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Viewpoint/Perspectives (Theme Section: Mental Health Care Bill, 2013)

Restraint and Seclusion in India

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Abstract

Psychiatric management in India often includes the practice of restraint and seclusion of violent and difficult to control patients, both in inpatient medical facilities and in places of traditional healing. However, without any informed guidelines and regulation, these practices have flourished from necessary last resort to accepted ways of control. The upcoming draft mental health bill have now provided with a set of basic guidelines for preventing restraint. The scientific literature is also sparse on the subject from India, despite a robust body of evidence being available from the Western literature. This review, summarizes the evidence from India, looks into the causes and outcomes of restraint and seclusion and also discusses methods and stratagems that might be beneficial for reducing restraint and seclusion in the country.

Key Words: *Coercive treatment, human rights, psychiatric management, restraint, seclusion*

Introduction

Seclusion and restraint have been a way of life when it comes to managing mental illness in India; be it in a family looking after its mentally ill member within the home or in a mental health treatment facility with inpatient services, such as a general hospital psychiatry unit or a mental hospital. Even in dargahs or other places of worship that are thronged by hordes of people with mental illness in search of relief, very often, the mentally ill are secluded or chained for days together with the intention of controlling them.[1,2] Our cinema reflects this reality, with films that sensationalize depictions of chained persons in mental asylums inadvertently invoking fear and dread of mentally ill people and mental health facility in the viewers' minds.[3-5]

Ironically, despite its widespread use, seclusion or restraint hardly ever becomes a topic of discussion, in the medical literature, or in human rights groups in our country. It is considered a "done thing," a part of standard protocols for management, and using it in any situation is not considered harmful or risky, or a violation of the rights of the mentally ill person. There has been no attempt to standardize protocols about when to consider seclusion and restraint, and what guideline to follow. Recently, the draft of mental health care bill has focused on this issue;[6,7] however, legislation cannot entirely resolve the inherent problems, as we shall discuss later in the paper.

This is in stark contrast with developed countries, where clear definitions of seclusion and restraint have evolved, alongside guidelines about their application in the clinical settings. Moreover, there are well-defined roles for each category of staff (psychiatrist, psychiatric nurse, social worker, etc.) in the clinical team. A brief and selective review of the major themes addressed in the literature is provided here in order to highlight the issues and motivate toward a more general discussion of seclusion and restraint in this country.

Current Status in India

Most of the information regarding the use of restraint or seclusion in India has been through newspapers. The tone of such reports has been to sensationalize the event, rather than to focus on the problem or issues related to it, and the focus is only on the event to the exclusion of the person. The report does not attempt to address the question of mental health gap, or the violation of rights of the victims. Thus, newspapers have reported on the chaining of mentally ill people in various faith-healing places, or sometimes by their own families. However, the worst kind of indignity mentally ill people could suffer has been to seclude them into prison along with people

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charged with criminal cases.[8] Most of the prisons in India have a number of mentally ill persons languishing there for as many as 30 years. In a series of instances, it was only with the intervention of the National Human Rights Commission[9] that they could be released.

Very few reports from India on this topic have entered the medical literature. In one of the earlier studies, Akhtar and Jagawat[10] lamented the fact that while India was approaching the 21st century, the number of patients brought chained and roped to psychiatric outpatient departments had remained unchanged. They wondered why some patients were brought chained in a mental hospital setting, while others were not. In a cross-sectional study, they found that besides aggressive and assaultive behavior, there seemed to be many other socioeconomic and clinical variables leading to restraining a patient. Thus, a restrained patient was more likely to be younger, of a lower socioeconomic status, from a rural background and was more likely to be diagnosed as manic. Ropes and iron chains were commonly used, leading to injuries such as abrasions, lacerations, and infected wounds. The justification provided by the relatives for restraining their own patients were violence or fear of violence, wandering away, ease of transporting the patient to the treatment facility, etc.

While discussing ethical issues in psychiatric practice, Agarwal[11] only mentioned in passing the issue of restraint as a violation of basic human rights of mentally ill persons. In an editorial, Goswami[12] pointed out the lack of studies on the consequences of restraint and seclusion on patients and family members. As the use of such practices in psychiatric patients may still be viewed as a "necessary evil" in a real world scenario,[13] there is an urgent need for guidelines. This becomes all the more necessary in view of the growth of consumer movements and focus on human rights.

In a survey, the first of its kind, Khastgir *et al*.[14] obtained opinions of 278 psychiatrists on their practice. They found that, although restraint was highly prevalent, with as many as 80% using restraint at some time or the other; none of the psychiatrists ever advised seclusion to manage a psychiatric patient. The common reasons for restraint were violence and agitated behavior, threats of self-harm, or delirium, and acute mania remained the most common diagnosis. Abrasions were found to be the most common injuries. All the respondents felt the need for a set of operational guidelines for prescribing physical restraint.

In India, many families, especially in the rural areas, are forced to restrain their mentally ill relatives and isolate them in a secluded room within the family home. Many such patients have either never received any psychiatric treatment, or the family has run out of its resources to continue treatment, which is found to be expensive and not adequately effective. This state of affairs is a direct reflection of huge mental health gap that exists in our country. One family member remarked very poignantly:

> "Doctor Sa'ab, it is not that I do not love my own son; I keep him chained and locked up only because otherwise he wanders away in disheveled state, and becomes a victim of public's cruelty, which throws stones at him and chases him away" (Gupta, 2013; personal communication).

While no clinical researcher, human rights, or consumer activists group have paid attention to this aspect of management of mentally ill person in India; in developed countries, mental health professionals have extensively and systematically studied this issue, focusing on a multitude of dimensions. A number of countries in Europe (The Netherlands, Norway, Ireland, and the UK in particular), various states of the USA, Australia, and New Zealand have come out with guidelines about the use of restraint and have also suggested means to reduce the frequency of restraint as well as seclusion, which merits consideration.[15-22]

Reasons for Using Seclusion and Restraint

Perkins *et al*.[13] elicited nurses' views and experiences on the use of physical restraint. The study found four factors that influenced decision-making to restrain a patient: contextual demands, lack of alternatives, the escalatory effect of restraint itself, and perception of risk. Nurses viewed restraint as a necessary evil, justified on the basis of the unpredictable nature of mental illness and the environment in which they worked.

In a study on the use of seclusion in the Netherlands, Janssen *et al*.[23] went through the governmental database and found that one in four psychiatric units was using seclusion, and the average duration of seclusion was 16 days; on both these accounts, the rates were higher as compared to other European countries, the USA, or Australia. The reasons were: different definitions, inconsistent methods of registration, different methods of data collection, and an inconsistent expression of the seclusion use.

Even in countries which have well laid out guidelines on restraint, the restraint itself may not be a reportable incident. On the other hand, violent incidents by patients may figure in official reports, or be the focus of research. Stewart *et al*.[24] reviewed the use of manual restraint of adult psychiatric inpatients. They found that up to five episodes of manual restraint might be expected per month on an average in a 20 bed ward, with episodes lasting around 10 min, and about half involving restraint of patients on the floor, usually in the prone position. Manually restrained patients tend to be younger, male, and detained under mental health legislation.

One of the most common reasons for seclusion and restraint cited in the clinical setting remains violence and

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aggression. Wright[25] compared physical restraint with other forms of interventions that may themselves reduce the chances of physical restraint; thus, appropriate design of the wards, effective alarm systems, reducing blind spots (where patients are not visible), well trained and adequate number of staffs to establish effective therapeutic relationship, staff's own behavior and attitude are some of the crucial elements needed to reduce the incidence of physical restraint. Frequently, restraint is applied in a manner that is degrading and an insult to a person's self-esteem and dignity. The guiding principle should be to use physical restraint only when other alternatives have been ineffective or are not reasonably practicable and to use the least intrusive means of restraint possible under the circumstances. While the use of physical restraint in care settings gives cause for ethical concern, it should also be remembered that its use does not preclude other approaches to care.[26]

Adverse Effects of Restraint

There is a close relationship between the use of restraint and seclusion and serious adverse events. The known adverse events associated with the use of restraint and seclusion include dehydration, choking, circulatory and skin problems, loss of muscle strength and mobility, pressure sores, incontinence and injury from associated physical/mechanical restraint, injury from other patients, increased psychological distress and, in rare circumstances, death.[27-31] It is essential that for the safe management of patients, restraint and seclusion be used in a manner consistent with defined protocols. Besides physical injuries, the act of secluding a patient may undermine his/her dignity and self-esteem to no end. Carers may also be left with an unpleasant experience when they find their own family member isolated in a dingy room with poor hygiene, lighting, ventilation, and totally cut-off from communication. The sight of a family member physically tied down can also be a traumatic experience. Not only mentally ill person and carer, but nursing professionals have also not infrequently felt traumatized by such an experience.[29,32]

We have been humbled by the most tragic incident that could have happened in the history of care of mentally ill people in India, the Erwadi tragedy. The Erwadi tragedy was a fire accident, which occurred on August 06, 2001, when 28 mentally ill people perished in the fire in a dargah, which was famous for curing mental illnesses through the powers of holy water. All these people were bound by chains and ropes to the trees and had no chance to escape the fire or be rescued.

> "Their death highlights the deplorable state of mental health care in the country and the need for the government to reach out to the mentally ill. Caught up in economic, social, cultural, religious and legal problems, most of the mentally ill persons are deprived of the right kind of treatment. Many of them end up being exploited at homes that are set up illegally. They are denied even the basic human rights."[33]

Eliminating Seclusion and Restraint

Experts have questioned if seclusion or restraint has any therapeutic value while it may indeed bring harm to the patient. A Cochrane review by Sailas and Fenton[34] noted that while there was an absence of control studies "the use of seclusion and restraint could lead to greater morbidity and mortality than other drug and nondrug approaches." There have been concerns expressed by all stakeholders about the use of restraint: the lack of identified good practice or agreed upon clinical standards for the use of restraint, the inappropriate use of interventions and variation in practice, for example, using the threat of restraint or seclusion to coerce particular behaviors; a lack of staff knowledge or skills to identify and use alternative interventions; a lack of training about restraint practices; and a lack of documentation and clinical audit of restraint practices; and aggressive and violent behaviors. The staff is inadequately trained to identify the triggers or early warning signs of violence or aggression (among the most common reasons) and in deescalating the situation. If mental health facilities intend to reduce or eliminate these practices, they have to be sensitive to the factors, which tend to create a situation leading to seclusion and restraint, and address those factors.[35,36]

The United Nation's "principles for the protection of people with mental illness and the improvement of mental health care"[37] states that:

> "Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient."

These UN principles, crystallized from country-wide policies and scientific literature represent a fair compromise position. Rather than suggesting a complete absence of restraint, the policy pragmatically provides targets for practical, humane, and safe restraint with a specific focus on responsibility sharing and stake-holder cooperation. It abhors restraint as a measure of patient control and

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stresses that strict rules be set, to stop restraint being used for "nonclinical" reasons. The UN principle also calls for proper documentation for situations, process and duration, authority for restraint, and outcome of restraint. Indeed, fixing responsibility through strict documentation might be one of the first steps to prevent situations where restraint is used tacitly by ward staff to subdue, intimidate, or control difficult but nonaggressive patients.

The proposed Mental Health Care Bill[38] of India, which is pending in the Parliament, has drafted some guidelines on the use of restraint and seclusion for the mental health facilities:

- Physical restraint or seclusion may only be used when it is the only means available to prevent imminent and immediate harm to person concerned or to others
- Physical restraint or seclusion may only be used if it is authorized by the psychiatrist in charge of the person's treatment at the mental health establishment
- Physical restraint or seclusion shall not be used longer than is absolutely necessary to prevent the immediate risk of significant harm
- The medical officer or psychiatrist in charge of the mental health establishment shall be responsible for ensuring that the method, nature of restraint or seclusion, justification for its imposition, and the duration of the restraint or seclusion are immediately recorded in the person's medical notes
- In no case will restraint or seclusion be used as a form of punishment or deterrent, and under no circumstances shall lack of staff at the mental health establishment be permitted as a reason for the use of restraint or seclusion
- The nominated representative of the person with mental illness shall be informed about every instance of seclusion or restraint within a period of 24 hours
- A person who is placed under restraint or seclusion shall be kept at a place where he or she can cause no harm to himself or herself or others and under regular ongoing supervision of the medical personnel at the mental health establishment
- All instances of restraint and seclusion at the mental health establishment shall be included in a report to be sent to the state panel on a monthly basis
- The state panel may from time to time, make regulations for the purpose of carrying out the provisions of this section
- The state panel may order a mental health establishment to desist from applying restraint and seclusion if the panel is of the opinion that the mental health establishment is persistently and willfully ignoring the provisions of this section.

The guidelines are a welcome addition, as it highlights the issue of restraint and seclusion in mental health care settings. Overall, they are in conformity with the UN guidelines, and parallel best practice documents from several other countries (vide infra). The draft accepts that restraint may be a necessary evil and, therefore, unavoidable in certain circumstances, but by highlighting it in the policy, it provides the act of restraint and seclusion a measure of seriousness, which was previously lacking. The drafts' focus to limit restraint to prevent only immediate harm to the patient and others is commendable, as is its denouncement of using restraint "as a form of punishment or deterrent." Like most international guidelines, the draft also talks about minimal time restraint, maximum safety in restraint and stake-holder cooperation in the form of nominated representative's awareness of the process. A final merit of the draft is in fixing the responsibility for restraint, via defining roles, responsibilities, and documentation. Thus, every event of patient restraint must be authorized by the "medical officer or psychiatrist in charge of the mental health establishment," who would be responsible not only for the act but also for the process, nature, and justification of the event.

Despite debate on merit and practicality of many of the included clauses, India's attempt to set its records right in terms of human rights in mental health is heartening. The primary shortcoming of the draft bill is that by nature, it is regulatory rather that guiding. The bill, therefore, provides an inordinate focus on control and reporting of restraint but fails to guide mental health establishments or professionals on how to minimize its use, avoid adverse effects, educate or destress all the stakeholders and take steps to decrease the antecedent causes resulting in restraint. Secondly, many events of restraint in resource-poor countries such as India are not events of malice, but due to the unavailability of alternate means. The absence of any directive in the bill to improve resources in the form of provision of quiet rooms, seclusion areas or mandatory training is a missed opportunity. A third problem with restraint reduction lies in its practical implementation. In the absence of any national guideline to fall back as minimum standards of care, the "medical officer or psychiatrist in charge" is essentially left all alone to decide on where and how to use restraint, which one may argue as the current practice anyway. What will happen to agitated patients in primary care situations without medical officers and psychiatrists also need to be thought about. Finally, restraint reporting procedure needs to be elaborated and standardized if it is to be of any value, as restraint is not a single homogenous event but a myriad of situations of varied severity and with different risk for potential harm.

This draft bill does provide a wakeup call and, therefore, should be taken as an opportunity, rather than an impediment, to improve mental health care delivery in our country. Restraint reduction guidelines and standards of care documents on process and protocol of restraint and seclusion needs to be developed. National uniform restraint reporting requires to be implemented. However more importantly, awareness of various effective and safe

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restraint reduction techniques needs to be generated in all cadres of mental health care workers. There is, therefore, a huge need and scope to design and implement courses, not only for restraint reduction but also on aggression and violence management in a psychiatric setting.

The Way Forward? Guidelines and Position Statements

The debate about the appropriateness of seclusion in inpatient settings in the 21st century continues with powerful and often emotive arguments from those who view it as an anachronistic and punitive form of ward management,[39,40] and from others who see it as a useful emergency measure to protect individuals from imminent harm.[41] This debate has led to the formulation of statements regarding the use of restraint and seclusion in the mental health establishments.

The aim of such documents are varied with some focusing on training of staff and others stressing on monitoring the use. Training staff for the safe and effective use of restraint and seclusion, including the techniques of restraint and duration[42] with the practical focus on maintaining the safety of the patient, other patients, and staff members seems to be effective when the outcome considered are injury due to restraint. However, critics maintain that this approach is narrow, and the desired outcome should be a reduction in the overall rate of coercive measures in the ward, to be achieved by training on restraint reduction methods, rather than on safe restraint techniques.[43] Hence, two parallel themes are evident: one aimed at ensuring safety in mental health facilities, which may include the use of coercive treatment, and the other aimed at the specific elimination of restraint and seclusion in the management of aggression. The authors believe that it would behoove practicing psychiatrists to be aware of both sides of the issue: restraint reduction may be a desirable outcome, but practically, it seems unlikely that it would be entirely possible to eliminate the use of such measures in all psychiatric settings (emergency, acute care, long-stay, correctional facilities).

Authoritative guidelines are available from national psychiatric bodies and governments in the USA, the UK, and Australia. In addition, guidelines at a state level or at the level of individual institutions are also available for some authorities in the UK, the USA, and Australia. In some of these, the stated aim is the reduction, minimization, or even the elimination of restraint and other coercive practices.[43] Measures aimed at these include enhanced monitoring of every coercive event occurring in the unit, along with strict guidelines to fix responsibility on when, where and who can order a restraint and seclusion. Such process changes appear instinctively meaningful, as without guidelines, in India, often there are patient reports of orderly or patient helper ordering restraint to control or intimidate the patient. Monitoring of the restrained patient to ensure physical safety and minimize duration is essential, and guidelines suggest having dedicated nursing staff and frequent assessment by clinician for every restrained patient for the whole duration of restraint as beneficial.

Guidelines also stress on the need to have a uniform reporting of restraint events across units, hospitals and country, to make the data understandable. For example, one restraint per week might have a completely different meaning for a chronic geriatric ward with long stay patients when compared to an acute emergency ward. Therefore, while reporting restraint rates, consideration should be made for the type of the facility, patient admission rate, the average duration of patient stay, and also the duration of the restraint.

Training staff in restraint reduction techniques features prominently in most guidelines. Trained staffs are more confident, and therefore resort to physical restraint less often. In addition, in long-term, training staff helps to prevent caregiver burnout, provide more job satisfaction, and decreases work anxiety. Multiple short and long term training courses have been cited, with most of them highlighting the benefits of talking calmly, talking while sitting, and providing a silent space for the agitated patient. Improving patient care facilities, preventing crowding, adequate construction of ward structures to minimize physical risk and provide for closer observation (e.g., maintaining a line of sight), have also been suggested.

Current guidelines do have certain limitations acknowledged by the authors themselves. Most important among these are the absence of generally accepted definitions and standards for what constitutes physical restraint, chemical restraint, or seclusion. An evidence base that would guide the appropriate use of such interventions is also absent. An attempted Cochrane review failed to identify a single controlled trial that addressed this question.[44] Thus, there is a lack of clarity between guidelines regarding the appropriateness of specific interventions and with respect to the choice for a given patient. In the absence of such evidence, current guidelines must be seen as expert opinion or consensus statements only.

Conclusions

Restraint and seclusion remain widespread in psychiatric practice in India. While they may be necessary in a minority of patients under very specific circumstances, the use of such measures is fraught with risks to patients and staff, besides contributing to stigma and discrimination, vitiating the working environment and being a violation of the human rights of the mentally ill. As legislation evolves, it is likely that restraint and seclusion will be more tightly regulated, and this would be in line with international practices and the concept of "least restrictive care." The authors believe that it is time for mental health practitioners

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to confront the issue of restraint and seclusion (and coercive treatment in general) and seek a consensus on whether such measures ought to remain a part of psychiatric practice in our country, and if so, what should be done to ensure that their use is appropriate to the needs of all stakeholders, and in line with ethical principles.

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