

The Use of Restraints in Mental Health Facilities

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Abstract

The restraint has been explained as making someone do something they don't want to do or stopping someone doing something they want to do. Three types of restraining are physical, chemical, mechanical, the purpose of restraining is to be proactive in preventing difficult situations arising and to use their skills to de-escalate situations that do arise. You should use an alternative method such as a partnership with the patient. The Approach of Restraining as you should be assessed, monitored and reevaluated of patient condition, Restraints may need to be applied one at a time while the other extremities are held down. You should follow the general recommendation debriefing method and other methods to protect patients from a complication of restraining.

INTRODUCTION

Restraint in medical practice can be anything or any method which is used to restrict a client's movement or to control his/her behavior, which categorized into three types: environmental, chemical and physical restraints (Gaten, 2007). Environmental restraint refers to control a client's behavior by modifying his/her surroundings to confine movement to a particular space; seclusion and time-out are examples of this. Physical restraints include all material appliances used to limit the client's mobility or conduct, such as limb ties, belts and bed rails. Chemical restraints refer to controlling the patient's behavior by using a psychoactive drug. Which is used to cause sedation, for instance, haloperidol, midazolam, and olanzapine (Practice standard restraints, 2009).

Restraints are used in some mental health facilities, especially inpatient facilities, to control patient's aggressive behavior only when there is actual potential harm to the patient himself, to other patients or staff members (Happell & Harrow, 2010; Stubbs et al, 2009). Restraints are provided based on the patient's current behavior and situation, never to be used with the thought of punishment, oppression, the convenience of staff or revenge. It should be the physician's last choice when all alternative interventions have failed (Springe, 2015).

The physical impact of restraints includes edema, cyanosis, muscular aches and rigidity, contractures, bedsores, and loss of movement (Demir, 2007). The psychological impact of restraints in psychiatric patients includes feelings of annoyance, uncertainty, loss of control, helplessness, lack of ability to trust others, feeling of anger and all negative past experiences, as well as past use of restraints, strike back to their memory in the form of flashbacks and nightmares. Patients may develop extreme agitation and frustration during periods of a physical restraint (Demir, 2007, Mohr, W, 2010). The use of restraints puts patients at risk for physical injury, death, and can be traumatic even without physical injury (Knox & Holloman, 2012).

Following the restraining procedure, psychiatric patients may experience feelings of shame, humiliation, and loss of self-respect in front of others due to which patient may go into isolation (Mohr, W, Petti, & Mohr, B., 2003, Mohr, W, 2010). All this affects their mental health and the patient could end up having severe depression. Chemical restraints may affect the client's cognitive abilities causing confusion, poor concentration, and loss of short term memory. Restraints are often recognized as cruel and tough by the psychiatric patient which contributes to developing antipathy toward clinical staff members. (Mohr, W, Petti, & Mohr, B., 2003, Mohr, W, 2010).

SIGNIFICANCE OF THE STUDY

Using a force to manage a patient will be a socio-cultural issue as it is always against the patient's will and it can be seen as tough and brutal. Patients' families often believe that the hospital staff is restraining a client as punishment, reprisal or for their conveniences. Autonomy is the right to liberty and self-determination; in restraining patients, both these components are violated. Paternalism means deciding on behalf of someone for her/his benefit. In the psychiatric setting, paternalism counts moreover autonomy of the client as the patient is mentally unstable, it is up to the health care member to take charge and act in the interests of the patient. So, it is a moral and professional dilemma for health care members, when to use restraints and when to respect their patients' autonomy. Safety is an important argument for using restraints, but also beneficence, dignity, freedom, and respect for autonomy should be considered (Goethals, et al., 2011).

LITERATURE REVIEW

The keywords "psychiatric" and "restraints" were primarily entered into Science Direct (2007 to 2017), MEDLINE, CINAHL, PsychINFO, and GOOGLE SCHOLAR databases. To extend my search the terms; seclusion, physical restraints, and psychiatric setting were used. After that, the reference list in each study was also checked to expand my search.

My search focused on both descriptive and experimental studies. Within the literature 986 articles presented. Fourteen articles were used to conduct this paper. Articles were eliminated if it didn't focus primarily on restraints in mental health care settings if it has been published before 10 years, and if it was written in language otherwise English.

DISCUSSION AND PRESENTATION OF CONTENT

Restraints are the most controversial practices that used in mental health facilities (Happell & Gaskin, 2011). The use of physical restraint in acute and residential mental health facilities is a widespread practice in many countries (Goethals, Dierckx de Casterlé, & Gastmans, 2011). Additionally, restraint is still a common practice with a prevalence of 30% use of physical restraint alone and another 30% used physical restraint combined with a chemical in the emergency department (Knox & Holloman, 2012). On the other hand, the use of restraints as a way of

managing the extreme behaviors in mental health facilities is a controversial yet often common practice, despite that there is a little evidence that restraints as a practice have any significant therapeutic value for the patient (Turner & Mooney, 2016).

A literature review about the incidence of seclusion and restraints recruited studies from 12 different countries, the results show a huge variety in the type, frequency, and duration of coercive measures used. On the other hand, both mechanical restraint and seclusion are illegal in some countries for ethical reasons. Also, available data recommend that there are massive differences in the percentage of patients subject to and the duration of coercive interventions between countries (Steinert et al., 2009).

A study about the use of coercive measures among involuntarily hospitalized patients from 10 European countries, included 2,030 patients. The study found that 1,462 coercive measures were used with 770 patients (38%). Also, the percentage of patients receiving coercive measures in each country varied between 21% and 59%. The most frequent reason for prescribing coercive measures was patient aggression against others. In eight of the countries, the most frequently used measure was forced medication, and in two of the countries, mechanical restraint was the most frequent measure used. Seclusion was rarely administered and was reported in only six countries. On the other hand, the diagnosis of schizophrenia and severe symptoms were associated with a higher probability of receiving coercive measures (Raboch et al., 2010).

A study about patients' perceptions of their hospital treatment measured after seclusion and restraining, included 90 patients'. Patients perceived that they received enough attention from the staff, and they were able to voice their opinions, but their opinions were not taken into account. Also, they denied the necessity and beneficence of seclusion and restraints. Also, the study found that women and older patients were more critical than men and younger patients regarding the use of restrictions. Besides, there were statistically significant differences in responses among patients at different hospitals (Soininen et al. 2014).

A randomized controlled trial compared subjective distress and traumatic impact after seclusion or mechanical restraint recruited 102 patients and followed up about 60% of them a year after

experiencing seclusion or mechanical restraint as an inpatient. The original study found no differences between patients who experienced seclusion or mechanical restraint, the follow-up study found significantly higher mean scores for CES (Coercion Experience Scale) items among patients who had experienced mechanical restraints. Patients reported experiencing a wide range of negative feelings during the measure, most frequently helplessness, tension, fear, and rage. However, 58% reported some positive effects. On the other hand, contact with staff members was most helpful in alleviating the patient's distress during the coercive measures (Steinert, Birk, Flammer, & Bergk, 2013). Also, another study found that patients' negative feelings during coercive interventions affected the therapeutic relationship and patients' self-esteem and may remind them of previous abuse (El-Badri & Mellsop, 2008).

Despite the importance of staff contact with patients during seclusion and restraining. A qualitative study recruited 14 nurses working in psychiatric hospitals in Iran, aimed to explore their perceptions about physical restraints. The nurses used physical restraint as an acceptable tool and intervention for different purposes in the ward. Also, they consider it a very important tool for management. Besides, they think that it prevents damage to the patients due to disorientation, dizziness, and sleepiness, which are mainly caused by the consumption of psychotropic drugs (Moghadam, Khoshknab, & Pazargadi, 2013).

A study conducted in 11 hospitals, some of them providing services for patients with intellectual disability (with or without co-morbid disorders), and others for patients with mental illness and/or personality disorder only. The study found that both gender and diagnosis were associated with differential seclusion rates. Male seclusions (for any diagnosis) were around twice as long as those in female services. No statistically significant association between the type of service and the reason for a patient being secluded. High rates of psychiatric co-morbidity and the complexity of patients admitted to services may also mediate the risk and use of seclusion. The study supports the use of early intervention techniques and the adoption of positive behavior support (Turner & Mooney, 2016).

Reports on patient death and injury as a result of restraints (Rakhmatullina, Taub & Jacob 2013, Cecchi

et al. 2012) and studies of patients' experiences in restraint and seclusion (Kontio 2011, Steinert et al. 2013, Soininen et al. 2013) prompted psychiatric-mental health nurses to question the benefit of restraining or secluding psychiatric patients. These studies present ethical dilemmas about the use of seclusion and restraints, and about violating the patient's right to autonomy and self-determination.

A recent literature review included 23 articles; to examine the effectiveness of seclusion and restraints reduction programs in mental health settings. The review concluded that, despite the wide variability in seclusion and restraints indicators and methodological rigor, it remains that the outcomes argue in favor of seclusion and restraints reduction program implementation (Goulet, Larue & Dumais, 2017)

Despite efforts to prevent the use of seclusion and restraint, there could be times that these measures are used. Thus, it is important to recognize the vulnerability of individuals who are secluded or restrained and the risks involved in using these measures (Huf & Adams 2012, Hollins & Stubbs 2011). Moreover, the dangers inherent in the use of seclusion and restraint include the possibility that the person's behavior is a manifestation of an organic or physiological problem that requires medical intervention and may predispose the person to increase physiological risks during the time the individual is secluded or restrained. So, skilled assessments of individuals who are restrained will not only ensure the safety of individuals in these vulnerable conditions but also will ensure that the measures are discontinued as soon as the individual can be safely released (American Psychiatric Nursing Association, 2014).

Psychiatric patients' positive perceptions of seclusion and restraint trigger the feelings of safety and security, trust, protection, helpful and decreasing stimulation (Kontio et al. 2012). Also expressing the reasons for seclusion and restraint helped patients to understand their restrictions (Kontio 2012). A study by Keski-Valkama et al. (2010) found that patients mostly (82.8%) felt seclusion to be beneficial and gave reasons for this as learning to control one's behavior, a positive effect on their condition and their privacy. Also, patient-friendly and safe environment reported that it helpful for patients (Keski-Valkama et al. 2010)

American Psychiatric Nursing Association (APNA, 2014) believes that psychiatric-mental health nurses

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play a critical role in psychiatric settings. This role requires that nurses provide effective treatment leadership to maximize the individual's ability to effectively manage potentially dangerous behaviors. So they strive to assist the individual in minimizing the circumstances that give rise to seclusion and restraint use.

Alternative methods and approaches are needed to shrink the use of seclusion and to change seclusion and restraint practices (Happell & Koehn, 2010). Alternatives that reduce agitation and aggressive behaviors aimed to reduce medication, work with the patients to find alternatives or solutions and partnerships with family members (Larue et al. 2010). Time out has been investigated as an alternative to seclusion in the UK in 31 hospitals and it's found that it could be used in similar situations for similar patients as an alternative to seclusion or restraints (Bowers et al. 2011). Time out means asking patients to stay in a room, mainly in their bedroom, until they have calmed down (Bowers et al. 2011). Also, another alternative found to the use of seclusion and restraint has been to reduce the use of these measures by introducing a comfort room, meaning a room with comfortable furniture, soothing colors, quiet music and other sensory aids (Cummings et al. 2010). On the other hand, there are suggestions for reducing seclusion by strong leadership, a review committee on the use of seclusion and restraint, and analyzing the incidence and use of post-incident debriefing (Scanlan 2010).

RECOMMENDATIONS

A chief recommendation is to increase the use of debriefing after restraining. The clients feel feeble and anguish, they need someone to talk to. It allows the client to ventilate their feelings regarding being restrained and also the chance to validate the reason for such violent behavior towards self or others (Bonner, Lowe, Rawcliffe, & Wellman, 2002).

As psychological patients are usually going through emotional trauma they need support from their family, friends and also from the staff members. Understanding and providing support also speed up the recovery of a patient after restraining. Lastly, since the use of restraints is very high in a psychiatric setting, a good surveillance system is also required to prevent the unnecessary use of it.

A Elshalabi (2015), listed a group of recommendations that must be addressed in mental health facilities. That includes; Nurses must use advanced directives to negotiate intervention strategies with patients to manage their behavior. Also, patients must be evaluated face to face by a physician or registered nurse who has met specified training within 1 hour of restraint. Also, the administration of an organization should develop a policy for assessment and management for uncontrollable behavior and restraints. The training program is required to deal with uncontrollable behavior and managing it. Also doing a personal safety plan on admission helps health care providers to gather information about the patient's response to distress and identify what interventions will be most helpful to keep them in control. Also chemical restraint by use of medication to control patient behaviors; the most often medication used in chemical restraint Diazepam (Valium), Lorazepam (Ativan), and Haloperidol (Haldol). This alternative is highly effective, legal to use, easy to apply through different routes (IM, IV) to the patient, lower cost to the organization, is safe for patient and staff, and accepted politically.

SUMMARY

In summary patients' opinions need more attention in treatment decisions. To achieve this, psychiatric treatment needs a genuine dialogue between patients and staff, and individual care should have other alternatives and no routine decisions. Therefore, the treatment culture must improve towards involving patients in treatment planning, and giving them a choice when restraints is considered.

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