REVIEW

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Physical Restraint in Psychiatric Care: Soon to Fall Out of Use?

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ABSTRACT

International directives all recommend that using restraints on psychiatric patients should be avoided, yet scientific literature shows that such practices are still largely in use. This article aims to lay out strategies that could be put in place in order to gradually discard the use of restraints, particularly through a "restraint-free" approach, nursing, logistic-environmental pathways, and locally centered health care provision. All such tools have proven valuable for the purpose of safeguarding the health of psychiatric patients. Hence, the failure to put in place such measures may lead to litigation and lawsuits against physicians and particularly health care facilities. Undoubtedly, the ability to effectively implement such methods largely depends on the financial resources available, which in countries such as Italy are poorer than in others. Still, the risk of being sued and held professionally liable may constitute a factor in raising awareness among operators, facilities, and public health care management, leading to the implementation of policy changes aimed at minimizing the use of restraints.

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INTRODUCTION

In medical and nursing parlance, "physical restraint" means a partial or total form of preventing patients from moving through the use of various tools to that end, such as belts, straps, chairs, and beds among others. Recent studies on the subject have concluded that the use of such tools is still widespread throughout Europe and is not limited to psychiatric care but is applied in other fields such as emergency, geriatric, and even pediatric care.

International legal- and ethical-centered recommendations[1-4] all agree that physical restraint runs counter to human rights enforcement by limiting personal liberties. Moreover, it can result in patients suffering injuries or even dying from it.[5] Restraint should therefore be viewed as a strictly regulated exception to the rule.

The same conclusion has been reached in Italy,[6] where, however, a research study has found that 20 instances of restraint for every 100 hospitalizations still occur, accounting for 11% of psychiatric patients overall.[7] Another study conducted in Rome's institutions has found that 11 out of 100 discharged patients were put in restraints[8] while hospitalized. The use of restraints is to be more prevalent in Italy than it is in other European countries,[9] roughly equating the international rate of use (i.e., Italy has a 6.3% rate, as opposed to 6.6% in Switzerland, 5.7% in Finland, 8.5% in the United States, and 9.5% in Germany).[10] Although incidences do vary, all point to the still unsolved fundamental issue.

Debates centered on the suitability and value of such practices have led to guidelines being issued and initiatives being promoted, which have confirmed how the use of restraints can be substantially limited through cultural changes and more effective organization in the delivery of health care services. The Danish project named National Breakthrough Project on Coercion in Psychiatry, for instance, which was implemented in 27 psychiatric wards from August 2004 to June 2005, has proven that in 33% of surveyed facilities, the use of restraints had dropped by 20%.[11] In Italy, another survey conducted among the SPDC (acronym for Servizi psichiatrici di diagnosi e cura, i.e., public psychiatric services) in the central region of Latium from 2005 to 2011 has found that over the 6-year period, the number of patients on whom restraints had been used dropped by a quarter. Those data prove that devising and implementing targeted programs, besides the consistent monitoring and analysis of restraint cases, can yield positive results.[12]

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Forgoing Restraint Is Closely Linked to the Availability of Resources

Psychiatric restraint is not only an ethical and technical issue, but it presents administrative and organizational traits as well. A literature analysis on the subject has laid bare a close connection between the structural characteristics of psychiatric facilities and the use of restraints: seclusion and restraint are in fact more commonly used under substandard structural and organizational conditions.[13,14] Hence, it would be safe to assume that the use of restraint and seclusion can constitute a marker of substandard quality of patient care.[15] Certainly, restraint cannot and must not be used to offset organizational flaws and malfunctions; for that reason, several studies have identified a set of "key strategies."[16-18]

From Restraint to Containment

In order for restraint use to be minimized and for quality of care to improve, it is necessary that health care systems be equipped to promptly and effectively intervene whenever patients exhibit anomalous behaviors. The first strategy in order to reduce the need for restraints is therefore to reconfigure the way services are provided.

To that end, several factors have been identified that induce doctors and nurses to resort to restraints: (1) unsuitable facilities; (2) understaffing, commonly due to high rates of attrition, in public health facilities; (3) professional burnout (high levels of job-related stress often leading to psychological and physical exhaustion), particularly widespread in psychiatric facilities; (4) inadequately trained professionals, thus unfit to manage agitated or aggressive patients.[19]

In Italy, a small number of SPDCs have resorted to the so-called *no restraints method*.[20] Such a method is characterized by 2 fundamental elements: (1) the patient's hands are never tied to the bed and (2) doors are always left open. The relationship between health care professionals and patients is pivotal. The main goal in no restraint wards is to contain and deescalate, as opposed to the coercion and immobilization that restraint entails.

MAIN POINTS

- Physical restraint tools are still widespread throughout Europe.
- International legal and ethical recommendations highlighted that physical restraint runs counter to human rights enforcement by limiting personal liberties.
- Health care policies promoting "restraint-free" approach, nursing, logistic-environmental pathways, and locally centered health care provision may gradually discard the use of physical restraint.
- Physical restraint tools further involve administrative and structural issues because of underfunding and a shortage of specific updated training programs for health care operators.

In order to achieve that, patients and operators need to develop a solid relationship. It is no coincidence that the most severe manifestations of mental diseases occur more frequently in wards where restraints are more widely used, as opposed to no restraint SPDC, which raises the doubt that coercive practices carried out in wards where restraint is frequently used may engender or at least exacerbate extreme manifestations from patients.[21] The main priority is to foster a climate of mutual listening and understanding between patients and nursing personnel, in a setting where professionals operate through teamwork and devise strategies aimed at enabling patients to overcome aggressive fits with no need to physically restrain them.[22]

The Italian Committee for Bioethics has pointed out only by spreading a restraint-free approach can the health of psychiatric patients be adequately catered to; at the same time, the obligations that doctors have toward their patients can be properly fulfilled, based on the guarantees and responsibilities in terms of protection and supervision, which constitute the cornerstone of the doctor-patient relationship as free as possible from coercion and solidly grounded in quality and effectiveness.[23] That change can be achieved through information campaigns aimed at professional and the reorganization of health care services.

NO RESTRAINT METHOD HOW IS IT CARRIED OUT?

Among the strategies that have produced positive results is the "holding" technique, based on "affection-based" containment. In 1958, British psychoanalyst Winnicott construed the term "holding" as hugging, protecting, caring for. Hence, by resorting to such sensory-affective-cognitive techniques, such as touching, addressing, and stimulating patients,[7] health care professionals can keep crises in check and reassuring patients by treating them with humanity, rather than authority. Each patient needs to have a nurse who personally follows him or her, constantly trying to establish dialogues and gain trust, so as to anticipate and stave off a crisis before it gets out of hand.[24]

According to De Benedictis et al.[25] health care personnel who have developed a positive relationship with their patients can manage adverse events more effectively and promptly, since they are more capable of controlling their emotional reactions. In practical terms, when using restraints, nurses merely bound their patients and leave the room. Holding, on the other hand, requires care providers to spend time with their patients, striving to relate and connect with them until they are calm again. Hence, the "open doors" concept does not mean that patients are allowed to leave the facilities without permission; it means that they will not try to escape, they will only leave after being instructed and allowed to do so by the nurses. Should patients fail to come back, a territorial search network will be alerted,[26] trying to figure out the reasons behind such a failure to comply.

REDEFINING WORKING METHODS AND APPROACHES TOWARD PATIENTS' NURSING STRATEGIES

Among the factors that can incentivize restraint use, high levels of stress experienced by the nursing staff certainly play a major role. Unlike doctors, in fact, nurses are tasked with practically managing the application of restraints and with overseeing the health conditions of restrained patients. Scientific research strongly recommends solid training of personnel in order to prevent violent outbursts, by teaching how to identify the initial stages of such crises.[19,27]

A valuable strategy that nurses can act upon is to get the patients closely involved in the therapeutic pathway, so as to figure out what bothers them and tailor the most suitable treatments for each patient. From a strategic perspective, it is essential to include in any therapeutic initiative all aspects inherent to the life of each individual patient: the activities he or she prefers, for instance, or the social relationships, emotions, and life conditions.[19] In order to gain such information, however, nurses need to be close to their patients, gain their trust, observe meaningful behaviors in order to figure out what factors unleashed the dysfunctional conduct, and to determine what conducts may require health personnel to restrain the patient. By applying those standards, the initial stages of potentially violent outbursts can be defined and prevented, thus minimizing the need for physical restraints.[19] At any rate, if any given patient exhibits warning signs of an impending crisis, nurses will have to alert a multidisciplinary medical crew and set in motion possible interventions always aimed at selecting strategies other than restraint. In order for possible violent outbursts to be anticipated, sound medical practice recommends setting up counseling and training initiatives for staff members, the use of tools such as risk assessment, crisis resolution team, involuntary commitment programs, agreements signed by patients including booklets laying out all available treatment options.[28]

According to scientific research, a higher level of empowerment for nursing and medical personnel is instrumental in allaying the feeling of alienation and burnout; in fact, a reasonably close, but not overly personal, approach goes a long way toward fostering greater awareness and knowledge of each patient.[29] Effective cooperation among colleagues is also essential: it has been found that the higher the perception of aggressiveness and anger in one's colleagues, the higher the likelihood of violent incidents between providers and patients, which negatively affects the overall safety of the work environment. Moreover, higher levels perceived of hostility are linked to more frequent use of restraints.[30] Other strategies may also prove valuable in that respect: (1) selecting those with the best relational inclinations among health care personnel,[31] (2) creating more opportunities for staff members and patients to interact with one another, (3) devoting space and time to reviewing cases in which restraints and seclusion were used, in order to outline reduction strategies or retrospective resolution.[32] Technical training and familiarity with the various types of restraints and close circuit camera systems are also essential for the supervision of facilities and to use the recordings for the review of clinical cases.[30] An open and forthcoming dialogue needs to be established, getting staff members, patients, and family members involved for the ultimate purpose of preventing and finding alternatives to restraint, within a dynamic of fruitful cooperation and communication.[19]

Logistic and Environmental Strategies

A given environmental setting can influence individual health conditions, anxiety levels, and the capacity for orientation in space. All interventions aimed at enhancing environmental safety and reducing the need for restraints should therefore be promoted. All facilities where patients with functional and/or cognitive impairments are hosted should be adequately lit, with easy to operate switches, anti-slip flooring, and safety locks preventing patients from getting out when unauthorized. Pathways without obstacles, possibly circular, should be set up for patients given to wandering behaviors. Restraint can be forgone in patients who tend to wander off but still have stable pace and gait and do not risk fall.[33] In order to make a thorough patient assessment, the so-called "structured" assessment protocols are followed that use standardized evaluation scales in order to draw up an analysis of motor capabilities (gait, balance, transfers). Scientific literature has expounded upon various methods for constraining a patient's ability to move while lying in bed: hollowed mattress, waterbed, rolled up blankets placed at the edges. Other interventions are aimed at warding off adverse consequences, should an accidental fall occur: soft carpets positioned on the floor right beside the bed, making the patient lie down on a mattress placed on the floor, or lowering the bed's height to a minimum.[34] A multidisciplinary staff is called on to discuss each case and initiate a therapeutic plan targeted to minimize the need to restrain and to establish a constructive climate of relationships among health operators, patients, and family members.

The degree of patient safety, which in turn determines a decreased need to restrain them, can be enhanced by the use of visual oversight systems, particularly in high-risk settings, and alarms designed to signal unauthorized access to certain areas. According to scientific research studies, allowing patients to take walks in gardens, parks, in close contact with nature, has a positive effect, in that it fosters psychological well-being and relieves stress.[19] It is also of utmost importance to uphold the patient's right to privacy and autonomy by allowing them to rely on a

private space, which could help them handle their social relationships.

Patient-Centered Strategies

One of the major ethical issues has to do with the ability of psychiatric patients to express a thoroughly informed consent for the therapeutic proposals made by their doctors. Overall, mental disorders may negatively impact the possibility to get patients involved in the decision-making process. Nonetheless, because of that, patients run the risk of being socially disenfranchised and discriminated against. It is important to use psychiatric advance directives to document patients' wishes for future mental health treatments, including coercive measures.[35]

Research has shown that emotionally unstable patients suffering from mental illness are usually capable of understanding the information provided to them by their doctors, can express their views and preferences, and agree on a given therapeutic pathway to undertake.[36] In such a way, the individual can be set up to regain a sense of control and consequently accept the treatment as less invasive and stifling.[37] The health care team should therefore strive to assuage the patient's anxiety and fear and enhance the sense of self-efficacy.[38] Patients will then be able to develop their own empowerment, in the form of progressive self-awareness and control over their choices within the framework of social interrelationships.[36] A study has pointed out that whenever patients were involved in activities during the day, they slept better at night, with fewer occurrences of behavioral disorders.[39]

Particular attention should be paid to family and friendly relations. Some of those may in fact prove particularly stressful and counterproductive: although it is advisable to allow patients to keep a network of relationships and friends through visits and other means (e.g., by phone, e-mail, and the like), it is necessary to preserve fragile patients whenever relational difficulties should arise.

Privacy is pivotal, and ought to be always guaranteed, since every patient is a free individual with rights that must be upheld. At the same time, it is sometimes beneficial to allow patients to leave the facilities when they wish so, as long as constant supervision is enforced.[40] Such a factor may in some cases turn out to be beneficial to the patient's quality of life.[19]

CONCLUSIONS

By poring over available scientific findings, 2 elements have surfaced. First, a discrepancy exists between legal and ethics requirements on one side and organizational conditions on the other. The former in fact tend toward a general ban on restraints, whereas the latter do not, because of underfunding and a shortage of specific updated training programs for health care operators.

Secondly, methods do exist designed to reduce the need for restraint to a minimum, such as the "no restraint" model. Such an approach may be deemed a good practice and thus influence the judgment on health care professionals in trials.[41] That factor may lead courts to hold doctors legally liable if they failed to implement a "restraint-free" approach. Nevertheless, the feasibility of such an approach is heavily influenced by the organizational decisions made by hospital management, which in turn depend on the funding available at a given time. It therefore stands to reason that operators may be in no condition to avoid the use of restraints. In cases where organizational conditions do not allow for any form of patient management other than restraints, their use should not entail liability for operators. Facilities should instead be held accountable for the failure to transition to a "no restraint" model through organizational changes, which is arguably more consistent with well-established legal and ethical norms.

The very risk of being sentenced to pay hefty sums by way of compensatory and punitive damages could ultimately work as a source of pressure for health care systems to invest adequately in all resources available and to discard the use of restraints altogether.

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REFERENCES

1. Council of Europe, Committee of Ministers. Recommendation no. REC(2004)10 of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory Memorandum. 2004. Accessed October 10, 2021. https://www.coe.int/t/dg3/healthbioethic/Activities/08_Psychiatry_and_human_rights_en/Rec(2004)10%20EM%20E.pdf
2. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Means of restraint in psychiatric establishments for adults (revised CPT standards). Strasbourg, France: Council of Europe; 2017. Available at: https://rm.coe.int/16807001c3, Accessed September 12, 2021.
3. World Health Organization (WHO). *WHO Resource Book on Mental Health. Human Rights and Legislation*. Available at: https://www.who.int/mental_health/policy/legislation/en/, Accessed September 16, 2021.
4. Council of Europe. *27th General Report of the European Committee for the Prevention of Torture and Inhuman*

or Degrading Treatment or Punishment. 2017. Available at: https://rm.coe.int/16807bc1cf, Accessed September 16, 2021.
5. Rakhmatullina M, Taub A, Jacob T. Morbidity and mortality associated with the utilization of restraints: a review of literature. *Psychiatr Q.* 2013;84(4):499-512. [CrossRef]
6. Conferenza Delle Regioni e Delle Province Autonome. Contenzione fisica in psichiatria: una strategia possibile di prevenzione [No. 10/081/cr07/c7]. Rome, Italy: Conferenza Delle Regioni e Delle Province Autonome; 2010. Available at: http://www.news-forumsalutementale.it/public/linee-contenzione.pdf, Accessed September 9, 2021.
7. Ferioli V. Contenzione: aspetti clinici, giuridici e psicodinamici. *Psichiatr Psicoter*. 2013;32(1):29-44.
8. Sangiorgio P, Sarlatto C. Physical restraint in general hospital psychiatric units in the metropolitan area of Rome. *Int J Ment Health*. 2008;37(4):3-16. [CrossRef]
9. Kalisova L, Raboch J, Nawka A, et al. Do patient and ward-related characteristics influence the use of coercive measures? Results from the EUNOMIA international study. *Soc Psychiatry Psychiatr Epidemiol*. 2014;49(10):1619-1629. [CrossRef]
10. Kallert TW, Glöckner M, Onchev G, et al. The EUNOMIA project on coercion in psychiatry: study design and preliminary data. *World Psychiatry*. 2005;4(3):168-172.
11. The Danish Council of Ethics. *The Danish Council of Ethics Statement on Coercion in Psychiatry*. Copenhagen, Denmark: The Danish Council of Ethics; 2012. Available at: https://www.etiskraad.dk/~/media/Etisk-Raad/en/Publications/Coercion-in-psychiatry-2012.pdf?la=da, Accessed September 12, 2021.
12. Mauceri S. Contenere la contenzione meccanica in Italia. *Quaderni Buon diritto*. 2017. Available at: https://old.abuondiritto.it/it/pubblicazioni/119-contenere-la-contenzione/file.html, Accessed September 9, 2020.
13. Husum TL, Bjørngaard JH, Finset A, Ruud T. A cross-sectional prospective study of seclusion, restraint and involuntary medication in acute psychiatric wards: patient, staff and ward characteristics. *BMC Health Serv Res*. 2010;10:89. [CrossRef]
14. Sashidharan SP, Mezzina R, Puras D. Reducing coercion in mental healthcare. *Epidemiol Psychiatr Sci*. 2019;28(6):605-612. [CrossRef]
15. Guivarch J, Cano N. Use of restraint in psychiatry: feelings of caregivers and ethical perspectives. *Encephale*. 2013;39(4):237-243. [CrossRef]
16. Scanlan JN. Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far: a review of the literature. *Int J Soc Psychiatry*. 2010;56(4):412-423. [CrossRef]
17. Colton D, Xiong H. Reducing seclusion and restraint: questionnaire for organizational assessment. *J Psychiatr Pract*. 2010;16(5):358-362. [CrossRef]
18. Italian Committee for Bioethics. Il trattamento dei pazienti psichiatrici: problemi bioetici. *Parere sul Libro Bianco Cons Eur Dedicato Trattamento Pazienti Psichiatr*. 1999. Available at: http://bioetica.governo.it/italiano/documenti/pareri-e-risposte/il-trattamento-dei-pazienti-psichiatrici-problemi-bioetici-parere-del-cnb-sul-libro-bianco-del-consiglio-deuropa-dedicato-al-trattamento-dei-pazienti-psichiatrici/, Accessed September 12, 2021.
19. Soininen P, Putkonen H, Joffe G, et al. Does experienced seclusion or restraint affect psychiatric patients' subjective quality of life at discharge? *Int J Ment Health Syst*. 2013;7(1):28. [CrossRef]
20. Toresini L. SPDC No restraint. La sfida della cura. In: AA. VV., *I Servizi Psichiatrici di Diagnosi e Cura. L'utopia della Cura in Ospedale*. Caltagirone, Italy: Edizioni Co.Pro.S. Omega; 2007. Available at: http://www.slegalosubito.com/wp-content/uploads/2017/11/Atti-VIII-Convegno-SPDC-No-Restraint.pdf, Accessed September 9, 2021.
21. Mauceri S. La dignità negata. Sguardi multifocali sulla contenzione meccanica negli SPDC. Ferrara, Italy: VIII Convegno SPDC NO RESTRAINT; 2016. Available at: http://www.slegalosubito.com/wp-content/uploads/2017/11/Atti-VIII-Convegno-SPDC-No-Restraint.pdf, Accessed September 9, 2021.
22. Gather J, Scholten M, Henking T, Vollmann J, Juckel G. What replaces the locked door? Conceptual and ethical considerations regarding open door policies, formal coercion and treatment pressure. *Nervenarzt*. 2019;90(7):690-694. [CrossRef]
23. Italian Committee for Bioethics. La contenzione: problemi bioetici. 2015. Available at: http://bioetica.governo.it/media/1808/p120_2015_la-contenzione-problemi-bioetici_it.pdf. Accessed September 9, 2020.
24. Jacob T, Sahu G, Frankel V, Homel P, Berman B, McAfee S. Patterns of restraint utilization in a community hospital's psychiatric inpatient units. *Psychiatr Q*. 2016;87(1):31-48. [CrossRef]
25. De Benedictis L, Dumais A, Sieu N, et al. Staff perceptions and organizational factors as predictors of seclusion and restraint on psychiatric wards. *Psychiatr Serv*. 2011;62(5):484-491. [CrossRef]
26. Ye J, Wang C, Xiao A, et al. Physical restraint in mental health nursing: a concept analysis. *Int J Nurs Sci*. 2019;6(3):343-348. [CrossRef]
27. Ye J, Xiao A, Yu L, et al. Staff training reduces the use of physical restraint in mental health service, evidence-based reflection for China. *Arch Psychiatr Nurs*. 2018;32(3):488-494. [CrossRef]
28. Dahm KT, Jensen JO, Husum TL, Leiknes KA. Interventions for reducing coercion in mental health for adults: a systematic review and the impact of updating. *J Brain Sci*. 2015;1(1):1-23. [CrossRef]
29. LeBel J. First randomised controlled-trial research on seclusion and restraint reduction achieves intent. *Evid Based Ment Health*. 2014;17(2):40-41. [CrossRef]
30. Soininen P, Putkonen H, Joffe G, Korkeila J, Välimäki M. Methodological and ethical challenges in studying patients' perceptions of coercion: a systematic mixed studies review. *BMC Psychiatry*. 2014;14:162. [CrossRef]
31. Bergk J, Einsiedler B, Flammer E, Steinert T. A randomized controlled comparison of seclusion and mechanical restraint in inpatient settings. *Psychiatr Serv*. 2011;62(11):1310-1317. [CrossRef]
32. Hendryx M, Trusevich Y, Coyle F, Short R, Roll J. The distribution and frequency of seclusion and/or restraint among psychiatric inpatients. *J Behav Health Serv Res*. 2010;37(2):272-281. [CrossRef]

33. Vieta E, Garriga M, Cardete L, et al. Protocol for the management of psychiatric patients with psychomotor agitation. *BMC Psychiatry*. 2017;17(1):328. [CrossRef]
34. Mangiacavalli B. *Audizione Presso Commissione Diritti Umani del Senato*. 2016. Available at: https://www.fnopi.it/archivio_news/attualita/1842/Audizione%20IPASVI%20SENATO%20CONTENZIONE.pdf, Accessed September 16, 2021.
35. Georgieva I, Mulder CL, Wierdsma A. Patients' preference and experiences of forced medication and seclusion. *Psychiatr Q*. 2012;83(1):1-13. [CrossRef]
36. Soininen P. Coercion, perceived care and quality of life among patients in psychiatric hospitals. *Int J Ment Health Syst*. 2014;7:2.
37. Hirsch S, Steinert T. Measures to avoid coercion in psychiatry and their efficacy. *Dtsch Ärztebl Int*. 2019;116(19):336-343. [CrossRef]
38. Tingleff EB, Bradley SK, Gildberg FA, Munksgaard G, Hounsgaard L. Treat me with me with respect: a systematic review and thematic analysis of psychiatric patients' reported perceptions of the situations associated with the process of coercion. *J Psychiatr Ment Health Nurs*. 2017;24(9-10):681-698. [CrossRef]
39. Hotzy F, Jaeger M, Buehler E, et al. Attitudinal variance among patients, next of kin and health care professionals towards the use of containment measures in three psychiatric hospitals in Switzerland. *BMC Psychiatry*. 2019;19(1):128. [CrossRef]
40. Laukkanen E, Vehviläinen-Julkunen K, Louheranta O, Kuosmanen L. Psychiatric nursing staffs' attitudes towards the use of containment methods in psychiatric inpatient care: an integrative review. *Int J Ment Health Nurs*. 2019;28(2):390-406. [CrossRef]
41. Vergallo GM, Zaami S. Guidelines and best practices: remarks on the Gelli-Bianco law. *Clin Ter*. 2018;169(2):e82-e85. [CrossRef]