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Means of restraint in psychiatric establishments for adults

Extract from the 16th General Report [CPT/Inf (2006) 35]

Preliminary remarks

36. In its 8th General Report covering the year 1997, the CPT addressed the issue of involuntary placement in psychiatric establishments for adults. In this context, the Committee made a number of remarks concerning the restraint of agitated and/or violent patients. During the intervening nine years, the debate over the use of restraint has continued to fire passions, with different psychiatric traditions advocating alternative approaches for managing such patients.

In many psychiatric establishments, recourse to means which limit the freedom of movement of agitated and/or violent patients may on occasion be necessary. Given the potential for abuse and ill-treatment, such use of means of restraint remains of particular concern for the CPT. Consequently, visiting delegations examine carefully the procedures and practice in psychiatric establishments as regards restraint as well as the frequency of resort to such means. Regrettably, it would appear that in many of the establishments visited there is an excessive recourse to means of restraint.

The CPT believes that the time is ripe to expand upon its earlier remarks and would welcome the comments of practitioners on this section of the General Report. It is in this spirit of constructive dialogue, with a view to assisting health-care staff in performing their arduous tasks and providing patients with appropriate care, that the following remarks are made.

On the use of restraint in general

37. As a matter of principle, hospitals should be safe places for both patients and staff. Psychiatric patients should be treated with respect and dignity, and in a safe, humane manner that respects their choices and self-determination. The absence of violence and abuse, of patients by staff or between patients, constitutes a minimum requirement.

That said, on occasion the use of physical force against a patient may be unavoidable in order to ensure the safety of staff and patients alike. Creating and maintaining good living conditions for patients, as well as a proper therapeutic climate - a primary task for hospital staff - presupposes an absence of aggression and violence amongst patients and against staff. For this reason, it is essential that staff be provided with the appropriate training and leadership to be capable of meeting in an ethically appropriate manner the challenge posed by an agitated and/or violent patient.

38. The line separating proportional physical force to control a patient from acts of violence can be a fine one. When that line is crossed, it is often due to inadvertence or unpreparedness rather than a result of malevolent intention. In many cases staff are simply not properly equipped to intervene when confronted with agitated and/or violent patients.

It should also be emphasised that CPT delegations have found that an active and alert role by management with respect to resort to means of restraint in a given establishment has usually resulted in a steady decline in their use.

Types of restraint in use

39. The CPT has come across various methods of controlling agitated and/or violent patients, which may be used separately or in combination: shadowing (when a staff member is constantly at the side of a patient and intervenes in his/her activities when necessary), manual control, mechanical restraints such as straps, straitjackets or enclosed beds, chemical restraint (medicating a patient against his/her will for the purpose of controlling behaviour) and seclusion (involuntary placement of a patient alone in a locked room). As a general rule, the method chosen in respect of a particular patient should be the most proportionate (among those available) to the situation encountered; for example, automatic resort to mechanical or chemical restraint is not called for in cases when a brief period of manual control combined with the use of psychological means of calming the person down would suffice.

As one might expect, using oral persuasion (i.e. talking to the patient to calm him/her down) would be the CPT's preferred technique but, at times, it may be necessary to resort to other means directly limiting the patient's freedom of movement.

40. Certain mechanical restraints, which are still to be found in some psychiatric hospitals visited by the CPT, are totally unsuitable for such a purpose and could well be considered as degrading. Handcuffs, metal chains and cage-beds clearly fall within this category; they have no rightful place in psychiatric practice and should be withdrawn from use immediately.

The use of net-beds, widespread in a number of countries until only a few years ago, appears to be in steady decline. Even in those few countries where they are still in use, net-beds are resorted to on a diminishing basis. This is a positive development and the CPT would like to encourage States to continue making efforts to reduce further the number of net-beds in use.

41. If recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, they should be subjected to the same safeguards as mechanical restraints. The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion.

42. As regards seclusion, this particular measure is not necessarily a proper alternative to the use of mechanical, chemical or other means of restraint. Placing a patient in seclusion may produce a calming effect in the short term, but is also known to cause disorientation and anxiety, at least for certain patients. In other words, placement in a seclusion room without appropriate, accompanying safeguards may have an adverse result. The tendency observed in several psychiatric hospitals to routinely forgo resort to other means of restraint in favour of seclusion is of concern to the CPT.

When to restrain a patient

43. As a general rule, a patient should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury or to reduce acute agitation and/or violence.

In reality, the CPT often finds that patients are restrained, usually with mechanical restraints, as a sanction for perceived misbehaviour or as a means to bring about a change of behaviour.

Moreover, in many psychiatric establishments visited by the CPT, the application of restraints is resorted to as a means of convenience for the staff; securing difficult patients while other tasks are performed. The usual justification provided to the CPT is that a lack of staff necessitates an increase in recourse to means of restraint.

This reasoning is unsound. The application of means of restraint in the correct manner and appropriate environment requires more - not fewer - medical staff, as each case of restraint necessitates a member of staff to provide direct, personal and continuous supervision (cf. paragraph 50).

Voluntary patients should only be restrained with their consent. If the application of restraint to a voluntary patient is deemed necessary and the patient disagrees, the legal status of the patient should be reviewed.

44. What can be done to prevent the misuse or overuse of means of restraint? First of all, experience has shown that in many psychiatric establishments the use of, in particular, mechanical restraint can be substantially reduced. Programmes set up in some countries for that purpose seem to have been successful, without this having led to an increased resort to chemical restraint or manual control. The question therefore arises whether complete (or almost complete) eradication of mechanical restraint might not be a realistic goal in the longer term.

It is imperative that every single case of resort to means of restraint be authorised by a doctor or, at least, brought without delay to a doctor's attention in order to seek approval for the measure. In the CPT's experience, means of restraint tend to be applied more frequently when prior blanket consent is given by the doctor, instead of decisions being taken on a case by case (situation by situation) basis.

45. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately. On occasion, the CPT encounters patients to whom mechanical restraints have been applied for days on end. There can be no justification for such a practice, which in the CPT's view amounts to ill-treatment.

One of the main reasons why such practices linger on is that very few psychiatric establishments have developed clear rules on the duration of periods of restraint. Psychiatric establishments should consider adopting a rule whereby the authorisation of the use of a mechanical restraint lapses after a certain period of time, unless explicitly extended by a doctor. For a doctor, the existence of such a rule will act as a powerful incentive to visit the restrained patient in person and thus verify his/her state of mental and physical well-being.

46. Once means of restraint have been removed, it is essential that a debriefing of the patient take place. For the doctor, this will provide an opportunity to explain the rationale behind the measure, and thus reduce the psychological trauma of the experience as well as restore the doctor-patient relationship. For the patient, such a debriefing is an occasion to explain his/her emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of his/her behaviour. The patient and staff together can try to find alternative means for the patient to maintain control over himself/herself, thereby possibly preventing future eruptions of violence and subsequent restraint.

How restraint should be used

47. Over the years, many patients have talked to CPT delegations about their experiences of being restrained. Patients have repeatedly said that they felt the whole ordeal to be humiliating, a feeling at times exacerbated by the manner in which the restraint was applied.

For the staff of a psychiatric hospital, it should be of the utmost concern that the conditions and circumstances surrounding the use of restraint do not aggravate the mental and physical health of the restrained patient. This implies, inter alia, that previously prescribed therapeutic treatment should, as far as possible, not be interrupted and that substance-dependent patients should receive adequate treatment for withdrawal symptoms. Whether these symptoms are caused by deprivation of illegal drugs, nicotine or other substances should not make any difference.

48. In general, the place where a patient is restrained should be specially designed for that specific purpose. It should be safe (e.g. without broken glass or tiles), and enjoy appropriate light and adequate heating, thereby promoting a calming environment for the patient.

Further, a restrained patient should be adequately clothed and not exposed to other patients, unless he/she explicitly requests otherwise or when the patient is known to have a preference for company. It must be guaranteed in all circumstances that patients subject to means of restraint are not harmed by other patients. Of course, staff should not be assisted by other patients when applying means of restraint to a patient.

When recourse is had to restraint, the means should be applied with skill and care in order not to endanger the health of the patient or cause pain. Vital functions of the patient, such as respiration, and the ability to communicate, eat and drink must not be hampered. If a patient has a tendency to bite, suck or spit, potential damage should be averted in a manner other than by covering the mouth.

49. Restraining an agitated or violent patient properly is no easy task for staff. Not only is training essential but refresher courses need to be organised at regular intervals. Such training should not only focus on instructing health-care staff how to apply means of restraint but, equally importantly, should ensure that they understand the impact the use of restraint may have on a patient and that they know how to care for a restrained patient.

50. The use of restraint in an appropriate manner requires considerable staff resources. For example, the CPT considers that when the limbs of a patient are held with straps or belts, a trained member of staff should be continuously present in order to maintain the therapeutic alliance and to provide assistance. Such assistance may include escorting the patient to a toilet facility or, in the exceptional case where the measure of restraint cannot be brought to an end in a matter of minutes, helping him/her to consume food.

Clearly, video surveillance cannot replace such a continuous staff presence. In cases where a patient is secluded, the staff member may be outside the patient's room, provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient.

The adoption of a comprehensive restraint policy

51. Every psychiatric establishment should have a comprehensive, carefully developed, policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated.

The policy should also contain sections on other important issues such as: staff training; complaints policy; internal and external reporting mechanisms; and debriefing. In the CPT's opinion, such a comprehensive policy is not only a major support for staff, but is also helpful in ensuring that patients and their guardians or proxies understand the rationale behind a measure of restraint that may be imposed.

Recording incidents of restraint

52. Experience has shown that detailed and accurate recording of instances of restraint can provide hospital management with an oversight of the extent of their occurrence and enable measures to be taken, where appropriate, to reduce their incidence.

Preferably, a specific register should be established to record all instances of recourse to means of restraint. This would be in addition to the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this; at their request, they should receive a copy of the full entry.

53. Regular reporting to an outside monitoring body, for instance a Health-Care Inspectorate, might be considered as well. The obvious advantage of such a reporting mechanism is that it would facilitate a national or regional overview of restraint practices, thus facilitating efforts to better understand and, consequently, manage their use.

Final remarks

54. It should be acknowledged that resort to restraint measures appears to be substantially influenced by non-clinical factors such as staff perceptions of their role and patients' awareness of their rights. Comparative studies have shown that the frequency of use of restraint, including seclusion, is a function not only of staffing levels, diagnoses of patients or material conditions on the ward, but also of the "culture and attitudes" of hospital staff.

Reducing recourse to the use of restraint to a viable minimum requires a change of culture in many psychiatric establishments. The role of management is crucial in this regard. Unless the management encourages staff and offers them alternatives, an established practice of frequent recourse to means of restraint is likely to prevail.