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**Means of restraint  
in psychiatric establishments for adults**  
(Revised CPT standards)

In the light of previous publications<sup>1</sup> on this subject matter and its findings during many visits in recent years to civil and forensic psychiatric establishments in various European countries, the CPT has decided to review its standards regarding the use of means of restraint and to consolidate them in the present document.

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<sup>1</sup> See paragraphs 47 to 50 of the 8<sup>th</sup> General Report on the CPT's activities (CPT/Inf (98) 12) and paragraphs 36 to 54 of the 16<sup>th</sup> General Report on the CPT's activities (CPT/Inf (2006) 35), as well as document CPT (2012) 28 on "the use of restraints in psychiatric institutions".

## Introduction

Given their intrusive nature and the potential for abuse and ill-treatment, the CPT has always paid particular attention to the use of various types of restraint vis-à-vis psychiatric patients.

At the outset, the CPT wishes to stress that the ultimate goal should always be to prevent the use of means of restraint by limiting as far as possible their frequency and duration. To this end, it is of paramount importance that the relevant health authorities and the management of psychiatric establishments develop a strategy and take a panoply of proactive steps, which should *inter alia* include the provision of a safe and secure material environment (including in the open air), the employment of a sufficient number of health-care staff, adequate initial and ongoing training of the staff involved in the restraint of patients, and the promotion of the development of alternative measures (including de-escalation techniques).

In most countries visited by the CPT, one or more of the following types of restraint may be used:

- (a) physical restraint (i.e. staff holding or immobilising a patient by using physical force – “manual control”);
- (b) mechanical restraint (i.e. applying instruments of restraint, such as straps, to immobilise a patient);
- (c) chemical restraint (i.e. forcible administration of medication for the purpose of controlling a patient’s behaviour);
- (d) seclusion (i.e. involuntary placement of a patient alone in a locked room).

### 1. General principles

- 1.1. The restraint of violent psychiatric patients who represent a danger to themselves or others may exceptionally be necessary.<sup>2</sup>
- 1.2. Means of restraint should always be applied in accordance with the principles of legality, necessity, proportionality and accountability.
- 1.3. All types of restraint and the criteria for their use should be regulated by law.
- 1.4. Patients should only be restrained as a measure of last resort (*ultimo ratio*) to prevent imminent harm to themselves or others and 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.
- 1.5. Means of restraint are security measures and have no therapeutic justification.
- 1.6. Means of restraint should never be used as punishment, for the mere convenience of staff, because of staff shortages or to replace proper care or treatment.

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<sup>2</sup> See also Article 27 of 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, as well as the judgments of the European Court of Human Rights in *Bureš v. the Czech Republic* (18 October 2012; application no. 37679/08; paragraph 86) and *M.S. v. Croatia* (19 February 2015; application no. 75450/12; paragraph 97).

- 1.7. Every psychiatric establishment should have a comprehensive, carefully developed policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should be aimed at preventing as far as possible the resort to means of restraint and should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. The policy should also contain sections on other important issues such as: staff training; recording; internal and external reporting mechanisms; debriefing; and complaints procedures. Further, patients should be provided with relevant information on the establishment's restraint policy.

## **2. Authorisation**

Every resort to means of restraint should always be expressly ordered by a doctor after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his/her approval. To this end, the doctor should examine the patient concerned as soon as possible. No blanket authorisation should be accepted.

## **3. Application of means of restraint**

- 3.1. Means of restraint should always be applied with skill and care, in order to minimise the risk of harming or causing pain to the patient and to preserve as far as possible his/her dignity. Staff should be properly trained before taking part in the practical application of means of restraint.
- 3.2. When recourse is had to physical (manual) restraint, staff should be specially trained in holding techniques that minimise the risk of injury. Neck holds and techniques that may obstruct the patients' airways or inflict pain should be prohibited.
- 3.3. For the purpose of mechanical restraint, only equipment designed to limit harmful effects (preferably, padded cloth straps) should be used in order to minimise the risk of the patient sustaining injury and/or suffering pain. Handcuffs or chains should never be used to immobilise a patient. Patients under restraint should always be face up with the arms positioned down. Straps must not be too tight and should be applied in a manner that allows for the maximum safe movement of the arms and legs. The vital functions of the patient, such as respiration and the ability to communicate, must not be hampered. Patients under restraint should be properly dressed and, as far as possible, be enabled to eat and drink autonomously and to comply with the needs of nature in a sanitary facility.
- 3.4. The use of net (or cage) beds should be prohibited under all circumstances.
- 3.5. Patients should not be subjected to mechanical restraint in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient); visits by other patients should only take place with the express consent of the restrained patient.
- 3.6. Staff should not be assisted by other patients when applying means of restraint to a patient.
- 3.7. If recourse is had to chemical restraint, 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.
- 3.8. As regards seclusion, the room in which patients are placed should be specially designed for that specific purpose. In particular, it should ensure the safety of the patient and provide a calming environment for the patient concerned.

#### **4. Duration**

- 4.1. The duration of the use of means of mechanical restraint and seclusion should be for the shortest possible time (usually minutes rather than hours), and should always be terminated when the underlying reasons for their use have ceased. Applying mechanical restraint for days on end cannot have any justification and could, in the CPT's view, amount to ill-treatment.
- 4.2. If, exceptionally, for compelling reasons, recourse is had to mechanical restraint or seclusion of a patient for more than a period of hours, the measure should be reviewed by a doctor at short intervals. Consideration should also be given in such cases and where there is repetitive use of means of restraint to the involvement of a second doctor and the transfer of the patient concerned to a more specialised psychiatric establishment.

#### **5. Selection of type(s) of restraint**

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 such as the patient's opinion (including any preferences expressed in advance) and previous experience should as far as possible be taken into account.

#### **6. Concurrent use of different types of restraint**

Sometimes seclusion, mechanical or physical restraint may be combined with chemical restraint. Such a practice may only be justified if it is likely to reduce the duration of the application of restraint or if it is deemed necessary to prevent serious harm to the patient or others.

#### **7. Supervision**

Every patient who is subjected to mechanical restraint or seclusion should be subjected to continuous supervision. In the case of mechanical restraint, a qualified member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide him/her with assistance. If patients are held in seclusion, the staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous staff presence.

#### **8. Debriefing**

Once the means of restraint have been removed, it is essential that a debriefing of the patient take place, to explain the reasons for the restraint, reduce the psychological trauma of the experience and restore the doctor-patient relationship. This also provides an opportunity for the patient, together with staff, to find alternative means to maintain control over him/herself, thereby possibly preventing future eruptions of violence and subsequent restraint.

#### **9. Use of means of restraint at the patient's own request**

Patients may sometimes ask to be subjected to means of restraint. In most cases, such requests for "care" suggest that the patients' needs are not being met and that other therapeutic measures should be explored. If a patient is nevertheless subjected to any form of restraint at his/her own request, the restraint measure should be terminated as soon as the patient asks to be released.

## **10. Use of means of restraint vis-à-vis voluntary patients**

In case the application of means of restraint to a voluntary patient is deemed necessary and the patient disagrees, the legal status of the patient should be reviewed.

## **11. Recording and reporting of instances of means of restraint**

- 11.1. Experience has shown that detailed and accurate recording of instances of restraint can provide hospital management with an oversight of the extent of their occurrence and enable measures to be taken, where appropriate, to reduce their incidence. To this end, a specific register should be established to record all instances of recourse to means of restraint (including chemical restraint). This should supplement the records contained within the patient's personal medical file. The entries in the register 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; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this entitlement; at their request, they should receive a copy of the full entry.
- 11.2. The frequency and duration of instances of restraint should be reported on a regular basis to a supervisory authority and/or a designated outside monitoring body (e.g. health-care inspectorate). This will facilitate a national or regional overview of existing restraint practices, with a view to implementing a strategy of limiting the frequency and duration of the use of means of restraint.

## **12. Complaints procedures**

Effective complaints procedures are basic safeguards against ill-treatment in all psychiatric establishments. Psychiatric patients (as well as their family members or legal representatives) should have avenues of complaint open to them within the establishments' administrative system and should be entitled to address complaints – on a confidential basis – to an independent outside body. Complaints procedures should be simple, effective and user-friendly, particularly regarding the language used. Patients should be entitled to seek legal advice about complaints and to benefit from free legal assistance when the interests of justice so require.