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(CPT)

THE USE OF RESTRAINTS IN PSYCHIATRIC INSTITUTIONS

Document prepared by Mr Georg HØYER

At its 78th meeting (July 2012), the CPT agreed upon the revised standards on use of means of restraints in psychiatric institutions, as set out in section 4. of this document.

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1. INTRODUCTION

1.1 Introductory remarks

The current standards on the use of restraints in psychiatric institutions are based on the standards established in the CPT's 8th and 16th general reports. As a point of departure in those reports, the following is stated: *“In many psychiatric establishments, recourse to means which limit the freedom of movement of agitated and/or violent patients may on occasion be necessary. Given the potential for abuse and ill-treatment, such use of means of restraint remains of particular concern for the CPT”*.

At the same time, the need to revise and develop these standards has been acknowledged for many years. In Lehtmetts and Pimenoff's paper on means of restraint (CPT (2006) 22), they conclude that: *“A new kind of comprehensive approach for the prevention of degrading treatment connected to the use of restraint in psychiatry appears to be needed and to be quite challenging. It will probably require delegations to engage in more in-depth discussions with both staff and patients as well as a careful comparison of the written rules (legislation, guidelines) with everyday practice”*.

In this paper the current standards on the use of restraint in psychiatric institutions are reviewed and needs for amendments identified. Finally, a proposal for revised standards is presented.

1.2 Definitions

Different types of restraint measures are used in psychiatric institutions. In this document the following definitions are used¹:

- **Mechanical restraint:** The use of leather straps (or other devices) to restrain a patient to a bed, strait jackets, leather belts or other mechanical measures used to restrict or immobilise the patient's movements.
- **Physical (Manual) restraint:** Staff holding or immobilising the patient by using physical force.
- **Seclusion:** Keeping the patient in a locked single room without the presence of staff.
- **Pharmaceutical (Chemical) restraint:** The use of tranquillisers or equivalent drugs, usually administered by injection, to manage acutely violent patients.

¹Bowers et al. 2007

1.3 Legislation on the use of restraints

The majority of Council of Europe (CoE) countries have a specific mental health act². It varies to what degree statutes on the use of restraints have been incorporated in these acts. From a legal point of view the use of restraints is always regarded as an act of necessity, and consequently only applicable in emergency situations, and for the shortest possible time in order to prevent imminent harm.

1.4 International law and recommendations on the use of restraints

There are no binding human rights instruments directly addressing the use of mechanical restraint.

Non-binding recommendations and resolutions comprise the following:

Council of Europe: Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder. This recommendation replaced Rec 1235 (1994) on Psychiatry and Human Rights. The latter stated that: “No mechanical restraint should be used” (para 7.iii. c), while the 2004 recommendation accepts the use of mechanical restraint “to prevent imminent harm to the person concerned or others” (Chapter V, Article 27, para 1).

United Nations: Resolution 1991, 46/119. The protection of persons with mental illness and the improvement of mental health care. According to this resolution, physical restraint or involuntary seclusion of a patient shall only be used when it is the only means available to prevent immediate or imminent harm to the patient or others (Principle 11, para 11).

The principle that restraint must not be prolonged beyond the period strictly necessary for the purpose is underlined in both the CoE Recommendation and in the UN Resolution.

In a recent statement (August 5, 2011) made by the UN Special Rapporteur on Torture, the Rapporteur recommends that solitary confinement (seclusion) of persons with mental disabilities should be prohibited in prison settings³.

² A CPT working paper of April 2010 found that 26 States had specific statutes authorising the use of mechanical restraint, while 15 States had not (information missing for 2 States, unclear for 1 State and 3 States declared that mechanical restraint was never used). In an EU survey (Salize and Dressing, 2002) it was found that only 6 of the then 15 EU member states had specific statutes for the use of mechanical restraint.

³ UN General Assembly, document no A/66/268

1.5 Use of restraints in practice

Restraint is used in most CoE member states. However, there is a remarkable variation in the use of restraint between countries as well as within individual countries. Some countries manage with practically no use of restraint, while in other countries as much as 50 percent or more of the patient population has been subjected to seclusion or mechanical restraint during hospitalisation⁴. In another review including seven European countries, the mean duration of reported mechanical restraint varied from 9 minutes to 1182 hours (55.5 days)⁵. Preferences for different restraint measures do also vary among countries, though undoubtedly the use of mechanical restraint is most commonly used in the majority of member states. Another striking feature is that a major part of all use of restraint applies to a small number of patients, both with regard to frequency and duration.

Because of the urgent need to intervene when violent episodes occur, the use of restraint is in most cases initiated by nursing staff on the ward. However, according to the legislation in almost all countries, the use of restraint can only be authorised by a medical doctor. Nursing staff do accordingly have an obligation to bring the use of restraint to the attention of the responsible medical doctor as soon as possible when restraints are applied.

1.6 Benefits and risks involved

There is no scientific proof in support of any therapeutic benefit from the use of restraints. Several thousand scientific papers have been published on the use of restraints, but only a handful of low quality papers suggest that use of restraint may be beneficial for the patient . Neither has it been proven that restraint is an effective measure to reduce the overall level of violent episodes or reduce situations where there is an imminent danger to self or others⁶. The question concerning benefits is in any case irrelevant, as the use of restraint is restricted to the prevention of danger and physical harm, and has no therapeutic justification whatsoever. The lack of any evidence of secondary benefits related to the use of restraint in the scientific literature is thus an additional argument for the further reduction of the use of restraint in psychiatric institutions.

Of the various restraint measures, it appears that mechanical restraint is the more dangerous compared to available alternatives. Fatalities as a consequence of using mechanical restraint are well documented, and have been reported in many countries. A report from the Joint Commission of Accreditation of Health Care Organisations (JCAHCO) looking into events resulting in death or major permanent loss of function identified 111 cases related to restraint or seclusion in US hospitals for the period 1994-2004. Of these 111 cases, only five were related to seclusion, two cases to seclusion and restraint in combination, and the rest concerned mechanical restraint alone⁷.

⁴ Sailas and Walbeck 2005

⁵ Steinert et al. 2009

⁶ This conclusion is made in two Cochrane reviews: Sailas and Fenton, 2002, and Muralidharan and Fenton 2008

⁷ Here cited from Paterson and Duxbury, British Journal of Nursing 2006; 14(22): 1235-1241. The figures are based on voluntary reporting from the institutions involved.

Mechanical restraint fatalities are most frequent in relation to the use of physical force in order to get the patient immobilised. Death is usually caused by stress and/or asphyxia, while some of the fatalities remain unexplained. Non-fatal injuries include fractures, head injuries, scratches and other consequences of being involved in a physical fight. The more time it takes before the restraint procedure is completed, the higher the risk of serious complications. It should be noted that risks of physical injuries also apply to staff when they are involved in restraining procedures. Fatalities have also been reported after the patient has been restrained. The most common causes at this stage entail VTE (venous thromboembolism) and other cardio-vascular events. Non-fatal events include decubitus (skin ulcers), blisters, constipation and sleep deprivation.

The inherent risks involved when patients are subjected to seclusion are first and foremost of a psychological nature, though there is a well documented increase in suicide risk, especially during the first period of isolation. Seclusion is also known to increase the risk of a psychotic breakthrough, and this risk increases with the length of isolation. Depressions and apathy are also common among patients who are secluded.

The scientific literature addressing the patients' experiences of being restrained unanimously report that the majority of patients feel degraded, helpless and humiliated.

1.7 Safeguards

Given the serious nature of restraining patients with mental disorders, effective safeguards must be in place to prevent abuse of restraint measures. A legal basis, authorisation by medical doctors only, meticulous record-keeping, supervision and effective complaint procedures are all important elements in this respect. It should also be required that whenever someone is subjected to restraints, the patient must be continuously supervised by staff and also seen by a medical doctor at reasonable intervals. In many countries such safeguards are already guaranteed in the legislation.

1.8 Trends in attitudes and regulations regarding the use of restraints

Over the last years it has been increasingly acknowledged that the use of restraint is potentially dangerous, traumatic and anti-therapeutic. Efforts have accordingly been made to reduce the use of restraint, both by restricting the legal authorisation for the use of restraints, and by the introduction of regimes that are likely to reduce the need for restraints. Over the last ten years a growing body of evidence has emerged, demonstrating that the use of restraint can effectively be reduced without increasing the risk of violence or injuries to patients and staff.⁸

With regard to the duration of restraint use, there is internationally a clear trend to reduce the maximum time limit for the use of both mechanical restraint and seclusion. In many jurisdictions, it is now more a matter of hours rather than days (or even weeks) which previously used to be the standard. For instance the New York State Office of Mental Health issued a directive in 2006 introducing a maximum time period of one hour for adults and 30 minutes for adolescents applying to both mechanical restraint and seclusion.

⁸Stewart et al. 2010, Sailas and Walbeck 2005, Sullivan et al. 2005

2. CPT'S POSITION ON THE USE OF RESTRAINT IN PSYCHIATRIC INSTITUTIONS

2.1 Current CPT standards

Even if the current standards on means of restraint in principle remain the same as laid down in the 16th general report⁹, a somewhat stricter view on the use of restraint has emerged over the last years. The source book (updated August 2011), contains 24 paragraphs referring to the use of restraint, citing 11 reports issued after 2006¹⁰. The more recent entries suggest more strict standards with regard to duration (e.g. Denmark 2008 visit), record-keeping (Portugal 2008 visit, Austria 2009 visit, Ukraine 2009 visit, Jersey (UK) 2010 visit) and requirements to inform patients about restraint policies (Serbia 2007 visit, Latvia 2007 visit).

In summary the current CPT standards, applying universally to all types of restraint, establish that:

- Restraint of agitated and/or violent patients may exceptionally be necessary.
- Psychiatric institutions should have a clear policy on the use of restraint. The policy should include complaint procedures and supervision. Patients should be properly informed about the policy on the use of restraint.
- Patients should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury or to reduce acute agitation and/or violence.
- Use of restraint has no therapeutic justification.
- Restraints should be used for the shortest possible time. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately.
- Restraint lasting for days on end cannot have any medical justification and amounts, in the CPT's view, to ill-treatment.
- Restraints should never be used as punishment, for convenience, because of staff shortages or replace proper care or treatment.
- Restraints should adhere to the principle of proportionality.
- The use of restraints can only be authorised and ordered by medical doctors after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his approval. (No blanket authorisation can be accepted).
- Trained staff should be continuously present whenever patients are subjected to restraints.

⁹ These standards were in turn based on the 8th General report and three discussion papers on restraint and seclusion produced in 2005 and 2006 (CPT (2005) 24, CPT (2005) 90 and CPT (2006) 22).

¹⁰ (CPT (2011) 65, Section E 4b).

- Strict record-keeping of all incidents of restraint must be in place, both in a specific register as well as in the patients' individual files. Records should include the time at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, staff who participated in the application and an account of any injuries sustained by patients or staff.
- Once means of restraint have been removed, it is essential to debrief the patient.

In addition, the following specific standards apply to individual restraint measures:

Mechanical restraint

Patients should not be (mechanically) restrained in view of other patients (unless the patient explicitly expresses a wish to remain in the company of designated fellow patients), patients should be adequately dressed, be able to eat and drink autonomously and to attend to natural functions when needed. Visits by other patients should only take place with the express permission of the restrained patient. Restraint means should be applied with skill and care, in order not to endanger the health of the patient or cause pain. Vital functions of the patient, such as respiration, and the ability to communicate, eat and drink must not be hampered.

The use of cage beds (net beds) is under all circumstances regarded as unacceptable and should be abolished. This also applies to hand-cuffs and chains.

Seclusion

The CPT seems to regard seclusion as a less preferable option compared to other coercive measures, and has welcomed initiatives to end the use of seclusion. The following statement on seclusion is made in the 8th general report: "There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive", while the following can be read in the 16th general report:

"As regards seclusion, this particular measure is not necessarily a proper alternative to the use of mechanical, chemical or other means of restraint. Placing a patient in seclusion may produce a calming effect in the short term, but is also known to cause disorientation and anxiety, at least for certain patients. In other words, placement in a seclusion room without appropriate, accompanying safeguards may have an adverse result. The tendency observed in several psychiatric hospitals to routinely forgo resort to other means of restraint in favour of seclusion is of concern to the CPT."

Other points on seclusion made by the CPT in various visit reports include the need for appropriate human contact, for staff to be especially attentive and that secluded patients should have ready access to a toilet.

Pharmaceutical (chemical) restraint

The CPT has only made a few statements regarding the use of chemical restraint. In the source book, the following can be read: “If recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, they should be subjected to the same safeguards as mechanical restraints. The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion.” (CPT(2011) 65).

Physical restraint

The CPT has recommended that physical restraint should be tried before recourse is had to more drastic measures. Apart from this, no detailed standards on the use of physical restraint have been issued by the CPT.

3. UNRESOLVED ISSUES AND THE NEED FOR REVISION OF RESTRAINT STANDARDS

The standards applying to all types of coercive measures listed in paragraph 2.1, second subparagraph, seem to be generally agreed upon and should in principle be kept as they are, though minor changes are needed in order to make the standards consistent and more specific. However, based on previous CPT working papers¹¹, the CPT source book, recent developments in mental health care and continuous discussions within the CPT’s medical group between March 2010 and November 2011¹², the need to supplement and expand the current standards on restraint has been acknowledged. In this context the following unresolved issues have been identified:

- The legal basis and justification for the use of restraints must be clarified.
- Current standards are vague on duration.
- More detailed standards on the practical application of restraints.
- More detailed standards on the use of pharmaceutical restraint are needed.
- Clarification of the CPT’s position on the use of different means of restraint.
- Standards on the use of restraint in minors and adolescents are missing.
- Standards on the use of restraints of patients voluntarily admitted or on patients’ own request are missing.
- More detailed standards on supervision and complaint procedures with regard to the use of restraint are needed.
- Prolonged use of mechanical restraint is not adequately addressed.

These issues will be addressed one by one in the following sections.

¹¹ CPT (2005) 24, CPT (2005) 90, CPT (2006) 22

¹² CPT (2010) 26, CPT (2010) 65, CPT (2010) 100, CPT (2011) 27

3.1 The legal basis and justification for the use of restraints must be clarified

Given the serious nature of the application of restraint measures, the use must be authorised and regulated according to national law in compliance with international legal standards. This may go without saying, but it should be mentioned as a fundamental principle governing the use of restraint. A reference to this principle should be included in the standards.

Regarding the current CPT standards on justification for the use of restraints, it appears inconsistent when it is established that the use of restraint has no therapeutic justification, while in the same set of standards, it is stated that “restraint lasting for days on end cannot have any *medical* justification ...”. The use of restraint can only be justified as a last resort to prevent danger regardless of the therapeutic implications. It is thus inconsistent to say that restraint for days on end has no *medical* justification. “Medical” should consequently be deleted, and the standard should simply say that the use of restraint lasting for days on end amounts to ill-treatment.

In the same context it can be questioned if “agitation” is a state justifying the use of restraint. Agitation should in general be dealt with in accordance with therapeutic principles and is not a condition where restraints can be accepted as an act of necessity or a proportional measure. Or the other way round: as the use of restraints has no therapeutic justification, agitation falls outside the conditions qualifying for the use of restraints. In the revised standards “agitation” has accordingly been removed from the criteria mentioned as conditions justifying the use of restraints.

3.2 Duration

Duration is first and foremost relevant with regard to seclusion and mechanical restraint. The trend over the last years has clearly moved towards a much stricter time limit for the use of both of them. The basic principle is that restraint measures should be used for the shortest time possible, and should always be terminated when the reason for the use of restraint has ceased. The implication of this principle is that upper time limits should be set in minutes rather than hours (not to mention days). Stricter time limits would be in line with the more recent statements on duration in visit reports. For instance in the 2008 visit report to Denmark, it is stated that: “*The duration of the application of means of mechanical restraint should be for the shortest possible time (usually minutes or a few hours). The exceptional prolongation of restraint should warrant a further review by a doctor*”. Many CoE member countries have already on their own initiative introduced more stringent time limits, e.g. in the case of Serbia two hours (CPT (2011) 39), and in Bosnia and Herzegovina four hours (exceptionally 8 hours) (CPT (2011) 40). In general the CPT has for more than 10 years said that the use of restraints for days on end amounts to ill-treatment.

Given the recent development in how the use of restraint is regarded, a new standard on duration should read:

The duration of the actual means of restraint should be for the shortest possible time (usually minutes to a few hours), and should always be terminated when the reason for the use of restraint has ceased. Physical (manual) restraint should never last any longer than it takes to stop or prevent acute dangerous situations, usually not more than a few minutes. If recourse is had to mechanical restraint and seclusion, the maximum duration should ordinarily not exceed 6 hours.

In the extremely rare cases where restraint is considered to be the only available measure to handle continuously dangerous behaviour, prolongation of mechanical restraint or seclusion after the six hours limit has passed, requires a further review by two medical doctors who must both agree on the decision to continue the use of mechanical restraint or seclusion. The same procedure applies if the use of mechanical restraint or seclusion of the same patient is repeated within 24 hours after previous use was terminated. Mechanical restraint and seclusion should under no circumstances exceed 24 hours.

Regardless of the time requirements stated here, repetitive use of restraint of the same patients should always initiate a reassessment of the patient's care and treatment, including the need to transfer the patient to a better staffed and more specialised unit as well as a review by independent experts.

All deviations from the time limits stated above should be reported to a relevant supervisory body.

3.3 More detailed standards on the practical application of restraints.

CPT delegations have come across cases where patients have been mechanically restrained face down and with arms above their heads. Such positions are painful and uncomfortable for the patients. It has also been observed that patients are fixated with straps or other devices not suited for the purpose. We thus suggest that the revised standards include the following paragraph:

Patients fixated to a bed should always be restrained face up with arms positioned down. Straps should be soft, preferably padded leather straps, and should be designed with the objective of minimising the risk of wounds or blisters as well as that of causing pain. Straps must not be too tight and should be applied in a manner that allows for the maximum safe movement of arms and legs.

As regards physical (manual) restraint the CPT has not issued any detailed standards on this. At the same time, CPT delegations have observed that patients have been exposed to dangerous techniques when being subjected to physical restraint, which, first and foremost, hamper the respiratory and circulatory functions of the patients. We therefore suggest that the following paragraph be included in the standards on physical restraint:

When recourse is had to physical (manual) restraint, staff should be specially trained in holding techniques that are safe and minimise the use of physical force. Neck holds and techniques that may obstruct the patients' airways or inflict pain must never be used under any circumstances.

3.4 Pharmaceutical (chemical) restraint

As mentioned in section 2.1 pharmaceutical restraint has been little commented on in CPT documents. The working paper by Lehtmetts and Pimenoff (CPT (2006) 22) addresses risks and benefits concerning the use of pharmaceutical restraint. The paper further underlines the requirement to adhere to the same safeguards as for use of other restraint measures when pharmacological restraint is used, including meticulous recording/reporting procedures.

The CPT has not discussed whether there should be any limitation on the type of drugs that might be used as pharmaceutical restraint. Lehtmetts and Pimenoff have listed antipsychotics, tranquillisers, hypnotics, sedatives and anaesthetics as actual options. At the same time they emphasise that the effect of pharmaceuticals cannot be removed quickly, as it can in the case of other means of restraint. In this respect it is consistent to exclude psychotropic drugs with long-lasting effect from the type of drugs that can be used as pharmaceutical restraint.

On these grounds the standard for the use of pharmaceutical restraint should be supplemented as follows:

If recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, only approved, well established and short acting drugs should be used. The side-effects that medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion.

3.5 Concurrent use of restraint measures

The most common combination of coercive measures refers to the administration of pharmaceutical restraint to patients already subjected to mechanical restraint. Other less frequent combinations comprise the use of pharmacological restraint in combination with either seclusion or physical restraint. Thus the typical situation when more than one restraint measure is used at the same time always includes the use of pharmacological restraint. The crucial question in this context is whether it can be justified to add a second restraint measure (pharmacological restraint) after the situation requiring the use of restraint has been brought under control.

The CPT has only indirectly addressed this issue in the revised source book (2011), where it is stated that: “(...) The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion”

The justification for administering psychotropics to patients already restrained, is that the combination will reduce the time needed to restrain someone, or in rare cases because it is necessary to prevent harm to the patient’s health. On the other hand to forcibly medicate someone with psychotropic drugs is perceived by many patients (and staff as well) as the most serious violation of integrity that patients in psychiatric institutions can experience. When balancing these considerations, emphasis should be put on the protection of the patient’s autonomy and integrity, as well as the potential side-effects of psychotropic drugs. Concurrent use of both traditional and new generation antipsychotic medication increases the risk of adverse cardiovascular events. Traditional antipsychotics also increase the discomfort resulting from movement restrictions, because of the restlessness associated with such medication.

Taking the above mentioned factors into consideration, the standard on the concurrent use of restraint measures should be as follows:

If the use of restraint is unavoidable, it can sometimes be justified to combine either seclusion, mechanical or physical restraint with pharmaceutical restraint. Such combinations are only justified when it is in the best interest of the patient, and only if it will reduce the duration of the application of restraint or if it is necessary to prevent serious damage to the health of the patient.

Competent patients subjected to mechanical restraint, physical restraint or seclusion should never be medicated without consent, except for situations where patients may be in danger of suffering serious health damage if medication is not administered. The same principle applies to incompetent patients. For incompetent patients additional medication can also be given without consent where the medication will significantly reduce the time needed to use restraints.

3.6 Different restraint measures

As mentioned in section 2.1, the CPT seems to have adopted the position that mechanical restraint is the more acceptable restraint measure among those available. There are good reasons to revisit this point of view. Seclusion is by no doubt less dangerous for the patient compared to mechanical restraint. Some countries (England being the prime example) have a clear preference for the use of seclusion over mechanical restraint, based on a strong conviction that seclusion is a more humane measure than other means of restraints. It is also a prevailing perception both among patients and health professionals that seclusion is a less intrusive measure compared to mechanical restraint.

Further, the CPT has clearly stated that the use of net and cage beds is unacceptable, and that they should be withdrawn from service. At the same time the CPT approves that patients can be fixated to a bed by means of straps. The basis for this position can be questioned. To place a patient in a cage bed is less dangerous compared to fixation. It is also likely that patients confined in net beds are more comfortable than those who are fixated and unable to move (though this has not been explored in research settings). Against this background the current CPT position on different forms of mechanical restraint can be said to be inconsistent.

Based on the above considerations, cultural differences and also the individual circumstances in each case, the CPT standards on preferences with regard to different means of restraint should be rephrased as follows:

In the rare cases where physical restraint, seclusion, pharmaceutical restraint and different forms of mechanical restraint may be justified, preference should be given to the least restrictive and least dangerous restraint measure. When choosing among available restraint measures, the patients' opinions and previous experiences, the staff's attitudes and skills as well as safe procedures, should be taken into account. The restraint measure least likely to endanger the health of the patients should always be given preference.

3.7 Minors and adolescents

The only reference to minors (children) with regard to the use of restraint is a reminder that seclusion of children should be avoided (CPT (2011) 65, para 756). This calls for more detailed standards for the use of restraint measures towards minors.

The following standards should apply:

Minors below 16 years of age should in principle never be subjected to means of restraint. The risks and consequences are indeed more serious taking into account the vulnerability of minors. In extreme cases where it is necessary to intervene physically to avoid harm to self or others, the only acceptable intervention is the use of physical (manual) restraint, that is, staff holding the minor until he or she calms down.

3.8 Application of restraints in practice

So far the CPT has not included in the standards how patients fixated to a bed by means of mechanical restraints should be positioned, and how straps should be designed and applied. Existing standards on the practical application of mechanical restraint should be supplemented as follows:

Patients fixated to a bed should always be restrained face up with arms positioned down. Straps should be soft, preferably padded leather straps, and should be designed with the objective of minimising the risk of wounds or blisters as well as that of causing pain. Straps must not be too tight and should be applied in a manner that allows for the maximum safe movement of arms and legs.

3.9 Use of restraints on patients' own request

It sometimes happens that patients ask to be restrained. Such requests often come from patients who experience a growing tension and who feel afraid of losing control and acting out. In such cases the following standard should apply:

Patients do sometimes ask to be subjected to restraint measures. Such requests should generally be rejected. That a patient asks for such "care" is in most cases an indication that the patient's needs are not met, and to comply with a request to restrain such patients is generally inappropriate and may also be habit-forming. If a patient is nevertheless subjected to any form of restraint on their own request, the restraint measure should immediately be terminated when that patient asks to be released.

3.10 Use of restraints on voluntarily admitted patients

As the purpose of using restraint is to prevent harm to self or others, and as it is legally classified as an act of necessity, it can in principle be applied to all patients regardless of their legal status. However, if a voluntarily admitted person is subjected to any form of restraint measures, he or she can leave the hospital if he or she wants, as long as the patient is capable of making autonomous decisions. Where the patient fulfils the criteria for involuntary hospitalisation, immediate steps must be taken to convert the patient's legal status if it is unsafe to discharge the patient.

3.11 Prolonged use of restraints

CPT delegations have in some rare cases come across persons who have been restrained for long periods of time (months and even more than a year). Those extreme cases apply to the very rare patients who are persistently and unpredictably violent, and at the same time treatment-resistant. Such cases are of special concern to the CPT and the subject has been discussed repeatedly in the medical group of the CPT in 2010 and 2011. In a working paper from 2010 the following was stated: "..... *the Medical Group's stand point on the practice of prolonged immobilization, on the justifications adduced, as well as on alternatives to the prolonged use of mechanical restraints, is of utmost importance in order to form a clear position of the Committee on this issue....*"

Given the current CPT standard that the use of mechanical restraint for days on end amounts to ill-treatment, and the revised standards suggested in this document, any use of seclusion or mechanical restraint extending 24 hours should initiate special procedures and actions. Such cases should be considered as cases requiring attention at the highest level of expertise available. Possible actions should include having the patient moved to a better staffed and more specialised unit, reassessment of diagnosis and treatment, as well as review by independent experts. The CPT has issued a working paper to assist visiting delegations if or when they encounter cases of prolonged use of restraint (CPT (2010) 100 REV). The longer the restraint has lasted, the greater the need for transferring the patient to the most specialised and best staffed services in order to put an immediate end to the use of restraint.

Based on the argumentation above, the following standard should apply to cases of prolonged use of restraint:

If patients in psychiatric institutions are secluded or mechanically restrained for more than 24 hours, immediate measures should be taken to end the use of restraint. Such measures should include having the patient moved to a better staffed and more specialised unit, reassessment of the patient's diagnosis and treatment as well as a review of the case by independent experts.

4. A PROPOSAL FOR REVISED STANDARDS

The following proposal combines the previous standards that should be preserved and the new standards proposed in this paper. The revised standards on the use of restraints in psychiatric institutions are based on a review of the current standards, the source book, reports from recent country visits and a review of the scientific literature.

Restraint-related issues have frequently been addressed by the CPT over the last years. The wording and focus may vary slightly in these CPT statements. In the revised and amended standards presented below, efforts have been made to edit, subsume and harmonise the various statements in order to keep the new standards as few and explicit as possible.

CPT standards on the use of restraint in psychiatric institutions (Revised 2012)

1. General principles

The restraint of violent patients, who represent a danger to themselves or others, may exceptionally be necessary. Patients should only be restrained as a measure of last resort; an extreme action applied in order to prevent imminent injury to self or others.

Restraint has no medical or therapeutic justification.

Restraints should always be used for the shortest possible time. When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately. Restraints should always adhere to the principle of proportionality.

Restraints should never be used as punishment, for convenience, because of staff shortages or replace proper care or treatment.

2. Legal basis and legal safeguards

All use of restraint measures must be authorised and regulated according to national law and international legal standards

All use of restraint should be subject to the same safeguards. Safeguards include detailed legal regulation of the use of restraint, a clear institutional policy and information on this policy to the patients, monitoring of practice, independent review of the use of restraints and effective complaint procedures.

Strict record-keeping of all incidents of all restraint measures must be in place, both in a specific register as well as in the patients' individual files. Records should include the time at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, staff who participated in the application and an account of any injuries sustained by patients or staff.

3. Authorisation

The use of restraints can only be authorised and ordered by medical doctors after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his approval. No blanket authorisation can be accepted.

4. The practical application of restraints

Restraint measures should be applied with skill and care, in order not to endanger the health of the patient and minimise the risk of causing pain to the patient. Staff should be properly trained before taking part in the practical application of restraints.

Qualified staff should be continuously present whenever patients are subjected to restraints.

When recourse is had to physical (manual) restraint, staff should be specially trained in holding techniques that are safe and minimise the use of physical force. Neck holds and techniques that may obstruct the patients' airways or inflict pain must never be used under any circumstances.

Patients should not be (mechanically) restrained in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient). Restrained patients should be properly dressed, be able to eat and drink autonomously and to attend to natural functions when needed. Visits by other patients should only take place with the express permission of the restrained patient. Patients should not be tied up with cotton strips. Handcuffs or chains should never be used. Vital functions of the patient, such as respiration and the ability to communicate, eat and drink must not be hampered.

Patients fixated to a bed should always be restrained face up with arms positioned down. Straps should be soft, preferably padded leather straps, and should be designed with the objective to minimise the risk of wounds or blisters as well as that of causing pain. Straps must not be too tight and should be applied in a manner that allows for the maximum safe movement of arms and legs.

The use of cage beds (net beds) is under all circumstances regarded as unacceptable and should be abolished. This also applies to hand-cuffs and chains.

If recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, only approved, well established and short acting drugs should be used. The side-effects that medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion.

5. Duration

The duration of the actual means of restraint should be for the shortest possible time (usually minutes to a few hours), and should always be terminated when the reason for the use of restraint has ceased. Physical restraint should never last any longer than it takes to stop or prevent acute dangerous situations, usually not more than a few minutes. If recourse is had to mechanical restraint and seclusion, the maximum duration should ordinarily not exceed 6 hours.

In the extremely rare cases where restraint is considered to be the only available measure to handle continuously dangerous behaviour after the six hours limit has passed, prolongation of mechanical restraint or seclusion require a further review by two medical doctors who then must both agree on the decision to continue the use of mechanical restraint or seclusion. The same procedure applies if the use of mechanical restraint or seclusion of the same patient is repeated within 24 hours after any previous restraint measure has been terminated.

Mechanical restraint and seclusion should under no circumstances exceed 24 hours.

Regardless of the time requirements stated here, repetitive use of restraint of the same patients should always initiate a reassessment of the patient's care and treatment, including the need to transfer the patient to a better staffed and more specialised unit as well as a review by independent experts.

All deviations from the time limits stated above should be reported to the relevant supervisory body.

6. Concurrent use of different means of restraints

If the use of restraint is unavoidable, it can sometimes be justified to combine either seclusion, mechanical or physical restraint with pharmaceutical restraint. Such combinations are only justified when it is in the best interest of the patient, and only if it will reduce the duration for the application of restraint or is necessary to prevent serious damage to the health of the patient.

Competent patients subjected to mechanical restraint, physical restraint or seclusion should never be medicated without consent. The only exception applies to situations where patients may be in danger of suffering serious health damage to their own health if medication is not administered. The same principle also applies to incompetent patients. For incompetent patients additional medication can also be given when the medication significantly will reduce the time needed to use restraints.

7. Preferences regarding different restraint measures

In cases where the use of restraint is considered, preference should be given to the least restrictive and least dangerous restraint measure. When choosing among available restraint measures, factors like the patients' opinions and previous experiences, the staff's attitudes and skills, as well as safe procedures, should be taken into account. The restraint measure least likely to endanger the health of the patient should always be given preference

8. Minors and use of restraint

Minors below 16 years of age should in principle never be subjected to means of restraint. The risks and consequences are indeed more serious taking into account the vulnerability of minors. In extreme cases where it is necessary to intervene physically to avoid harm to self or others, the only acceptable intervention is the use of physical restraint, that is, staff holding the minor until he or she calms down.

9. Use of restraint on the patient's own request

Patients do sometimes ask to be subjected to restraint measures. Such requests should generally be rejected. That a patient asks for such "care" is in most cases an indication that the patient's needs are not met, and to comply with a request to restrain such patients is generally inappropriate and may also be habit-forming. If a patient is nevertheless subjected to any form of restraint on their own request, the restraint measure should immediately be terminated when that patient asks to be released.

10. Use of restraint towards voluntarily admitted patients

If a voluntarily admitted person is subjected to any form of restraint measures, he or she is entitled to leave the hospital whenever he or she wants, as long as the patient is capable of making autonomous decisions. Where the patient fulfils the criteria for involuntary hospitalisation, immediate steps must be taken to convert the patient's legal status if it is unsafe to discharge the patient.

11. Debriefing

Once means of restraint have been removed, it is essential that a debriefing of the patient take place

12. Prolonged use of restraint

Restraint lasting for days on end amounts, in the view of the CPT, to ill-treatment.

If patients in psychiatric institutions are secluded or mechanically restrained for more than 24 hours, immediate measures should be taken to end the use of restraint. Such measures should include having the patient moved to a better staffed and more specialised unit, reassessment of diagnosis and treatment as well as review by independent experts.