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The Use of Physical Restraints: Ethical Approach, Legislative Framework and Patient Experience

S. Karroumi[1*], K. Akbour[1], C. Sebbar[1], F. Manoudi[1]

[1]Department of Psychiatry, University Hospital Mohamed VI, Marrakech, Morocco

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***Corresponding author:** S. Karroumi
Department of Psychiatry, University Hospital Mohamed VI, Marrakech, Morocco

Abstract **Original Research Article**

Physical restraint is used very often in psychiatry, as a means to control agitated and violent patients, in order to provide protection for the patient and others, after failure of alternative measures. Our cross-sectional descriptive study of 30 patients hospitalized in the psychiatry department of the university hospital MOHAMED VI in Marrakech, who have undergone physical restraint, over a period of 6 months; intended to describe the feelings and experiences of these patients in relation to physical restraint, and to determine the symptoms related to it. The analysis of the results revealed the following: a male predominance at 80%, the most frequent age group was between 31 and 40 years old. 57% of patients were diagnosed with schizophrenia, and the most common reason for restraint was agitation at 60%.We found that patients had mainly negative feelings during the period of restraint, with helplessness at 90%, loneliness at 73%, sadness at 60%, fear at 40%, anxiety at 36.6%, anger at 36.6%, humiliation at 16, 6% and injustice at16.6%.We also found unpleasant physical perceptions during restraint, with pain at 63.3%, sleep difficulties at 23.3%, cold at 16.6%, and thirst at 16.6%. On the other hand, the analysis of the traumatic experience of patients after the physical restraint, through the PCLS scale, revealed a low percentage (7%) of patients with a score compatible with PTSD. This indicates a less traumatic effect of restraint in our population compared to the Western world.

Keywords: Psychiatric disorders, Physical restraint, Ethics, Law.

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INTRODUCTION

In Morocco, mental health is a significant public health issue. The numbers speak for themselves. According to statistics from the Ministry of Health, 26.5% of individuals aged 15 and older have experienced a depressive disorder during their lifetime, and over 200,000 Moroccans aged 15 and older suffer from a schizophrenic disorder. The peculiarity and difficulty in treating mental illnesses are linked to the denial of disorders and the refusal of treatment that accompany almost all of these illnesses, often leading to involuntary hospitalization, during which therapeutic measures, often restrictive, are implemented. Physical restraint is one such measure, regularly used when patients in acute crisis lose control and become agitated and aggressive towards those around them. In such cases, the aim of physical restraint is to control and limit the movements of these patients, not only to protect themselves but also to protect those around them, including caregivers. Although physical restraint is often used in psychiatric care settings, it is the subject of much ethical debate because it represents a significant restriction of patients' individual freedom and autonomy.

Objectives of the study:

To study the experiences of patients following physical restraint, focusing on describing their feelings to better understand the symptoms associated with this measure.

PATIENTS AND METHODS

This is a retrospective cross-sectional descriptive study conducted over 6 months (November 2017-April 2018), involving a series of 30 patients hospitalized in the psychiatry department of the CHU MOHAMED VI in Marrakech, who were subjected to physical restraint. We included in our study sample 30 patients hospitalized for various psychiatric disorders. We excluded unstable patients and those who did not consent. Data collection was done using an exploitation form, allowing us to collect characteristic data for each patient. It provided information on the following: sociodemographic characteristics (gender, age, education level, occupational status), clinical characteristics, diagnosis, reason for restraint, course of restraint, mode of hospitalization, type of room, duration of restraint. Patients' feelings about restraint (Feelings

during restraint, perception of caregiver behavior, emotions and thoughts towards caregivers). The study of patients' traumatic experiences regarding restraint (PCLS Scale).

RESULTS

The mean age of the included subjects ranged between 31 and 40 years (40%), with 30% aged between 19 and 30 years, 20% aged between 41 and 50 years, and 10% aged between 51 and 60 years. The average age was 36.2 years. The majority of patients in our sample were male (80%). Almost two-thirds of our patients had a secondary level of education (63%). Only 4 patients had never been to school (14%). More than half of the patients were self-employed (56.6%), 7 patients were employed in the private sector (23.3%), and 6 patients were unemployed (20%).

More than half of our patients were diagnosed with schizophrenia (57%), 20% with schizoaffective disorder, 20% with bipolar disorder, and 3% with acute psychotic episode.

Almost two-thirds of our patients had agitation as the reason for physical restraint (60%).

Nearly half of the studied patients believed that the decision for physical restraint was made by the nurse (46.6%). Almost two-thirds of the studied patients were restrained in isolation rooms (37%), while the rest (63%) were in regular rooms. Almost half of the studied patients were restrained for 12 hours. The average duration of restraint was 21.7 hours, ranging from one hour to 90 hours. The intervals between the last episode of physical restraint and our interview with the patients varied, with an average of 78.7 days, ranging from one day to two years. More than a third of our patients (36.6%) had their last episode of restraint more than a month ago. More than half of our patients received sedative medications during restraint (57%).

More than half of the studied patients experienced feelings of sadness (60%), 40% felt fear, and 36.6% felt anxious. More than half of our patients did not have positive feelings during restraint (57%). A third of the patients in our sample (33.3%) believed the act was justified. Almost two-thirds of the patients in our sample found physical restraint tolerable (63%). The majority (90%) of our patients felt powerless during restraint. The majority of our patients (83.3%) attributed their sense of powerlessness to motor incapacity. More than two-thirds of our patients felt lonely during restraint. Almost three-quarters (73%) of the studied patients experienced unpleasant physical sensations during restraint. Almost two-thirds of the patients (63.3%) felt pain during restraint.

More than three-quarters of the patients in our sample had a positive perception of caregivers' behavior (77%). Almost two-thirds of the patients in our series said the caregivers were competent (63.3%). Only 43% of the patients had a negative perception of caregivers' behavior. According to 23.3% of the patients in our sample, caregivers displayed violent behavior, humiliating behavior in 23.3% of cases, and dominating behavior in 20%. Almost three-quarters of the patients in our series (73%) had positive emotions towards caregivers. Positive emotions in our sample were represented by appreciation in 66.6% of cases, trust in 43% of cases, and respect in 3.3% of cases. A third of the patients in our series (33%) had negative emotions towards caregivers. Negative emotions in our sample were represented by hatred in 20% of cases and loss of trust in 20% as well.

The average PCLS score in our study was 24.2 with extremes ranging from 17 to 52. In our sample of 30 patients, only 2 of them (7%) had a positive threshold for post-traumatic stress disorder.

DISCUSSION

The use of physical restraint aims to ensure patient and bystander safety and to prevent therapeutic rupture. Its use is justified only after other management measures have failed, and this should be clearly documented in the patient's medical record due to potential medicolegal issues. The decision and prescription for restraint require close collaboration between physicians and caregivers to design treatment in its various dimensions and ensure risk management. A Cochrane literature review evaluated the effectiveness of physical restraint and seclusion for patients with mental illness. It concluded that no controlled studies assess the value of seclusion or restraint in patients with severe mental disorders, and serious adverse effects associated with these techniques have been documented in qualitative reviews. The ongoing use of seclusion or restraint should therefore be questioned based on well-planned and documented randomized trials that can be generalized to routine practice [1]. Similar conclusions were reached by Nelstrop in 2006, who found only studies of low power, with a small sample size, many biases, or a lack of clarity on how restraints are used [2].

The use of restraint methods is associated with numerous risks reported in the literature. In 2013, a prospective Japanese study investigated an increase in D-dimers, a biological marker of venous thromboembolic disease, in patients under physical restraint. Among the 181 patients restrained during the inclusion period, deep vein thrombosis was found in 21 of them, representing 11.6% of the sample. All patients had received preventive treatment with compression stockings and heparin therapy [3].

Legislative Overview

In Germany, patient restraint is regulated by the law concerning mentally ill persons of March 20, 1985. Paragraph 29 considers measures known as "special security": they should only be implemented if there is an

immediate considerable risk that the patient will seriously harm themselves or others, or leave the healthcare facility without authorization, and if this risk cannot be reduced in another way [4].

In Quebec, law 118-1 is even clearer: "Force, isolation, any mechanical means, or any chemical substance may only be used as a control measure for a person in a facility maintained by an establishment to prevent them from inflicting harm on themselves or others. The use of such a measure must be minimal and exceptional and must take into account the physical and mental state of the person" [5].

In Morocco, basic legislative texts can be found in Decree No. 1-58-295 of April 30, 1959, and Decree No. 1-73-282 of May 21, 1974; but without specifics regarding the use of isolation rooms or physical restraint. However, on May 2, 2016, the Minister of Health presented a new bill "Bill No. 71-13 on the fight against mental disorders and the protection of the rights of persons suffering from these disorders". Article 73 states: "The patient may only be restrained or isolated: in a mental health hospital; upon prescription of the treating physician" [6].

Beauchamp and Childress proposed an approach based on respect for four principles in 1978: the principles of autonomy, beneficence, non-maleficence, and social justice [7-9]. In the case of physical restraint, the principle of beneficence is sought if restraint is considered by the caregiver as a therapeutic act and/or as a protective measure for the patient and others.

Reasons for Physical Restraint:

The most frequently cited reasons for using physical restraints in the literature are aggressive behaviors towards others [9]. In our study, the most common reason for restraint was agitation, accounting for 60% of cases, followed by hetero-aggression in 40% of cases. The remaining patients exhibited auto-aggression in 6.6% of cases, and suicidal risk in another 6.6% of cases.

CONCLUSION

Despite the indications and benefits of physical restraint, it also has negative consequences on the mental health of patients. Numerous studies have demonstrated that the use of physical restraint leads to undesirable psychological and somatic effects, sometimes even resulting in death. In this regard, our study confirms the literature by showing an overall negative experience among patients subjected to physical restraint.

Conflicts of Interest: The authors declare no conflict of interest

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