Principles for the Elimination of Restraint

An ICSPP Report

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for The Joint Commission on Accreditation of Health Care Organizations

This report is offered in response to the Joint Commission's request of February 18, 1999 for ICSPP's recommendations on "restraint use and therapeutic holding." This report focuses on two aspects of your inquiry: "Criteria for the use of restraints in individuals with mental illness" and "Effective alternatives to the use of restraints." ICSPP offers ten specific recommendations:

(1) Restraint should be defined as broadly as possible in order to facilitate the goal of reducing coercion as much as possible in health care organizations.

(2) Restraint can be defined as the use of force or the threat of force for the purpose of controlling the actions of a person. Restraint includes a broad range of activities such as the use of "take downs," "therapeutic holding," and other bodily interventions; isolation rooms; strait jackets and four point restraints; and neuroleptic drugs and other central nervous system depressants. The definition of restraint can also be broadened to include any restriction on the individual's freedom to reject a specific treatment or to leave the facility or setting. In this regard, involuntary treatment of any kind should be viewed as a form of restraint.

(3) Restraint should be limited to acute emergencies involving threats to the physical safety of people, and only when other non-coercive methods are clearly ineffective.

(4) The use of restraint should be viewed as a therapeutic failure. Conversely, it should never be viewed as "therapeutic." The attempt to impose "treatment" by force is always counterproductive -- creating humiliation, resentment, and resistance to further treatment that might be more effective. Even if a hypothetical use of "therapeutic holding" could be proposed for specific situations, the overall therapeutic disadvantages of restraint are sufficient to rule it out as a treatment alternative. For these reasons, the

concept of "therapeutic holding" is self-contradictory and unacceptable in a health care setting.

(5) Most violence perpetrated by patients and inmates in psychiatric settings is the direct result of actions initiated by health care staff, including the use or threat of force, ridicule and humiliation, lack of respect for basic human needs and rights, and especially the failure to make a meaningful relationship with the individual. Before resorting to restraint, the staff should immediately examine the aggravating role of its own omissions or commissions, and especially focus on factors disrupting the relationship with the individual.

(6) Most violence in any setting is motivated by feelings of humiliation. To avoid the use of restraint, to create a therapeutic environment, and to maintain a high standard of ethics, all health care settings should aim at eliminating humiliation and encouraging respect. This requires empathic attention to the feeling and needs of clients or patients.

(7) Patience is an antidote to the use of restraint. In most cases, avoiding direct conflict or confrontation with an individual who is upset or angry will reduce the likelihood of an adverse outcome.

(8) Relationship is the single most important therapeutic modality for ameliorating threats of violence, emotional crises, and the need for restraint. Too much emphasis is placed on becoming skillful in the use of restraint. Much more emphasis should be placed on becoming skillful in the development of caring, respectful, empathic relationships during time of stress and conflict. Almost all "emergency" situations in which restraint is used can be better resolved by a non-coercive, caring intervention from a person willing and able to spend time with the upset or angry individual with the aim of peaceful conflict resolution.

(9) All psychiatric and health facilities should conduct regular training programs on the handling of emotional crises or psychosocial emergencies through empathic, caring relationship and conflict resolution without the use of restraint.

(10) As a part of informed consent for potential patients, all health care organizations should be required to make public their rates of seclusion and restraint, and to compare them to regional or national averages.

While the Joint Commission cannot itself change state law, it is important to recognize the harmful effects of involuntary treatment. As long as the law endorses involuntary treatment, the use of restraint will persist and will interfere with the delivery of genuinely helpful treatment. Involuntary treatment motivates doctors to use coercion rather than to build therapeutic, empathic relationships. It also frightens people away from mental health services. Therapeutic issues should be separated from public safety and police issues. Mental health services should never be coercive; they should be liberated from the burden of involuntary treatment.

Bibliography

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