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ORIGINAL ARTICLE

On the concept of restraint in psychiatry

A.A. Negroni

Department of Law, University of Genoa, Italy

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Abstract The aim of the present article is to provide a concise clarification of the concept of ''restraint'' in the psychiatric context, with particular reference to the official sources. The concept of restraint in general refers to the measures that restrict the freedom of movement of an individual and comprises various types of restraints; an essential characteristic of restraint in psychiatry is its fundamentally coercive nature. The various types of restraint defined here are the following: physical restraint (manual and mechanical), physical psychological restraint (a concept I introduce that completes the concept of physical restraint), chemical restraint, environmental restraint and psychological restraint.

Introduction

The aim of this article is to provide a concise clarification of the concept of ''restraint'' in psychiatry, with particular reference to the official sources. Any aspect of legitimizing restraint, whether clinical, legal or ethical, is beyond the scope of this article.

The concept of ''restraint'' refers to various restraint techniques, the definitions of which, sometimes, manifest major differences with respect to laws, regulations and scientific literature.[1] Even if we limit our investigation to Europe, we find that the regulations (wherever exist) and clinical practice on restraint in psychiatry vary considerably.[2,3]

It is noteworthy that the difficulties experienced by many scholars, in getting precise data on the use of restraint in various countries, are due not only to the lack of available data, but also to the high degree of variability in reference sampling and non-uniform terminology.[4]

I have considered the so-called *de-escalation* strategies (guidelines on communication such as softening voice volume, speak calmly, avoid excessive visual contact, negotiating etc.) as not pertaining to ''restraint'', even though they are sometimes referred to as ''verbal restraint'' or ''relational restraint'', because they are usually considered to be *alternatives* to restraint.[5]

Regarding the alternatives to restraint, it should be noted that *The American Association for Emergency Psychiatry*

E-mail address: ale.negroni@outlook.it

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Project BETA De-escalation Workgroup created the ''Ten domains of de-escalation'' which included: (1) Respect Personal Space; (2) Do Not Be Provocative; (3) Establish Verbal Contact; (4) Be Concise; (5) Identify Wants and Feelings; (6) Listen Closely to What the Patient Is Saying; (7) Agree or Agree to Disagree; (8) Lay Down the Law and Set Clear Limits; (9) Offer Choices and Optimism; (10) Debrief the Patient and Staff.[6]

Restraint

The term ''*restraint*'' can be defined as something that limits an individual's freedom of movement. Restraint is not confined just to psychiatry: it is indeed employed both in non-medical use (e.g. by law enforcement) and in medical use, including various medical fields such as emergency medicine, geriatrics and orthopedics. However, due to various reasons, the use of restraint by psychiatrists is controversial and specific compared to other medical specialties. First, historical reasons (it is sufficient to remember the use of restraint tools in asylums). Second, the fact that, in psychiatry, restraint is normally carried out against the patient's will whereas, in other areas of medicine (except geriatrics and intensive care units) restraint is ordinarily carried out with the patient's consent.

A further argument is that the very same need for the restraint in psychiatry is doubtful and controversial: already in the late 1700s William Tuke (1732–1822) and later John Conolly (1794–1866) proposed and implemented *no restraint* treatment methods for the psychiatric patient; and it is worth to note the existence in Italy of psychiatric wards where the use of restraint is strictly abhorred (the so-called no-restraint wards) and the experience of a few Pennsylvania hospitals where, as of 1997, the use of restraint has been dramatically reduced and, in some cases, completely abandoned.[7,8]

Even if, as noted earlier, the term ''restraint'' recalls the act of somehow limiting an individual's freedom of movement, it is nonetheless important to emphasize how the term, in psychiatry, refers more precisely to a *coercive* act that limits freedom of movement; this also applies to the judicial and bioethical arenas: when it comes to medicine, ''restraint'' implies coercion.

According to the Académie Suisse des Sciences Médicales, we may say that all actions that are carried out against the patient's stated will (or presumed will, if he is not able to communicate) or cause him to resist must be considered ''coercive acts''.[9]

A definition of ''restraint'' that includes both coercion and limitation of freedom of movement, is the one found in *Mental Capacity Act* (2005): «[A person] D restrains [another person] P if he (a) uses, or threatens to use, force to secure the doing of an act which P resists, or (b) restricts P's liberty of movement, whether or not P resists».[10]

It is worth to note that point (a) of this definition refers to the literal meaning of the word ''coercion'' as given in *Black's Law Dictionary*, «compulsion by physical force or threat of physical force».

Other definitions of ''restraint'' that may be quoted are the ones given by the US *Joint Commission on Accreditation of Healthcare Organization* (JCAHO): «Any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body»,[11] and by the Italian National Bioethics Committee (NBC): «Mechanical or pharmacological limitation of an individual's possibility of autonomous movement».[12] These definitions clearly describe how restraint may be performed by different means, physical or chemical, as we will elaborate further on.

Physical restraint (manual and mechanical)

Although ''physical restraint'' is not the only form of restraint, it represents the psychiatric restraint par excellence; very often, the literature reference to otherwise non-specified ''restraint'' usually refers to physical restraint.

In the most recent version of *U.S. Code of Federal Regulations* we find a definition of ''restraint'', as given by the US Federal Agency *Centers for Medicare and Medicaid Services* (CMS), *Department of Health and Human Services*. The first part of this definition refers to physical restraint: «Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely»[13]; the second part pertains instead to chemical restraint, of which we shall deal with later.

We recall another definition given by CMS: «''Physical Restraints'' are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body».[14]

Physical restraint can be implemented by two different means, although the goal is common, i.e. to limit a person's possibilities of autonomous and spontaneous movement. The first requires one or more staff members (usually, at least three) who physically grab or engulf the patient in such a way as to control his ability to move freely: we refer to this as ''manual restraint'' or, more simply, ''physical restraint''.

Let us exemplify this: physically grabbing of a patient and immobilizing him with the purpose of administering some drugs is manual restraint; in contrast, sustaining a patient so that he can be escorted to a given place is not manual restraint as long as the person can easily free himself from the staff members' grab.

The second means of physical restraint is carried out by suitable mechanical devices which, either directly applied to the patient's body or adjacent to him, and not easily removable, preventing, limiting or controlling his body movements: we then speak this as to ''mechanical restraint''.

Among the devices used in psychiatry for mechanical restraint – the historical straightjacket, the belt with wrist-cuff, wrist and ankle cuffs tied to the bed, bed-side bars – according to CMS interpretation, may as well be considered to be restraint devices to the degree that they are used to prevent a person from leaving his bed. Conversely, they are not restraint devices: if they are used to prevent a fall-prone patient from hurting himself, if they leave a free opening by which the patient may leave the bed, if the patient may easily remove the device or, finally, if the patient cannot leave the bed even without bars.[15]