara. I'm going home. I'll see you another day [372-374]

The foregoing suggests that an 'incident' may not always be a clearly self-contained event that runs a predictable course, which staff can decisively intervene in. Such non-linearity within the trajectory of events is recognised (Körner & Staller, 2018). The incident itself spanned two days and included eight discrete occasions when behaviours of concern required some form of response from staff. The impression gleaned here is that things can build up over time and are not always cleanly resolved by any singular intervention. The result is that lots of residual thoughts and feelings can ebb and flow within an array of staff over the duration. In this case Mum was away, visiting a family member. This seems to have unsettled Sara. Russell arrives [following a night involving an incident, see excerpt 1]. Then there are various localised demands placed upon her, the expectation that she will clean the Duck House [that she overturned in excerpt 2], to go bike riding [see excerpts 4 and 5], which was an attempt to distract her, to minimise Mum's absence. Then staff were required to intervene to stop her picking herself after she has moved into the Blue Room [excerpts, 6, 9, 11 and 12]. The peaks in escalation, or physical crisis points seem unpredictable. The Duck House was tipped over by Sara in front of Russell [excerpt 2] was without warning, whilst the rising resistance to being taken out riding was reportedly seen by Russell, to be inevitable [excerpts 7 and 8]. The responses to Sara's behaviour involved different staff members. The extent of the diversity in their attitudes and approaches is unknown, but across the span of this protracted event staff members were struck on two occasions.

Whether others felt events were predictable or not is unknown, but in Russell's account he seems to feel they were. This may of course be post-hoc rationalisation, which will be picked up in the chapter on researcher reflections.

From Russell's account of this incident, what can be discerned is his rising sense of frustration with how things are. To begin with he seems wounded by what he perceives as an admonishment made by the Senior following the Duck House incident. Whilst Sara's behaviours provide the throughline to which Russell's experience is anchored, the nature of his engagement changes. There are moments when he is present, and others when he is not [such as the night before when he was not on shift]. However, he is 'thrown in' to its lingering aftermath by his colleague. There are differences of opinion between staff members as to how to deal with various aspects of the unfolding day, and Russell seems at least once to foretell an assault. In addition to the two assaults there is self-injury, and two instances of property damage. Towards the end there is a self-imposed seclusion that becomes a formal seclusion because Russell is deemed by Sara to be controlling the door to the Blue Room.

Russell does not explicitly describe his feelings across the span of the incident [Fig 41.2, excepts 1-16]. This seems telling, perhaps indicating something about his willingness or ability to express his emotions. It would not be too much of a leap to suggest that his rationalism may have some bearing on this. One could speculate as to at least some of the feelings that *could* be present in such a situation, this only requires a consideration of the disclosures of others and exercising vicarious empathy. Perhaps there could have been anxiety, concern, and frustrated resignation, or alternatively or even concurrently a state of being attuned to Sara and of having some insight to her feelings. There could have been an intensification of anxiety, of the development of fear or anger linked to the presentation of behaviours of concern [including pain, when Russell was kicked] and could be amplified or attenuated by previous experiences [he worked in the service before]. When Sara struck his colleague,

Russell may have experienced concern or even outrage. After the event there may have been some sense of relief. All that is actually revealed however is the frustration experienced by Russell arising from a dysfunctional working relationship, where he perceived he is unfairly criticised or taken to task for his actions: 'that takes some sticking. I tell you. That takes some swallowing' [185-186]. What also seems to be present within Russell's experience is the feeling that everything is more complex than he is used to, and that less than rational decisions and actions by others only add to the unsettling complexity. This arguably suggests an absence of empathy.

The Physicality Is Trial and Error, Not Training

Something that comes through in Russell's account is the sense that the training he received has ill-prepared him to do his job, and that he is often left to his own devices to contrive a response. His criticism of training is something that will also echo within the final PET. Russell reflects on the training received as he was about to conclude his tenure within Sara's service, 'I wouldn't say Tim's training taught me anything that I've used.' [484]. The question this raises, which goes to the heart of Russell's lived experience, is how do you respond when some form of physicality is required? Russell spoke about the most intense periods of physicality, such as when he and team members had to get Sara in the Blue Room.

His account of this experience reveals that the policy expectation can yield to a situational pragmatism in the chaos of the moment: ''Quick! Just get her in and get the door shut''. This was a spontaneous directive issued by Mum to the team. Russell has interpreted this: 'It was just anything and everything you could do to hurl her in there as quick as possible'. The word 'hurl is quite ugly and does not seem to fit within the lexicon of care. The word was predicated by two other words describing the parameters that were placed on the response 'anything and everything'. The notion of 'anything and

everything' seems to speak to an approach that might be described as 'no holds barred'. This interpretation is re-enforced verbatim by Russell in an earlier remark, 'Its no holds barred. It's a matter of grabbing hold of whatever you can of her, to get her from A to B, without her lashing out, with any of them for limbs' [614-615]

The phrase 'No holds barred' speaks to being 'without limits or controls' (Cambridge Dictionary, 2022). This gives rise to two immediate areas of concern; that the force used could be unlimited [in both the amount used, and time it is applied for] and that there are no concurrent controls, which in this context could manifest itself in adverse outcomes. Such outcomes are associated with certain body positions and technique types (Stubbs *et al.*, 2009) as well as defined physiological processes (Aiken *et al.*, 2011). It is possible that this reading may be veering towards an overtly literal or overly catastrophic reading of Russell's interpretation. Those actions at the heart of the phenomenon under scrutiny however can be read in many ways: practically, physiologically, experientially, philosophically and politically.

It is known that staff have been given broad policy guidance, that physical intervention is permissible in these sorts of circumstance, and that training has been provided to prepare them to utilise approved or authorised techniques. I witnessed some training and spoke at length with the trainer. The holds [techniques] – to my technical mind- were of a lower order of restrictiveness and not designed in any way to cause pain. I would characterise them as standing guides or escorts. When staff are faced with a situation that is unique and pre-specified techniques do not work, one might argue that they have been set up to fail. Russell's stated goal was to keep Sara safe, and in this instance getting her into the Blue Room was a function of doing this. The officially mandated 'means to that end' had been found wanting by Russell. So, by willingly stepping in to find a way to achieve the goal he was operating in a fuzzy realm beyond policy reach. It was an open, messy, and dynamically

evolving event which required him to find a way through. In essence to define a response on his own terms. Such conjuring up of a physically viable response has been spoken to by other participants. There is something of a DIY-type revealed here. This starts with nothing, and so 'anything' is possible. As a result, 'everything' is considered. What defines what is right is Russell, and his innate sense of what is acceptable, 'What training I have had, that would make me aware you should only use what force is necessary to get the end result. So, I would never go over the top' [695-696]. Here there is a reference to training, and the legal framework within which Russell is expected to formulate his response. The latter part of the sentence is future-orientated, speaking to what he would not do in the future. This to me feels like an assurance I had not asked for. It feels like a verbal insurance policy against assumptions that he felt might be forming in my mind. It feels like he anticipates some form of judgement. Interestingly he muses on the 'what if?', 'Deep down I know I would never have done anything more than [pause] as much [pause] I used the minimum amount of strength, [710-711]. Furthermore, he stated:

> I didn't have to think about that. I didn't think 'Oh, I'll give her a good slap or whatever, or kick her back, that might help'. That was never on my mind. It was more how much I was going to get hurt, than 'I hope I haven't hurt her.' Because I knew I wouldn't [717-718]

The focus has now shifted to the fact, as he sees it, that within the context of past events he knew he would never hurt her. It feels to me like the defence of his actions is now complete, everything he has ever done or will do would never cause harm. The research was designed to get participants to focus on specific recent events. The interviews revealed, not unexpectedly, that there can be a tendency to reach back into the generality of individual experiences. In this instance it seems important to him that he provide a universal declaration as to the nature of any force he has or ever will use, that is

unbounded by time or number of incidents. This shift in his perspective seems to be important to him, and so I conclude that he anticipates judgement for his actions.

Returning to the aspects of Russell's answer that spoke to his involvement in an incident. It seems to speak to a notional morality manifest amidst a very real, heightened physiological state that he recognises is likely shared by Sara, 'your heart is pounding because there is a heightened state of anxiety for yourself as well as her'. He then goes on to declare that he is entering a time and space with no definitive solution in hand, 'It's the unknown, you don't know how this scenario is going to play out'. Tellingly Russell seems to speak to the potential of what Sara could do to him, rather than he would do to her, 'You don't know how much she is going to hurt you. You don't really'. So, he would never hurt her, but she could hurt him at any moment. To me, the component relating to his conduct has echoes of 'verballing' or 'gilding the lily' (Holdaway, 1980) and is imbued with a self-serving protectionism. It no longer describes something that happened, and so is a form of words that creates distance between the parties, by severing the link to any lived reality. It also seeks to invest any unlived reality with a certainty, 'I would not, could not and cannot cause harm', with an aside, 'but she could hurt me!'. In extremis such defensive accounts hide poor practice. To be very clear I do not think that this is the case with Russell, rather the fact that he feels the need to defend himself makes me feel that his greatest fear is judgement.

Whilst Russell had expressed some issues with the official training, he did not preclude the value of learning, 'You obviously have recollections of scenarios because its all learning all the time' [800], which also speaks to how he takes forward with him anything which comes out of an incident. The incident under exploration seems to have taken him out of his comfort zone, into what seems to be an uncomfortable place where uncertainty, unpredictability and complexity abound.

Russell's previous career, and the certainty present within the highly technological industrial processes, could be conceived of as the opposite of social care with its focus on the vagaries of human beings. In this instance Sara with her LD, PDA, and history of poor care experience provide the potential to impact on her mood and behaviour, as well as his capacity to self-regulate. This is not to say that social care per se is system-less or does not embrace logic. Social care, as well as healthcare, can be conceived of as utilising a very structured top-down delivery model. Boards, directors, and senior managers are responsible for agreeing and implementing a host of operational policies that ensure that service delivery is compliant with various regulations. Such structures are often said to embody neoliberal principles, focused on meeting the needs of a mythical 'typical' human: 'Homo Economicus' (Houston, 2010), with 'Professionalism' and 'Managerialism' (Ruch & Julkenen, 2016; Harlow, 2003) the somewhat constraining structures that proliferate under such conditions, often stifling creativity and artistry.

It could be argued that the frustration that Russell reveals, and the action he has taken in leaving, bear a passing resemblance to the protective actions taken by the nursing staff within Menzies 1960 hospital study. Here, nurses overwhelmed by the nature of their working conditions, and the accumulation of unresolved anxiety, sought to defend themselves from further psychological harm by detaching from relationships with patients, and de-personalising encounters. In effect sealing themselves off from experiencing the overwhelming feelings associated with caring for individuals in distress or facing death. Russell seems less to be experiencing anxiety, rather he presents with frustration, which is something that can be conceived of as 'the thwarting of impulses or actions that prevents individuals from obtaining something they have been led to expect based on past experience' (APA, 2024). His frustration is not directed at Sara, or the complex and demanding nature of the

behaviours. Rather it is with the absence of clear systems and processes. He seems to yearn for the comfort provided by the certainty, and defensible predictability that such technical rational approaches provide. In Sara's service it seems he perceived informality, blurred lines, fuzzily defined responsibilities, conflicts of interest, inconsistency and above all emotion, all of which jarred with his way of working and framing of the task at hand. One of the issues explicitly identified within the interview, which caused Russell frustration was what he referred to as Mum's 'conflict of interest', 'There is a huge conflict of interest with her, a manager and a mother for starters' [77]. He then states his reason for leaving, 'Its not because of Sara, I just can't cope with Mum anymore' [80]. It is clearly a state of affairs that unsettles Russell:

> You either need a manager with a mother, or to me, in my opinion it shouldn't and doesn't work. It doesn't work. Too many conflicts, too many angles to work at. When you really think about it, it can't work can it? It can't. Sort of feelings dictate too much when you are a mother as well, and you can't manage in a systematic and consistent approach if you've also got your mothers hat on [98-102]

A clear root of the conflict for Russell seems to be the presence of feelings, 'feelings dictate too much when you are a mother as well'. Whether this was because he feels that 'feelings' are fundamentally irrational, and should not inform any work-based decisions, or whether as a mother, she is deemed unable to partition her feelings from those rational decisions that a manger needs to take, is unclear. The sense gleaned from his account is that Russell struggles with the sheer number and diversity of feelings that arise within the context of a service, that to Russell's way of thinking should be wholly founded on detachment and objectivity. It seems that the sheer emotional complexity, including the wider family dynamics [including tensions and challenges] are too much for him, 'She does my head in. With her husband, her other daughter. You don't do 'the job' you have to buy into 'The Family'. It

just does your head in' [80-82], 'That's why I want out. I can hack it. Its too much. Its not a job. Its more. Its too big' [572]

Russell elaborated on what he felt was missing within the service, in his words an 'infrastructure'. He seems to feel that such an infrastructure would offer certainty and by extension the necessary control of events. Given that the risk of Sara presenting some form of risky behaviour was deemed by him to be ever present, 'She's never in green. There's no green', he seems to feel that the ongoing uncertainty is too much for him. These feeling are compounded by Mum's seeming failure to take his input onboard, 'Doesn't matter what you say, she will always say 'no', 'No, we'll do it this way'. There is no encouragement to contribute, or to have an opinion, at all' [837-839]. The feelings of frustration seem to arise from both not feeling listened to, and what he perceives to be admonishment. It is possible to conclude that Russell is unable to find his centre within a service that does not have clearly delineated systems and processes, albeit he has been able to respond to behaviours of concern in a measured way that seems protective of Sara. It seems paradoxical that this has taken place within a service that he has suggested should not permit emotionality to govern it, yet he himself is driven by his own emotions. These unresolved, and perhaps unresolvable tensions have proven too much for him to continue working within the heart of Sara's service.

Appendix 42: Setting Two, Case Study: Jill

Introducing Jill

Jill is a member of the nursing team, responsible for several patients. She describes her current role as a registered nursing associate on the ward. A role that is ‘very, very new to most places’, that bridges the gap between healthcare assistants and band five qualified nurses. A sense of achievement was discerned, with particular words imbued with a sense of professional pride: ‘registered’, ‘very, very new’, ‘two years at uni’ and ‘you have an NMC pin’. Her drive to care was revealed throughout the PET that arose from her account:

1. I Work Inside a Resource Sensitive Role
2. I Invest Time and Thought into Individuals and Relationships.
3. It Involves Person Centred ‘Pushing’.
4. Carefully Disentangling and Understanding Human Messiness
5. Celebrating The Successes and Learning from The Failures in Order to Grow

These were based on 21 ‘Experiential Statements’, originating from 94 ‘Exploratory Notes’ [Fig 42.1].

I Work Inside a Resource Sensitive Role
• A role with variable goals
I Invest Time and Thought into Individuals and Relationships
• Giving to get • I am bound up in him. • I must think how others feel but not everyone can. • Making an investment in them and us • The right relationship is unique & essential. • Time as a magic ingredient • Us vs the team
Its About Person Centred 'Pushing'
• It's not plain sailing on stormy waters. • Nine times out of ten • You must push but carefully
I Carefully Disentangle and Understand the Inevitable Human Messiness
• Behaviours are person centred. • Drugs, ligatures and holding. • One very messy restraint • Physicality unbound. • Responses are person centred
I Celebrate the Successes and Learning from The Failures In Order To Grow
• Experience does & doesn't change me - I'm hard & soft. • Looking back & letting go to look forwards. • The reward is personal and professional. • What I do makes me feel • Winding down and working things out together

Fig 42.1: Jill's 'Personal Experiential Themes'.

I Work Inside a Resource Sensitive Role.

Jill described a role which permitted different ways of working. A more traditional nursing role was foregrounded, concerned with addressing physical healthcare needs, with reference to being 'hands on with wounds, injections and things like that' suggesting attendance to bodily needs. Jill continued, revealing that she does not get the chance to explore this technical aspect of her role, revealing a shift to what she describes as a 'health care assistant' role. A Health Care Assistant, unlike a Nurse or Nursing Associate, is not a professional role necessitating the completion of a university course. Jill

describes this role as involving sitting in the day room, where one-to-one time and attention are central rather than secondary to the facilitation of technical tasks. She refers to a quasi-technical aspect to the role, such as doing meds and contributing to care plans, but the telling addendum is 'from experience [on] my ward now I don't get that time to do that'. Short staffing, and the lack of available time on the women's ward precluded the one-to-one working that was possible on the LD ward, which she felt was 'valued'. The disparity between the technical and non-technical dimensions of the role remained, 'because you still got your nurse inside on you' [44-45]. Jill expresses pride in her technical competency and yearns to realise her whole 'professional self', but it was the social connection that came to the fore throughout the experiences spoken to in her interview. Jill began by talking about a patient with LD who was on a journey to recovery, or at the very least towards being able to live without as many restrictions being imposed on them. This included a progression from 'strong clothing' to 'normal clothing', and to being able to have 'a normal quilt, normal pillows'. This all changed when a new Doctor came in and altered his medication. At this point she states, 'we started seeing some really silly behaviours'. Expanding on this she described how he would tie sock around his neck. Interesting Jill had her own reading of this behaviour, that it was 'just for you to get hands on, not because he wants to self-harm, or he wants to potentially kill himself. He literally just wants that hands on approach where you are touching him' [62-65]

In her account she touches upon tangible, real-world, quality-of-life improvements, including a significant reduction in the restrictions the patient had been living with. The sub-text seems to be that this has its origins, at least in part, in the support provided by Jill. The perceived risks he was presenting were also in decline, when a [technical] decision seems to have been made to revise medication. Whilst seemingly clinically reasoned, it appears to have preceded a breakthrough of self-ligating behaviour, where someone uses an item, such as belts, laces, torn sheets, or clothing, to cause compression of the airway and/or blood vessels which in turn cause injury or even death (HEE, 2023).

Of particular interest is her characterisation of the patient tying a sock around their neck as a 'silly behaviour', and the belief that the physical intervention that resulted was principally utilised by the patient to resolve some form of touch starvation (Pierce, 2020) or touch hunger (Mortenson-Burnside, 1973), rather than being needed to avert the real prospect of harm. The overall impression is that Jill drew carefully considered conclusions from knowing and respecting the patient. The term 'silly' therefore was not attached in a pejorative, or demeaning sense, to the patient, or the behaviours per se. Rather it leant into the idea of something being ridiculous, or without foundation. In this instance the belief held by Jill was that the intent to hurt was not present. In describing the behaviour in this way, she was neither calling the patient themselves silly, nor behaving dismissively. The sense is that she stayed with him because the behaviour was communicating a need for support and connection.

I Invest Time and Thought into Individuals and Relationships.

Jill's experience spoke to the power of investing time in developing relationships, which in themselves can be expanded, deepened, and strengthened, to be harnessed to serve therapeutic (Wright, 2021) or developmental (Li & Julian, 2012) goals. In the previous PET she indicated that investing time is central to both building relationships and making progress. In purely biological or clinical terms individuals do not recover from an LD, but they can make progress on a recovery journey from a period of concurrent mental illness or the impact of trauma. One can make progress in their capacity to cope, self-regulate and develop relationships that may provide their own reward. Both the mentally ill and those living with LD have been stigmatised historically and subject to paternalistic and coercive treatment, which increases insularity (Ali *et al.*, 2015). Within forensic settings, recovery and/or progress is often considered as something that is realised slowly over months and years, rather than quickly in days or weeks. Jill uses her available time to attend to practical tasks, 'So, I was doing the named nurse roles, but as an associate nurse. and I was getting things in place. So, I got them section

17 leave[11]' [58-59] which can nourish the development of a relationship. Jill reveals something more about her time in this space:

> So, I think that you've got all this knowledge, and I think just I always tend to give them, you know, depending on where I'm going, where I'm working, give them a little bit of information about yourself and let them get to know you and your personality a little bit. So, you have got that sort of equal basis. You're always going have that where you do know a bit more, and that's where they're quite vulnerable because you know them, but they don't know you. So, I do think you need to give them that little bit of 'you' [752-757]

To me this reveals a recognition of the asymmetry in power, in the imbalances in the knowledge of one another. Jill asserts 'you know them, but they don't know you'. This seems grounded in the reality that when someone arrives in a forensic setting, so does their social and medical history. This 'official' history is something that the person themselves may not be privy to, necessarily understand, or agree with. It is written from an impersonal perspective and effectively reduces a person to finite events and facts. There will be details of any criminal offending and risk behaviours, as well as comments made by MDT members along the way. This leads Jill to conclude that this leaves them 'vulnerable'. Whilst the consequences were not elaborated upon, from the patient's perspective one can imagine how the physical, procedural, and relational security arrangements flowing from this information can compound such vulnerability. How Jill takes steps to equalise this asymmetry is elegantly revealed:

[11]Where a patient is granted an agreed 'leave of absence' from the hospital in which they are detained for a period subject to conditions under the Mental Health Act 1983

> On one of the wards I work with a patient that had a catheter fitted, which is very traumatic for her with her history. I empathised with her and said I fully understand you're not comfortable, you don't want males fitting it, you don't want it in, you want to pull it out. I said 'I understand its uncomfortable. I've had one myself before'. I get it. And it's about that little bit of information. She doesn't need to know why I've had one, but the same time, we're all human, aren't we? So, you know, just by saying, you know, I've been in your position. I understand exactly how you feel. That sort of makes her feel a little bit better. Like, people do have these things. Just because I'm in here and you're not in here, this has happened to you. Do you know what I mean? So, it's just about giving a little bit [757-764]

Jill seems to be engaged in co-feeling, identifying how the patient was feeling, and recognising that the emotions are likely to be compounded by prior trauma. According to Gilligan (1982), to 'co-feel' was to participate in an attitude of engagement rather than an act of judgement. Zhang *et al.* (2023) posit that rather than focus on emotions as an individual level phenomenon, it is their social function that should be acknowledged. The role they play in motivating individuals to act, based on how they feel in response to the experiences of others, seems to have relevance here. As a female Jill seems minded to the potential the impact that male staff may have when involved in such an intimate procedure. Jill recognises not only the physical discomfort but the psychological distress. To mitigate this, she elects to disclose an event from her own medical history, that she too has been catheterised. In this she seeks to establish common experience, to allow the patient to recognise her as someone who understands something of how she might be feeling. Jill concludes 'we're all human, aren't we?', which seems to be a foundational value, as well as an explanation for her personal decision to reveal her own private vulnerability, 'So, it's just about giving a little bit'.

The next theme will further explore what is possible within a trusting connection. For now, it is important to look at the implications of the unique relationship that has developed. Jill's account revealed she has spent time over years working with this patient. Time spent with someone who has been involuntarily detained, in a setting over which he had no choice, very likely with additional restrictions periodically imposed. Jill's account reveals that she was diverted offsite into her own professional development. Her reading of the impact of this absence on the patient was that it was perceived by him as an act of abandonment. For those who have experienced trauma, abandonment and disconnection may be central to how they experience absence [however innocent it may be] which can give rise to a protective hostility as they damage that that they perceive has been damaging to them. This can require repair and rebuilding, which once again takes time.

Some staff may slavishly follow rules and can reach for the certainty that restrictive procedures provide rather than engaging with the complexity and working with feelings and emotions. Some can find this difficult [as was the case with Russell in setting one]. What should also be borne in mind is that there will be times when a patient may be shouting, or screaming, issuing threats and abuse or even self-injuring, perhaps self-ligating, all of which may be witnessed, heard, felt, and experienced, and absorbed by the staff member. To respond with empathy, people such as Jill people must be ready to deal with such sights and sounds, and to continue to engage in providing meaningful support. This forbearance and energy to endure a combination of difficulties, provocation and challenge can be thought of as a form of resilience (Foster *et al*., 2023), and an essential resource. My own experiences of working with patients in physical pain, of anguished by indignity and the loss of their sense of self to disease left me with a sense of feeling burdened by their suffering. I recognise the distress experienced by Jill may be rooted elsewhere, but I still think keeping going will still require resolve, and a belief in what you might be termed the greater project: the primary task.

It Involves Person Centred ‘Pushing’.

Jill’s experiences suggest that working to develop and maintain a relationship is not easy, and what you then do with the relational capital can present its own challenges. There is clearly a risk that trust can be damaged or result in a breakdown of the relationship. This could mean that those benefits that flow from it can be reduced or lost. In describing her mode of working, Jill uses the term ‘we’, suggesting progress made by individual patients is often the result of the work of numerous individuals [this was discerned across both cohorts]. What is obscured is the extent to which that progress is seamless or faltering. Jill’s account, and her transition to her individual perspective, denoted by her use of ‘I’ seems to suggest that where she pushes and progresses, there are times when other members of the team do not do this, or have not done so. The benefits accrued by the patient are then listed. She recognises he is scared, then pushes him to work through the anxiety provoking demands. There is a clear suggestion that in her absence he would not push through to the other side of the anxiety. Jill pushes him to push himself, ‘I would sort of, I'd like to say I'd make him do things that maybe he did not initially want to do because he was a bit scared, but he does really want to do so. Then he'd go off and do it himself’. She does this by working alongside him, going with him, and then scaffolding his engagement. This resonates with ‘Active Support’ which has been mentioned previously (Jones *et al.*, 2012).

The support seems to help this patient to develop confidence and mastery of day-to-day tasks and possibly to be meet a simultaneous attachment related need. This of course is no scientific conclusion, only one interpretation of what Jill’s investment in the patient seems to return. That it appears to reduce the potential for self-ligation is noteworthy and one can conjecture that this is because Jill has made him feel safe and secure through feeling valued and recognised. Despite this supporting role, Jill

is responding to behaviours of concern. A question was asked: ‘Do you think the fact that you've been involved in restraints with him alters your relationship?’:

> No. I think that he feels a bit safer, I think that if I’m on shift I won’t restraint him. If he's going to tie that sock around his neck, then let him do it and nine times out of ten, it's so loose. This is going to sound really awful, but you probably would leave him about 10 minutes now. Just say like ‘I'm just going to leave you because you’re just being silly. I'm not coming in there’ and know that I'm not coming in. He’ll actually take the sock off himself because he's just sort of being a bit silly. I think sometimes if you really do need restraint, I will get ‘hands on’ and he'll probably talk to me about it for a good half an hour after. ‘Oh, you held me. You held me. Did you hold like this?’. He's quite obsessive over what you held. But unless it's really necessary I won't get hands on with him [531-538].

Jills conclusion is ‘I think that he feels a bit safer’ before immediately stating ‘I think that if I’m on shift I won’t restraint him’. At face value she seems to be suggesting that the patients’ feelings of safety are linked to not restraining him unnecessarily. There appear to be occasions however when it is necessary, as it becomes clear that he has been restrained by her. In these instances, he actively seeks a conversation after. My tentative reading of this is that Jill does not participate in restraint for its own sake, and when she does restrain him, she does so carefully. I think there are powerful messages bound up in both the act and the omission, which both appear to register with the patient. There are instances when he is engaging in a self-ligating presentation and while she will remain aware and present in the area, she will not resort to physical intervention. This suggests that the fundamental [social] need being is met by her attending to him, and not through any maladaptive strategies including restraint. This non-restraint seems as important to Jill as it may to the organisation.

I Carefully Disentangle and Understand Human Messiness.

Jill spoke in depth about one incident involving her and a colleague interceding in an incident where one patient attacked another. It was one that was bookended by contrasting emotions:

> I think you're a bit scared. Like ‘Shit! If it ends up with two patients, and two staff. You don’t know what's going to happen. You press your alarm at the same time, hoping that people are going come, and yeah, we did laugh about it after because it was one of those situations where you just couldn't stop it. But at the same time, you could see it. Definitely scared [282-285]

It seemed clear to me that the fear did not preclude her intervention in the incident, and the laughter was not directed at the patient or their behaviour. Rather it arose from the messy events which she and her colleague were involved in, their best attempts to impose some form of order, and the mistakes they made amidst that chaos. Laughter typically that someone has enjoyed themselves or found something somehow funny. It seems the situation they found themselves in, was funny in and of itself, this was because in the melee that ensured the two staff members ended up restraining each other! Laughter also has a stress reducing function (Yim, 2016) which seems relevant. Jill paints a more detailed picture of the incident that developed without warning:

> So, it was towards the end of the evening and on that ward, they tend to go to bed early, so they get locked in at twenty to 9, but nine times out of ten, they go back to the rooms and probably about 8:00 o'clock as most of them get quite tired. So, this particular day I was with another staff member who worked very much like me. So, we work very well together we manage the patients pretty much the same. So, we knew we kind of know what's going on.

> On this one particular day and the patient in particular is on arm's length. So therefore, wherever he goes, we go. I'd just gone out with this patient, and he's quite impulsive. So, he came out the day room, and the other staff member went to lock the dining room door off, as we do when we're going to bed. And I had this patient on arm's length and next minute he just started walking, I said, 'Oy, come back here, don't be silly'. But he just legged it, and I knew in my mind. I dropped my bottle on the floor because I knew what was going on, and he legged it straight through the open area, straight into another patient side room. This patient had been mardy and shouting, and just a bit challenging earlier. [He] had his door open, shouting abuse at staff who were walking past, and I think the patient I'm talking about, had just had enough of it, and went straight into this room. So, me and this other staff member just dropped everything we had ran straight into the room. As we've done so, he'd obviously got there just before, and jumped on this other patient. Luckily, we were just behind. So, we had managed to jump on them both, shout some staff, try to remove one off the other, and in this particular restraint, I ended up holding on to somebody else's legs, and then somebody else had hold of my legs, and then we managed to sort of sort the situation out [252-269]

Jill points out she was with another member of staff 'who worked very much like me'. This is a deceptively simple comment, and the nature of the shared working ethos is undeclared. Does it mean that the colleague 'has patience like me?', 'is compassionate like me?', 'Uses comparable communication strategies? 'Adapts to circumstances in the same way?' or 'Reflects and grows in the same way?' Whilst this is unknown, what does come through is a sense that her colleague would be there with her, helping and not hindering. What happens next in any event is unknown up until the point that it happens. This means that there is a degree of spontaneity involved, and a degree of having to embrace uncertainty and unknowing. Note that this type of response or restraint is often described

as an emergency rather than planned one. Here there no time to plan. The following exchange speaks to this:

> INTERVIEWER: 'Do you remember if you were pulling them apart, was any technique going on, or was it just you just doing whatever you had to do to get?
>
> JILL: Doing whatever we needed to do to get him apart, I'll be quite honest. Nobody was hurt in the restraint anyway. Then the idea, after you've got them apart, is to pin the limb on a patient. So as long as you pinned a limb, it didn't really matter. It tends to be as long as you've got that limb down your PMVA then naturally comes in. Does that make sense?
>
> INTERVIEWER: Go on.
>
> JILL: So, once you've once you've got them, and they stopped fighting or wriggling, it's not really fighting, it's like wiggling, then you, your PMVA would then be able to automatically come into place because despite what you taught on PMVA, there's no way that you can grab a patient and get them straight into a hold. Initially you have to pin that limb in order to get that whole. Does that make sense? [326-340]

Jill describes 'Doing whatever we needed to do to get him apart, I'll be quite honest'. That staff are not able to use textbook techniques does not come as a surprise. As indicated in the very opening chapter, I was often in receipt of such disclosures as a trainer. On reflection, I think at the time I was most keenly focused on the *why* of what I was categorising as a failure, rather than *how* of any individual's actions taken to recover the function of the task. Also, looking at the accounts of Jill and others I ask myself was it actually even a failure? Are techniques too tightly drawn, and situations so complex and dynamic as to preclude invariably correct applications? To return to Jill, what her account reveals is her strategy to pin a limb and then find a way of achieving the application of one of the

techniques covered on the mandatory training session. One can speculate the rationale of this strategy. That contact is made with a limb, and not the head or body, is because constraining a limb is central to mitigating the potential for harm arising from behaviour likely to manifest in punching, grabbing or scratching. This strategy then slows everything down and reduces both the intensity of the behaviour and the ability for it to spread for the person to move from A to B, to continue to attack, or alternatively to expand the behaviour and utilise involve other body parts (e.g., from punching to biting or headbutting). Jill's description seems to suggest that it is a mixture of instinct and dynamic problem solving that orientates her within a spontaneously evolving physical response. Resorting to the same bricolage (Levi-Strauss, 1962) that was evident in setting one, Jill describes assembling a physical response made entirely from her physicality, mental acuity and shards of memories from training and prior restraint events. Ultimately it then seems to transition into a more coherent, proceduralised mode of physical containment. It is worth noting that everything seems to be physical during this initial chaotic phase, with opportunities to communicate, de-escalate and co-regulate [or emotionally contain] pending the resolution of the physical messiness. The urgent need to find some form of effective physicality perhaps commands all her mental resources.

Interestingly Jill says, 't's not really fighting, it's like wiggling'. No more explanation is offered. It is unclear whether this is a broad generalisation which speaks to all patients or this patient. The safest interpretation would seem to be that she means just this individual, suggesting that in other instances, and with other patients, the resistance *could* be more active or aggressive. Or perhaps she is downplaying the behaviour, mindful that violent characterisations can be condemnatory and othering (Akerstrom, 2002) conversely it may just be an accurate description and that the behaviour she encounters once contact is made is best described as 'wriggling'. It is important to note this distinction, because historically, within the training context, the techniques and strategies offered are framed as responses to specific actions (e.g., a punch, a straight punch, a haymaker or a downward blow to the

head) (Piorkowski *et al.*, 2011). Jill's experience indicates that aspects of behaviour may not align with archetypal forms.

It is perhaps useful to think about the behaviour occurring at a given moment as being secondary to the behaviour that initially necessitated the intervention of staff. If the patient is engaging in self-injury [such as self-ligation] the totality of the harm is likely to be borne by the patient. When staff intercede, the patient may try to repel staff so that the self-injury can continue [or be completed] or maybe try to harm the staff. Alternatively, the restraint may hurt the patient, and they engage in self-defence. A final possibility is that the restraint is immaterial, and that the patient simply wants to hurt staff. Whilst this is conjecture, it does illustrate similar or singular types of behaviour can manifest for very different reasons, and the challenge that staff face is in trying to respond to the individual rather than just the behaviour. Jill's account reveals something about how she interprets what is going on and how this informs how she subsequently responds. Jill explains why her force was used:

> So, the reasons for the restraint for my guy was because he had gone into assault. So, he was still quite high and wanting to attack. He felt as though he hadn't done what he needed to do I suppose. Therefore, he was still fighting against staff restraint. And the other guy was purely because he had tried to fight back in self-defence, which you can understand. But the same time because he'd had that situation, and because he'd been quite aggravated all night, you know towards staff and things. I think he was then restrained because of that. He then tried to fight back with us, so it just led to that sort of restraint being even more. Whereas it could have been a case of [pause] He started crying, you know, within 5 minutes of restraining. That's purely because he'd gone all the way up, elated and then sort of brought himself back down again. And yeah, it was. He was upset [433-441]

This reveals two reasons for restraint: to prevent Jill's patient from attacking the other, and somewhat paradoxically to prevent the other patient from defending himself. That staff could use force against someone who is exercising a lawful and moral right to self-defence is a complex proposition. It seems patient 2's self-defence was directed against those staff who he perceived were assaulting him, meaning that staff created the conditions leading to restraint. This is all happening very quickly, with a time lag likely built into everyone's interpretation and response. Action begets reaction, and by the time the reaction has taken place the action has changed. In this case, staff can be understood as immediately defending themselves from a perceived attack, which Jill has characterised [after the fact] as the patient's self-defence response. In which case both parties are defending against non-existent attacks. This messy and shifting response seems to be made up of readings relating to past events, and continuing based on the signals send through the close physical contact. A surge in movement can just as easily be flight orientated as fight orientated, but there is no time to make categorical determinations when one is inside the physical morass. This vicious cycle of interpretation and misinterpretation seems governed by what Kahneman (2011) characterised as the fast, emotional thinking. As in cases of this type, any moral or legal reading only takes place after the event has ended. Often, such detailed readings are assembled at leisure, from a distance when all sense of time and the challenges of perception are lost. On this basis how fairly can any such judgements ever be? Jill's patient then seems to have very quickly transitioned from 'attack' mode, to being overwhelmed by distress. Restraint was then no longer necessary or appropriate, so Jill's response needed to change rapidly to accommodate the new demands being placed upon her. That distress is revealed as a slower behaviour that did not [in this instance at least] contain any risk of immediate harm [to staff] seemed to expand the opportunities for thinking and selecting appropriate responses. Slower thinking (Kahneman, 2011) was then possible. The speed of events and the opportunities that exist within their context for critically balanced, or measured thought, are present within the following passage:

> So, me and the staff that were on with this patient in particular, we as we both ran in the room, we've managed to split them apart. And I got on the legs, or attempted to get on the legs of one, but somebody else had got on the legs. So as this happened, we were the first in the room, but other staff came at the same time. We managed to split them almost straight away. I think. I think he'd managed to get a punch in, but the other guys quite big. He's like 7-foot, 6 foot 5 something like that. So, he's a bit slow and wasn't as quick to react. So, we had managed to split them like straight away, but to be quite honest with you after that, I don't really remember what happened [314-320].

That two or more staff are trying to rapidly make functional physical contact at the same time alludes to its initial fragmented nature, where people are working independently. That the perceived counterattack develops amidst the rescue of that person, as well as the unique characteristics of those involved, represent just some of the many pieces of situational information Jill must grapple with and try to hold onto. Reference is made to the significant height of one individual, whereas elsewhere in the account adaptations to the nature and pace of communications were made because both individuals were learning disabled. Different characteristics perhaps matter in different ways at different times. This suggests there is need for a flexibility of thought, on top of the ability to handle physical diversity and complexity. That Jill states 'I don't really remember what happened' comes as no surprise as the incident resulted in the colleagues grabbing hold of each other in the confusing physical turmoil. With the luxury afforded by time and space, Jill can think in more depth about the event now she is removed from it. At the time the sense I had was that she was largely feeling her way through the situation, relying on instinct and fragmented recollections of past training experiences and prior restraints. As a bricoleur (Levi-Strauss, 1962) Jill seems to have assembled a response from what was to hand and to mind, channelling this through her values base.

I Celebrate the Successes and Learning from The Failures in Order to Grow

When asked about the most rewarding aspect of her experience, Jill listed the reduction in restrictions imposed on the patient, the increase in his level of social engagement, and improvements in his quality of life. It was interesting that the reward was framed as the patient's progress, rather than in her accomplishment. The interview continued with a follow up prompt 'So beneath the accomplishments, how does that actually feel for you?':

> It feels good because it feels like I've accomplished something. It feels like I've actually helped somebody, and that I've been a part of that so, that does feel very good. It just feels like I mean, something, like my role's good for something, and that it's not just being sat in a day room, it's not. It's much more than that. You're doing a lot more, so it makes me feel good, really.

Jill's reward was captured in feelings, 'my roles good for something', 'it makes me feel good, really', and she then went on to say, as a result I feel 'Happy. Excited. Fulfilled'. It seems that Jill is saying that she fulfilled her 'Primary Task' (Rice, 1963), and that in so doing this was affirmed by deep, personal, and unseen feelings. According to the NMC (2018), the principal role of a nurse is 'providing, leading and coordinating care that is compassionate, evidence-based, and person-centred' (p.3), a description which seems to suffuse the technical with the practical, and the rational with the emotional. Jill's experiences reveal she is involved in connecting with and supporting the individual as they journey from where they *are*, to where they *can* be. Interestingly the success for Jill was not in the technical completion of the task, but rather in the protection and nurturance of another in need. This is irrespective of the fact that that the need manifested itself in messy, hostile, and potentially harmful behaviours, and that there was no immediate or coherent gratitude expressed by any patient.

Jill's pride in her pioneering Nursing Associate role, and her descriptions of working through complexity suggest that she strives to do good work despite the challenges. She does not just complete work tasks, but endeavours to do the right thing by balancing respect with the need to challenge compassionately. The higher mission this seems to serve is building the individual's personal reserves and social resources and enhancing their immediate life circumstances as they progress towards their own medium to long term goals. Jill's own personal and professional growth was revealed to be part of her lived experience. It seemed to occur organically, with her being there 'with' and 'for' or 'on behalf of' her patients in a way that was meaningful to them.

In the immediate wake of incidents, where events were still fresh and raw, Jill's account speaks to a need to process thoughts and feelings, to address those that are unhelpful or hurtful, and hold on to any important learning. She said, 'I think I would generally speak to someone who I was quite close to. So, the staff member that I was with at the time when it first happened' [566-567]. This reveals an informal processing of events taking place with her colleague, which she makes clear can only take place within the context of a trusting relationship. In this instance one shared by two people involved in the same incident, meaning that reflections were processed within a shared situational 'frame of reference'. Jill also mentions the need to 'offload' when she was made uncomfortable by the contribution of others. It is unclear whether this related to events she had been involved in, or whether it extended to events she had borne witness to. Her answers suggest that there is often no such thing as a clear 'cognitive' closure. Jills answer reveals that uncertainty remains, as at least some of the many questions that flow from conscious reflection remain unanswered. Whether any of the feelings of unease underpinning the unresolved questions remain is unclear.

It would be fair to characterise the bringing to bear of some degree of certainty an undeclared goal of training and development. Firstly, through the professional training an individual undertakes to qualify

as a ‘Nursing Associate’ then the mandatory PMVA training that all staff undertake. Thereafter there is the development of the innate wisdom that arises out of the accrued experience, self-reflection and processing with others formally and informally (Klein & Bloom, 1995). Jill was asked to expand on her own experience of such personal/professional development, and specifically the role training plays in readying a staff member to respond:

> It never goes how it's [pause] It's like you're driving test. You can learn to drive, but you don't ever learn to drive until you actually go and do it. So, you know, when you do your PMVA, and things like that, it never goes that way. It's not that straightforward. But by the time you've done your first restraint, it kind of gets that. What would the word be? You'd be a bit scared to get involved to begin with, but then it sort of takes that away. Once you've had your first restraint, and I think once you've done one or two, that's when you're kind of learning. You know how to do what, you know what's required of you, and how things work and how to sort of deal with the situation [632-645]

Jill’s answer reveals the developmental power of practice. Whilst training is an annual event, with success determined against a relatively fixed criteria by a third party, practice is a daily lived experience wherein real-world decisions and actions are determined successful or not by resort to more nebulous criteria, including feelings. It seems it is not about whether the strategy was applied as specified, or the technique was performed accurately, rather it is about whether the distress was resolved, harm averted, or whether the trust present with a particular relationship was damaged, revised, or enhanced. In Jill’s answer she gravitates towards how her competency in relation to restraint grows physically and psychologically over time. She remarks that ‘It never goes how it's….’, the words ‘supposed to’ feel like what was left unsaid before she pivoted into an analogy around learning to drive, a real-world competency that develops after passing your test and again is defined

by situational demands. She is not at all critical of training, rather she seems to frame it as a launchpad to practice development.

Finally, Jill concedes that practice has changed her. More accurately she first suggests it has not, before acknowledging that it had. My reading of this apparent volte face is that Jill has not experienced fundamental changes. The caring values, and empathic, person-centred approach have endured, 'I think for me, myself as a person, I tend to do it quite a lot anyway'. This has not been diminished by time or any workforce resourcing challenges. She has remained true to herself, which appears to be something that she is proud of. But exposure to what by any stretch of the imagination are events which can be considered difficult to bear, have changed her, 'It does harden you up'. Becoming inured to events that in the great scheme of things might be expected to generate feelings such as disgust, guilt, anger, sadness, helplessness, and inadequacy, can clearly have negative consequences. It can create distance between the caring professional and the cared-for person, which could conceivably lead to a reduction in the caring provided (Menzies-Lyth, 1988). In Jills account she seems to have remained able to stay with someone despite their actions. Speaking of one patient she described how 'he'll throw that colostomy bag around the seclusion room, and it absolutely smells vile. But then you get someone like myself, who [pause] I'll sit down in that seclusion room' [681-683]. She describes being willing to dwell with someone in distress, in difficult circumstances whom it would be easier to abandon and leave in isolation. So, whilst the work can 'harden you up', this should not be interpreted as losing the ability to empathise or respond with compassion. The ability to 'push', 'disentangle' and continue all speak to expressions of resilience (Foster *et al*., 2023), whilst the spontaneous assemblage of responses (e.g., 'It never goes how it's [supposed to]') speak to bricolage (Levi-Strauss, 1962). Jill's lived experience appears to reveal both growth and change. This may not always be conscious but seems to be one that serves the patient, the therapeutic relationship, the nursing role, and Jill herself simultaneously.

Appendix 43: Setting Two, Case Study: Sabrina

Introducing Sabrina

Sabrina described her role as a team leader working in a forensic service for male patients. Like her colleagues, a sense of professional pride in an important role, was discerned. The fact that it is a male only service becomes significant when she contrasts the behaviours of concern, she experiences with those she faced working in an exclusively female service:

> My ward, it could be that you're going to get punched, kicked, bit, you know, the aggression is towards the staff. Whereas on female wards, it's a lot of self-harm and it's quite serious, self-harm [145-146]

Five PET were discerned within Sabrina's account:

1. I Am Inextricably, and Sometimes Gratefully, Located Within a Secure Environment.
2. I Lead a Carefully Considered Team
3. My Work Is Human Chess
4. Its Quickly All Bodies and Blicks, But I Do Try to Talk to Everyone.
5. Then It's All About Checking, Reflecting Learning, And Growing.

These were built on 24 'Experiential Statements', arising from 94 'Exploratory Notes' [Fig 43.1].

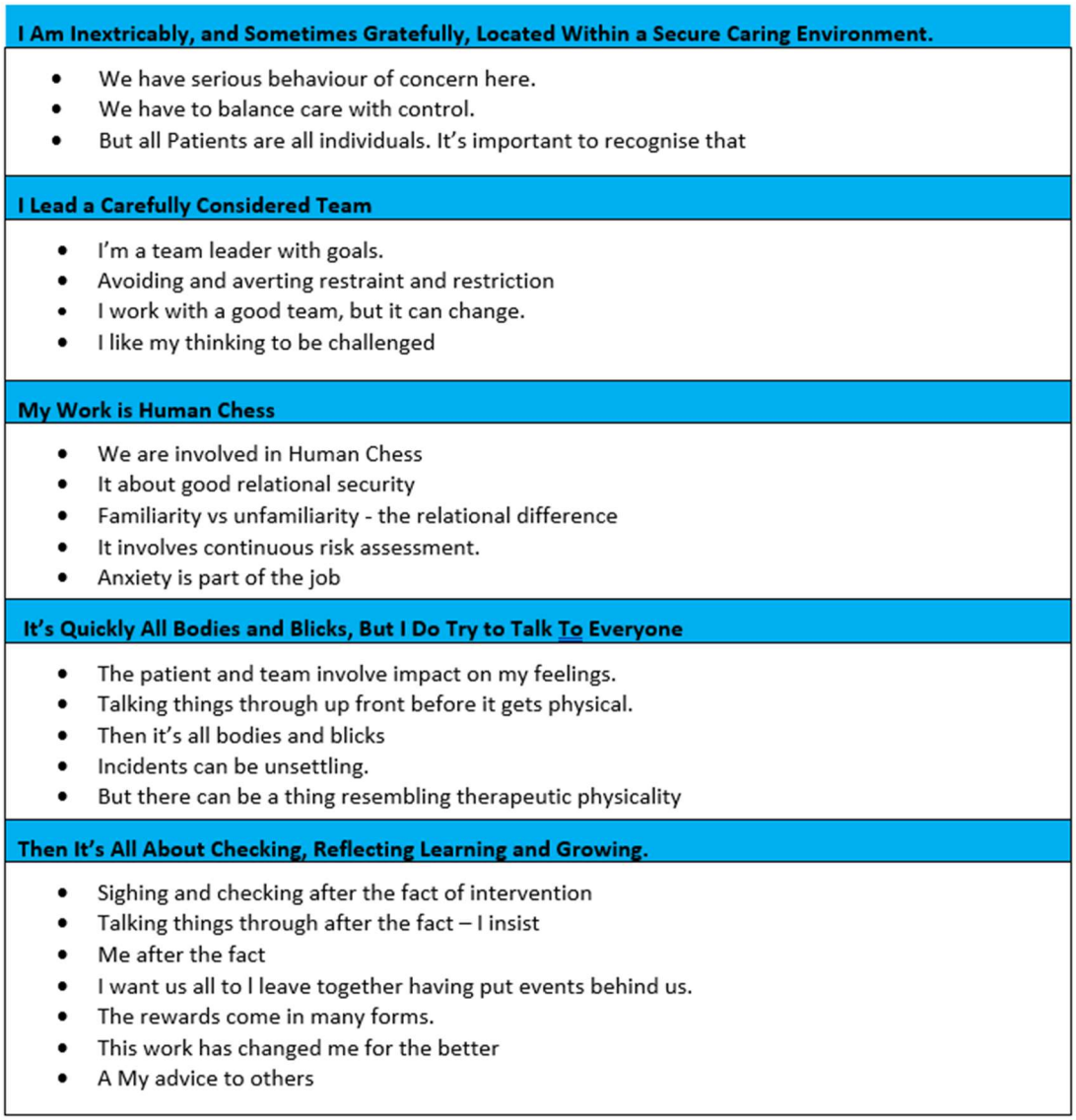


Fig 43.1: Sabrinas 'Personal Experiential Themes'.

I Am Inextricably, and Sometimes Gratefully, Located Within a Secure Caring Environment.

Sabrina cannot escape from the fact that she works in a secure care setting, where individuals are held having been convicted of offences or deemed to pose a serious risk of harm to themselves or others (DoH, 2015). Sabrina describes patients who 'become more paranoid' [393], who 'punch you, kick you, bite you, spit on you. Quite a lot of our patients can be sexually inappropriate. So, we've seen quite a

lot of sexual assaults' [394-395] as well as referring to having to respond to 'self-harm' [146]. This is not to suggest that the risk of serious violence is always inherent in all patients, or that this precludes any unguarded or warm interactions. Rather it reveals how risk management is built into the fabric of the service and its delivery. Staff are directly implicated in the de-facto containment of patients, with keys and alarms issued to all staff, and responsibility for numerous lockable areas including seclusion rooms, as well as following non-negotiable security protocols ('with 'physical security' and stuff, you can't have a female go into the room by themselves' [208-209]). There are also search procedures, CCTV and a preparedness to respond to eventualities such as hostage taking (revealed in the organisational policy). Such environments can be characterised as oppressive, even traumatising. Unexpectedly, Sabrina refers to the 'beauty' of them:

> I think though the beauty of a secure service is that you've got a lot of physical security, so if worst comes to worst, you know you can. It's the most restrictive environment that you can ever be in really, so those restrictions can sort of aid us to keep everybody safe. I used to work in a low secure environment, and I would say my anxiety was a lot higher, because you don't have the same restrictions that you can apply. Obviously, you don't live by restrictions, but they are something that you can do. They personally for me take away a lot of my anxiety [52-57]

The word 'beauty' does not relate to any aesthetic aspect of the environment, rather its ability to keep people safe from harm. This safety dividend Sabrina suggests is something that as extends to 'everybody'. There is then the 'being' of safety, and the 'feeling' of safety. Sabrina seems to be referring to the latter. To use an analogy, one might wear a seatbelt and experience a 'feeling' of safety when one drives at speed. Only when that vehicle is involved in a collision does that device serve its intended purpose and prevent that person from 'being' harmed. From her reference to anxiety, my

sense is that the security arrangements go a significant way to attenuating those feelings. When working within a setting with lower levels of risk and less tangible security in place, she reported feeling more anxious. Its speculation on my part but were one to feel anxious or vulnerable one may be reluctant to work closely, and choose instead to work at a physical, psychological, or emotional distance. This is borne out when she says that 'in secure settings you can become like, really deskilled as a patient' [102], something that results from having the patient languishing 'at a safe distance', disconnected from the relationships that may offer stimulation and nurture. Paradoxically the security arrangements, rather than being cast as dividing mechanism disruptive of connectivity, seem to enable Sabrina to practice in the way that enables her to feel safe to serve patients.

I Lead a Carefully Considered Team.

Sabrina identifies as a Team Leader. When a range of caring professionals coalesce around meeting the needs of a particular patient, it would constitute a team. Here it seems to relate to a collection of individuals, working on the same ward. Individuals who support each other personally, as well as professionally. Sabrina describes the experience of assembling her team at the start of a shift, and of them being a 'strong' team. In an NHS service there is the regular prospect of absences through illness and leave as well as training and secondments. As a result, there are often agency staff filling in, or staff from other services being temporarily re-deployed. Sabrina talks about the 'gender mix', being relevant because she is currently working with exclusively male patients. The 'gender mix' is not further elaborated on but seems to have been important to the support provided by the team. She then moves on to talk about their inherent qualities, 'I don't want to say good staff, but they're really a really strong team'. How is 'good' different to 'strong'? Good might be thought of as a moral virtue (Arries, 2005), and doing good seems to suggest that justice and care might feature in decisions and be revealed through actions. Sabrina seems to search for another term that reveals more pointedly

what she means, arriving at ‘strong’. This doesn’t seem to relate only to physical strength, but rather psychologically strength. Any strength in and of itself is nothing without some way of meaningfully realising it. The sense I get from Sabrina’s overall interview was of her personally valuing endurance, of persisting with people over time despite difficulties. The absence of immediate tangible gains or gratitude was also explicitly expressed. Resilience is a term that speaks to this quality, ‘the capacity to withstand or to recover quickly from difficulties; toughness’ (OED, 2023). As noted already, it speaks to a capability for positive adaptation or the ability to cope with and adapt to adversity (Foster *et al*., 2023). The inclusion of the word ‘toughness’ could be interpreted as indifferent to the plight of others or at least disposed towards moving forwards in the interests of ones’ ‘self’. When Aburn *et al.* (2016) described resilience as involving ‘great personal strength, courage and adaptability’ (p.6), it captures the essence of endurance which would seem to speak to mental toughness. What Sabrina does not say is ‘trained’ or ‘experienced’. This may or not be relevant, but she does conclude by saying that with her team displaying the quality or qualities that it does, ‘you know, everything's going to be OK’. Later, under the theme that references the lived experience of being in amongst physicality (‘Its quickly all bodies and blicks, but I do try to talk to everyone’) this strength, resilience, as well as work as a bricoleur (Levi-Strauss, 1962), will be returned to.

Sabrina further expands on this group of individuals and refers to ‘trust’, which seems key and relevant to the qualities previously mentioned. Trust seems to me to mean to be able to rely upon, or place confidence in that person. In practical terms this can mean following someone’s instructions or directions without question, on the basis that those instructions or directions are expected to be sound. In a secure setting this might mean initiating a response to behaviours of concern or joining others, knowing that colleagues will be with you in all respects.

Every patient in a healthcare setting is in receipt of some form of treatment. Whilst some of the individuals have serious convictions, the setting is not a prison. The function of prison is to deprive people of their liberty as punishment for the crimes they have perpetrated against society. Whilst rehabilitation does take place in prisons, this is not the same as treatment. In a secure care setting [run or commissioned by the NHS] the person is a patient there to have their mental illness treated. Either because of their illness, their experience of confinement, or as a by-product of the discomfort that can arise from confronting what can sometimes be uncomfortable admissions or retraumatising explorations of past actions, people can become distressed, vocal, physical, harmful, and injurious to themselves or others. Unlike the jailer, whose first resort is to further restrict and confine without having to seek answers, the staff team Sabrina describes seem to actively try to avoid restraint, aware of how harmful it can be. Therefore, they can find themselves acting as buffers or containers (Douglas, 2007), drawing off the damaging feelings and emotions. 'Self-Regulation' (Vohs & Baumeister, 2004) These can be absorbed into the team, which Sabrina seems to recognise. Her leadership seems to be a significant aspect of her experiences. Here she seems concern with the make-up of the team, and its ongoing functioning. This seems to me to indicate she recognises both the resources residing within, and the limits of individual team members, and that these are central to their effectiveness [see the final PET]. That the practices which flow will be right and proper because of managing the balance, but that situations in and of themselves are complex.

Sabrina is clear that individuals who don't share the communal values and perspectives can compromise the team. She indicates that rogue individuals can compromise the team effort, but that this does not mean to say that individuals cannot question or challenge her thinking, 'I also like when people like give me alternative ideas, or someone that will come to me and say 'what about we do it this way instead of that way? How do you feel about that?' So, I like people that think outside the box' [78-80]. A current concern is the development of closed cultures, when one person's thinking or style

of working dominates (CQC, 2019). A leader's role is to ensure good practice. This is not to say that leaders always have a three-hundred-and-sixty-degree perspective on every situation or have all the answers. A leader who is open to the views and suggestions of others can engender respect and trust as well as commitment, being what Price-Dowd (2020) refers to as a democratic leader. Sabrina seems to have firm ideas on what is right but remains open to the input of others when it serves the best interests of the patient. This inclusive, morally, and relationally focused mode of working is something that Sabrina seems to see as being needed and welcomed by staff. She refers to the balancing of patients' needs, rules, boundaries, restrictions, and care, something that echoes an earlier sentiment, 'it's literally about balancing who goes where, what staff are with who. It's just all yeah, maybe a bit messy' [39-40]. In appreciating the value and function of a team, one needs to think about the experience and implications of not being part of such a team. Being such an outsider can be a jarring, and even frightening experience. Sabrina offered up an example of bearing witness to an incident, whilst on a neighbouring ward of the team's response and most importantly of her experience of not being or feeling part of that team:

> I think a couple of weeks ago I'd seen an incident where a lady had occluded her airways, and I wasn't familiar with the staff team, and I wasn't that familiar with that type of incident. So, like I panicked, and I thought, 'Oh my God, like she is going to die'. And 'This is really bad'. And it took me the rest of the shift to gather my thoughts. The staff team who were familiar with the patient weren't even fazed by it. It was a normal day for them. But for me I thought 'Oh shit! This is quite bad' [146-151]

Sabrina did not know the patient, was unfamiliar with their behaviours and unclear how to respond. This gave rise to cognitive disconnect, resulting in panic and catastrophising, 'Oh my God, like she is going to die.' In contrast with her response, she revealed that the local team members did not seem

to be fazed at all and coped with the situation. A team then is important, and the leadership of such a team a critical role. This will be returned to later when looking a processing events. When asked 'how successful are you avoiding restraint?', she stated 'I think we do it literally, continuously, every day on here, and it's about the relationships keeping people busy and stuff' [410-413]. It suggests that avoiding physical encounters, where the focus is on balancing the external aspects of an interaction, is achieved by investing energy (mental, more so than physical) in balancing the internal dynamics of interactions.

My Work Is Human Chess.

Day-to-day Sabrina provides strategic influence as a team leader, and as an individual involved in day-to-day dealings with patients and in situational responses to behaviours of concern. It was clear that this could be an unpleasant experience. To this end, Sabrina spoke about her first restraint, 'I think my first ever incident traumatised me'. She then slips into a more generalised comment about the experience of restraint, 'A lot of patients scream quite a lot. So, there's that noise and you think Oh my God, it's like ear piercing, and you think 'God' they sound like they're being killed' [124-128]. The way in which the event is described suggests that far from it being an intellectual challenge requiring a rational and detached response, it seems like something one is virtually assaulted by. The reference to 'ear piercing' screams, seems to speak to a sensory trespass. The impression is of a sound issuing from the patient and entering Sabrina's brain and forcing her to make sense of it. That Sabrina recalls this incident so vividly, after what appears to have been years, suggests the screams remain vivid when called to mind. She then transitions effortlessly into subsequent experiences, 'They can be intense'. Given such responses can be so difficult, and uncomfortable, one is left wondering why anyone would voluntarily participate in them. In contemplating this I am reminded of the impact shrieks and screams had on me in my role in healthcare settings. The origins were somewhat different [bed sores, and

having soiled themselves] but to me hearing someone in distress seems to tether you to them. You cannot deny their suffering. You might be able to avert your eyes but sounds and smells find you. As has been established, the consideration here is of events plural, not a singular one-off experience. So, why would someone stay with that person, and push on through the difficulties and discomfort, and then invest time, creativity, mental or emotional resources in helping, supporting or guiding that person? Asked what she finds rewarding about her role, she indicates that it lies within what patients can achieve, tied to the incremental, but by no means guaranteed, reduction in restrictions. To me this suggests that Sabrina has expectations for patients, and for herself in respect to individuals. She has spoken to the traumatising nature of incidents, of the inescapable screams and as we will shortly see the intense physicality sometimes required. To stay with a person, despite the uncertainty, danger, and complexity, requires a commitment, and an investment. Perhaps even a willingness to be vulnerable to that person. Sabrina describes staying with her patients through their distress. When asked, she revealed an emotional dimension to the reward she experienced 'pride' linked to a 'sense of accomplishment'. She talks about her 'input' having 'a positive effect on a person's life'. It is possible to read this as something that Sabrina has given to her patient which speaks to the nurturing potential of interactions, with interdependence bolstering independence. Care will need to be balanced against control, and autonomy against paternalism, especially in an environment in which security is foregrounded. Sabrina has previously referred to her work of 'balancing'. Sabrina also characterises the work involved in getting it right, thus, 'A lot of the time it's like human chess' [37-38]

The chess analogy to me seems to speak to strategising, planning, and making decisions before taking actions and evaluating their impact. Sabrina indicates that she is thoughtful, and that proactive, anticipatory thinking is part of her practice, 'So personally. I like to get in early in the morning because I like to sort of gather my thoughts and sort of plan my day' [46-47]. This seems to be a prelude to

finding a way of working with her patients, as individuals. She concedes that many of her patients can present as 'needy'. Whilst typically a pejorative determination, in this instance she follows it with a reference to a way of working referred to as 'Relational Security' (DoH 2023, 2015, 2010). This is a recognised approach to working in secure settings and serves as a formal adjunct to the inevitable physical security and procedural security. Defined as 'the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care' (DoH, 2010 p.5). It speaks to a dynamicism and fluidity, that contrasts with hard security measures and fixed procedures, which is revealed through the 'knowledge and understanding' an individual has and uses within the context of their unique 'responses and care'. So, the relationship, the deep knowing of the other, the rapport developed, the trust engendered seem to be a resource, which Sabrina seems to utilise intuitively. To confirm this reading Sabrina is asked, 'In your opinion, to what extent is the relationship with the individual a critical success factor for a response versus, say, being competent in restraint techniques?'. Her reply is resonant with the earlier analysis which spoke to balancing the internal over the external:

> I think the 'Relational Security' part of it, and the 'relationship' is more significant than… obviously you need to be trained in your restraint. But I think the 'relationship' side of it is much more significant because that patient has a level of trust in you that you're going keep them safe, that you're going to make the right choice for them, and they will respond to you [160-164]

Interestingly a throwaway remark highlights something important, 'To me it's to me it's a lot about 'Relational Security' which depends on my mood. It depends on who I am with [laughs]' [60-61]. To me, this statement includes two key determinants of Sabrina's version of 'Relational Security', that it 'depends on my mood' and that 'It depends on who I am with'. Both say something about the fact that

the relational way of working is complex and dynamic, and that its power and utility are far from predetermined. The staff member it seems must be present, focused, and mentally agile enough to make it work. If decisions are made, and actions taken, how the staff member feels seems likely to have a bearing on their application and outcomes. If they were tired, stressed, scared or angry this could have implications. I have taken care to say 'could', rather than 'would'. This because it seems to be intuitive that one's internal state can influence the external actions of an individual. As was found in setting one, staff who care *can* hold on to these feelings, keep them contained, and go on to make decisions and take actions unaffected by them.

In positing that certain actions might work well for some patients but be completely inappropriate for others, Sabrina seems to be suggesting that the efficacy of this resource ['Relational Security' (DoH, 2010)] is determined by the individual deploying it. When reading Sabrina's comment within the context of her interview, what she says does not come across as an excuse or an explanation for getting things wrong. As will be seen in the next sections, nothing goes right all the time. Rather than being offered up against that possibility, Sabrina's remark seems to foreground what she recognises as the fragility of any response to behaviours of concern, and the humanity of those involved. The outcome of any interaction or intervention is not pre-ordained or guaranteed, and any success, partial or otherwise rests on nurses like Sabrina being mindful throughout events, retaining the capacity to reevaluate and adapt as required, and engage in 'human chess'.

Its Quickly All Bodies and Blicks, But I Do Try to Talk to Everyone.

Sabrina recollects a recent event:

> We have an individual, and me and another staff member went into his room. I've got quite a good rapport with the individual. But with 'physical security' and stuff, you can't have a female go into the room by themselves. So, the staff member that I took with me, I suppose I didn't really think… This patient had been a very long time without assaulting anyone. I was a bit complacent and thought it would be alright and take him in to lock this individual's wardrobe off because he is at risk of self-harm. So, when we went in. Then he's took a run, and assaulted another staff member, but then by that stage he was in full restraint. He needed it. It was a quite a prolonged restraint as well. It was all very traumatic, but I suppose in hindsight, I thought to myself, you know, that could have been avoided, if I had a thought, and been a bit smarter and thought ahead more. If I maybe should have taken someone different in because the patient responds better to this person. So, I think, yeah, I sometimes it's not avoidable, to have a restraint, but I think sometimes you can reflect on them and think I should have done that a bit different [207-218]

The situation seems to have developed rapidly. From entering the room belonging to a patient she had 'a good rapport with', aiming to take steps to circumvent possible self-injury, to him running at and assaulting her colleague, to him being subject to a prolonged restraint. On reflection Sabrina concedes she may have been 'a bit complacent', going into the room with someone who 'had been a very long time without assaulting anyone'. Although unsaid, this may have engendered feelings of guilt or regret. What is certain is that she frames the event as one that was 'avoidable'. This is a revealing determination. Were someone to want to assuage any blame or mitigate feelings of guilt or regret one would be better off charactering the event as 'unavoidable', or 'just one of those things'. More maladaptive readings of events would be to shift responsibility by blaming the patient for 'playing up', or 'kick[ing] off', or even the other member of staff for 'dropping their guard' or 'leaving themselves exposed'. That this does not happen, seems to speak to an honesty in Sabrina's reflection.

I expand further on this reflectivity in the last theme. For now, the practical aspects of the response remain the focus.

> So, my first response was that to make sure I obviously… So, he sort of threw himself back onto his bed. So that kind of works in our advantage, because you can sort of block his legs and hold his arms. But I had his arm and his head because he was trying to bite the other staff member. So, in that incident I thought, 'Oh God, I hope people come quick', because I can't contain these both forever. But yeah, we had a good staff team, and then I was able to come off the restraint, because I knew I'd be in the position to verbally deescalate them. So, I knew… I think in a restraint I'll always look and see does anyone need to come off and be swapped out with someone else [237-243]

This event became suddenly very physical. Action was required to end the 'assault', then to remove the patient from the room and move them to a seclusion area in which opportunity exists for the individual to self-regulate. The initial physicality employed seems not be one of fully formed techniques, but rather of blocking actions designed to limit the movement of the arms and legs. So, the incident presents as suddenly and chaotically developing, with Sabrina and her colleagues trying to bring some sort of order to the situation. When she says, 'because I knew I'd be in the position to verbally deescalate them', it is immediately unclear whether she is speaking about the patients, or her colleagues, or both, but that she felt confident to physically and emotional contain the whole situation, with all its living, breathing, emoting, autonomous parts seem evident. There is a tension though. The exclamation, ''Oh God, I hope people come quick' because I can't contain these both forever', is indicative of a sense of panic arising out of being involved in a physical struggle that might be lost imminently and potentially present an opportunity for a further assault.

Knowing the patient Sabrinas also spoke to the risk factors included the high presence of male staff. This suggests to me that such a presence may give rise to feelings of threat which have the potential to increase the risks to staff if he increased his level of resistance. It is pure conjecture on my part but in this description, you have the ingredients necessary for a cycle of vicious escalation. A restraint that may well result in harm, not because of the index behaviour, or the fact of necessary restraint but rather the attendant social dynamics, such as gender imbalances in the response. The extent to which this was clearly recognised in the moment or was more fully appreciated in reflection, is unclear. Either way it does further speak to both the complexity of this event, and those features of it that registered or resonated with Sabrina. That there is an issue with men, and that the escalation linked to their presence and involvement positions Sabrina as seeing and feeling the restraint from the patient's perspective. She did not indicate 'he made staff have to increase the level of restraint because he was so violent' or 'staff tried their best, but he was not having any of it'. In such hypothetical examples the perspective of the patient is absent. They are reduced to a cause of restraint and a threat to staff. But Sabrina located herself in a different place and was able to empathise. This resulted in a very different perspective, which seems to speak to the existence of a relationship and a commitment to ensure care. This seems to me to suggest that restraint in Sabrina's mind is not neutral, or not simply a tool or means to a situational end. It is an intervention upon that person, rather than just something that starts and ends purely in the limited realm of the externalised component of their behaviour. Holding a person does not just limit the movement of the arm, it affects the movement of the body, it restricts their autonomy and choice and takes away agency, the psychological as well as the physical are restricted. Sabrina was able to speak to her continuing negotiation of the external physical component:

> INTERVIEWER: So, this first response is very sudden, I think you said you held the head and the leg?

SABRINA: So, I had his head and his arm.

INTERVIEWER: So, what you did there, is that a trained technique that comes pristine out of the training environment, or is that you just turning around and saying, 'I've gotta just get hold of something'.

SABRINA: You just grab hold of something until it's safe. So that's why I had had these two [head and arm], until another staff member arrived. Then you can sort of fix yourself. In the immediate moment you'll just grab on.

INTERVIEWER: So is it fair to say starts messy, you just do whatever you do, and then you said you 'fix yourself'. They come in, and then what you move towards is something more closely resembling what you see in the classroom.

SABRINA: Yep [245-261]

The techniques that were taught in the classroom are ultimately employed, but only after working through a messy phase where goals were pursued [the seizing of the limb, and the minimisation of its movement], via ad hoc physicality that is possibly never to be exactly repeated. The team, and Sabrina's trust in those members to do what is needed and expected once again comes to the fore. From her current position Sabrina can reflects on the physicality involved in a response:

Some people panic and maybe hold a bit tighter than they should do [pause] I think it depends on the incident, depends on the person. We've got an individual that used to come out of his room in holds. But that was his request, to make him feel safe. The hold was like that [demonstrates a touch prompt with light elbow contact]. It wasn't even, you didn't have any sort of grip on him [pause] and he responded really well to it. It's just it's just a safety

> mechanism for that person. And so yeah, I do think it can be therapeutic, but obviously in a controlled environment [190-196]

These comments are both rich in information and continue to speak to what the restraining component of her response seems to mean to Sabrina. There is reference to the proportionality of the response, as well as its therapeutic function. She indicates that a different patient requested holds, and that this was to make him feel safe. Of course, one can't truly speak for anyone else, and certainly not for someone who does not give voice to their rationale and feelings, but it is a recognition that in some instances physical contact, pressure, and the attendant attention that an individual receives as a result of the intervention can all be things that some individuals draw comfort from for different reasons (Kodua & Eboh, 2023; Bestbier & Williams, 2017; Radoux, 2017), however maladaptive they may appear to be. More important than any conjectured reason, is that this seems to be the reading of Sabrina. This balancing, or perhaps blending, of the technical and the therapeutic, the physical and the verbal, the rational as well as the emotional, the self and the other seems to speak to the notion of bricolage (Levi-Strauss, 1963) and to the resilience (APA, 2018) required to get through the event and arrive at a place where the caring and treatment can resume.

Then It's All About Checking, Reflecting Learning and Growing.

Sabrina's account shows that the endpoint in any response is not as clear as one might think, 'I'll probably always have a sigh of relief, and think right, OK. Everybody's out and everybody's safe' [300]. This inclination or need to check in with others says something about her regard for them and the nature of that regard. That this includes the patients says something about inclusivity, or the absence of a hierarchy of regard. One would understand if the instant response was 'are my team, OK?', but

this event involved a patient as well, and Sabrina's instinct seems to be to both check the welfare and sense making of one and all. 'I always say, 'right, let's all have 10 minutes. Let's all talk about it' [313]

This act of checking in, is not just to establish in simple terms that individuals are OK. Rather it seems to be to see how they have made sense of things, whether they have unanswered questions, or any concerns, or criticisms they wish to raise or emotions to vent. Ten minutes seems a relatively modest amount of time to address any issues arising. Perhaps describing it as such positions it as something that is doable. Over and above the sense making, the act of calling for the welfare check must say something to the team members about where they stand in relation to Sabrina. There is a sense that in calling for that chance to talk thigs through Sabrina is communicating that she cares about them and wants to take time to reflect, learn and repair together. It is also noticeable that this is sensitively facilitated through a strength-based approach (Morgan & Ziglio, 2007), but she does not discount a need to challenge unsafe or unsuitable practice, 'Instead of saying 'you done that wrong', I would say 'I think maybe if we had done it this way it might have gone a bit differently?' [326-328]

Sabrina seems sensitised to the presence and impact of the emotions that swirl in the wake of often difficult, and demanding responses required to attenuate behaviours of concern. This reveals itself in the 'time and place' remark. A critical conversation can be constructive or destructive depending on when and how it is handled, and Sabrina seems to intimate she has a feeling for the right 'time and place'. Her skilful timing and sensitive exploration of events, decisions, actions, and implications may well strengthen the team. To me this reveals that Sabrina's style of responding very much prioritises collective thoughts and feelings. Responding to behaviours of concern, particularly when some element of risk is present can lend itself to urgent action. Such urgent action, the nature of that action, is the goal of establishing control of events, is often marked by autocratic leadership and unthinking adherence to it. That people can and do die in restraints has led to a drive to empower individuals

involved to intercede on the grounds of safety when the use of force continues despite the growing signs of a developing medical emergency (RRN, 2021). This style of working seems resonant with the masculine characteristics included in BEM's sex role inventory (Bem, 1974), including traits such as being 'forceful', 'willing to take risks', 'dominant', 'individualistic' and 'competitive'. Whereas Sabrina's approach, unsurprisingly speaks of being 'sensitive to other's needs', 'compassionate', 'understanding' and yielding', traits characterised by Bem almost 50 years ago as decidedly feminine. Over the last half century sex roles have changed, and the current deconstruction and redefining of the meanings of sex and gender make such distinctions somewhat anachronistic. It is less contentious to suggest that Sabrina is demonstrating an 'ethic of care' as described originally by Gilligan (1982), and whilst this itself has been described as part of a feminist revolution in thinking and writing (Josselson, 2023), it does not claim that the standpoint she posits is exclusive to women. Sabrina's objective seems to be to do right by both the patient and the team, so what happens within the context of a response is 'with' and not 'to'. Her belief in this collective style of working was captured early in the interview where she remarked fleetingly on what constitutes a good day, 'If I'm walking off at night with it, with no incidents that day, with everybody safe, nobody's been hurt' [90-91]

Reflecting on her responses, and her style of working I asked her 'Have those experiences changed you as a person?'. She describes herself as a swan on the surface but paddling furiously beneath the waterline. This is a well-used analogy, that speaks to the divergence between the internal and external self in a moment of crisis. She also states that she has become more resilient. This suggests to me that going into a response is never something Sabrina can do with absolute certainty, or complete confidence, and that those feelings and emotions that surface, notably anxiety in this statement, are best concealed, at least temporarily. There is a sense that the assumption of the 'Poker Face', or neutral demeanour indicates that telling emotions are not shown. This ensures the patient and team do not discern those feelings, reducing the possibility of anxiety contagion between them, a

manifestation of the managed heart as Hochschild (1983) described it. Anxiety is what we feel when we are worried, tense, or afraid about things that are about to happen. It is a natural human response when we feel we are under threat, experienced through our thoughts, feelings, and physical sensations (MIND, 2021). It can be a precursor to 'fight or flight' being revealed through our behaviours. Within the context of Sabrina's teams' response, were anxiety to reveal itself individually or collectively there is the potential for the response to lose its caring integrity and for damage to be done. That 'Poker Face' would seem to be a powerful regulating mechanism. That she has presumably endured this anxiety on many occasions over the years, again speaks to the 'resilience' (APA, 2018) she has developed, which also seems to lay the ground for accumulating practice wisdom (Klein & Bloom, 1995). That this was an adaptation suggests that the decisions and actions themselves are situational, whilst the values and philosophies are perhaps enduring traits, which shape what happens. The reflection on events, the change in her 'self', and development of her 'practice' is the result, and how wisdom accumulates. She appears to share this wisdom with her team through the many discussions she has, whilst at that same time drawing upon the wisdom of others.

Appendix 44: Setting Two, Case Study: Charlie

Introducing Charlie

Charlie is a staff nurse whose role basically depends on whether he is in charge or not. Sometimes he leads the team, other times he does not. A nurse's role has a host of mandated responsibilities, including to: 'Treat people as individuals and uphold their dignity', 'Act in the best interests of people at all times', 'Recognise and work within the limits of your competence', 'Always offer help if an emergency arises in your practice setting or anywhere else', 'Act without delay if you believe that there is a risk to patient safety or public protection' and 'Be aware of, and reduce as far as possible, any potential for harm associated with your practice' (NMC, 2023). Charlies' leadership role, or more specifically the scope it offers for influencing practice and disruptive innovation, is revealed as a key aspect of his lived experience.

In total there were eight PET:

1. I Come 'In' With Relevant Knowing and Experience.
2. I Invest Time and Effort in Building Relationships and Trust
3. As A Leader I Am an Independent Thinker Who Is Prepared to Disrupt and Challenge
4. There Are All Sorts of Behaviours I Am Involved in Responding To.
5. My 'Extra' Knowing and Experience Help Me When Things Get Messy.
6. Each Response Is Different
7. You Have to Find a Way to Pick Up the Pieces However Hard That May Be.
8. I Believe We Are Wrongly Judged.

These are based on 40 'Experiential Statements', arising from 164 'Exploratory Notes' [Fig 44.1].

I Come 'In' With Relevant Knowing and Experience
• I've always studied martial arts. • I used to help with my cousin
I Invest Time and Effort In Building Relationships and Trust
• I do my best to help others develop the right way. • Taking the time to build relationships is crucial. • My style of working
As A Leader I Am an Independent Thinker Who Is Prepared To Disrupt And Challenge
• I don't like to conform but I do strive to develop. • I am a leader. • I observe and question practices around me. • I advocate working differently sometimes based on my experiences. • Some people don't like that i question and challenge and argue. • I know I am accountable for my decisions and actions. • The naysayers and disbelievers can see if it works or not
There Are All Sorts of Behaviours I Am Involved in Responding To
• I'm a staff nurse but my role varies. • Despite often not having enough staff on shift • A lot of the job involves managing all sorts of behaviours. • Patients can be difficult & dangerous, but its par for the course in here. • I find self-harm very difficult to deal with • Despite the challenges progress can be and feel rewarding
My 'Extra' Knowing and Experience Help Me When Things Get Messy
• I'm pretty used to all behaviours. • One recent incident that comes to mind. • Staff training is a mixed bag and takes multiple forms. • But my martial arts came through
Each Response is Different
• The guy apologised which suggest the connection remained intact. • Another made allegations. • And another seemed to think I shouldn't be missed with!
You Have to Find a Way To Pick Up The Pieces However Hard That May Be
• Sometimes I just keep going. • Sometimes I take time to reflect. • Sometimes laughter can be enough. • I watch out for others. • I am quite guarded who I talk to after serious events. • The acknowledgement and gratitude of others is appreciated
I Believe We Are Wrongly Judged
• Restraint is messy - that is its reality. • People can see a push as a strike. • If a patient's trips, has the carpet thrown him to the floor. • It's an injustice - we are prisoners of perception. • It's unfair that others judge us. • I've had friends suspended for restraining messily. • Lots of us - not all - are very skilled leave us to do our job. • I'm not saying there aren't imperfect people amongst us. • Too many people live under a rock

Fig 44.1: Charlies 'Personal Experiential Themes'.

I Come ‘In’ With Relevant Knowing and Experience.

Unbidden Charlie made two important disclosures. The first was about training outside of work, and the second a past, personal experience of caring for a family member who needed to be restrained. The first relates to his lifelong involvement in martial arts training. He describes the two styles he currently training in:

> Muay Thai. If you know what it is? It's like a version of kickboxing. Essentially that’s a position where you ‘clinch’ them to, to maintain control [300-302]

> I suppose, like, you know, the focus of my training now is on Brazilian jujitsu, which is a grappling art. You start off standing, but you try and take them to the floor and submit people. You know with chokes or joint manipulation on the floor [315-318]

These statements came about halfway through his interview, when the actions he had taken within an incident following an attack, were being explored. This was when he started to speak about his martial arts training. It seemed to provide him with an explanatory framework, as well as offering words like ‘clinch’ to describe what he had done. As has been declared [appendix 27], I have a background in martial arts which provided a common frame of reference. Charlie spoke about his immersion in Muay Thai, a style of hand-to-hand fighting used by soldiers when their weapons are lost (Lobban, 2018). The immediate reaction to talk of resorting to training that foregrounds physical ‘control’ in a caring setting may be incredulity, or even outrage. Further to this in Charlies own words, he described Jujitsu as involving taking people to ‘the floor’ and causing them to ‘submit’ through the use of ‘chokes’ or ‘joint manipulation’. To dwell on this harmful physicality would be to focus on only

a small part of what martial arts training offers, and to misinterpret what Charlie was saying or indeed doing. Croom (2022) talks about the significant misunderstanding and misrepresentation of the martial arts. He suggests that they are deemed to be immoral, that damage is their primary goal, with their practice invariably resulting in the dehumanisation of others. Croom argues, and Charlie's experience seems to reveal, that what he brings into the work setting with him, as part of him, is not destructive. Indeed, I found it to be creative. This will be returned to later.

Charlie also described his personal experience of providing support to a family member, 'a cousin who was autistic'. Charlie revealed this immediately after having described working for ten years, dealing with people 'who present with aggressive risk behaviours'. By talking about his involvement with his cousin in the same breath, he brought both experiences together. This suggests that the physical and mental labour, perhaps even emotional labour, expended in both instances was a similar order of magnitude and complexity:

> I would see my auntie, who was always in a panic, and you know, she would have been in hysterics because he was out in the in the garden head banging. I would just, you know, there was no approved like [pause] I was just teenager, and I would peel him up off the floor trail him inside, put him on the seat and tell him to wise up! And he'd be fine [566-569]

That his Auntie was panicked was possibly down to the shock of seeing her son injure himself, and perhaps not knowing what to do or how to respond. Charlie describes stepping in and taking steps to 'peel him up off the floor'. This conjures up an image of moving his cousin from the horizontal to the vertical and then relocating him into the family home. To peel something seems to suggest that some effort was involved, but the physicality seems to give way to a swift transition to the non-physical

wherein Charlie tells his cousin, 'To wise up!'. To end his detour into his early life experiences Charlie talks of his quasi-guardianship role before revealing something about what has drawn him to a role in which he routinely faced unpredictable, and potentially dangerous situations. This included a combination of 'excitement' and the challenge of making 'difficult decisions' [574]. That such an event can meet both needs simultaneously, seems to say something about how the complexity of the experience. The statement suggests that there can be a reward in responding to behaviours of concern, and that it is not always something that is endured or feared by staff. In the final sentence he seemed to make his point and then stop. This relatively sudden end to disclosures occurred several times. Perhaps to his mind, he felt that he has said enough, or even too much? That he had revealed hitherto undeclared aspects of his experience, and any more might be extraneous. An alternative reading could be that those thoughts which were forming in his mind were difficult to express, or perhaps it was difficult to ascertain whether they would be misconstrued. Whatever the reason, there is a recognition that disclosure is difficult and leaves a person vulnerable. The term self-disclosure is often attributed to Jourard, who defined it as 'the act of making yourself manifest, showing yourself so others can perceive you' (Unhjem *et al.*, 2018). A distinction can be made between self-disclosure, and self-presentation. Whilst self-disclosure involves revealing facts about oneself with no regard to the impression created, self-presentation involves disclosure that is designed to project a desirable representation of the self (Schlosser, 2020). The sense here is that Charlie is making disclosures in the true sense, and in so doing increasing his personal or professional vulnerability.

I Invest Time and Effort in Building Relationships and Trust

Charlie was asked about the development of relationships with patients.

> I think that to have any success with patients, especially the patient group that I work with, who all have experience of trauma. So, like, if they don't trust me as their named nurse, or have that level of trust that has been built through the relationship, it's harder to achieve a positive outcome for them. But yeah, you know, a lot of the time relationship building, spending time with patient and maybe doing activities with them [37-42]

He identifies developing relationships as a key part of the role and suggests that having 'any success with patients' requires a relationship. The words 'success' and 'with', speak to respectful collaboration to achieve situational goals. He quickly follows this by adding a qualifying statement, 'especially the patient group that I work with, who all have experience of trauma'. Here he seems to be saying that relationships are especially important when the individual patients have such events in their personal histories. He later adds:

> I think I think female patients are more complex, and I mean that [pause] I would suggest that they're probably more likely to have experienced trauma. I've no evidence or anything to [pauses] that's just personal experience [pause] You know, a lot of the trauma that they've experienced has been committed by men. So, it's unusual because, you know, we have a patient here who has been abused by men all of her childhood but connects really well with me [70-74]

The word 'complex' is not expanded upon. A person with complex needs is one who has two or more needs affecting their physical, mental, or social wellbeing (APPG, 2022), potentially requiring different programmes of treatment. The sense in which Charlie seems to use of the word likely relates to the nature of the individual and their needs, rather than any defining number. When something is

complex, one cannot predict with certainty the result of actions (NHSE, 2023). Charlie describes having to do much to get relatively little, that it is more difficult and more time consuming to develop an authentic and genuinely therapeutic relationship with a person who has experienced trauma. He also states that most of the harm done to these female patients was likely by males, which seems to suggest that as a male it could be more difficult for him to be accepted. He states, 'if they do not trust me as their named nurse or have that level of trust that has been built through the relationship, it's harder to achieve a positive outcome for them'. This suggests to me that his success in developing a relationship, has led to success for the individual patient. This is distilled in one statement, 'we might have a patient here who has been abused by man all of her childhood but connects really well with me'.

Charlie' s role shifts from nurse to charge nurse, from following to leading. My sense was that even when operating in a more strategic role his decisions were in service of the relationship he had with patients, providing opportunities for their needs to be met through others. Charlie went on to elaborate on the power and influence of a personal connection, as well as how he was able to bring his knowing to bear through decisions that had implications for others working more closely with a particular patient:

> I think that in big institutions like this, people get very stuck in managing risk with restrictions rather than thinking, 'oh, we can actually manage risk by taking a risk' if that makes sense. …I would describe him as a patient who wasn't much liked by the staff, based on the incident that led to him getting placed in segregation which was quite a serious one that involved a weapon. And you know, trying to explain to people that, that he is less likely to, well, that was my opinion, that he was less likely to attack people if he had more time out of his room. I suppose it was a bit counterintuitive because he would have more time to plan an attack or

> to, you know, to attack somebody. I suppose it to comes down to me getting to know the patient. You know that I had worked with him for two years at that point. Me and him instantly had a therapeutic relationship, that developed over time, he responded quite well to my approach, which was, I don't like to use the term, but firm but fair. You know, I was always fair with him, but I had to put boundaries in at times, and reinforce set limits [122-133]

There is a sense that Charlie is averse to a type of thinking that pervades 'big institutions', of 'managing risk with restrictions'. He states, 'we can actually manage risk by taking a risk'. In taking a risk in such a highly regulated environment one is putting a lot on the line: bodily integrity, [as well as that of others], the relationship between himself and his colleagues as well as his professional reputation. No one will follow a leader if they get things wrong. In this sense Charlie seems to be intentionally making himself vulnerable by hedging the risk of harm and damage against the development of deeper trust and therapeutic progress. His statement affirmed the strength of the relationship he has with this individual who was recently involved in a serious incident involving a weapon. The strength of this relationship is the basis of him being prepared to be vulnerable, to put a great deal on the line for the patient

There Are All Sorts of Behaviours I Am Involved in Responding To.

Charlie spoke to the need to intervene in the behaviours of patients, and suggested the reasons why people behave in the way they do is impossible to state definitively. At the very least it is likely to be rooted in their history, and their diagnosis as well as the physical and social environments they find themselves in. A setting with lots of rules and gatekeepers will invariably mean that there are occasions when interactions have the potential to produce conflict or develop into confrontations. Charlie describes the behaviour as he sees it:

> I tend to use the word 'risk behaviour'. I think that it seems like every organisation you go to, or every couple of years, there's 'no, you can't say challenging behaviour because it might not challenge'. It could be challenging for you, but it might not be challenging for somebody else. Then they want to say, 'behaviours that could be *perceived* to be challenging'. To me it's just 'risk behaviour.' That's what I go with. That's what I'm using in their notes, so I'll just use that term. It covers 'directing aggression towards others', 'directing aggression towards themselves'. Then probably 'verbal' and then, the 'security risk behaviours' you might get here, you know, like 'subverting security', and 'inciting other patients' and 'manipulating' [others] and 'coercion'. That sort of thing and can be quite risky (235-242)

Charlie's favoured term here is 'risk behaviour', as opposed to 'behaviours of concern' or 'challenging behaviour', which Charlie suggests others use. He then briefly detours into the ongoing debate around what different words ['challenging'] mean to different people, with a variety of standpoints often being in evidence. That there is power in the use of language is not disputed, with the prevailing discourse maintaining firmly that it has the power to enable, disable, validate or invalidate (Trescher, 2017). Charlie has consciously chosen to use the word 'risk'. This seems to speak to a potential for harm that is proximal and embodied. In broad terms the meaning residing within words or semantic labels is usually unpacked, discussed, and debated, at a distance from the actuality to which it refers. This includes conjectures around the role of power, its misuse or abuse. By contrast, in this context, Charlie's use of language seems to be focused mainly its use in describing the contents of an event that has already come to pass. If a patient is reported to have been 'directing aggression towards others', 'directing aggression towards themselves', or to have been 'subverting security', it refers to that which has occurred, and the contents of which had necessitated investigation, or intervention as necessary. Of course, there have always been cynical and corrupted incident reporting practices, where behaviours are amplified after the fact to legitimise staff actions, which as previously stated,

Police ethnographers have referred to as ‘verballing’ or ‘gilding the lily’ (Holdaway, 1980). However, in the lived experience of participants such as Charlie, words themselves actually appear to be superfluous in those moments when a body part is making forceful contact. It does not matter if it is called ‘challenging’, ‘disruptive’, ‘aggressive’ or ‘risky’ behaviour, nothing will alter the actuality and implications of the impact. Charlie describes trying to deal with a situation when a patient could not get his solicitor on the phone. He started problem solving, with a view to establishing the connection, ‘So, I checked his phone list, and the phone number was correct. As soon as I went out the office door and told him that, he ran at me, he punched me maybe three or four times’ [266-267]. Aside from any relevant CCTV footage, the words he used in any report would likely have been the only lasting record of the event. Such footage [where it exists] may not be shared with staff in the normal run of events. All that therefore remains are the written words, spoken words, and memories. The next paragraph is lengthy but reveals his experience in his own words:

> I sort of instantly [pauses] My arms were sort of inside and over his shoulders near his neck. I wouldn't say my hands around his neck. I was sort of closing in and trying to stop these punches. We managed to get him pressed up against the wall, and then we took him to the floor. For context, this is a man who's six foot three and a hundred and fifty kilos. So, we managed to get this patient to the ground, sort of, and he landed in supine with one of his arms in between my legs. And because there was only two of us, you know, and he would hit you, kick you, bite you and spit at you. We had a lot of to maintain before other staff arrived. So, I managed to hold his arm with my leg. The other staff member had the other arm, and I had control of his head. We didn't really need control of the legs at that point because there was nobody around. More staff arrived [267-276]

Again, there is a sense that in the moments of his response, words were immaterial. They only became contemplatable after the fact, and upon reflection. Charlie says, ‘‘I sort of instantly [pauses]’. So, instantly something happened, ‘sort of’ to quote him. In this context ‘sort of’ seems to relate to that something which happened, that did not seem to register in such a way as to enable a clear description. He pauses, as this aspect of his disclosure ends, as if ‘I have nothing more to add’. Then he continues, ‘my arms were sort of inside and over his shoulders near his neck’. Again, ‘sort of’. It seems to me; his mind is trying to first recall and then articulate something that cannot be clearly recalled or precisely described. His sense was that he was ‘closing in’ and ‘trying to stop these punches’. This does have resonance with both his Muay Thai, and Jujitsu wherein the closing down of space and clinching or grappling are embodied stratagems (Pinto, 2021). Suddenly, his recollection transitions to ‘we’: ‘We managed to get him pressed up against the wall, and then we took him to the floor’. Here he is joined in the physical struggle by a partner who seemed to understand one goal after another, ‘to the wall’, then ‘to the floor’. When someone is held against a surface, either vertical or horizontal, it can have the effect of increasing the degree of physical containment applied by staff. Next comes an interlude in the recollection, as some context is given. The patient is six foot three and weighs twenty-four stone. This allows us to understand something of both the scale of the challenge, and to conjecture the risks involved. Charlie returns to describe managing to get the patient to the ground. Again, he uses the phrase ‘sort of’. There is no definite structure to his individual, and the pairs joint, response: It is just, ‘sort of’. The presence of risk is then quickly returned to, ‘he would hit you, kick you, bite you and spit at you’. The phraseology here is a little out with the rest of the passage, not ‘he was hitting, kicking, biting and spitting’. That ‘he would’, seems to speak to events in the past tense, in the form of a recollection. This could be a distancing mechanism, pushing the reality of the harm that could have been caused even further back than the immediate reflection. Or it could just as easily be a slip of the tongue, or inadvertent verbal tic. Irrespective of the words used, it remains the case that the behaviours he faced presented a real rather than semantically attenuated potential for harm.

As A Leader I Am an Independent Thinker Who Is Prepared to Disrupt and Challenge.

Charlie identified himself as a 'Charge Nurse', an individual who oversees a specific ward while working. This places him in a position of responsibility, and influence. He determines whether a particular intervention is made, a planned restraint is approved, or a seclusion considered. With this power comes responsibility. This links back to the previous PET. His decisions place his colleagues in proximity to situations where risks can be realised. He talks about having the general responsibility for deciding to seclude a patient. If he says 'yes', it must be done. Staff are then required to impose control that may be violently resisted. He has placed them in harm's way. Were he to say 'no' to seclusion, the individual would remain in an area that may be shared by others, where he may be placing them at risk of harm. The sense gathered here is that it is the latter type of decision that Charlie is prepared to take, even when the easier decision may be to seclude. If the decision does not lead to incident or harm, his judgement is noted, as well as his way of evaluating the potential strengthening his relationship with a patient by not removing their freedom. Charlie is all too aware of the price to be paid for making the wrong call, saying there is 'an expectation to get every decision right, and there's very little leniency for making errors'.

If Charlie illustrated how he is prepared to take risks, he explained how he was cognisant and critical of the risk taking of others:

> So, there might be like you know [pauses] I suppose everybody's a different sort of way of doing things. You know, we might be doing a room entry on a patient. We'd have maybe eight men lined up, ready to go in their room to restrain a patient who may be being violent or destructive to the room. All sorts of things. [pauses] Like there the way everybody does it is to run at the patient. It's almost like you don't know what they are trying to do because they're

> just running. The first person always gets punched, and they always have to go home. And then the rest of staff end up in this like 'pile on'. Which like you know. [pauses] I like to think I'm a bit of a free thinker and I'm like, 'well, hold on. We can just walk in'. What's the point of a run, for the sake of ten feet?' [463-474]

The practice at the heart of this is a 'room entry'. To the lay ear this already has overtones of 'tactical' actions employed by Police teams, of hostage rescue (Blair *et al.*, 2019). The use of the word 'on', in the phrase 'a room entry on a patient' can be read as an overbearing or overwhelming act. If one strips reference to the entry procedure back, along with its interpretive overlay, one is left with a group of clinicians initiating an interaction with a patient, who is currently in a bedroom, perhaps some sort of clinical intervention is mandated by a medical team. In the example given there is reference to 'being violent or destructive to the room.' Whilst inert material may have been the focus of the patients' 'violent' energies, fragments of the environment could be used to cause significant injury. It is also possible that such actions that may pave the way for feelings of regret, shame, and guilt once the immediate state of arousal subsides (Tangney *et al.*, 2011). The prospective intervention comprises 'maybe eight men lined up'. Perhaps one for each limb, one for the head, and a leader or controller to co-ordinate what will be a planned response. The other two may have been tasked with administering rapid tranquilisation. Charlie sums up what is likely to happen next, 'The first person always gets punched, and they always have to go home. And then the rest of staff end up in this like 'pile on''. It is unclear whether such an approach is procedurally determined, or whether the simultaneous entry is something of a protective group strategy. Either way, Charlie is critical of the strategy, 'I like to think I'm a bit of a free thinker'. This is taken to mean he is able and willing to examine orthodoxies and question them, rather than accept them unthinkingly. Apps (2021) examined the psychology of firefighters in 'in the wake of the Grenfell Tower fire and spoke about the identity of the UK firefighter being bound up in the notion of fighting and beating the fire, and of effecting the rescue of people.

He compared this with the response of European firefighters to a similar high-rise fire, where the onus was on evacuating residents rather than fighting the fire first. The result of the European firefighter's approach was no loss of life, with the building left to burn out. Whilst Charlie is not advocating sitting and waiting for the person to stop destroying the room, he states 'I'm like, 'well, hold on. We can just walk in', What's the point of a run, for the sake of ten feet?' Rather he seems to be suggesting that by claiming control of pace of engagement and the proximity of staff there may be options for other interventions, perhaps even purely non-physical ones. This reveals a mindedness to challenging, as well as influencing practice.

He spoke about proximity in the run up to the discussion around tactics:

> I think proximity is a big thing. Because I fight people in my free time. If you know, you're boxing somebody or trying to strike them, why would you want somebody who is extremely aggressive to be on arm's length observations by a number of staff. You know, because one person's going to get hit. You have no time to react before you can intervene. Which always seems to be the way here, which I find quite interesting. Is that like the really aggressive patients tend to be on a number of men at arm's length. You know, I'd rather be two arm's length. If somebody takes a run of me, I can maybe manage to block or whatever [446-452]

> Staff are getting down like, you know, haunching, trying to talk to them, very close to their face, you know, or their legs. And you're just thinking, like, you know, if I was that patient, I could knee you in the head right now. There are loads of things I could do... But yes, I think that I'd personally be up for a few adaptions [453-458]

Again, Charlie is questioning the orthodoxy, the practice of 'arm's length observations' on 'really aggressive patients'. He suggests he would rather be 'two arm's length'. He provides a rationale for this, in that it once again gives the staff member more time, and so a wider range of response options, as well as making them less likely to be harmed. He switches to consider the impact of proximity from the patient's perspective, 'you're just thinking, like, you know, if I was that patient, I could knee you in the head right now.' Immediately this speaks to the ease with which a patient could harm a staff member, and the options at their disposal to do so. What is not said, is that encroaching on a patient who is likely to be in an existing state of heightened arousal, has the potential to be triggering, to be perceived as being invasive and to give rise to a fight response. He concludes by saying 'But yes, I think that I'd personally be up for a few adaptions'. I read this as welcoming of a change to the current approaches, possibly policy and training. As 'an independent thinker', he seems to be disrupting orthodoxies and inviting colleagues to challenge their own attitudes, assumptions and approaches.

My 'Extra' Knowing and Experience Help Me When Things Get Messy.

Charlie's states, 'I fight people in my free time'. This leads me to consider Charlie's 'self' as an indivisible whole. He may well keep parts of himself in a state of latency at work, but he is not disconnected from them. Whilst his professional self is at the forefront of his being, he remains that fighter. He captured the act of holding a part of himself in abeyance vividly when he was speaking about ending up in a clinch, 'No, I didn't [Laughs] I didn't knee him or hit him with my elbows! [laughs]'. Such striking would have been permissible in the gym or the ring, but not at work. In this moment Charlie is a Thai Boxer, literally seizing on the clinch as a situational risk management strategy, but in the next second, he is the nurse again. He does not strike and even finds the prospect of that worthy of a laugh. His whole self is in attendance when he takes action to bring a potentially dangerous situation under safe control.

As a regulated health professional Charlie must abide by a professional code of conduct. The obligation to ‘Recognise and work within the limits of your competence’ seems to take on a new meaning given that competence is derived from his whole self. He further examines how his personal self was in effect his professional self:

> I think it's interesting because the position that I ended up in, is a position that I would get into our training. You know I train three or four times a week, and I'm completely obsessed by it. The position with his arm between my legs, I just knew because of my training I could hold it there, and it wasn't extended or anything. And then I could also hold something else. Then as soon as I could release it and get to the appropriate way. But you know, would I have needed anybody else there to come and you know hold? I wouldn't have because I was able to hold [318-323]

This unorthodox holding position does not appear to be approved or authorised, but seems to get the job done, and keep the patient safe. He was able to hold both the arm, and ‘something else’ and would not have needed anyone else ‘to come and you know hold’. This speaks to a freedom of both mind and body to adapt to situation and circumstance unencumbered by any limitations, it is the work of a bricoleur (Levi-Strauss, 1962). He continues:

> You know, you don't really think once it first happens. You know, before I had taken hold of him, and got him up against the wall - I don't want to say push him up against the wall, like driven to the wall - Took him to the floor, and then once I had everything maintained and I wasn't getting hurt no more. [352-356]

Here Charlie does two things in quick succession. He had ‘got him up against the wall’ and ‘Took him to the floor’. If one casts one’s mind back to his experiences with his cousin, Charlie was moving him from the horizontal to the vertical, whilst here he is moving the patient from the vertical to the horizontal. It is unclear whether this is prone or supine. Prone positioning has been constructed in many ways. As either the largely unofficial forcible prone restraint position (Sethi *et al.*, 2018), the maximal restraint position which came to light during the George Floyd trial (OAC, 2022), the notorious ‘pindown’ manoeuvre used in residential childcare settings (Levy & Kahan, 1991) and the position most associated with restraint death in the UK (Aiken *et al.*, 2011). That many of us sleep safely in prone, that during covid proning was held to optimise the transfer of oxygen into the blood (Gattinoni *et al*., 2022), and that it is a very close cousin to the recovery position are held to be immaterial. The position has been cast out of acceptable practice (MIND, 2011).

In Charlie’s account, the technical details of this repositioning are scant. He says, ‘I don't want to say push him up against the wall, like driven to the wall’, a qualitative distinction between getting someone against a wall and pushing someone against the wall. The words here seem important to Charlie as they convey the explicit nature of his actions. Once again, words used in the description of the actuality for the record. As has been alluded to, there are enormous sensitivities around the use of force, its legality, and the extent to which it is ethical. As much of this hinges on whether it was necessary and proportionate, or whether it manifested in those forms that dare not speak their names. The distinction between ‘getting’ and ‘pushing’, seems to me to be for third party consumption. It appears to me that he is endeavouring to clarify the physical nature of his actions, not redefine what he did. The sense I had was that he is trying to stem the tide of judgement that often follows disclosures of force, and which can become effectively weaponised by those who place great store in the words used. To me, Charlie had let me into his world and his experiences, warts and all, where Charlie’s ‘extra’ knowing and experience helped him when things got messy.

Each Response is Different.

The incident spoken to above continued. More staff arrived, and a fully developed restraint appears to have been implemented. The arrival of additional staff permitted a transition from the ad-hoc adaptive holding into the approved holds and then the authorised procedure. The response is now back on official track. The remorse and regret swirling around within the patient subsequently become manifest, 'he started to cry, and just started the say 'I'm sorry, brother. I'm sorry'. And he kept saying it'. So, the patient journeys from overt violent attack to tearful regret in a matter of seconds. The actions of Charlie, on the face of things, appeared to be the transformative intervention. If Charlie's actions had been perceived by the patient to be unjust or hostile, my feeling is that regret would have been less likely to materialise. Perhaps anger or a resurgence in violence might have been the consequence. An alternate reading might be that the patient cried from fear because he regretted his impulsive actions and anticipated punishment or retaliation. It is impossible to know with certainty when making a second-hand interpretation without having seen the incident. This having been said, it feels to me like the tears were a surprise to Charlie, but which he seems to acknowledge were sincere. To me the work Charlie was leading moved from physical to non-physical work, from latent to expressed emotions, and from danger to un-danger very quickly. Charlie had to revise and restructure, revealing the multi-dimensional nature of interpreting and implementing actions within policy parameters.

Charlie recalls another incident, within which he describes being 'assaulted'. The patient was duly restrained and secluded. The patient then put in several allegations against Charlie. He was fully exonerated was exonerated by CCTV footage, but the experience seems to have stayed with Charlie, 'I still didn't really, you know [pauses] If I could never work with him again' [388-389]. There are no details other than his report that this took place. The immediate response of the patient also goes

unstated, but the fact of the subsequent allegations seems central. These would have to have been investigated. One wonders how long the investigation took, and what it was like to be under investigation during that time, accused of assaulting a patient or in some way being complicit in an act tantamount to physical abuse. As a result, there was no meaningful relationship between the two parties, 'It was just there was [pauses] more like the deceit and the, you know. It was more cunning'. This faltering disclosure of feelings has a stop/start element to it. One acknowledges that sometimes feelings of injustice can compromise the power or speech and degrade the ability to elegantly express oneself. Charlie's account seems to reflect a sense of injustice, with him appearing to experience the same righteous anger he felt when he was subject to the phone attack, 'I was angry because I done an awful lot for him, and he was taking the situation out on me, even though, it was absolutely not my fault'. It seems Charlie is saying is that his reasoning was sound, the actions were proportionate, and his response was justifiable, and that he did not do a bad thing. The question unanswered is did he work with this patient again? And if not, could he? Was there a way to revive the relationship?

There must always be a valid reason for a specific physical intervention at the time of its use. How Charlie feels about that behaviour or that person is something else entirely. Consider the following:

> Whereas the other gentleman, it was more, he was just emotionally dysregulated all the time. Like, he just blows off the handle. I suppose that might be something to do with it. You know, I've done a lot of work with people with severe learning disabilities, people who couldn't talk, who probably had a comorbid diagnosis of autism, and who would assault you nearly every day, or try to. And you know, you sort of thought of that more as their communication style and there was no - I'm trying to use the right word, there was no heart, you know [395-401]

Charlie reveals having been attacked on multiple occasions ‘nearly every day’ by people with ‘severe learning disabilities, people who couldn't talk, who probably had a comorbid diagnosis of autism’, and he has accepted this as ‘their communication style’. This is a statement that he does not append with complaint or criticism, rather he goes on to say that ‘there was no heart, you know’. This is taken to mean that he felt there was no ill will or intent to harm on the part of the patient. This seems to suggest that exposure to violence can be understood and processed by a staff member in different ways. Charlie did not seem to take umbrage at the fact the previous patient engaged in behaviour that necessitated intervention, nor that the intervention itself was difficult or dangerous. What he did resent was the malicious allegation, and the element of cunning and manipulation he perceived to be in evidence. This was something that could be perceived to run counter to his authentic efforts to provide support and treatment, and to respond carefully.

You Have to Find a Way to Pick Up the Pieces However Hard That May Be.

Notwithstanding any physical or emotional first aid, and any immediate disruption or damage that needs to be remediated, there comes a time when people often look back and reflect on what has happened. It is a space where some people critique events and reconstruct themselves in order that next time, they will be better prepared to do things differently. I asked Charlie whether he talked things through afterwards, ‘I suppose it depends on who is doing the debrief. If you know them and have that trust in them. You know you don't want to be, you know, the talk of the hospital! [smiles]’ [552]. He indicated that there was ever something that really bothered him he would talk it through with ‘mates’, ‘I won’t talk to a randomer, or somebody who's done defusion training and works on a different ward and doesn't know the patient. I’ll talk to somebody who knows the patient and the situation’ [555-557]

If one takes this statement, along with 'I'll talk to mates', and I'll only talk to someone I have 'trust in', one is left to conclude that for Charlie at least there is a relational component running through examining what came to pass and answering difficult questions. The act of venting can be understood of as one example of a coping strategy where an individual communicates their adverse feelings to others (Rosen *et al*., 2020). The resulting catharsis can go some way towards attenuating those negative emotions that accumulate (Shah & Huang, 2022). It might not be pretty, hence the need to ensure it only takes place in protected spaces or within trusted relationships.

To summarise, Charlie seemed to favour private reflection but stated he would participate in a formal 'defusion' or 'debrief', with the right facilitator, that you need to 'have that trust in them'. He then makes a key point, with a light touch, 'You know you don't want to be, you know, the talk of the hospital!' [smiles]. This seems to suggest that things can come out of conversations that he would not want to be public knowledge. Notwithstanding obligations to maintain confidentiality, what could it be that might come out? Perhaps, the concern relates to the possibility that a disclosure might be construed as detrimental? Such as 'I froze', or 'I wasn't sure', or perhaps the venting that can be forthcoming may not be particularly edifying. It is unclear but it seems that matters are sensitive and therefore protected. My feeling was that some of Charlies reticence to be candid in front of others was tied into his sense that when matters are honestly spoken to, it runs a risk of judgement. This is explored in the final PET.

I Believe We Are Wrongly Judged.

Charlie has spoken to the complexity of events and sought to clarify statements lest they be misunderstood. As is clear, there are enormous sensitivities around the use of force. At the end of the

interview Charlie was asked if he had anything to add. He immediately began speaking about being judged by others:

> I always laugh when these people come out and say things like, 'you know, we shouldn't be restraining people anymore'. Well, how else are you supposed to manage them? [laughs] You know, in these areas, a lot of us are very skilled. Not everybody, but a lot of us are very skilled at the verbal de-escalation and there isn't many people. I'm not saying, there isn't people who don't look for, you know a fight with patients, or you know what won't create an incident. But there's many, many skilled people and we still require a lot of restraint, and it's just a fact of life [661-666]

He quickly dismisses a perspective that is widely held. A perspective that exists on a continuum between an assertion that there should never be any restraint, to a position that accepts that restraint will occur (Barnett *et al.*, 2018; Aiken *et al.*, 2011; Paterson *et al.*, 2003). That he says, ''I always laugh' underscores what he believes is the inherently flawed nature of the perspective. As if to invite a counter argument he then says, 'Well, how else are you supposed to manage them?'. This is then appended with a short, incredulous laugh. The use of the term 'manage' can catch in the mental filter of those who are sensitive to language and how it is used. The word 'manage' seems impersonal and distancing, dispassionate and unconnected. Mandate, manipulate, manoeuvre and manacle all share the same etymological root, with the Latin *manus* meaning 'hand, strength, power over; armed force' (OED, 2023). However, it is also relevant to point out the use of the word 'manage' as an umbrella term for lots of activity or activities. For example, Cancer UK (2024) talk about 'managing cancer fatigue' and the British Pain Society (2010) of 'managing cancer pain'. In both instances person centred care is at the heart of the ambition, but the inventory of work undertaken under these umbrella terms is far too extensive to elaborate upon or list.

Charlie then makes the point that there are all sorts of different staff working in services, some of them may be disposed to restraint [who perhaps exhibit the big institution thinking he critiqued earlier], and those who are disposed to finding reasons to 'a fight with patients'. Overwhelmingly however, he asserts there are lots of good staff, 'very skilled at the verbal de-escalation' who are required to restrain patients for valid reasons. In effect he is pitting his lived experience, of working day in and day out for years, building relationships and trust and 'Trying to deescalate the stress before it reaches crisis point and then if it does reach crisis point, obviously managing that, in a least restrictive way', against the perspective of outsiders looking in. He next details the perspectives of a cohort of outsiders coming in:

> When I was in uni, because I had a bit of experience restraining people and whatnot, we had a class on restraint. I was one of the oldest, at like 24 years of age! with probably 29 18- to 19-year-old girls in my class. And we're talking. I'm talking about restraint and the majority of that room said they agreed with that the use of restraint is just barbaric and you shouldn't restrain somebody in this and that. I just couldn't believe it. You know what I mean? Like, I just thought, do you know what, you just live under a rock, because you know, you should see my reality. And they came, to my ward on placement, the ward that I worked. And, yeah, they saw the need for it. You know that's a big thing like. It's a sign of the times, I suppose all this sort of, one way thing, you know? [666-674]

In this excerpt we get a sense of the journey of understanding that trainee nurses go on. The opening position being 'they agreed with that the use of restraint is just barbaric and you shouldn't restrain somebody'. Barbaric is a very vivid word, 'relating to, or characteristic of a group of people who are alien to another land, culture, or people and who are usually believed to be inferior: of, relating to, or characteristic of barbarians', of 'having a bizarre, primitive, or unsophisticated quality', and

finally of being ‘marked by a lack of restraint: Wild’ (Merriam-Webster, 2023). In its pure form it seems to be an outing, or othering term. That those to whom it is levelled at are primitive and unsophisticated, as having the characteristics of a barbarian or savage.

Charlie seems to feel that those practices that he and colleagues are routinely required to engage in are unfairly criticised. His monologue in undeniably impassioned and included the word assault. It is a legal term, and he appears to be saying that staff like him often face behaviour that could be classified as criminal. In the second part of the excerpt, he leans into how staff find themselves responding to such events. The sense here is that when he talks about ‘not knowing what you have done until you have done it’, he is echoing the contents of his early disclosures, revealing how violent attacks can happen suddenly and unexpectedly, resulting in the individual staff member being thrown into an incident without a plan and with no time to think. In these moments Charlie reported how his body can seem to react independently of his mind [NB. All participants spoke of finding themselves suddenly thrown into such events]. Charlie goes on to make much of the consequence of what he appears to perceive as ill-founded judgements, ‘there are too many people getting suspended, losing their jobs, losing their pins. You know, being unable to provide for their families’ and ‘you know, there's many of my friends that are and still suspended’. The sense of outrage is palpable. He points to the level of scrutiny, ‘The last hospital I worked in is quite big news in the learning disability world. I think it has been described as the biggest safeguarding investigation in Europe’. The point he seems to be making here is that the entire staff cohort are damned by the actions of a minority, those who ‘fight with patients’.

What he then focuses on is the messy spectacle of restraint, and how these can be conflated with unjustifiable actions. He states, ‘I know some of my restraints were very much not textbook’, before going on to describe an incident where a patient was ‘trying to kick me and bite me and punch me and

head butt me and everything. And I plonked him down on the edge of the seat, and the next thing he fell over the edge, the back of it, you know'. Something that was unplanned and unexpected. Charlie seems to be saying if you had walked alongside me, in the same space, and worked with the same patients you would know the reality of restraint in all its chaotic unpredictability and uncertainty, and you would not then be so quick to judge so harshly. At a distance it is possible for a commentator to say, 'well I would have done this' or 'you should have done that' but they were not 'hands on' and did not have to make split second decisions. Charlie spoke candidly to the developing nature of the physicality, 'because you do things you don't know you're doing until you've done them.' The sense from Charlie it that as a response becomes physical, what happens next is both unknown and unknowable in that moment. It reveals itself as it happens. It is a synthesis of action driven by the conscious and the unconscious mind, the product of instinct and muscle memory and of urgent adaptation, in short, the work of a careful and resilient (Foster *et al*., 2023) bricoleur (Strauss, 1962).

Appendix 45: Setting Two, Case Study: John

Introducing John

John described his role as a trainee nurse associate. In stating he is a 'trainee', who is 'training', and who hopes to 'progress' with 'qualification' on the horizon, John seems to be revealing something about himself as the unfinished article, with both the potential and willingness to develop. Having worked in the service for some time, he could just as easily have said, 'I've been here X years, and know the ropes', but as the rest of the analysis bears out, he recognises that he is constantly growing and changing. John describes his work setting as 'intense', which says much about his experiences before even discussing them.

I identified Six PET in John's account:

1. Entering a Rigid World
2. Going with the Flow
3. Navigating the Complexity and Mess
4. I Bring Myself and My Edge
5. It's Us Vs Them for Moments
6. Its Them and Us or We Have Nothing in This Rigid World.

These were built on 34 'Experiential Statements', underpinned by 179 'Exploratory Notes' [Fig 45.1].

Entering a rigid world
• It's a very restricted world. • We live and exist within these restrictions
Going with the flow
• My job and my role or purpose • You take the rough with the smooth • The rewards are big personal and fundamental
Navigating the complexity and mess
• There more to challenging behaviours than violence. • The art of relating and connecting is unique & tenuous. • We come together in times of crisis most of the time. • I feel vulnerable too. • The physicality required messy and ordered. • A typical non typical event
I bring myself and my edge
• It is an emotional roller coaster but... • Sometimes things can be resolved but not this time. • On the edge
It's us vs them for moments
• I am a boxer but • First things first defend yourself. • Defending can be covering up or moving away. • What I would tell others coming into this world
Its them and us or we have nothing in this rigid world
• Looking back to look forwards. • Making sense of my decisions and actions • Picking up the pieces where I left off. • We are all in this world together - united we stand

Fig 45.1: John's 'Personal Experiential Themes'.

Entering A Rigid World

John's description of the service spoke to tight control, where a succession of events directed by staff, took place in a prescribed sequence at mandated times. Patients are offered opportunities to participate in a range of activities, over which they had varying levels of control. It is worth noting that very early in John's account he refers to a depleted work force [caused by covid], where the required 'thirteen' is currently 'nine'. He suggests this is 'significant' because it has a direct impact on what he and the other staff can do. John continues, 'So, then we'd unlock'. This is a very simple practice, but emblematic of the power vested in staff. When exploring practices within the Lincoln and Hanwell Asylums in the 1830's Topp (2018) found that the forcible confinement was a routine practice which campaigners argued blurred the boundaries between a prison and an asylum, between a place designed principally to care and a place designed solely to punish. 150 years later the practice of door locking on acute psychiatric admission wards continues, 'because of legislation', 'to prevent patients from escaping', 'to provide patients and others with safety and security' as well as 'staff's need of control' (Nijman *et al.*, 2011). In John's account, the locking and unlocking seemed entirely procedural and not punitive, but it remains the titration of someone's freedom, which John seems sensitised to. Some patients remained locked up, 'If the staff aren't there, then we can't open them. It's sort of like an injustice really' [30-31]. The real-world implications of the depleted workforce are thus revealed, which clearly troubled him, but at the same time he is unavoidably complicit.

I have not worked in a forensic environment. I have had occasion to spent brief periods of time within such spaces as part of my job role, but here I am a transient visitor, with no direct responsibility for patients. Indeed, on such visits I do not even interact with them. What I have come away with is a sense of security and an awareness of risk. It feels to me that it could be an environment that easily provokes anxiety or fear. I have worked in different environments that provoke such feelings, where

violence is anticipated. John did not appear to visibly carry the weight of concern. He did not appear in any way anxious, so seems to have found a way of working that keeps any such feelings in abeyance. He then revealed that the enforced lockdown limited his work to 'assess' the patients, to work with them, and to 'move them on to other wards'. This speaks to specific operational goals being thwarted, as the patient's progression and recovery are held on pause. John's comment makes me realise his working goal involves reaching out, through any potential risks, to connect to care. To my mind this speaks to the power of the caring impulse. At the same time my sense is that care cannot be guaranteed. It is not an amazon parcel to be delivered within a set timeframe. It seems much more indeterminate than that. It left me to conclude that the provision of care and support can be thought of as a collection of moments of opportunity that are taken, missed, or squandered, and that these are important, as the 'what might have been' does not come into existence.

Going With the Flow

Continuous professional development is a registration requirement of the NMC (NMC, 2018), and John's declaration that he seeks to professionally qualify, implies his commitment to this. But John is simultaneously changing in his personal life, as is later revealed, when he disclosed that he boxes. Interestingly we will see that he brings personal developments in that space into work, which will also be explored in a later theme.

John stated, 'We're there to gauge, because they're an unknown quantity really when they come in'. This indicates that what might happen next is unknown, which is resonant with the indeterminate nature of the care that I had earlier discerned. Whilst this may hold true universally, in a secure setting the acuity of illness, and historical propensity for concerning and harmful behaviours speaks to a very particular type of potential future, wherein practitioners must be ready to respond. I chose the word

respond here deliberately, over the word ‘react’. Less conscious thought seems to go into a reaction, whilst a response seems more measured. Ultimately John’s account of his experiences shows evidence of both. He describes ‘trying’ to facilitate things for the patient, despite the depleted staffing levels. One might conclude that whilst he tries, he often fails. His ambitions for that unknown future are not realised. Interestingly he then marks out the parameters of his practice: ‘maintain[ing] a safe environment’, ‘providing meaningful activities’ and ‘trying to build therapeutic relationships’. He is ‘maintaining’, ‘providing’ and ‘trying’. This feels different from the ‘unlock[ing]’, ‘get[ting] medication out’, ‘sort[ing] breakfast and ‘open[ing] the communal areas’ that he mentioned earlier. These feel perfunctory in and of themselves, whilst he is indicating increased mental engagement on his part. The comment relating to patients ‘they're quite new to the Anytown Forensic Service, so they're just learning the ropes really’, can be understood in different ways. That they are having to familiarise and conform to the procedures, is one reading. That they are getting to know the staff, and the possibilities available to them through them is another. Whilst the rules and regulations do pose limits on what can be done, it seems like some of what can be achieved in part may be determined by the approach of individual staff. John is then asked about how he invests his time with a patient:

> Well, it's hard at first. There are challenges. Because it obviously it depends on what they’re faced with in the morning. One day they might be in a good mood and engage with you. But another day they've might have had a rough night or might something from the day before is on their mind. It's just about overcoming them. For me, I perceive that if you are straight with them all the time, and you ride the rough with the smooth. If they need a hand, you reach out, and you try to encourage them to speak openly to you. I think that builds the foundations, because a lot of the patients that we have, they've come from other medium secure units, where they're being isolated for months like up to a year really. Because they can't be managed there or perceived not to be managed there. And then they come to us and we're

having to build up that interaction socially as well. So, it's a big challenge for them, but that just really gets the foundations going for recovery [51-60]

He describes things being 'hard at first'. But the use of the words 'at first' seems to suggest that things change, and get easier. He states, 'it depends on what they're faced with in the morning', suggesting that what happens next all depends. Interestingly he uses the word 'faced' rather than 'confronted' or 'presented' with. The word 'confronted' might suggest an attribution of hostility, whilst 'presented' seems more clinical and detached. He also used the word 'faced' a number of times. The word 'faced' has a personal quality and suggests a recognition of the patient's human-ness. The acknowledgement of shared humanity can open shared moments of possibility. John speaks of his own policy of honesty, his perception of the need to be 'straight with them all the time', and its value within the context of overcoming challenges. Deceit can be a stratagem employed to gain a situational advantage [or to perpetuate denial] and can be used tactically to defuse or distract someone in that moment. This would not be synonymous with building trust and creating a relationship that can be used to greater therapeutic advantage. The next comment is the most interesting to me, 'you ride the rough with the smooth'. This seems to suggest something about the inevitability of success as much as of failure, of recognition and of rejection, and very specifically to that failure, or rejection being embodied in hostility and harmful behaviours. John used a related form of wording on several occasions, 'It's not all smooth sailing and happy times' [135-136], 'You just take day by day and you just let it slide over your head' [635-636], and 'I just take it with a pinch of salt and move on' [675]. On reflection this to me seems to speak simultaneously to his desire to take opportunities to care as and when they arise, as well as to the need to adapt to the demands of situations and the opportunities that present within them.

Elsewhere John states, ‘I'd probably just emphasize on the point, that when you are faced with hostility, or if someone's coming to attack or anything, it's just ‘defend yourself’ as much as possible for the first bit’ [756-757] The use of the word ‘faced’ again reinforces that notion of proximity, intimacy, and vulnerability. The reference to having to ‘defend yourself’ will be explored further in a later theme. What his answers and reflections do not fully reveal is the extent to which he is emotionally impacted by the ebb and flow of events. This is picked up in other themes along the way. What is very clear though is his sense of accomplishment, ‘I'd say quite proud to be fair. Proud of the whole team’ [172], and ‘Yeah, it's quite empowering’ [156-157]

That John feels ‘proud’, and that the work is ‘empowering’ are potent rewards for all the work put in. Work revealed to be demanding, difficult and dangerous. The remark about the pride extending to the whole team suggests that John sees himself as part of a larger whole. This theme has been about the state of uncertainty that John enters willingly in his role. It gives a sense of the unpredictable environment within which he engages with patients. This being something that he deliberately often faced alone, whilst at other times with others. His ability to persist, absorb, adapt, and overcome seems inherent in this. That such unwanted and potentially damaging outcomes are to a certain extent inevitable, suggests that resilience (Foster *et al*., 2023; APA, 2018) is required to move forwards through these challenges on one’s own or as part of a team.

Navigating The Complexity and Mess

What becomes clear to me when John speaks of his experiences of responding to behaviours of concern is the sheer breadth and diversity of these behaviours. He spoke to a much broader range of behaviours than I had expected. These included ‘subverting security’ and ‘trading’, both expressly prohibited activities. The former, a behaviour that could be a precursor to subsequent violence,

including ‘Someone trying to take cutlery to their room, like a knife or a fork’ [349]. Trading involves patients exchanging, lending, loaning, borrowing, or gifting personal property, money, or services, which has been found to be associated with disputes, illicit behaviour, and exploitation in secure settings (Cleall & Smith, 2023), which again seem likely to precede overt eruptions of verbal or physical hostility. John also identifies being ‘elated’, ‘giddy’ and ‘overexcitable’, as well as dipping into a ‘low mood’ as behaviours of concern. These seem like shifts in internal states of being, rather than overt or fully physically expressed behaviours. That John has already spoken of his role in ‘assessing’ and ‘gauging’ patients leads me to sense a connectedness with patients, which raises his awareness of any minor deviations from their baseline, such as dips and surges in mood. That is not to suggest that he sees everything or can always work proactively to prevent escalation. Indeed, he speaks at some length about an incident in which he was attacked, and in effect did not see the ‘superman punch’ coming [more later]. Rather, my reading says something about how he attends to patients in general and the closeness with which he observes them, to glean something in some way about their disposition:

> A lot of it time it can be gut feeling. You can see the escalation. You might have given some advice already, and they might not have taken it. Then you are sort of thinking, that as a team, if there's anymore, if it continues, then there's got to be an intervention put in place. Or sometimes it can just be so unpredictable, like someone could just be talking to you, being fine. Then next minute they hit you or attack you or attack someone else. Uh. So yeah, it can go up pretty quick. Sometimes it can be a point where you think it's going to just explode, but then it just trickles back down. Either due to staff interventions in the form of de-escalation, or just down to the fact that the patients handled it themself and coped with it in a way [356-368]

John speaks of orientating through a ‘gut feeling’, of the sense that an intervention may be required and necessitating the co-ordinated efforts of a team. He speaks in general terms of the rapid transformation from ‘being fine’, to the launch of an attack. There is a moment when, whilst force might be legally justifiable, it might not be the *right* thing to do. John points out, the patient can be at a ‘point where you think it's going to just explode’ before defying expectation and the escalated individual ‘just trickles back down’. That he includes this possibility seems to suggest that he has waited such situations out and recognises this possibility. This has resonance with the earlier reference to the unknown future are not realised. To me it also speaks to the rise and fall of anxiety, and the need to continue to hold it in abeyance.

As has been stated one of his three primary goals was the development of a therapeutic relationship. Usefully, when he was asked, John was quickly able to proffer his own definition, ‘My own definition would be, ‘A relationship between a staff member and a patient, which is formed to have positive care outcomes’. That's what I would probably put it as’ [214-215]. The development of such a relationship was something that he elaborated on at length. During which he spoke of finding ‘common ground’, and of this providing an opportunity for a dialogue to develop. He indicated that this led to minor disclosures from patients that could have major implications for progress, ‘They might come to you if they're feeling low, they might open up to you’, which then generates a degree of trust. John builds on this, ‘it works in both ways, really. Because if you as a staff member, if you're not trusting of that patient then how are they gonna be trusting of you?’. What was established was that John has a way of working which brings him close to a patient, and of being prepared to be relatively vulnerable, whilst riding the ‘rough with the smooth’. John indicated that relationships are very hard to acquire and simultaneously very fragile. He spoke to being pushed away, by an individual who likely had a traumatic early life, ‘there’s been some instances where a patient’s just gone completely off and came to assault me’. Johns next step in unpacking this experience was not to immediately describe the

legitimacy or effectiveness of a physical response, rather it is to reflect and ask if things could have been handled differently, 'You try and look back at it and think is there anything that I should have done? or is there anything it's down to?'. My reading here is that this relates to the interactions immediately preceding the rejection, and the attempts to explore how he might attenuate any future distress rather than look back on any restraint or safety-based actions. John talks about the need to try to persevere. Defined as 'continued effort to do or achieve something despite difficulties, failure, or opposition' (Merriam-Webster, 2024b) it seems to be conceptually related to resilience (APA, 2018). Once again, my sense here is that that Johns willing exposure to the possibility of rejection, and attack along with his preparedness to press on despite it, meant that he too would have a recovery of sorts to make [more later].

As previously stated, a situation is complex when one cannot predict with certainty the result of any actions, there is no direct cause and effect, and the same actions may produce a different result each time (NHSE, 2023). It is further posited that complexity is characterised by unpredictability and interconnectivity, with the required flexibility and adaptation required being underpinned by relationships. It suggests that staff need to be able to work with constant change and emergence. John's earlier statements which speak to change and growth, and subsequent examples of the difficult and dynamic events that he has dealt with, seem to indicate that he possesses a willingness and ability to work and learn within complex events taking place within an extra-ordinary environment. One emergence from such interactions would be that of the relationship, that can be strengthened or damaged, and another would be that of John, strengthened or damaged, physically, or psychologically. An example of one such experience is revealed in the following excerpts:

> At this point I didn't need to press my Personal alarm because there was no reason. Because that might have heightened him and caused him to feel like [pause] [399-401]

> The staff nurse spoke to him and agreed that he was going seclusion, which the patient was happy to do, so [402-403]
>
> Then the patient just got up, he walked out of the day room, and started to walk down the corridor, so I followed. For some unknown reason, no staff members followed me.' [405-406]
>
> This patient walked to a door, which was our laundry door. He started kicking it with the back of his foot whilst facing me. So, at this point, we needed to put hands on. Because it's obviously escalated to a point where we need some physical intervention [407-409]
>
> And then the patient leapt off the door and just Superman punched me. And then me and the patient were tussling, I was trying to hold him to stop him hitting me because he continued to try and punch me [412-414]
>
> When staff members responded it was all fine. It was contained. The patient had begun to calm down then I was taken off [417-418]

This was the incident which came to mind when I asked John to reflect upon one that stayed with him. It may have been because he was injured and required to take time off work, 'which I think I was off for over a week because I injured my shoulder. Which I'm still having repercussions from now' [656-657]. I also suspect that it had repercussions because it left so many questions unanswered, 'You try and look back at it and think is there anything that I should have done? or is there anything it's down to?' This will be looked at in more detail in a later theme. The event itself did not and does not seem to make sense to John. A polite request to go to seclusion which seemed odd, given it is typically reserved as a place of regulation for the overtly distressed. John does not alert colleagues at this point as he is concerned with the impact of doing so 'Because that might have heightened him and caused him to feel like [pause]'. Quite what it might have made the patient feel was left unsaid. Perhaps

because in his mind he is now associating with other aspects of the event, because he does not have the exact word, or because the interviewer should be able to guess. My sense is a mixture of the first two. Then the patient starts to direct force at a door. This constitutes a rule infraction. Is this to justify his requested seclusion? Or as a release of pent-up emotions? John follows the patient, apparently aware that, for some reason, he has not been followed by alert colleagues. Then, suddenly there is a powerful attack. Fig. 45.2 shows the technique that John describes, drawing on the technical language used in the combat sports space. You will see that is a punch that is optimised by a combination of forward and downward motion as well as body weight. In John's case, the door further provided a launch platform.

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Fig 45.2: A 'superman' punch

When the patient started kicking the door John says. 'I don't really know how I felt at that moment. I don't know if I felt alright, because I had a bit of a safe distance' [466-467]. John is unable to name his feelings, perhaps because what he encountered was unclear, or perhaps he is unable to relocate them. He's not even sure whether he felt 'alright', which is taken to mean safe, because he then talks about distance. But he stays and perseveres. That he is apparently on his own perhaps adds to his un-nameable feelings. The lack of staff was probed, and John describes the staff who were filling in, 'These staff members that were here were like out of the Education Department, so they weren't used to

this' [479-480]. This comment suggests that the staff covering [due to covid] were in an environment that they were unfamiliar with, that responding to behaviours of concern was perhaps not something they routinely did. Perhaps their PMVA training provided their only insight into such events. The application of that training, and the physical response to the attack was then probed:

> You, just you have to grab what you can really. Obviously, there's no striking. So, I wouldn't strike back or anything like that. It would be more of, like a wrestle. That's how I'd describe it. It'd be you're trying to disarm them in a sense, where I'd try and get my arms around him. When you're that close to someone, you can try and [pause] If you close to someone then they can't really strike you can they. The only risk you've got is biting or anything like choking. So, I'd grab his arm, and I think I had my hand over his head, [John demonstrates a hooking/clinching type hand placement], because wherever the head goes, the body goes. Really. Yeah. So, trying to like, navigate his body, to which he would just struggling and trying to still attack me. To a point where we both went down on the floor. As I went down, I managed to get on top. Not on top of the patient, he was laid on his stomach, in a prone position. I was still in control of the head, so I had 'effective head management' at that point. Then staff came and jumped on and grabbed his arms and his legs and put them in an appropriate restraint [495-505]

This passage reveals how messy and dynamic events can be. The word 'managed' seems inappropriate, being somewhat technical and detached, perhaps navigated or negotiated is more apt. The passage also reveals a huge amount of activity taking place in a very short space of time, with John adapting to the patient's resistance. To me this is another example of the bricolage (Levi-Strauss, 1962) which has been discerned within other participants accounts. Here John only skims the surface of what happens. I suspect he cannot recall all the intricate individual actions and reactions in detail, or in

order. After the event his mind simply forgets all his body had done. In the moment they appear to have been working as one, but on a sub-conscious or instinctive rather than conscious level. Irrespective of how responses are formed, John indicates that staff need to work within anxiety, 'I think at first, especially when I first started here, there was a fair bit of anxiety surrounding it because it's something people don't really get faced with isn't it?' [230-231]. Here John acknowledges that such encounters in forensic settings are outside of the social norm, 'It does heighten you in a sense anyway, because you've got to start to think quite proactively quite quickly' [234-234]. It seems that time and exposure to the day-to-day, anxiety provoking work gives John what he calls his 'edge'. Earlier reference was made to John functioning at a sub-conscious or instinctive level, his 'edge' then is something that can be thought of as facilitating his responses. It appears to be a mental state that permits him to dwell within chaotic and disconcerting situations and not to be derailed by the inevitable emotional shifts. This can be seen as a form of fortitude, or perhaps resilient tenacity that allowed him to remain true to his core caring tasks. Tellingly he then states, 'Obviously, we're under a lot of scrutiny' [271]. To me, irrespective of the fact that he is required to rapidly make sense of difficult and dangerous situations he knows he will be judged. I am left to wonder how those who judge arrive at readings and draw conclusions when they are unlikely to have inhabited the moments in question as the unique individual under scrutiny has. This is perhaps another experience that required exploration.

It's Us Vs Them for Moments

It was when probing John for his reflections on his experiences of responding to patients in difficult circumstances that his role as a boxer was revealed. It was not something that was scheduled to be discussed or known about prior to the interview. Something in his answers, turns of phrase such as the 'superman punch' and how he described holding onto a patient spoke to an ease with physicality.

There was a sense that his mind and body were 'as one', rather than needing to be integrated rapidly 'in the moment'. It spoke of confidence and ease. I asked him if he did any training outside of work, and he disclosed that he boxed. I wondered about the extent to which being a boxer was intrinsic to the sense of who John was in moments of crisis. I asked whether his boxing physicality came with him into the workplace:

> INTERVIEWER: Just on this boxing stuff that you do. Do you think that type of stuff is useful?
>
> JOHN: I'd say, yeah, definitely. In defending yourself. Obviously, that point, I didn't defend myself, because no way did I ever expect him to launch off of the door like he did. It was quite magnificent, to be fair. And I give credit for it [laughs]. But yeah, it I feel it gives you a sense of calmness more [528-534]

His answer reveals a tension, in that boxing is useful 'yeah, definitely. In defending yourself', but that John then says, 'I didn't defend myself.' Boxing and defence are becoming conflated. The notion of 'defence' and of 'defending' oneself is not necessarily universally understood. To unpack this, one must first consider what boxing may mean to the lay person [Fig.45.3].

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Rocky Balboa vs Ivan Drago in Rocky IV [source]

Muhammed Ali defeats Sonny Liston [source]

Fig 45.3: Representation of boxing.

Boxing conjures up images of two fighters, usually men, punching each other. We perhaps associate it with inevitable pain and injury, cauliflower ears and broken noses, brain injuries and tragic deaths in the ring which make news headlines. And all for what? So that one can lay claim to being the victor, having defeated their opponent. So great is the potential for harm that the British Medical Association have called for it to be banned as a sport (White, 2007). Surely then John's fighting instinct would have been to lash out to defend himself from the attack:

> Yeah, yeah, yeah, yeah. For me though, ever since being here, I've never had an instinct like that. I've always had a sense of feeling like I'm in control, and of analysing everything. Because obviously when you're boxing, it's about discipline. I can read situations, so rather than see him [pause]. In the boxing ring it would be my opponent, but here it would be if a patient was coming to attack me. I'd see what they'd [pause], you know, [pause] I mean, I can try and read it better to try and defend myself and then react to in an appropriate way [535-544]

John's answer involves making a distinction between the boxing ring and the workplace, and how there is a difference between an opponent and a patient. He states emphatically that he has never had 'an instinct like that', 'in here' seems to be intimated but unsaid. He then talks about a feeling of being 'in control', again 'of myself' seems to go unspoken. He talks of 'analysing' and being able to 'read situations', 'so rather than see him' 'as an opponent' is what I think he is thinking but not saying. Finally, he concludes by saying 'I'd see what they'd [pause], you know [pause] I mean, I can try and read it better to try and defend myself and then react to in an appropriate way'. What seems to fit in those pauses is 'do or say' and 'and work out whether I needed to do something'. It appears that he is thinking whilst he is speaking and struggling in small part to articulate something he does instinctively but has never been required to put in words. This is where an approach like IPA allows

researchers to get to aspects of experience that are routinely unprocessed and unexplored (Smith *et al.*, 2009). To return to the more superficial impression lay people have of boxing:

> A lot of people do associate it with aggression and intimidation tactics like martial arts or boxing. But I find it completely different. I find it more disciplined. For the people who wouldn't do anything, compared to the ones who don't do boxing. Out on the streets and stuff. They just want to fight all the time don't they [561-564]

John seems to be making two key distinctions, and in so doing making two claims about himself. In the first instance he is distinguishing between those drawn to violence of boxing, rather than to its inherent craft. These are the individuals who 'just want to fight all the time', and for whom punching others out of the ring confers some sort of status or standing, as a 'tough guy' or 'hard man' [they are often men], and as a result can engender fear in others (Woodward, 2007). This is not why John states he is attracted to boxing. The second distinction is between the less commonly regarded interior of boxing and its unmistakable and prolifically marketed exterior. John speaks of the 'discipline' he finds [something he mentioned twice] and previously spoke of it enabling him to feel 'in control'.

Practitioners of combat sports are said to find and improve themselves through their journey towards mastery. Jump and Smithson (2020) have written on the transformative power of boxing within the context of desistance. Within particular social spaces, where masculinity is as an accomplishment held in place by a discourse valorising physical prowess, dangerousness and tough unemotionality, boxing and other combat sports can exert influence. Used skilfully boxing can assist in the reimagining and restructuring cognitions to motivate individuals to become active and responsible agents in their own reformation process (ibid, 2020). The sense I have here is that John was not a young man needing

reformation. Rather a combination of him surmounting the physical challenges appears to have given him the opportunity to develop self-discipline and confidence, and that the code that boxers tacitly sign up to when joining a club imbue him with a sense of morality. As someone who has spent years in such training environs, and who has experienced the cultures and codes that define them first hand, I feel a proximity to John's account of his training. I am also aware of the criticism levelled at boxing and martials arts. It would be fair to say my immersion has meant that it registers in a way it does not with those who have never trained or find forceful physicality a repugnant or dangerous endeavour. My sense is that this aversion to force is in play within some sections of the anti-restraint commentariat. I do not offer this as a fact, merely a personal opinion.

John speaks effusively of the training, that 'its massively on de-escalation. Lots of theory, but that's the best form of response; de-escalation. Its verbal isn't it?'. At face value this seems to run counter to the preceding sentiment 'if someone's coming to attack or anything, it's just defend yourself as much as possible for the first bit. They do teach it. But I'd just emphasise it even further'. The word 'defence' is used' again, and it feels as if John is associating it wholly with physicality, although were one to look upon 'defence' as a state of mind it would include more than just physicality. His addition of the phrase 'as much as possible' drew me back towards physicality and was understood by me to speak to the amount of force used. In saying 'as much as possible' it seems unconstrained, and so potentially dangerous. One might have expected talk of proportionality to the threat being faced, or reference to a reasonable amount of force. He was asked to expand:

> So, say if someone was coming to attack me. Depending on the situation, whether I was on my own or if there was a colleague with me. If they were coming to me and they was 'at me'. The first thing I would do was defend myself, by covering up or trying to move out of the way. Then the next thing I do, you sort of do it instantly really, is you try and respond to it in a way

> where it might be required to be taken to the floor. So, you might have to take the patient to the floor. There's no technique in that sense. Its [pause] You can't run [and] rugby tackle someone, obviously because that's just bizarre! [laughs] You got to try to manage that first. But here, we're quite [pause] as you've heard the alarm going off. You would have already activated your Personal alarm, and there should be some staff present. So, you're not dealing with it on your own [594-303]

Very early on the nature of defence will be 'Depending on the situation'. This suggests different possibilities for dealing with the 'unknown future'. John then talks about a situation, where someone was coming 'at me', that 'The first thing I would do was defend myself, by covering up or trying to move out of the way'. This echoes a reflection made by Nelson Mandela in his autobiography, 'I did not enjoy the violence of boxing so much as the science of it. I was intrigued by how one moved one's body to protect oneself' (Mandela, 1995 p.110). John continues, 'you try and respond to it in a way where it might be required to be taken to the floor'. So, first he explores how to get 'out' of danger, then he reverses and talks of stepping 'in' and preparing to go to the floor. In this situation John is on his own, and so a planned team intervention is not likely to be what he has in mind. Here he states, 'There's no technique in that sense. Its [pause] You can't run [and] rugby tackle someone, obviously because that's just bizarre!', whilst elsewhere he says, 'Obviously there's no striking. So, I wouldn't strike back or anything like that. It would be more of, like a wrestle. That's how I'd describe it' [496-497]. He seemed to be describing a seizing hold, where the person's upper limbs are contained. This seems akin to the clinch which gives the boxer a moment to catch their breath and take stock. Sometimes it can be used to reposition the person and to simultaneously limit their ability to strike. From John's description it seems to have been used proactively, to limit any strikes that came. Paradoxically it is serving a defensive function but did not involve John using the most potent of boxing tools, strikes.

When John was in forceful opposition to the patient, he was defending himself but not engaging in what is traditionally meant by the term 'self-defence', exemplified in the 'Bash and Dash' approach promoted by the Suzy Lamplugh Trust as a personal safety strategy (Judd, 1997). He was not counter striking, seeking to nullify the will of the person [patient] to continue in their course of action. Rather, he seems to be describing how he was simultaneously up against the 'other', physically in opposition to them and using force against them, to move forward to a place of non-violence or non-restraint. This PET was titled 'It's Us Vs Them for Moments'. My intention was to acknowledge that in moments when force is used there is opposition, where one person is expected to dominate or win out, but that this triumph or success [as it may be characterised] does not constitute a new state of power-over (Pansardi, 2012) that is expected to be maintained. John does not appear to see patients as any less human than him. The sense is that he is facing something he needs to move through to get to a different place with new possibilities.

Its Them and Us or We Have Nothing in This Rigid World

In the previous PET, the fleeting 'Them versus Us', seemed to yield to a greater and more enduring 'Them and Us'. This however is not easy for others to grasp and emulate, especially new staff. Before looking at the advice John offered such staff, its useful to pause and reflect on how those staff who were temporarily covering during covid, failed to support John. What might seem straightforward, or even logical, is not always so when one finds oneself within this *other* world of security and restriction, where danger and risk may be perceived within every patient. Flight [or avoidance] is an entirely understandable strategy, but such a natural and normal urge to withdraw might be seen as unhelpful or even a dereliction of duty in such a complex and risky environment. He then suddenly pivots, 'A big thing, that just came to mind', before talking about talking things through afterwards, of 'reflections'. He then adds a very precise addendum, 'That's the only way that you're going to improve

and get better.' Talking things through may improve how you assess situations, manage emotions, make decisions, utilise relationships, and work in a way that maintains trust, all of which have been issues that John has spoken of.

He then went on to speak of the cost of working in such a difficult and challenging environment, and here speaks of the need to talk to colleagues to head off burnout. He also talks to colleagues to make sense of events. He starts by referring to those unseen, sometimes cumulative impacts that can have an adverse effect on staff, 'You don't know what might tips someone over the edge. We just need to look out for each other' [781]. He seems to be drawing attention to the fact that the ability to make sense of what is happening, and to make good decisions is degraded by a combination of the place and all its security measures, its covid-depleted workforce, and working with people who can frighten or provoke over forceful reactions. When talking about reflections on the use of restraint he says, 'it's not normal', which speaks volumes. John seems cognisant of the how patients can suffer when staff find their humanity depleted. Bennett and Hanna (2021) found that patients felt that staff were routinely using their authority to threaten them and institute a regime of control. It seems like John is issuing a warning of sorts, suggesting that if we are not careful and do not speak to each other, we can become changed people. He points to not 'using your de-escalation effectively', to 'overreacting' and to turning to 'restraint' when it is not necessary. He captures the implications of this happening by using a strangely twee turn of phrase, 'it's obviously not going to be nice for the patients'. When something is 'nice' it is pleasing or agreeable (Merriam-Webster, 2024b). Time spent in a forensic setting, against ones will, with one's autonomy curtailed is unlikely to enjoyable. It is more likely to be endured. A trusting relationship where there has never been one, having a person who does not reduce patients to an index offence, or who stays with you through a crisis might be construed as welcome new feature of life, and perhaps give rise to positive feelings. In his statement, it is possible that John is alluding to the loss of what might fail to come into being when staff do not look after

themselves. That talking things through is part of his experience seems clear. Talking things through, appears to have allowed John to take onboard different perspectives. It is conceivable that he also gets an opportunity to think and feel, as well as see and know differently by dwelling within someone else's perspective. He talks of discussions as helping to 'air out anything' and providing the chance for others to explain their actions. John indicates he feels able to say to others, ''you put me in an element of risk there when it wasn't needed, or that wasn't required''. This was not said angrily and did not give the impression that any processing event became a forum for airing grievances. He immediately says, 'Then you get their side of it, and you sort of come to some sort of conclusion or resolution. When you are in a risky situation, it can sort of open your eyes sometimes'. It is perhaps more accurate to say John displays curiosity: what happened? Why did you do that? Could I, or should I see things differently? One finds oneself returning to one of the very first readings of John, where John seemed to see himself as the unfinished article, with the potential and willingness to open himself up to opportunities for development. This feels like it speaks very directly to John's way of being, and of knowing. Earlier John spoke about the restraint he was involved in, where he ended up getting injured, and taking time off. What came to pass seemed to trouble him. What is telling is that he is looking at what he did or did not do or could have done differently. He is not blaming the patient, 'In that moment I thought like I did everything definitely the best of my ability. I had good feedback from the team as well, So yeah'. He thought he did things right but seems to value feedback from his trusted colleagues. He says he does not really think about it anymore, although earlier had indicated that the shoulder injury still troubled him. It is possible to conclude from this that perhaps he does not think about it in the same way, or to the same extent anymore, but that the event still surfaces periodically. Immediately after the incident he clearly dwelt deeply on it, 'Is there anything that I should have done differently?' and 'Why did it happen to me?'. Especially when it's the first time being assaulted. It's not a normal thing to be assaulted, is it?' [663-664]

Again, he refers to the abnormality of his normality. That he can see and know this seems to indicate that we have at least two John's; John at work, and John outside of work. We know from the foregoing that John's work followed him home and consumed his mind whilst he recovered. So, perhaps it is more accurate to make the distinction between John in work mode, and John in out-of-work mode. Perhaps with friends and family members he leads that normal life where risk and restrictions, attack and injury are absent. If we return briefly to his pride in his work, and the sense of accomplishment when people progressed, perhaps we can say that his goal or mission is to give people a chance at a normal life. John seems to move forward, going with the flow on occasions then working through sometimes dangerous complexity and mess. Without being paternalistic, he seems to see others as less fortunate than himself, and in need of care. The wholeness of his care, and the resilience needed to implement it seem to have been distilled in the words of Foster et al (2023 p.871):

> An attitude of win/win wherever possible, us[ing] empathy, tr[ying] to maintain a positive mindset, rational perspective, and calm demeanour, advocat[ing] on behalf of consumers and colleagues, work[ing] to resolve differences and conflicts and aimed at achieving their and others' goals wherever possible