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Mental Health Nursing, Mechanical Restraint Measures and Patients' Legal Rights

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Abstract: Coercive mechanical restraint (MR) in psychiatry constitutes the perhaps most extensive exception from the common health law requirement for involving patients in health care decisions and achieving their informed consent prior to treatment. Coercive measures and particularly MR seriously collide with patient autonomy principles, pose a particular challenge to psychiatric patients' legal rights, and put intensified demands on health professional performance. Legal rights principles require rationale for coercive measure use be thoroughly considered and rigorously documented. This article presents an in-principle Danish Psychiatric Complaint Board decision concerning MR use initiated by untrained staff. The case illustrates that, judicially, weight must be put on the patient perspective on course of happenings and especially when health professional documentation is scant, patients' rights call for taking notice of patient evaluations. Consequently, if it comes out that psychiatric staff failed to pay appropriate consideration for the patient's mental state, perspective, and expressions, patient response deviations are to be judicially interpreted in this light potentially rendering MR use illegitimated. While specification of law criteria might possibly improve law use and promote patients' rights, education of psychiatry professionals must address the need for, as far as possible, paying due regard to meeting patient perspectives and participation principles as well as formal law and documentation requirements.

Keywords: Coercive measures, legal rights, mechanical restraint, mental health nursing, professionalism, psychiatry, shared decision making.

INTRODUCTION

Coercive mechanical restraint (MR) in psychiatry represents one of the most significant exemptions from the general health law requirement for informed consent obtainment and patient involvement in decision making in care provision. Coercion in psychiatry in itself constitutes a serious collision with patient autonomy principles and MR materializes this clash in one of its most momentous forms [1].

Literature points out variations both in rates, frequency, indications, and duration of MR use among countries [1 - 7]. Regarding involuntarily admitted inpatients, Raboch *et al.* found that among 10 European countries the proportion of patients subject to MR varied from 17% to 69% [5]. The authors suggested variations to be due to differences in societal attitudes and clinical traditions. Likewise another study of MR duration in 7 different countries revealed huge variations with mean durations between 4.5 and 1,182 hours which were suggested to be partly due to data of varying quality [6]. Bak and Aggernaes found that when making a comparative analysis with Denmark, Sweden, Norway, Finland, Iceland, Belgium, The Netherlands, United Kingdom, Ireland, France and Italy only Norway, Finland, Sweden and Denmark had comparable representative data on coercion [8]. It was found that MR was applied in all countries under study except for the UK. Also study findings suggested that Denmark used more mechanical restraint than Finland and Norway; however Sweden used twice as much as Denmark.

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The annual number of MR interventions in Denmark is rising even though there are severe adverse effects [1, 3, 9 - 15] and reports have questioned the effects of MR [16]. So the total number of patients exposed to mechanical restraint increased from 1,777 in 2003 to 2,084 in 2013 [17]. The use of MR in Denmark has been repeatedly criticized and referred to as amounting to ill-treatment by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[18, 19]. There is a Danish political agenda for a 50% reduction on coercion [17, 20], legal requirements for use of coercive measures are stringent (Act on Coercive Measures in Psychiatry 1729, dated 02/12/2010; see below), and it is widely acknowledged that MR should only be used short-term and in due proportion to the benefits and risk entailed [21]. While health care systems in many countries struggle to challenge increasing rates of coercive measures in psychiatry, there is growing understanding that increasing coercive measure figures cannot be addressed only through means of adding novel antipsychotic agents or adjusting, *e.g.*, drug use practices [22 - 24]. Research findings have shown that several factors influence MR use such as organizational, treatment-, patient- and staff-related factors [3, 25 - 28]. Most of the patient time used during psychiatric admissions is spent with nurses, other care givers, and patients rather than with psychiatrists and so mental health care encompasses a broad spectrum of activities with potential impact on patient course [29].

MR use puts particular demands on health professional performance while inappropriate behaviour may seriously deteriorate the intervention [30, 31]. It was previously suggested that the majority of violent and aggressive incidents across in-patient psychiatric settings are triggered when staff interact with patients [32]. Therefore it is reasonable to explore further into staff attitudes and actions which are inappropriate from the point of view of MR use reduction and to particularly identify patterns of MR use which are unauthorized. Various groups of health professionals are involved in exercising coercion and MR. Normally, however, nurse staff is frontline and may have substantial impact on the course of events during its enforcement.

This paper illustrates the issue by presenting a tenet case assessed by the Danish Psychiatric Complaint Board system [33]. Emphasis is put on basic legal principles concerning patient participation in health care and use of coercion, what is the role of staff in preventing need for MR, and some notes from the point of perspective of psychiatric patients' legal rights.

CASE DESCRIPTION

The case concerned a psychiatric patient that was voluntarily admitted because of worsening posttraumatic stress disorder. The patient suffered from anxiety and ideas of persecution and was deemed to need a 'safe setting'. Subsequent to the admission, according to nurse chart material, the patient appeared 'clear-headed and relevant'. After having told about the patient's situation and need for psychiatric help the patient worsened and commenced to hyperventilate. However, when psychiatric health care staff tried to help calm dawn, the patient suddenly left the room, slammed the door, and took position in front of the door with clenched hands. The staff succeeded to exit the room and pick up additional personnel. In the course of the subsequent case clarification it was explained by the patient that during the discussion a nurse student moved very close to the patient. As a result anxiety markedly increased as the patient actually perceived to be physically intimidated. Immediately afterwards, according to the patient's description, four male staff members came to the room and pushed the patient into the corner. Allegedly, the patient asked them to leave the room in order to permit to relax and handle the hyperventilation and anxiety. Subsequently more people came into the room and the patient was pushed further into the corner. Then the patient tried to escape through the door. According to the patient's description the patient was very scared but then was restrained with belt and hand and foot straps, and furthermore received a coercive sedative injection.

Patient descriptions were not subsequently contested by the psychiatry department staff members or chart documentation. In the case summary the Psychiatric Complaint Board emphasized that their decision was based on an overall assessment of procured information, including information about the patient's diagnosis which was well known by the psychiatric department, in conjunction with the information that the patient arrived with symptoms of PTSD-associated anxiety. The Board found that the sequence of happenings resulted from the staff's handling of the situation. Staff behaviour was judged to be highly anxiety-provoking and it was concluded to directly cause the patient response leading to coercive fixation with belt, hand, and foot straps in addition to sedative injection. Furthermore the Board concluded that there was not sufficient evidence in records material to indicate that there was a concrete and demonstrable risk complying with law requirements. So it was considered that the physical behaviour was an isolated anxiety response to the situation, and not a sign that the patient was up to cause real danger to others. By way of conclusion MR use was concluded unlawful.

DISCUSSION

Legal Issues

The Danish Act on Coercive Measures in Psychiatry (1729 dated 02/12/2010, Para 14) makes clear that “As means of mechanical restraints only belt, hand, and foot straps and gloves may be used. Fixation with mechanical restraints may be used only to the extent it is necessary to avert patients from either exposing themselves or others to imminent danger of harm to body or health, pursuing other patients or by similar means causing coarse inconvenience to other patients, or producing significant damage”. According to Para 17, coercive sedative injection can be used if considered necessary for relieving the state of a very distressed patient.

Otherwise, as it was mentioned in the introduction, Danish health legislation joins up with common health law principles concerning requirement for obtaining informed consent in health care provision. Informed consent and the concept of patient participation in a somewhat ‘shared’ decision making explicate the bioethical principle of respect for patient autonomy and basically recognize patients’ rights in a broad sense to make decisions about their care with appropriate opportunity to consider, agree, or decline about the next course of action (see, *e.g.* [34 - 37]). Correspondingly from the outset Danish psychiatry law upholds common informed consent principles (“*No treatment may be commenced or continued without the patient’s informed consent, unless in accordance with law [...]*”; Danish Health Care Act, Section 5, Para 15 1202 dated 14/11/2014) together with various ‘minimum intrusive remedy’ provisions in the Act on Coercive Measures in Psychiatry (*e.g.* Para 4 and 11). There is a demand for, as far as possible, to obtain the psychiatric patient’s consent (Para 3) and it is maintained that coercive measures cannot be used unless proper efforts have been exercised to obtain patient participation (Para 4). Nonetheless there is relatively little advice available on how to bring these requirements into practice. Ministerial Orders (see, *e.g.*, Ministerial Order 1338 dated 02/12/2010) to a high degree reiterate formal law requirements and offer little advice on, *e.g.*, how and when proper efforts are exercised to obtain patient participation. At the same time there is research evidence suggesting this task particularly be subject to challenges.

Professionalism in Mental Health Nursing, Staff Conceptions on ‘Normality’ and Preventing Need for MR Use

In the previously mentioned work by Papadopoulos and colleagues it was shown that limiting of patients’ freedom by staff by either placing some sort of restriction or refusing a patient wish, is among the most significant antecedents of violence and aggression incidents in adult psychiatric in-patient settings [32]. Likewise the authors of a Swedish study recently maintained that “*When mechanical restraints were unavoidable, the presence of committed staff during mechanical restraint was important, demonstrating the significance of training acute psychiatric nurses correctly so that their presence is meaningful. Nurses in acute psychiatric settings should be required to be genuinely committed, aware of their actions, and fully present in coercive situations where patients are vulnerable*” [38].

Research has suggested that staff interaction can be characterized by the use of ‘behaviour and perceptual-corrective care’ in order for staff to halt or impact patient’s behaviour in accordance with staff perceptions of ‘normality’ [29, 31]. This form of normality-imposing strategy is, according to staff, intended to teach the patient ‘normal behaviour’ by correction and simultaneously maintain control and security with the purpose of avoiding potential staff-patient conflicts [29, 39]. The notion of using informal social activities such as small talk, humour and informal activities so as to assess patients’ degree of normality seems a dangerous path as long as normality is subjected to staffs own personal beliefs and values; that is, if patients are assessed and observed by staff with the intention of spotting and correcting ‘abnormal social behaviour’ from within staff’s own concept of normality. Herein lies a real risk: that mental health staff, because of settings, legal conditions, and the notion that they are ‘normal’ end up addressing the patient under a different category of ‘humanity’ [29, 40]. Since this form of care seems to take place unarticulated in the background of the everyday staff-patient interaction potential discrepancies between situational perceptions should be expected which may tend to be accompanied with correctional use of MR unfounded in present legislation. The question of patient involvement and use of minimum intrusive remedies may simply drown in misinterpretations and pre-judgmental staff-attitudes in regard to the assessment of normality and staff perceptions of ‘the dangerous insane’ patient behaviour and intentions.

More appropriately, patients should be first addressed under the category ‘human’ rather than the rubric ‘insane’. The latter perspective is fundamentally needed in nursing since individuals with mental health issues are ‘humans’ in all aspects of life at all times, while the same cannot be said about insanity: patients are not insane in all aspects of life at all times. This does not entail a position of neglect in regard to the often complex issues associated with psychiatry. It

simply entails a focus on patient resources and understanding of what ever can be understood in a human to human relationship and with regard to, *e.g.*, the entire context in conflict and MR situations. Also this position does not reject the need for MR in special cases when necessary to avoid harm but rather puts ‘understanding’ in the forefront of the social situation while averting pre-labelling prejudice. In as so far as newly graduated nurses are dependent on their colleagues’ acceptance in order to learn how to act in the role as a mental health nurse [41] *e.g.* new nurses will replicate existing practice in order to gain acceptance; attention must be drawn to training programs, informal local ward cultures and existing staff perceptions of mental health patients. If possible, training interventions in order to counter the downsides of a ‘custodialistic’ perception on patients should be considered.

Taking Account of Psychiatric Patient’s Legal Rights: Basic Requirements

So staff may fail to address the mental health patient as a human being and to overlook that only very few patients are entirely ‘out of control’ [29]. By trying to explain, understand, and interact towards the perception and behaviour of patients in health care only from the rationale of psychiatry and always assuming the role of the one that defines ‘normality’, staff are in danger of overlooking healthy normal parts of the person in front of them and thereby overlook the possibility to encourage them to draw strength therefrom [29]. Thus, an ironic contrast to the staff seemingly conducting themselves in a non-judgmental way is that the patients are in fact judged, evaluated and observed in relation to a sphere of normality from which, because of their illness, they are from the very outset excluded [31, 39]. With reference to general concepts of respect for patient autonomy and patient involvement in decision making, this poses a crucial challenge. Any true patient participation and consent about health care provision can hardly be expected under these conditions and one would be tempted to suppose that patient participation is prone to evolve into coercion.

As it appears, the legal rights countermeasures to this challenge may seem meagre and mostly formalistic. Even if formal legal requirements according to, *e.g.*, Danish law are rather stringent as mentioned above, there is little guidance about at what time mechanical restraints can be considered “[...] *necessary to avert patients from either exposing themselves or others to imminent danger [...]*” *etc.* (Act on Coercive Measures in Psychiatry, Para 14). Furthermore, even though a requirement for ‘actuality, concreteness, and demonstrability’ is consistently interpreted into Para 14 by the Psychiatric Complaint Board system, this requirement is not apparent in formal law and also is not explicated in ministerial orders *etc.* Any such explication would possibly force psychiatric staff to reconsider MR use in some instances.

In Danish formal law there is no explicit demand for, *e.g.*, ‘putting reasonable emphasis on patient perceptions and preferences’ though the Danish Act on Health Care (Section 5) rather formalistically emphasizes the rights associated with “Patients’ involvement in decisions” (see above). Legal requirements mostly derive from the bioethical demand for respect for patient autonomy, ‘minimum intrusive remedies’, and due proportionality principles and are materialized in the formal laws mentioned above. These requirements are supplemented by law and ministerial order requirements for medical records keeping. The Danish Act on Authorization of Health Care Professionals (877 dated 04/08/2011) requires authorized Health Professionals to journalize every relevant information related to health care provision and when using coercive measures requirements for documentation are intensified (Para 21; see also Ministerial Order 3 dated 02/01/2013, Para 5 and 10 and Act on Coercive Measures in Psychiatry, Section 6). Medical records keeping and clinical information documentation are prerequisites for safeguarding patients’ legal rights. Despite the possibility that medical record information is incorrect, the claim for documentation can be used to encourage inter-subjectivity and due consideration to what is deemed to be the patient’s perspective. Moreover the legal requirement for medical records keeping is prone to have some (more or less ‘technical’) implications. As the quoted case decision illustrates, if the record contains no further clinical information regarding a concrete MR use and the use is subsequently questioned by the patient (which of course has no duty, nor any opportunity, to provide documentation), a patient’s plausible explanation may receive particular consideration. As it is exemplified in, *e.g.*, Danish legislation clarification and documentation of the patient’s course during admission is a health professional responsibility not least when the patient’s sense of judgment is contested.

In Denmark the legal rights according to formal law requirements are accompanied by rights provided through means of the Danish Psychiatric Complaint Board system (see *e.g.* [42]). This system is established by law (Para 34, Act on Coercive Measures in Psychiatry). The Board is composed of 3 person committees chaired by a governmental administration representative, a medical doctor, and a layman representing the health care users (Para 3; see Ministerial Order 1339 dated 02/12/2010). It is free of charge for patients to file a complaint with the Board and there are no formal requirements for its filing. Psychiatric hospital departments are obliged to forward any complaint to the Board and

according to Act on Coercive Measures in Psychiatry Section 8, every patient subject to coercive measures is assigned an independent patient adviser that is of assistance when guiding the patient and commencing a complaint (Para 24). The Board may conclude that a concrete MR use was illegitimated. Board decisions about MR use can, without charge, be brought before the courts (Para 37). Finally, according to Danish law, failure to comply with medical records keeping requirements can be brought for a National Health Professionals' Disciplinary Board which may assign the health professionals a formal reprimand (Section 2, Act on Complaints and Compensations 1113 dated 07/11/2011). Though, in the case described above, there was no such information.

CONCLUSION

Ample professional education and maintenance of high professional standards would seem crucial to proper use of coercion in mental health care [43]. The case law described above signifies that even if a concrete course of events may finally end up with MR use apparently being necessary, patient handling may subsequently be considered improper and the intervention illegitimated by the authorities. Additionally, and more generally, the case signifies the overall importance of staff conduct during episodes of potentially escalating patient behaviour [39]. Legal requirements for staff to respect patient autonomy with proper consideration to patient perspectives, 'minimum intrusive remedy' principles, and obligations to thoroughly assessing and documenting MR use are crucial in safeguarding psychiatric patients' legal rights. Intensified research based education of psychiatric staff in MR use (incl. which legal requirements to be met), conflict management *etc.*, together with upgraded legal instruments (*e.g.* specifying requirements in agreement with case law), possibly would be steps in the right direction.

LIST OF ABBREVIATIONS

CPT	=	The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
MR	=	Mechanical Restraint
PTSD	=	Post Traumatic Stress Disorder

CONFLICT OF INTEREST

The authors confirm that this article content has no conflict of interest.

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