Journal of Psychiatric Intensive Care

Journal of Psychiatric Intensive Care
Vol.5 No.1:1–4
doi:10.1017/S1742646409001411
© NAPICU 2009

Editorial

Mechanical restraint – A philosophy of man, a philosophy of care, or no philosophy at all?

A question from Norway

Valentina Cabral Iversen

Associate Professor, Consultant at Østmarka Department of Psychiatry, St Olav's Hospital, Department of Neuroscience, Norwegian University of Science and Technology (NTNU), Trondheim, Norway

The use of mechanical restraint as an intervention in the care of psychiatric patients dates back to the origins of psychiatry and has been a consistent topic of ethical controversy. Philippe Pinel has been widely celebrated as one of psychiatry's first reformist pioneers, removing the shackles in the Bicêtre hospital in Paris during the 1790s (Janner, 2007). Enlightened physicians regarded psychiatric illness as 'the loss of reason' and many advocated the use of restraints to help violent patients regain their reason. In 1838, Robert Gardner Hill successfully abolished the use of mechanical restraints at the Lincoln Asylum in England. Later, John Connolly followed Hill's example at the Lunatic Asylum in Hanwell, England. John Connolly was a British alienist in the mid 1800s who claimed it was possible to treat psychiatric patients without using mechanical restraints, but he made liberal use of seclusion and physical restraint by attendants to manage violent behaviour (Gamwell & Tomes, 1995).

Today, mechanical restraint remains in frequent use in the USA and in many European countries. A notable exception is the UK, where its use has almost been almost completely abolished. Patients can expect to be restrained, by one means or another, eight times more often in North America than in the UK (Tiivel, 1997). Nevertheless, many practitioners, myself included, remain deeply uneasy about the use of mechanical restraint. Consequently there are ongoing efforts to lessen or eradicate the use of mechanical restraints in many European countries and the USA.

Guidelines have been proposed to attempt to ensure that mechanical restraint is safe, used only when appropriate and in as a respectful manner as possible – trying to preserve the person's dignity and rights. However, the role and benefit of mechanical restraints as part of a patient's treatment remains a source of controversy and ongoing debate. Profound, troubling and hitherto unanswered questions about the use of mechanical restraint include (Mayoral & Torres, 2005):

- What is the evidence in relation to the short and long-term effectiveness of mechanical restraint?
- How is the balance drawn between patient protection, safety and the patient's human rights?
- What is the true effect of the use of mechanical restraints on compliance and a patient's relationship with the staff?

With such profound unanswered questions, the use and abuse of mechanical restraints

Correspondence to: Valentina Cabral Iversen, Østmarka Department of Psychiatry, St Olav's Hospital, Department of Neuroscience, Norwegian University of Science and Technology (NTNU), Trondheim, Norway. E-mail: valentina.iversen@ntnu.no

https://doi.org/10.1017/S1742646409001411 Published online by Cambridge University Press

remains a source of concern for many staff members within the psychiatric field, including myself. The practice of mechanical restraint in mental hospitals has been critically examined using two post-positivist constructions of validity, the pragmatic and the psycho political, and no favourable conclusions were drawn. For these reasons, the practice itself should either be stopped or used very sparingly. Judgements regarding the validity of any intervention that is coercive must include reference to the psycho political dimensions of both practice and policy. The current literature provides only weak support for the pragmatic validity of restraint as an intervention, and provides no support to date for its psycho political validity (Paterson & Duxbury, 2007).

Norway is one of the European countries where mechanical restraint is frequently used. Several reasons have been given for the use of restraint: patient agitation, harm, danger to others, destruction of property and to carry out necessary care or treatment. In Norway, Kirkevold & Engedal (2004) concluded that the main reason for the use of force or pressure in medical treatment was patient non-compliance. The nurse in charge or other caregiver most frequently decided that restraint should be used.

Quality assurance routines for decision-making and documentation of the use of restraint were lacking. At the psychiatric hospital (Østmarka) situated in central Norway (Trondheim), we are in the midst of discussions regarding the use of mechanical restraints, and our official policy has been to reduce their use.

Consequently, it was surprising and very disappointing to learn that use of mechanical restraint has, in fact, increased. In our hospital, the reduction, or rather the abolishing of patient activities in psychiatric intensive care units during a period of an economical crisis in the health system is one possible explanation for the extended use of mechanical restraint. It is also possible that the increase is because of ward and hospital culture that, for several reasons, views mechanical restraint as a legitimate and preferable option. For me, this is deeply concerning at a time when we are trying to make psychiatry more humane. Is the increased use of mechanical restraint part of a more

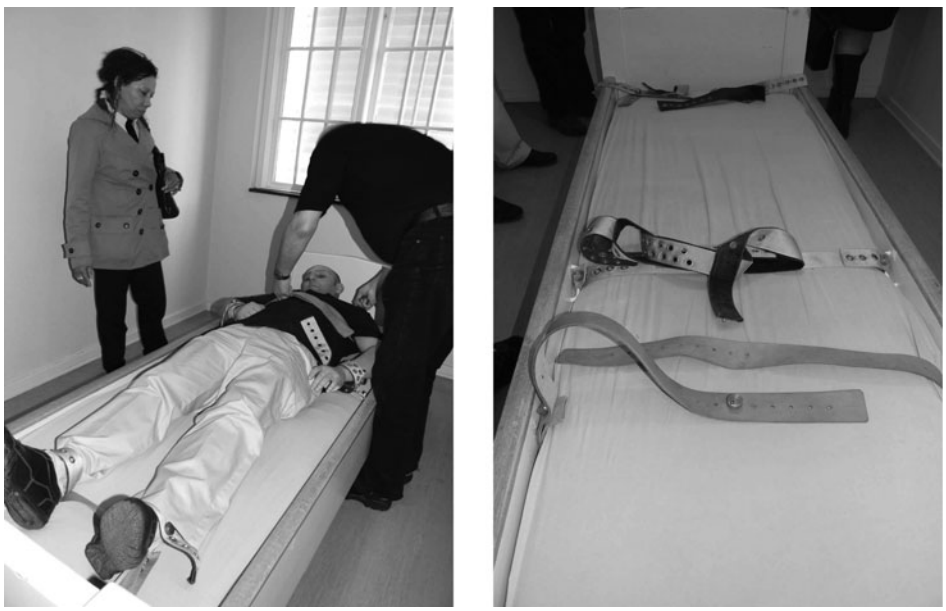

Figure 1. *Mechanical restraints commonly used in Norway; the pictures show a five point restraint both hands, both feet and an optional leather belt across the chest*

https://doi.org/10.1017/S1742646409001411 Published online by Cambridge University Press

general attitude towards mental patients, perhaps a 'philosophy of man'? Or is it because of a tacit assumption that it is actually an acceptable way to treat patients and thus a 'philosophy of care'? Or, is it that – when considered in the context of the profound and complex human issues associated with mechanical restraint – its use is really underpinned by no philosophy at all?

My own contribution to the philosophical challenges associated with the use of mechanical restraint is to increase the awareness of other philosophies and interventions when engaging with patients' aggressive behaviour. That was the motivation behind a seminar at Østmarka hospital Trondheim, Norway, organised in the spring of 2008. Mrs Jeri Hawkins from the UK National Health Service Institute for Innovation and Improvement and Mr Roland Dix – Consultant Nurse at Wotton Lawn Hospital in Gloucester, UK and Editor-in-Chief of this journal – were invited to share their experiences of engaging with disturbed patients without the option of mechanical restraint. Jeri Hawkins focused on how to deliver a good mental health service in psychiatric intensive care units. Roland Dix shared with us practical ideas for improving the daily experiences and treatment outcomes of acute mental health inpatients. The main focus was on therapeutic engagement, activity and de-escalation techniques as a way of preventing and engaging patient's aggressive behaviour.

The seminar included some spirited debate and also revealed that there were indeed members of staff from the hospital who were very willing to develop a clinical philosophy that did not include the use of mechanical restraint. Although, the seminar may have also revealed how difficult it can be for those willing to support change to be heard amongst to views of the traditionalist.

For practitioners who work in countries that still use mechanical restraint and would like to see it stopped or reduced, what should be done in the future? My contention is that staff philosophy, competency in the use of alternative techniques and leadership are major issues to be discussed. We know that mechanical restraint is used too frequently. Poor documentation and the arbitrary nature of decision making makes it reasonable to assume that the use of restraint is more often a result of ill defined philosophy and inadequate ward routines rather than the careful judgment of each case (Kirkevold & Engedal, 2004). In Norway, it is well documented that patients from racial or ethnic minority groups have a higher rate and longer duration of mechanical restraint than white patients, especially in the younger age groups (Knutzen et al., 2007). It is also documented that a combination of medication and mechanical restraint is more often used on patients with immigrant backgrounds compared with native-born Norwegian patients, on whom it was more common to use mechanical restraint alone.

I would suggest a set of principles that could underpin the efforts to diminish or eradicate the use of mechanical restraint. Alternative interventions that create a better environment in patients' units are one of several efforts to decrease or eradicate the use of mechanical restraint. Occupational therapy practices could be integrated into patient treatment strategies. Whenever possible it also seems reasonable to let patients take part in their own treatment plan. More important is to find new ways to provide each patient with a more active life, to improve the staff's skills to identify patients at risk, and to develop the staff's ability to utilize suitable early interventions. This includes communication training and learning de-escalation techniques to prevent aggression and anger. Our goal is to increase staff members' confidence and decrease their level of fear when dealing with aggressive or violent behaviour. Effective treatment aimed at increasing the patient's chances of recovery cannot include mechanical restraint.

Most of all, should we have to wait for the re-emergence of reformist pioneers of centuries past in order to achieve a truly 21st Century approach to the treatment of mental illness – without mechanical restraint? There is a need for new and inspirational leadership around the issue of mechanical restraint. All staff who

https://doi.org/10.1017/S1742646409001411 Published online by Cambridge University Press

find themselves deeply uncomfortable with the use of mechanical restraint, both in Norway and beyond, have the responsibility to lead the debate and challenge complacency. It will be behind these leaders that increasing number of patients, staff and policy makers can voice their support for the immediate eradication of mechanical restraint in the treatment of mental disorder in the developed world.

References

Gamwell, L., and Tomes, N. (1995) *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914*. Cornell Studies in the History of Psychiatry. Ithaca, NY: Cornell University Press; and Binghamton, NY: Binghamton University Art Museum.

Janner, M. (2007) From the inside out: Star Wards – Lessons from with acute in-patient wards. *Journal of Psychiatric Intensive Care*. 3(2): 75–78.

Kirkevold, Ø. and Engedal, K. (2004) A study into the use of restraint in nursing homes in Norway. *British Journal of Nursing*. 13(15): 902–905.

Knutsen, M., Sandvik, L., Hauff, E., and Svein, F.O. (2007) Association between patients' gender, age and immigrant background and use of restraint. A 2-year retrospective study at a department of emergency psychiatry. *Nordic Journal of Psychiatry*. 61: 201–206.

Mayoral, F. and Torres, F. (2005) Use of coercive measures in psychiatry. *Actas Españolas Psiquiatría*. 33(5): 331–338.

Paterson, B. and Duxbury, J. (2007) Restraint and the question of validity. *Nursing Ethics*. 14(4): 535–545.

Tiivel, J. (1997) The use of restraints in dementia. http://www.caregiver.on.ca/cgcihidmrs.html

https://doi.org/10.1017/S1742646409001411 Published online by Cambridge University Press