



FEATURE ARTICLE

Secluded and restrained patients' perceptions of their treatment

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ABSTRACT: *Though some empirical and anecdotal accounts can be located in the extant literature, it remains the case that little is known about how secluded/restrained (S/R) patients perceive their overall treatment. The purpose of this study was to explore patients' perceptions of their hospital treatment measured after S/R. The data were collected with a Secluded and Restrained Patients' Perceptions of their Treatment (S/R-PPT) questionnaire from S/R patients aged 18–65 years. Ninety completed questionnaires were analysed. Patients perceived that they received enough attention from staff, and they were able to voice their opinions, but their opinions were not taken into account. Patients denied the necessity and beneficence of S/R. Women and older patients were more critical than men and younger patients regarding the use of restrictions. There were also statistically-significant differences in responses among patients at different hospitals. It is concluded that patients' opinions need more attention in treatment decisions. To achieve this, psychiatric treatment needs genuine dialogue between patients and staff, and individual care should have alternatives and no routine decisions. Therefore, the treatment culture must improve towards involving patients in treatment planning, and giving them a say when S/R is considered.*

KEY WORDS: *coercive measure, patients' perception, restraint, seclusion.*

INTRODUCTION

In many countries, seclusion and restraint (S/R) are used to 'treat' psychiatric inpatients as the last resort to ensure their safety and that of others (Adams *et al.* 2007; Hellerstein *et al.* 2007). Seclusion is the isolation of a patient in a single, closed, unfurnished room, with only a mattress

on the floor. Mechanical restraint (further referred to as restraint) is the tying of a patient to a bed with bands and belts (Sailas & Fenton 2009). The decision to use S/R often produces an ethical dilemma: whether to restrict a patient's autonomy and possibly cause emotional and/or physical trauma (Frueh *et al.* 2005), or to maintain the safety of all patients and staff (Hellerstein *et al.* 2007).

In recent decades, shared decision-making between patients and staff has been demanded by patients, and has been vividly discussed in the literature. It has been shown that shared decision-making increases patients' satisfaction with treatment (Duncan *et al.* 2010). In psychiatric care, patients' opinions should be taken into account when decisions and treatment plans are made in difficult situations with possible coercive measures (Hellerstein *et al.* 2007). Recent studies have shown that patients

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diagnosed with severe mental illness can participate in shared decision-making (Hamann *et al.* 2009). Although it has been found that legislation alone is not enough to reduce the use of S/R (Keski-Valkama *et al.* 2010), many countries have renewed their legislation with an emphasis on patients' rights and patient-centred treatment (Sjoststrand & Helgesson 2008). In Finland, the Finnish National Plan for Mental Health and Substance Abuse Work (2009) emphasizes the importance of enhancing and supporting psychiatric patients' own choices in their care, including coercive measures, the use of which has still to be reduced (Ministry of Social Affairs and Health, Finland 2009). To reduce coercion, a variety of steps have been undertaken in clinical practice (Hellerstein *et al.* 2007; Kontio *et al.* 2010; Salize & Dressing 2005). Nevertheless, despite all these data and regulations, paternalism has continued to be the dominant model of decision-making in health care (Hoyer *et al.* 2002).

Studies have been conducted to ascertain patients' opinions, preferences, or perceptions of S/R (Frueh *et al.* 2005; Kontio *et al.* 2010; Meehan *et al.* 2004). They have shown that patients' perceptions of S/R differ from staff's perceptions (Adams *et al.* 2007; Meehan *et al.* 2004). Patients might believe that S/R are used by staff to exert power and control over patients, while nurses might think that seclusion is necessary, and is rather a therapeutic intervention than punishment (Meehan *et al.* 2004). Further, nurses and physicians tend to pay too little attention to the patients' perspective (Kontio *et al.* 2010). Patients require information on why and how seclusion is implemented (Wynaden *et al.* 2002); they want to participate in making the decision on their own S/R (Vuckovich & Artinian 2005) and they emphasize the importance of respect (Jackson & Stevenson 2000), and their interpersonal relationship with staff (Hopkins *et al.* 2009). In addition, inpatients wish that nurses spend less time in the office, and instead allocate more time for therapeutic interaction and psycho-education (Brimblecombe *et al.* 2007).

A body of qualitative data on psychiatric patients' perceptions of coercive measures exists (e.g. Kontio *et al.* 2010; Meehan *et al.* 2004). However, there are only few quantitative instruments that measure patients' preferences. The MacArthur Admission Experience Interview and Survey is an instrument that assesses patients' experience of coercion, but it refers only to the hospital admission process (Gardner *et al.* 1993; Wallsten *et al.* 2006). Bergk *et al.* (2010) created the Coercion Experience Scale, an instrument that measures the impact of coercive measures on the patients' subjective experience during coercive measures, such as seclusion and mechanical

restraint (Bergk *et al.* 2010). Secluded and Restrained Patients' Perceptions of their Treatment (SR-PPT) is a new instrument developed to measure the perceptions of these patients' of their overall treatment (Noda *et al.* 2012). It is a well-known fact that patients who need S/R are especially challenging for staff, and that treatment after S/R might have either a healing or detrimental effect on the S/R experience and on further therapeutic alliances and treatment outcomes. Therefore, in this study, we focused on psychiatric patients' perceptions of their overall treatment. This information will help to assess care routines and improve the practices towards a more patient-centred treatment culture. The study formed part of a Japanese and Finnish collaborative research and development project, Sakura, focusing on S/R in psychiatric hospitals.

Our aim was to describe the perceptions of care of patients experiencing S/R during their hospital stay. In addition, we wanted to investigate which factors were associated with patients' perceptions of their care. The research questions were as follows:

1. What are the patients' perceptions of cooperation with staff?
2. What are the patients' perceptions of S/R?
3. Are there any associations of basic background variables (age, sex, duration of S/R, diagnoses, choice of S/R (seclusion, restraint, or both) or hospital) with patients' perceptions of treatment, cooperation, and perceptions of S/R?

METHODS

Setting

Three hospitals in southern Finland participated in this study. The data were collected on seven wards: three acute psychiatric wards in a city hospital (further referred to as hospital A), two forensic wards in a rural psychiatric hospital (hospital B), one ward for difficult-to-treat patients (Mantosh & Ronald 2001) at a university hospital (hospital C) between January 2009 and July 2010, and an emergency ward in hospital A during 2009. All wards were closed with 12–19 beds functioning 24 hours a day, 7 days a week. The three acute wards provided treatment after emergency care. The two closed forensic wards treated forensic psychiatric patients who were not convicted, but instead committed to involuntary hospital treatment due to a diagnosis of major mental illness. The difficult-to-treat patients were those with violent behaviour. The emergency ward was a closed ward with an affiliated acute outpatient clinic and inpatient beds. The

average duration of care ranged from 24 hours (emergency) to 150 days (forensic) versus an overall mean of 34 days duration' in Finland (National Institute for Health and Welfare 2011). The mean staff/patient ratio on these wards was approximately 1.2–1.4. There were five to six educated/registered nurses on the day shift, four nurses on the evening shift, and two nurses on the night shift on each ward. The study wards were chosen if they used S/R, and the hospitals represented a broad range of Finnish psychiatric hospitals.

Secluded patients were monitored by nursing staff who visited them every 15 min, and a physician who visited them every 8 hours or less. The need for seclusion had to be assessed at each monitoring occasion, and seclusion had to be ended as soon as possible. Mechanically-restrained patients were constantly monitored by their bedside to ensure their safety and high-quality treatment (Mental Health Act 1116/1990).

The patients' inclusion criteria were: age between 18 and 65 years, a sufficient command of the Finnish language, secluded and/or restrained during their current hospital stay, and had given written informed consent. Exclusion criteria were delirium (International Statistical Classification of Diseases and Related Health Problems-10, World Health Organization) or other serious mental conditions (e.g. intellectual deficiency) rendering the service user incapable of giving informed consent. Each S/R patient received complete information on the study in written and oral form, and gave written, informed consent within 5 days of S/R when they were able to adequately communicate with the personnel. Permission to use their SR-PPT forms and their hospital records for relevant background information was asked for separately. If the patient experienced S/R more than once, only the first questionnaire per hospital was analysed. Of the 307 patients who were S/R, 149 (48.5%) fulfilled the inclusion criteria. Altogether, 90 questionnaires were eligible for analyses. For details of the patient flow, see Figure 1.

Sample

Of the 90 questionnaires analysed, 55 (61%) were filled by men, and 35 (39%) by women. The mean age of the participants was 36 years (range: 18–63, standard deviation (SD): 11.7). The biggest age group was 25–44 years (34%). The mean age for men was 34 years, and 39 years for women. The duration of S/R varied from 75 min to 396 hours (i.e. approximately up to 16 days (mean: 3210 min, SD: 4598 min, median: 1270 min)). Detailed sample characteristics are described in Table 1.

Instrument

To explore how patients who have experienced S/R perceive their overall treatment during the hospital stay, a new original questionnaire, the SR-PPT, (Noda *et al.* 2012) was used. The instrument consists of 11 questions, three of which (items 9, 10, and 11) were derived from the Working Alliance Inventory (Horvath & Greenberg 1989), and one of which (item 1) was adopted from Kjellin *et al.* (1997). The remaining seven items were originally developed in Japan, based on previously-published literature (Noda *et al.* 2012). The instrument employed a Visual Analogue Scale; a 100 mm-long horizontal line where the left end (0 mm) meant 'strongly disagree' and the right end (100 mm) 'strongly agree' (item 2 exceptionally used a reverse order, from 0 mm, 'strongly agree' to 100 mm, 'strongly disagree'). Patients expressed their opinions on each item by marking a crossing vertical line on the horizontal line. Based on the factor analysis in the original study (Noda *et al.* 2012), the items fell into two clusters (further referred to as subscales): 'cooperation with staff' (9 items) and 'perceptions of S/R' (2 items). The SR-PPT items are listed in Table 2.

Previous experience in Japan has shown that the instrument is easy to understand and complete for patients with a diagnosis of mental illness (Noda *et al.* 2012). The internal consistency of the instrument for the two subscales was as follows: Cronbach's alpha was 0.93 in Japan and 0.89 in Finland for 'cooperation with staff', and 0.89 in Japan and 0.77 in Finland for 'perceptions of S/R'.

The Finnish version of the SR-PPT was created using an iterative process of translation and independent back-translation (Jones *et al.* 2001). The English version was translated into Finnish and back-translated into English by two of the research group members; one from English to Finnish, and another one from Finnish to English. The back-translated English version was checked by the author of the original version and by an English native speaker proficient in Japanese. In order to enhance the future practical possibilities for its use, the English version of the SR-PPT was formed.

Data analyses

First, descriptive analyses (frequency, percentage, mean, SD, and median) were performed for individual items of the SR-PPT. Second, mean scores were calculated for each of the two subscales as sum variables. Third, the items within each subscale were compared using repeated measures ANOVA. Pearson's or Spearman's correlation coefficients were used to examine the correlations between patients' age, S/R duration, and score values for the SR-PPT subscales. Further independent samples

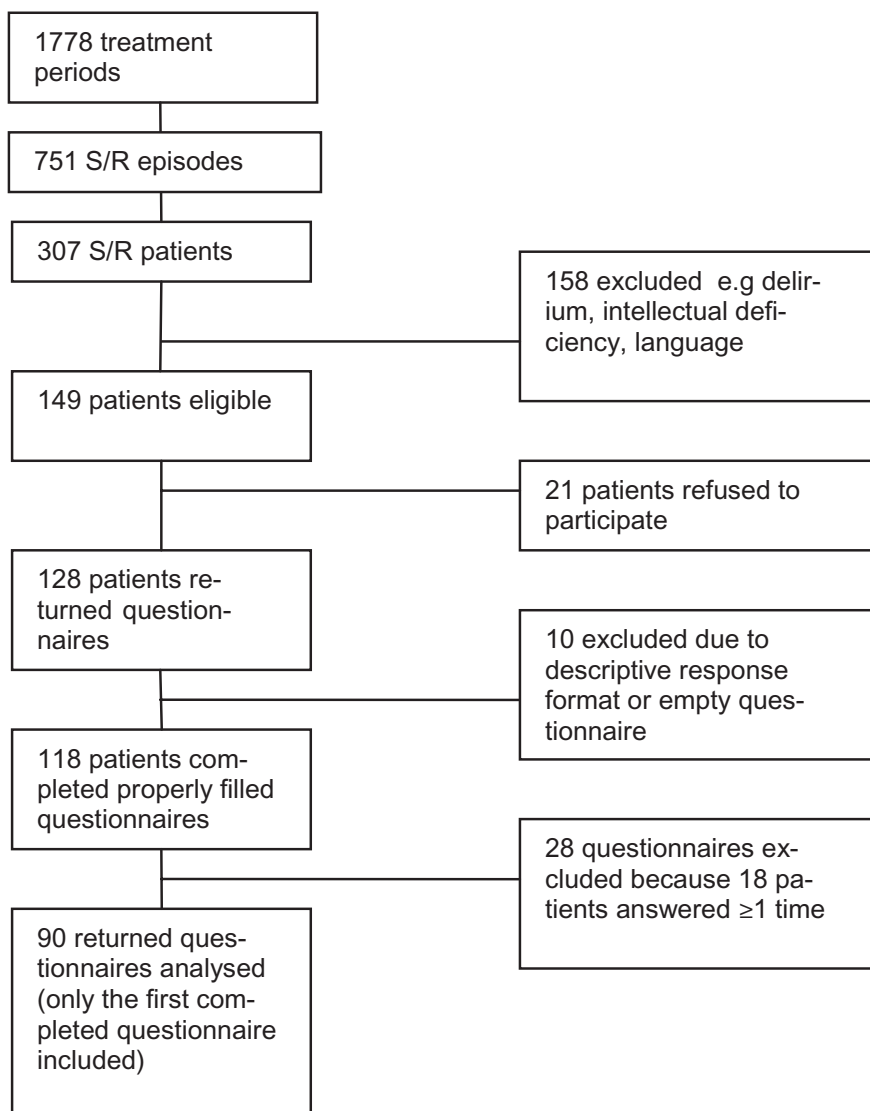


FIG. 1: Patient flowchart. S/R, seclusion and restraint.

t-test or ANOVA were used to test differences between groups and associations among patients' background variables (gender, diagnoses, and S/R) and their perceptions of treatment and two SR-PPT subscales. In the case of non-normal variables, non-parametric Wilcoxon and Kruskal–Wallis tests were used. Lastly, a post-hoc Tukey's test was used to examine pairwise differences among means. *P*-values 0.05 or less were interpreted as statistically significant. Statistical analyses were performed using Statistical Package for the Social Sciences (version 17.0; SPSS, Chicago, IL, USA) and SAS for Windows (version 9.1; SAS, Cary, NC, USA).

Ethical issues

The study was approved by the local ethics committee and by pertinent institutional authorities. After a complete

description of the study, participants gave written, informed consent. Participation was voluntary, and data were treated in confidence (Medical Research Act 488/1999). It was emphasized that participation or refusal did not affect treatment.

RESULTS

Cooperation with staff

Patients' perceptions of co-operation with staff varied grossly, ranging from zero to 100 for each item. There were statistically-significant differences between items within the subscale ($P = 0.001$). Items 2 ('Do you feel that staff members have ignored you in any way?') and 7 ('Are you being given enough time during your treatment or care?') scored highest, while items 3 ('Is your opinion taken into

account with regards to your treatment?') and 8 ('Do you feel that the staff members understand your concerns?') scored lowest (Table 2). Overall, patients' perceptions of cooperation with staff fell in the midpoint of the subscale.

TABLE 1: Sample characteristics ($n = 90$)

	<i>n</i>	%
Age (years)		
18–24	19	21
25–44	42	47
45–64	29	32
Sex		
Male	55	61
Female	35	39
Diagnosis†		
F10–19	11	12
F20–29	54	60
F30–39	18	20
F60–69	5	6
Missing‡	2	2
Seclusion and/or restraint		
Restraint	40	45
Seclusion	26	29
Both	24	26
Hospitals		
Hospital A (acute/emergency)	50	56
Hospital B (forensic)	11	12
Hospital C (difficult to- treat)	29	32

†F10–19, mental and behavioural disorders due to psychoactive substance abuse; F29–29, schizophrenia, and schizotypal and delusional disorders; F30–39, mood (affective) disorders; F60–69, disorders of adult personality or behaviour. ‡Patients filled the Patients' Perceptions of their Treatment questionnaire, but did not give consent to check their records.

TABLE 2: Patients' perceptions of their treatment

	<i>n</i>	Mean	Median	Standard deviation	<i>P</i> -value†
Cooperation with staff	87	49.00	45.11	21.45	0.001***
1. Have you been respected on the ward as a person?‡	87	47.06	50.00	28.69	
2. Do you feel that staff members have ignored you in any way?§	88	65.20	76.00	30.90	
3. Is your opinion taken into account with regards to your treatment?	87	41.03	36.00	31.45	
4. Can you voice your opinion?	87	46.43	45.00	29.35	
7. Are you being given enough time during your treatment or care?	86	55.22	59.50	28.16	
8. Do you feel that the staff members understand your concerns?	88	41.70	36.00	29.68	
9. Do you collaborate with the staff on setting goals for your treatment?¶	87	44.78	40.00	31.11	
10. Are you and staff working towards mutually-agreed upon goals?¶	86	50.34	48.00	29.68	
11. Do you and the staff agree about the things you will need to do in treatment to help improve your situation?¶	85	48.97	45.00	28.94	
Perceptions of seclusion and restraint	86	37.90	32.50	30.60	0.0029***
5. Was it necessary for you to be restrained and/or secluded?	87	33.01	17.50	33.45	
6. Was being restrained and/or secluded beneficial in treating your difficulties?	85	43.43	40.00	34.81	

***Differences between subscales 'cooperation with staff' and 'perceptions of seclusion and restraint' were statistically significant. †Significance of the difference between the items of the sum score. ‡Kjellin *et al.* (1997). §Scale reversed, high score means positive experience. ¶Horvath & Greenberg (1989), Tracey & Kokotovic (1989). Items 3–8 Noda *et al.* (2012). There were minimum (0) and maximum (100) responses for each variable.

Patients' perceptions of S/R

On the 'patients' perceptions of S/R' subscale, ratings varied from zero to 100 on each items, with the scores for item 5 ('Was it necessary for you to be restrained and/or secluded?') being lowest for the whole questionnaire. The ratings for item 6 ('Was being restrained and/or secluded beneficial in treating your difficulties?') outranged those for item 5 with statistical significance ($P = 0.0029$) (Table 2).

Factors associated with patients' perception of treatment

Patients' age and hospital were found to be significantly associated with their perceptions during their hospital stay. First, there was a negative correlation between age and the two factors of patients' perception of S/R; the older the patients were, the less satisfied they were with S/R use ($r_s = -0.23$, $P = 0.034$). Second, hospital B (mean: 6.8) differed from hospitals A (mean: 45.7) and C (mean: 55.5) in terms of beneficence of S/R (item 6) in favour of the latter ones (Table 3). Third, in the subgroup analyses by gender, the correlation between age and the S/R necessity/benefit subscale persisted only for women and the necessity item ($r_s = -0.40$, $P = 0.019$), but not for men nor for the benefit item for either gender. Women did not consider S/R necessary and were less satisfied with the use of S/R than men. Women assessed their treatment more critically than men on all items, but the difference was not statistically significant.

TABLE 3: *Patients' perceptions of their treatment by hospital*

	<i>n</i>	Mean	Median	Standard deviation	<i>P</i> -value†
Cooperation with staff					0.085*
Hospital A	50	50.9	52.0	20.3	
Hospital B	11	37.3	34.2	20.8	
Hospital C	26	50.3	43.6	23.1	
Perceptions of seclusion and restraint (total)					0.0011***
Hospital A	49	39.8	34.0	31.2	
Hospital B	11	10.0	8.0	10.3	
Hospital C	26	46.2	46.0	29.1	
5. Was it necessary for you to be restrained and/or secluded?					0.094*
Hospital A	49	34.9	22.0	34.4	
Hospital B	11	13.2	11.0	16.6	
Hospital C	26	37.8	28.0	34.9	
6. Was being restrained and/or secluded beneficial in treating your difficulties?					0.0002***
Hospital A	50	45.7	40.5	33.8	
Hospital B	11	6.8	4.0	6.0	
Hospital C	26	54.5	55.5	34.4	

*Statistical significance in responses between different hospitals in subscale 'cooperation with staff'; ***Statistical significance between responses in different hospitals in subscale 'perceptions of seclusion and restraint'. †Significance of the difference between the hospitals.

DISCUSSION

We found that patients were unsatisfied with their overall treatment following S/R. This finding supports previous studies, in which patients reported most dissatisfaction with informing, restrictions, compulsory care, and atmosphere/milieu (Kuosmanen *et al.* 2006). Our findings are not surprising, as S/R are coercive measures used against the patient's own will. However, if the measures were decided on together, patients might be more satisfied (Duncan *et al.* 2010). The crucial question is: how to allow patients to participate in preparations for threatening situations? How do patients want to be treated at such times? This is important because S/R are measures for managing aggressive behaviour as the last resort to prevent patients from harming themselves or others. To avoid limiting individuals' human rights, autonomy, and self-determination (Wynaden *et al.* 2002), all efforts should be made to find alternative ways, thus reducing the use of S/R.

In the present study, patients felt that S/R was hardly necessary at all. Yet they did report some benefits of S/R. Older patients in particular seemed to be against S/R. Further studies are needed to ascertain why age is associated with the perceived lack of necessity for S/R. Older patients might expect more shared decision-making than younger ones, or perhaps older patients are more aware of

their diagnosis and thus expect individual treatment (Hamann *et al.* 2009). Summing the variables' necessity and benefits showed a need for individualized treatment. Indeed, alternatives to S/R should be offered first (Kontio *et al.* 2010).

The results of the present study suggest that patients' opinions were not included in treatment planning. This might show that paternalistic decision-making still exists in psychiatric hospitals (Duncan *et al.* 2010; Hoyer *et al.* 2002), or that there is a lack of open and respectful dialogue between patients and personnel (Bressington *et al.* 2011). Yet patients felt they received time and understanding from staff; they also felt they could voice their opinions, but that they were not taken into account. The patients hoped for different treatment methods than what they received. Thus, it is not a question of not listening or a lack of empathy, but rather a question of not valuing or implementing the patient's argument in decision-making. Was it a question of patients being treated indifferently, or was it that, despite nurses' suggestions, the physician did not consider the patients' opinions, or were the patients' wishes not considered at all in the process of decision making? Further studies are needed.

As many studies have shown, cultural factors are associated with the use of S/R (Raboch *et al.* 2010). We found statistically-significant differences among hospitals and

patients' perceptions of benefit from S/R. This might be because of cultural elements, the character of the ward, or the severity of patients' illnesses. The most critical patients were being treated at the forensic hospital. This hospital is classified in the Finnish forensic psychiatric system as a medium-security hospital. Many of the patients had their illnesses for a long time and were first treated in a high-security hospital. They were committed to long-lasting treatment instead of a prison sentence. To date, only few studies on patients' satisfaction in forensic inpatient care have been conducted. Bressington *et al.* (2011) found that patients in forensic units are quite satisfied with their treatment, especially rehabilitation and perceived safety. Their satisfaction seemed to strongly associate with the therapeutic relationship with their key-workers and the social climate on the ward (Bressington *et al.* 2011). Daffern *et al.* (2006) found that less than half of the patients admitted were aggressive during their first year (Daffern *et al.* 2006), and in other studies, only a small number of patients are responsible for all the recorded aggressive behaviour (Thomas *et al.* 2009).

Female patients were more critical than males on all variables, even though this trend was not statistically significantly associated with the studied variables. Women in particular were more critical of the necessity of S/R than men. This is in line with earlier studies. According to Veltkamp *et al.* (2008), men prefer seclusion before forced medication more often than women, and men prefer both seclusion and forced medication more often than women. They also concluded that patients who understood the reason and necessity for the measure held more positive views of its efficacy (Veltkamp *et al.* 2008).

As restraint restricts patients' autonomy more than seclusion (Sjostrand & Helgesson 2008), we found it surprising that the perceptions of our patients who were mechanically restrained did not differ from the perceptions of those who were secluded. This was possibly due to receiving more of the nurses' time, human contact, interaction, and presence, which the restrained patients received, as in Finland, constant bedside monitoring is mandatory for restrained patients, but not for secluded patients.

Strengths and limitations

The strength of our study was that only 14% of patients refused to participate. It seemed that the patients were pleased to participate, and perhaps felt respected when their opinion was elicited. The present study showed that the SR-PPT is suitable in measuring patients' perceptions of their treatment after S/R, and is easy to com-

plete. Unfortunately, a few returned questionnaires were filled with descriptive answers (word by word, not coded) and they had to be excluded. The patients coded minimum (0) and maximum (100) responses for each variable, indicating strong opinions on some items. This allowed us to assume that there was little response bias, that is, patients were quite honest in their responses. According to Mazor *et al.* (2002), patients' satisfaction is related to the response rate, which is possibly associated with response bias; the higher the satisfaction, the higher the response rate (Mazor *et al.* 2002). In our study, the response rate was 60.4% (90/149 patients who were asked for informed consent), and the mean of the most variables was around the middle point of the scale. Unfortunately, almost 50% of the secluded or restrained patients did not get the opportunity to participate. The reasons included staff being too busy (i.e. occasionally understaffed or too much indirect patient work and recording.), substitutive staff (the information of ongoing research did not reach the staff), the person in charge of the research was not present and consent was not asked for, short treatment periods and quick discharge after S/R, or the patient's insufficient command of the Finnish language.

The number of patients who completed the SR-PPT was 90, and 18 patients completed it twice. The reasons for the relatively low number of respondents compared with all S/R episodes included the fact that the same patient was secluded or restrained several times, and for some patients, an incapability of giving informed consent due to psychosis. When a patient is seriously psychotic, her/his ability to give informed consent might be limited. This is yet another ethical limitation; one has to be sure the informed consent is valid.

Generalizability of our results is limited because of the small number of participants, and because practices differ among countries. The data for this study were collected only in Finland. Yet we gathered data in all units for a minimum of 1 year, which can be considered a lengthy period of time. Furthermore, the SR-PPT as a measure is based on an extensive review of relevant literature and clinical experience, and it has already been used cross-culturally (Noda *et al.* 2012).

Clinical implications

Based on our results, it can be concluded that psychiatric treatment needs to be developed on a more ethically-sound basis. We need to allow patients to voice their needs and be part of their treatment. Staff need to listen, understand, and consider patients' wishes, and accept patients as active partners in their own lives, even when

their mental condition and capacity are weak. There is also a need for planning crisis situations together with patients, so that personal wishes, gender, and age are considered, that is, the personal life situation of each patient is taken into account. More options for S/R are needed. In order to achieve this, personnel must be trained and the whole treatment culture improved and brought up-to-date at all organizational levels. Furthermore, the patients themselves need to be empowered and supported to take a more active role in their own treatment.

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