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Patients' Perspectives on Seclusion and Restraint Experience at Mathari National Teaching and Referral Hospital Nairobi City County, Kenya

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Abstract

Mental health research across the world has elicited various perspectives regarding the experiences of seclusion and restraint of mentally unwell, aggressive patients. Despite the need of understanding some of the determinants of seclusion and restraint of mentally ill patients, there has been limited publications particularly in the Kenyan context addressing the experiences of seclusion and restraint on social demographic characteristics of a mentally ill patient, patient, and Institutional factors leading to seclusion and restraint as well as exploring the experiences of the mentally ill patients undergoing seclusion and restraint at Mathari National Teaching and Referral Hospital. The present study therefore aimed to explore patients' experiences with seclusion and restraint at MNTRH. A phenomenological research approach was adopted and qualitative data was gathered using an interview guide. The study targeted all the patients who had been nursed in seclusion and restraint during admission to (MNTRH) Nairobi City, Kenya. The results revealed that the seclusion procedure at MNTRH was not patient-friendly as they were forced to do it and not provided with the basic needs apart from medication. The interviewees also described two main themes relating to experiences of patients undergoing seclusion and restraint at MNTRH including desirable views of seclusion and restraints and undesirable views on seclusion and restraints experiences. The desirable view on seclusion experiences included that seclusion and restraint provided relief and a less stimulating environment in which they felt safe and secure. Patients were grateful for the constant support and supervision of healthcare providers. However, the undesirable experiences as mentioned by the respondents were that during seclusion and restraint, they experienced abandonment, mistreatment, and neglect. The study concludes that seclusion and restraint is a crucial but contentious treatment that should only be used as a last resort, and steps should be taken to guarantee that patients' dignity is preserved throughout the seclusion and restraint procedure, as guided by the Mental Health Act 2016. The study recommends that MTRH have the seclusion sessions customized to each patient's unique cognitive ability and mental condition.

Keywords: *Patients' Perspectives, Seclusion, Restraint, Experience*

1.0 Introduction

Mental health research across the world has elicited various perspectives regarding the experiences of seclusion of mental health patients in psychiatric Nursing. Studies in China stress the need to reduce the adverse effects of seclusion, especially by building appropriate patient-to-nurse relationships as a strategy to increase staff engagement, but similarly stress the importance of promoting guidelines for seclusion (Zheng et al., 2020). In the Netherlands, Noorthoorn et al. (2020) emphasize the essence of reduction in the incidences of seclusion and revealed the importance of continuous efforts, particularly on the institutional awareness of the use of seclusion. Moreover, a study done by Zaami et al. (2020) discussed seclusion, particularly by taking note of the fact that there has been poor scientific evidence to back up the effectiveness of seclusion as a method of restraint for mental health patients.

There are several definitions of seclusion in the context of mental health which have been proposed in scholarly literature. For instance, seclusion refers to the supervised confinement and isolation of a patient in a room that has been specifically designed for that purpose. Seclusion can also refer to confining a patient in a closed room in such a way that he or she cannot exit freely (Chieze et al., 2021). From time to time, challenges related to seclusion have received considerable attention in the scholarly literature (Vennola-Stover, 2021) reflecting on the controversy associated with the use of seclusion especially as it is viewed more as a punishment than a therapeutic intervention.

Progressively, various studies have postulated factors that can lead to the seclusion of mental health patients. For instance, it has been shown that Mental health patients face a range of challenges while undergoing seclusion at mental health facilities. For instance, it has been reported that a shortage of therapies and inaccessibility to social support endanger the inpatient setting (Vennola-Stover, 2021). Lack of sufficient facilities can be one of the challenges experienced by mental health patients undergoing seclusion (Wang & Zhen, 2021). Beames and Onwumere (2021) report that coercive practices such as restraint and seclusion can pose a health risk to patients. Research in Nigeria also revealed that lack of resources can be one of the challenges faced by patients undergoing seclusion at mental health facilities (Ezeno, 2020).

Demographic characteristics of mental health patients can also lead to seclusion in mental health facilities. In this regard, some studies have proven that the question of whether mental health patients have family back at home can be a determinant of their seclusion in mental health facilities (Mayberry et al., 2019). Studies have also shown that gender of the mental health patients can determine their seclusion in mental health facilities (Dekelver et al., 2020).

Moreover, research has also shown that patient-related factors can lead to their seclusion in mental health facilities. For instance, patient factors such as the real health situation of patients (Nakagawa & Saijo, 2020). There is evidence in the literature that family can influence the seclusion of mental health patients (Gupta., 2020). Recent studies also show that patient-related factors such as family support can lead to their seclusion in mental health facilities (Yurtbasi et al., 2021).

Research studies have reflected on the lived experiences of patients undergoing seclusion. For instance, it has been demonstrated that some of the experiences of patients undergoing seclusion include psychological effects, caring demands, and responsibilities, as well as a lack of coping strategies and support (Molepo, 2018). Hiedari et al. (2020) pointed out that some of the experiences of mental health patients have to do with a feeling of stranger to oneself as well as the degradation of the position and also shame of diagnosis.

On the basis of the foregoing research findings, the present study also reflects on the challenges of seclusion, demographic characteristics of a mental health patient, patient factors leading to seclusion, Institutional factors that may lead to seclusion as well as exploring the lived experiences of the mentally ill who have undergone seclusion at MNTRH.

1.1 Problem Statement

Studies across the world have provided various reflections regarding the practice of seclusion in mental health care (Varpula et al., 2020). In Kwa-Zulu-Natal South Africa, (Vennola-Stover, 2021) reveals that such practices have led to loneliness, humiliation, and powerlessness of the affected patients. There has also been evidence showing that challenges such as a lack of enough resources and facilities can lead to the seclusion of mental health patients (Vennola-Stover, 2021; (Wang & Zhen, 2021; Beames & Onwumere, 2021). Demographic characteristics of mental health patients such as lack of family support and their gender can also influence their seclusion in mental health facilities (Ruud et al., 2021; Dekelver et al., 2021).

Moreover, studies have shown that patients factors such as their health situation and family support can influence their seclusion in mental facilities (Nakagawa & Saijo, 2020; Gupta, 2020; Yurtbasi et al., 2021; Pan et al., 2021). Studies indicate that some of the lived experiences such as psychological effects, lack of coping strategies and support, and fear of being diagnosed can influence their seclusion in mental health facilities (Molepo, 2018; Hiedari et al., 2020).

Despite the significance need of understanding some of the determinants of seclusion of mental health patients, there has been limited publications, particularly in the Kenyan context addressing the experiences of seclusion, demographic characteristics of a mental health patient, patient and Institutional factors leading to seclusion as well as exploring the lived experiences of the mental health undergoing seclusion at MNTRH. This study aimed to provide recommendations to the stakeholders on the best practices when making use of seclusion as a method of restraint for mental health patients. This study therefore focused on psychiatric unit in MNTRH to explore experiences as they undergo seclusion, describe the demographic characteristics, explore how patient and Institutional factors can lead to their seclusion, and also describe their lived experiences.

1.2 Research Objectives

1. To explore patient-related factors leading to seclusion and restraint among mentally ill patients at Mathari National Teaching and Referral Hospital
2. To explore institutional-related factors of seclusion and restraint among mentally ill patients at Mathari National Teaching and Referral Hospital
3. To explore experiences with SR seclusion and restraint among mentally ill patients at Mathari National Teaching and Referral Hospital mentally ill patients' experience associated with seclusion and restraint at MNTRH.

2.0 Literature Review

2.1 Theoretical Review

This study was anchored on theoretical postulations of Human Caring Theory which provides advocacy for a relationship-centered approach to caregiving. Hayter and Brewer (2018) advocate for the theory, particularly for nursing professionals, as it promotes culture change as well as environmental change that aims to realize improved caregiving experience for the patients (Hayter & Brewer, 2018). This theory was developed by Jean Watson (1997), who

contends that caring regenerates life energies and potentiates human capabilities. The benefits are immeasurable and promote self-actualization on both a personal and professional level. Human Caring Theory will therefore be essential for the present study in terms of understanding how mental health patients can be well cared for by the psychiatric nurses in MNTRH (Nikfarid et al., 2018).

The structure of Human caring theory is premised on ten factors including embrace which highlights the need for altruistic values to practice loving kindness with self and others. Moreso, we need to inspire faith and hope also honoring others is critical when applying this theoretical framework. The framework also places emphasis on the issue of trust in self and others as well as nurturing to help others. The need to forgive and accept the positive and negative feelings is also stressed in this theoretical framework. The question of balance has to do with teaching and learning to address individual needs, co-create provides a healing environment for the physical and spiritual well-being with respect to human dignity, lastly, it is important to minister by focusing on their emotional well-being, and spiritual needs and also their physical well-being while providing care, it also is open and allow miracles to enter (Nikfarid et al., 2018). They also argue that the human caring Theory places much importance on being spiritual rather than the physical aspects of human beings and emphasizes the self - self-actualization of nurses in their experiences in their care. Wei and Watson (2019) advocate for the need to address challenges related to the applicability of human caring theory in the nursing profession (Vanaki et al., 2020). Provides evidence of the significance of human caring theory for nurses providing Palliative care in health facilities. Human caring theory was, therefore, essential for the present study in terms of understanding how mental health patients can be well cared by the psychiatric nurses in MNTRH.

2.2 Empirical Review

2.2.1 Demographic Characteristics of Mental Health Patients

Prior research has provided reflections on the importance of understanding demographic characteristics relating to caregiving for mental health patients. Hartini et al. (2018) contend that the extent of anti-stigmatization efforts for mental health patients can be successful depending on demographic factors such as age, sex, experience of contact, history of mental disorder, marital status, and income level.

Carpar et al. (2018) explored demographic factors affecting the hospitalization of mental health patients (n = 356) in Ireland and Turkey. The findings showed that living alone and the age of the patient determined their length of stay in mental facilities. Dekelver et al. (2020) explored the experiences of infant mental health in the Netherlands. Analysis of the findings showed that there were significantly more boys 69% and girls 31% being referred to infant mental health teams. Even though the study was conducted on children at a tender age, the findings provide important insights with regard to exposure to mental health challenges based on based on sex.

2.2.2 Patient-Related Factors Leading to Their Seclusion

There has been evidence in research showing that patient-related factors (PRF) can lead to the seclusion of mental health patients. This is in agreement with a survey conducted in Pakistan showing that patient-related factors such as family support can influence their seclusion in mental health facilities (Gupta, 2020). In addition, a research survey in Japan by Nakagawa and Saijo (2020) revealed how seclusion of mental health patients can be attributed to patient factors such as violent behavior, abusive language and threats to staff and fellow patients.

In addition, Yurtbasi et al. (2021), who applied nested case controls were used to compare 72 afternoon shifts in which seclusion occurred to 216-afternoon shifts in which no seclusion occurred, between 2010 and 2013, at an Adolescent Psychiatric Inpatient Unit. The findings illustrated how patient-related factors can lead to the seclusion of mental health patients in the facility. Nursing research in China also shows that patient-related factors such as the kind of family support they receive can lead to their seclusion in mental health facilities (Pan et al., 2021). Moreover, a research study in Zambia by (Lungu and Banja,2021). was in support of the fact that the background of the mental health patient can have an impact on whether they can be put under seclusion in a mental health facility.

2.2.3 Institutional factors leading to seclusion

In China, studies show that some of the experiences associated with seclusion of mental health patients include lack of sufficient facilities in psychiatric units (Wang & Zhen, 2021). In addition, an empirical study conducted among nursing professionals (n = 55) in Taiwan revealed that a lack of expertise among these professionals can be an impediment to implementation of seclusion of mental health patients (Huang et al., 2021). In Australia, Beames and Onwumere (2021) point out that coercive practices such as restraint and seclusion are common features of all mental health care systems; however, care must be exercised when using such coercive practices, particularly due to the risk associated with such practices. On the other hand, research in Poland showed that the lack of sufficient well-trained nurses dealing with psychiatric care can be one of the challenges during the implementation of seclusion of mental health patients (Taylor, 2021).

Research studies across different African countries have also reflected on the different experiences of mental health patients undergoing seclusion. In Zambia, reports suggest that insufficient facilities in psychiatric wards can lead to the ineffectiveness of the seclusion program (Tromans et al., 2020). The findings are also in agreement with the results of a study that was done in South Africa by (Berzins et al., 2020) who provided much advocacy for the need to ensure sufficient facilities in the implementation of seclusion of mental health patients. The study findings resonate with what was observed in an empirical study in Nigeria that illustrates the importance of sufficient facilities in the implementation of seclusion in mental health hospitals (Ezeno, 2020).

2.2.4 Lived Experiences of Mental Health Patients Who Have Undergone Seclusion

Previous research provides evidence on the experiences of mental health patients undergoing seclusion. This is evidenced in a study by Hiedari et al. (2020). who explored the lived experiences of patients with psychiatric disorders on self-stigma. The study performed hermeneutic phenomenology research by targeting psychiatric patients (n = 12) in the year 2017. The results of the study showed that “Broken Personality” was identified as the main theme of the phenomenon and included seven subthemes: “Injured feelings”, “Like wax in the hands of others,” “Scandalous symptoms of disease,” “Coming from another land,” “Stranger to oneself”, “Degradation of the position”, and “Shame of diagnosis”.

Suhail et al. (2020) researched India's experiences with the COVID-19 crisis and how it impacted mental health. The researchers used semi-structured interviews to elicit the responses. Analysis of the findings revealed that some of the key themes relating to the experiences of mental health patients were the “impact on mental health”, “positive experiences” as well as “ways of coping amid the crisis”. Kovac et al. (2021) reflected on the long-term experiences about caregiving for mental health patients the study applied interpretative phenomenological

analysis where the findings revealed that nurses need to keep connected with the patients to help them with their memories and past selves through different activities.

3.0 Methodology

The study made use of a phenomenological research approach which provided a better understanding of individual's experiences and perceptions regarding seclusion and restraints as a form of intervention in the management of an aggressively ill person. The researcher conducted the study in MNTRH. The institution is the major referral hospital for patients suffering from mental health disorders around the Nairobi region. The facility has been in existence since the Year 1910. The study used a purposive sampling method to select participants whereby the sample consisted of 10 participants who were interviewed until saturation of data was reached. Audio recorder was used to record the patients as they narrated their experiences. Data was collected for about two months. The data was transcribed verbatim, coding was done and that similar codes were grouped into the same categories. Similar categories were grouped into themes.

4.0 Results and Discussion

4.1 Social Demographic characteristics associated with patients seclusion and restraints

Thirteen participants were sampled. Three of them did not participate because they were coming from far away and had to travel back immediately after the clinic. Ten participants were interviewed, their ages ranged from eighteen years and forty-five years, and there were six males and four females. They were all not married. Four had secondary education, five had college and only one had gone to university.

Table 1: Social Demographic Characteristics of the respondents (ten participants in total)

Characteristic	Frequency	Percentage
Gender		
Male	6	60
Female	4	40
Age		
18 – 25 years	1	10
26-35 Years	5	50
36-45 Years	3	30
Above 45 Years	1	10
Marital Status		
Married	0	0
Not married	10	100
Education Level		
Secondary	4	40
College	5	50
University	1	10

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4.2 Themes

Table 2: summary of themes and subthemes

Categories	*Sub-themes*	*themes*
Room at a corner Location of seclusion room lack of optimal social interaction A small room set for disturbed patients	•*Awareness* of what seclusion is •Characteristics of the room	**Awareness of Seclusion and Restraint status**
Lack of freedom Treated like dogs and not taken care Demeaning and less valued Sometimes no medication given Kept alone in a room Feeling of boredom Felt ashamed No toilets in the seclusion Benefits of seclusion Freedom of expressions Other measures to employ apart from seclusion Interventions to be included Felt relieved alone	•Undesirable views on SR •Benefits of seclusion and Restraint	. **Perceptions while in seclusion**
Craving for substance abuse Fighting with fellow patients If medication not working hence one becomes violent Shouting a lot Reasons for seclusion Disturbing nurses doctors and other patients If not taking your medication well Reason for seclusion and restraint Seclusion to reinforce rules attempting to abscond increased agitation Refusal to care It's like a routine	*Patient-related acceptable and non-acceptable reasons* *Institution related. acceptable and non-acceptable reasons*	**Perceptions on reasons for SR**

4.2.1 Theme 1: Awareness of seclusion and restraints status

All the respondents were aware of what seclusion entails or had a rough idea of what it meant to be secluded and restrained. They unanimously termed it as being in a closed room where they are isolated from the rest of the patients and there is restricted movement. They described it as a way of hindering any interaction with other patients or staff members. To them, the room was very separate from others and kind of abandoned. They were aware that seclusion restricted them from interacting with other patients and they seemed to be very much against it and they were upset about it. An interviewee also termed it as

> *"The confinement of a patient at any time of the day or night alone in a room or area from which movement prevented." (Participant 003)* to another
>
> *"A side room which one is locked into" (Participant 004).* Another one described it as
>
> *"A room in which one is placed when they are not in their normal condition. For example, I sing along and not want medication." (Participant 005).*

They further described it as a behavioral intervention to protect the person or others from harm, however, its use is associated with significant risk for physical and psychological harm to those who experience seclusion and restraints. Understanding the meaning of seclusion is the first step to embracing its importance and all the interviewees were fully aware of having been placed in seclusion for at least once.

Sub-Theme 1: Awareness of what seclusion and restraints is

From the research findings, patients knew what seclusion and restraints was all about and they described it as a way of preventing patients from harming themselves or other patients and staffs who were offering services. As one of them described: "*it is being put in a small room set at a corner away from others where you are locked"* (participant 006)

Another interviewee described it as *"It is a room set aside where those patients who are violent and disturbing put so that they can calm down" (participant 003)*

Also, another one described it as *"Being kept in a separate room from others so that you do not disturb the doctors or other patients" (participant 007)*

To another "It involves forcing patients in a small room where you are alone and not talking to other patients" (participant 009"

Sub-theme 2 Characteristics of the room

From the research findings, patients described the rooms as small dark rooms that are poorly ventilated, set in a corner and do not have toilets and no lights. The seclusion spaces were also indicated to be too small with larger rooms being preferred. The interviewees further agreed that the provision of amenities in the seclusion room would improve the effectiveness.

One interviewee described it this way

> "*The room is small with no toilets so when you want to help yourselves one is forced to do it on the floor*" (Participant 002)

Most of the respondents reported being denied interaction with their relatives while under seclusion. They claimed to hate the whole idea of not being allowed to see their relatives and others could not tell whether their relatives had visited or not. They described that they were denied some of the services like sometimes they could go without food. They termed this as being punished as food is a basic right of human beings. An experience narrated by the interviewee *was the same, "I am never allowed visitors when I get secluded. I just stay there till when the doctors will authorize me to be released from the institution." Participant 003. Another interviewee reported "There was a day my mother and my sister came to visit me and they were told that am very disturbed that they go home until the doctors called them, I felt bad because I saw them through the window"* It was noted that by them not being allowed to have their relatives to see them during seclusion this made them hate being secluded. Hence provision of relatives to see and interact with their patients even while under seclusion could enhance their acceptance and outcome of seclusion.

Another interviewee noted, "I am in seclusion for less than 24 hours, so it is not such a problem. If I didn't get removed, that would be a problem."(Participant 008) On the provision of the prescribed medication, one respondent reported that they were being given their medication as prescribed and the medicine was to help them, an interviewee described, *"When we are in seclusion, we are given good medicine. For example, a person must be injected with a modicate injection first to calm down and then to be stable". (Participant 008)* This participant appreciated being in seclusion and didn't view it as a punishment and knew that the injection given modicatewas to calm him down. However, another interviewee complained, *"The injection is sometimes given to all the patients regardless of what mental illness hence is not effective as required."(Participant 010)*

In terms of the provision of basic needs such as food and access to the washroom facilities, this was noted to be a challenge. The seclusion rooms lacked necessary amenities like toilets and bathrooms which made patients have undesirable views towards being under seclusion. This was found to an influence their acceptance of the intervention.

4.2.2 Theme- 2 Perceptions while in seclusion

Respondents viewed Seclusion and restraints differently they described it as a form of punishment for their actions and they did not like how they were handled. Others felt that their human rights were being denied and would not wish it repeated either to them or any other patient. According to their description, different approaches can be used which is friendlier than being forced into seclusion. *An interviewee stated, "Seclusion is just a punishment! The seclusion process is done in a forceful manner, and as a result, it is not something I would like" (participant 003)* another one described it, *"The doctor called two soldiers who dragged me into seclusion saying that am quite disturbed and disturbing other patients".*

The reasons for seclusions were also not explained thoroughly to them as it was just a 'mandatory' procedure. They were more positive if they understood why they had been secluded. For example, an interviewee described that *"I am willing to corporate more as in most cases I always don't understand why and what had happened that caused me to be secluded" (participant 005)* According to their explanation if only the respondents were given chance to talk of their experience after seclusion and the health care provider help them to understand the benefits of seclusion, they could at least appreciate the intervention accorded. This is supported by another interviewee who also indicated that, *"If we were educated more on the importance of seclusion in mental health facilities, this will substantially affect the effectiveness. We will be able to even encourage the health personnel to seclude as more if we are not in a manageable condition." (Participant 009)*

Sub-theme 1 Undesirable views on seclusion

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Another interviewee went on to explain, *"I was beaten with a stick by the doctors even the watchman while into seclusion. I was not told why I was being kept in seclusion; I was just shocked". (participant 007*) The participants felt that they were mishandled and disliked the whole process and verbalized that they would not wish the same to anyone else. Respondents described the process of seclusion and restraints as mistreatment and the act that they were not explained as to why they were being secluded and restrained made them hate the whole procedure.

Another interviewee complained, *"There was a day when I was caught and started to be beaten as I had refused the injection. I was called by security and they beat me so much that I was not happy. I don't want the same experience and we always complain to the sisters to explain our mistakes. Also, if you are left for the whole day, it is so painful to be locked in there. Then there is also no toilet to help yourself, so it is not fun, we always knock on the door to be released". (Participant 009)*

The participants also described feelings of fear, anger, frustration, powerlessness, and sadness. For example, another interview stated, *"I was feeling very low, I couldn't have felt any lower I thought, until they put me in seclusion and then I realized you could go lower. But by then there was nothing I could do about it. ...I felt fear and anger, especially towards those who put me in the seclusion room. Nurses and physicians used power and authority over patients. I didn't know how long it lasted, it was terrible…." (participant 0010)*

From the study findings, there was a feeling of embarrassment especially to ladies as they were being dragged into seclusion by soldiers who were men. The ladies hated the idea of men handling them and expressed their discomfort. One interviewee described it this way,

"it was not good at all imagine two male soldiers dragged me they could not care that I was a lady, they were manner and they even shouted at me to stop pretending" (participant 006) This description showed that they did not like the way they were being treated and thought that those doing it were unprofessional. Human beings should be treated with dignity and their rights respected.

Being put in seclusion was described as causing a feeling of sadness as participants expressed having a low mood while in seclusion. Being separated from other patients had a negative effect on the patients as there was no one to interact with. As one interviewee narrated, *"I felt so bad and was feeling sad I did not even want to see anyone passing by, I felt everyone was against me and they hated me," (participant 003)*

The respondents expressed panic episodes as they did not know what to expect next. Seeing soldiers with sticks made them feel as if they were being treated like criminals. As one interviewee said, "*I panicked especially when I saw two male soldiers who had big wooden sticks and I had only got relief when I was locked inside seclusion and I thanked God that they did not beat me."*

The majority of the respondents also were distressed and felt anxious and verbalized that they would never want to experience that again. Interviewee said *"How I wish they told me what is expected of me or even how seclusion is, even no one told me where I was to go to help myself if I needed." (Participant 006)*

Seclusion rooms were dark and patients expressed feelings of loneliness and felt that their right to associate with other people was being denied, they hated the whole procedure. Staying in a room alone made them feel less wanted and felt life was meaningless to them. One interviewee described it as… *"While you are in that dark room alone there is no one to talk to even if you want to express yourself you find no one, those doctors who come to give you medication" (participant 005*) All the participants expressed feelings of Isolation, loneliness, and boredom while in seclusion this was especially because while in seclusion one is not in contact or communication with other patients. An Interviewee put it this way, *"they give you through the window and when you start asking any question, they say you are bothering them" (participant 002)*

Sub-theme 2 Desirable views of seclusion

The research findings found that seclusion and restrains was viewed as a relief from disturbance from other patients who were seen to bother or disturb, hence appreciated the intervention. Having been provided with their own room without sharing with others gave them a good feeling. This was seen to have a positive outcome for the intervention. Particularly, an interviewee noted that *"Seclusion is helpful, in that it provides relief and offers a less stimulating environment in which I feel safe and secure. It also allows me to get constant support and supervision of the doctors as well as the nurses." (Participant 007*). This interviewee expressed that seclusion and restraints were quite beneficial to him and being alone was relieving, had time to be alone and there was no disturbance from either fellow patients or the staff.

An interviewee described, *"Seclusion helps me a lot, even when I get out of there, I don't find myself bothered by singing too much. For four days I was kept there, it helped me to stop screaming" (participant 009)*

Another interviewee added, *"I feel much better and calm after the seclusion period as it gives me the time to recollect my thoughts." (Participant 004)*

Some respondents viewed being in seclusion as a relief and liked the idea since they thought that being put together with the other patients one would not get sleep due to what they put as disturbance from other mentally ill patients.

One interviewee described it as *"The night is very good, during those hours you are locked alone, and there are not many things. You just go in and then you sleep". (Participant 002)*

To make the experiences of mentally ill patients to be better, an interviewee suggested that,

"The nurses and other health staff should hear the side of the story of the patient. They should be given a chance to express themselves more as they know themselves better concerning their mental illnesses."(Participant 004). It was also revealed by the participants that they are constantly faced with psychological effects, caring demands and responsibilities, effects on their schooling performance, and lack of coping and support were positively affected by seclusion initiatives. Therefore, the lack of coping strategies and support and fear of being diagnosed can influence their seclusion in mental health facilities.

4.2.3 Theme 3 Perceptions of reasons for seclusion and restraints

The study findings reported that patients who were violent and could cause harm to themselves or others were restrained and secluded until they were mentally calm to join the others. Some of the respondents admitted to abusing drugs and reported craving the substance of abuse. Among those who admitted to use, the most abused were alcohol and cigarette smoking. The use of substances of abuse was viewed to contribute to their seclusion and restraints. An interviewee described it this way *"I used to use drugs, but I stopped. I was using alcohol and cigarettes." (Participant 003)* Another interviewee noted, *"I don't normally use drugs of substance abuse, just these for my mental condition." (Participant 003). An interviewee narrated, "I agree that drugs of substance abuse are the ones which prompted them to seclude me since I become disturbed when I don't use". (Participant 001*) Some participants with reported being addicted to some drug abuse were prone to be secluded as they had attempted to escape or abscond from the facility to obtain their drug of choice.

The study also found that some of the patients who refused oral medication were subjected to seclusion and restraints and injections administered while in seclusion as an interviewee reported, *"I was very disturbed and refused to take medication, the doctors forced me to be injected then they told the soldiers to lock me in the seclusion" (participant 007)*

Other drugs substances. Another interviewee noted*, "My mental health condition worsens when I take alcohol which normally causes me to be excluded". (Participant 009*) According to the participants' description, they did not like their being aggressive to be attributed to their substance abuse.

Sub- Theme 1. Patients-related acceptable and non-acceptable reasons

Most of the patients who had undergone seclusion and restraints were reported to have been fighting with other patients' others were shouting a lot hence causing a lot of disturbance. One of the interviewees reported *"For me when I am sick I disturb a lot so when the doctor sees that they lock me up until I settle" (participant 003)*

Other Patients reported that their seclusion and restraints were not warranted and thought if they had time to express their feelings, they would feel better. One interviewee described it this way; *"for me am an eloquent speaker but when I try to express myself the doctors think am disturbing them" (participant 006)*

Sub-theme 2 Institution-related acceptable and non-acceptable reasons

From the study findings, the Interviewee narrated that seclusion and restraints were the first step after admission. Specifically, all the disturbed patients were noted to be put in seclusion regardless of their mental health condition. It was felt that there was a routine of all mentally disturbed or aggressive patients being subjected to seclusion and restraints. However, one interviewee clarified that *"Not everyone is put in seclusion as it is not mandatory. Only those who are in a 'bad' state, as there are other mentally ill patient in the facility who have never been put into seclusion. Again, there are those patients who are known to disturb, so they are normally secluded as soon as they are brought to the hospital" (participant 007*) The study also found that it is not all disturbed patients who are subjected to seclusion and they seemed to be aware that only those who were very violent and uncontrollable faced seclusion.

The interviewee thus unanimously agreed that seclusion at Mathari National Teaching and Referral Hospital mainly depends on the 'patient's behavior. An interviewee described, *"This normally depends on the status of the patient, such as through the use of weapons or cause of threat to others." (Participant 005)* Another interviewee described, *"There are those who come*

here who are very violent and bother people, so they have to be put in seclusion. So, they must be given an injection and then put in seclusion to calm down." (Participant 008) In this description, it was made clear that seclusion was for only those patients who warranted it.

Not all aggressive patients are secluded and this made patients realize that their being secluded emerged from their behavior like being disrespectful to the mental health nurses. Some of the patients were not respectful to the staff and could hurl insults at them. Hence one of the interviewees described *"I was very disrespectful to those Doctors, I insulted them and that led to me being put in seclusion for two days, there was one day I was denied food due to my behavior. When I was let out of seclusion, I started befriending those Doctors and told them I would not repeat." (Participant 006)* Patients who perceived seclusion and restraints in a positive manner felt sorry for their actions and could even apologize for their actions.

4.3 Discussion

4.3.1 Social Demographic Characteristics of the Patients

The main characteristics of individuals who had undergone seclusion and restraints included age, gender, marital status, and level of education of the respondents. Majority of the participants were between the ages of 26 to 45 years and were single. These social demographic characteristics were established to affect not only their behaviors but also the community's perception of them. Due to their demanding health condition which is not easy to manage, it was established that it was practically impossible to not only initiate intimate relationships but also maintain marriage responsibilities. Men were also perceived by the health personnel to be more violent and more likely to cause harm to not only themselves but others. This compares to a study by Hartini et al. (2018) which reported that the extent of anti-stigmatization efforts for mental health patients can be successful depending on social demographic factors such as age, sex, experience of contact, history of mental disorder, marital status, and income level.

Other studies also established that social demographic characteristics of mentally ill patients such as age and gender can also influence their seclusion and restraints in mental health facilities (Ruud et al., 2021). Particularly, the study found that patients between the ages of 20 and 30 years old were more prone to be secluded. Studies have also shown that gender of the mentally ill patients can determine their seclusion in mental health facilities in that men tend to be more excluded as compared to their female counterparts (Dekelver et al., 2020).

4.3.2 Patient-Related Factors leading to Seclusion and restraints

Themes: Acceptable and non-acceptable reasons

From the interviews, the main themes on patient-related factors that emerged included acceptable and non-acceptable reasons for seclusion and restraints, participant views, and attitudes towards seclusion and restraints. The study found that patient perceptions of seclusion was essential in promoting the outcomes of the seclusion processes. This is similar to a study that has also shown that patients related factors can lead to their seclusion in mental health facilities such as real health situations of patients (Nakagawa & Saijo, 2020). In terms of patient awareness, research findings in relation to the seclusion of mental health patients revealed that knowledgeability can have a significant influence on the seclusion of mentally ill patients (Candler et al., 2021). There is also evidence in the literature that family can have an influence on the seclusion and restraints of mentally ill patients as they have not been given moral and social support during their mental breakdown episodes (Gupta., 2020). Similar results were observed in an earlier empirical survey in Tanzania where research findings indicated that the

nature of the support given to mentally ill patients can be the deciding factor on whether they will undergo seclusion or not (Knettel et al., 2018).

4.3.3 Institutional factors that may lead to patients' seclusion and restraints

Themes: Institutional-related acceptable and non-acceptable reasons

The main institutional themes that lead to patients' seclusion in a psychiatric hospital which emerged from the interviewees were institutional-related acceptable and un-acceptable reasons for seclusion and restraints. It was revealed that the patients were forced into seclusion and not provided with basic needs apart from medication. Similarly, Wang and Zhen (2021) described lack of sufficient facilities as one of the challenges experienced by mentally ill patients undergoing seclusion and restraints Research in Nigeria also revealed that lack of resources can be one of the challenges faced by patients undergoing seclusion at mental health facilities (Ezeno, 2020). This is also in agreement with a survey conducted in Tanzania by Mrema, (2020) whose findings showed that a lack of enough resources can compromise the effective implementation of seclusion programs in mental health facilities.

4.3.4 Experiences of Mental Health patients undergoing seclusion and restraints at MNTRH.

Themes: Desirable and non-desirable views

The interviewees described two main themes relating to experiences of mentally ill patients undergoing seclusion and restraints at MNTRH including desirable views and non-desirable experiences. The desirable views experiences included providing relief and a less stimulating environment in which they felt safe and secure, plus they were grateful for the constant support and supervision of professionals. However, the non-desirable experiences were that during seclusion, they experienced abandonment, and mistreatment through being forced into seclusion and neglected without even visitation. They also complained that the seclusion rooms felt too small and cold, and they experienced a fear of humiliation, depression, sadness, panic, anxiety, distress, isolation, boredom, or loneliness. This is explained by Molepo (2018) who argued that some of the experiences of patients undergoing seclusion differed depending on the psychological effects, caring demands and responsibilities, as well as lack of coping strategies and support. Hiedari et al. (2020) also pointed out that some of the experiences of mentally ill patients have to do with a feeling of the stranger to oneself as well as the degradation of the position and the shame of diagnosis. There also emerged several sub-themes that included, embarrassment, loneliness, panic, anxiety, distress, and boredom. From the study it came out clearly that seclusion and restraint were viewed differently by the participants, some felt that it was quite beneficial to them as they felt relieved from other patients and they had time to relax alone, while some viewed it as being denied an opportunity to interact with others.

The present study has provided new knowledge on the subject matter exemplified by;

- Patients should be given time to interact with healthcare providers and share their views after seclusion and restraint
- The undesirable effects of seclusion and restraint could be improved if seclusion rooms were customized to patient's needs, for example installation of toilets and should be well lit.
- Patients also expressed that if they were allowed to interact with their relatives even during seclusion they were likely to appreciate the intervention.
- Patients need to be educated on the relevancy of seclusion and restraint procedures and benefits to appreciate the intervention.

- While some studies are against seclusion and restraints of mentally ill aggressive patients it has been reported by some participants to have some beneficial effects to them.

5.0 Conclusion

The study found that the main social demographic characteristics affecting seclusion and restraints include age, gender, marital status, and level of education of the respondents. These social demographic characteristics were established to affect not only their behavior but also the community's perception of them. The study concludes that the social demographic characteristics of patients play a role in their handling their mental disorders and capability of managing seclusion periods.

The study found that the patients' awareness, perception, and attitude on the relevancy of seclusion and restraints affected their acceptance of the seclusion and restraints intervention and resulting outcomes as well as the support given to them. The study concludes that patient awareness, patient perception, and patient attitude affect not only the urgency for seclusion but also the patients' perception of seclusion and subsequent gains obtained from the interventions at MNTRH.

The results revealed that the seclusion procedure at Mathari National Teaching and Referral Hospital was not patient-friendly as they were forced to do it and not provided with the basic needs apart from medication. The study concludes that MNTRH still has some shortcomings in the execution of the seclusion process which may limit the outcomes of the process. The institution-related factors including the method of secluding patients and handling of patients during the seclusion procedures substantially affect the seclusion efficacy.

The study found that the benefits of seclusion and restraints were that they provided relief and offered a less stimulating environment in which they felt safe and secure, plus they were grateful for the constant support and supervision of professionals. However, despite the undesirable views on seclusion and restraints, they experienced abandonment, mistreatment, and neglect. They also complained that the seclusion rooms felt claustrophobic or cold, and they experienced a fear of humiliation, depression, sadness, panic, anxiety, distress, isolation, boredom, or loneliness. The study concludes that seclusion is a crucial but contentious treatment employed in inpatient mental health facilities to temporarily control potentially dangerous behavior. Therefore, it should only be used as a last resort, and steps should be taken to guarantee that service users' dignity is preserved throughout the seclusion procedure.

6.0 Recommendations

From the study findings, it is recommended that MTRH should employ other measures such as psychosocial intervention, alternative environment, verbal de-escalation, and low stimulation environment to manage aggressive patients other than seclusion. Seclusion rooms should be well equipped with facilities such as toilets and bathrooms should be well-lit so that patients are also comfortable when secluded. From the study findings it is recommended that there should be ongoing patient health education and awareness on seclusion procedures should be enhanced to reduce the misunderstanding and perceived lack of care during seclusion. They should be well informed of the benefits of seclusion and how they can cooperate to improve patient seclusion outcomes.

From the study findings, it is recommended that patients should be given a chance to freely discuss their seclusion experiences with others which will act as a source of encouragement and motivation to prevent acts that can lead to seclusion.

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