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Patient restrictions: Are there ethical alternatives to seclusion and restraint?

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Abstract
The use of patient restrictions (e.g. involuntary admission, seclusion, restraint) is a complex ethical dilemma in psychiatric care. The present study explored nurses' ($n = 22$) and physicians' ($n = 5$) perceptions of what actually happens when an aggressive behaviour episode occurs on the ward and what alternatives to seclusion and restraint are actually in use as normal standard practice in acute psychiatric care. The data were collected by focus group interviews and analysed by inductive content analysis. The participants believed that the decision-making process for managing patients' aggressive behaviour contains some in-built ethical dilemmas. They thought that patients' subjective perspective received little attention. Nevertheless, the staff proposed and appeared to use a number of alternatives to minimize or replace the use of seclusion and restraint. Medical and nursing staff need to be encouraged and taught to: (1) tune in more deeply to reasons for patients' aggressive behaviour; and (2) use alternatives to seclusion and restraint in order to humanize patient care to a greater extent.

Keywords
acute psychiatric care, aggressive patient, inductive content analysis, patient restriction, restraint, seclusion

Introduction

The use of patient restrictions, especially seclusion and restraint, is a complex ethical dilemma in psychiatric care.[1] These restrictions are linked to issues of an individual's right to self-determination, human rights, and the

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ethical responsibilities of mental health care staff.[1,2] In general, every human being has the right to life, personal liberty, security and physical integrity.[3-5] This also applies to psychiatric patients.[2,6,7]

There are certain situations in psychiatric care, however, in which patients may be hospitalized, controlled and treated against or regardless of their will.[8,9] Aggressive behaviour that is potentially harmful to patients themselves or others is the most widely accepted reason for using restrictions (e.g. involuntary admission, forced medication, seclusion and restraint).[10,11] Seclusion and restraint are probably the most harsh of these restrictions.[2,6,7] Furthermore, there is a lack of evidence regarding the clinical effectiveness of seclusion or restraint in reducing or alleviating patients' aggressive behaviour or serious mental disorders.[12,13] Moreover, earlier studies have shown that they are frequently harmful or traumatic to patients.[14,15] The use of seclusion and restraint in most countries is thus limited by legislation and a range of recommendations and professional guidelines. They must be used: (1) as a last resort only, when it is absolutely necessary to protect the patient's or others' safety; (2) as safely as possible; (3) with respect for the patient's human dignity; and (4) under the supervision of a physician.[6-8,16,17] It is essential that the restrictions are applied, when possible, within a context of mutual understanding between the patient and the staff.[2,6,7]

From the staff's point of view, the use of patient restrictions, particularly seclusion and restraint, causes ethical problems. There exists an inbuilt conflict – to seclude or restrain, or not. Both options entail drawbacks and benefits[18-20] because they conflict with staff's feelings of professional, legal, ethical and personal responsibility to protect patients.[21,22] Medical and nursing ethics both emphasize respect for the autonomy and dignity of patients by promoting choice, rather than paternalistic practices.[21-23] Staff normally wish to develop a therapeutic relationship with their patients, which is usually perceived as a basic trustworthy ethical relationship between nurses and physicians and patients. This relationship can be readily undermined by the use of seclusion and restraint.[23,24] Furthermore, it is often difficult to weigh the best interest of patients against other people's best interest.[21] Moreover, a lack of structured and evidence-based practices and guidelines increases pressure, conflict and ethical dilemmas among nurses.[18-20] All these legal, ethical and clinical issues related to professional identity and the role of the therapeutic relationship call for exploration, development and implementation of alternative ways to treat aggressive behaviour.[16,19]

Although there is strong evidence supporting the use of alternative methods to reduce seclusion and restraint in psychiatry,[25] their implementation in clinical practice has been insufficient.[26] Mental health care staff thus need to be encouraged and educated in the use of alternative methods for the prevention of assault and harm to themselves or others. To be more successful, these efforts should be complemented, for example, by programmes in clinical leadership, change management, monitoring of seclusion and restraint episodes, and change to a more therapeutic environment.[27-29]

What actually happens with an aggressive patient on a ward and what alternative methods are available in normal settings? These are issues that, from an ethical perspective, have not been explored in sufficient depth, although they form a real-life context for the implementation of alternative methods. The present study was set up to explore the ethical aspects of nurses' and physicians' perceptions of: (1) what actually happens when an aggressive behaviour episode occurs on a ward; and (2) what alternatives to seclusion and restraint are in use as normal standard practice in acute psychiatric care. This study is a part of an international research project funded by the European Commission (Leonardo da Vinci; FI-06-B-F-PP-160701), which focuses on nurses' vocational training related to the management of distressed and disturbed psychiatric inpatients in six European countries.

Method

Pilot study and data collection

A qualitative method using focus group interviews was selected for data collection to encourage the natural spontaneity of peer-group discussion.[30] The rationale for the focus group method is that group processes can

Table 1. Study components: participants, data collection and data analysis

Component	Details
Study setting	2 psychiatric hospitals in Southern Finland
Data collection time	22–26 March, 2007
Ward type	Acute closed adult wards ($n = 6$) practising seclusion and/or restraint
Inclusion criteria	Registered nurses and physicians, adequate command of Finnish, voluntary participation, written informed consent received
Study population	22 nurses and 8 physicians screened. Of these, 3 physicians dropped out (not attended, $n = 2$; discontinued the interview prematurely, $n = 1$)
Focus group interviews	4 focus groups comprising 3 groups of nurses (total $n = 22$) and 1 group of physicians (total $n = 5$)
Researchers	4 researchers pretrained to conduct focus group interviews; 2 researchers in each group
Length of interview	80–100 (mean 90) minutes
Method	Inductive content analysis
Unit of analysis	Utterance: a sentence or part of a sentence consisting of thematic content relevant to the research question
Analysis process	1) The transcribed text was read several times after the unit of analysis had been chosen 2) Reduction of the data by asking a question and picking out phrases answering that question 3) Coding: the reduced phrases were given a description according to their thematic content 4) Subcategories were developed for these codes by grouping those with similar content 5) Main categories were created by grouping subcategories with similar meaning 6) Data from nurses and physicians were handled separately, but, since they appeared similar, the final analysis comprised both groups
Validity	Pilot study; two focus groups with nurses ($n = 13$)
Reliability	Two researchers analysed the same dataset independently and thereafter compared and verified the obtained content and categories

help people to explore and articulate their views in ways that would be less easily accessible in a one-to-one interview.[31-33] Focus groups explore collective, not individual, phenomenology (Table 1).[30,31]

A pilot study was conducted to evaluate the suitability of focus group interviews for elucidating the study phenomena, the feasibility of the semistructured interview form used and a definition of the researchers' role in the data collection process (13 nurses from two acute psychiatric adult wards; no physicians). The focus group questions were open ended, allowing the respondents to express their views in their own words. On the basis of this pilot study, one of the two questions was revised to make it shorter and clearer. In addition, the role of the researchers was revised so that one was a moderator whose function was to create a non-threatening atmosphere to encourage the participants to share their views, while the other taped the focus group discussions, took notes, and, if needed, also asked supplementary questions.

Thus, the questions asked in the study presented in this article were: (1) What actually happens when a patient becomes aggressive on your ward/in your hospital? and (2) What alternative methods do you have instead of seclusion or restraint on your ward/in your hospital?

Participants and data analysis

There were 30 eligible participants (22 nurses and eight physicians) from two study hospitals; three physicians dropped out (Table 1). Their mean age was 44 years (range 26–59) and their mean working experience was 22 years (range 1–39); 52% were women. A majority (70%) had completed upper secondary education

and 56% (all physicians and 45% of the nurses) had received vocational in-service training in mental health care.

The data obtained from the focus group interviews were analysed using inductive content analysis, a process used for the systematic and objective analysis of documents.[31-33] In this study, the group members stimulated each other's discussion but did not reach total consensus on the the research question issues. Comparison of the data from the various focus groups permitted inferences to be drawn concerning the presence or absence of certain views or issues across groups, but not in terms of their relative strength (Table 1).[31-33]

Ethical considerations

The basic principles of research ethics were followed at every stage of the study, which was approved by the local Ethics Committee. Permission for data collection was obtained from both the study hospitals' directors. The nurses' and physicians' participation was voluntary. They received oral and written information about the purpose of the study and about their own rights as research participants; all provided written informed consent. To ensure that they would feel free to express their views, the researchers who conducted the interviews were not employed on the study wards. Using two researchers per focus group enabled better group cohesion and more thorough observation of group dynamics and collection of data. The data were treated as confidential.[23,34]

Findings

Management activities related to patients' aggressive behaviour

The nurses and physicians described the management of patients' aggressive behaviour as a decision-making process occurring: (1) before; (2) during; and (3) after seclusion and restraint.

Measures before seclusion and restraint: patient's versus others' best interests as an ethical dilemma. The participants discussed the ethical principles that guided their decision making in instances where a patient became disturbed or aggressive. The patient-related ethical principles included: respect, dignity, patient's self-determination and safety, as well as sufficient knowledge of the patient's history among the staff, as illustrated in the following example:

> We have a conversation with the patient and respect his or her opinion. We check the information we have on the patient. Has he or she behaved aggressively before? What has helped him or her? Are there agreements or plans? Has he or she been secluded or restrained before?

Ethical concerns relating to other people included the safety of other patients and staff, their welfare and a peaceful, therapeutic atmosphere. This was illustrated in the following example:

> The patient's situation, and also who is at work, do indeed affect the community's safety and atmosphere. If there are many male nurses and experienced staff, everything is much easier. Clear written instructions and alarm systems are useful; they produce safety.

However, an ethical dilemma emerged when the staff had to balance the patient's best interests and those of other people when making decisions to seclude or restrain or not. For example, the nurses had to assess the likelihood of serious bodily self-harm or harm to others. With aggressive patients, these decisions often have to be made quickly, and the nurses felt that they did not have enough time for discussion with other staff members, especially with physicians. The nurses were therefore uncertain about their own decisions and

tended to think about whether they thought they had done enough for the patient. They were also concerned about their failure to find alternatives to seclusion and restraint.

> You have to make the decision on seclusion or restraint very quickly when a patient is aggressive. You do not have enough time to confer with other members of the team. Seclusion or restraint is a last resort intervention and its use causes a sense of dread.

The physicians, in turn, experienced an ethical dilemma in situations when a nurse informed them by telephone about an immediate need for or an enacted decision to seclude or restrain, and the physician had to regularize the decision either ad- or post-hoc, sometimes even without seeing the patient.

Measures during seclusion and restraint: patient's versus others' best interests as the time- and labour-division dilemma. The participants described co-operation with patients during seclusion or restraint. One nurse stayed with restrained patients at all times, and another visited secluded patients at least every 15 minutes. This indicated that these nurses spend a lot of time with patients who are secluded or restrained and they continuously evaluate these patients' condition.

> We are present and near the patient as much as possible and ensure that the seclusion or restraint is as short as possible.

In cases of aggressive behaviour, the nurses also calmed other patients down. They guided other patients away from the situation and gave information on what had happened. The participants described ethical conflict related to them not having enough time to spend with other patients because secluded or restrained patients take so much time and energy.

> There are also 17 other patients who may be scared and their condition may deteriorate if one patient behaves aggressively. It is important that the nurses also have time for them and inform them about the situation. We do not have enough time for them.

The participants indicated that patients' aggressive behaviour requires good co-operation between nurses and physicians. They emphasized the importance of a clear division of labour and good communication among team members. If they had worked a long time together, the division of labour was very clear and everyone knew their role. Both the nurses and the physicians had to think about how long patients needed seclusion or restraint and whether or not there were other alternatives.

> Male nurses take care of the aggressive situations and female nurses take care of the medication and co-operate with the physicians. Physicians make decisions on medication and restrictions, seclusion and restraint.

Measures after seclusion and restraint: psychological consequences and needs of patients and staff. When a seclusion or restraint episode is over, the nurses said they experience relief. They may feel tired and hopeless and try to focus on the urgent things that have to be done (e.g. written report, medication). An oral report after the episode was the first opportunity for staff to evaluate the situation together.

> Oral and written reporting after the situation is useful. Then we evaluate what helped the patient and what else we can try next time. Sometimes we also discuss what we have learnt from the situation.

The participants emphasized that, after a few days, it is important to discuss the seclusion or restraint situation in multidisciplinary teams and with managers. The nurses experienced fear, anxiety and helplessness when caring for aggressive patients. They felt guilty for having not done enough and/or found alternatives to

Table 2. Alternatives to seclusion and restraint

Categories Subcategories	Excerpts from nurses' and physicians' interviews
Nursing interventions	
Being present	Nurses are in sight of and with patients at all times on the ward
Conversation	Patient can talk about feelings, fears and possibilities
Giving responsibility to the patient	It is important that we hear the patient's opinion on how to treat him or her. We can give responsibility to him or her, treating the patient as an active participant in seclusion and restraint interventions
Providing activities for the patient	The patient can go for a walk, have physical exercise or be in occupational therapy groups
Changing the patient's environment	It is useful to take into account the patient's environment; we can change the patient's room or ward
Multiprofessional agreements involving the patient	
Giving medicine	Often we start by giving medicine and we collaborate with the patient about how we give the medicine
Caring in the patient's own room	We agree with the patient that if he or she is restless he or she can go to his or her room and stay there alone
Placing in the seclusion room with the door open	We can agree with the patient to place him or her in the seclusion room with the door unlocked if he or she is restless
Constant observation	Nurses can stay with the disturbed patient for a prolonged period of time, they can stay in the patient's room. We use this especially with suicidal and disturbed patients
Physical holding	If the patient is aggressive and disturbed, we may hold him or her physically
Use of authority and power	
Physician	The aggressive situation was over when the physician arrived on the ward, because [the physician] had the authority over the patient
Male nurses	Male nurses represent authority and power to the patient, and in aggressive situations we must have many male nurses; it is safer then
Police officer	We can call a police officer if the situation is dangerous; it always makes the situation more peaceful

seclusion and restraint. Therefore, managers (head nurses, nursing directors, medical directors) had an important clinical supervisory role to play in this regard. The participants also reported that the best and quickest support came from team members. Confidence among team members and peer support were key points. Confidence depended on how long the team members had worked together. They also mentioned the importance of occupational health care as a means of support.

> We discuss the situation and what feelings and thoughts team members have. We discuss how we can avoid the seclusion or restraint situation next time and why we did not find alternatives this time.

The participants also reported that it was useful to debrief the seclusion or restraint situation with these patients. This was noted to be useful for the patients and also a learning experience for staff, yet it did not happen after every seclusion or restraint episode.

> It is important to listen to the patient's own opinion, what has helped him or her and how to manage the next time, which alternatives we can use instead of seclusion or restraint. But we do not use this debriefing option with patients after every seclusion or restraint situation.

Alternatives to seclusion and restraint

Both the nurses and the physicians had considered alternatives to seclusion and restraint. Their perceptions fell into three categories: (1) nursing interventions; (2) multiprofessional agreements involving the patient; and (3) the use of authority and power (Table 2).

Nursing interventions. As a first step, being present, conversation, giving responsibility, providing meaningful activities and changing the environment were the nursing interventions used in everyday clinical practice. They were mentioned as first-step alternatives to seclusion and restraint. Nurses being present and conversing with patients give patients a feeling of safety and comfort, and also potentially give nurses a better insight into what is happening with and to the patient. Being present and having a conversation also enable patients to feel that nurses are trying to support and understand patients' experiences. Primary nurses know patients the best and can also avert aggressive situations. Both the nurses and the physicians stressed the importance of regular conversation with patients. To be familiar with patients makes it easier to decide what responsibility they could handle and with what resources and limitations. The nurses and physicians both emphasized that patients' meaningful everyday activities could prevent aggressive behaviour, while idle days cause patients frustration, which could contribute to aggressive behaviour on the ward.

The participants indicated that patients' environment and the atmosphere on the ward were very important in providing patients with a safe, comfortable and therapeutic place. An aggressive patient often needs a quiet place with little stimulus. If required, staff said they changed aggressive patients' room or ward to ensure they were under observation. Sometimes this was needed because other patients required a safe and peaceful care environment.

Multiprofessional agreements involving patients. Multiprofessional agreements involving aggressive patients were mentioned as an essential component of multiprofessional meetings. In such agreements patients were seen as active participants, whose opinions and thoughts on their own treatment are valuable (step two). Co-operation and negotiation with patients were deemed useful. Nurses and physicians have a central role in negotiating and making written or oral agreements with patients about treatment plans and possible alternatives. A treatment plan would include agreements about medication and care in a patient's own room, leaving a seclusion room door open, constant observation and physical holding.

The use of authority and power. In this study, authority and power were associated with a physician's position, male nurses, and number of nurses on the ward. The participants reported that, instead of seclusion and restraint they could calm down aggressive patients by using authority and power (step three). This alternative was used especially for severely aggressive and unco-operative patients. Some stated that a feeling of personal authority and power was important for staff because otherwise power would shift to the patients. They reported that they do use power, but not in an inhumane way. There were situations in which a physician's presence or conversation with a patient was more effective than that of nurses. Male nurses represented authority and power in patients' eyes and tended to defuse aggressive situations. The participants also stated that, in threatening and aggressive situations, they summoned more male nurses to the ward. Sometimes their presence alone would pacify a situation. Sometimes police also had to be called to handle dangerous situations.

Discussion

In this study, the participants declared aggressive patients' best interests to be their first priority, in accordance with the principles of health care ethics, human rights, and international and national legislation,

recommendations and professional guidelines.[5–8,21-23] However, despite the ethical issues raised by the use of seclusion and restraint, the participants overemphasized their role in the care of aggressive patients. Similar findings have been reported previously by other authors[26] and correspond with the high seclusion and restraint rates in Finland when compared with other European countries.[2] Furthermore, when our participants faced the ethical conflict of choosing between a patient's and another person's best interests, the latter was often preferred, as was the other person's safety. This finding is also in line with previous reports.[35,36]

It is interesting to note, in this context, that the subjective point of view of these patients received negligible attention in our study. There was little spontaneous discussion between participants regarding aggressive patients' own feelings and fears. There is, however, a body of research that shows that tuning into the reasons for a patient's aggressive behaviour can facilitate better ways of dealing with aggression on the ward.[26,27,37] There is also a body of work in nursing ethics to support this perspective on the basis that understanding where patients are 'coming from' is an important element in identifying imaginatively with them. Such imaginative identification, it is argued, is a key element for the accurate assessment of patients' needs and thus of appropriate, ethically sensitive interventions and care provision.[38,39] The future challenge is thus to improve methods of patient–staff communication, that is, to sensitize staff to mindful reflection on patients' feelings and thereby enable understanding of the causes and prevention of aggression.[26,37] Health care ethics is grounded in relationships. Although the context of these relationships varies, they are nurtured and sustained by the reliance on dialogue and mutual concern. They support and inform ethical reflection and, in clinical disciplines such as nursing, both ethical and clinical judgement and decision making.[38-40]

Both nurses and physicians reported ethical conflicts related to decision making about seclusion and restraint. Although the nursing staff had to balance the best interests of patients with those of other people, the physicians experienced ethical conflict when making a post-hoc decision on a seclusion or restraint that had already taken place. The latter was an intriguing and novel finding, especially in the light of the Finnish Mental Health Act, according to which seclusion and restraint should be used only after physicians' clinical assessment and decision, and under their supervision.[8,16] It appeared that, in reality, the nurses were not only the key informants describing these patients' clinical condition and the events preceding seclusion or restraint, they were also often the key seclusion or restraint decision makers.[41] This is therefore a legal dilemma that obviously requires re-examination of the law and guidelines. The division of labour between physicians and nurses in this context also needs to be reassessed.

For the nurses, other ethical problems that caused frustration and feelings of guilt and dread were: (1) the inability always to find alternatives to the use of seclusion or restraint; and (2) the amount of time spent with secluded or restrained patients, which inevitably decreased the amount of time spent with others. These findings were also concordant with those of earlier studies.[18,41] As a means to lighten the ethical burden, the nurses and physicians highlighted the importance of multiprofessional team work and a need for training and supervision for multidisciplinary teams. Debriefing with patients after seclusion or restraint was also described as useful, but seldom occurred. All these findings also confirm earlier reports.[42,43]

Although the nurses did not always feel able to find alternatives to seclusion or restraint, both they and the physicians raised numerous alternatives, as did health personnel in some earlier reports.[25-27] The participants described: (1) nursing interventions; (2) multiprofessional agreements involving patients; and (3) the use of authority and power as, chronologically, the first, second and third steps. The first two approaches were already defined in earlier studies as collaborative practices.[43,44] Step three was an interesting finding. This seems to be a paternalistic rather than a collaborative practice because the reliance on manpower (e.g. physical force), especially that of male nurses, is not consonant with the active role of patients as mentioned by our interviewees. In fact, some earlier studies have reported that these manpower-orientated practices[45] can exacerbate patients' aggressive behaviour.[19] This unofficial use of power is the grey area of free will in psychiatry and has long been discussed. Michel Foucault perceived surveillance in psychiatry as a means of disciplining people so as to create useful citizens.[46,47] No matter what the viewpoint on this subject, it is

painfully obvious that ongoing discussion within the professions is needed to keep this use of power under scrutiny and find better solutions to empower patients without compromising ward security; otherwise the declared high ethical principles may remain theoretical and not become clinical practice.

Furthermore, the participants mentioned the importance of clinical experience-based tacit knowledge on seclusion and restraint and the confidence built up among staff who have worked together for a long time. Reliance on tacit knowledge and a shared common experience may not be only a strength; it can also be a weakness. It can undermine development and impede desirable changes in treatment methods and the surrounding nursing culture and practices. Although doing what has always been done seems easy, it is fraught with repetition of the same mistakes and managing the ethically dubious elements of tradition.[27-29] This finding again highlights the need for training using an evidence-based approach to nursing practice.[48]

There exist ethical issues that are specific to focus group interviews. For a researcher, a major issue is potential over-disclosure by participants, particularly if the research topic is sensitive or emotionally loaded. In the present study, participation was voluntary and the drop-out rate was low. We recruited nurses and physicians who were willing and likely to provide pertinent information on the study issues. We thus strictly followed the ethical requirements for studies of this kind (voluntary participation and willingness to share experiences about an emotionally sensitive topic with the researchers).[30-32] The use of two researchers also enabled better control of focus group dynamics and enhanced the protection of participants from possible harm.[30,31] The study did not comprise a representative sample and the results thus cannot be generalized to other psychiatric hospitals.[30-33]

Future research should focus on patients' perspectives and be analysed both separately and in parallel with the views of staff. This may highlight some covert aspects of patient restrictions and alternatives to seclusion and restraint that are not salient in routine clinical work. There is also a need to study multiprofessional approaches to alternative interventions in the treatment of aggressive inpatients. These diverse information sources may provide a more comprehensive multidimensional picture of patient restrictions and alternative approaches.

Implications for nursing

There is an obvious need for more patient-centred nursing, for which staff are trained to tune into the reasons for patients' aggressive behaviour and where alternatives to seclusion and restraint are negotiated with patients and written into their treatment plan. Nurses have a key role not only in delivering information regarding aggressive patients, but also as seclusion and restraint decision makers. More co-operation between nurses and physicians is thus needed to shift the focus from seclusion and restraint to alternative, less restrictive and more collaborative methods. In addition to existing seclusion and restraint-related treatment directives, there seems to be a need for structured, evidence-based guidelines on the prevention and de-escalation of aggressive behaviour in psychiatric care. Their implementation could become an essential component of pertinent vocational education programmes.

We suggest that, to foster psychiatric hospital care of a high ethical standard, future vocational educational programmes should focus on: (1) written clinical guidelines on alternative treatment approaches to diminish or replace restrictions on patients; (2) patient–staff communication with a focus on sensitization of staff to patients' feelings and the types of interpersonal factors that provoke aggression; and (3) ethical and legal issues emerging during multidisciplinary team collaboration.

Conflict of interest statement

The authors declare that there is no conflict of interest.

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