Letter

The Present Legal Status Regarding the Utilization of Mechanical or Pharmacological Restraints in Psychiatric and Social-Health Settings

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Issues regarding the use of restraints persist as a subject of discussion and debate among mental health professionals [1–4], and increasingly, within society at large. While the use of physical and pharmacological restraints remains controversial, it is now acknowledged as unavoidable and necessary for managing behavioural disturbances and psychomotor agitation that pose a risk to the patient or others [1]. It is widely recognized that coercive interventions are associated with an elevated incidence of physical and psychological harm to both patients and healthcare workers, leading to detrimental short and long-term effects on the patient-professional relationship [5,6], including fatalities [7]. Consequently, there is a growing awareness of the importance of using these restraints in psychiatric or mental health units, as well as in residential and social health centres.

The shift in approach, centered on the imperative to recognize human dignity, commenced at the close of the 20th century and is evident in the successive statements of international organizations. Although the goal of achieving a "zero restraint" system remains distant, it is imperative to establish clear regulations that ensure the respect of the fundamental rights of the individuals involved.

In this context, given the absence of specific regulations at the national level and the proliferation of various regional regulations, Instruction 1/2022 from the Public Prosecutor's Office on the Use of Mechanical or Pharmacological Restraints in Psychiatric or Mental Health Units and Residential and/or Social Health Centers for the Elderly and/or Disabled [8] lays down the primary rules of action and organization in this domain. Consequently, we deem it mandatory for all mental health professionals working in Spain to be acquainted with it.

Firstly, it should be clarified that this instruction is restricted to the utilization of restraints on elderly and/or disabled individuals during involuntary admissions to mental health units and their application in residential and/or social health centers. It does not encompass the use of restraints in other healthcare or hospital settings.

Secondly, it should be emphasized that the Public Prosecutor's Office does not intend to conduct a comprehensive assessment of the standard of care (lex artis) in the use of restraints for each case and each patient, because such an evaluation is well beyond the resources, training, and function of the prosecutors [8].

Thus, Instruction 1/2022 outlines the prerequisites for the application of restraints (Table 1, Ref. [8,9]). Additionally, the Instruction empowers the Public Prosecutor's Office to oversee residential centers, socio-sanitary centers, and psychiatric units to verify: (a) the existence of a medical prescription, either for its initial adoption or through prompt ratification by the medical director in emergency situations, along with the establishment of guidelines for continuous monitoring and periodic assessments to determine its continuation; (b) the presence of a protocol for the use of restraints within the center, encompassing indications, the application procedure, and monitoring; (c) the maintenance of a documentary record detailing the indication, utilization, and type of restraint applied to each patient, including specified durations; (d) adherence to rules gov-

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Table 1. Factors to consider when employing restraints, as outlined in the Public Prosecutor's Office Instruction 1/2022 concerning the use of mechanical or pharmacological restraints in psychiatric or mental health units and residential and/or socio-healthcare centers for the elderly and/or disabled [8].

1. Adherence to the dignity, freedom, and promotion of the autonomy of the individual. This entails that any use of restraints should be preceded by an effort to employ verbal restraint or other less invasive strategies. Subsequently, the reasons for the failure of these measures should be documented for assessment by the treatment team.
2. No individual should undergo any form of immobilization, physical restraint, or pharmacological treatment without a prescription, except in cases of imminent danger to the physical safety of the individual or others. In such instances, the responsible professional must agree to this course of action in line with the applicable protocol, without prejudice to subsequent ratification and/or correction by the authorized personnel.
3. Ensuring the presence of informed and documented consent is essential, following the stipulations of Law 41/2002, dated 14 November, which governs patient autonomy and the rights and obligations related to clinical information and documentation [9]. Depending on the case's circumstances, documentation may occur before, during, or after the intervention. General or delayed consents are considered invalid.
4. Adherence to the principles of care, exceptionality, necessity, proportionality, temporality, and prohibition of excessiveness requires the use of restraints with the minimum intensity and only for the time strictly necessary. Routine use, particularly concerning the elderly, should be avoided.
5. The decision to employ seclusion and restraint should arise when all other preventative methods have proven ineffective or in situations of imminent and serious danger to the individual or others. In instances involving individuals with mental health problems, the objective is to manage episodes of decompensation characterized by psychomotor agitation and/or severe behavioural disturbances that pose significant risks.

erning informed consent, with particular attention to cases involving individuals unable to provide consent independently or requiring assistance in doing so.

The evaluation of professionals working in mental health units and social health centers concerning compliance with the standard of care in the use of mechanical or pharmacological restraints will align with the aforementioned principles. In this assessment, adherence to protocols and action guidelines is paramount, ensuring the proper indication and monitoring of these measures. Equally essential is the effective communication of information to the patient, respecting their autonomy in decision-making. Documentation in the clinical history, encompassing the indication, utilization, type of restraint applied to each patient, and the duration of the restraint, is a crucial aspect in evaluating the overall professional practice.

Availability of Data and Materials

Not applicable.

Author Contributions

CMF contributed to the design of the manuscript, drafted the manuscript, provided approval of the final version and agreed to take responsibility for all aspects of the work. APR and JAM have contributed to the design of the manuscript, have critically reviewed the manuscript, have given their approval in the final version and have agreed to take responsibility for all aspects of the work.

Ethics Approval and Consent to Participate

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Conflict of Interest

The authors declare no conflict of interest.

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