Chapter 14

Paterson B. Restraint, seclusion and compulsory medication. In Barker P (Ed) *Mental Health Ethics: The Human Context*, Routledge, London.2010

Introduction.

"*Our science enables us to call your madness illness and diagnose a madness in you that prevents you being a patient like other patients: hence you will be a mental patient*" [1]

Unlike most other medical specialists, psychiatrists have the legal power to coerce patients into accepting treatment.

In a UK post asylum era, focused on facilitating recovery through partnership with service users, not just in treatment but also in the design, delivery and evaluation of services, it is tempting to suggest that the complex ethical questions about coercion in treatment are somehow less relevant or less important than they once were. Unfortunately nothing could be further from the truth because coercion in its various forms continues to play a central role in mental health practice both in the UK and across the world. This chapter will briefly explore the history of coercive practice in mental health, and discuss its use in contemporary practice. However, its primary focus will be on an evaluation of whether and if so how, the continued use of restraint, seclusion and compulsory medication can be justified ethically? For the purpose of this chapter however *both* seclusion and compulsory medication will be considered sub types of restraint. Seclusion, because substituting a locked door for a restraining hand or belt merely replaces one means of restricting movement with another. Compulsory medication - particularly rapid tranquilization - because "*a medication used to control behaviour or to restrict a patients freedom of movement,* is in reality "*not treatment but restraint*".[2] The focus of the discussion will be on their use in services for working age adults but it is acknowledged that such interventions are used in other services.

As Thomas Szasz[3] observed state legitimized coercive interventions whilst *"always morally problematic"* are also always *"inherently political in nature".* This chapter eschews therefore the use of a more conventional ethical framework in favor of two post modernist constructions of validity, the 'pragmatic' and the 'psychopolitical'. The decision to do so requires however some justification for those unfamiliar with this approach. Validity as a concept has several well known dimensions central to the positivist tradition in research in the behavioural sciences, particularly 'content', 'construct' and 'predictive' validity.[4] This 'traditional' construction of validity reflects a modernist worldview, whereby knowledge provides a map of a reality, which is assumed to be objective. If instead an alternative post-modern worldview is taken the search for certainty in knowledge is replaced by that of identifying defensible 'claims' regarding all

knowledge. Validation then becomes the process of choosing among competing interpretations each framed as potentially falsifiable and thus open to exploration.[5] Truth in this context is not defined with reference to an objective reality but retains significant value as a concept, albeit interpreted now, in terms not of accuracy, but of utility, in the sense of "*whatever assists us to take actions that produce the desired results*".[6] The process however, whereby "*the results desired"* are agreed upon, involves consideration of both values and ethics. The consequence is that validity itself becomes an ethical question and it is this perspective, which will inform the exercise undertaken.[7]

The Coercion Continuum

Before such an exploration can be conducted it is however necessary to clarify what coercion involves and describe contemporary practice in the area. Coercion is defined for purposes of this chapter as "*any action or threat of actions, which compels the patient to behave in a manner inconsistent with his own wishes*".[8] It exists on a continuum and can be overt and explicit such as the use of restraint (whether accomplished by means of physical holding or mechanical device) seclusion (whether accomplished through locked doors or threats to enforce isolation) or 'as required medication' administered in the absence of consent. It can also be implicit. The suggestion that if medication is not taken 'orally other options will have be explored' is readily understood as a barely veiled threat by the service user in many mental health in-patient services.

The latter appears most common with 48% per cent of service users who responded to an audit of English in-patient services agreeing that "*they felt that the threat of medication or seclusion was used to control behaviour'*.[9] Such threats are clearly not idle, in the first national audit 8% of inpatients in England and Wales were reported to have been restrained at least once during their current stay in hospital. With one point five per cent having been restrained more than 5 times and 0.7% restrained on more than 10 occasions. Seclusion was less common with 3% of patients reported as having been secluded at least once.[9]

Similar and sometimes much higher figures for the use coercive interventions are reported across Europe and the rest of the world[10] although remarkable variation in the specific type of coercion used exists.[11] The use of mechanical restraint is almost unknown now in the UK but remains common practice in much of Europe ,with less common variations such as the use of net beds (large cot type structures) in widespread use in Austria. Seclusion, used in much of Europe, is banned in Italy. Compulsory medication in the form of rapid tranquilization is however it appears used almost every where.[11] Such variation in an era of evidence based practice and common European guidance[12] requiring that services adopt and implement the principles of least restrictive environment and least intrusive treatment may seem surprising. The pattern and frequency of use of such interventions reflects however the gradual emergence over time of consensus on what represents acceptable practice, which have eventually become enshrined in local and sometimes national guidance. [13] These are not

evidence based interventions but forms of 'custom and practice' reflecting local culture hence the variation.[13] Ultimately, these practices represent value judgements. This is best illustrated perhaps with reference to an example in British Colonial India. When the non-restraint movement swept the UK in the 1800's many British psychiatrists came to view mechanical restraint as archaic and sought to eliminate it. Interestingly however, British psychiatrists practising in India during the colonial period dissented vehemently. This was not because they saw mechanical restraint as necessary to control the 'native' population. Rather, it was because the public institutions for the insane, which catered for European colonials, employed only Indian orderlies and nurses. In practice such direct care staff (as today) were largely responsible for managing aggressive and violent patients. The discourse then prevalent made mechanical restraint essential for British patients because it avoided what, for a British patient, would have been profoundly shaming in that culture, at that time: i.e. physical domination by 'native' orderlies.[14] What practitioners judged 'reasonable' and thus acceptable reflected the local cultural imperatives. Whilst the nature of these imperatives will vary over time and place, the process by which it is decided which coercive interventions are used remains the same, explaining the wide variations in practice observed.

Coercion: A brief history

The use of coercion to manage acute mental distress is not new, predating both the development of the asylum and psychiatry itself. The origins of organised care in mental health stem in part from desires to protect those vulnerable to abuse and exploitation from the public but also to protect the public from those whose behaviour was perceived as representing a threat to themselves or others, or to the broader social order. Legal provisions in England dating back to at least the 14th century have provided for the "*imprisonment of a lunatic*".[15] Such legislation permitted not only for detention but that they might "*bind him and beat him with rods*" not as punishment but in an attempt to restore sanity. [16] The use of coercion in the form of mechanical restraint to protect staff from dangerous behaviour was however also commonplace. Michael Foucault [17] records that a variety of "*marvelous instruments*", including the "*fixed chair*", "*handcuffs, muffs straitjacket*" the "*fingerglove garment*" and "*wicker caskets in which individuals were enclosed*" were in widespread use in French hospitals before the actions of Pinel at the Bicetre called them into question. It has been suggested that Pinel, while widely credited with freeing lunatics from their chains, remained comfortable with threatening patients with the *camisole* or *gilet de force* (the straightjacket) and considered the effects achieved by such intimidation justified to gain compliance. [18]

The practice of coercion also came to be questioned in the UK. Inspired initially by the treatment of a fellow Quaker admitted to York asylum in England and his horror at the conditions he subsequently found there William Tuke went on to establish 'The Retreat', a service based on the principles of 'moral treatment'. (See Chapters 2 and 3). A critical element of moral treatment was *"A system*

which, by limiting the power of the attendant" made *"it his interest to obtain the good opinion of those under his care"*. This approach, Tuke argued, provided more "*effectually for the safety of the keeper, as well as of the patient"* than any *" chains, darkness, and anodynes*". [19]

In a bizarre irony, because Tuke rejected the medical treatment of insanity as ineffective, 'moral treatment' came to be adopted by medical campaigners in favour of the asylums. They were eventually successful in entwining the notion of cure with the concept of the *'benign institution*" [20]. Later advocates of what eventually became known as '*non restraint'* in the new system of asylums, which developed in the UK during the 19th century, including James Connolly, [21] were however subject to considerable criticism. Concerns were expressed about *'serious physical effects (such as broken ribs,)*' sustained by staff in struggles with service users in at least one asylum.[22] Non-restraint was therefore never universally popular or adopted everywhere despite the somewhat mythical status it has since came to enjoy.[22] Although mechanical restraint did fall out of favour in the UK, at least for adults of working age, physical restraint, strong clothing and 'strong rooms' (later renamed *seclusion)* remained part of common practice in many British institutions and elsewhere throughout the 19th and 20th century.[24]

The debate over the use of compulsion in services for people with mental health needs is therefore far from new. The dominant conceptualisation of validity adopted by those who support the need for seclusion, restraint and compulsory medication even if only implicitly, can be described as 'pragmatic'. Kvale [25] asserts that, in a pragmatic construction of validity, the need for theoretical "*justification is effectively superseded by application*". In the context of the use of coercion in-patient mental health in-patient services interventions that 'worked' in terms of their effectiveness in producing the desired results (e.g. improving service users mental health; reducing injuries to staff; or even increasing the likelihood of future compliance with 'treatment' for fear of repetition, might therefore be considered to enjoy *pragmatic* validity). Unfortunately whist we may know which combinations of 'as required medication' can achieve rapid tranquilization most effectively, and with fewer adverse effects, [26] evidence of the effectiveness of restraint and seclusion, as systematic review indicates, is at best ambiguous. [27]

Justifying Coercion

This legal justification for the use of restraint, seclusion, or compulsory medication is that such forms of coercion represent forms of necessary 'treatment' so that staff can fulfil their 'duty of care' and *'ensure that control is exercised over the patients*'. [28] It has been suggested that coercive interventions might be more usefully understood not as part of 'treatment' but instead as indicative of "*treatment failures,"* suggesting a need to urgently review the care delivered.[11] In English law however, a treatment need not be effective to be considered 'lawful' and can even be harmful. [29]

An in-patient unit in which service users were free to refuse all medication, to refuse to have their persons or their rooms searched for contraband items such as illegal drugs might in certain circumstances spiral out of control leading to an unsafe environment for both staff and service users. Mental health in-patient settings consistently emerge from research as potentially violence prone. [30,31] Such a situation calls for staff to be trained in restraint and rapid tranquilization, and the case for the use of seclusion, once in decline, to be revisited, as an option can seem compelling. Coercion in this framing of the problem is represented as undesirable but "progress in treatment can only be expected if safety has been established," [32] According to this justification, restraint, seclusion and ''as required medication'' are therefore 'regrettable necessities', used only with extreme reluctance, as an absolute last resort to manage dangerous behaviour arising from the service users' 'mental illness', which poses a serious risk to the safety of the service user or others.

Suggestions however, that restraint, seclusion or as required compulsory medication actually 'work' in terms of improving safety is however scant. Evidence for the necessity of restraint must be considered, therefore, in the light of evidence garnered largely from studies on the effects of training.[33] There are potentially strong arguments in favour of training in restraint as part of wider training in the prevention of violence.

Fisher[34] argued that restraint can prevent: imminent harm to self or others; substantial damage to the physical environment; and the serious disruption of treatment programmes. It can also decrease stimulation. He has also raised the issue that it may be valuable when implemented in response to service user requests.

Lee et al's[35] review found that the literature indicates several potential benefits arising from the introduction of structured training in physical restraint including an increase in staff confidence, a decrease in the seriousness of assaults and assault related injuries and a decrease in the levels of fear expressed by staff when interacting with patients. Reductions in the use of restraint following training have also been reported.[36]

Unfortunately, as Allen[37] observes negative outcomes have also been found with all these measures. In the UK one explanation offered for the negative results associated with training has been that the 'importing' of training models from non health service (prison) led to a widespread and persistent overemphasis on physical intervention during training in the prevention and management of violence in some programs.[38] Unfortunately, this led to the neglect of training in interpersonal skills and the wider aspects of violence prevention. Such training was it appears misconstrued as a 'stand alone' intervention: i.e. it was interpreted as capable by itself of resolving the problems of workplace violence rather than as a necessary, but discrete, component of a total organisational commitment to

a public health model.[39] This led, at least in some settings to the development of service cultures in which nurses were "*trained to expect violence and how to react it but not how to stop it happening*". [40] Such approaches it is suggested contributed to the emergence of a "*culture of violence in mental health care in the UK*". [40]

Framing the problem of safety in mental health services as one that can be solved by increased control, whether by restraint, seclusion or compulsory medication, is at best simplistic if not profoundly misleading. An emerging body of research into the perceptions of service users around coercion suggests that many consider it is being used to *punish* rather than enable treatment, or manage high risk behaviours.[41] Given the history of mental health services this is unsurprising. The use of systematic punishment to induce compliance was once orthodox practice, and threats of such 'punishment' as service users perceive it are clearly commonplace. The belief that "*fear (is) the most effectual principle to reduce the insane to orderly conduct*" may have appalled Daniel Tuke[42] in the 19th century. However, to assume that such long established discourses no longer exert any influence on practice would be naive. As Shapiro[43] observed it is precisely because such discourses are so familiar that they are able 'operate transparently'. Those affected are effectively blinded to such influences on both their thinking and behaviour.

In settings where the needs of service users have become superseded by the needs of the culture for order, routine, predictability and deference to power, the misuse of such interventions to enforce compliance, can easily become commonplace. Wardhaugh and Wilding[44] have described this process as "*An active betrayal of the values upon which the organisation is supposedly based*" In such services '*the primary aims of care have become subordinate to what are essentially secondary aims such as the preservation of order, quiet and cleanliness*'.[45] The problem is that giving permission to staff to use such interventions whose subtle (or not so subtle) misuse under the guise of treatment has long been identified as a key factor in the development of corrupted cultures, which can then become self perpetuating.[46] Over time a range of explanations have been offered as to the origins of what we presently choose to describe as 'mental health needs' or 'problems'. Amongst the lesser known is the phenomenon of the 'insane ear'. A characteristic swelling of the ear lobe was once thought by some asylum physicians in the early 19th century to be a symptom of the long sought physiological basis of insanity.[47] It took William Tuke[19] to suggest a somewhat more prosaic explanation. In what might be described as an early epidemiological study he noted the phenomenon now described as 'haematoma auris', occurred much more frequently in the left ear of 'disruptive' male patients than their right. This led him to suggest that this was more to do the majority of asylum attendants being right handed than any underlying propensity in the population to the condition known more colloquially in the UK as 'cauliflower ear'.

Considering Alternatives

If the problem of violence or other disturbed behaviour is framed as something to be controlled, needing restraint, seclusion and rapid tranquilization, what are the alternatives? Prillenetsky[48] asserts that a focus on causation is of critical importance. He has criticised approaches to defining and/or assessing validity, which focus merely on 'what works', arguing that implicit to such approaches is a reductionist perspective on pathology, which neglects the social dimensions of causation. This he observes neglects the potential for the transformation of the conditions that may have given rise to the phenomena in question, typically in this case violence in inpatient mental health settings. Instead, he argues in favour of a model of validity which he terms 'psychopolitical' arguing that interventions must be judged on the extent to which they seek to transform the conditions that give rise to the problem.[48] To qualify as psychopolitically valid an intervention must:

- recognize and challenge inequalities of power and their negative effects on both service users and staff
- help to prevent the acting out of ones own oppression on others
- build awareness of internalised oppression
- illustrate and challenge dominant discourses that promote victim blaming
- challenge collusion with exploitative systems, the causative role of these inequalities in terms of their impact on communities and individuals and the need for interventions to address such inequalities
- contribute towards the struggle to establish and sustain a positive individual identity

This perspective on validity prompts a focus on primary prevention and consideration of the structural determinants of violence that might otherwise be neglected. Irrespective of the setting common reactions in staff exposed to aggression and violence include fear, frustration and anger. Unless recognized and constructively managed such feelings can influence their future interactions with patients and other staff. Counter transference, in the form of the adoption of aggressive coping styles by staff can then embed a cycle of retaliation and revenge in the culture.[49] Counter transference by staff can however, have roots other than in violence by service users. Bowie[50] proposes an extension to the violence typology proposed by the California Division of Occupational Safety and Health i.e.

Type 1 *intrusive violence:* Criminal intent by strangers' terrorist acts mental illness or drug related aggression and protest violence

Type 2 *consumer related violence:* Consumer, clients, patients (and family) violence against staff, vicarious trauma to staff, staff violence to clients and consumers

Type 3 *relationship violence:* Staff-on-staff violence and bullying domestic violence at work

Bowie proposes a further '*Type 4*' category, which he suggests, comprises '*organisational violence*' i.e. that which 'the organisation' perpetrates against consumers, clients and patients.[50] Direct care staff in many services are invariably at the lowest point in organisational hierarchies, often marked by rigid boundaries.[51] These hierarchies can however all too readily foster the development of abusive, bullying or 'toxic' cultures. The central dynamic of such toxic organisations is a culture of shame and humiliation, which can be pursued actively or allowed to happen by default.[51] Workers (and even whole professional groups) at the bottom of hierarchies can become acutely sensitised to any perceived threat to their limited degree of status and self-esteem. One consequence is that, low-level verbal abuse, or even non-compliance by a service user, can evoke a disproportionate emotional response because of the implicit threat to the staff member's vulnerable self-esteem. Restraint, seclusion and/or 'as required' medication provide an all too ready means for staff to exorcise such feelings by controlling, punishing and humiliating the service user.[53]

Actual or threatened violence is the most commonly reason reported reason for the use of seclusion, restraint or rapid tranquilization in mental health in-patient services. However, such violence appears much more often to escalate from low level conflict related to rules, rather than stemming directly from the individual's pathology.[54] The use of restraint, seclusion or ''as required medication' in services for people with mental health needs must therefore be understood as arising not simply from the pathology of the individual, however construed but as stemming from the pathology of a society whose individualising and victim blaming processes the service cultures may simply replicate.

To reduce the use of coercive measures transformative interventions are required[48] These focus on the primary prevention of violence, recognising and addressing the central role the culture of individual mental health services should play in preventing violence. The underlying reasons for violence in in-patient settings often lie in structural inequalities of power, the unrecognised affects of trauma on both service users and staff, and the failure to develop supportive and therapeutic cultures. The potential effectiveness of system wide meta-interventions complemented by targeted training in crisis management to reduce restraint and seclusion has now been convincingly demonstrated.[55,56,57,58] David Colton has produced a checklist for services contemplating pursuing restraint and seclusion reduction, to assess their readiness to implement such initiatives.[59]

Key Ethical Dilemmas

Even where the root causes of violence have been identified and addressed there may still be situations where coercion occurs. Whether or not to restrain, seclude or medicate patients can present staff with a decision dilemma for nursing staff, where they attempt to manage the risks to all involved including themselves. In such circumstances, nurses may regard the conflicting choices of

intervention / non-intervention as equally unwelcome options.[60] However, there remain scenarios where restraint, seclusion or rapid tranquilization may be warranted in exceptional circumstances.

- A service user diagnosed with bi polar disorder who is experiencing an acute crisis has repeatedly refused oral medication. She is manifestly psychotic, delusional, and evidently pyrexic, appears acutely dehydrated and repeatedly refuses fluids. She is reported as not having slept for 72 hours. Her physical health will rapidly deteriorate in such circumstances. Should staff decline to enforce medication ?

- A service user detained under mental health legislation refuses access to his/her room by standing in front of the door obstructing the planned search of a room carried out as part of a 'random search' strategy in a medium or high secure service. The service user has a previous history of constructing and using weapons. Should staff physically restrain him to permit the search?

- A service user with a diagnosis of anorexia refuses to accept oral supplements or oral sedation to permit intravenous feeding. Medical opinion is that without rapid intervention she will die within days or weeks. Should staff restrain her to administer treatment?

- An acutely psychotic young service user, also diagnosed with autistic spectrum disorder, struggles badly to manage his symptoms in an acute in-patient unit which can be noisy and sometime chaotic. When acutely distressed he aggressively confronts other service users and will repeatedly attempt assault. If physically restrained he reacts badly continuing to struggle for long periods causing staff serious anxiety that he may experience acidosis and suffer cardiac arrest. If secluded the low stimulus environment appears to help him calm. Should staff seclude him?

Conclusion

Recent years have seen the emergence of a new restraint reduction movement whose aims include the reduction of all forms of coercion. This movement has explicitly sought to reframe the problem of violence towards staff and to challenge what it has described as the almost exclusive focus on the pathology of the individual resulting from the dominance of biological psychiatry and the near demise of social psychiatry. In seeking to reduce recourse to coercion it has argued that the root causes of the behaviors leading to such interventions can often be found in what services do to both service users and staff. The role of the organization is thus increasingly recognized as of critical importance (See also Chs 8 and 23).

There is now persuasive evidence that multidimensional meta-interventions are capable of significantly reducing the use of seclusion, restraint and as required compulsory medication. As the examples above illustrate, it may be impossible to eliminate the use of such interventions in all settings. However, it may be possible to reduce them significantly in most. It is also clear that that such reduction strategies offer the most effective route to making mental health in-patient settings users safer for both service users and staff. Given such clear evidence, and the legal requirement now imposed on many European countries to provide services in the 'least restrictive manner', any service, which fails to attempt to reduce the use of such interventions must offer god reason.

It may be apt to end with the words of a service user, once a mental health nurse, who may be uniquely qualified to comment. Discussing his experience of restraint he observed:

"For me the real issue is not so much about restraint per se, but about restraint carried out by people who think restraining a patient is not a violent act. There may be times when it is a necessary violent act. A person who knows this, and believes violence to be basically wrong, will strive to minimise the violence. A person who thinks restraining a patient is not a violent act will not. They will also not understand why someone would be upset by being restrained and will not be in a position to deal with that upset in a positive way". [61]

Coercive interventions remain commonplace in mental health but can be open to abuse in the corrupted cultures that continue to exist in some in-patient settings

Coercive interventions can be significantly reduced in most in-patient settings via meta-interventions that start by reframing the problem of violence toward staff

All services should be required to publish their rates of restraint, seclusion and compulsory medication. Such transparency would do much to encourage services to reduce their use

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