

# Should you restrain yourself from ordering restraints?



Douglas Mossman, MD

Dear Dr. Mossman:

We often have to administer sedating medications to aggressive patients who pose an immediate threat of harm to themselves or others. But I am unsure about whether these “chemical restraints” create more liability problems than “physical restraints”—or vice versa. Does one type of restraint carry more legal risk than the other?

Submitted by “Dr. L”

**M**ental health professionals view “mechanical” or “physical” restraints in a way that really differs from how they felt 2 decades ago. In the 1980s, physical restraint use was a common response when patients seemed to be immediately dangerous to themselves or others. But recent practice guidelines say physical restraints are a “last resort,” to be used only when other treatment measures to prevent aggression fail to work.

What should psychiatrists do? Is use of physical restraints malpractice? Are “chemical” restraints better?

This article looks at:

- definitions of restraint
- medical risks of restraint
- evolution and status of restraint policy
- what you can do about legal risks of restraint.

## Definitions

In medical contexts, restraint typically refers to “any device or medication used to restrict a patient’s movement.”<sup>1</sup> The

longer, official US regulatory definitions of physical and chemical restraints appear in *Table 1*.<sup>2</sup> Two important notes:

- Neither regulatory definition of restraint is limited to psychiatric patients; both definitions and the accompanying regulations on restraint apply to *any* patient in a hospital eligible for federal reimbursement.
- The definition of physical restraint would include holding a patient still while administering an injection.

The detailed interpretive rules (“Conditions of Participation for Hospitals”)<sup>3</sup> for these regulations require hospitals to document conditions surrounding and reasons related to restraint incidents and to make this documentation available to federal surveyors.

## Medical risks of restraint

In 1998, the *Hartford Courant* investigative series “Deadly restraint”<sup>4</sup> reported on 142 deaths of psychiatric patients and alerted the public to the potentially fatal consequences of physical restraint. Often, restraint deaths result from asphyxia when patients try to free themselves and get caught in positions that restrict breathing.<sup>5</sup> Other injuries—particularly those produced by falls—can result from well-intentioned efforts to protect confused patients by restraining them.<sup>6</sup>

## Evolution of restraint policy

Although restraining patients might inadvertently *cause* harm, isn’t it better to re-

### DO YOU HAVE A QUESTION ABOUT POSSIBLE LIABILITY?

■ Submit your malpractice-related questions to Dr. Mossman at [douglas.mossman@qhc.com](mailto:douglas.mossman@qhc.com).

■ Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.

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Table 1

## Federal regulatory definitions of 'restraint'

Physical restraint	Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
Chemical restraint	A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition

Source: Reference 2

strain someone, which *prevents* harm from aggression and accidents? Mental health professionals once thought the answer to this question was, "Of course!" But scientific data say, "Often not."

Studies conducted when physical restraint was more common found order-of-magnitude disparities in restraint rates at sites with similar patient populations. This suggested that institutional norms and practice styles—not patients' problems or dangerousness—explained why much restraint occurred.<sup>7-9</sup>

Reacting to these kinds of findings, psychiatric hospitals in the United States and abroad implemented various methods and policy changes to reduce restraint. Follow-up studies typically showed that episodes of restraint and total time spent in restraints could decrease markedly without any increase in events that harmed patients or staff members.<sup>10</sup> In addition, mental health professionals now recognize that being restrained is psychologically traumatic for patients, even when restraint causes no physical injury.<sup>11</sup>

Patients in psychiatric settings represent a minority of persons who get restrained. On inpatient medical/surgical units, patient confusion and wandering, fall prevention, and perceived medical necessity can lead to physical restraint use.<sup>12</sup> Yet physical restraints as innocent-seeming as bed rails can lead to deaths and injuries.<sup>13</sup>

Nursing homes are another environment where restraints may be common but sometimes detrimental. A recent study

found that in all aspects of nursing home patients' health and functioning—behavior, cognitive performance, falls, walking, activities of daily living, pressure sores, and contractures—physical restraints lead to worse outcomes than leaving patients unrestrained.<sup>14</sup>

For all these reasons, restraining patients is often viewed as "poor practice"<sup>14</sup> and a response of last resort for behavioral problems.<sup>15-17</sup>

## Federal regulations

Publication of the *Courant* article spurred Congress to develop standards<sup>18</sup> that, a decade later, permit restraint or seclusion only when less restrictive interventions will not prevent harm, only for limited periods, and only with careful medical monitoring. Restraint is permissible when no alternative exists, but facilities that use restraint must train staff members to recognize and avert situations that might lead to physical interventions and must generate proper documentation each time restraint is used.<sup>2</sup>

Federal regulations also apply to "chemical restraints" and aim to restrict their use. This doesn't mean you can't use drugs to treat patients, however. Regulations explicitly *allow* you to prescribe "standard treatment" (*Table 2, page 38*)<sup>3</sup> to help your patients function or sleep better, to alleviate pain, or to reduce agitation—and such uses of medication are *not* "chemical restraint." Rather, you're using "chemical restraint" if you prescribe a drug to control bothersome

## Clinical Point

Studies suggest that institutional norms and practice styles explain why much restraint occurs

## Clinical Point

The best way to avoid liability is to minimize physical restraints and avoid using medications as chemical restraints

**Table 2**

### Federal criteria for ‘standard treatment’

Medication is used within FDA-approved pharmaceutical parameters and manufacturer indications

Medication use follows standards recognized by the medical community

Choice of medication is based on patient’s symptoms, overall clinical situation, and prescriber’s knowledge of the patient’s treatment response

Source: Reference 3

behavior—for example, to “knock out” a patient with dementia whose “sundowning” bothers staff members.<sup>19</sup> Psychiatrists should be familiar with the risks of medications used for behavioral control, particularly in elderly patients.<sup>20</sup>

### Avoiding legal risks

No study or systematic data will ever tell us whether physical or chemical restraints create a greater liability risk. Obviously, the best way to avoid legal liability for restraints is to minimize use of physical restraints and to avoid using medications as chemical restraints. Psychiatrists who work in hospitals or other institutional settings can politely but firmly decline to prescribe medications or to order physical restraints when staff members request these measures for non-

therapeutic reasons—ie, for a patient who has calmed down but whom staff members believe “needs to learn a lesson” or “get some consequences” for throwing a chair. When restraints are necessary, psychiatrists (along with other staff members) should document the reasons why, including what other interventions were tried first.

Many psychiatric facilities and care systems have reduced incidence of restraint and time spent by patients in restraint through programs that broadly address institutional practices. Such programs usually involve a multi-disciplinary, multi-strategy commitment to alternatives—to helping staff members see that restraints represent a failure in treatment rather than a form of treatment, and to developing other mechanisms for averting or responding to patients’ aggression before restraint becomes the only option.<sup>10,21</sup> Individual psychiatrists can play an important role in advocating and supporting institutional policies, practices, and training that help staff members minimize restraint use.

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## Bottom Line

Restraints are sometimes necessary, but like many medical procedures, applications of physical or chemical restraints can be dangerous. Psychiatrists who are concerned about restraint-related liability should support and encourage steps to minimize restraint use at the facilities where they work.

# Bipolar News You Can't Afford To Miss

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### Editor's note

This issue of Bipolar Update addresses the ever-elusive search for a valid bipolar screening tool as described by Gaynes et al. It also covers features of at-risk youth: Lee and colleagues link early-onset bipolar disorder with later rapid cycling, and Biederman et al find that ADHD predisposes depressed children to bipolar disorder. In terms of predictors of poor functional outcome and recovery, Dodd et al tell us that smoking belongs on the list, whereas STEP-BD researchers report that comorbid substance abuse does not, although it may promote cycling from depression to mania. As for treatment, Hlastala et al find clinical improvement with interpersonal/social rhythm therapy for adolescents with bipolar disorder, and Rowlands et al show that adding ziprasidone to a mood stabilizer results in a longer time to relapse after mania, although all treatment groups relapsed fairly soon after randomization.—Joseph F. Goldberg, MD, Associate Clinical Professor of Psychiatry, Mt. Sinai School of Medicine, New York, NY

### A 5-minute screen for bipolar disorder?

Gaynes RN, DeVouge-Gelso J, Wix S, et al. *Am Fam Med.* 2010;8(4):460-466.  
Researchers evaluating a new 5-page, 20-item, patient-rated checklist to screen for bipolar disorder, major depression, any anxiety disorder, or posttraumatic stress disorder in 667 consecutive primary-care patients found the My Mood Monitor (M<sub>3</sub>) was a valid, efficient, and feasible tool. The M<sub>3</sub> bipolar module had a sensitivity of 0.88 and a specificity of 0.78. As a screen for any of these disorders, the M<sub>3</sub>'s sensitivity was 0.83 and specificity was 0.76. [Read more](#)

### Rapid cycling linked to younger age at onset, other factors

Lee S, Tsang A, Kessler RC, et al. *Br J Psychiatry.* 2010;196(2):177-182.  
Researchers using the Composite International Diagnostic Interview to evaluate more than 54,000 individuals in six countries found that approximately one-third of those with a lifetime BD diagnosis met criteria for rapid cycling. Compared with non-rapid-cycling, rapid-cycling bipolar disorder was associated with younger age at onset, higher persistence, more severe depressive symptoms, greater impairment from depressive symptoms, more use of sick days from mania/hypomania, more anxiety disorders, and an increased likelihood of using health services. [Read more](#)

### ADHD predisposes depressed children to bipolar disorder?

Biederman J, Petty CL, Brent D, et al. *J Affect Disord.* 2009;116(1-3):16-24.  
Looking at data from 2 controlled trials of 468 boys and girls with and without attention-deficit/hyperactivity disorder (ADHD) and their siblings followed for an average of 7 years, researchers found that ADHD is associated with a significantly higher risk of switching from unipolar major depression to bipolar disorder. In those with ADHD, switches were predicted by baseline comorbid conduct disorder, school behavior problems, and history of parental mood disorder. [Read more](#)

### Bipolar smokers have worse outcomes

Dodd F, Brubaker AM, Berk L, et al. *Current Psychiatry.* 2010;19(6):467-471.  
In a 2-year, naturalistic, longitudinal study of patients with bipolar disorder or schizoaffective disorder, researchers

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