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Shielding in Mental Health Hospitals: Description and Assessment by Staff

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Abstract

Shielding is defined as the confinement of patients to a single room or a separate unit/area inside the ward, accompanied by a member of staff. It is understood as both a treatment and a control. The purpose of this study is to examine how staff in psychiatric hospitals describe and assess shielding. This qualitative study uses a descriptive and exploratory design with an inductive approach. The material was acquired through the Acute Network (in Psychiatry) nationwide shielding project. Data collection was carried out by the staff, who described the shielding procedure on a semi-structured form. The analysis was inspired by Graneheim and Lundman's qualitative content analysis. Shielding has been described as an ambiguous practice, that is, shielding can be understood in several ways. There is a clear tension between shielding as a control and shielding as a treatment, with control being described as more important. The important therapeutic elements of shielding have also been mentioned, and shielding involves isolation to different degrees.

Keywords

coercion, mental health, seclusion, segregation area, shielding

Introduction

Shielding and seclusion are methods commonly used in mental health hospitals and they require an administrative decision authorized by law. It is difficult to find an unambiguous term for Norwegian shielding because there are variations in the concept's use (Norvoll, 2007). Thus, practice can be similar to "open-area seclusion," "segregation nursing," "segregation area," "quiet rooms," or "sheltered areas" in the international literature (Bowers, Alexander, Simpson, Ryan, & Carr-Walker, 2004). Husum (2011) uses the word shielding, which she defines as "patients confined in a single room or in a separate unit/area inside the ward, accompanied by staff" (p. 5). Placing the patients in a separate unit inside the ward may also be defined as a psychiatric intensive care unit (PICU; Vaaler, Morken, Fløvig, Iversen, & Linaker, 2006). We chose to use the term "shielding" because it gives the best description of current practice. One main difference between the international use of the term "seclusion," and the Norwegian practice, seems to be that, in Norway, the patient would never be left alone, but observed by staff at all times (Husum, 2011). The fact that the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has used the word "shielding" to refer to the Norwegian practice since 2000 made it a natural choice (CPT, 2006). The fact that the Norwegian practice is difficult to translate into English (Husum, 2011) calls for more research into what staff actually do when they use shielding.

To be allowed to shield a patient legally, that person must have a mental condition or disruptive behavior that makes shielding necessary, and the shielding must be initiated based on therapeutic reasons or consideration of other patients (Norwegian Mental Health Act, 1999: https://lovdata.no/dokument/NL/lov/1999-07-02-62?q=psykiskhelsevernloven), for example, it may be necessary to limit a patient's perceptions. Sensory modulation is a common rationale for shielding (Norvoll, 2007), and can help to reduce the disturbance caused by patients, with the result that there may be less need for more restrictive seclusion practices (Lloyd, King, & Machingura, 2014). Seclusion is "the placement and retention of an inpatient in a bare room for containing a clinical situation that may result in a state of emergency" (Sailas & Fenton, 2000, p. 2). Different forms of agitation, aggressive behavior, and disorientation, of different severities, are the most common reasons for seclusion (Bowers et al., 2010; Keski-Valkama et al., 2010; Larue, Dumais, Ahern, Bernheim, & Mailhot, 2009; Thomas et al., 2009). Patients and staff have, on the whole, different views and perspectives about the use of seclusion. Staff perceive it as highly therapeutic and vital for the running of inpatient units; they

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also believe that it can help patients to calm down and feel better, and feel that it is necessary and not particularly punitive (Bowers et al., 2010; Keski-Valkama et al., 2010; Larue et al., 2009; Thomas et al., 2009). Patients perceive seclusion negatively; they believe that it results in feeling punished and that it has little therapeutic value (Meehan, Bergen, & Fjeldsoe, 2004; Van Der Merwe, Muir-Cochrane, Jones, Tziggili, & Bowers, 2013). However, some findings show that both staff and patients attribute more negative than positive feelings to patients' experiences of seclusion (El-Badri & Mellsop, 2008). A review suggested that most nurses support the continued use of seclusion as a strategy for the management of violence and aggression (Happell & Harrow, 2010). Patients' experiences of shielding differ: Some have only positive experiences, whereas others have only negative ones. Some have partially contradictory experiences, which could result from criticism of the care they received while being shielded, and also expressing their feelings about the safety of meaningful encounters with some of the staff (Karlsson, 2004). In Norway, shielding is understood as both a treatment and a control (Husum, 2011; Norvoll, 2007; Vaaler et al., 2006; Norwegian Mental Health Act, 1999). *Mechanical restraints* that prevent a patient's freedom of movement (including belts, straps, and special clothing to prevent injury), *short-term confinement* behind a locked or closed door with no staff present (isolation, seclusion), *involuntary medication* as an acute intervention in crisis, and *short retention* are, however, described as coercion (Husum, 2011; Husum, Bjørngaard, Finset, & Ruud, 2010; Norwegian Mental Health Act, 1999). These methods are enshrined in legislation and require a separate administrative decision; they can be used only when absolutely necessary to prevent the patient from injuring himself or herself, or others, or to prevent serious damage to buildings, clothing, furniture, or other things (Norwegian Mental Health Act, 1999). This decision has to be made by a psychiatrist or a psychologist (Norwegian Mental Health Act, 1999). There were 45,627 admissions among 25,424 patients in Norwegian mental health hospitals during 2013, of which 4,650 shielding decisions were made (Helsedirektoratet, 2014). This is roughly 10% of the admissions for shielding.

A series of discussions in network meetings and an informal group affiliated to the Norwegian Acute Network in Psychiatry (a network for evaluation, professional development, and quality improvement in acute psychiatry) suggests that understanding of both the concept and the practice of shielding vary considerably in psychiatric emergency units (Ruud & Hynnekleiv, 2012)[1]. More research regarding how shielding is carried out in practise is desirable, to gain a better description of current practice and possible improvement in treatment for people with mental health problems. The law (Norwegian Mental Health Act, 1999) describes the conditions for shielding and its implementation, but has no clear definition of what shielding involves (Norvoll, Ruud, & Hynnekleiv, 2015; Paulsrud, 2011).

Power and Shielding

The mental health services have special obligations to exercise social control and power. Max Weber (1990) defines power as the chance of one or more people implementing their will in a social relationship, even with resistance, regardless of what this opportunity is based on. Power is relational in the sense that it is something that concerns and occurs within a relationship between people. According to Weber (1990), power does not necessarily need to be exercised to be present, it may also be seen in the ability to carry out one's will. In other words, the opportunity for exercizing power will always be present.

Weber's (1990) definition of power is related to a domination relationship in which someone has "power over someone else." Power can also be understood as "the power to do something." Foucault (1990) exemplifies this by focusing on power as something that may constitute positive, creative, and productive forces in society. Foucault (2008) emphasizes that power is relational—it is something that happens, the dynamics. According to him, exercise of power is a way in which certain actions affect others' actions (Foucault, 2008). A discourse is related to power in the sense that it has a particular view of knowledge in the way it perceives, describes, and defines its reality. The knowledge discourse can, therefore, help to maintain power relations within a practice, but can also undermine them (Foucault, 2008).

Pierre Bourdieu (1996) emphasizes that cultural power and symbolic power are a key form of power in society. Symbolic power is often called "norm power" because it affects who has the greatest opportunity to define what should be considered right or wrong in a society or an organization. "Symbolic violence" is the most effective form of domination. It does not need to be legitimized or justified, but is taken for granted, perceived as natural, or misrecognized as something other than a condition of dominance and social inequality (Bourdieu, 1996). Communicative power is the basic concept in Habermas's theory of power (Habermas, Smith, & Smith, 1999). This is a force that does not act through the communication of threats and coercion. The power forms in communicative action, in which understanding through dialogue is, for all participants, an end in itself. The communicative power arises between people and groups jointly seeking appropriate norms of social cohabitation; it works through the norms that we share because we have willingly been convinced of their entitlement (Habermas et al., 1999).

Milieu therapy and shielding may be used together, and both approaches can have elements of power. Milieu therapy is a form of treatment in which the main emphasis is on therapeutic processes that can be mobilized and initiated (Geanellos, 2000). Milieu therapy involves facilitating a systematic treatment milieu and culture to promote the patient's potential for learning, coping, and personal responsibility. The therapeutic elements in milieu therapy are the opportunity for the person

to learn more about himself or herself and others, to gain greater self-knowledge and thereby to elevate problem-solving methods (Oeye, Bjelland, Skorpen, & Anderssen, 2009b; Skorpen, Anderssen, Øye, & Bjelland, 2009). It has been argued that teaching patients practical and social skills is an important part of milieu therapy (Gunderson, 1978; Oeye, Bjelland, Skorpen, & Anderssen, 2009a) and, by so doing, milieu therapy becomes a therapeutic arrangement to prepare patients for an independent life outside the hospital (Hummelvoll & Severinsson, 2001).

Shielding may be described as a strict form of setting limits. Limit setting can be understood as a wide range of approaches for regulating patients' behavior: "From administrative social control arrangements, from the application of mental health legislation and imposition of institutional regimes, to direct physical and verbal interventions" (Vatne & Holmes, 2006, p. 588). Limit setting may be required if the patient shows destructive behavior, smeared behavior, violent reactions, or other indiscriminate and unacceptable behavior. The purpose is to maintain and/or create safety for the patient, the other patients and staff, and to facilitate patients' development and growth.

The aim of the present study is to examine how staff in psychiatric hospitals describe and assess shielding.

Method

This study was based on material from a nationwide shielding project in Norway carried out by the Acute Network in Psychiatry. It has a descriptive and exploratory design using an inductive approach (Brink & Wood, 1998; Elo & Kyngäs, 2008). Through the use of a qualitative methodology, we obtained in-depth, detailed, and empirical knowledge about shielding.

Data Collection and Selection

A semi-structured survey was sent to 64 wards; 57 different wards participated and we received a total of 149 descriptions, completed by experienced staff. In the surveys, we asked the informants (staff) to describe a situation in which shielding was used as a method. They were asked to use the following points: background and rationale, objectives, measures, ethical aspects, and termination of shielding. The wards were mainly acute wards, but also some psychosis and rehabilitation wards, and adolescent wards (acute). Data collection was carried out by the staff, both therapists (psychiatrists and psychologists) and ward staff (psychiatric nurses, social workers, and social educators). It was emphasized that we were looking for as specific and detailed a description as possible: What patients and staff say and do, what assessments are made, what decisions are made, what actions are implemented, the physical environment, and anything else that is pertinent (Ruud & Hynnekleiv, 2012). Several forms had brief descriptions with little information. To gain a deeper understanding and find idiosyncrasies in the descriptions, we carried out a randomized selection of 20 forms from all forms with more than 1,000 words (51 forms)—the descriptions on these forms were more detailed, with more information.

Ethical aspects are a central part of shielding and will be discussed in a separate paper.

Data Analysis

The analysis was inspired by Graneheim and Lundman's (2004) qualitative content analysis and followed these steps:

- All the descriptions were read several times to familiarize ourselves with the material and obtain a sense of wholeness, as recommended by Creswell (2003).
- Meaningful units were identified.
- Each meaningful unit was condensed and given a code. Condensing involved shortening the meaningful unit while still preserving the core. Labeling the meaningful unit is supposed to make you think about it in new and different ways (Graneheim & Lundman, 2004).
- Meaningful units that belonged together were grouped, and categories and subcategories were identified and named.
- Abstraction is the process by which codes, categories, and themes are made at different abstraction levels.
- Validation was done by ensuring that the results were sustainable, supported by empirical data.
- The final step was presentation of the main theme, categories, and subcategories, exemplified by statements from informants to show the content.

Ethical Considerations

All informants gave their informed consent voluntarily. Each ward decided for itself whether to submit descriptions, and which descriptions to submit. They were informed that data were treated confidentially, with all patient descriptions being anonymized. The name of the ward, the people who filled out the form, and the patients were anonymous. The ethical principles of the World Medical Association's Declaration of Helsinki were followed. The study was approved by the Data Protection Officer at Akershus University Hospital.

Findings

One theme and three categories, each with four subcategories, emerged in the analysis, with the results shown in Table 1. The main finding was "shielding is an ambiguous practice." This means that shielding can be understood in different ways. Control is seen as most important, although treatment is also an important part of shielding. Shielding involves different degrees of isolation from other patients. The theme is overarching in the sense that the categories show ambiguous

Table 1. Shielding in Mental Health Hospitals: Overview of Theme, Categories, and Subcategories.

Theme		
Shielding is an ambiguous practice		
Categories		
Control is described as the most important part of shielding	Treatment is described by staff as an important part of shielding	Shielding involves isolation from the rest of the patients to different degrees
Subcategories		
Safety is an important reason for shielding and measures under shielding	Stimulus restriction is an important part of the patient's recovery process	Short shielding periods throughout the day are the least intrusive type of shielding
Patients are shielded because they create unrest, rebel, and quarrel with fellow patients	Structuring contributes to overview and coping for the patients	Patients are shielded in a room with staff present
Different kinds of limitations are an important measure to ensure order and safety in the shielding environment	Shielding is part of the treatment for patients with mental health disorders	Shielding involves staying at a private shielding section
Inappropriate behavior is limited by staff deciding and telling the patient when a limit has been reached	Being shielded involves patients having intensive personal contact	Shielding may include strapping a patient to a bed with mechanical devices (belts)

understanding of shielding. The category "shielding involves different degrees of isolation from other patients" also showed that the theme recurred within a category, because it had an ambiguous understanding of what level of isolation shielding involves. The other two categories are quite distinct in the sense that they individually understood shielding as control and treatment, respectively.

Control Is Described as the Most Important Part of Shielding

Most informants described control as important. It recurred in many of the points in the semi-structured questionnaire, and during the analysis, most codes were placed under the category control. *Safety* is the word that emerged most frequently. The subcategories are closely related to the category because they all describe various measures intended to achieve control. Quotes from informants are highlighted in *italics*.

Safety is an important reason for shielding and measures under shielding. Safety is important for the staff, fellow patients, and the patients themselves. The informants described threatening behavior as a justification for shielding:

> *In a conversation the patient showed menacing behaviour and promised to break the staff.*

When the patient is shielded for reasons of safety, measures are often implemented with the aim of preventing violence. This may include restricted access to objects of risk and continuous assessment of the risk of violence. Violence may not always be prevented:

> *A decision to shield was made because the patient injured one of the staff by head butting him twice.*

This shows that shielding is beeing initiated when violence has already been excerised.

Patients are shielded because they create unrest, rebel, and quarrel with fellow patients. The reason for shielding in this case is consideration of other patients. An upset patient is shielded to protect the other patients:

> *Protecting other inpatients in the ward from the patient's indiscriminate and disruptive behaviour.*

Staff believe that a lot of unrest in the common areas will affect other patients in a negative way. Examples of indiscriminate and disruptive behavior are unpleasant statements, noise at night, screaming, dancing, running, unwanted visits to other patients' rooms, and undressing and walking around in just their underwear.

Different kinds of limitations are an important measure to ensure order and safety in the shielding environment. This is about limiting what the patient has access to inside the room during shielding—both the ward's assets (radio, television, etc.) and the patient's own assets. Individual assessments have to be made, and what the patient can access depends on the security risk. They wanted to *limit the access to objects of risk*. Some patients do not have access to anything other than their own clothes. Decisions about a limited connection to the outside world were also described by several informants, but this is enshrined in legislation and requires a separate decision. It involves mainly limiting telephone usage, but also Internet usage and sending letters. The reason for this limit is that patients use the phone more, are verbally loud on the phone, and act indiscriminately and in a threatening manner. Staff described a particular case in which they were afraid that the patient would sell her apartment and regret it when she was healthy again:

> *Essential for the determination was that we did not want the patient to sell her own apartment [when] in a disease stage, as she possibly could regret it or not stand behind the decision.*

The patients are, despite the decision to limit connection to the outside world, allowed to call a lawyer or the supervisory commission (the main responsibility of which is to ensure each patient's legal rights in the face of mental health care).

Limitations are a control function used to achieve order and safety. The main focus is safety, not treatment.

Inappropriate behavior is limited by staff deciding and telling the patient when a limit has been reached. It may be that the staff limit unacceptable behavior:

> *The patient was told that he could not be inside the dining room with this behaviour.*

Limit setting can occur both before and after the limit has been reached, an informant described a situation in which boundaries occurred afterwards:

> *When the patient hit the member of staff she or he was limited by persons who held her or him.*

Not all behavior is limited by someone saying that a limit has been reached, some informants described ignoring the patient, disregarding and diverting him or her. This is used especially in connection with delusions. Limit setting is mainly understood as a control mechanism by which staff use limits to control what behavior is or is not tolerated.

Treatment Is Described by Staff as an Important Part of Shielding

Many informants described treatment as an important part of shielding. *Stimulus restriction* is the code that emerged most often. The subcategories are closely related to the category because they all describe key elements of shielding as treatment.

Stimulus restriction is an important part of the patient's recovery process. Peaceful surroundings with clear and limited surroundings can contribute to recollection, reduce anxiety, and accelerate the recovery process:

> *Regulate stimuli in a transparent and limited environment to hasten the recovery process.*

The informants described stimulus reduction as the grounds for shielding, an objective for shielding, and a measure under shielding. Stimulus reduction also focuses on the termination of shielding. Several informants described gradual habituation to the common areas at the end of shielding. Patients are gradually tested in common areas with other patients to see whether they are fit to handle the stimuli. If it goes well, staff gradually increases the patient's time in common areas. Staff use the stimulus reduction method to ensure that the patient is well enough to cope with the stimuli, in common areas, before the shielding is being concluded.

Structuring contributes to overview and coping for the patients. This is about creating procedures and a structured approach. An example would be to set up a daily plan for the patient:

> *Structuring the day by creating daytime, evening and night plans, when the patients have difficulties maintaining the structure on their own.*

The plan includes daily tasks and is an agreement between the patient and the staff. Tasks can be meals, conversations, medications, and activities such as walking, playing (card games, board games), or drawing. Structure is also about helping the patient to keep track of his or her room and guidance in relation to the number of things that should be in the room.

Shielding is part of the treatment for patients with mental health disorders. This is about the fact that some informants reported psychotic symptoms and mental disorders in general, as a reason for shielding. Delusions and paranoia are the psychotic symptoms that were used by most of the informants as a reason for shielding:

> *The patient in question is seen as having chaotic thinking, many delusions and much suspiciousness.*

A patient believes that the staff are agents of secret organizations such as the Central Intelligence Agency (CIA) and PST (Norwegian security police); one patient thought the room was bugged, and another was scared that the Committee for State Security of the Soviet Union (KGB) would pay the doctor for information and, therefore, refused to answer questions. Elevated mood is a reason for shielding and informants described lack of sleep. In this context, shielding is understood as a place in which patients can relax and rest to recover.

Being shielded involves patients having intensive personal contact. Shielding involves a form of availability in which staff are either with the patient or available within a short distance:

> *Staff alternated between being with him or standing available in the doorway.*

The informants in this study thought that available staff could provide a sense of safety and help patients. They also described the importance of continuity. The patient should not have to deal with too many staff. Several informants described two staff accompanying the patient during a shift and taking turns every hour.

Shielding Involves Isolation From the Rest of the Patients to Different Degrees

All informants described a degree of isolation in connection with shielding. Patients were "shielded in a room with staff present" and "staying at a private shielding section"—these are the two subcategories described most often in the material. There is a clear correlation between the category and

subcategory in the sense that all the subcategories describe a form of isolation.

Short shielding periods throughout the day are the least intrusive type of shielding. These can be planned and structured shielding periods or random shielding when the patient shows unwanted behavior, for example, the patient is shielded in the room for 30 min every hour:

> *We suggest that she should be 30 min in the room and 30 min in the common area.*

Short shielding periods throughout the day are the least intrusive type of shielding described by the informants. They served as a kind of limiting behavior without having to implement further isolation.

Patients are shielded in a room with staff present. This is implemented when the short shielding periods throughout the day are insufficient to protect the patient's condition and concern for other patients. Staff are either present in the room or sitting right outside the door. The degree of isolation varies depending on the patient's condition; some have access to a common area for short periods and walking, whereas others must stay in the room all the time:

> *Patients should not move beyond the threshold of the room. If they do, the patient will be deemed as not being inside the room. If this occurs, staff shall encourage the patient to return. If the patient does not return, staff shall lead the patient into the room.*

Shielding involves staying at a private shielding area. This involves taking the patient out of the regular ward and moving him or her into a separate area (segregation area/shielding area/PICU):

> *He was moved from his room in the ward and into the shielding area.*

Not all psychiatric wards in Norway have this facility. Some describe the possibility to lock doors, so creating a kind of shielding section in one of the wings when necessary. Some patients are admitted directly to the shielding area, and others are admitted to the regular ward and then moved to the shielding area if necessary. The degree of isolation among patients who are in the shielding area differs; for some, it involves being there around the clock (with staff available), whereas others, for example, have access to common areas during meals.

Shielding may include strapping a patient to a bed with mechanical devices (belts). This is not described by many informants, but we chose to include it because it is an important finding. It may be necessary if the patient is very aggressive and/or threatening, and if violence has been committed against staff or other patients:

> *. . . he beat a female staff when he walked past her. The alarm was triggered, and the patient was shielded on technical room (belt room) for a few hours until he had control over his behaviour.*

This is the type of shielding in which the degree of isolation is highest. In practice, it means that the patient is attached by belts to a bed, which is often in a bare room. There is always continuous observation by staff when mechanical restraints are used.

Discussion

Shielding and Power

Several studies have suggested alternatives to seclusion. In a review, medication was identified as the first option in 13 of 20 articles (Griffiths, 2001). To create an environment that minimizes the development of conflicts, early assessment of aggression risk and systematic review of seclusion episodes are other options (Huckshorn, 2004). We believe that shielding is a good alternative to seclusion and may be a more humane form of isolation/confinement. There are two good reasons for this: first, shielding does not involve as high a degree of isolation/confinement as seclusion; second, shielding involves staff being present with the patient to a much greater extent. In this study, the informants described intensive personal contact as a key element in providing safety and helping patients. This can be interpreted as informants thinking that the presence of staff in an emergency situation should contribute to calming of anxiety, having a unifying effect, and making the patients better able to cope. This means that shielding is a form of treatment.

Despite this, shielding involves a great deal of control, which can contribute to a correcting perspective (Vatne & Fagermoen, 2007). This may lead to patients experiencing powerlessness, a condition characterized by lack of control, influence, and impact opportunities; exit strategies and solution opportunities; and contact in terms of being seen, heard, understood, and recognized (Isdal, 2000). In this study, the focus on control clearly illustrates the power that staff have in a shielding situation. Power and coercion are a central part of shielding, both consciously and unconsciously. This is also a central element in this study and we wonder how aware staff are of their use of force. Possibly this is not discussed sufficiently. If a compulsorily admitted patient has to be shielded, but refuses, the staff are legally allowed to physically accompany the patient to the place of shielding (Norwegian Mental Health Act, 1999). It is obvious coercion when staff uses physical force to move the patient. It is also possible that shielding involves a more subtle, informal, and unconscious use of force. There may be cultures or discourses within the staff group for which certain patterns of behavior are perceived as natural and good professional actions on the part of the staff, but in which patients still feel

exposed to abuse of power or perceived coercion (Foucault, 1988, 2008). Discourses such as this are dangerous because they may lead to treatment cultures being affected by "symbolic violence" (Bourdieu, 1996).

Examples of this can be subtle communication techniques in which staff try to manipulate patients, to persuade, decide for, or conclude agreements that enable them to achieve their will (Lützén, 1998). We believe that there will always be a balance between respectful paternalism, in which one acts in the patient's best interest, and a "smart aleck attitude," in which one thinks that one knows what is best for the patient and uses power to effect this (Weber, 1990). Both attitudes seem to be present in this study, although the staff were largely perceived as being genuinely paternalistic. Although the patient is voluntarily admitted and the staff are acting with the best of intentions, it may still be perceived as coercive. A study shows that 32% of voluntarily admitted patients experienced a high level of perceived coercion (Iversen, Høyer, Sexton, & Grønli, 2002) and 20% reported that they had been subjected to measures against their will during their hospital stay (Kjellin et al., 2004). This shows that legal status is not a sure indicator for the experience of coercion (Iversen et al., 2002; Kjellin et al., 2004). An interpretation of the findings in this study and previous research suggests that shielding involves increased risk of being exposed to perceived coercion (Karlsson, 2004), but further research is necessary in this area.

A treatment relationship, in which the staff focuses on gaining acceptance for their own thoughts and opinions, does not safeguard and recognize the patient sufficiently. This can lead to an I-it relationship where the patient becomes objectified and seen as a thing (Buber, 1992). These relationships are characterized by being asymmetrical, where one part—the staff—have more power than the other part—the patients. The patients will then find themselves in a powerless position. Implementing good milieu therapy can be difficult in these situations. We might assume that the treshold of manipulation, persuasion, and execution of other coercive techniques are lower when the staff relates to the patients as an object than if they relate to them as a person. Hence, making time to build good I-you relationships is essential (Buber, 1992). Patients must be empowered and have a central voice in the treatment program. This can be done by focusing on the therapeutic elements of shielding found in this study, such as intensive personal contact. The presence of the same staff over time will help to build safe and good relationships in which staff and patients relate to each other as human beings. This is a solid foundation for developing the best treatment for the patients.

Shielding and Milieu Therapy

The findings in this study suggest that as a method, shielding can safeguard the treatment element at the same time as its controls agitation, aggression, and violent behavior, with as low a degree of isolation as possible. We argue the importancy to look at shielding as an important part and a natural extension of general milieu therapy in the ward. Finding the balance in which one safeguards the patient, other patients, and staff at the same time as providing good treatment is not always easy; several factors must be taken into account. Shielding will, as this study shows, always involve some form of isolation from other patients. This contributes to safety, and gives the other patients the tranquility that they need to focus on their own recovery process. However, our findings show that being shielded does involve a degree of restriction for the patient. This is why it is so important to find an appropriate degree of isolation when implementing shielding—to ensure that fellow patients are protected and simultaneously to ensure that the patient being shielded does not receive more restrictions than necessary. This is a balancing act requiring high professionalism among the staff. It is important to look at shielding as a specialized therapeutic intervention that requires special knowledge and skills from the staff. The staff should work constantly to develop a good basis for assessment and critical reflection practice, and they should strive to have a team with variable work experiences because this is associated with less seclusion (Janssen, Noorthoorn, van Linge, & Lendemeijer, 2007). One should strive for both a flexible approach and an approach with individual assessments. The treatment plan should be structured, with an opening for extending reviews and the patient should have a central part in creating the plan. The staff should be coordinated and have the same academic vision and culture—to ensure that the patient receives relatively similar responses from the staff. This will in all probability strengthen the quality of the professional work during shielding.

This study shows that in practice, shielding involves a high degree of control, but at the same time there will be a focus on key therapeutic elements. The high degree of control can contribute to a more corrective perspective, so it is important to be conscious of highlighting the acknowledging perspective. This involves creating a fellowship with the patient in which together they can arrive at solutions through dialogue, negotiation, and cooperation (Vatne & Fagermoen, 2007). Fellowship should be characterized by a communicative power in which patient and staff, through understanding by dialogue, seek appropriate norms for treatment (Habermas et al., 1999).

Methodological Considerations

To gain deeper understanding, an anonymous and randomized selection from all the forms with more than 1,000 words was carried out. Due to the randomization, we could not guarantee representation of all the wards. As those who decided on and conducted the shielding undertook the descriptions, this strengthened the confirmability. A limited part has been analyzed. However, the forms are rich with data of good quality and time was used to familiarize ourselves with the

material and to make a thorough analysis (Creswell, 2003). Analysis triangulation strengthened the trustworthiness (Polit & Beck, 2004). Both authors participated in the analysis, and the analysis was reviewed by the research team. This strengthened the credibility (Graneheim & Lundman, 2004). Dependability was secured by presentation of the findings from the study in mental health settings. The selection was not representative of all the forms completed, but gave a deep and rich understanding of shielding. The findings cannot be generalized, but are considered to be transferable within the context of psychiatric hospitals, perhaps particularly acute wards. It is important to remember that this study investigated staff's experience with shielding. When we, for example, state that restriction of stimuli is an important part of the patient recovery process, this is based on analysis of staff statements. We do not have objective patient outcome data to support this. However, important knowledge emerged from a comprehensive qualitative analysis process.

Conclusion

Staff at psychiatric hospitals described and evaluated shielding in different ways. The main finding showed that shielding is understood as an ambiguous practice—it can be understood in several ways. There is a constant tension between control and treatment, with control being described as the more important factor. Important therapeutic elements are described, such as intensive personal contact, stimulus restriction, and structure. Safety, limitations, setting limits, and shielding of patients who create unrest are control functions described as more important than the therapeutic elements. Isolation is described as a key element and different degrees of isolation were described. We can assume that the degree of isolation and the location where shielding took place had some impact on the experience of shielding and possibly also the effect. This is also significant for comparison of results across hospitals, and hence the need for more research of the effect of shielding and patients' experiences of shielding. It would be especially interesting to investigate differences in patient outcome and patient experience between those who are shielded in a room and those who are shielded in a larger segregation area or PICU.

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1. Aparantly the Norwegian Acute Network has removed this document from their website. Therefore, ufortunately, we are not able to provide a URL that lead directly to the reference. The project description can be retrieved by contacting the Norwegian Acute Network or the corresponding author.

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