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Documenting Restraint: Minimizing Trauma

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Introduction

Chemical and physical restraints and seclusion[1] are coercive practices that are regularly used in psychiatric emergency and inpatient settings (Emmanuel et al., 2013; Jacob et al., 2016). While national data are not consistently available, the Canadian Institute for Health Information (CIHI) reports that in the Canadian Province in which this project was based, over 25% of people (i.e., 1 in 4) admitted to inpatient mental health hospitals experience some form of chemical or physical restraint[2] or seclusion (Emmanuel et al., 2013). Data suggest that dedicated psychiatric facilities (i.e., inpatient mental health hospitals) where staff are trained in verbal and other de-escalation strategies reliably show lower rates of restraint use compared to other health care

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A. Daley and M. D. Pilling (eds.), *Interrogating Psychiatric Narratives of Madness*,
https://doi.org/10.1007/978-3-030-83692-4_5

settings (e.g., general hospitals) (Gaynes et al., 2017; Huizing et al., 2007). Importantly, however, the likelihood of being subjected to a "control intervention" (Jacob et al., 2018, p. 93) is disproportionate across race and class, suggesting the operation of race- and class-based bias in mental health care. For example, evidence suggests that Black male patients are at higher risk of restraint than white male patients, and that homeless individuals are disproportionately subjected to restraint use (Schnitzer et al., 2020). A retrospective chart review conducted in Montreal, Canada has also shown that Black persons of Caribbean or African descent with first episode psychosis were significantly more likely to be coercively treated (including use of seclusion, physical restraints, and intermuscular chemical restraint) (Knight et al., 2021).

Undoubtedly, being subjected to restraint of any kind can be (re)traumatizing and cause significant mistrust of mental health professionals (MHPs) and the mental health care system for individuals (Jacob et al., 2018; Lanthén et al., 2015; Lu et al., 2017; Spinzy et al., 2018; Wong et al., 2020). Jacob et al.'s (2018) exploration of women's experiences of mechanical restraints revealed that "feelings of abuse and violation" were "prominent elements in the recollection of these experiences" (p. 100). The authors emphasized that the violation of the body in the application of mechanical restraints raised questions from women about "ethical conduct, personal rights, and inhumanity in the application of restraints while concurrently exposing their humiliating effects" (p. 101). Not surprisingly, experiences of restraint can negatively affect patients' engagement with mental health care as it is associated with negative feelings and mistrust of staff, resulting in patients being less likely to seek for help and engage with treatment in the future (Khatib et al., 2018; Kontio et al., 2012; Tingleff et al., 2019; Wong et al., 2020).

Research with patients also reveals important process issues that may stem from poor communication between MHPs and patients. For example, many patients cannot identify the reason why they were secluded or restrained as punishment (Kontio et al., 2012), and a major driver of their negative emotion has been identified as the lack of interaction and communication about their restraint, whether before, after, or during it (Kontio et al., 2012; Lamanna et al., 2016; Spinzy et al., 2018).

Some studies of psychiatric inpatients, including patients who have experienced restraint or seclusion, suggest they believe that the use of physical restraints could be justified in certain situations where the risk of violence was clear and imminent and when initiated respectfully and nonpunitively could be justified and even helpful, promoting a sense of calmness and security (Jacob et al., 2018; Kontio et al., 2012; Lanthén et al., 2015; Spinzy et al., 2018). Similarly, some MHPs report that some forms of restraint have some benefit with respect to fostering the safety of patients and staff members and setting behavioral boundaries (Kinner et al., 2017). In one study, MHP respondents described mechanical restraints as "a necessary evil, but a last resort," while acknowledging that the use of restraints can create significant difficulties in developing a trusting therapeutic relationship (Walker & Tulloch, 2020). Many studies indicate that MHPs find the process of restraining patients to be traumatic and distressing (Ling et al., 2015; Walker & Tulloch, 2020).

More generally, large survey datasets and qualitative research indicate that MHPs and service users have similar beliefs about restraint and seclusion, believing that they cause harm, breach human rights, compromise trust, and enact new trauma and trigger previous trauma (Kinner et al., 2017). In one study, the majority of MHPs and service users felt it was both desirable and feasible to eliminate mechanical restraints (Kinner et al., 2017). As such, the inappropriate and overuse of restraints is a major focus of attention for patient advocacy groups, the health care system, and human rights organizations (Allen et al., 2003; Pariseau-Legault et al., 2019; Walker & Tulloch, 2020). This chapter contributes to critical analyses of restraint use by examining the ways in which patients' trauma from being subjected to restraints and MHPs' causing of this trauma is minimized through psychiatric chart documentation practices.

Locating Myself in the Text

As an emergency department psychiatrist, I am ultimately responsible for making the decision whether to enact institutionalized violence against patients through restraint use. This is a decision that I do not take

lightly. While everyone with whom I work would prefer that patients were never subjected to the trauma of restraint, we also witness patients' violence directed toward other patients and MHPs. Our commitment to preventing or minimizing harm between patients and between patients and MHPs means that, at times, we make the difficult decision to use restraints to manage a patient's behavior. Critically reflecting on the decision-making processes of MHPs and our biases and complicity in a carceral system, such as a psychiatric institution, transparency and accountability are of utmost importance.

I choose to write in the first person because during my review of the psychiatric documentation data I was struck by the way that MHPs "disappear" into the chart. This happens through documentation patterns such as the use of language to convey patient passivity and asymmetrical reporting. These documentation patterns can be reflective of whether we as MHPs are able to connect with or see ourselves in patients, as well as how we use narrative strategies to absolve our responsibility for institutional violence. Through documentation we remove ourselves from patient narratives of distress. As a psychiatrist, I do not want to see myself or my colleagues causing trauma rather than—or at the same time as—providing urgently needed mental health care. The psychiatric documentation data analyzed in this chapter illustrates this tension.

Methods

Of the 161 charts abstracted for this study, this chapter engages 13 charts that explicitly and implicitly documented use of restraint including chemical restraint (coercive rather than consensual administration of medication to control behavior), physical restraint (the coercive use of devices applied directly or adjacent to a patient's body to reduce physical movement), and seclusion (a type of restraint that involves confining a person in a room). While the 161 charts reveal repeated instances of MHPs engaging strategies to support patients in crisis to avoid restraint and seclusion, I am interested in patient–MHP interactions where traumatic control interventions were enacted. As such, the analysis presented in this chapter does not include charts where documentation indicates

only implicit coercive use of restraint, such as the documentation of PRN (as needed) medication that is often presented as a "choice" or is "offered" to patients in distress (e.g., to calm or sedate patients). In this regard, I note that many patients, especially those who are racially and economically marginalized, may not be able to choose not to take or, rather, refuse this medication without traumatic consequences.

The analysis of chart documentation data entailed reading through all 13 chart files that contained de-identified data and chart summaries (see Chapter 1, Introduction). Following this, I identified all documentation data related to restraint use, as well as other relevant documentation of trauma, restraint use debriefing, and the administration of PRN medications (i.e., documentation of implicit chemical restraint). This documentation content was analyzed for key themes related to the documentation of restraint use in psychiatric inpatient units.

Findings

Three key themes were identified through the analysis of documentation data that point to how I will examine the ways in which patients' trauma from being subjected to restraint, and the implication of MHPs' in this trauma, is minimized: (1) *framing patient trauma as disruptive or demanding*, (2) *providers' use of the passive voice and asymmetrical documentation*, and (3) *discounting structural violence*. The minimization of the trauma caused by restraint use is refracted through the lens of gender, race, and class, in this chapter. As the third theme presented in this analysis indicates, in many cases, concerns or "disruptions" from white, middle-class patients were conceptualized as more rational, and MHPs were more likely to use the active voice in documentation.

To contextualize the analysis, I note that in keeping with best practices, the policy of the institution being studied is that restraint without the consent of the patient or their substitute decision-maker is only used in emergency situations and that it should only be used as a last resort when a patient's aggressive or violent behavior presents an immediate risk of serious bodily harm to themselves or others. Restraint should only

be used after all reasonable alternatives, less restrictive measures, and de-escalation strategies have been considered or implemented and assessed as not effective. Notably, there is no clear consensus on what is "immediate risk"; different clinicians have different thresholds, and there is no clear definition of "considered or implemented and assessed as not effective." Formally, psychiatrists make the determination on restraint or seclusion use, but practically, the nursing team and psychiatrist make the decision together.

Of the 13 patients whose charts were included in this analysis, five were documented as cis women, seven as cis men, and one as a transgender woman. The mean age of the patients was 42.3 years (20–65 years). Patients were identified as white (5), Black (4), mixed heritage—Indigenous and white (1), mixed heritage—Black and white (1), and Latin American (1) (one chart did not document race). I note the disproportionately high number of Black patients given their relatively low numbers ($n = 22$) in the overall sample of charts (see Chapter 1, Introduction). Eight patients were identified as heterosexual and one as lesbian. The sexual orientation of one patient was listed as "other: transgender." The remaining charts did not list sexual orientation. Nine patients were identified as having an income below $15,000, one above $15,000, and three were listed as "income not known." Reasons for admission included safety concerns (suicide risk, risk of harming others), need for medication or medication stabilization, substance use disorders, symptoms of mood disorders (mania, depression), and psychosis. All patients in this sample were admitted involuntarily under a Form 1[3] of the Mental Health Act and almost all were eventually placed on a Form 3[4] of the Mental Health Act. Length of stay ranged from several days to over two weeks.

Framing Patient Trauma as Disruptive or Demanding

In this section I articulate the ways in which the responses of patients to involuntary hospitalization and restrictive institutional practices and policies (e.g., frequent checks every 15 minutes, forced engagement with MHPs, no smoking policies, and "offering" PRN medication in

response to early signs of distress) are documented by MHPs as disruptive or demanding rather than as expressions of trauma, thereby justifying the use of control interventions. Overall, trauma caused by involuntary hospitalization and other confining practices was rarely documented by MHPs as a source of patients' agitation, anger, and fear. For example, documentation of William's[5] (65 yrs., white, cis man, heterosexual, income unknown) behavior implies that he was unpredictably and unreasonably agitated ("without any clear stressor"), thus requiring locked seclusion:

> In the middle of the interview and without any clear stressor, William became precipitously agitated … blocking the door of the l/s [locked seclusion] room, refusing to discuss (treatment) plan any further. (psychiatrist)

However, a critical reading of this documentation illuminates the possibility of two interactional stressors that may have motivated William's response:

> Discussed current (treatment)
> Says that he does not feel he needs any medication … but rather "to be left alone."
> Adherent with Ola [Olanzapine] 10 mg po qhs … however, finds it too sedating.
> We discussed the idea that his current sedation is likely secondary to PRN meds which have been used to contain his aggression.
> Writer proposed a continued titration of olanzapine.
> However, patient declined. (psychiatrist)

First, William was forced to continue a conversation with the psychiatrist after expressing a wish "to be left alone," and second, he was told that the doctor would like to increase the medication dosage against his wishes. Rather than understanding William's distress in the context of these stressors, documentation describes him as unpredictably (read unnecessarily) aggressive, necessitating his locked seclusion and chemical restraint.

Similarly, Devon, a 20-year-old cis man of Indigenous and white descent (heterosexual, income <15K), with a history of intellectual

disability, trauma, and substance use was subjected to locked seclusion for verbally and physically (banging on nursing station door, kicking chair) expressing distress in response to being involuntarily hospitalized. There was no documentation that the nurse considered whether his intellectual disability, trauma, and potential experiences of colonial violence impacted his ability to tolerate confinement and communicate distress:

> Patient was also stating he is not crazy, and that he does not belong to this fucking place. He wants to be out with his friend, nothing wrong with his life, but you people pushed medication on him and locked him up making him losing his mind. (nurse)

Other documentation in Devon's chart constructs him as entitled and willfully disruptive in the context of forced confinement:

> After waiting for only a brief time for NSG [nursing] assistance in accessing the internet, Devon began to act out. He became belligerent and physically threatening with staff; kicking the NSG station door and banging on the window, upon returning to his room repeatedly slammed the door. Not able to settle with support. Code white activated and with security present, Devon accepted prn lox 25mg and ativan 2mg po. Still unable to accept any ownership of his b/h [behavior]. (psychiatrist)

Coercive and restrictive hospital practices associated with involuntary admission are also implicated in MHP documentation that characterized patients' trauma responses as disruptive or demanding. Ebo, a 33-year-old, Black, cis man (heterosexual, income <15K) with a recent immigration history was documented as "escalating with agitation over the morning. Asking and demanding for 'my break … let me out to smoke.' NRT [nicotine replacement therapy] offered multiple times, but he refused" (nurse). Ebo was placed on continuous observation, with a staff member following him on the unit. His inevitable frustration with being followed was documented by the provider: "Client spent majority of time pacing around unit. Client became agitated and verbally aggressive toward writer. Client in a hostile tone stated to writer if writer is not going to give him break, writer should stop following him" (nurse). This documentation illustrates how the imposition of

repeated unwanted "interventions" by MHPs affect a patient's behavior, which is then responded to with coercive force. Moreover, documentation reveals how restrictive and coercive institutional practices and policies, such as no smoking and continuous observation, are deemphasized in documentation, receding into the background as sources of patients' distress. Instead, MHPs' documentation narratives abstract patients' distress responses from the institutional context, constructing patients as innately demanding, disruptive, or hostile and in need of control intervention.

Of critical importance is that at times responses that do not actually place patients or staff at imminent risk of bodily harm are assessed as disruptive enough to necessitate restraint. This can have detrimental trauma consequences for patients. For example, the documentation below suggests that Monica, a 50-year-old, white, cis woman (lesbian, income <15K), was restrained and given intramuscular (IM) medications in the absence of a clear indication of her being a safety risk:

> Client was noted to be awake all night; pacing+++, disruptive – opening and banging the doors; rearranging the furnitures [sic] at the lounge; putting books in the freezer; moving and turning chairs upside down; going to the male's washroom; she was offered but refused PRNs even with security's assistance; difficult to redirect and she has a lot of demands – single room, to open the TV, activity room; insight and poor judgment noted; MD on call was called – MD from emerg came and assessed client – ordered STAT [immediately] dose of IM PRNs (2mg ativan and 25mg loxapine) – administered with presence of security; client remains disorganized; will continue to monitor and assess. (nurse)

It is important to note that the presence of security is a coercive intervention, and if Monica had taken the medication when she was initially offered it, it would have been documented as "chemical restraint." In other words, if a patient refuses a PRN and security is called for the purpose of enforcing medication adherence, the patient is considered to have been chemically restrained. Many patients, especially those who have been involuntarily held in psychiatric settings, are offered PRN medication in the absence of security. While this is not considered restraint, it may be the first step down a coercive pathway. While the

justification for PRN medication is to calm and sedate a distressed patient and to prevent the use of restraint to manage distress responses, a patient's refusal to take the PRN often results in being chemically or physically restrained or secluded.

Undoubtedly, the threat to safety for patients and MHPs in some situations is real. Nursing staff, who are most likely to be women, are most often at risk of physical harm during patient interactions (Itzhaki et al., 2018). However, it is imperative that psychiatric institutions recognize the productive effect of their policies and practices to motivate patients' trauma responses, including agitation, fear, and anger, and subsequently to put patients at risk for control interventions. In this regard, some documentation indicates institutional and MHP recognition of the (re)traumatizing impact of restraints. For example, Juan, a 41-year-old, Latin American, cis man (heterosexual, income <15) with a trauma history was documented as "quite re-traumatized by the restrains" (psychiatrist) and as having experienced seclusion as "more traumatizing and counter therapeutic" (based on restraint use during a previous admission) (psychiatrist). Notwithstanding this recognition and that debriefing following restraint use is part of hospital policy and trauma-informed care, very few charts include detailed documentation on the impact of restraint use on patients. Typical documentation includes "Pt. debriefed following incident," "Debrief refused by client," and "Supportive communication and orientation provided." When trauma debriefs after restraint use are documented, they often focus on having a patient explain their behavior leading up to restraint rather than an exploration of trauma associated with restraint itself. For example, the chart of Sean, a Black cis man (heterosexual, income unknown) includes the following post-seclusion debrief:

1. What do you believe caused the restraint or seclusion?

   I posed a question to Dr. [name redacted] perceived as a treat, I had conviction + was defiant. I did not refuse medication, only desired to speak with doctor first therefore it was not not-compliance. After, the standoff took place, I took my medication in front of all present + submitted to them for seclusion.

2. a) a) What could staff have done differently that might have prevented the restraint or seclusion?
   The fact that I was admitted + kept confined without fresh air for a period of 48 hrs goes against [the institutions]'s mandate.
   b) What could you have done differently that might have prevented the restraint or seclusion?
   Taken the medication as directed.
   c) Could something have been done during the restraint or seclusion that might have helped to end it sooner?
   The compliance of the doctors to my request.
   d) While you were restrained or secluded is there anything staff could have done to help you (eg cover you with a blanket or play music)
   Give me my ipod
   e) Did you sustain a physical injury …?
   No
   f) How has the restraint or seclusion affected you?
   In no way.
   3. What was it like for you to be restrained? (this includes being in seclusion …)
   Used to it, had it done during previous admissions to hospital
   4. Did you and the treatment team develop a plan of care to help prevent another restraint or seclusion?
   No
5. a) Left blank
   b) Is there anything else the treatment team can do now and over the next few days to help you recover from this event?
   No. (Written by patient and transcribed verbatim)

This practice (documenting a trauma debrief in a structured format) is atypical and not observed in any other chart. I note that in this debrief, Sean asserted his agency in multiple ways including emphasizing that he "did not refuse medication, only desired to speak with doctor first therefore it was not non-compliance" and contextualizing his response in relation to institutional policies that kept him "confined without fresh air for a period of 48 hrs." Of particular concern is the assumption of alliance between the patient and MHP, whereby after experiencing the

violence of restraint Sean was expected to work collaboratively with the MHP to explore how being subjected to coercive force impacted him (How has the restraint or seclusion affected you? What was it like for you to be restrained?) and develop a plan of "care" to prevent the use of future force (Did you and the treatment team develop a plan of care to help prevent another restraint or seclusion?). It's not surprising that Sean responded "no" to the question of whether "the treatment team can do anything now and over the next few days to help [him] recover from the event."

Providers' Use of the Passive Voice and Asymmetrical Documentation

The excerpt above from Monica's chart also serves as a segue into this second theme, which illuminates the ways in which MHPs' agency in restraint use and coercive force (i.e., violence) is effaced from the psychiatric chart through documentation. Notably, the nurse documented that Monica refused the IM PRN "even with security's assistance" but then eventually received it "with presence of security." In similar ways, MHPs' use of the passive voice characterizes the documentation of restraint use in other charts, drawing the readers' attention to who is being acted on (the patient) rather than the person who is responsible for the action (the MHP). This is used through commonly used terms such as "present," "placed," "required." In another case, Glenda's (50 yrs., white, cis woman, sexual orientation and income not listed) forced confinement was documented as an intervention that she "required": "Today pt. is labile. Requiring locked seclusion over the weekend" (psychiatrist). Similar documentation excerpts in other charts abound:

> Security were called and she took emergency medication by mouth. She required seclusion for only a short period and slept the majority of the night in her room (Joanna, 28 yrs., white, cis woman, heterosexual, income >30K). (psychiatrist)

> Required restraints and chemical sedation in ER. (Chris, 31 yrs., white, cis man, heterosexual, income <15K) (psychiatrist)

> At 0355 hrs, with three security staffs [sic] present, patient received PRN ativan 2 mg PO and loxapine 25 mg PO. Duty doctor [name redacted], and nursing supervisor present. Locked seclusion ordered. At 0400 hrs, patient placed in unit 2-2 locked seclusion room. (Devon) (nurse)

Use of the passive voice suggests that the MHP is an irrelevant or insignificant actor, thus requiring only a vague reference in restraint use documentation. The effacing of MHPs in chart documentation serves to absolve them—and the institution—of responsibility and accountability for the events leading up to restraint use. The reader is not given details about MHPs' actions, including their knowledge of and ability to implement trauma-informed support strategies and de-escalation interventions (see next theme). Moreover, the likelihood of restraint use being seen as (re)traumatizing is minimal as this documentation pattern paradoxically puts responsibility squarely on the patient.

As previously stated, most psychiatric institutional policies are intended to ensure that restraints are used only after all reasonable efforts are made to find alternative, less coercive, and restrictive measures and identify de-escalation strategies. However, the analysis of chart documentation reveals scant documentation of MHPs considering de-escalation strategies compared to the frequent and detailed documentation of patients' responses that led to restraint use. This asymmetrical documentation pattern, the over-documentation of patients' responses and under-documentation of MHP actions, works in collusion with the inferences of patient passivity to recede MHPs into the psychiatric chart. It serves to erase MHPs' actions leading up to and during restraint use. This is seen in Glenda's chart:

> At 1540 patient was yelling at others, agitated, not redirectable and not willing to follow directions, and threw a book into the nursing station, trying to hit staff. Security was called and patient walked over to the seclusion room by staff and security. At 1545 pt. was put into seclusion room, and is currently being monitored by staff. (nurse)

Similarly, in the excerpt below, the language of "disruption" is used to justify the use of locked seclusion, while the reader is left wondering about the MHP's use of alternative de-escalation strategies before Glenda

was mechanically and chemically restrained, "Client has been loud and disruptive most of the night thus far. Singing, talking loudly, and being verbally abusive towards staff. Redirection ineffective" (nurse).

Discounting Structural Violence

The context of gender, race, and class, and structural violence in the form of sexism, racism, colonialism, and classism as they relate to patients' expressions of distress and restraint use are never explicitly documented. However, this analysis of restraint use documentation raises important considerations related to how sexism, racism, colonialism, and classism are implicated in the "unevenness" with which restraints are employed in psychiatric institutions. First, the analysis reveals that men engaging in sexual violence were not as readily subjected to control interventions as were women who were often characterized as "sexually inappropriate." While sexual violence enacted by men was often minimized through euphemistic language such as "sexually inappropriate," women were restrained because they were being "sexually inappropriate." Ebo, who engaged in sexually threatening behavior toward a female co-patient, was documented thus:

> Client was observed entering a female co-client's personal space. Female co-client kept asking her [sic] to move away and client did not listen. Writer then intervened and redirected client. A short while later client was observed touching another female co-client inappropriately on the waste [sic]. Client was again redirected and counselled regarding the need for him to respect people's personal boundaries. (nurse)

> At 1840 hours, staff LT reported he saw client "grabbing" co-client's behind while they were walking in the hallway; co-client did not resist and observed her smiling instead. Will monitor client. (nurse)

Comparatively, Glenda was placed in locked shut down for blowing a kiss to a male staff and, shockingly, because another patient was "sexually disinhibited": "Called to unit at 1130PM to assess this and another patient. She has been pacing the unit and is having difficulties settling.

She is sexually inappropriate towards male staff. Observed to blow a kiss. Difficult to redirect" (psychiatrist). The psychiatrist continued: "In locked seclusion due to her agitation and since there is another patient on the unit who is sexually disinhibited and has been targeting her" (psychiatrist).

Second, in several charts, documentation suggests that the broader context of colonial violence and intergenerational trauma evaded MHPs' understanding of patients' distress responses. For example, notwithstanding Devon's incarceration and trauma history as an Indigenous man, his distress was described as "what appears to be tantrums" (psychiatrist). The psychiatrist identified psychosis or "personality factors" as the possible source of his distress response:

> Code white activated and with security present, Devon accepted prn lox 25mg and ativan 2mg po. Still unable to accept any ownership of his b/h [behavior]. Making statements that the police "beat up" people and now security was there to do the same. Self-entitled with his own needs and unable to appreciate the response his b/h was provoking in the staff. (psychiatrist)

> This is the first adm for this 20 year old with cannabis addiction, a one year hx [history] of increasing paranoia and erratic behaviour and a strong family hx of psychosis, mainly bipolar disorder. Pt has explosive outbursts and what appear to be tantrums. It is hard to distinguish between personality factors and psychosis/mood disorder as the cause of these outbursts. (psychiatrist)

The psychiatrist dismissed Devon's experiences of police violence and the retraumatizing effects of security enforcing coercive measures. Similarly, institutional anti-Black racism and, relatedly, police use of deadly force against Black people were not factored into the MHP's response to concern expressed by Ebo's wife about calling police:

> Met with wife and cousin.
>
> Reviewed hx with them.
>
> Wife reports he has been physically assaultive, has struck her and thrown lighters at her. She fears for her safety but was afraid to call police,

> even though family advised her to do so. I advised her to call the police. (psychiatrist)

The experiences of the Indigenous and Black patients described above are different from Joanna's, a 28-year-old, white, cis woman (heterosexual, income >30K), who was noted to be a professional. A closer look at documentation in Joanna's chart explicates institutional privilege at the intersection of gender, race, and class. Joanna's distress was often documented in terms of being fearful and anxious, rather than aggressive, and situations in which other patients were restrained (e.g., "trying to get out of door") were met with significant de-escalation efforts by MHPs:

> Client was escalating in her behaviour. Yelling trying to get out of door. Writer attempted to close door to prevent another client from entering and client made a lunge for the door. Given Lorazepam 2 mg and Olanzepine 5 mg with a great deal of persuasion. Client is very paranoid and fearful. (nurse)

Joanna's verbal threats toward co-patients were contextualized, with MHPs focusing on her emotional experience as a justification for her behavior:

> Patient approached 2 co-patients on separate occasions while they were being attended to by staff. She yelled at them in a threatening manner as though they posed a threat to her, believing they could cause her some harm. Settled with PRN meds. (nurse)

In striking contrast to other charts, MHPs documented their attempts to understand Joanna's distress, spending time with her in the lounge after she threw a weighted chair rather than locking her in a seclusion room:

> Pt was getting slowly agitated and loud this morning offered prn same refused, able to calm down on her own for a while. She came out of a group this afternoon and started screaming agitated and loud. Went to the lounge area grabbed a chair and threw the chair in the middle of the lounge area as witnessed by staff. Staff approached very agitated unable to

calm down, prn was offered refused initially and took same after encouragement. Pt became tearful still wants discharged from hospital. Given Olanzepine 5mg and Lorazepam 2mg po prn at 1340hrs for agitation.

Pt stated did not want to be in hospital was fine and does not know why she's in hospital. Staff spent time with her in the lounge area. (nurse)

Documentation also suggests implicit understanding that the hospital milieu (15-minute checks, changing staff, having co-patients around clients) may have impacted Joanna's distress responses:

took hs medication and tried to settle to bed

was startled by staff doing rounds and quickly became very agitated–asking if 2 cops were here–asking where her boyfriend went–not recognizing staff/saying we look different–not able to re-settle–not receptive to reassurance/re-direction to room; accepted prn olanzapine 5mg and lorazapam 2mg @ 2230hrs with minimal encouragement–pending effect. (nurse)

patient is suspicious and paranoid, "other patients were walking around my room, they are dangerous, I am afraid of them." reassurance and support given to patient. (nurse)

Code white documentation for Joanna offers more detail about her emotional state ("very scared," "does not feel safe on the unit," "wanting to go home"), although MHPs also used the passive voice (e.g., "was placed on Form 1," "placed on locked seclusion") in documentation to recede into the chart:

Pt came at the nursing station @ 2135 hrs and barge in to the door as soon as staff opened the door to talk to pt. Pt was very anxious, agitated and appeared very scared stated that she does not feel safe on the unit wanting to go home, sat by the window in the nursing station refusing to come out, grabbed the phone and tried to call 911 while staff was trying to talk to her and encouraging to take PRN meds to help her calm down, declined offered med. Pt. escalated, uncooperative, resistive to redirection, grabbed and hit staff on the arm and scratched another staff on her left arm. Code white was called @ 2142hrs. Pt continues to be resistive to redirection while security staff and duty doctor present. Pt.

> continues to refuse oral Prn, was placed on Form 1, stat IM meds ordered. Pt then decided and took oral Prn Lorazepam 2mg po and Olanzapine ODT 5mg @ 2215hrs. Pt placed on locked seclusion and maintained on constant observation for 1 hour. Pt remains awake banging on the door. Locked seclusion with q15 min observation continues. (nurse)

Overall, the restraint-related documentation in Joanna's chart at the intersection of gender, race, and class—middle-class, white woman—might be characterized as more empathic and humane. Documentation suggests that MHPs were less fearful of Joanna as a middle-class, cis, white woman than of other patients who were poor, Black, or Indigenous, and therefore focused more on her emotional experience and did not subject her to coercive measures as frequently.

Concluding Thoughts

This chapter illustrates the ways in which the trauma enacted on patients through the use of restraints is minimized in psychiatric documentation. Chemical, physical, and mechanical restraints are (re)traumatizing for patients. They cause psychological trauma, physical harm, in some instances death, and lack of trust in MHPs and mental health care institutions (Funayama & Takata, 2020; Kontio et al., 2012). Qualitative research with patients who have experienced restraints or seclusion documents significant emotional trauma from this practice. Emotions identified by patients include anger, humiliation, confusion, loneliness, helplessness, and powerlessness (Khatib et al., 2018; Kontio et al., 2012; Spinzy et al., 2018). Many patients with histories of institutional trauma report a retriggering of previous trauma (Khatib et al., 2018; Wong et al., 2020).

Strategies to reduce rather than eliminate restraint use are often discussed in the literature (Kinner et al., 2017). In 2008, the National Association of State Mental Health Program Directors in the United States released "Six Core Strategies to Reduce the Use of Seclusion and Restraint," a report and recommendations that have been enacted throughout the US, showing reductions of 47% to 92% in the use

of restraint in 70 facilities (Fernández-Costa et al., 2020; Huckshorn, 2008; Kinner et al., 2017). Common components of restraint reduction strategies in hospitals include enhanced staff training in de-escalation techniques and personalized treatment plans for those who are at risk of being restrained or placed in seclusion (Fernández-Costa et al., 2020; Jacob et al., 2016; Richmond et al., 2012). Studies also indicate that adequate staffing and support are crucial to ensure least-restraint policies (Brickell et al., 2009; McKeown et al., 2019). Other studies have recommended that MHPs receive regular training on the impact of restraints and strategies to minimize them. For example, one study recommended regular educational sessions on the potential psychological impact of restraints as well as reflective practice groups to review and interrogate policies and procedures, while another recommended education and support on strategies to reduce restraint use in specific groups, for example, older people with poor mobility (Huizing et al., 2007; Walker & Tulloch, 2020). Several studies recommend improved communication with patients (e.g., providing information and support in a calm and sensitive way, mandatory staff presence during the duration of restraint use, and supportive debriefing) (Lanthén et al., 2015; Ling et al., 2015).

Qualitative research with patients who have experienced restraints suggests improvements are needed in several domains. The first is in preventing these events, including providing patients with meaningful activities, documenting patients' wishes, and making patient–staff agreements ahead of time (Kontio et al., 2012; Lamanna et al., 2016; Ling et al., 2015). Other recommendations include more comfortable units and the ability to go outside for fresh air and smoking breaks (Kontio et al., 2012; Lamanna et al., 2016; Ling et al., 2015). Supporting patient autonomy by allowing them to make decisions on clothing and when to eat, sleep, and attend to hygiene were also strategies that reduced the frequency of control interventions (Kontio et al., 2012). The second is improved communication and interaction before, during, and after the restraint (Kontio et al., 2012; Ling et al., 2015; Spinzy et al., 2018). Patients have expressed a desire to have MHPs speak with them genuinely and empathically during the restraint or seclusion and also have expressed a need to discuss the event and their feelings afterward in a supportive, empathic, and nonpunitive way (Khatib et al., 2018;

Kontio et al., 2012; Lanthén et al., 2015). Engagement in the treatment process helped patients to feel like active participants in their own care and less confused, frightened, and perplexed (Kontio et al., 2012; Krieger et al., 2018; Lanthén et al., 2015). Third, soothing experiences during restraint use, including reading books, listening to music, or engaging in exercise can be helpful (Kontio et al., 2012; Krieger et al., 2018). Beautiful and comfortable physical spaces were also identified as helpful and healing rather than punitive and frightening, including comfortable bedding and access to a bathroom, proper ventilation, and appropriate temperature (Khatib et al., 2018; Kontio et al., 2012). The fourth and most important improvement is the engagement of patients in the practical development of policies and procedures (Kontio et al., 2012). As Kontio et al. (2012) point out, to ensure high-quality, patient-centered psychiatric care, engagement of and co-creation with patients in policy formation is necessary. The importance of incorporating service users' perspectives in the development of inpatient "aggression" management strategies has been identified by several organizations as being of utmost importance (Kinner et al., 2017; Kontio et al., 2012; Tingleff et al., 2019).

It is important to point out that MHPs working in acute care settings often face very real violence in their day-to-day work, as demonstrated in the documentation in this chapter and in the literature (Lanthén et al., 2015; Walker & Tulloch, 2020). These experiences of physical aggression, sexualized language, and verbal threats can lead to distress and burn out. While violence flows in all directions (toward patients, between patients, and toward staff), it is governed by hierarchal power dynamics that disadvantage patients, particularly patients who are marginalized because of gender, race, sexuality, and class. An interrogation of institutional and structural violence, as discussed in this chapter, is required to create a more humane and equitable system. As an emergency department psychiatrist, I understand that situations will occur in which I will need to make the decision to restrain a patient because I—and my colleagues—believe that the risk for violence is high and know that other strategies have been ineffective. However, I also understand that my decision will cause trauma for a patient. As such, it is my responsibility, along with the institution, to review how institutional policies and

procedures contribute to patient distress and aggression, and to support patients who experience this trauma at our hands. Changing documentation patterns to make more visible the trauma done to patients and MHPs' attempts to de-escalate a situation before restraint is used, as well as their and security's active participation and coercion in instances of control interventions are critical steps in this process.

Acknowledgements The author wishes to thank Dr. Andrea Daley and Dr. Merrick Pilling for their analytical contributions to this chapter.

Notes

1. The term "restraint" recalls the act of limiting an individual's freedom of movement. It is, nonetheless, important to emphasize how the term in psychiatry refers more precisely to a coercive act that limits freedom of movement. Any action that is carried out against the will of a patient is considered to be a coercive act (Negroni, 2017).
2. Physical restraints are also referred to as mechanical restraints.
3. A Form 1 is a provision under the *Mental Health Act* in the province where the study took place that allows a physician to detain a patient for a psychiatric assessment for up to 72 hours at a psychiatric facility. A Form 42 (Notice to Person) is always given to a patient to notify them that they are under a Form 1. A Form 1 is only for an assessment and not an involuntary admission per se.
4. A Form 3 (Certificate of Involuntary Admission) is a provision under the *Mental Health Act* in the province where the study took place that is filled out when a patient meets criteria for an involuntary admission.
5. All names given to patients are pseudonyms.

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