Perspective on the Use of Seclusion and Restraint

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By Avrim B. Fishkind, MD [2]

Dr Zun has done an excellent job of reviewing the many controversies and complexities that surround the use of mechanical and chemical restraint as well as seclusion. He also shows us how many unanswered questions there are about such interventions. For example, an insightful psychiatric resident once raised the question of which intervention was more restrictive and stigmatizing: seclusion or restraint?

A review of the legal and medical literature did not reveal the answer. However, when the psychiatric emergency service (PES) staff was polled, the overwhelming response was that restraint was more restrictive than seclusion. This led to an intense discussion about the meaning of the word "restrictive." Is it spatial or temporal? Is it a measure of how much hands-on force is applied or a reference to limitation of movement? Or does it better describe the ability of the patient to communicate with a staff member, which is arguably easier in restraints with an open door versus seclusion with the door closed and locked, cutting off direct contact with other persons. Consumer Perspective

Perhaps the PES staff was trying to answer the question from the usual stance: the clinician-centered universe. In fact, consumers may best answer many of the unanswered questions about restraint and seclusion. In a well-designed and well-executed study, mental health consumers were asked to define their wants and needs during a psychiatric emergency. Thirty-six consumers who had been placed in restraints were interviewed. The mean number of years since the event was 8.8, and their responses implied that the acts of restraint were indelibly etched in their minds. While the memory of the event lingers in a patient's memory, it may amount to an incorrect memory and not reflect the positive efforts by the staff to avoid restrictive measures.

A remarkable 67% reported that staff had not tried another intervention before restraint. Sixty-eight percent said they had been kept in restraints too long, and 77% said that no one had listened to them or responded to their requests. The most critical statistic was that 54% said that being in restraints had made them unwilling to participate in outpatient psychiatric treatment. The use of restraints, therefore, may have catastrophic impact on outpatient treatment compliance, leading to a vicious cycle of noncompliance followed by admission to a PES, with the possibility of repeated use of restraints. Consumers also had strong opinions about what factors make it easier or harder to be in restraints (Table 1).

Thirty-nine consumers were interviewed regarding seclusion. The median number of years since they had been placed in seclusion was 6.4. Similarly, 67% reported that no other intervention had been tried before initiation of seclusion. Only 38% said that vital needs, such as food, water, and elimination, had been adequately provided. Seventy-eight percent thought that they had been in seclusion too long, and 55% thought that they had not been checked on often enough. As with restraint, 60% said that being secluded made them unwilling to participate in outpatient treatment. In the study, consumers were quite verbal about factors that make it easier or harder to be in seclusion. The responses were similar to those for restraints, but with some notable additions (Table 2).

So, which is more restrictive, seclusion or restraint? We can now see more clearly that the answer lies in the mind of the consumer. If all efforts to avoid coercive interventions, such as physical restraint, seclusion, and "chemical restraint," have been exhausted, I suggest offering consumers the choice of seclusion or restraint. You may be surprised how often they can tell you their choice, even in the presence of severe psychotic agitation. Chemical Perspective

A wide variety of psychological and social influences in a PES can contribute to the use or avoidance of seclusion and restraint. The PES staff can easily fall into the habit of using such interventions as a defense against their fears of injury or to lessen a burdensome caseload on a busy shift by putting the consumer into deep sedation or putting him or her in isolation.

In recent times, much attention has been focused on physician choice of pharmacotherapy to
manage acute aggression and psychomotor agitation. Reportedly, several state offices of mental health have been investigating the use of chemical restraint. The issue is whether the use of psychopharmacologic medications given to aggressive consumers in an emergency situation is a form of treatment or restraint.\(^3\)\(^4\)

Both the Centers for Medicare & Medicaid Services and the Joint Commission on Accreditation of Healthcare Organizations have waded into this controversy. Common to both these organizations' criteria for chemical restraint is that the treatment is either "inappropriate" or "not standard." This, of course, leads to the need to develop standards for the pharmacologic treatment of patients with aggression and agitation. There are no current standards because of a paucity of evidence-based practice and a general reliance on consensus guidelines.\(^5\)

The difficult task for emergency psychiatrists is to develop guidelines for the use of chemical restraint. It is clear that chemical restraint reduces injuries and manages aggression and agitation. I recently learned that across different cultures and continents, some psychiatrists think that controlling agitation to the point of the patient being calm and awake is the goal, while others think that deep sedation is the appropriate end point. Currier and colleagues\(^6\) estimate that 135,000 persons per year undergo chemical restraint in PES units. What they receive--which drugs, doses, and combinations--remains a mystery. Is giving 10 mg of haloperidol and 2 mg of lorazepam intramuscularly plus 50 mg of benztropine chemical restraint? These doses might be considered "inappropriate" or "not standard." However, there are no studies that would distinguish between those patients requiring the traditional strategy of haloperidol, 5 mg, and lorazepam, 2 mg intramuscular, and those needing the doses described above because they might be more severely agitated.

**Facility Perspective**

PES staff should be made aware of the factors that contribute to increased use of restraint and seclusion in the emergency setting. Many of these issues are challenging to discuss and may strike a raw nerve in staff members, who may feel heavily criticized when, in fact, they believe that they are acting to prevent injury and treat the patient.

A review of these PES influences is too broad for this commentary, but I will touch on several critical factors. First, staff members must be well trained, frequently tested through drills, given positive feedback for placing themselves in harm's way daily, and listened to closely by management. This will make for a staff that is willing to work more closely with aggressive consumers, use verbal de-escalation techniques, and offer oral medications to avoid use of seclusion and restraint.

Multidisciplinary conflict leads to more injuries because of miscommunication. Smaller PES spaces and workloads that are too high for current staffing will cause an increase in restraint and seclusion to relieve pressure on the "overburdened" staff. Burnout, common in the PES, will also influence the issue. If the staff is predisposed to prefer sleeping patients who are waiting for hospitalization to treating and stabilizing patients for release, there will be more coercive interventions, especially the use of medication to induce sedation.

One area that causes great controversy is the suggestion that staff members may restrain a patient because of prejudices or cultural biases. This should be addressed through cultural competency training. Emergency psychiatrists are often influenced by nurses or other staff members, who may chide doctors with comments that they are too soft or undermedicate patients, leaving staff and other patients at risk for assault and injury. Staff may relish the notion that if restrained or secluded, the consumer becomes the next shift's problem when the consumer wakes up or is released. At times, sleeping may actually be beneficial if, for example, the consumer is manic or has been ingesting stimulants in excess without sleeping.

However, safety of staff and consumer is the highest responsibility of the PES psychiatrist. His or her decisive and protective actions establish whether the unit has a safe and therapeutic milieu and therefore whether employees want to come to work each day and know they are protected.

**ED Perspective**

Let's move from the perspective of the PES to the medical-surgical emergency department (ED) described by Dr Zun. In his clinical case presentations, Dr Zun asserts that the patient should be treated with "dignity, respect, and understanding." He correctly states that in a similar fashion to the PES, "cooler minds must prevail." In addition, these same minds should be aware that they are not only dealing with a biologic condition but also psychological and sociologic conditions. Overcrowded EDs are not conducive to devoting the time and energy needed to complete reviews of psychiatric history, environmental stressors, or even a mental status examination to screen for depression, bipolar disorder, or personality disorders.

As such, ED personnel frequently can only address the biologic nature of a person's presentation, carefully documenting a history of present illness, medical history, review of systems, and physical
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examination. There is an ongoing challenge for emergency medicine to train nonpsychiatric physicians with a skill set to enable them to work well with agitated and psychotic patients. This is a future area of collaboration and training between emergency medicine and emergency psychiatry. Patient A demonstrates the principle of imminent danger. He is actively violent with police officers and does not respond to verbal intervention. He received an injection of a traditional antipsychotic and a benzodiazepine in addition to being restrained. A patient who becomes obtunded after such injections must still be attended to and a medical workup must be completed. This can be very difficult if the patient is subsequently unarousable and cannot answer questions, as was the case with Patient A. In addition, with the use of a traditional antipsychotic, there is rarely a period of calm before extreme sedation during which to question and examine the patient. This period of calm is an advantage when using the newer intramuscular atypical antipsychotics. In a useful teaching case, a frail 55-year-old woman without identification presented to the PES. She was extremely combative, was given intramuscular haloperidol and lorazepam, and was arousable only to sternal rub within 30 minutes. The patient was placed in a room far from the nurses' station and "allowed to sleep." Approximately 3 hours later, a technician coming on shift mentioned to staff members that a funny odor was coming from the patient's room. The odor turned out to be the fruity smell of a person in diabetic ketoacidosis. The staff had overmedicated the patient, performed inadequate medical workup and observation, and missed the medical cause of her delirium. Medicating patients to deep sedation leaves the physician vulnerable to missing important medical conditions, especially in the PES.

With Patient B, Dr Zun raises very important points regarding the capacity of agitated patients to make treatment decisions. One interesting scenario I see played out over and over is a physician approaching a mildly agitated patient and offering oral medication, getting no immediate response, then ordering injectable medication. It is often necessary to help the psychotically agitated patient by repeating oneself several times, using clear, nonambiguous language. After all, how often does your spouse or significant other hear you the first time you say something? You will find that by offering medication several times and being clear about the choices and benefits, the medication will be voluntarily accepted by most patients. Dr Zun is correct to point out that this may include accepting or even choosing injectable medications, which may work more quickly in relieving the dysphoria inherent to agitation. Agitated patients may also experience severe psychic anxiety and dread or even dissociation, symptoms that cause enormous mental anguish. Offering voluntary medication quickly can also prevent rapid escalation to the point of needing seclusion or restraint. This can restore a sense of autonomy and control to the patient and help build trust toward a good therapeutic relationship.

In Patient C, Dr Zun illustrates the use of one-to-one observation as an alternative to restraint and seclusion. In a busy ED, the actively suicidal patient may induce anxiety in the staff, who may feel the patient must be detained no matter how restrictive the intervention. In addition, one-to-one observation is labor-intensive, and inadequate staffing may preclude its use. What is unique to one-to-one observation is the increased opportunity to build relationships, verbally calm the patient, and offer a less stigmatizing intervention. Agitation without imminent risk is not a criterion for restraint or seclusion, even if, as Dr Zun notes, it is "for staff convenience."

During one-to-one observation, there is room for acts of kindness so appreciated by patients in mental health crisis--short walks, stretching, getting food, moving to less stimulating locations, and even seeing family and friends. This type of observation can be done at arm's length if risk is high, and staff should be trained in what to do if the patient tries to leave the ED. Also of note in the case of Patient C is that the medical acuity does not necessitate immediate diagnostic interventions that would require restraint, as was seen with Patient A.

Seclusion and restraint with regard to the elderly, medically compromised patient is presented in the case of Patient D. As Dr Zun asserts, agitated patients need the same physical evaluation as that afforded to strictly medical patients. The cause of agitation must always be assumed to be medical until proved otherwise, especially if there are clear signs of delirium. A strictly psychiatric emergency setting often lacks protocols to accomplish complex testing, such as CT, quick blood analysis, and even unclothed physical examinations (which may be perceived as a boundary violation).

Unclothed examinations, venipuncture, obtaining vital signs, or placement of leads for cardiac monitoring often cannot occur in the agitated patient without the use of restraints. Even with restraints, completing the examination (eg, hearing cardiac sounds) may be impossible. In this case, the elderly woman could be assessed with urging, persuasion, and redirection to get the necessary medical information and accomplish the testing. Delirium caused by a myocardial infarction and congestive heart failure could have impaired her insight and judgment (ability to voluntarily consent)
to the point at which restraint would have been warranted because of imminent physical injury or
death. **Summary Perspective**

Dr Zun's conclusions are illuminating. Seclusion and restraint are procedures of "high emotions" and
government regulation. Documentation is intensive, time-consuming, and difficult to complete
accurately. Persons who execute the seclusion or restraint procedure in error are at risk for losing
their jobs. Proper training does, in fact, limit risk to staff and patient. Continuous efforts at quality
improvement, as well as monthly drills to promote success, will result in dramatic decreases in
injuries to the point where there is a low rate of complications.

With regard to the point that "use of newer agents early in the course of treatment is essential to
remove restraints as quickly as possible," an interesting study showed the powerful combination of
hospital culture and pharmacology. In this study, the PES switched from using droperidol for
intramuscular sedation of the agitated patient to intramuscular ziprasidone, a newer atypical
antipsychotic. The mean time in restraints when droperidol was used was 91 minutes (n = 80). After
the switch to ziprasidone, the mean decreased to 45 minutes in restraints (n = 51; P < .01). When
the decreased restraint time was noted after the switch to ziprasidone, 3 patients received a
traditional antipsychotic, with a mean time in restraints of 42 minutes. The authors postulated that
this was a "halo effect" that had decreased the time in restraints by nearly 50% for those receiving
conventional treatment, demonstrating the institutional culture change concerning release from
restraints.

Finally, Dr Zun successfully makes the case that restraint and seclusion are for patients with
"extreme agitation." As he clearly states, these procedures, when properly performed, are absolutely
necessary to ensure safety of staff and patient. Administration must always be aware of the balance
between the pressures to decrease seclusion and restraint and the possibility of injury and death if
these procedures are underutilized. Hopefully, there will be an increase in research to illustrate more
"evidence-based conclusions" regarding the future use of seclusion and restraint. *

**References:** REFERENCES

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**Links:**