Bilagor
S2022/04744 (delvis)
SBU 2023/33
Förstudie avseende alternativa metoder till tvångsåtgärder

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Innehåll

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Bilaga 1 Målgrupper och tvångsåtgärder enligt regelverket

	Målgrupp	Avskiljning	Fastspänning	Övriga åtgärder
LPT[1]	Tvångsvård får ges endast om patienten lider av en allvarlig psykisk störning och på grund av sitt psykiska tillstånd och sina personliga förhållanden i övrigt 1. har ett oundgängligt behov av psykiatrisk vård, som inte kan tillgodoses på annat sätt än genom att patienten är intagen på en sjukvårdsinrättning för kvalificerad psykiatrisk dygnetruntvård (sluten psykiatrisk tvångsvård), eller 2. behöver iaktta särskilda villkor för att kunna ges nödvändig psykiatrisk vård (öppen psykiatrisk tvångsvård). En förutsättning är att patienten motsätter sig sådan vård/vården inte kan ges med samtycke. (se 3 §)	Sluten psykiatrisk tvångsvård En patient får hållas avskild från andra patienter endast om det är nödvändigt på grund av att patienten genom aggressivt eller störande beteende allvarligt försvårar vården av de andra patienterna. Ett beslut om avskiljande gäller högst åtta timmar. Tiden för avskiljande får genom ett nytt beslut förlängas med högst åtta timmar. (se 20 §) En patient som är under 18 år får hållas avskild från andra patienter endast om det är nödvändigt på grund av att han eller hon genom aggressivt beteende allvarligt försvårar vården av de andra patienterna och det är uppenbart att andra åtgärder inte är tillräckliga. (se 20 a §) Patienten under 18 år får hållas avskild högst två timmar (se 6 a §). Tiden för avskiljandet får förlängas (se 20 a §).	Sluten psykiatrisk tvångsvård Om det finns en omedelbar fara för att en patient allvarligt skadar sig själv eller någon annan, får patienten kortvarigt spännas fast med bälte eller liknande anordning. (se 19 §) Om det finns en omedelbar fara för att en patient som är under 18 år lider allvarlig skada och det är uppenbart att andra åtgärder inte är tillräckliga får patienten spännas fast med bälte. (se 19 a §) Patienten under 18 får spännas fast med bälte högst en timme (se 6 a §). Tiden för fastspänningen får förlängas (se 19 a §).	Sluten psykiatrisk tvångsvård Tvångsåtgärder såsom förbud att lämna vårdinrättningens område, inskränkning i rätten att använda elektroniska kommunikations-tjänster, omhänder-tagande av egendom, kontroll av försändelser, kroppsvisitation och ytlig kroppsbesiktning, undersökning av väskor och andra föremål. (se 18 §, 20–24 §§)
LRV[2]	Lagen gäller den som 1. efter beslut av domstol skall ges rättspsykiatrisk vård, 2. är anhållen, häktad eller intagen på en enhet för rättspsykiatrisk undersökning, 3. är intagen i eller skall förpassas till kriminalvårdsanstalt eller	Vid sluten rättspsykiatrisk gäller bestämmelserna i 18–24 §§ LPT (8 §). (se ovan)		

[1] Lagen (1991:1128) om psykiatrisk tvångsvård.
[2] Lagen (1991:1129) om rättspsykiatrisk vård.

	4. är intagen i eller skall förpassas till ett särskilt ungdomshem till följd av en dom på sluten ungdomsvård. (se 1 §) I andra fall än efter beslut av domstol får personen ges rättspsykiatrisk vård om: personen lider av en allvarlig psykisk störning, har behov av psykiatrisk vård som kan tillgodoses genom intagning på en sjukvårdsinrättning, och motsätter sig sådan vård/vården kan inte ges med samtycke. (se 4 §)			
LVM[3]	Tvångsvård skall beslutas om 1. någon till följd av ett fortgående missbruk av alkohol, narkotika eller flyktiga lösningsmedel är i behov av vård för att komma ifrån sitt missbruk, 2. vårdbehovet inte kan tillgodoses enligt socialtjänstlagen (2001:453) eller på något annat sätt, och 3. han eller hon till följd av missbruket a) utsätter sin fysiska eller psykiska hälsa för allvarlig fara, b) löper en uppenbar risk att förstöra sitt liv, eller c) kan befaras komma att allvarligt skada sig själv eller någon närstående. (se 4 §)	Om det är särskilt påkallat på grund av att den intagne uppträder våldsamt eller är så påverkad av berusningsmedel att han eller hon inte kan hållas till ordningen, får den intagne hållas i avskildhet. Den intagne får dock inte hållas i sådan avskildhet längre tid än vad som är oundgängligen nödvändigt och inte i något fall under längre tid än 24 timmar i följd. (se 34 b §)	-	Särskilda befogenheter som omhändertagande av egendom, kroppsvisitation och ytlig kroppsbesiktning, provtagning, rumsvisitation, säkerhetskontroll, begränsning i rätten att använda elektroniska kommunikationstjänster eller ta emot besök, förbud att lämna hemmet och annan begränsning av rörelsefriheten (som vård vid låsbar enhet), vård i enskildhet, kontroll av försändelser. (se 31–35 §§)
LVU[4]	Anledning till ett omhändertagande enligt LVU: (2 §) om det på grund av fysisk eller psykisk misshandel, otillbörligt utnyttjande, brister i omsorgen eller något annat förhållande i hemmet finns en påtaglig risk för att den	Om det är särskilt påkallat på grund av att den unge uppträder våldsamt eller är så påverkad av berusningsmedel att han eller hon inte kan hållas till ordningen, får den unge hållas i avskildhet. Den unge får inte hållas i sådan avskildhet längre tid än vad som är oundgängligen	-	Särskilda befogenheter som förbud att lämna hemmet och annan begränsning av rörelsefriheten, begränsning i rätten att använda elektroniska kommunikationstjänster eller ta emot

[3] Lagen (1988:870) om vård av missbrukare i vissa fall.
[4] Lagen (1990:52) med särskilda bestämmelser om vård av unga.

	unges hälsa eller utveckling skadas. (3 §) den unge utsätter sin hälsa eller utveckling för en påtaglig risk att skadas genom missbruk av beroendeframkallande medel, brottslig verksamhet eller något annat socialt nedbrytande beteende. Under 18 år – kriterier enligt 2 § eller 3 § och att vård inte kan ges med samtycke. Från 18 år upp till 20 år – kriterier enligt 3 §, om sådan vård är lämpligare än någon annan vård och om vård inte kan ges med samtycke. (se 1 §) Vården ska upphöra senast när den unge fyller 21 år. (se 21 §)	nödvändigt och inte i något fall under längre tid än fyra timmar i följd. (se 15 c §)		besök, vård vid låsbar enhet, vård i enskildhet, omhändertagande av egendom, kropps-visitation eller ytlig kroppsbesiktning, provtagning, rumsvisitation, säkerhetskontroll, övervakning av brev och andra försändelser. (se 15–19 §§)
LSU[5]	Ungdomar från 15 år upp till 18 år som har begått brott med påföljden sluten ungdomsvård istället för fängelse. (1 kap. 6 § och 32 kap. 5 § brottsbalken)	Om det är särskilt påkallat av att den dömde uppträder våldsamt eller är så påverkad av berusningsmedel att han eller hon inte kan hållas till ordningen, får den dömde hållas i avskildhet. Den dömde får dock inte hållas i sådan avskildhet längre tid än som är absolut nödvändigt och inte i något fall under längre tid än fyra timmar i följd. (se 17 §)	-	Kontroll- eller tvångsåtgärder som t.ex. begränsning av rörelsefriheten, vård vid låsbar enhet, vård i enskildhet, inskränkning i elektroniska kommunikationstjänster eller ta emot besök, provtagning, andra åtgärder motsvarande LVU. (se 13–18 §§)

[5] Lagen (1998:603) om verkställighet av sluten ungdomsvård.

Bilaga 2 Material av betydelse för förstudien i urval

Organisation	Publikation	Vårdform aktuell för uppdraget
Statens offentliga utredningar mm.	Barn och unga i samhällets vård (pågående) [81]	ungdomsvård
	Vissa särskilda befogenheter vid SiS särskilda ungdomshem (pågående) [51]	ungdomsvård
	Från delar till helhet – Tvångsvården som en del av en sammanhållen och personcentrerad vårdkedja (2023) [6]	missbruksvård psykiatrisk tvångsvård rättspsykiatrisk vård ungdomsvård
	God tvångsvård – trygghet, säkerhet och rättssäkerhet i psykiatrisk tvångsvård och rättspsykiatrisk vård (2022) [14]	psykiatrisk tvångsvård rättspsykiatrisk vård
	Barnkonventionen och svensk rätt (2020) [5]	ungdomsvård psykiatrisk tvångsvård rättspsykiatrisk vård missbruksvård
	För barnets bästa? Utredningen om tvångsåtgärder mot barn i psykiatrisk tvångsvård (2017) [82]	psykiatrisk tvångsvård
Socialstyrelsen	Stärka och stimulera den barn- och ungdomspsykiatriska heldygnsvården, inklusive tvångsvården (2022) [83]	psykiatrisk tvångsvård rättspsykiatrisk vård
	LVM – handbok för socialtjänsten (2021) [7]	missbruksvård
	Utvärdering av metoden självvald inläggning (2021) [50]	psykiatrisk tvångsvård
	LVU – handbok för socialtjänsten (2020) [84]	ungdomsvård
	Utveckling av integrerad vård för barn och unga i SiS särskilda ungdomshem (2020) [20]	ungdomsvård
Statens institutions-styrelse	Utvärdering av de särskilt förstärkta avdelningarna, SFA (2022) [2]	ungdomsvård missbruksvård
	Integrerad behandling av missbruk och psykisk sjukdom: Pilotimplementering inom LVM-vården (2021) [85]	missbruksvård
	Särskilda vård- och resursbehov (2020) [11]	ungdomsvård missbruksvård
	Tillsyn av SiS särskilda ungdomshem 2021–2022 (2023) [13]	ungdomsvård

Inspektionen för vård och omsorg	Delredovisning av uppdraget att förstärka och utveckla tillsynen och uppföljningen av den psykiatriska tvångsvården och den rättspsykiatriska vården (2022) [86]	psykiatrisk tvångsvård rättspsykiatrisk vård
Statskontoret	SiS vård av barn och unga enligt LVU – förutsättningar för en trygg och ändamålsenlig vård (2022) [18]	ungdomsvård
	Myndighetsanalys av Statens institutionsstyrelse (2020) [19]	ungdomsvård missbruksvård
Vetenskapsrådet	Kartläggning av rättspsykiatrisk forskning (2017) [87]	rättspsykiatrisk vård
Barnombuds-mannen	Vem bryr sig – när samhället blir förälder. Barns röster om att växa upp i den sociala barnavården (2019) [88]	ungdomsvård
Patient-, brukar- och anhörig-organisationer	Nationell Samverkan för Psykisk Hälsa (NSPH) har på uppdrag av Socialstyrelsen genomfört en undersökning av patienters och anhörigas erfarenheter av psykiatrisk tvångsvård, rättspsykiatrisk vård samt tvångsåtgärder. Undersökningen är en del av regeringsuppdraget att genomföra en kartläggning av den psykiatriska tvångsvården respektive den rättspsykiatriska vården (S2021/02640).	psykiatrisk tvångsvård rättspsykiatrisk vård
	Riksförbundet Attention: ”Vad är det för fel på dig?” Tjejer med NPF på SiS (2022) [29]	ungdomsvård
	Civil Rights Defenders och Riksförbundet för Social och Mental hälsa: Inlåst – men inte utan rättigheter. En handbok om mänskliga rättigheter i svensk tvångsvård (2018) [89]. Civil Rights Defenders bedriver ett projekt Tvångsvård men inte utan rättigheter, i samarbete med NSPH, RSMH, Attention, Shedo och Autism- och Aspergerförbundet.	psykiatrisk tvångsvård rättspsykiatrisk vård ungdomsvård missbruksvård
Sveriges Kommuner och Regioner	En meningsfull heldygnsvård. Grundkomponenter för trygg och meningsfull heldygnsvård med minsta möjliga behov av tvång vid psykiatriska tillstånd (2022) [23]	psykiatrisk tvångsvård
	Vårdens innehåll i rättspsykiatrin (2018) [90]	rättspsykiatrisk vård
	Tvångsvårdstillfällen och tvångsåtgärder (2015) [91]	psykiatrisk tvångsvård rättspsykiatrisk vård
	Bättre vård – mindre tvång (2013, 2014) [21, 22]	psykiatrisk tvångsvård

Bilaga 3 HTA-rapporter

Organisation	Publication
FHI, Norway	Jardim P, Ames H, Hestevik C, Kirkehei I. Tvang i psykisk helsevern og vold: systematisk litteratursøk med sortering. Oslo: Folkehelseinstituttet (FHI); 2023. Available from: https://www.fhi.no/publ/2023/tvang-i-psykisk-helsevern-og-vold/.
	Jardim P, Borge T, Dahm K, Müller A, Hval G. Effekt av antipsykotika ved behandling uten pasientens samtykke sammenlignet med frivillig behandling: systematisk oversikt. Oslo: Folkehelseinstituttet (FHI); 2021. Available from: https://www.fhi.no/publ/2021/effekt-av-antipsykotika-ved-behandling-uten-pasientens-samtykke-sammenligne/.
	Steiro A, Dahm K, Strømme H, Brurberg K. Tvangsmedisinering i psykisk helsevern – en systematisk kartleggingsoversikt. Oslo: Folkehelseinstituttet (FHI); 2018. Available from: https://www.fhi.no/publ/2018/tvangsmedisinering-i-psykisk-helsevern--en-systematisk-kartleggingsoversikt/.
CADTH, Canada	CADTH. Trauma-Informed Care for Adults Involved in the Correctional System: A Review of the Clinical Effectiveness, Cost-Effectiveness, and Guidelines (CADTH rapid response report: summary with critical appraisal). Canadian Agency for Drugs and Technologies in Health (CADTH); 2018. Available from: https://www.cadth.ca/sites/default/files/pdf/htis/2018/RC1028%20Trauma%20Informed%20Care%20for%20Correctional%20Systems%20Final.pdf.
	CADTH. The Use of Safe Rooms for Inpatient Psychiatric Care: Clinical Effectiveness and Guidelines (CADTH Rapid Response Report: Summary of Abstracts). Canadian Agency for Drugs and Technologies in Health (CADTH); 2017. Available from: https://www.cadth.ca/sites/default/files/pdf/htis/2018/RC1028%20Trauma%20Informed%20Care%20for%20Correctional%20Systems%20Final.pdf.
NICE, Great Britain	NICE. Violence and aggression: short-term management in mental health, health and community settings (NG10). National Institute for Health and care Excellence (NICE); 2015. NICE guideline. Available from: https://www.nice.org.uk/guidance/ng10.
MSEI, Australia	Gooding P, McSherry B, Roper C, Grey F. Alternatives to Coercion in Mental Health Settings: A Literature Review. Melbourne: Melbourne Social Equity Institute, University of Melbourne; 2018. Available from: https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf.
	Melbourne Social Equity Institute. Seclusion and Restraint Project (Prepared for the National Mental Health Comission). Melbourne Social Equity Institute, University of Melbourne 2014. Available from: https://www.mentalhealthcommission.gov.au/getmedia/33238bca-2e8d-494c-80a0-38b9d0151b77/Seclusion-and-Restraint-University-of-Melbourne-Overview.

HTA = Health Technology Assessment; **FHI** = Folkhelseinstituttet, Norway; **CADTH** = Canadian Agency for Drugs and Technologies in Health, Canada; **NICE** = National Institute for Health and Care Excellence, Great Britain; **MSEI** = Melbourne Social Equity Institute, Australia.

Bilaga 4 Publikationer som uppfyllde relevanskriterierna för att inkluderas i förstudien

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
Low risk of bias								
Dahm et al. 2017 [59] 21 studies included	Systematic review	Adult patients (18-65) with severe mental disorder, including substance abuse.	To systematically review the available research on interventions intended to reduce coercion in mental health care.	Proactively address restraint or seclusion	Interventions towards: patients in the community, patients in institutional settings and inpatients about to be discharged.	Systematic evaluation of aggressive behaviour and counselling towards staff may reduce **seclusion and restraint.** Joint crisis plans (JCP) can probably reduce the number of compulsory admissions.	JCP probably reduce the number of compulsory admissions in mental health care. Systematic evaluation of aggressive behaviour in acute psychiatric wards and counselling towards staff in high security wards may reduce the use of restraint and seclusion.	Studies that evaluate the impact of crisis plan, ACT-teams, crisis resolution team and treatment contracts. There is a particular need of intervention intended to reduce forced medication.
Haig et al. 2023 [58] 18 studies included	Systematic review	Adults in psychiatric inpatient settings, including patients with substance use (including forensic mental health settings).	To identify how effective sensory rooms are at reducing patient violence and restrictive interventions.	Proactively address restraint or seclusion	Sensory room interventions	Descriptive data on sensory room design and procedures for use is provided. Six studies examined the efficacy of sensory rooms in relation to **rates of seclusion, restraint**, and **aggression**; one study found reduction in incidents of seclusion, and one in incidents of restraint.	There is a lack of evidence as to whether sensory rooms are effective at **reducing seclusion, restraint or violence.** They are, however, likely to support a **reduction in patient distress.**	Research is needed to identify what works, for who and in what circumstances in relation to the design of sensory rooms.

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
Moderate risk of bias								
Bergsund et al. 2023 [56] (update on the review below) **8 studies included**	Scoping review	Children and youth in residential childcare and foster care (5 studies consider gender).	To review research on use of force and limit-setting in child welfare institutions. One of the research questions: How is the use of force prevented in child welfare institutions and foster homes?	Proactively address seclusion (force and coercion)	Program SafePath aimed at the staff's cognitions. Monitoring and feedback system.	Descriptive results were reported. Positive effect on **repressive behaviour** after SafePath. Reduction in use of **seclusion** after SafePath, the monitoring and feedback system.	The studies demonstrate how a good relationship between children and professionals can be important for preventing conflicts and violence. At the same time, working in an institution can lead to exhaustion, which exacerbates relationship-building.	Occurrence, understandings and long-term consequences of the use of force, as well as the consequences of seeing others being exposed to use of force.
Nøkleby et al. 2020 [57] **12 studies included**	Scoping review	Children and youth in residential childcare and foster care (6 studies consider gender).	To explore prevalence, types, understandings, consequences, preventative measures and experiences with force and setting limits. One of the research questions: How can force be prevented in child welfare	Proactively address restraint or seclusion (force and coercion)	Non-violent resistance, social work aimed at preventing the use of force, and trauma-informed parenting/care.	Six studies explored different aspects of preventing the use of force (**restraint** or **seclusion**). One common theme was the importance of relationships. Another theme was employees' need for guidance, and reflections on the ethics and their own feelings during acute situations.	Findings highlight the overall negative experience of children and youth regarding force, both when experienced personally and as witnesses. Youth expressed interest in good relationships with opportunities for discussion in acute situations. Not able to answer research questions	A clear need for research on: the prevalence of different types of force, explorations of setting limits in foster homes and the relationship of setting limits and using force, evaluations of preventative measures.

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
			institutions and foster homes?				regarding prevalence or consequences of force, reported quantitatively, from the included studies.	
Fernandez-Costa et al. 2020 [60] **21 studies included**	Scoping review	Agitated psychiatric patients, including patients with substance use. Most studies occurred in mental health units for adults, and some occurred in high-security or forensic psychiatry units.	To assess the impact of the main alternative measures to prevent or limit the use of coercive measures.	Proactively address restraint	Simple interventions (staff training, risk assessment, use of data post seclusion/restraint, patient involvement, therapeutic environment, organizational changes) and complex programs (Omega Training Program, Six Core Strategies (6CS), Safewards, and Prevention and Management of Aggression and Violence (PMAV).	Training in de-escalation techniques, risk assessment, and implementation of 6CS or Safewards program were the most assessed and effective interventions to reduce **aggressive behaviors** and the use of **coercive measures**.	It is possible to reduce the use of restraints and coercive measures and not increase the number of incidents and violent behaviors among the patients through a non-invasive and non-pharmacological approach.	Further research and further randomized clinical trials are needed to compare the different alternatives and provide higher quality evidence.
Finch et al. 2022 [61] **13 studies included**	Systematic review	Patients (adolescents and adults) in mental health settings (including	To explore the effectiveness of Safewards.	Proactively address restraint and seclusion	Safewards, a method developed to reduce conflict and containment in mental health inpatient services.	Descriptive results are reported on **conflict**, **containment** and ward climate.	The results indicate that there is good evidence to support its use in general mental health services.	It is not yet possible to say that Safewards is effective for reducing conflict and

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
		forensic units), including patients with substance use.						containment in other clinical settings.
Giacco et al. 2018 [62] **19 studies included**	Systematic review	Adults receiving involuntary psychiatric inpatient care. Comorbid substance use or eating disorders were included.	To review literature on existing interventions in order to identify helpful approaches to improve outcomes of involuntary treatment.	Proactively address restraint	Structured patient-centred care planning, specialist therapeutic interventions, systemic changes to hospital practice.	Descriptive results on e.g. involuntary readmissions, patient involvement in discharge planning, **aggressive behaviour, mechanical restraining episodes***.	Preliminary evidence supports that structured patient-centred care planning interventions influence long-term outcomes (such as readmission), and that specialist therapeutic interventions and systemic changes to hospital practice have an effect on reducing the use of coercive measures on wards.	Structured patient-centred care planning interventions show promise for the improvement of long-term outcomes and should be further evaluated.
MacInnes et al. 2019 [64] **9 studies included**	Systematic review	Forensic inpatients in low, medium and high secure units > 18 years.	To examine the evidence for the use of psychological and psychosocial interventions.	Proactively address seclusion	Psychoeducational strategies, cognitive behavioural therapy, interpersonal psychotherapy, non-directive counselling, supportive interactions	Only 7 out of 91 comparisons revealed statistically significant results with no consistent significant findings. The most frequently reported outcomes were	This review suggests psychoeducational and psychosocial interventions did not reduce violence/risk, but there is tentative support they may	More randomized control studies are required with larger sample sizes, representative

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
					and tangible assistance, through individual or group sessions.	**violence/risk** and **symptoms**. 61% of the violence/risk comparisons and 79% of the symptom comparisons reported improvements in the intervention groups. One study reports on **seclusion** outcomes.	improve symptoms (e.g. self-esteem, depression).	populations, standardized outcomes and control group interventions similar in treatment intensity to the intervention.
Mullen et al. 2022 [63] **19 studies included**	Systematic review	Adult patients within inpatient mental health, including forensic mental health units.	To synthesize the current knowledge about Safewards in terms of its implementation, acceptability, effectiveness and how it meets the needs of consumers.	Proactively address restraint and seclusion	Safewards	Descriptive results were reported om six key categories: training, implementation strategy, staff acceptability, fidelity, effectiveness (**coercive practices**, **rate of conflict**) and consumer perspectives.	Safewards can be effective in reducing containment and conflict although this outcome varied across the literature. The results indicate limitations of fidelity measures and the importance of involving staff in the implementation.	Consumer perspectives on the Safewards model.
Oostermeijer et al. 2021 [65] **35 studies included**	Rapid review	Mental health inpatient units, including adult, child and adolescent services and	To study what physical design features of mental health facilities can reduce the use of seclusion and physical restraint.	Proactively address restraint and seclusion	A beneficial physical environment (e.g., access to gardens or recreational facilities); sensory or comfort rooms; and private, uncrowded and calm spaces.	Descriptive results were reported on preliminary evidence that the physical environment has a role in supporting the reduction in **the use of seclusion and restraint.**	This is likely to be achieved through a multi-layered approach, founded on good design features and building towards specific design features which may	Future designs should include consumers in a codesign process to maximise the potential for change and

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
		forensic mental health inpatient units.					reduce occurrences of seclusion and restraint.	innovation that is genuinely guided by the insights of lived experience expertise.
Ward-Stockham et al. 2022 [66] **14 studies included**	Systematic review	Adults and adolescents in mental health wards, including adolescent mental health wards, adolescent inpatient wards, forensic mental health inpatient units etc.	To evaluate the effect of Safewards on conflict and containment events and the perceptions of staff and consumers.	Proactively address restraint and seclusion	Safewards	Descriptive results were reported. The implementation of Safewards reduced **rates of conflict** in three studies and **rates of containment** in five studies. Other outcomes related to rates of total containment including **coerced medication, seclusion, mechanical restraint***. Most staff and consumers reported Safewards improved therapeutic relationships, cohesion, and ward atmosphere. One study shows - as mechanical restraint decreased, forced medications increased.	Safewards improved the experience of safety from the perspective of staff and consumers when combined with ongoing training, leadership and time for consolidation.	While results are promising they should be used cautiously until more robust evidence is established.

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
High risk of bias								
Allen et al. 2019 [67] 3 studies included	Systematic review	Patients (adolescents and adults) in acute inpatient psychiatric hospitals.	To identify evidence-based alternatives to physical restraint application in acute inpatient psychiatric hospitals.	Proactively address restraint	Multimodal intervention strategies, including staff training in de-escalating techniques, debriefing after restraint episodes, patient-specific crisis management plans.	**Hours of restraint use** decreased from 50% to 99% across studies.	Multimodal intervention strategies may reduce the number of hours of physical restraint used in inpatient psychiatric settings.	Evidence to support specific strategies is lacking.
Bak et al. 2012 [68] 59 studies included	Systematic review	Adult psychiatric inpatients. Including patients with substance abuse.	To identify interventions preventing mechanical restraints* and describe the quality of evidence and the effect of intervention.	Proactively address restraint	Cognitive milieu therapy, combined interventions, and patient-centered care.	**Use of mechanical restraint*** decreased from 27% to 87% across studies.	Implementation of cognitive milieu therapy, combined interventions, and patient-centered care were the three interventions most likely to reduce the number of mechanical restraints.	There is a lack of high-quality and effective intervention studies.
Baker et al. 2021 [69] 175 studies included	Scoping review	Adults in inpatient mental health services (including forensic services).	To identify interventions that seek to reduce restrictive practices in adult mental health inpatient settings.	Proactively address restraint and seclusion	Non-pharmacological interventions to reduce restrictive practices (behaviour change interventions). 150 unique interventions, the majority of which aimed to reduce the use of seclusion or restraint (or	Outcomes: e.g. **rates and duration of seclusion and restraint**, use of **pro re nata medication, rates of conflict and containment, de-escalation.**	Many interventions have clusters of behaviour change techniques in common, suggesting that they have been developed based on an unstated set of assumptions of how they are intended to	Future interventions should test individual procedures (and their constituent components) in isolation and be

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
					both). The most common were training/education and changes to nursing approaches (e.g. implementing Trauma-Informed Care).		work and through what mechanisms.	thoroughly described.
Baker et al. 2022 [70] **76 studies included**	Scoping review	Children and young people in institutional settings (including forensic units and criminal justice context).	To identify, standardise and report the effectiveness of components of interventions that seek to reduce restrictive practices.	Proactively address restraint or seclusion	Interventions to reduce restrictive practices use - a variety of behaviour change interventions. Behaviour change techniques (BCT), 82 different techniques (4 clusters, goals and planning, antecedents (avoiding stressful situations), shaping knowledge feedback and monitoring) were identified.	228 outcomes are reported, including use of **mechanical restraints*,** staff development and activity, resource implications, patient progression and satisfaction.	These findings suggest that individual providers are delivering untested interventions and reporting positive findings that imply that they are effective. However, the trustworthiness of such claims is undermined by e.g. poor reporting of intervention content and tests using the least robust methods.	Rigorous, theory-driven testing of individual components is required.
Gaynes et al. 2017 [71] **17 studies included**	Systematic review	Adult patients in acute care settings, including inpatient	To compare the effectiveness of strategies to prevent and de-escalate	Proactively address restraint and seclusion	Risk assessment, multimodal interventions, staff training, environmental or group	For prevention, risk assessment reduced both **aggression** and **use of seclusion and restraint**, and multimodal	Available evidence is very limited. Two preventive strategies, risk assessment and multimodal	More research is needed on how best to prevent and de-escalate

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
		psychiatric or forensic hospitals.	aggressive behaviors.		psychotherapeutic interventions, medication protocol.	interventions reduced the use of seclusion and restraint (low SOE).	interventions consistent with the Six Core Strategies principles, may lower aggressive behavior and use of seclusion and restraint.	aggressive behavior in acute care settings.
Goulet et al. 2016 [72] **28 studies included**	Scoping review	Adults in psychiatric settings.	To examine existing models (including theoretical foundations) on post-seclusion and/or restraint in psychiatry.	Respond to seclusion or restraint risk	Post-seclusion and/or restraint review (PSRR), e.g. post-event analysis, debriefing, debriefing with the consumer.	One study (n=31) reported no difference in reported PTSD-like symptoms, but significantly fewer hours of **seclusion** in the experimental group than the control group (t (29) = 2.70, p = 0.01).	Although only one study specifically addressed the efficacy of PSRR, programs with a PSRR component show a 50% to 75% reduction in seclusion and restraint events. Theoretical origins are from the concepts of debriefing in psychology and reflective practice in nursing.	This leads to the question of what the relative weight of the various components, including PSRR, might be.
Goulet et al. 2017 [73] **23 studies included**	Systematic review	Adults in psychiatric settings, including forensic psychiatry.	To examine the effectiveness of seclusion and restraint reduction programs.	Proactively address restraint or seclusion	Six key components in seclusion and restraint reduction programs: 1) leadership, 2) training, 3) post-seclusion and/or restraint review, 4) patient involvement, 5)	Measurements of seclusion and restraint varied, but results from two studies indicated a decrease of **rates and length in seclusion and restraint**.	Despite a wide variability in seclusion and restraint indicators and methodological rigor, the results argue in favour of seclusion	Little evidence exists on the relative effectiveness of the components of an seclusion and restraint

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
					prevention tools, 6) therapeutic environment.	Secondary outcomes mainly addressed injury, aggression, and perceptions. Overall, seclusion and restraint reduction, whether significant or not, was observed in almost all the studies analysed, without an increase in aggression and injury.	and restraint reduction programs.	reduction program.
Hammervold et al. 2019 [74] **12 studies included**	Scoping review	Adults, children and adolescents in mental health care.	To explore the current knowledge of post-incident review (PIR), assess to what extent PIR can minimize restraint-related use and harm, support care providers in handling professional and ethical dilemmas, and improve the quality of care.	Respond to seclusion or restraint risk	Post-incident review (PIR)	No significant outcome was related to using PIR alone. Patients and care providers reported PIR to: 1) be an opportunity to review **restraint** events, 2) promote patients' personal recovery processes.	Scientific literature directly addressing PIR after restraint use is lacking. However, results indicate that PIR may contribute to more professional and ethical practice regarding restraint promotion and the way restraint is executed.	PIR use and consequences is needed, especially PIR's potential to contribute to restraint prevention in mental health care.

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
Perers et al. 2022 [75] 18 studies included	Systematic review	Children and adolescents in psychiatric inpatient units, including inpatients with substance abuse.	To summarize the last 10 years of literature regarding methods and strategies currently used for reducing seclusions and restraints.	Proactively address restraint and seclusion	Trauma-Informed Care (TIC), Six Core Strategies, Child and Family Centered Care (CFCC), Collaborative & Proactive Solutions (CPS), Strength-Based Care, Modified Positive Behavioral Interventions and Supports (M-PBIS), Behavioral Modification Program (BMP), Autism Spectrum Disorder Care Pathway (ASD-CP), Dialectical Behavior Therapy (DBT), sensory rooms, Mindfulness-Based Stress Reduction Training (MBSR) of staff, and Milieu Nurse-Client Shift Assignments.	Most of the interventions reduced **the use of seclusions** and/or **restraints**. Two child-centered and trauma-informed initiatives eliminated **the use of mechanical restraints*.**	This review shows that the use of coercive measures can be reduced and should be prioritized. Successful implementation requires ongoing commitment on all levels of an organization and a willingness to learn.	Future studies should evaluate different standardized parameters.
Rajwani et al. 2022 [76] 10 studies included	Scoping review	Adults in hospital settings, including patients with cognitive impairment and patients	To highlight the best practices and limitations of Behavioral Emergency Response Teams (BERTs) use.	Proactively address restraint and seclusion	BERTs. De-escalation techniques, education for staff about the incidents.	Narrative descriptions are given per study. Outcomes were e.g. **use of physical restraints**, assaults directed at staff, staff satisfaction.	BERTs are effective at reducing assaults directed at staff and are associated with increased staff satisfaction.	

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
		with substance abuse.						
Slaatto et al. 2021 [77] **14 studies included**	Scoping review	Children and youth < 22 years in inpatient, residential facilities, juvenile justice facilities, forensic units et al.	To 1) describe and review the effects of interventions to prevent and manage aggression and violence, 2) describe and review the effects of restraint and seclusion and experiences of youth and staff and 3) identify potential gaps.	Proactively address restraint and seclusion, response to seclusion and restraint risks	Staff-training, Juvenile Justice Anger Management (JJAM) for girls, Children and Residential Experiences (CARE model), implementing psychiatric guidelines, milieu nurse-client shift assignment, Six Core Strategies, collaborative problem-solving approach, Trauma-Informed Care (TIC).	Narrative descriptions are given per study. Outcomes were e.g. **restraint** and **seclusion rates**, staff and patient injuries.	The results indicate that interventions that contributed to a reduction in episodes of restraint and seclusion differed from those that led to a reduction in conflicts and aggression. Both youth and staff have negative experiences of physical restraint.	The effects and experiences of physical restraint and the effectiveness of de-escalation measures in preventing violence and aggression.
Vakiparta et al. 2019 [78] **28 studies included**	Integrative review	Adult patients in psychiatric units, including forensic psychiatric hospitals.	To describe interventions aimed at reducing seclusion and mechanical restraint use and their possible outcomes.	Proactively address restraint and seclusion, response to seclusion risks and mechanical	Environmental interventions, staff training, treatment planning, patient and family involvement, risk assessment, meaningful activities, sensory modulation, therapeutic atmosphere,	Outcomes related to both **seclusion** and **mechanical restraint*** reduction were varied, with several interventions resulting in both reduced and unchanged or increased use.	Much of the research focused on implementing several interventions simultaneously, making it difficult to distinguish outcomes.	The effectiveness of interventions and the contexts they are implemented in.

Reference	Study design	Population	Aim	Type of intervention	Intervention	Outcome and results	Authors' conclusions	Possible evidence gaps
				restraint risks	interventions to manage patient agitation (=staff availability in patient environment + support for agitated patient), mechanical restraint regulations, review of mechanical restraint risks.			
Ye et al. 2018 [79] **8 studies included**	Systematic review	Patients in psychiatric hospitals.	To synthesize the evidence regarding the reduction of physical restraint, to seek some practical recom-mendations.	Proactively address restraint	Staff training	An effect on reduced **duration** (IV= −0.88; 95% CIs =−1.65 to −0.10; Z =2.22; p =0.03) and **adverse effect** (RR, 0.16; 95% CIs = 0.09 to 0.30; Z=5.96; p < 0.00001) of **physical restraint,** but not on **frequency of physical restraint** (RR, 0.74; 95% CIs = 0.43 to 1.28; Z=1.07; p =0.28).	Staff training was an effective measure to minimize the duration and adverse effects of physical restraint.	The effectiveness of staff training in relation to the prevalence of physical restraint.

* mechanical restraint as an outcome

Bilaga 5 Publikationer som exkluderats efter fulltextläsning på grund av bristande relevans

Excluded articles	Reason for exclusion
Corrigendum to: Decreasing Physical Restraint in Acute Inpatient Psychiatric Hospitals: A Systematic Review (Journal of the American Psychiatric Nurses Association, (2018), 25, 5, (405-409), 10.1177/1078390318817130). Journal of the American Psychiatric Nurses Association. 2020;26(2):219. Available from: https://doi.org/10.1177/1078390319883630.	Wrong publication type
Allison R, Flemming K. Mental health patients' experiences of softer coercion and its effects on their interactions with practitioners: A qualitative evidence synthesis. J Adv Nurs. 2019;75(11):2274-84. Available from: https://doi.org/10.1111/jan.14035.	Wrong study design
Barbui C, Purgato M, Abdulmalik J, Caldas-de-Almeida JM, Eaton J, Gureje O, et al. Efficacy of interventions to reduce coercive treatment in mental health services: umbrella review of randomised evidence. Br J Psychiatry. 2021;218(4):185-95. Available from: https://doi.org/10.1192/bjp.2020.144.	Wrong population
Borckardt JJ, Grubaugh AL, Pelic CG, Danielson CK, Hardesty SJ, Frueh BC. Enhancing patient safety in psychiatric settings. J Psychiatr Pract. 2007;13(6):355-61.	Wrong study design
Bryson SA, Gauvin E, Jamieson A, Rathgeber M, Faulkner-Gibson L, Bell S, et al. What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. Int. 2017;11:36. Available from: https://doi.org/10.1186/s13033-017-0137-3.	Wrong outcome
Chase S. The Effectiveness of De-Escalation Techniques as Compared to Physical Restraint/Seclusion on Inpatient Psychiatric Units: A Quantitative Systematic Review. CNS Spectrums: The International Journal of Neuropsychiatric Medicine. 2021;26(2):175-6. Available from: https://doi.org/10.1017/S1092852920002874.	Wrong publication type
Dahm KT, Leiknes KA, Husum TL, Kirkehei I, Hofmann B, Myhrhaug HT, et al. Interventions for Reducing Seclusion and Restraint in Mental Health for Adults. Knowledge Centre for the Health Services at The Norwegian Institute of Public Health (NIPH). 2012: Executive Summaries.	Updated 2017
De Hert M, Dirix N, Demunter H, Correll CU. Prevalence and correlates of seclusion and restraint use in children and adolescents: a systematic review. Eur Child Adolesc Psychiatry. 2011;20(5):221-30. Available from: https://doi.org/10.1007/s00787-011-0160-x.	Wrong study design
Driscoll A, Grant MJ, Carroll D, Dalton S, Deaton C, Jones I, et al. The effect of nurse-to-patient ratios on nurse-sensitive patient outcomes in acute specialist units: a systematic review and meta-analysis. Eur J Cardiovasc Nurs. 2018;17(1):6-22. Available from: https://doi.org/10.1177/1474515117721561.	Wrong population
Du M, Wang X, Yin S, Shu W, Hao R, Zhao S, et al. De-escalation techniques for psychosis-induced aggression or agitation. Cochrane Database Syst Rev. 2017;4:CD009922. Available from: https://doi.org/10.1002/14651858.CD009922.pub2.	Wrong outcome

Espinosa L, Harris B, Frank J, Armstrong-Muth J, Brous E, Moran J, et al. Milieu improvement in psychiatry using evidence-based practices: the long and winding road of culture change. Arch Psychiatr Nurs. 2015;29(4):202-7. Available from: https://doi.org/10.1016/j.apnu.2014.08.004.	Wrong study design
Gaskin CJ, Elsom SJ, Happell B. Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. Br J Psychiatry. 2007;191:298-303.	Wrong study design
Gaskin CJ, McVilly KR, McGillivray JA. Initiatives to reduce the use of seclusion and restraints on people with developmental disabilities: a systematic review and quantitative synthesis. Res Dev Disabil. 2013;34(11):3946-61. Available from: https://doi.org/10.1016/j.ridd.2013.08.010.	Wrong population
Gaynes BN, Brown C, Lux LJ, Brownley K, Van Dorn R, Edlund M, et al. Strategies To De-escalate Aggressive Behavior in Psychiatric Patients. Agency for Healthcare Research and Quality (US). 2016:07.	Wrong setting
Gleerup CS, Ostergaard SD, Hjuler RS. Seclusion versus mechanical restraint in psychiatry - a systematic review. Acta Neuropsychiatr. 2019;31(5):237-45. Available from: https://doi.org/10.1017/neu.2019.22.	Wrong outcome
Gooding P, McSherry B, Roper C. Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies. Acta Psychiatr Scand. 2020;142(1):27-39. Available from: https://doi.org/10.1111/acps.13152.	Wrong study design
Hirsch S, Steinert T. Measures to Avoid Coercion in Psychiatry and Their Efficacy. Dtsch. 2019;116(19):336-43. Available from: https://doi.org/10.3238/arztebl.2019.0336.	Wrong study design
Hui A, Middleton H, Vollm B. P-659 - The use of coercive measures within forensic psychiatry. European Psychiatry. 2012;27:1-. Available from: https://doi.org/10.1016/S0924-9338(12)74826-5.	Wrong publication type
Johnson ME. Violence and restraint reduction efforts on inpatient psychiatric units. Issues Ment Health Nurs. 2010;31(3):181-97. Available from: https://doi.org/10.3109/01612840903276704.	Wrong study design
Kynoch K, Wu CJ, Chang AM. The effectiveness of interventions in the prevention and management of aggressive behaviours in patients admitted to an acute hospital setting: a systematic review. JBI Libr Syst Rev. 2009;7(6):175-233.	Wrong population
Kynoch K, Wu CJ, Chang AM. Interventions for preventing and managing aggressive patients admitted to an acute hospital setting: a systematic review. Worldviews Evid Based Nurs. 2011;8(2):76-86. Available from: https://doi.org/10.1111/j.1741-6787.2010.00206.x.	Wrong population
McKay K, Ariss J, Rudnick A. RAISe-ing awareness: Person-centred care in coercive mental health care environments-A scoping review and framework development. J Psychiatr Ment Health Nurs. 2021;28(2):251-60. Available from: https://doi.org/10.1111/jpm.12671.	Wrong outcome
Melvin CL, Barnoux M, Alexander R, Roy A, Devapriam J, Blair R, et al. A systematic review of in-patient psychiatric care for people with intellectual disabilities and/or autism: effectiveness, patient safety and experience. BJPsych Open. 2022;8(6):e187. Available from: https://doi.org/10.1192/bjo.2022.571.	Wrong population

Nawaz RF, Reen G, Bloodworth N, Maughan D, Vincent C. Interventions to reduce self-harm on in-patient wards: Systematic review. BJPsych Open. 2021;7(3). Available from: https://doi.org/10.1192/bjo.2021.41.	Wrong intervention
Roy C, Castonguay A, Fortin M, Drolet C, Franche-Choquette G, Dumais A, et al. The Use of Restraint and Seclusion in Residential Treatment Care for Youth: A Systematic Review of Related Factors and Interventions. Trauma Violence Abuse Rev J. 2021;22(2):318-38. Available from: https://doi.org/10.1177/1524838019843196.	Wrong outcome
Rzhevskaya NK, Ruzhenkov VA, Ruzhenkova VV, Khamskaya IS, Moskvitina US. Psychiatric coercion and violence: ethical, legal and preventive aspects. Archivos Venezolanos de Farmacologia y Terapeutica. 2020;39(5):568-72.	Wrong study design
Sashidharan SP, Mezzina R, Puras D. Reducing coercion in mental healthcare. Epidemiol Psychiatr Sci. 2019;28(6):605-12. Available from: https://doi.org/10.1017/S2045796019000350.	Wrong study design
Scanlan JN, Novak T. Sensory approaches in mental health: A scoping review. Aust Occup Ther J. 2015;62(5):277-85. Available from: https://doi.org/10.1111/1440-1630.12224.	Wrong study design
Stovell D, Morrison AP, Panayiotou M, Hutton P. Shared treatment decision-making and empowerment-related outcomes in psychosis: systematic review and meta-analysis. Br J Psychiatry. 2016;209(1):23-8. Available from: https://doi.org/10.1192/bjp.bp.114.158931.	Wrong outcome
Sturmey P. Reducing Restraint in Individuals with Intellectual Disabilities and Autism Spectrum Disorders: a Systematic Review Group Interventions. Advances in Neurodevelopmental Disorders. 2018;2(4):375-90. Available from: https://doi.org/10.1007/s41252-018-0088-y.	Wrong study design
Tang Z, Zhu Z, Zhang X, He Y. The Effects of Tai Chi and Baduanjin Activities on Physical Interventions With Substance Use Disorders: A Systematic Review and Meta-analysis. Hong Kong J Occup Ther. 2022;35(1):25-34. Available from: https://doi.org/10.1177/15691861221090551.	Wrong outcome
Tolland H, McKee T, Cosgrove S, Drysdale E, Gillespie M, Paterson L, et al. A systematic review of effective therapeutic interventions and management strategies for challenging behaviour in women in forensic mental health settings. Journal of Forensic Psychiatry and Psychology. 2019;30(4):570-93. Available from: https://doi.org/10.1080/14789949.2019.1627387.	Wrong intervention
Tolli S, Partanen P, Kontio R, Haggman-Laitila A. A quantitative systematic review of the effects of training interventions on enhancing the competence of nursing staff in managing challenging patient behaviour. J Adv Nurs. 2017;73(12):2817-31. Available from: https://doi.org/10.1111/jan.13351.	Wrong population
Valenkamp M, Delaney K, Verheij F. Reducing seclusion and restraint during child and adolescent inpatient treatment: still an underdeveloped area of research. J Child Adolesc Psychiatr Nurs. 2014;27(4):169-74. Available from: https://doi.org/10.1111/jcap.12084.	Wrong study design
van de Ven-Dijkman MV, Schoevers R, Sikkens E. A systematic literature review on application and effects of forced admissions. BMC Psychiatry. 2007;7:1-. Available from: https://doi.org/10.1186/1471-244X-7-S1-S151.	Wrong outcome

Bilagor
S2022/04744 (delvis)
SBU 2023/33
Förstudie avseende alternativa metoder till tvångsåtgärder

Bilaga 6 SNABBSTAR – Mall för bedömning av risk för bias

Snabbstar – Mall för bedömning av risk för bias (PDF)