RESTRAINT DEBATE
To the Editor:

Regarding the article by Moylan, “Physical Restraint in Acute Care Psychiatry: A Humanistic and Realistic Nursing Approach” (March 2009, Vol. 47, No. 3, pp. 41-47), I strongly disagree that the use of restraints has a “therapeutic effect.” The basic tenets set out in this article regarding the need to ensure safety and for nurses to ensure that patient rights and dignity are maintained when restraints are used in emergency situations are correct. The extrapolation toward achieving a therapeutic outcome is outdated and sets our accomplishments in achieving restraint-free environments back by decades. Like the author, I too have been an advanced practice nurse with more than 35 years of experience, and I well understand patients’ feeling fearful about their own sense of being out of control, but there are many ways to reassure and assist patients.

Offering the premise as noted on the issue cover, “Physical restraint: Can it be therapeutic?” is a hindrance to the excellent work of many who are diligent in assisting staff at the point of care to change the culture away from the premise that restraint use is ever therapeutic. The short answer is NO, it is not therapeutic.

Marlene Nadler-Moodie, MSN, APRN, PMHCNS-BC
San Diego, California

Response:

While Ms. Nadler-Moodie agrees with my premise that restraints may be required in an emergency situation and that a patient’s rights and dignity can be maintained by a compassionate nursing approach, she states unequivocally that restraint use can never be therapeutic. As a strong patient advocate, I agree that inappropriate and insensitive use of restraints will have significant untherapeutic results of both a physical and psychosocial nature. However, the assertion that restraint can never be therapeutic, although frequently stated by some in our profession, is not supported by scientific evidence in the literature. The fact that restraint can be detrimental is well supported (Gorden, Hindley, Marsden & Shivayogi, 1999; Paterson & Duxbury, 2007), but this is not evidence that it is always untherapeutic. Contrarily, my article provided data from clinical studies that did identify therapeutic effects, which included the perceptions of patients themselves who had previously been restrained.

In addition, in my clinical experience, a patient who was actively attempting to enucleate herself was restrained and her eyesight was preserved. At the time, she was hearing voices that verbalized the biblical exhortation “If thine eye offends thee, pluck it out.” After she was stabilized on antipsychotic medication, she was profusely thankful for our interventions. I believe that any reasonable professional would identify this as a positive therapeutic effect. In many other less dramatic situations, patients have reported positive feelings about a restraining experience when the intervention was carried out with compassion and expertise. My colleagues reported similar findings when I was researching this topic in preparation for writing this article.

I agree wholeheartedly with Ms. Nadler-Moodie that we should continue to move forward in our pursuit of a restraint-free environment. However, when no other measure except physical restraint can preserve safety on a psychiatric unit, I believe the evidence demonstrates that this intervention can be carried out in a manner that achieves a therapeutic response for the patient.

REFERENCES
Letters to the Editor

To the Editor:

Hallelujah! Moylan (“Physical Restraint in Acute Care Psychiatry: A Humanistic and Realistic Nursing Approach,” March 2009, Vol. 47, No. 3, pp. 41-47) is a voice of common sense and reality. In my own reality, I have sometimes been successful in verbally de-escalating volatile situations. Other times, no matter how hard I tried, the situation necessitated the use of physical restraints so no one was injured.

I witnessed a patient turn a hospital bed upside down—after I had medicated him. I had no opportunity to attempt less restrictive measures for another patient brought in by emergency medical services (EMS), with whom both police and EMS struggled to restrain to the transport stretcher. The nurse who was nearly bashed over the head with a computer reacted with the life-saving “fight or flight” response and fled the immediate area. Another nurse recently sustained a hand and wrist injury by blocking a flying object from hitting her in the head.

I am all for a safe environment, milieu management, early intervention, and de-escalation, abiding by the rules, regulations, and policies to keep physical restraints a last resort to be used only in those situations when there is imminent risk of physical harm. But I am more for safety of all, including myself, when all other efforts have failed. Personally, I would not work in an acute behavioral health setting if restraints were totally outlawed. I value myself too much to put myself in that kind of risky situation.

Jean Horan, RN, MS
Waterbury, Connecticut

PARTIAL HOSPITALIZATION VERSUS DAY TREATMENT

To the Editor:

I have just read the article by Yanos, Vreeland, Minsky, Fuller, and Roe, “Partial Hospitalization: Compatible with Evidence-Based and Recovery-Oriented Treatment?” (February 2009, Vol. 47, No. 2, pp. 41-47). As a program director for a partial hospitalization program (PHP), I am concerned that readers of your journal would believe that the program highlighted in this article was a typical PHP. The average length of stay for the program in this article is 136 days. The average length of stay in my program is 14 treatment days, and this number is more reflective of PHPs in general. For example, the regulations in Maryland stipulate a 30-day cap because it is anticipated that patients will receive maximum benefit with a brief treatment model before stepping down to a lower level of care.

PHPs offer intensive, acute outpatient services to avert inpatient care. They improve the level of functioning and reduce symptoms. By definition, PHPs are short-term programs. Day treatment is not the same, yet the authors clearly state that they use these two terms interchangeably.

Day treatment often refers to programs that offer a rehabilitation model that usually lasts more than 30 treatment days.

Alice Jonas, MSN APRN/PMH, BC
Baltimore, Maryland

Response:

In response to Ms. Jonas’ letter, it should be clarified that different states and jurisdictions have used different terms for the kind of service described in the article. In New Jersey, where our study was conducted, this kind of service is referred to as partial hospitalization; however, we noted that it is also referred to as day treatment in other settings. By describing the kind of service in detail and alluding to other terms that have been used, we hoped it would be clear that we were describing programs that do not have a preset “maximum” length of stay, such as the kind described by Ms. Jonas. These kinds of programs (called acute partial hospitals in New Jersey) have been less controversial and are not the focus of our study. We hope this further clarifies the issue raised by Ms. Jonas’ letter.

Philip T. Yanos, PhD
New York, New York
Betty Vreeland, APN-C, PMHCNS-BC, ANP-BC
Piscataway, New Jersey

doi:10.3928/02793695-20090428-06