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Attitudes Towards the use of Mechanical Restraints in Psychiatric Facilities: *Contrasting Practices In Ireland and Ontario*

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Ethical Discussion

The use of restraints on patients with mental illness is controversial within healthcare and society at large.

One must balance the liberty and safety interests of patients and staff to minimise harm and maximize freedom. The inhumanity of inappropriate restraint use in hospitals has been portrayed in the media and popular culture. Restraints must only be used with proper legal authorization. Ethical issues related to the use of restraints arise when considering patient autonomy, power imbalances between patients and staff, gender differences, and the safety of all persons involved. The term "restraint" is broad and its meaning can vary across different settings. For example, in the province of Ontario, in Canada, restraint is defined under the Mental Health Act 1990 as to

"place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient." [1]

In psychiatry, a restraint can be categorized as environmental, chemical, or physical. Environmental restraint involves limiting the patient's access to their surroundings by keeping them in seclusion rooms or locked units. Chemical restraint involves the use of psychotropic medications to place a person under control to manage harmful behaviours and prevent their occurrence. Lastly, physical restraints or mechanical restraints involve limiting the patient's bodily movement by means of healthcare staff or security holding him or her down or using devices such as lap belts, wrist restraints, pelvic restraints, or sheets. Restraint is not a form of treatment to which a patient consents and should only be used when less intrusive measures to control behaviour have been considered. Least restrictive measures should be considered first, since all forms of restraint can be traumatizing for the patient [2].

Having reviewed the literature and completed psychiatry placements both in Ireland and Ontario, I have learned that these settings have different attitudes towards the use of mechanical restraints. While both agree that least restrictive measures need to be considered first, there appears to be more reluctance towards using mechanical restraint devices in Ireland than in Ontario. Conversely, this does not imply that in Ontario mechanical restraints are preferred, simply that this approach is more commonly used. Between 2006 and 2010, approximately one quarter of psychiatric inpatients in Ontario were restrained, and of that, 20.7% were restrained by mechanical or physical means [2].

During my psychiatry placement in Ontario, there were few instances when I witnessed a patient being restrained. In these circumstances, after failed attempts to control an aggressive situation with verbal talking-down techniques and oral PRN (as needed) medication, the patients were placed in seclusion. They were subsequently monitored via a room camera and staff attending periodically to check on their wellbeing. The only time I saw a patient in mechanical restraints was when they were being moved from the maximally secure facility to the minimally secure unit for treatment. No form of restraint is consistently more traumatizing for a patient than another, and by no means should it ever be used as part of the patient's treatment. Additionally, there are risks and negative outcomes related to each form of restraint. However, understanding the risks, evaluating the current situation, and having the option to use different modalities of restraint can be beneficial for both patients and staff. For example, it may not be safe to use chemical restraint in certain patients based on their medical and drug history, as it can lower seizure threshold, precipitate respiratory depression or cardiac arrest, or result in neuroleptic

malignant syndrome [2]. In these patients, environmental or mechanical restraint would be a safer option; however, these are not without consequences either. Environmental restraint can lead to a patient feeling isolated, stigmatized or hopeless, and can increase suicidal ideation and self-harm [2]. Physical restraints also carry some of these risks in addition to thrombosis, blunt trauma, and even death [2]. Patients who are restrained need to be carefully monitored to mitigate some of these risks [3]. While mechanical restraint is used under specific circumstances in Ontario, this is not default practice for challenging behaviours, and other techniques are considered first.

In Ireland, only one psychiatric facility, the Central Mental Hospital in Dublin, is approved to use mechanical restraints [4]. In 2016, this facility reported using mechanical restraints on less than five occasions [4]. Under legislation of the Irish Mental Health Act 2001, "a person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules."[5] The Mental Health Commission implemented rules in accordance with this section which states, "a person may not be placed in bodily restraint or seclusion unless it is absolutely necessary or as a last resort."[6] In 2016 there were 52 approved centres in Ireland for the use of physical restraint, which involves using physical force, not devices, to restrict movement [7]. Abandoning the use of mechanical restraints certainly has commendable benefits such as increasing patient autonomy, moving away from previously cruel practices, and preventing injury to patients and staff. From my experience with psychiatry in Ireland, the thought of using mechanical restraints on psychiatric patients was met with disdain by mental health professionals and was perceived as reverting to inhumane practices. While there is no denying that psychiatry has a dark history of treating mental illness, and current practices can still be improved, the appropriate use of mechanical restraints theoretically should not pose more risk than any other form of restraint. However, the justification to remove the use of mechanical restraint from practice in Ireland holds merit and allows for comparisons in practice to be made.

The use of restraints in patients with mental illness is controversial. However, considering risks and benefits to patients and staff from all forms of restraint allows healthcare providers to challenge current practices and beliefs and lead to improvements in care. The traumatic effects of restraint on patients cannot be ignored. Sensitivity and respect always need to be maintained when they are used. Having observed practices in both Ireland and Ontario, I conclude that there are valid points to be made on both sides of this ethical debate. Perhaps developing less harmful techniques to manage challenging behaviours can make psychiatric facilities and hospitals as safe as possible for patients and staff, and efforts should be made to strive towards this.

References

1. Mental Health Act, R.S.O. 1990, c. M.7 [Internet]. [cited 2020 Jun 2]. Available from: https://www.ontario.ca/laws/statute/90m07/v5

2. Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, et al. Module 13d: Mental Health Care: Seclusion and Restraint: When All Else Fails [Internet]. [cited 2020 Jun 2]. Available from: www.patientsafetyinstitute.ca

3. Sethi F, Parkes J, Baskind E, Paterson B, O'Brien A. Restraint in mental health settings: Is it time to declare a position. Br J Psychiatry. 2018 Mar 1;212(3):137–41.

4. Restrictive Practices: Use of Seclusion and Restraint Activity Report 2016. Mental Health Commission [Internet]. Available from: https://www.mhcirl.ie/File/restrict_prac2016.pdf

5. Mental Health Act, 2001, Section 69 [Internet]. [cited 2020 Jun 2]. Available from: http://www.irishstatutebook.ie/eli/2001/act/25/section/69/enacted/en/html#sec69

6. Reidy M. Rights and wrongs of patient restraint. WIN. 2008;16(2):22-23. Available from: https://www.inmo.ie/tempDocs/legal_Feb08.pdf

7. Mental Health Commission (2009), Code of Practice on the Use of Physical Restraint in Approved Centres. Version 2. (Dublin). Available from: https://www.mhcirl.ie/File/Revised_COP_PR.pdf