Physical Restraint: A Historical Review and Current Practice

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ABSTRACT
The use of physical restraint in the management of psychiatric patients has a history dating back at least 300 years, with its origins in society finding a *quid pro quo* legal justification for taking action against unruly citizens. It became increasingly obvious through the years that such practices were violations of patients’ civil rights. The consumer movement in mental health in the 1960s and patients’ rights cases involving the 14th amendment to the US Constitution that soon followed changed the views and policies related to the use of physical restraint in psychiatric patients. This article discusses current practices and strategies to minimize the use of physical restraint.

**HISTORY OF RESTRAINT IN PSYCHIATRIC PATIENTS**
Restraining patients to stop their assaults toward others or themselves has a history dating back at least 3 centuries. Restraint can take 1 of 3 forms: (1) physical restraint is the involuntary restriction of a patient’s freedom of movement by one or more staff members, (2) mechanical restraint is the involuntary restriction of a patient’s freedom of movement with straps or portable restraint boards; and (3) chemical restraint is the involuntary restriction of a patient’s freedom of movement with a medication.

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sation in their unruly behavior. Although the benefit of this intervention was certainly not accepted by the person (who often ended up being placed in stocks in the middle of the town square), it still provided legal justification for the action.

For the next 200 years, reducing the use of restraint became a cause of reformers, mostly psychiatrists who were superintendents of mental health facilities. The most famous was Philippe Pinel, who in 1794, during the “Reign of Terror” of the French Revolution, delivered an address to the Revolutionary Council advocating that mental patients be accorded the same rights as promised in the Revolution’s Declaration of the Rights of Man (written in 1789),\(^{2,3}\) namely liberty, freedom, and to be treated as brothers and sisters. This required their release from physical restraint unless there was evidence of imminent physical danger, and therefore freedom from being chained almost perpetually to walls.

In 1856, John Conolly, the superintendent of the Middlesex Lunatic Asylum at Hanwell, published Total Abolition of Personal Restraint in The Treatment of the Insane,\(^4\) describing his practice there. What both Pinel and Conolly noted was the tendency for the attendants at these facilities to abuse and assault patients, particularly in response to verbal threats and gestures of defiance. Reports of these abuses and prolonged mechanical restraints led the British Parliament to establish a “Lunacy Commission” in the 1840s,\(^5\) whose mission was to pressure mental health asylums, through their superintendents, to diminish or abolish the use of restraint on patients in their care.\(^1\)

In American, there was a more positive view of the use of restraint, as it was deemed beneficial for the peculiar nature of “American violence” according to Eugene Grissom, and because it was beneficial for the patient.\(^3\) Special boxes were built in which to place agitated patients. Well-known psychiatrists such as John Gray, who was the editor of the American Journal of Insanity, agreed with this justification.\(^2,5\) This prompted an editorial in the Lancet in the 1870s by John Charles Bucknill,\(^6\) an English psychiatrist who had visited asylums in America, in which he stated that the reliance on restraint was an infernal barrier to the care of mentally ill patients. The difference of opinion between American and English psychiatrists on the issue of restraint seemed to be that the American physicians saw restraint as a procedure ordered by a physician in his or her role as the caretaker of the patient. The English psychiatrists, however, saw themselves as part of a team that included mental health staff, who required governance in the application of restraint.

These debates continued to the end of the 20th century. The consumer movement in mental health in the 1960s brought concerns about the use of restraint to public attention.\(^6\) This set off a decade of regulatory and administrative efforts to curtail the use of physical restraint and to provide education about avoiding its use, to monitor all restraints at all times, and to collect data about restraint rates and incidents for further reduction efforts.

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Sufficient exists in many forms, including legislative, judicial, administrative, and professional. This has been amplified by the American Journal of Psychiatry’s advocacy in 1969 that during the previous 10 years, 140 patients in the United States had died as a result of physical and mechanical restraint.\(^11\) Many of these were children who had died of asphyxiation, either due their chest being compressed by the person(s) restraining them or to the child’s restraint position.\(^11\) This set off a decade of regulatory and administrative efforts to curtail the use of physical restraint and to provide education about avoiding its use, to monitor all restraints at all times, and to collect data about restraint rates and incidents for further reduction efforts.

**Curtailing the use of restraint**

Both the Joint Commission and the Center for Medicare and Medicaid Services (CMS), which accredit most hospitals and psychiatric residential facilities, established guidelines\(^12\) for use of restraint. This is a lengthy document, but the relevant CMS Standard summarizes it as:

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ways to communicate and listen to each patient about their treatment preferences, and ways that could promote deescalation of anxiety- or anger-provoking situations. Two major programs providing these strategies are collaborative problem solving, and the trauma informed care curriculum of the National Association of State Mental Health Program Directors.

Supplementing these efforts were specific programs aimed at de-escalating a patient already in crisis, with use of physical or mechanical restraint as the last resort. Such programs included Cornell University’s therapeutic crisis intervention and the Crisis Prevention Institute’s non-violent therapeutic crisis intervention.

**Restraint Application**

Both the Joint Commission and CMS limit the use of patient restraint (physical, mechanical, and chemical) to situations in which the patient is an immediate danger to himself/herself or others. This means that patients cannot be restrained as punishment, reprisal, for rowdy behavior, or because of refusal to follow rules or to take medications. Any restraint can only be ordered by a licensed medical practitioner (LMP), which, depending on the state, could include physicians, nurse practitioners, physician assistants, and sometimes psychologists. The restraint has to be terminated as soon as the patient shows evidence of having regained self-control. Restraints cannot be ordered pro re nata (ie, as needed).

Combining restraint with seclusion is not permitted. Also, if a patient is being given an intramuscular medication for a chemical restraint and is being physically restrained at the same time, then they must be noted as two different restraints, so orders, monitoring, and data collection are required for each.

**Restraint Monitoring**

According to the Joint Commission and CMS regulations, all restraints require continuous visual monitoring. All patients must be examined by a trained professional in the use of seclusion and restraint and alternatives within 1 hour of the restraint order. Any restraint lasting longer than 1 hour has to have a follow-up order from an LMP. If the restraint lasts longer than 1 hour for a patient younger than age 10 years, 2 hours for a patient age 10 to 18 years, or 4 hours for patients older than age 18 years, then it has to be accompanied by a face-to-face encounter with the ordering physician or the designee. In all cases where the restraint is terminated prior to the end of the ordered time, there has to be a face-to-face visit with the ordering physician or the designee within 24 hours. All of this information has to be entered into the patient’s medical record, and can then be used as data for restraint-reduction efforts.

All restrained patients have to be monitored for vital signs, respiratory status, and dehydration. Because asphyxiation is a common cause of restraint deaths, the use of pulse oximetry to monitor oxygenation during restraints has been suggested and supported by clinical experience. Generally, the participation of the treating physician should be concluded with a debriefing of the patient by a staff member.

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physician or therapist in the physical restraint of patients is not recommended, as it can void the trust of the patient and disrupt the therapeutic alliance.20

**DATA COLLECTION**

All instances of restraints should be concluded with a debriefing of the patient by a staff member, preferably one involved in the restraint, as well as a separate staff assessment of the restraint. The goal of this activity is to prevent future restraints by making changes to the treatment plan, staff/patient interactions, and, where appropriate, with family input. This activity is important because in many cases the immediate precipitant to a restraint is an issue within the family of the patient, rather than a disagreement with another patient or staff. Information about the total number of restraints and their length of application in a fixed time period (eg, monthly) can be used to examine the restraint process in an individual unit, whether it is the inpatient or emergency department.

Information about the repeated restraint of a patient can be used to involve the family, staff, psychiatrist, and patient in revising the treatment plan to prevent recurrence of use. Indeed, when patients are restrained several times during the course of a day, an immediate review of the circumstances and suggested alternatives are a regulatory requirement.21

**CONCLUSION**

We have come a long way in understanding of our responsibilities in the management of troubled patients, from the *quid pro quo* of the village stocks, to shared working through of stress, misunderstandings, and knee-jerk reactions with patients. However, improvement is always possible, and perhaps technologies such as virtual reality will provide new understandings of restraint situations as it has for other mental illnesses such as anxiety and posttraumatic stress disorder. Meanwhile, our constant efforts to use alternatives and to minimize physical restraint is an abiding commitment for those who work in this field.

**REFERENCES**