

RESTRAINT AND SECLUSION IN A NORWEGIAN UNIVERSITY PSYCHIATRIC HOSPITAL

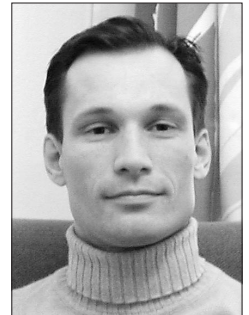
ABSTRACT

Objectives. There has recently been an increased focus on the use of coercion in psychiatric care and on the need to consider the patients' autonomy. Staff that are faced with aggressive, violent, or self-harming inpatients, must consider patient and staff safety, as well as the need to provide humane and efficient treatment. Although physical and pharmacological restraint and seclusion are used regularly in psychiatric institutions in many countries, little has been published about staff's motivation for using the interventions, and the effects they have. In the present work, the objectives were to identify the number of incidents and the characteristics of the patients involved, the staff's reasons for the use and choice of a particular type of intervention, the effects of the interventions, and possible alternatives to the use of restraint and seclusion.

Study design. Data were collected from the Psychiatric Departments of the University Hospital of Northern Norway (located in Tromsø). The dissertation comprises four studies; one study was based on hospital records of the use of restraint and seclusion during a 5 1/2-year period, two studies were based on questionnaires distributed to hospital staff, and one study was based on qualitative interviews of 12 patients that had been physically restrained.

Methods. The data retrieved from hospital records and from questionnaires were analysed statistically (including Chi-square tests, t-tests, ANOVA, stepwise multiple regression). The data collected by means of interviews were analysed qualitatively (Grounded theory).

Results. At the study hospital, physical restraint was used most often, followed by pharmacological restraint. Seclusion was



Rolf Wynn

used rarely. In approximately 1/4 of emergencies where restraint, or seclusion were used, physical restraint, or seclusion, was combined with pharmacological restraint. Patients' assaults on staff and co-patients were significant problems. Nursing staff reported being assaulted most often. Patients' violence and self-harm were the reasons most frequently given for restraining patients. The majority of staff believed that restraint and seclusion were used correctly. Despite the fact that most staff believed that restraint and seclusion made patients calmer and did not cause aggression, as many as 70% reported having been assaulted in connection with the use of the interventions. Staff did believe that restraint and seclusion could violate the patients' integrity, could harm the provider-patient alliance, and could frighten other patients. When staff that responded to case histories were given the choice between different types of interventions in emergencies, staff tended to favour the least restrictive interventions, and reserve restraint and seclusion for those emergencies where patients were actually violent and dangerous. Some patients that had been physically restrained were critical of the use of the intervention, and believed restraint could have been avoided. Other patients, and especially those that had psychotic symptoms while in restraint, were more understanding. Patients' anxiousness, anger and hostility were pervasive feelings during restraint, as was a sense of being protected against inflicting injury. There were reports of minor physical injuries and revived memories of physical abuse. Some patients were angry, fearful and distrustful of staff after having been physically restrained.

Conclusions. The findings underline the staff's need for safety, suggesting ample attention should be given to this aspect when discussing alternatives to restraint and seclusion. The studies also point to the importance of educating staff about the consequences of the use of restraint and seclusion. Continuous attention to, and evaluation of, the use of formal and informal emergency interventions represents an important means for securing improved care for violent and self-harming patients. Focusing on the less restrictive interventions as an integral part of comprehensive guidelines for crisis management, may help staff to favour these instead of restraint, when they are clinically warranted and safe.

Although it may be difficult to treat acutely ill and aggressive inpatients without having the maximum restrictive interventions available in emergencies, the potentially negative effects of the maximum restrictive interventions on patients and staff point to the importance of implementing less restrictive interventions whenever possible. The findings also underline the importance of systematically debriefing patients after the use of restraint, thus helping patients to understand why restraint was used and allowing the early identification of problems that may arise as a consequence of the use of the intervention.

Keywords: psychiatry, coercion, violence, physical restraint, pharmacological restraint, seclusion, staff's attitudes, patients' experiences, Norway

*Rolf Wynn, M.D., Ph.D.
Psychiatric Centre for Tromsø and Karlsøy
University Hospital of Northern Norway
N-9291 Tromsø
Norway
Email: rolf.wynn@unn.no*