

RESTRAINED PSYCHIATRIC OUTPATIENTS: NECESSITY, JUSTIFICATION OR VIOLATION OF HUMAN RIGHTS?

SAYEED AKHTAR, T.JAGAWAT

SUMMARY

Seventy patients were brought restrained to a Psychiatric outpatient department over a three month period, with the commonest site of restraint being the wrist. They were compared with controls and it was found that restrained patients were more likely to be younger, belonging to a lower socioeconomic status, from a rural background and were more likely to be diagnosed as manic. The significance of these findings and their implications for the human rights of the mentally ill are discussed.

It sounds unbelievable, but this is a cruel fact that while we are approaching the horizon of the twenty first century, a visibly large proportion of patients are brought restrained to psychiatric facilities in our country. The use of restraint and seclusion within the psychiatric hospital in India is considerably less and comparable with any other Western country, but the number of patients brought chained and roped to psychiatric OPDs has remained unchanged.

In most of the communities, there are three basic theoretical aspect of restraint (Gutheil, 1978): [a] containment of a patient's potential to do harm to himself and others [b] isolation from a pathological relationship and paranoid interpretation of other's behavior and [c] to decrease the sensory input for those having a sensory overload. Most of the studies have reported interpersonal violence as the best predictor of restraint. The prototype of the patient who is most likely to be restrained is a young psychotic male, who is illiterate, unemployed and a drug abuser. Disruption of the environment by his noisy behavior has been suggested as one of the commonest precipitating factors (Matteson & Sacks, 1978).

To the best of our knowledge there is no systematic study on restraint. Interest is generated as to why some of these patients require various degrees of restrains while others do not. Aggressive and assaultive behavior apart, there seem to be many other confounding socio-demographic and clinical variables related to the act of restraint. In addition, the question whether the restraint of psychiatric patients is a violation of human rights also needs to be discussed.

METHODOLOGY

The study was conducted at Central Institute of Psychiatry, Ranchi, Bihar (India). All patients who were brought restrained to the OPD either for the first time or at a follow up during a period of three months (i.e. from October 1, 1991 to December 31, 1991) were included in the study. For each patient, two controls were taken, one registered prior and the other after the index patient, and controlled for sex. The socio-demographic data of each patient was gathered and a detailed psychiatric history, including a history of substance abuse was taken. The patients were interviewed using the Insight and Treatment Attitude Questionnaire, (INTAQ: McEvoy et al, 1989). A short questionnaire which assessed their attitude towards hospitalization as well as their level of voluntary participa-

tion in psychiatric treatment was also administered.

The psychiatric and physical examination was done in detail and psychiatric diagnosis was made according to the ICD-9 (WHO, 1978). Relatives, neighbors and friends who brought the patient were interviewed using a semi-structured questionnaire, which contained enquiries regarding the need, necessity and justification for restraint. Level of aggression was ascertained using a structured schedule. Details of the materials used for restraint, the parts restrained and the injuries caused by this act were specially looked for.

RESULTS

During the period of study, 2785 patients attended the Psychiatric OPD of the Central Institute of Psychiatry, Ranchi, of whom 1845 patients were males; a total of 70 patients were brought restrained (63 males and 7 females). Males were restrained significantly more often than females. The mean age of the control patients was 32.7 years, which was significantly more than the restrained group (28.1 yrs). The marital status, level of education, unemployment, the distance of hospital from the place of falling ill were not found to be factors significant for the restrained patients as compared to the control group. Patients who belonged to a lower socio-economic group and from a rural background had a significantly higher usage of restraint; also, patients a shorter duration of illness or an abrupt onset with a diagnosis of MDP-Mania [ICD-9] were more frequently brought tied to the OPD. However, abuse of alcohol or other substances was not found to be significantly different between the two groups. Importantly, the level of aggressive behavior and the extent of voluntary participation in psychiatric treatment were not different in the restrained and the control groups, though the level of insight was significantly lower in the restrained group.

The material used for restraint were ropes (64.3%), clothes (25.7%), and iron chains (10%). The most frequent site of restraint was the wrist (58.6%) followed by wrist and ankle together (35.7%), wrist and waist (4.3%) and lastly, waist and ankle (1.4%). The common injuries occurring as a result of restraint were abrasion (47.2%), followed by lacerations and infected wounds (11.4%); however, 41.4% of the restrained did not have any injury. The advice to restrain the patient, in most cases, came from "non-significant others", and the justification for this act

TABLE 1
Socio Demographic Variables and Restraint

VARIABLES	RESTRAINED n=70	CONTROL n=140	SIGNIFICANCE on Chi square
1. Age Mean (SD)	28.14 (9.8)	32.7 (10.2)	p<.01
2. Marital status			
Married	57 (81.4)	110 (78.6)	NS
Unmarried	13 (18.6)	30 (21.4)	
3. Education			
Literate	48 (68.6)	108 (77.1)	NS
Illiterate	22 (31.4)	32 (22.9)	
4. Domicile			
Rural	54 (77.1)	69 (49.3)	p<.01
Urban	16 (22.9)	71 (50.7)	
5. Employment			
Employed	58 (82.9)	113 (80.7)	NS
Unemployed	12 (17.1)	27 (19.3)	
6. Socio Economic Status			
Lower	57 (81.4)	72 (51.4)	p<.01
Middle	11 (15.7)	55 (39.3)	
Upper	2 (2.9)	13 (9.3)	
7. Mean Distance from hospital in kilometers (SD)	290 (42.8)	311 (32.4)	NS
8. Acuteness of Episode			
0-2 days	46 (65.7)	52 (37.1)	p<.01
2 days - 2 weeks	13 (18.6)	39 (27.9)	
2 weeks & more	11 (15.7)	49 (35)	

(All figures in parentheses are percentages except where otherwise indicated)

TABLE 2
Diagnosis, Substance Abuse and Restraint

Variables	Restrained n=70	Control n=140	Significance on Chi square
1. Diagnosis			
MDP (M)	52 (74.3)	47 (33.6)	p<.01
Schizoaffective	8 (11.4)	18 (11.4)	
Schizophrenia	7 (10.0)	23 (16.4)	
Others	3 (4.3)	54 (38.6)	
2. Substance abuse			
Cannabis	36 (51.4)	51 (36.4)	NS
Alcohol	14 (20)	37 (26.4)	
Nil	20 (28.6)	52 (37.1)	

put forward by the relatives and informants were: Violence 30%; Wandering behavior 17.3%; Anticipated violence 15%; Suicidal threats 10%; Unpredictable behavior 10%; Ease of transport 8.6%; Refusal of psychiatric treatment 8.6%.

TABLE 3
Level of Insight, Voluntariness, Aggression and Restraint

Variables	Restrained on Chi square (n=70)	Control (n=140)	Significance*
1. Insight			
Full	2 (2.9)	16 (11.4)	p<.01
Partial	7 (10)	41 (29.3)	
Nil	61 (87.1)	83 (59.3)	
2. Voluntariness for Psychiatric treatment			
Willing	2 (2.9)	21 (15.0)	NS
Not willing but no refusal	10 (14.3)	57 (40.7)	
Refuses	43 (61.4)	49 (35.0)	
Protest	15 (21.4)	13 (9.3)	
3. Level of Aggression [†] (in increasing severity)			
I	2 (2.9)	27 (19.3)	N.S.
II	13 (18.6)	24 (17.1)	
III	12 (17.1)	28 (20.0)	
IV	16 (22.9)	31 (22.1)	
V	15 (21.4)	25 (17.9)	
VI	9 (12.2)	4 (2.9)	
VII	3 (4.3)	1 (0.7)	

See Appendix

DISCUSSION

Most of the studies done on restraint and seclusion have primarily dealt with the inpatient population. With the advances made in psychopharmacology, transformed treatment models have led to considerable decrease in episodes of restraint (Angold, 1989). The reported incidence among the inpatients varies from 1.9% (Tardiff, 1981) to 51% (Phillips & Nasr, 1983), and this data is too divergent to be meaningful. Restraint has been reported more among patients who are unemployed, young and male, who are violent towards others and disruptive to the environment. The restraint of patients by members of society in order to deposit them in an "asylum", is a more complex behavior and is due to many confounding variables.

This study has shown that restraint is more common in younger patients who belonged to a lower socio-economic status and hailed from a rural background; they were more likely to be diagnosed as manic and were perceived as assaultive and threatening. Most of the other studies have found the same variables true for patients restrained inside a psychiatric facility except that restraint was more common among patients with schizophrenia. The only other study where manics have been subjected to more restraint is that of Matteson and Sacks (1978). These factors apart, our study did not find that unemployment, marital status, substance abuse, literacy and level of aggression were significantly related to the act of restraint.

It was also found that some patients were apparently not violent and disruptive, but the relatives had tied him

in order to prevent him from jumping out of the train or bus (8.6%). Some were restrained because they were not willing to come to psychiatric hospitals. Others (15.9%) were tied just because of anticipation of violence, which reflects the archetypal notion that a person with a psychiatric illness is almost always unpredictable.

The majority of patients were tied at the wrist and sustained injuries. We have, during the past few years, observed very serious injuries like fractures and nerve damage due to restraint, although no such injuries were found in this study. Though the wrist was the most common site of restraint (58.6%), a large number of patients (35.71%) were restrained at both wrist and ankle, in order to be doubly sure. Forty three patients refused and fifteen actively protested against psychiatric treatment. Most of them were later admitted as voluntary patients, which raises the legal issue of voluntariness (Akhtar et al, 1988).

Restraint of psychiatric patients has become a social practice and tradition and even if the patient is not threatening, he is restrained, the decision of which is enforced on the relative (61.4% in this study) by other members of the community. This is based on erroneous and faulty judgement that all patients with psychiatric illness are always dangerous.

Justification for the act of restraint as perceived by relatives is not without any problem. Acts of violence (30%) and suicidal threats (10%) may be said to be only plausible reason of restraint. Anticipation of violence, wandering tendencies, ease of transporting the mentally ill to a mental hospital, unwillingness for treatment and a past history of unpredictable behavior cannot be adequate justification for restraining a psychiatric patient. A study in the United States (Floud, 1985) has shown that when against advice, mentally ill patients who are deemed to be dangerous to self or others are released into the community, not more than 50%, and even fewer than them have caused harm as predicted. Therefore the reason of restraint because of anticipation of violence cannot be justified.

Another significant finding is the lack of insight in the restrained patients. The question of restraining on the grounds of lack of insight is debatable, if not rejected forthright.

There are, in fact, two issues at stake. First, the claim of the potential victim of the risk of suffering at the hands of mentally ill. This is a logical constituent of any collective claim of protection. But the risk is diffuse and assignment of threatened harm to a specific individual is impossible; thus the concept of general welfare cannot be invoked to justify the invasion of human rights, mostly on a presumptive ground.

The next important issue is the individual claim of mentally ill and the risk of unnecessary restraint. The patient's reaction to being restrained is the subject of very few studies. Patients frequently saw it in a very negative way and were unconvinced of its usefulness. In one of the studies (Soliday et al, 1985) 65% of them regarded it as punishment and 51% felt humiliated. Thus, we are of the

opinion that the restraint of psychiatric patients only because of anticipated violence based on archetypal notions, ease of transporting him to a hospital, etc. are gross violation of the human rights of the mentally ill. We do not argue that a really dangerous and disruptive patient should never be restrained- they should be, but before that we should redefine 'dangerous and disruptive behavior', and we should be able to train our primary care physicians in the usage of drugs to control such behaviors. When we have finally decided to restrain a patient, we should be careful not to induce physical and psychological trauma in him or her. We hope that with the growing awareness of the human rights of the mentally ill, this issue will soon be addressed in the Indian subcontinent.

APPENDIX

DEGREE OF AGGRESSION

LEVEL I: No Aggression

LEVEL II: Curses, Viciously uses foul language in anger, makes moderate threat to others and self.

LEVEL III: Makes clear threat of violence towards others or self or makes requests to help to control self.

LEVEL IV: Makes threatening gesture, swings at people, gropes at clothes.

LEVEL V: Strikes, kick, pushes, pulls hairs (without injury to them)

LEVEL VI: Attacks others causing mild to moderate injuries, bruises, sprains.

LEVEL VIII: Attacks others causing severe physical injuries (broken bones, deep laceration and internal injuries).

REFERENCES

- Akhtar, S., Verma, S.M. & Verma, A.N. (1988) How Voluntary Are The Voluntary Boarders. *Indian Journal of Social Psychiatry*, 4, 22-25.
- Angold, A. (1989) Seclusion. *British Journal of Psychiatry*, 54, 437-444
- Floud, J. (1985) Dangerousness in Social Perspective. In *Psychiatry, Human Rights and The Law* (ed. M.Roth & R.Bluglass). London: Cambridge University Press.
- Gutheil, T.G. (1978) Observation on the Theoretical Basis of Seclusion of Psychotic Patients. *American Journal of Psychiatry*, 135, 325-328.
- Matteson, M.R. & Sacks, M.H. (1978) Seclusion: Uses and complication. *American Journal of Psychiatry*, 135, 1210-1213.
- McEvoy, J.P., Apperson, L.J., Appelbaum, P.S., Ortilip, P., Brewskey J., Hammil, K., Geller, J.L. & Roth, L. (1989) Insight and Schizophrenia. The relationship to acute Psychopathology. *Journal of Nervous and Mental Disease*, 177, 143-144.

Phillips, P.A. & Naar, S.J. (1983) Seclusion and Restrain and Prediction of Violence. *American Journal of Psychiatry*, 140, 229-232.

Soliday, S.M. (1985) A Comparison of Patients and Staff Attitude Towards Seclusion. *Journal of Nervous and Mental Diseases*, 172, 282-286.

Tardiff, K. (1981) Emergency Control Measures For

Psychiatric Inpatients. *Journal of Nervous and Mental Disease*, 169, 614-618.

World Health Organization (1978) *Mental Disorder: Glossary and Guide to their classification in accordance with the 9th Revision of International Classifications of Diseases*. Geneva: World Health Organisation.

Sayeed Akhtar MD,DNB(Psy), Chief Medical Officer; T.Jagawat DPM, Resident, Central Institute of Psychiatry, Kanke, Ranchi 834 006.*

*Correspondence