Supplementary material for Bak J, et al., Comparing the effect of non-medical mechanical restraint preventive factors between psychiatric units in Denmark and Norway, Nordic Journal of Psychiatry, 2015;69:433–43.

Supplementary Appendix: A description of mechanical restraint (MR) preventive factor measurements.

MR preventive factors	Measurement description
Cognitive milieu therapy vs. no cognitive milieu therapy	The clinical nurse manager described the care in his or her unit as “cognitive behaviour therapy” or “cognitive milieu therapy”, and the staff had participated in 40 h of training or more in this care method—The care method was not described.
Patient involvement vs. no patient involvement	One of the following factors was present: the patients participated in ward rounds/conferences or the patients influenced the rules imposed by the unit or influenced what was written in the nurse’s journal—Patients did not participate in these areas.
Patient-centred care vs. no patient-centred care	The clinical nurse manager described the care in his or her unit using the words “individual”, “cooperative” or “patient-centred”, and the staff participated in 40 h of training or more in this care method—These words were not used to describe this care method.
Identification of the patient’s crisis triggers vs. no identification	The initial nurse evaluation of at-risk patients always contained a written evaluation of aggressive, self-mutilating or suicidal behaviours (e.g. crisis triggers, unique calming techniques and coping strategies)—The initial evaluation only occasionally or never contained a written evaluation.
Risk assessment vs. almost none or no risk assessment	The risk of developing aggressive/violent or self-mutilating/suicidal behaviours was always or almost always systematically evaluated and documented, and care actions were initiated—These behaviours were only occasionally or never evaluated and documented.
Mandatory review vs. no mandatory review	An audit, review or similar systematic follow-up evaluation was conducted after all MR episodes—The evaluation was only conducted after some or none of the MR episodes.
Staff training (> 50% vs. less)	An average of 50% or more of the staff participated in training regarding de-escalation, avoiding physical attacks, careful restraining techniques, legislation, MR predictors/antecedents and suicide prevention—Less than 50% of the staff experienced such training.
Positive staff attitudes vs. less positive	All staff directed their attention towards the patient and possessed communicative skills, optimism and empathy—Not all of the staff possessed these skills.
Patient-staff ratio (> 3 staff per patient vs. fewer)	The staff-to-patient ratio was higher than or equal to three-to-one on average—This ratio was lower than three-to-one on average.
Staff education ($\geq$ 3.5 years vs. fewer)	The staff received basic training for at least 3½ years—The staff had less than 3½ years of training.
Staff experience (> 5 years vs. fewer)	The staff had an average of more than 5 years of experience in the psychiatric speciality was more than 5 years on average—Staff experience was 5 years or fewer.
Debriefing and defusing vs. none	Follow-up evaluations were initiated after each MR episode for debriefing, defusing or other crisis interventions—No follow-up was initiated.
Positive patient responses to rules vs. negative responses	The patients reacted positively to the rules, and limit-setting was motivational—The opposite occurred.
Activity-based nursing vs. no activity-based nursing	Individual patient-activity plans were devised, and the patients participated in many or several physical or other types of activities—The patients had no activity plans, and they participated in few or no physical or other activities.
Acceptable work environment vs. poor work environment	The unit had the following features: a workplace environment assessment was present, no or only insignificant physical or mental work-environment problems existed, and the overall work environment was evaluated as acceptable—The workplace environment was not assessed, more work-environment problems existed and the overall work environment was evaluated as poor.
No crowding vs. crowding	Two of the following three factors were evident for no crowding: only one bed in a patient’s room, more than 25 m ² of all day-accessible space per patient and the perception of no crowding—Only one or none of these factors was evident.
Substitute staff (< 50 vs. more)	Substitute staff was used less than 50 times (8-h shifts) over the year—These employees were used greater than or equal to 50 times.
Staff opposition to MR (many vs. some)	All staff had the attitude that “MR should be initiated rarely to protect the lives of the patient and others”—Not all staff had this attitude.
Alarm systems (numerous well trained responses vs. less well trained responses)	More than three night-shift staff members responded to an alarm call, and they were all trained in this task—Not all of the night-shift staff members were trained, or they were trained but failed to respond.
Communication (all staff possess communicative skills vs. less than all)	All staff had general communicative skills or special skills with regard to communicative de-escalation—Less than all the staff had these skills.
Well maintained, clean and tidy surroundings (always vs. seldom)	The unit was perceived as well maintained, clean and tidy—The perceptions were otherwise.
Separation of acutely disturbed patients vs. no separation	The unit was able to separate acutely disturbed patients from other patients—The unit was unable to do so.