REVIEW ARTICLE

Restraint guidelines for mental health services in India

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ABSTRACT

Restraint use in mentally ill patients are regulated by Mental Healthcare Act 2017 in India. At times, persons with mental disorders become dangerous to self, others or towards the property, warranting an emergency intervention in the form of restraint. Restraint as a matter of policy, should be implemented after attempting alternatives, only under extreme circumstances as last resort and not as a punishment. It should be an intervention focused at managing the concerned behavior for a given point of time. Restraint should always result in safety and should ensure that the human rights of mental health care users are upheld. This guideline was developed towards Indian mental health services in conjunction with international evidence-based strategies following a decade of collaborative research work between Indian and European mental health professionals.

Key words: Guidelines, Indian mental health, restraint

INTRODUCTION

Mental health experts from India and Europe came together in Mysore, India, for an international symposium on coercion in 2013. The delegation discussed a culturally adequate way to address coercion for the Indian medical context. As a result, the Mysore declaration was drafted, discussed, and ratified defining coercive measures for the Indian context and outlining the aims, safe application, and ways for minimization of coercion in all medical settings in India.[1] Following this, there were two more international symposia on coercion in mental health care. The collaborations encouraged both qualitative and quantitative research on coercion in Indian Mental Health Services.[2-6] This was a significant development at a time when national discussions around Indian Mental Health Legislation led to the drafting of a new Mental Healthcare Act (MHCA 2017). The Act of parliament received assent on April 7th 2017. Restraints are discussed in Chapter XII under admission, treatment, and discharge.[7] The Act prohibits seclusion, and the use of restraints should be as per subsections (1)-(9) of section 97. The act requires all mental health establishments (care providers) to record all instances of restraint in a report to be sent to the concerned review boards every month. Our experiences in research collaborations with countries that have guidelines and the results of the research done allowed us to develop these restraint guidelines from an Indian mental health services perspective while taking into account the best practice and up-to-date research from around the world. These guidelines are an attempt to combine best practice, research, and a deep understanding of Indian mental health care to provide guidance for clinicians, as well as reassurance for patients and relatives in strict compliance with the MHCA 2017.

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Restraint may be used only when all less intrusive or restrictive methods have been ineffective or determined to be inappropriate. They must be performed in a manner that is safe, proportionate, and appropriate to the service recipient's age; size; gender; physical, medical, and psychiatric condition; and personal history. The use of restraint must be evaluated continuously and ended at the earliest possible, based on an assessment of the service recipient's condition and behaviors.[8,9]

These guidelines are based on the MHCA 2017 requirements and closely based on the consensus reached in the Mysore declaration, and other international guidelines, namely the British NICE guidelines and the German guidelines for the prevention of coercion.

DEFINITIONS

For the purposes of this guideline, the following terms shall mean, based on existing guidelines and restraint protocols;[10,11]

Assessment

The systematic collection and integrated review of patient-specific data, assessment specifically targets key medical and psychological needs, competency to consent to treatment, co-occurring medical and mental illness (including substance abuse), clinically significant neurological deficits, traumatic brain injury, physical disability, developmental disability, need for assistive devices, physical or sexual abuse or trauma, and antecedents to violent behavior.

Containment/restraint

The brief physical holding of an aggressive or agitated patient to effectively gain quick control of and minimize harm to the patient or others.

Restraint incident is any event that involves the use of a physical intervention (excluding observation).

Continuous visual observation

A minimally restrictive intervention in which the assigned staff maintains uninterrupted visual contact of the patient at all times to ensure the safety of the patient and others.

Emergency

A situation where the patient's behavior is violent or physically aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff, or anyone else in the vicinity.

Personal safety plan/advance directive

A document containing information regarding calming strategies identified by the patient as helping avoid restraint (Advance directives are encouraged under the MHCA 2017). This document is completed by the patient, with assistance from facility staff, if needed.

Physical escort

A "light" grasp to escort the patient to the desired location. If the patient can easily remove or escape the grasp, this would not be considered manual restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered manual restraint, and all the requirements for restraint would apply.

Pro Re Nata

An individualized order for the care of a patient which is written after the patient has been seen by a physician (Psychiatrist). The Pro Re Nata sets parameters for attending staff to implement the ordered intervention according to the circumstances set out in the order.

Prone restraint

Brief physical holding of a patient in a facedown position, usually on the floor, for effectively gaining quick control of an aggressive and agitated patient.

Protective medical device

A special category of medical restraint that includes devices or combinations of devices, to restrict movement for purposes of protection from falls or complications of physical care, such as Geri chairs, Posey vests, mittens, belted wheelchairs, sheeting, and bed rails. A protective helmet could be considered a medical restraint or a behavioral restraint, depending on how it is used. The requirements for the use and documentation of medical restraints are different from the general requirements for the emergency use of restraints for behavioral management purposes.

Rapid tranquillization

The use of medication (intramuscular or intravenous), if oral administration of medication is not possible or contraindicated, or if urgent sedation with medication is needed.

Restrictive intervention

An intervention that may infringe a patient's human rights and freedom of movement.

GUIDING PRINCIPLES FOR USE OF RESTRAINTS

The following are the general principles followed for the use of restraints.[11-13]

1. The safety and dignity of the patient must be ensured
2. The safety and well-being of staff is also a priority
3. Prevention of violence is key
4. De-escalation should always be tried before the use of restraint

5. Restraint is used for the minimum period
6. All actions undertaken by staff are appropriate and proportional to the patient's behavior
7. Any restraint used must be the least restrictive, to ensure safety
8. The patient must be closely monitored, so that any deterioration in their physical condition is noted and managed promptly and appropriately. Mechanical-restraint requires 1:1 observation
9. Only appropriately trained staff should undertake restrictive interventions, to ensure the safety of patients and staff.

RESTRAINTS CONSIDERED

The different restraints to be considered are enumerated below.[1,11,14-17]

1. Physical restraint involves direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behavior displayed by an individual
2. Chemical restraint involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a direct therapeutic purpose but is primarily employed to control undesirable behavior
3. Mechanical restraint involves the use of equipment. Examples include specially designed mittens in intensive care settings, everyday equipment such as using a heavy table or belt to stop the person getting out of their chair, or using bedrails to stop a person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks, and keypads– can also be a form of mechanical restraint
4. Environmental restraint involves buildings designed to limit people's freedom of movement, including locked doors, electronic keypads, double door handles, and baffle locks
5. Seclusion is an important subtype of environmental restraint. It is defined as "placing of a person, at any time and for any duration, alone in an area with the door(s) shut in such a way as to prevent free exit from that area"
6. Psychological restraint includes constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up. It might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example, removal of walking aids, glasses, or outdoor clothing or keeping the person in nightwear with the intention of preventing them from leaving
7. Broadly speaking, the need to use restraint, particularly physical restraint arises from two distinct circumstances: those which are *planned* and those which are *unplanned*. *Unplanned physical restraint* refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. Under these circumstances, immediacy does not allow time to plan. Staff is guided by best practice guidelines and training. *Planned physical restraint* refers to restrictive physical interventions which have been planned through risk assessment and where there is an expectation that predicted circumstances are likely to occur. There is time for planning, and restraint plans are structured and documented in health-care records
8. Types of restraint devices include:
    1. Manual restraint: A skilled, hands-on method of physical restraint used to prevent patients from harming themselves or others. Its purpose is to immobilize the patient safely. It includes the application of physical body pressure by another person to the body of the patient in such a way as to restrict the freedom of movement
    2. Leather, nylon, or vinyl waist belt and wrist cuff: Used as a less restrictive method than a four- or five-point restraint for patients who engage in severe agitation and primarily involves the hands or arms. A canvas camisole may be used instead of a waist belt and wrist cuff to effectively provide the same level of restraint
    3. Leg restraint: A leather, nylon, or vinyl cuff with connecting strap, which allows ambulation but limits the ability of the patient to run or engage in aggressive kicking
    4. Protective helmet: Used to protect the head of a patient who engages in self-directed violence such as head banging
    5. Five-point restraint: A physical-restraint technique in which a patient's wrists and ankles are secured to four points on a bed with leather, nylon, or vinyl cuffs, and straps while the patient is in a supine position on a plastic-covered mattress with a waist belt to immobilize all movement. A five-point restraint comprises the highest level of physical restraint, and its use presupposes a judgment by appropriate clinical staff that lesser restrictive techniques of control, such as verbal intervention, have not or would not be effective. If head restraints are also used, it may amount to seven-point restraint
    6. Restraint chair: A chair specifically designed to restrain a patient who is in danger of hurting himself or others during a severely agitated episode
    7. Leather, vinyl, or plastic cuffs: Used instead of metal handcuffs to restrain a patient who is in danger of hurting himself or others during a severely agitated episode
    8. Metal handcuffs, shackles, and chains. These are abolished in the MHCA 2017 and strictly forbidden.

STANDARDS REQUIRED

The priority for any health-care provider must be the reduction of aggression and coercion in their facilities. This requires proactive measures to anticipate the risk of violence with the aim to prevent aggression toward staff and coercion toward patients. Person-centered and value-based approaches to care are vital to achieving this. All current guidelines convey the same, clear, and unambiguous message: Proactive and preventative approaches should precede any use of coercive measures. The staff could use evidence-based risk assessment tools such as the Broset Violence Checklist or the Dynamic Appraisal of Situational Aggression – Inpatient Version rather than unstructured clinical judgment alone. Staff should work within a framework that allows de-escalation whenever possible.[11,17-19]

There may be occasions when staff needs to consider the use of physical restraint as a management strategy. The purpose of restraint is first to take immediate control of a serious, significant, or dangerous situation, and second to contain or limit the person's freedom for no longer than is necessary to end or significantly reduce the threat to themselves or those around. Ideally, a multidisciplinary team including psychiatrist, nursing staff, and pharmacists should develop an individualized strategy to reduce the risk of violence, including a pharmacological strategy appropriate for each patient. Such a strategy should have clear aims, clarified target symptoms, a likely timescale for the response to medication, and a maximum total dose.

The person in control of the incident will have to carefully assess the situation and use their own judgment as to what may be deemed "serious" or "significant" before employing physical interventions. Furthermore, any physical restraint used must be justifiable, appropriate, reasonable, and proportionate to a specific situation and should be applied for the minimum possible duration. Restraint should be viewed as a last resort and only used when all other interventions have failed.

An advance directive can help to develop care plans for emergencies. It should be remembered that person-centered care and effective communication should not cease during restraint, as this will help in terms of gaining co-operation and returning autonomy as soon as possible, as well as ensuring that the intervention has therapeutic value and that the therapeutic relationship is maintained.

a. Each facility should provide a therapeutic milieu that supports a culture of recovery, individual empowerment, and responsibility. Each patient will have a voice in determining his or her treatment options. Facility staff should be particularly sensitive to patients with a history of trauma and use trauma-informed care. The following principles of trauma-informed care shall guide restraint practices: assessment of traumatic histories and symptoms, recognition of culture and practices that are retraumatizing, processing the impact of a restraint with the patient, and addressing staff training needs to improve knowledge and sensitivity
b. Ensure that the safety and dignity of patients and the safety of staff are priorities when anticipating or managing violence and aggression. When a patient demonstrates a need for immediate medical attention in the course of an episode of restraint, medical priorities shall supersede psychiatric priorities
c. Restraint must only be used in full compliance of the MHCA 2017
d. Patients should ideally not be restrained in a prone position. Prone restraint should be used only when required by the immediate situation to prevent imminent serious harm to the patient or others. To reduce the risk of positional asphyxiation, the patient should be repositioned to a sitting, standing, or supine position as quickly as possible. Responders should pay close attention to the respiratory function of the patient during containment
e. Restraint must never be used as punishment, for the convenience of staff, or as a substitute for the treatment programs
f. Objects should not be placed over a patient's face. In situations where precautions need to be taken to protect staff against biting and spitting, staff should wear gloves, masks, or clear face shields when possible for purposes of infection control
g. Unless necessary to prevent serious injury, a patient's hands shall not be secured behind the back during containment or restraint. If it is necessary, staff shall be present, within arm's reach, to prevent falling or injury
h. The criterion for release of a patient from restraint is the achievement of the objective, i.e., that the patient no longer represents an imminent danger to self or others. Every restrained patient shall be informed of the behavior that caused his or her restraint and the behavior and conditions necessary for their release. The patient shall be released from restraint as soon as he/she is no longer an imminent danger to self or others.

TRAINING REQUIREMENTS

We recognize that training in restraint techniques is not widespread in India. MHCA 2017 should be seen as encouragement to develop safe and culturally appropriate restraint techniques for Indian health settings that are taught in a systematic and standardized way. Certain principles will have to apply: Staff responsible for or participating in the restraint process will demonstrate relevant competency in the following areas before participating in a restraint event or related assessment, monitoring or provision of care during an event:[20,21]

a. Strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan
b. Use of nonphysical intervention skills as well as bodily control and physical management techniques based on a team approach
c. The safe application and use of all types of restraint devices
d. Observing for and responding to signs of physical and psychological distress
e. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the face-to-face evaluation
f. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary
g. The use of first aid techniques
h. Certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

GENERAL PROCEDURES

The points to be considered while using restraint procedures in general.[22,23] Also, see Table 1 for the checklist before initiating any restraint procedure.

Preventing the use of restraint

1. Use de-escalation techniques to divert, distract, or withdraw. Use available spaces to distract the patient and keep other persons safe
2. Employ breakaway techniques for staff safety while continuing to communicate with the patient
3. Only use taught restraint techniques when restraint becomes necessary.

Initiating restraint use

1. The implementation of restraint shall only be pursuant to an order by a physician (Psychiatrist), if permitted by the facility to order restraint and stated within their protocol. The attending physician (psychiatrist) must be consulted as soon as possible if he/she has not ordered the restraint
2. An examination of the patient should be conducted and shall include:
    a. A face-to-face assessment of the patient's mental status and physical condition
    b. A review of the clinical record for any pre-existing medical diagnosis and/or physical condition which may contraindicate the use of restraint
    c. A review of the patient's medication orders, including an assessment of the need to modify such orders during the period of restraint
    d. An assessment of the need or lack of need to elevate the patient's head and torso during restraint
    e. A decision of whether to continue or terminate the restraint
    f. A decision that the risks associated with the use of restraint are significantly less than not using restraint.
3. Documentation of the examination required above, including the time and date completed, shall be included in the patient's medical record
4. The written order shall:
    a. Be written on the order sheet and included in the patient's medical record
    b. Specify the facts and behaviors justifying the intervention and identify the time of initiation and expiration of the authorization
    c. Specify the type of restraint ordered
    d. Specify the positioning of the patient for respiratory and other medical safety considerations; patients should never be restrained in a prone position
    e. Specify the physical proximity of the staff member assigned continuous visual observation (i.e., within arm's length and outside the room.)
    f. Include any special care or monitoring instructions, including medical risk considerations for age and fragility issues
    g. Include the criteria for release.
5. Prior to or immediately after placing a patient in restraint, he/she shall be searched for potentially dangerous or contraband objects by a staff member of the same gender. Any potentially dangerous/contraband objects shall be removed and documented in the patient's medical record
6. The patient must be clothed appropriately for temperature and at no time shall a patient be placed in restraint in a nude or semi-nude state
7. On the initiation of restraint, the physician/psychiatrist/registered nurse shall inform the patient of the behavior that resulted in the restraint and the behavior, and the criteria reflecting an absence of imminent danger that is necessary for release
8. For patients under the age of 18 years, the facility must notify the parent(s) or legal guardian(s) of the patient who has been restrained as soon as possible, but no later than 24 h after the initiation of each restraint event. This notification must be documented in the patient's medical record, including the date and time of notification and the name of the staff person providing the notification.

Restraint

1. The use of prone restraint must be minimized, and the duration must be only long enough to gain control. Sitting on top of any part of a patient during this process is prohibited. At all times during a prone containment, the weight of the staff shall be placed to the side of the patient, rather than directly on top of the patient. Staff is prohibited from placing significant body weight on the patient, including staff's knees, elbows, and torso

Table 1: Checklist that may be followed while using restraint

Name and describe the behaviors of concern
- Name and describe the behavior
- When did this behavior commence? Is it new?
- How often does it occur?
- When does it occur?
- What appears to be the trigger?
- How is it being interpreted by the patient/people who know him/her?
- How is it being interpreted by caregivers?
- Is the behavior independently observed, i.e., are people forming an opinion based on case notes rather than their own observation?
- Would the behavior change if other issues were addressed? For example, is the patient receiving adequate pain management? Is the patient suffering from an infection or delirium?
- Has a relevant expert assessed the person?
- Has a review been conducted of the medication the patient is being administered?
- What is the risk to the patient if restraint is not utilized?
- What are the risks to others?

Communication and documentation
- Has the patient been informed about the fact that the restraint is going to be used and why? What are their wishes/advance directives?
- Have the people who have an interest in the welfare of the patient to be restrained been consulted (family members, friends, advocate, guardian, etc.)?
- Have the carers who are involved in the administering of the restraint been informed why the restraint is being utilized?
- Has the decision to use restraint, and the reasons for it, been documented?
- If guardians are asked to sign forms, they should be clear about what they are being asked to authorize and whether it is within their powers and duties to do so

Justify the use of restraint
- Is the use of restraint consistent with best practice?
- Are there alternative and less restrictive ways to achieve the stated goals?
- Is it lack of resources which is informing the use of restraint when there may be alternative ways to achieve the stated goals?
- Is the use of restraint expedient and for the convenience of others?
- Why does the person who is administering or proposing the restraint consider it to be in the best interests of the person?
- Are there any risks to the patient if restraint is utilized? How will these risks be managed?
- How have been the competing rights weighed? For example, has the right to dignity been sufficiently considered or the right to safety been considered paramount?
- Has there been compliance with legislation, relevant professional standards and with organizational policy?

Precautions and contraindications for using restraint
- Prevention attempts with alternative restrictive measures
- Revise procedures for assessing medical conditions of psychiatric patients
- Promote staff training in alternatives to physical restraint and the proper use of holding and restraint
- Constantly observe all patients in restraint
- Avoid prone restraint
- With supine restraints, allow patient's head to rotate freely. Do not cover the patient's face with a towel, bag, etc., during therapeutic holding
- Restraint patient is kept away from all dangerous items

2. During containment, all staff involved must constantly observe the patient's respiration, coloring, and any other possible signs of distress and immediately respond if the patient complaints of shortness of breath or not being able to breath, or otherwise appears distressed
3. When containment is initiated, nursing staff must assess the patient as soon as possible, including checking the patient's circulation and vital signs. The patient must be seen and assessed (including respiration and other vital signs) by a nurse within 15 min of the restraint and at least every hour thereafter while the patient is in restraint
4. Unless necessary to prevent patients from injuring themselves or others, the patients' hands must not be secured behind their backs during containment. If this is necessary, the duration must be only long enough to gain control. If the patient is lying down, assistance to a standing or sitting position must be provided as soon as possible.

Monitoring patients in restraint

1. Restrained patients should be on continuous visual observation. Documentation of the patient's condition should occur at least every 15 min by trained staff for behavior, potential injury, circulation, and respiration. Staff shall document their observations, their name, and the date and time of the observation on a restraint form developed by the facility. At least one time per hour, the observation must be conducted by a duty physician
2. Patients in restraint shall be monitored to ensure that his/her physical needs, comfort, and safety are properly addressed. Patients must be offered the opportunity to drink and to go to toilet, as requested, and have a range of motion, as needed, to promote comfort. Staff assigned to do the monitoring shall be competent to recognize the physical and psychological signs of distress
3. For each use of restraint, the following information shall be documented in the patient's medical record:
   a. The emergency situation that resulted in the restraint event
   b. Alternatives or other less restrictive interventions attempted, or the clinical determination that less restrictive techniques could not be safely applied
   c. The name and title of the staff member initiating restraint
   d. The date/time of initiation and release
   e. The patient's response to restraint, including the rationale for continued use of the intervention
   f. That the patient was informed of the behavior that resulted in restraint, and the criteria necessary for release.
4. This documentation should be in the patient's medical record and in a facility, a registry maintained for this purpose

5. A restrained patient must be located in an area not subject to view by other patients and where the restrained patient is not exposed to potential injury by other patients.

Releasing the patient from restraint

1. A patient shall be released from restraint as soon as he or she no longer appears to present an imminent danger to themselves or others and meets the behavioral criteria for its discontinuation. Every restrained patient shall be informed of the behavior that caused his or her restraint and the behavior and conditions necessary for their release. Documentation shall also include the name and title of the staff releasing the patient; and the date and time of release
2. Upon release from restraint, a nurse shall observe, evaluate, and document the patient's physical and psychological condition
3. After a restraint event, a debriefing process shall take place to decrease the likelihood of a future restraint event for the patient and to provide support. Each facility shall develop policies to address the following:
   a. A review of the incident with the patient who was restrained. The patient shall be given the opportunity to process the restraint event as soon as possible and not beyond 24 h of release. This debriefing discussion shall take place between the patient and a preferred staff member. This review shall seek to understand the incident within the framework of the patient's life history and mental health issues. It should assess the impact of the event on the patient and help the patient identify and expand coping mechanisms to avoid the use of restraint in the future. The discussion will include constructive coping techniques for the future. A summary of this review should be documented in the patient's medical record
   b. A review of the incident with all staff involved in the event and supervisors or administrators. This review shall be conducted by the close of the next day after the event and shall address: The circumstances leading to the event, the nature of de-escalation efforts and/or alternatives to restraint attempted, staff response to the incident, and ways to effectively support the patient's constructive coping in the future and avoid the need for future restraint. The facility should document the outcomes of this review for purposes of continuous performance improvement and monitoring. The review findings should be forwarded to the Restraint Oversight Committee
4. Each facility utilizing restraint procedures shall establish and utilize a Restraint Oversight Committee that includes medical staff to conduct at least weekly reviews of each use of restraint and monitor patterns of use, to assure least restrictive approaches are utilized to prevent or reduce the frequency and duration of the use with patients. Even though it is not prescribed by MHCA 2017, it would give credibility to the mental health establishment.

CONCLUSION

Learning to recognize the signs of assaultive behavior and preventing behavior that can escalate and lead to violence are essential for safety. The primary goals of learning to manage assaultive behavior are to preserve safety and dignity and to prevent assaultive behavior before it occurs. However, in mental health care, there can be clinical situations where restraint may be used only in an emergency situation to assure the physical safety of the patient or nearby persons or to prevent significant destruction of property. Restraint must not be imposed in any form as a means of punishment, discipline, the convenience of or retaliation by staff, or because of a lack of staff presence or competency. Training should be developed to allow standardized and safe restraint techniques to be taught throughout India.

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