

# Use of restraints in psychiatry - ethical dilemmas

Vypracovala MUDr. Klára Knápková, předmět 2ETZE, 2021/2022, UTB

## Introduction

This work takes a look at an ethical dilemma about the use of restraint in psychiatry. What exactly the use of restraints means, how are they applied and what is the legislation? Are restraints still humane care and how is the use of restraints connected with general ethical principles? What kind of negative consequences does the use of this specific approach in treatment bring for the object (patients) and the executor (health care personnel)?

## The issue of restraints in psychiatry from the perspective of ethics

Person working at a psychiatric hospital, especially in the urgent care department, can sometimes come together with practices restricting a patient's movement and/or his or her behavior. Such practices are also called restraints, means of restraint or restrictive means. These restrictions mostly concern patients with an acute mental disorder or derangement and in a state of being unable to distinguish surrounding reality or control their actions, for example during a psychotic experience with the risk of auto or hetero aggressive behavior, during a loss of consciousness, with changes of cognitive functions caused by dementia or with emotional changes leading to suicidal behavior.

Some of those restraints are controlled by law, some are described by experts or in specialized literature and some are just being repeatedly applied out of habit.

Division of means of restraint can be found, for example, in the norms of CPT (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment): „*physical restraint (i.e. staff holding or immobilising a patient by using physical force – “manual control”), mechanical restraint*

*(i.e. applying instruments of restraint, such as straps, to immobilise a patient), chemical restraint (i.e. forcible administration of medication for the purpose of controlling a patient's behaviour), seclusion (i.e. involuntary placement of a patient alone in a locked room)“.* (CPT, 2017)

Other ways are on the verge of mechanical restraint and isolation, which allows the patient some movement but not entirely freely. For example the use of net or cage beds. In some cases are individual means of restraint combined, primarily with chemical (pharmacological) restraint.

Experts are debating whether a chemical / pharmacological restraint or involuntary commitment are still just simply restraining measures or rather a separate medically-legal issue in wider conception of restraint a patient's free movement.

The difference between chemical / pharmacological restraint and medical treatment without the patient's consent is not, within the present legislation, clearly defined. Pharmacological management of a patient is a method *lege artis* applied in a case of aggressive and violent behavior with pathological cause as a method which could prevent the use of other means of restraint. Simultaneously, under certain circumstances, the use of pharmaceuticals is considered a mean of restraint. According to CPT those circumstances are: the use of a force or a threat in order to manage the patients behavior.

The legal scope of the use of restraints in the health service in Czech Republic (CR) is defined in Act 372/2011 Statute book about health services and circumstances for provision of health services, specifically in § 39 which defines 6 various methods on how to restrain patients from movement, including possible combinations of these methods, they are in short: grasp/grip, use of handcuffs/legcuffs, net bed, isolation, straitjacket, psychopharmaceuticals or other medications suitable to restrain patient's movement, administered intravenously. § 39 also defines in which situations can be restraints used. § 40 describes statutory conditions that need to be fulfilled. In Vestník No. 4/2018, Ministry of Health CR published methodical recommendations about the use of restraints in which it specifies not just the

individual possible ways of a restraint but also the care necessary for the restrained patient as well as other related instructions. (MZ ČR, 2018)

In many countries various means of restraint are looked at as inhumane, nevertheless, opinions on what is more and what is less human vary not just between countries but also between individual health organizations within each country. (Švarc, 2008)

Analysis of use of restraints, done in 2018 and published on a website of “The project of the Ministry of Health CR psychiatry reform”, which assessed data from 26 psychiatric hospital care providers in CR, highlights continuous disunity in interpretation of the use of restraints as well as deficiency in preventive measures that would lower the need for use of restraints. Further, the analysis exposed the fact that the personnel have inadequate training in communication skills and safe psycho-motoric agitation techniques without the need for the patient’s restraint. Also came to light, that beside the means of restraint described by law, some psychiatric hospital care providers use other methods of restraint (e.g. sheet, artificial food administration without the patient’s consent, etc.) Some of the providers’ internal regulations included exceptions which they do not consider a restraint (the use of a belly belt as protection against fall, restraint of one limb during intravenous application, application of restraint based on the patient’s wish). (MZ ČR, 2021)

The fundamental ethical principles in health care which have to be observed while health care is being provided, especially when using restraints.

Autonomy (also respect for person): acknowledging patient’s right to be fully informed and that patients who have the decision-making capacity have the right to make decisions regarding their own care, even when their decisions contradict their clinicians' recommendations.

Beneficence: “to act for the good of patients ” obligation of the health care provider to act in the best

interests of the patient, in other words - to benefit the patient.

Non-maleficence: obligation of the health care provider not to do harm to the patient, although it needs to be considered that *„harmful side effects and other risks are routinely accompanying modern medical treatments and research. Perhaps a better concept is to ensure that any harm is necessary and outweighed by direct benefits to the patient or research subject.“* (Phalen, 2017)

Justice: the fair, equitable, and appropriate distribution of health-care resources determined by justified norms that structure the terms of social cooperation.

Privacy: Protecting privacy and confidentiality of sensitive information is an obligation to patients. (Phalen, 2017)

Cheryl Boodt pointed out that beneficence can lead to “paternalism” when health care provider believes that he knows what is best for the patient and thus makes decisions for him without considering and respecting the patient’s will, consequence of which could basically contradict the principles of not just the autonomy but also of the beneficence itself.

Could a strong paternalistic action such as a decision for pharmacological restraint or involuntary commitment, both of which are interfering with the patient’s autonomy, still be ethically justified?

According to Beauchamp and Childress for a strong paternalistic act to be justifiable, several important conditions or circumstances would have to be present, they are:

- „1. A patient is at risk of a significant, preventable harm.*
- 2. The paternalistic action will probably prevent the harm.*
- 3. The paternalistic action is necessary to prevent the harm.*
- 4. The anticipated benefits of the harm prevention to the beneficiary outweigh the risks of the intervention to the beneficiary.*
- 5. The anticipated benefits of the harm prevention to the beneficiary outweigh the principle of respect for autonomy in this case.*
- 6. The paternalistic action involves the alternative that least restricts the beneficiary’s autonomy while*

*still securing the benefits for him or her.* “ (Ashcroft, 2007)

From the previously mentioned, it is evident that the primary purpose of physical restraint is a prevention of an injury, whether a self-inflicted injury of the patient who is due to his or her mental disorder aggressive toward himself, or an injury of others if the patient's aggressiveness is directed to people in his or her surroundings.

Application of a physical restraint can be traumatic for both sides, for the patients who are the subject of restraint as well as for the health care providers who perform the restraint. Even if the physical restraint is performed in compliance with all rules and regulations, injury can happen, especially in high risk patient groups, particularly polymorbid patients in their senior years. Use of restraints can cause, apart from physical injuries, also a negative psychological impact for both sides. *„Qualitative research has found that most nurses involved in a restraining incident, experience negative feelings such as sadness, guilt and emotional, while service users who are subjected to restraint, describe feeling anxious, angry, confused, powerless, vulnerable and dehumanized.“* (Hughes, 2016)

Which ethical dilemmas, in regards to the use of restraints, can come to the forefront?

Psychiatry is the only health care field which substantially intervenes with the basic human rights especially particularly with the personal freedom of the patients.

A significant dilemma in psychiatric care comes with a question whether psychiatry should act in a complete agreement with the patient's wish and will or whether psychiatry should provide care to the patient even if it limits his autonomy. For example a psychiatric patient often does not have a correct view on his health condition resulting in non-adherence of his health care which could become a life threatening situation e.g. patients with mental anorexia, psychotic depression, schizophrenia and patients

with suicidal tendency.

Similar dilemma emerges in case of patients who are, due to their mental disorder, dangerous to people in their surroundings e.g. patients with pedophilia, schizophrenia or people under the influence of drugs.

According to Foucault, a form of freedom restriction, such as involuntary commitment of people showing signs of a mental disorder, differs from other cases of freedom restriction such as incarceration or quarantine by the fact that in the first case the society not only protects themselves from the mentally ill person but in many cases also protects the patient from himself. (Foucault, 1994).

According to McLachlan, should the health care provider's primary goal be the patient's stabilization with restoration of his decision-making competence and autonomy for which an involuntary commitment and treatment without patient's consent is sometimes necessary. Healthcare paternalism is able to justify situations when a patient endangers others.

If hospitalization of a patient who is due to his/her mental illness an imminent danger to others is necessary, then the goal of such hospitalization should benefit not the society but the patient e.g. by sparing him of possible criminal charges and prosecution. On the other hand, McLachlan believes that this approach can only justify hospitalization which will ultimately lead to patients regaining autonomy.

In cases of dementia, mental retardation and serious personality disorders in which the autonomy regaining is not expected, use of the above approach would be controversial. (Petr, 2014)

## Conclusion

It is evident that this problem can never be completely resolved but it is crucial and necessary to approach each case with particular thoroughness to avoid generalization and use of identical methods for different cases. Staff and personnel, well trained at all levels is important to eliminate the necessity for use of restraints. Such staff could have specialists from various fields such as legal experts, psychologists, field workers within the framework of multidisciplinary social- medical services. This team could cooperate on a methodology conventional with a sensitive approach to the patients and in compliance with the legislation and the human rights. The field workers would assess the condition and needs of patients who are being treated at home (outpatients), for which they could use risk assessment tools.

Last but not least, a public debate and education are crucial in order to destigmatize mental illness, psychiatric patients would then not be ashamed of their problems and try not to deny downplay and address their illness.

## References

- [1] CPT/Inf (2017), *Means of restraint in psychiatric establishments for adults (Revised CPT standards)*, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)  
<https://rm.coe.int/16807001c3>
- [2] Sběrka Zákonů, MV ČR, Zákon č. 372/2011 Sb., *Zákon o zdravotních službách a podmínkách jejich poskytování (zákon o zdravotních službách)*  
<https://www.zakonyprolidi.cz/cs/2011-372>
- [3] MZ ČR, 2018. *Věstník č. 4/2018 MZ ČR*  
<https://www.mzcr.cz/vestnik/vestnik-c-4-2018/>
- [4] Švarc, J., 2008, *Omezující prostředky v psychiatrii*, *Psychiatrie pro praxi* 2008; 9 (5)  
<https://www.psychiatriepropraxi.cz>
- [5] MZČR, 2021. *Doporučený postup používání omezovacích prostředků*.  
<https://www.reformapsychiatrie.cz/clanek/doporuceny-postup-pouzivani-omezovacich-prostredku>
- [6] Phalen, R. F., 2017, *Core ethics for health professionals: principles, issues, and compliance*. Vydání první. Springer. Irvine, CA, USA. ISBN 978-3-319-56090-8.  
<https://vufind.katalog.k.utb.cz/Record/97467>
- [7] Ashcroft, R. E., Dawson, A., Draper, H., & McMillan, J., 2007. *Principles of health care ethics*. Vydání druhé. John Wiley & Sons, Ltd., Chichester, England. ISBN 978-0-470-02713-4.  
<https://www.pdfdrive.com/principles-of-health-care-ethics-e185666573.html>
- [8] Hughes, L., Lane., P., 2016, *Use of physical restraint: ethical, legal and political issues*.  
Article in *Learning Disability Practice*.



DOI: 10.7748/ldp.19.4.23.s21

[https://www.researchgate.net/publication/301673173\\_Use\\_of\\_physical\\_restraint\\_ethical\\_legal\\_and\\_political\\_issues\\_Layla\\_Hughes\\_and\\_Paula\\_Lane\\_describe\\_the\\_implications\\_of\\_restraint\\_procedure\\_in\\_intellectual\\_disability\\_practice\\_in\\_Ireland\\_and\\_how\\_policy\\_](https://www.researchgate.net/publication/301673173_Use_of_physical_restraint_ethical_legal_and_political_issues_Layla_Hughes_and_Paula_Lane_describe_the_implications_of_restraint_procedure_in_intellectual_disability_practice_in_Ireland_and_how_policy_)

[9] Foucault, M., 1994, *Dějiny šílenství v době osvícenství : hledání historických kořenů pojmu duševní choroby*, Praha : Lidové noviny, ISBN 80-7106-085-2

[10] Petr, T., Marková, E., a kol., 2014, *Ošetřovatelství v psychiatrii*, Vydání první. Praha : Grada Publishing, a.s., ISBN 978-80-247-4236-6

<https://www.bookport.cz/e-kniha/osetrovatelstvi-v-psychiatrii-609744/>