Rate and pattern of the use of physical restraints at a single psychiatric centre

Master thesis in Medicine

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ABSTRACT

Introduction: During psychiatric care the need sometimes arises to treat patients against their will due to the patients' inability to make rational decisions on their own treatment. There are different aspects of compulsory treatment, ranging from restricting access to mobile telephones to the use of physical restraints to stop the patient from hurting themselves or someone around them, usually their caregivers or other inpatients. Today the most common method of physical restraints is using a specialised bed with straps. **Aim:** To study the rate and pattern of physical restraint use at a single psychiatric center. **Method:** All patients, who in their case records, had a registered administrative code of physical restraints between January 1 2012 and June 30 2014 were included. The material was limited to the psychiatric clinics at Östra sjukhuset including wards specialized in the care of most mental disorders except psychotic disorders. Patients that had two or more separate events of compulsory treatment were only counted once in the demographics, but when looking at the use of physical restraints all the separate events where taken into account. **Results:** A total of 80 patients were physically restrained a total of 135 times out of 10.706 admissions (>1%). Mean age was 32.6 years and 54% were men. Women more often had a diagnosis of a personality disorder ($p<0.05$) while men more often had mood- or substance use disorder ($p<0.05$). Those that had had contact with psychiatric services less than one year had a lower risk of physical restraints (19%), and among women the number was even lower (3%). **Conclusion:** The use of physical restraints is relatively uncommon, being registered in less than 1% of admissions. Patients who are new to psychiatric treatment are less likely to be restrained than patients who has been in contact with psychiatric care for more than a year.

Keywords: Mechanical restraints, compulsory treatment, psychiatric care

INTRODUCTION

Compulsory treatment is a last resort in the care of the psychiatric ill and the use of physical restraints should always be the last option used by mental health care personal. However, physical restraints can be necessary in order to protect the patient from harming him- or herself or others as well as ensuring that severely ill patients get necessary treatment.

Definitions

The different physical compulsory actions that exist are: seclusion, manual restraints, and mechanical restraints. Manual and mechanical restraints are grouped and called physical restraints in some sections of this thesis.

1. Seclusion: The patient is isolated from other patients and is not allowed in any common areas on the ward. Some clinics have separate rooms for secluded patients. Seclusion is only allowed to be used if patients are disruptive to the treatment of other patients.

2. Manual restraints: A patient is manually restrained by being held down by two or more staff members. This may be required when the duration of restraining is expected to be short for example when the patient refuses necessary medication.

3. Mechanical restraints: If the duration of restraining is expected to last longer mechanical restraints are used. This means that the patient is securely fastened to a bed with straps around arms, legs and waist. All of the straps do not have to be used for it to be considered use of mechanical restraint.

Beside these measures the patient may be confined from telephone communication, e.g. use of cell phones, computers. During compulsory actions, the use of treatment options such as medication and in rare cases even electroconvulsive therapy (ECT) may be required against a

patients' will. Beside above mentioned any action directed at a patient under manual or mechanical restraints should be reported to the National board of health and welfare. When using seclusion or restraints there is a separate report that has to be filed if certain time limits are breached. For seclusion that time limit is eight hours, if a patient is secluded for more than eight hours the event should be reported to the Health and Social Care Inspectorate (IVO), for physical restraints the same time limit is four hours.

The laws surrounding compulsory treatment

The idea of treating a person against his or hers will is not a new one, there is passages of law dating back as far as the 13th century that states what to do when someone can't care for him- or herself due to psychiatric illnesses (Wallsten et al. 2013). Today, compulsory treatment in Sweden is governed by "Lag om psykiatrisk tvångsvård" or LPT and "Lag om rättspsykiatrisk vård" or LRV, the one first applies to severe mental illness without a crime and the latter to forensic psychiatry.

In order to be treated under LPT a patient has to fulfil a set of criteria, as stated in §3 in the law of compulsory psychiatric treatment (Lag (1991:1128) om psykiatrisk tvångsvård). The criteria for compulsory care are that a person is:

1. Suffering from a severe psychiatric disorder.
2. Is in need of immediate and indispensable psychiatric treatment around the clock
3. Is opposed to such care as stated in #2 above or is in such state that due to his or her psychiatric disorder has clearly impaired capability of decision making regarding their own treatment.

Compulsory treatment in other countries

The methods of compulsory treatment have changed drastically through the ages and many practices previously used are considered inhumane, such as straitjackets (Svedberg, 2002). Furthermore, in some countries the use of mechanical restraints in psychiatric care has been abandoned altogether. In Iceland the use of restraints has been banned since 1933(Gudmundsson, 2012). Instead of mechanical restraints they use verbal communication and de-escalation techniques. The psychiatric clinic often has a team of personnel with extra training in those fields that can be called upon if the need arises. If the situation gets out of hand they can use manual restraints, which is when 3-4 persons holds the patient to the floor or bed. The United Kingdom is another country where mechanical restraints have been abandoned due to ethical conciderations, instead the psychiatric staff have the same deescalation techniques at hand as well as seclussion and rapid tranquillisation and other techniques stated by the National institute for Health and Care excellence (NICE, 2005, Davvison 2005). In Finland the parliament tried to reduce the use of restraints by issuing new legislation in 2002 a followup study in 2007 showed that only legislation was not enough to reduce the use of both seclusion and restraints instead the study showed that traditions of hospitals may be more important then legislation in some cases (Keski-Valkama et al. 2007).

In Switzerland forced admissions are applied to 21.7% of all psychiatric inpatients. Out of all inpatients physical restraints or seclussion were applied to 5.6%, forced medication to 3.7%. (Lay et al. 2011)

Comparing the other Nordic countries, the use of mechanical restraints is more frequent in Sweden, two times more often than Denmark and more than three times as often as Norway and Finland (Bak & Aggernaes, 2012). At the same time forced admissions are less frequent in

Sweden (114 individuals per 100,000) compared to both Norway (135 per 100,000) and Finland (218 per 100,000).

Inpatients and their relatives view on compulsory treatment

A study performed between 1997 and 1999 show that among involuntarily committed patients the acceptance for forceful measures are lower than among the corresponding group of voluntarily admitted patients, 67% vs 86% gave the answer that involuntary admission should be possible. Next of kin to the patient in this study showed that relatives to the committed patients in higher extent focused on coercion being used to protect the patient while it was slightly more common among next of kin to voluntarily admitted patients to view protection for the general public or relatives as a reason for involuntarily admission. (Wallsten et al. 2008)Among both patients and relatives it is the most common view that doctors should bear the responsibility to make the decision if a patient should be involuntarily admitted, though most of those who answered wanted the decision to be made by more than just one profession. 61% of the relatives to voluntarily admitted patients and 55% of the relatives to committed patients wanted to be part of the decision to involuntarily admit a relative. (Wallsten et al. 2008)

Rate of physical restrains

Since 2007 it is mandatory to report when a patient has been restrained by using the administrative code systems, since 2011 there is a list of 10 different actions with specific codes that are considered compulsory treatment(SOSFS 2008:26, (Arbetsgruppen för professionsgemensam samordning av åtgärdsregistrering inom psykiatrin, 2012). In 2012 there

were in total 10,780 patients treated according to LPT accounting for about 20% of all psychiatric inpatients (Socialstyrelsen, 2012). The use of mechanical restraints was registered in 4,159 occasions during 2012(Socialstyrelsen, 2013) compared to 3,442 in 2011 which may indicate an increase in the number of patients who were mechanically restrained or the rate of registration. The national board of health and welfare, the institution in charge of collecting these data, believes that the registration has improved but is far from being good enough to be used as a tool to evaluate the psychiatric wards (Socialstyrelsen, 2013). Furthermore, in practice it seems that methods that have been banned are sometimes still used. A recent example from a forensic psychiatric clinic in the North of Sweden is the use of helmets and closed leather gloves to prevent self-harm in the 21st century (Åkerman & Eriksson 2011).
While working on this paper found that <1% of all admissions where affected by the use of mechanical restraints, a swiss/german study from 2007 puts that ratio in Switzerland at 6.6% and in Germany at 10.4% (Martin et al., 2007).

Mechanical restraints

A patient may get mechanically restrained for different reasons, most commonly due to agitation (Keski-Valkama et al., 2010) or to administer medication. According to the law the use of restraints should be ordered by a specialist in psychiatry. However, a patient may be required to be mechanically restrained due to self-defence. In such case the action shall be evaluated by a specialist without delay.

Risk factors that can be identified by studying statistics from the National board of health and welfare points out gender and age where young women are most likely to get put in restraints (Socialstyrelsen 2013). During 2013 1,713 women between the ages of 18 and 44 were

mechanically restrained. During the same period of time 1,116 men were restrained. In total, female patients accounted for 57% of all events of restraints while only representing 44% of all restrained patients (Socialstyrelsen, 2014). In women getting mechanically restrained the most common type of diagnosis was personality disorder, while in men psychosis and schizophrenia were the most frequent. (Socialstyrelsen, 2012, Dumais et al., 2011) Among other reasons for use of restraints we find violent behaviour. A patient's violent behaviour is multifactorial (Björkdahl et al. 2007), including relations between the patient and the staff, relations between the patient and other patients, patient-related issues and issues relating to the ward. A study from 2004 suggest that more attention should be given to ward-related issues, staff-related issues and patient interaction as a mean to reduce patient aggressiveness (Johnson, 2004).

Photo: Charlotte Partanen

Bed with mechanical restraints at ward 364 at Östra sjukhuset

AIM

The aim of this study was to study the use of mechanical restraints at a single modern psychiatric clinic in Sweden. Primarily, to see differences in demographics. Secondly, to see if there are any particular factors that influence the frequency and duration of the use of restraints.

MATERIAL AND METHOD

Study design

The study is a retrospective study of patient case records from department of psychiatry, Östra sjukhuset, Gothenburg.

Study population

Patients admitted according to the law of Compulsory psychiatric care (LPT) are common in most of the psychiatric wards at Östra sjukhuset. They get treated in the same units as voluntarily admitted patients. These patients are subject to the use of physical restraints in certain situations. Be it to administer medication or ECT or because the patient is violent and a threat to him-/herself or others. The psychiatric center at Östra sjukhuset consists of one clinic for general psychiatric disorders, such as depression and personality disorders and one clinic for substance abuse where patients get treated either for acute states related to alcohol or drug abuse but also those suffering from co-morbid severe psychiatric illness with substance use disorder. Patients were found by searching the computer database for the following codes of intervention or KVÅ-codes:

XU001 - Use of restraints for up to 4 hours

XU003 - Use of restraints for more than 4 hours but less than 72 hours

XU004 - Use of restraints for more than 72 hours.

A few patients which had one of these codes registered were excluded due to lack of information about any use of mechanical restraints in the written chart and it was deemed more likely that the code was used by mistake than a patient was physically restrained and the entire staff failed to mention this in their notes. Furthermore, two patients younger than 18 years old were excluded.

Data

The data consists of information collected from patient case records at Östra sjukhuset, the selection were made by means of one of the three codes as inclusion criteria. This was followed by a manual review of all charts concerning the specific admission to the hospital. The patient data recorded were: age, gender, diagnoses (one main diagnosis and up to two secondary diagnoses, only including psychiatric diagnoses), employment status, marital status, first recorded contact with the psychiatric clinic (including outpatient service, emergency ward or inpatient services). The data regarding the use of compulsory methods that were recorded were admission and discharge date, ward, number of times restrained, weekday, month and time of day for use of physical restraints, medication, duration and indication, i.e. whether agitation or medication was the primary reason for the use of mechanical restraints.

Data analysis

All data has been de-identified and collected into an excel sheet. All statistical analyses were made using IBM SPSS statistics 22.0.0. (SPSS Inc., Chicago, IL, USA). User defined missing values are treated as missing. The groups compared in this study are mainly sex and indication for use of restrains. All comparative analysis has been tested for significance using either students' t-test for continuous variables and Chi-square or Fisher's exact test (if the number in either group was >6) for categorical variables. A p-value ≤ 0.05 was considered as statistically significant.

Ethics

To conduct this study I had to take part of patients' charts for the admission in question. Working with this material care was taken to ensure patients' anonymity. Only one person has

worked directly with the patients' identity during the process to gather the information needed. After all the relevant data had been gathered from the charts the patient was assigned a code number and all identifying markers where deleted from the work material. A list with code numbers and identity were transferred to a USB-drive if needed for further studies. To read a patient' chart is a rather big infringement of personal integrity, however, the patient should not be harmed by this as long as the data is kept secure and anonymous. For most patients it was enough to study the notes from the time at the ward when the restraining event took place, but in a few cases it was necessary to read older notes to get a better view of the patient and find the data needed. This includes the action of examining if the patient had any previous contact with the psychiatric clinic. By taking part of a patients chart without their approval you take on a big responsibility, first of all you need to make sure that the information comes to some sort of use; otherwise the intrusion in integrity has been in vain. Furthermore the patients' integrity has to be protected as much as possible, restricting data collection from case records to information that are important for this study. Patients have to feel safe that the information in the medical databases are kept safe

The study has been conducted according to the regional ethic guidelines and all effort have been taken to adhere to the Helsinki declaration. Approval was collected from the managers of operations at the clinic for substance abuse and the clinic for psychiatric illnesses at Östra sjukhuset.

RESULTS

During the study period a total of 10,706 individual admission were found and in 80 cases there was registered the use of physical restraints giving a rate of 0.75% (95%-confidence interval (CI) 0.58 to 0.92%). This study included these 80 individuals comprising a total of 135 episodes where physical restraints where used.

Demographics

Demographic variables of the patients who were physically restrained are shown in table 1. Similar sex ratio was found, 54% were men and 46% women. A minority were in a steady relationship (15%), in one case (1%) the information regarding relationship status is unclear), 7% of the men were living in a relationship corresponding number for women was 32% (p = 0.06). Among the female patients 30% where employed at the time of being admitted to the psychiatric ward, among the male patients 23% where employed, for all patient the employment rate is 27% (p = 0.57).

Table 1 - Demographics of patients admitted to Östra sjukhuset that where physically restrained

Variable	n = 80
Male sex	53.7%
Age (years)	32.6 ±12.7
Relationship	15%
<1 year contact with psychiatric services	18.8%
Full employment	27.3%

The mean age was 36.2 years for women and 29.4 for men (p=0.016), average age for all patients was 32.6. The majority of the study group was between 18 and 34 (64%) (figure 1).

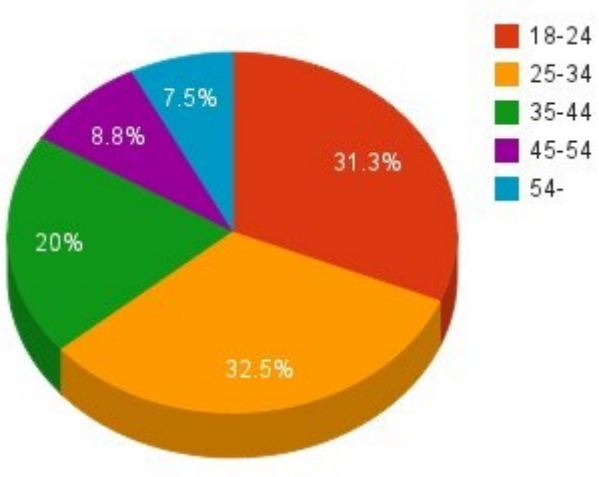

Figure 1 - Use of mechanical restraints by age categories

Cause for use of restraints and use of self-defence

The most common reason to restrain a patient was agitation (in 95 events out of 135, 70.4%). The second most common reason was to administer medication or ECT (in 35 events, 25.9%) (Figure 2). In one case the chart was unclear about the reason and in two cases the patients were restrained in order to be transported to ECT treatment. On two occasions, patients were voluntarily restrained.

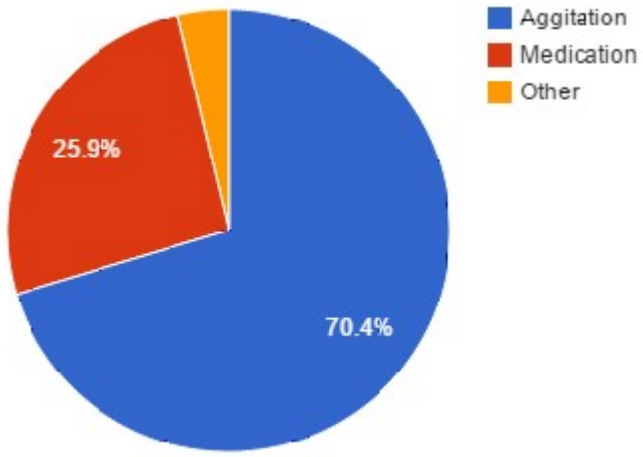

Figure 2 - Indication for use of restraints

Factors starting the event were either that a physician prescribed the action or that the staff felt that the situation called for immediate action those event were described as self-defence and accounted for 60.7% of the events (figure 3).

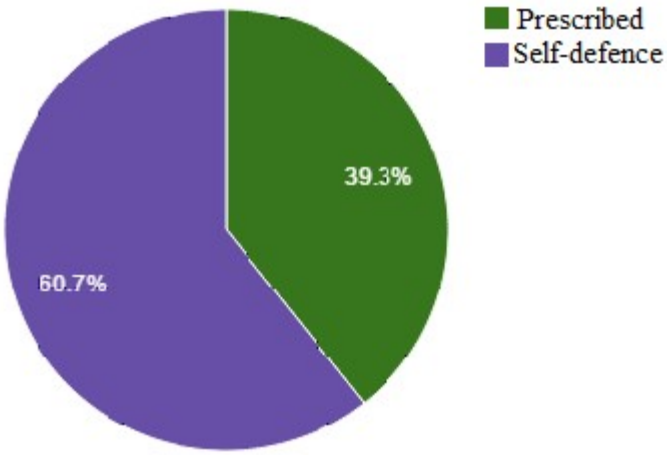

Figure 3 - Use of self-defence as reason for restraints

Administered treatment

In the group where medication administration was the indication medication was given in all of the 35 cases. In the second group those who were restrained due to agitation, medication was given in 64 out of 95 events (67.4%). Both of those who were voluntarily restrained received medication under restraints (Table 2).

Table 2 - Administered treatment and indication for restraints

Indication	No treatment	Single treatment	Combined treatment	Total
Agitation	31	34	30	95
Voluntarily	0	1	1	2
Medication	0	24	11	35
Transport	2	0	0	2
NA	1	0	0	1
Total	34	59	42	135

The most commonly administered substance was Diazepam (37.7%) followed by Olanzapine (16.7%), Zuklopentixol (14.4%), Haloperidol (14.4%), Aripiprazol (4.3%) and Klonazepam (6.5%) Clomethiazole was used in just one case. In one case intravenous glucose was administered under restraints, this was given to a psychotic patient that refused to eat or drink. In cases of agitation patients who received treatment received about as much benzodiazepines as antipsychotic medication. However, it was more common with single treatment with benzodiazepines in this group (50%), while patients that were restrained for medication more often got antipsychotic medication as single treatment (83%). Most patients were given some sort of medical treatment during restraints (83%).

Out of those who received medication, 39 individuals where given a combination of substances or in one case ECT. Getting a second substance or treatment was more common for

patients with agitation as indication. The most common complementary treatment was benzodiazepines in 37 out of 39 occasions (table 3). Diazepam was used as a complement to antipsychotic medication in all cases.

Table 3 - Combination of treatments

	Diazepam	Zuklopentixol	Klonazepam	ECT
Diazepam	-	0	0	1
Olanzapine	10	0	2	0
Aripirazol	2	0	0	0
Haloperidol	11	1	1	0
Zuklopentixol	10	-	1	0

A patient that received medication during mechanical restraints had a mean length of event of 5 hours (median = 3.2 hours) while a untreated patient had a mean length of 1.9 hours (median = 1.6 hours, $p = 0.03$) (table 4).

Table 4 - Treatment and length of mechanical restraint events

Treatment	Mean	n Std. dev,		Median
No treatment	1.9	34	1.3	1.6
Medication	5	93	9.6	3.2
ECT	5.2	8	3.2	5.3

Characteristics of the episodes

Most commonly, patients were restrained only once during his/her stay, and the typical episode occurred within 48 hours of being admitted (Figures 4 and 5). The mean number of episodes was 1.7 with a median of 1. The mean length from admission was 4.7 days with a median of 2 days. The length of the episodes varied from five minutes to 76.7 hours. The mean length of an episode was 4.2 hours (std. dev. 8.1) with a median of 2.75 hours. Nine patients were restrained more than two times and had a total of 53 recorded events of mechanical restraints, accounting for 39% of all episodes (figure 4).

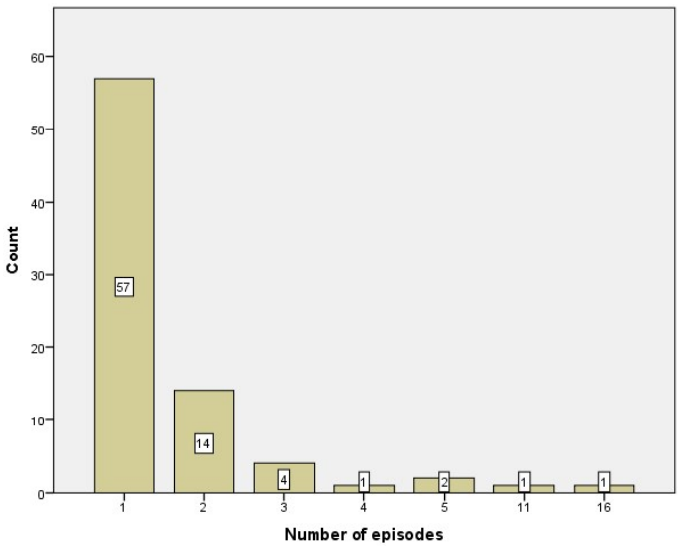

Figure 4 - Distribution of number of episodes among restrained inpatients

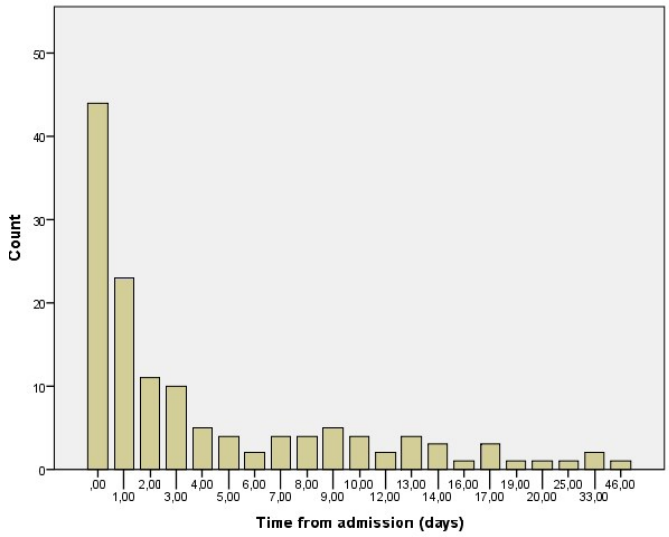

Figure 5 - Time from admission for each episode of use of mechanical restraints

Differences between genders

Women had more often a diagnosis of a personality disorder than men, 32.4% compared to 9.3%, respectively ($p<0.01$). Among men, substance abuse was the most common diagnosis (65.1%) while women 27% were diagnosed with some sort of substance abuse ($p<0.01$). Mood disorders were more common among women (43.2%) whereas for men it was 25.6% ($p=0.02$, figure 6).

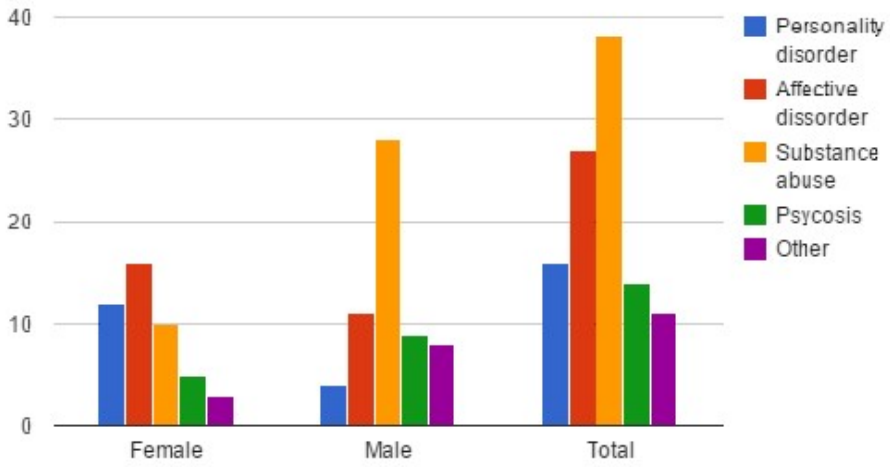

Figure 6 - Diagnosis among mechanically restrained patients

Among women the share of patients restrained due to agitation was 63.9% while the same ratio among male was 75.7% (p=0.17, Figure 7).

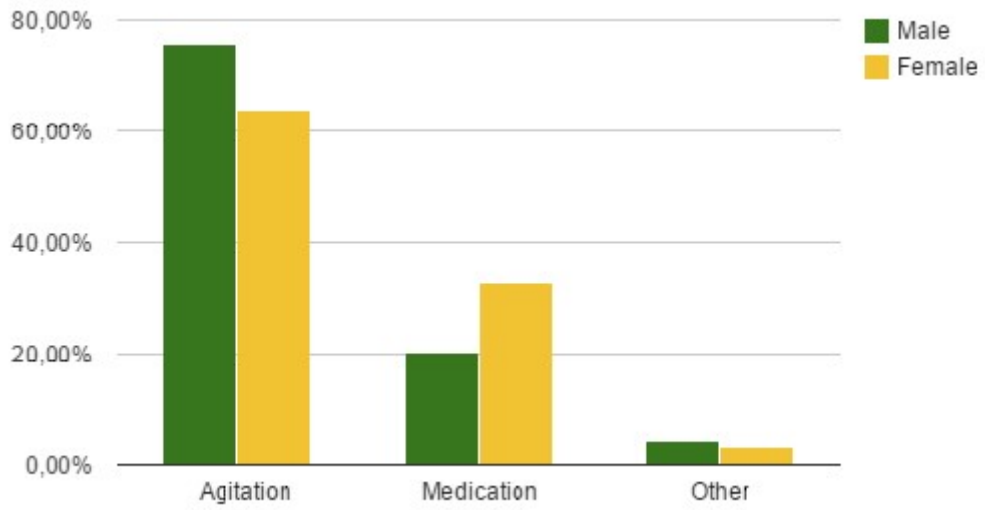

Figure 7 - Indication for use of restraints

Women were more unlikely to be physically restrained if their first contact with psychiatric services was within the last year (Figure 8). Among women 2.7% of those restrained had first contact within a year compared to 32.6% among men ($p<0.01$). In the total group the proportion was 20%.

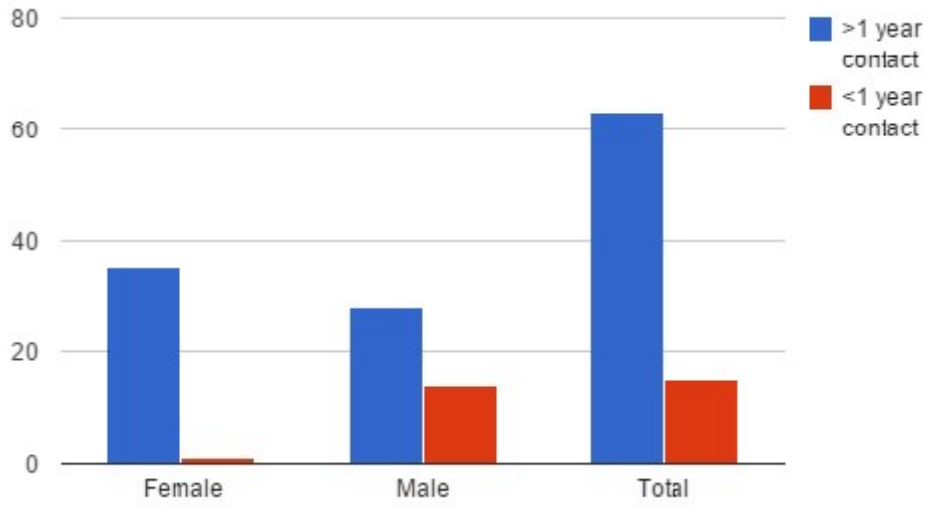

Figure 8 - Use of restraints on patients with short or no contact with psychiatric care

DISCUSSION

Most patients admitted to Östra sjukhuset are not subject to mechanical restraints and those that are, get restrained once during their stay most commonly within the first 48 hours. Just over 10% of restrained patients get restrained more than two times during their stay and 46.3% of all restraining episodes occurred during the first 24 hours.

There was only a small difference in rate of restraints between women and men. However, there was a sex difference regarding age, female patients being older than male patients. Furthermore, women were less likely to get restrained during the first year after first contact with psychiatric care. Women were more commonly diagnosed with personality disorders and men with substance abuse (Dumais et al. 2011). Mood disorders were also somewhat more common among men. The fact that female patients tended to have been in contact with some sort of psychiatric care for at least a year could be connected to the difference in discharge diagnoses.

Coercive measures

Coercive measures are supposed to be used as a protection for the patient, co-patients and staff (Svedberg, 2002). The use of coercive measures varies among different countries but also between clinics in the same country. In Germany 9.5% of all psychiatric inpatients are subjects to at least one episode of coercive action, in Finland 32% of psychiatric inpatients where either restricted or subject to involuntarily medication (Lay, Nordt, & Rössler 2011). The method of coercive actions also varies between countries some nations have completely banned the use of mechanical restraints (Davison, 2005).

Documentation

A striking observation when collecting data for this thesis was how variable the quality of documentation was. Most of the information gathered when reading the case records was from notes made by nurses. If at all there was a note written by the doctor in charge around the time of the episode, it was mostly just a comment that the patient had been restrained and a short explanation why, very rarely was there any follow-up noted in the charts. Only in the cases of those restrained for long periods of time (>4 hours) there was a note about ending the restraining episode. This problem of deficient documentation has been acknowledged by the National board of health and welfare are aware of. (Socialstyrelsen, 2014)

Indications and self-defence

When looking at the use of self-defence compared to restrain use on a physician' order it is important to keep in mind why a patient gets restrained. As shown in the result section of this work we see that by far the most common reason is agitation (Keski-Valkama et al. 2010). Since a physician isn't available most of the time and situations of agitation can be hard to foresee it is likely that agitation will continue to be the most common indication.

Among the different reasons for use of restraints mentioned are a few cases with patients asking to get restrained. This does not actually qualify as a compulsory measure in the strict view of the law, however I chose to include these two events because this is likely to happen at different clinics and needs to be registered and evaluated if this is a valid indication.

Medication

When putting a patient in restraints it has to be followed up closely. In most cases it comes down to either letting the patient calm down on his/her own or administer some sort of medication. In the cases where the patients were put in restraints for the sole reason of giving medication the follow up is clear but in the case of patients being restrained due to agitation it isn't that obvious what the next step should be. In this study 1/3 of all cases where the patient where restrained due to agitation no treatment was administered. What was interesting to see is that those patients who did not receive any treatment tended to have shorter episodes of restraint use. This can be credited to the fact that all patients who did not receive any treatment were patients who were restrained due to agitation and it is likely that such a patient will be released from the restraints as soon as said patient has calmed down. An explanation for the longer time in restraints in a patient who gets medicated might be that he is kept in restraints as long as the sedative effect of the medication remains.

Diagnosis

The data in this study corresponds well with the data from the national board of health and welfare when looking at the ratio of individuals in this study the percentage of male patients where 54% in the national data 56% of the individuals are male (Socialstyrelsen, 2013). The results differs from the data available at the National board of health and welfare regarding how often restrains are used in female vs. male patients. In the national data female patients are restrained almost twice as often as male patients while in this study there is no significant difference. Reasons for this may be because the data for this thesis is gathered from one single psychiatric centre, comprising a section for affective disorders and one section of substance

abuse disorders, thereby not representing the whole spectrum of psychiatric disorders, for example psychotic disorders are not included in this study

Weaknesses of this study

The study sample is rather small, only 80 individuals and 135 episodes, where 9 patients are responsible for roughly 40% of all episodes. It is a descriptive retrospective study with no controls. It is based on the documentation available, which in some cases were very scarce, especially from the physicians' part. Furthermore, there is reason to believe that some cases of mechanical restraints are not registered and therefore have been missed in the present study.

Further research

This thesis has focused on a narrow spectrum of patients, the fact that the entire clinic for substance abuse in Gothenburg was included but not the entire psychiatric-division has most likely skewed the results. A larger study needs to be performed where all the psychiatric centres in Gothenburg are included to get more accurate results. More focus should also be put on when and where patients have been restrained, in my data I have included this factor but chose not to analyse that data for this thesis.

Conclusion

The most important result in this study is that fact that most patients that get restrained have had a longer contact with psychiatric care, less than 1/5 of all patients that got restrained had been receiving psychiatric care for less than a year, the prevalence of new patients among females are even smaller, 1/40. Further review and investigation should try to find the reason for this in order to both reduce the use of physical restraints and ensure right indication.

SAMMANFATTNING PÅ SVENSKA

När en patient vårdas inom psykiatrin kan det ibland uppstå behov att vårda en patient mot dennes vilja. Tvångsvårdade patienter utgör ungefär 18 % av alla patienter inom sluten psykiatrisk vård i Sverige. En av grundpelarna inom vården är att den ska bedrivas med ett informerat samtycke från patienten, detta blir ogörligt i samband med tvångsvård. Vad man istället måste försöka göra då är att bedriva vården på ett sådant sätt att den utgör ett så litet ingrepp som möjligt i patientens integritet.

Den här studien utgår från alla patienter som lagts i bälte på Östra sjukhuset i Göteborg mellan den 1/1 2012 och den 30/6 2014. Studien försöker utröna om det finns några skillnader eller likheter mellan patienterna som bältas, om det finns något som påverkar hur ofta en patient bältas och hur länge bältningarna pågår. Studien gick ut på att granska journalanteckningar rörande de olika patienternas vårdtillfällen som innehöll minst en bältesläggning. Ur journalerna hämtades information om sådana saker som anställning, om patienten levde i ett förhållande, hur lång kontakt patienten haft med psykiatrin samt information om patientens diagnoser och specifika uppgifter rörande de aktuella bältningstillfällena.

Studien kunde inte påvisa någon signifikant skillnad mellan könen när det gällde antal bältningar eller bältningslängd, inte heller när det gällde arbete eller huruvida de levde i ett förhållande. Det fanns en signifikant åldersskillnad mellan kvinnor och män, kvinnor hade en medelålder på 36 år, männens medelålder var 29. En annan tydlig skillnad var diagnosfördelningen. Män i studien hade i mycket stor utsträckning missbruksdiagnoser, bland kvinnor var den mest typiska diagnosen någon form av personlighetsstörning. En annan skillnad var att endast en av de bältade kvinnorna hade haft kortare kontakt med psykiatrin än ett år (3 %) bland männen hade 1/3 av patienterna haft kontakt med psykiatrin kortare tid än ett år.

Jämfört med det material som finns att tillgå fritt från Socialstyrelsen kan vi se att könsfördelningen med avseende på individer stämmer väl överens. Kvinnor är dock kraftigt

överrepresenterade i antalet bältningar i det nationella materialet. Denna skillnad antas bero på det faktum att de två kliniker inom psykiatrin som finns på Östra sjukhuset inte omfattar ett fullt spektrum av psykiatriska diagnoser, störst påverkan gör avsaknaden av psykosvård på Östra sjukhuset. Då den ena kliniken är en bereoendeklinik är det inte oväntat att beroendediagnoser svarar för en så pass stor del av alla bältningar. Vidare studier behövs på området och framförallt behöver man utröna vad som förändras över tiden som gör att patienterna med längre kontakt med psykiatrin är de med störst risk för att bältas.

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