The patients' view on mechanical restraint in Austrian adult psychiatry

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Introduction

Types of coerive measures:

- **mechanical restraint:** strapped to the hospital bed
  (Fogel und Steinert, 2012)

- **isolation:** locked in a closed room
  (Steinert, 2008, S. 106)

- **physically restraint (holding):** immobilized by physical force
  (Department of Health, 2015)

Introduction

Austrian psychiatry 2020:

23.513 patients → involuntary admission

from that 8.018 patients → restraint or locked in a closed room

(VertretungsNetz, 2021)

Netherlands psychiatry 2019:

870 restraints

5.390 „separatie“

1.380 „afzondering“

∑ = 7.640

(Inscpectie Gezondheidszorg en Jugend, 2019)

The exact data on the type, duration and frequency of the coercive measures is incomplete.

Introduction

International comparsion (Steinert et al. 2010)

Australia
Germany
Finnland
Canada
New Zealand
Norway
South Africa
Switzerland
USA

→ mechanical restraint, isolation and holding

Austria → primary singular mechanical restraint

Introduction

correct implementation of a coercive measure:

- low restriction of movement
- as short as necessary
- ensuring safety (DGPPN 2020; SAMW 2018; Kopetzki 2012, S. 554)

Guidelines recommend choice regarding coercive measures (DGPPN 2020)

Treatment quality as a function of dealing with coercion (DGPPN 2020)

Problem statement

– A singular choice of coercive measures is no longer appropriate (Steinert 2008, S. 110)

– mechanical restraint:
  – can cause **injury** and **death** (Kersting et al,. 2019; Hick et al., 1999)
  – can lead to **traumatization** (Klein & König, 2016)

– Ethical challenge (SAMW, 2018)

– In Austria, only one study exists on patients' experiences with mechanical restraint. (Frajo-Apor et al., 2011)

Research objective

Primary research question:

"How do inpatients in Austrian adult psychiatry experience the coercive measure of mechanical restraint?

Secondary research question:

"What suggestions for improvement do inpatients in Austrian adult psychiatry have for the coercive measure of mechanical restraint?

Method

Design: - qualitative research

Data collection: - 12 guided interviews

Field access: - Vienna Gesundheitsverbund

Sample: - Voluntary psychiatric inpatients who have experienced mechanical restraint

Ethics Committee : - pos. vote of the City of Vienna

Method

Data analysis:

- transcription (Kallmayer und Schütze, 1976)
- familiarise with the data / MAXQDA2020
- coding (Saldana, 2016)
- creation of categories → interpretative reductive anlaysis (Mayer, 2019)
- creation of prototypes (Murphy, 2002)

Results

Interview participants

7 ♀

5 ♂

3 prototypes

8 general categories

10 suggestions for improvement

Results

Prototyp 1

PSYCHOLOGICAL STRESS

- fear and horror
- loss of control & panic
- traumatization

"So that's exactly how it feels, like a horror movie, horror. I thought they were going to kill me. [...] So the last stay here was really not funny. It was horror." (Interview 4_Q, Pos. 48-51)

„The traumatization is definitely there if you have experienced restraint. That's the drama." (Interview 9_S, Pos. 115-116)

Results

Prototyp 2

PHYSIOLOGICAL STRESS

- violence from without
- violence from within
- pain

„That wasn't nice at all, because they used violence at the highest level
(Interview 1_F, Pos. 14-15)

„There is really beating around and raving"
(Interview 9_S, Pos. 29-30)

"It was extremely hard, very uncomfortable, it hurts a lot. I can take a lot, but it still hurt."
(Interview 12_T, Pos. 49-51)

Results

Prototyp 3

GREAT FEEL-GOOD

- super feeling
- securitiy
- satisfaction

„the feeling of a gift of protection.“
(Interview 8_M, Pos. 26)

„That felt super!
(Interview 8_M, Pos. 14-15)

Results

General categories

- lack of understanding
- disregard for basic needs
- medication experience
- unpleasant atmosphere
- loss of trust
- relief from falling asleep
- calmness, protection, safety and understanding
- empathic care

Results

improvements

- dignified treatment
- breaking up old structures
- control
- communicative de-escalation
- medicated de-escalation
- calming touch
- physical restraint
- isolation
- participatory decision-making
- debriefings

„There are nurses who are really very good, I have to say. They make sure you come down, they put their hand on your shoulder, they ask you what's wrong (,) look at me, calm down, it's no use ... they just give you a good talking to. Yes, that's exactly what I remember as a big positive step forward.“ *(Interview 3_Y, Pos. 9-13)*

Discussion

- analogies to other study results are recognizable

  → especially for Prototype 1 + 2 and for the General Categories (Wostry & Schermann, 2018)

- Special case: Prototype 3 with the subcategory "super feeling".
- New finding: De-escalation and keeping the relationship in the form of calming touch

- Improvements

  Culture change

  Enabling choice and participation

  (Borbé 2016; Gather et al., 2016)

Summary for research

Potential fields of research:

- → calming touch
- → Assessment tools for correct selection of coercive measures
- → Alternatives such as **isolation** and **holding**
- → Benchmarking
- → experiences of the nurses / therapeutic relationship

Summary for practice

- reflect on their own role and actions
- concepts for de-escalation and coercion reduction → Safewards / Six Score Strategies
- debriefings
- regular advanced training → especially verbal de-escalation
- Joint decision making … → Isolation, mechanical and physically restraint

Implement, teach and observe guidelines!

e.g. S3 –Guideline: Preventing coercion: prevention and therapy of aggressive behaviour in adults

Quesitons & discussion

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