

ORIGINAL ARTICLE

The nature and extent of the use of physical restraint and seclusion in psychiatric practice: Report of a survey

UDAYAN KHASTGIR, ANIRUDH KALA, UTPAL GOSWAMI, SATINDRA KUMAR, DEBAKANTA BEHERA.

ABSTRACT

Restraint and seclusion has been used to manage patients despite all controversies. Our study analyzed the opinions of different psychiatrists on the use of this method in their clinical practice. Most of them (80%) practice restraints as a treatment modality and believe that they are integral to the management of psychiatric patients. None is using seclusion.

Key words: restraints, seclusion, psychiatric patients

INTRODUCTION

Seclusion and restraint continue to spark debate regarding their therapeutic value and ethical, legal and humanitarian implications, yet they remain frequently used forms of treatment in psychiatric settings (Thompson et al, 1986; Carpenter et al, 1987).

The little that is known about usage of restraint/seclusion remains inconsistent, at best. The reasons for their use vary with no accurate use rate for either. The incidence of seclusion has been reported to be in the range of 4% to 44% in adult populations (Wells, 1972; Mattson et al, 1978; Schwab et al, 1979, Soloff et al, 1981, Oldham et al, 1983, Hammill et al, 1989; Angold et al, 1993). The overall incidence of physical restraint has been reported to vary from 6% to 13% with an increase of 18% to 22% for elderly patients (Robbins et al, 1987, Lofgren et al, 1989, Mion et al, 1989). The fact that the definitions of seclusion as well as restraint are numerous and varied further complicates the scenario, thus the actual rates of restraint/seclusion are not really known. What precipitates their use also varies; but professionals claim they are necessary to prevent and treat violent or agitated behavior (Wells, 1972; Mattson et

al, 1978; Oldham et al, 1983; Leindemeijer et al, 1997).

Most of the data on restraint and seclusion are from the western countries. Since there is such paucity of literature on this important issue from India, the present study was conducted in order to learn about the factual position regarding the practice of physical restraint and seclusion in our country and also to determine what we need to focus on in our research efforts in the future.

MATERIAL AND METHOD

The study was planned in the Department of Psychiatry, Lady Hardinge Medical College and associated Hospitals, New Delhi. A questionnaire was prepared that consisted of different aspects of physical restraint and seclusion like indications, contraindications, side effects, frequency of use, consent, implementation etc. This questionnaire was used on different mental health professionals in India. They were communicated either by email, post or personally at national conferences. The responses were then analyzed for descriptive statistical expressions and interpretations.

RESULTS

We received completed questionnaires from 278 qualified psychiatrists from all over India. 60% of them were from government hospitals and rest from a private setup. It was found that 80% of the psychiatrists use physical restraint sometime or the other. Most of them (70%) take informed consent from the relatives before advising physical restraint. In most cases, the maximum period restraint is given varies from 8 to 10 hours. Only a few reported the use a little longer than this.

About 70% of the professionals agreed that if the patient requires physical restraint, it was advised by the doctor on duty in consultation with the consultant in charge of the case. The most frequent reasons for which physical restraint is used, irrespective of the diagnosis, were found to be violent and agitated behavior (81%), patients who were harmful to self (31%) and delirium (24%). Among the diagnostic groups, acute manic episode is the most common reason for using restraint followed by acute and transient psychotic disorder and schizophrenia.

Approximately two-thirds of the psychiatrists surveyed responded that the most common factor that determines the removal of restraint was their own observation followed by the ward attendant's report (56%) and relatives' request (39%)

The most common method of physical restraint was found to be the use of cotton wool and gauge. Special hand and leg cuff is being used in some centers but it is not common. Abrasions were reported to be the commonest side effect of restraint.

All the mental health professionals who use the restraint believe that it definitely helps in managing a violent patient better, but at the same time they used it along with pharmacological treatment to control the patients. All felt that there is a need for a set of operational guidelines for prescribing physical restraint.

In our survey, none of the psychiatrists ever advised seclusion to manage a psychiatric patient.

DISCUSSION

The use of physical restraint and seclusion in psychiatry has always been controversial. It has been termed as tyrannical and anachronistic (Guirguis, 1978) by some, who strongly object to its use on the basis of its violation of the patient's right to freedom and dignity. However, many professionals agree that the restraint and seclusion is important to ward off or treat violence and potentially dangerous behavior. Research has also shown its use to be clinically effective and even preferable to the use of tranquilizers (Antoinette et al 1990). Medication takes its own time to act and since all violent behaviors do not respond to simple pharmacological approaches, the risk to the patient of aggressive pharmacotherapy must be weighed against the potential benefits of buying time with physical controls. While least restrictive alternatives are used, there is a little empirical evidence regarding their efficacy in controlling behaviour (Bower et al, 2003).

There have been a number of indications and contraindications proposed by different authors for the use of physical restraint and seclusion. The APA task force has developed implementation guidelines for physical restraint and seclusion. County Durham and Darlington, NHS Trust also has its policy on restraint and seclusion that gives important definitions, indications and contraindications, initiation, duration, nature of seclusion rooms and restraints, and care and observations of patient. The individual's clinical judgement, taking into consideration the patient's history, circumstances, age, mental state, physical ability and environment should be ultimate factor in deciding if restraint and seclusion is necessary.

In India, there is a lack of both studies and guidelines for the use of restraint and seclusion. In our survey, we found that most of the clinicians use restraint as a method of control in violent and agitated, suicidal and delirious patients. Restraints are used temporarily for a period not exceeding 8-10 hours on an average, in conjunction with sedatives, when the verbal intervention fails. According to the diagnosis, acute manic episode, acute psychotic disorder and schizophrenia were reported to be the

common conditions necessitating the use of restraint. Studies in the west have shown psychosis, personality and character disorders, manic symptoms, abnormal EEG's and mental retardation to be associated with higher seclusion and restraint use (Bower et al, 2003). While the use of leather restraints are in vogue in the west, it is the cotton and gauge that is the most common method of restraints in our country. That seclusion is not reportedly used by any of our respondents is a matter of debate. As has already been pointed out, it may be because of varying definitions of the term.

There has been felt a growing need for the development of indigenous guidelines on restraint and seclusion in our country. The participants at the national conferences held in Pune and Kolkata have worked towards making a consensus in this regard. In general, it was agreed upon that there must be written specifying guidelines outlining the major indications, contraindications, implementation and monitoring etc., being approved by the respective hospitals and the state. The use of restraints should be limited for the purpose of taking immediate control of a dangerous situation by a trained staff with clearly defined roles and for a period not exceeding 12-24 hours. It should be implemented when verbal interventions like counseling, persuasion and negotiation have failed to resolve the situation. The case in-charge or doctor on duty, in his absence, should write the order for restraints, preferably four-point restraint after taking informed consent from the caregivers. The patient should be seen within 1 hour of the initiation of the procedure and monitored for his physical and mental status, at least twice a day. The nursing staff should make regular observations of the vitals, preferably every 15 min, and give particular attention to the feeding and toileting needs of the patient. Seclusion rooms, if used, should be safe, with high ceiling, plain plastered walls without protuberances, non-inflammable mattress and without any injurious objects. There should be continual dialogue between the case in-charge and the patient. Restraint/seclusion should be discontinued when members of staff agree that patient is once again in control of himself and not harmful to self or others.

Overall, restraint and seclusion is perceived as an unavoidable (and valuable!) form of treatment for acutely agitated patients, which warrant systematic research and proper guidelines. To treat these patients safely and effectively, we must accept the limitations of psychotherapies and pharmacological management and develop a pragmatic balance of treatment approaches.

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UDAYAN KHASTGIR, MD, International Fellow, Pierremont Unit, Darlington Memorial Hospital, UK; A.K. KALA, MD, 95A, Model Gram Ludhiana 141 002; *UTPAL GOSWAMI, MD, DPM, Professor & Head; SATINDRA KUMAR, Senior Resident; DEBAKANTA BEHERA, MD, Senior Resident, Department of Psychiatry, Lady Hardinge Medical College & Associated Hospitals, New Delhi 110 001.

*Correspondence