Patient Choice: Deciding Between Psychotropic Medication and Physical Restraints in an Emergency

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The legal requirement to use least restrictive interventions in emergency psychiatric treatment does not stipulate whether physical restraints or medication is least restrictive. There is no current consensus about how to determine least restrictive interventions in a generalizable manner. In this study patients who were clients in a public psychiatric emergency service were anonymously surveyed and asked to state their preferences for specific interventions in a psychiatric emergency. In a choice between physical restraints versus psychotropic medication, 64 percent of clients preferred medication; 36 percent preferred seclusion or restraint. The rank order of preferred modality was 1) benzodiazepines—31 percent, 2) neuroleptics—26 percent, 3) seclusion—24 percent, 4) restraints—10 percent. The rank order of last choice was different. Patients preference is an important factor in determining the appropriate intervention in an emergency. Patient participation offers an opportunity reconcile to clinical and legal objectives, to i mprove compliance, and to enhance patient and staff safety.

A widely accepted legal principle, the least restrictive alternative concept requires that deprivations of personal freedom be limited to the minimum necessary to achieve the purposes of the intervention. [1] Initially applied in the mental health field to challenge the appropriateness of institutionalization, [2] the principle has been extended in the courts to challenge the nature of the institution in which the patient is placed, [3] the treatment modalities provided in the institution,[4] and the limitation on patient liberties in the institution. [5] But while setting forth the requirement that limitations on personal freedom be viewed on a continuum of restriction, the courts have yet to determine where physical restraints and nonconsensual medication each lie on that continuum.

In most states psychiatric patients have the right to make decisions about their care and treatment so long as they are not determined incompetent to do so or there is no emergency situation. [6]

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Even when a patient is determined to be incompetent, decision-makers in most states are required to make decisions consistent with the wishes and preferences of the patient (substituted judgment*). In emergency situations, however, physicians have exercised almost exclusive discretion in determining what type of intervention will be employed.

In California, the site of this study, the law requires that the clinician exhaust least restrictive measures before using physical restraints.[8] Paradoxically, it also requires that least restrictive alternatives be utilized before emergency medication is used,[9] but the law does not specify which of these interventions, medication or physical restraint, should be employed to address the emergency first.

Physicians tend to favor psychotropic medication over physical restraints since medication achieves ongoing neurochemical alteration for a period of time following administration. They view medication as an important form of direct treatment that can ameliorate or resolve the symptoms of psychosis rather than merely as a form of restraint. Physicians argue that medication frees the patient from delusional thinking and allows the patient to move about and associate with others. Therefore, they conclude, it is less restrictive than physical restraints.

The reasons that physicians prefer medication are the very same that raise legal concerns. Emergency medication and physical restraint, in different respects and to different degrees, raise fundamental legal issues regarding privacy and autonomy.[10] Whereas an individual's short-term freedom of movement, association with others, and bodily integrity are more immediately affected by the physical restraint process, medication, sometimes conceptualized legally as "chemical restraints,"[11] also results in immediate effects. These include alterations in an individual's thought, expression, and motor activation. In addition, medication may have longer-term effects, including the potentially permanent disabling side effect of tardive dyskinesia. Because psychotropic medication affects the most individual, private part of a person, cognitive and emotional processes, and because of the potential of harmful long-term effects, a number of courts have recognized and moved to protect the significant rights at stake in the medication process.[12]

Several clinical studies[13, 14] have examined dimensions of restrictiveness in different treatment settings, finding that there was a high rate of interrater reliability of judgments about restrictiveness of settings, treatment modalities, and restrictiveness of treatment experienced individually by patients; however, all of the raters in these studies were clinicians. In a different study[15] when treatment modalities were independently rated by clinical and legal experts and according

* Substituted judgment is the process by which treatment decisions are made by another person on behalf of an incompetent patient. In making treatment decisions, the surrogate decision-maker must be guided first by the individual patient's wishes or preferences. Where the patient's wishes regarding the treatment are not known, the surrogate decision-maker may base the decision on the patient's best interest as determined after considering the individual patient's values, beliefs, circumstances, and concerns.[7]

to standards in legislative statutes, there was no correlation of judgments regarding relative restrictiveness among involuntary treatment modalities. Some authors [16] have, therefore, questioned the appropriateness of the "least restrictive alternative" as a generalizable concept.

Part of the confusion may be due to the failure to distinguish the dual purposes of medication and the different contexts in which it is utilized. Physicians focus on the therapeutic value of medication and are likely to see it as least restrictive because, in addition to controlling behavior in the short term, it can initiate a longer-term therapeutic regimen. The clinical analysis of what is less restrictive consistently includes clinical standards of therapeutic benefit. Lawyers argue that since it is the competent patient's right to decide long-term therapeutic benefit, the only permissible nonconsensual use of medication in an emergency situation is control. They frame the question as which intervention is less restrictive to control the behavior and which intervention can bring the emergency to an end so as to allow the patient to regain the ability to make long-term therapeutic choices.

Decisions about the use of physical restraints or medication, including assessments of relative restrictiveness of each intervention, should be case-by-case determinations requiring consideration of specific circumstances and subjective interests. Neither clinical nor legal principles alone resolve the question of what constitutes least restrictive treatment. Clinical analyses are based on outcome from a psychiatric perspective, incorporate institutional concerns, and frequently do not factor in abridgement of patient liberty. Legal analyses focus almost exclusively on individual freedom interests and have no mechanism for weighing patient benefit in an institutional context.

An alternative to seeking clinical or judicial determination of whether to employ medication or physical restraints in an emergency is to provide the patient an active role in deciding the treatment of choice. Through the informed consent or substitute decision-making process, the clinician is able to identify the preferred intervention with a contemporaneous, individualized assessment.

The clinical advantages of involving the patient in treatment decisions even during an emergency include ensuring appropriate treatment, understanding the patient perspective, and encouraging voluntary compliance. As a first step in this direction we conducted a survey of patient opinions about the use of medication and physical restraints in an emergency situation. The survey site we chose is a county emergency psychiatric service located in a metropolitan area that serves a large number of seriously mentally ill clients (people who have lifelong major psychiatric disorders as defined by DSM-III-R and who require ongoing treatment). This population is most affected by decisions about medication or physical restraints, since during emergency treatment or hospitalization they may be treated with either or both of these modalities.

Methods

The study was conducted in the emergency psychiatric service of Santa Clara Valley Medical Center, a large metropolitan county hospital in San Jose, California, that provides the only public psychiatric emergency services to a population of 1.5 million people. A sample of 100 clients was obtained over a six-week time period starting in October 1990. All of the clients who were present in the emergency psychiatric service (EPS) between the hours of 9 a.m. to 10 a.m. and 2 p.m. to 3 p.m. Monday, Wednesday, and Friday were asked to complete a short questionnaire. Participation was entirely voluntary, and no identifying data were obtained. The questionnaire was distributed by an outside research consultant. The consultant did not work in the emergency services and told this to clients when she handed out the questionnaire. She also stated that the questionnaire would not have an effect on clinical care and would not be read by any staff present. Clients completed the forms by themselves. The research consultant was available to answer questions. 163 clients were asked to complete the questionnaire; 100 responses were obtained for a 63 percent response rate. The questionnaire was as follows: If staff were to decide your behavior is out of control would you prefer: (check one)

_____ To be secluded and/or restrained
OR
_____ To receive psychiatric medication (Haldol, Ativan, Prolixin, Xanax)
(Please rank your choices 1–4)
_____ Seclusion
_____ Restraints
_____ Ativan or Xanax
_____ Haldol or Prolixin or Navane

Results

Table 1 shows the responses to the questionnaire. In response to a choice between physical restraints (seclusion or restraints) versus psychotropic medication including both neuroleptics and benzodiazepines, 64 percent of clients preferred medication and 36 percent of clients preferred seclusion or restraint. The rank order of preferred treatment modality was 1) Ativan or Xanax (31%); 2) Haldol, Prolixin, or Navane (26%); 3) seclusion (24%); 4) restraints (10%). The distribution of choices for last choice was different, with 49 percent of clients selecting restraints as last choice, 30 percent of clients selecting Haldol, Prolixin,

Table 1
Choice of Treatment Modality

	Percentage of Clients			
	Seclusion or Restraints 36%		Psychiatric Medication 64%	
	Seclusion	Restraints	Benzodiazepine	Neuroleptics
Rank order				
1	24%	10%	31%	26%
2	21%	18%	31%	24%
3	40%	16%	23%	12%
4	6%	49%	8%	30%

or Navane as last choice, eight percent of patients selecting Ativan or Xanax as last choice, and only six percent selecting seclusion as last choice.

Table 2 shows demographic data pertaining to all clients evaluated in the emergency psychiatric service during the last quarter of 1990, when the survey was completed. As Table 2 shows, the diagnostic categories included 35.2 percent adjustment disorders; 21.8 percent schizophrenia, including schizoaffective disorder; 13.8 percent major affective disorders; 11.1 percent other psychoses; 6.3 percent alcohol, substance abuse/dependence; and 4.8 percent all others.

Employment status included 73 percent not in the labor force, and 27 percent in the job-related categories of training, part-time or full-time employment. Average educational level was 8.5 years of schooling. Ethnicity was 64 percent White, 19 percent Hispanic, 8.5 percent Asian, eight percent Black, one percent other. Average age was 33.6, and 65 percent had never been married.

Discussion

The results indicate that the majority of the patient sample (64%) prefer psychotropic medication to physical restraints, but a significant minority of patients (36%) do not. When this is further stratified, patients discriminate between benzodiazepines (first choice) and antipsychotic medication (second choice), and between seclusion (third choice) and restraints (fourth choice). There appears to be a group of patients who object strongly to antipsychotic medication since it was ranked only slightly less often than restraints as last

Table 2
Demographic Characteristics of Emergency Psychiatric Services: Acute Services, Santa Clara County Mental Health Bureau, October–December 1990

	Diagnosis					
	Adjustment Disorders	Schizophrenia	Major Affective Disorders	Other Psychotic Disorders	Alcohol or Substance Abuse	Other
	35.2%	21.8%	13.8%	11.1%	6.3%	4.8%
Ethnicity	White	Hispanic	Asian	Black	Other	
	64%	19%	8.5%	8%	1%	
Employment status	Full-time	Part-time	Students or Job Training	Unemployed	Not in Labor Force	
	8.8%	1.9%	14.5%	1.5%	73.4%	
Educational level	Grade School or Less	Some High School	High School Graduate	Schooling Beyond High School	Average	
	38%	19.6%	32.4%	10%	8.5 yrs	
Age	0–17	18–30	31–62	62+	Average	
	12.4%	35.2%	47.9%	4.5%	33.6 yrs	
Marital status	Unknown	Never Married	Married or Cohabiting	Widowed, Separated or Divorced		
	8.1%	65.0%	12.1%	14.8%		

choice. The discrepancy between benzodiazepines ranking as first choice and neuroleptics ranking frequently as last choice differs from what would be expected if patients considered all "chemical restraints" [11] (all psychotropic medication) as automatically more restrictive than physical restraints. Our results, in which different types of medication and physical restraints are ranked differently, indicate that patients are weighing more than one factor in their preferences.

One factor may be the perceived benefits of benzodiazepines in alleviating not just anxiety but also psychotic agitation. Studies have shown that benzodiazepines are useful in the adjunctive treatment of schizophrenia, mania, and psychotic depression with agitation. [17–19] It is reasonable to conclude that patients who experience symptom relief with benzodiazepines prefer them to other modalities of treating agitated behavior.

Another factor having an impact on patients' preferences includes the therapeutic effects and side effects of antipsychotic medication. Some patients experience enormous relief from psychotic symptoms with antipsychotic medication. However, patients may also experience side effects including acute extrapyramidal reactions and tardive dyskinesia. The incidence of extra-pyramidal reactions ranges from 2.5 to 5 percent for acute dystonic reaction to 20 to 50 percent for akathisia.[20] Studies show up to 62 percent of inpatients and 43 percent of outpatients on neuroleptics for more than a year have tardive dyskinesia. [21, 22]

Just as opinions about medication vary with the type of medication, opinions about physical restraints depend upon the particular type of physical restraint. Some patients request seclusion as a form of isolation to decrease external stimuli and a means of helping to control their impulses, whereas others regard it as a form of punishment. [23] Most patients regard restraints as, at best, physically uncomfortable, and often degrading or punitive. [24] Our results are consistent with others in the literature in which 74 percent of patients surveyed think restraints are more unpleasant than seclusion. [23]

An important limitation of our study is that there was only a 63 percent response rate. Not knowing the clinical characteristics of the patients who responded to the questionnaire, we do not know the extent to which they are representative of the general EPS population diagnostic categories and demographics shown in Table 2. For example, they may not have been as acutely ill as the overall population served in the EPS, may have included a lower number of schizophrenics, or may have been different demographically in a variety of ways. Future studies would be improved by providing information about the relationship between clinical characteristics and treatment preferences. Another limitation is that although the research consultant was available to answer questions, we do not know how much patients understood about medication and whether they were correct in their assessment of the medication options presented. Nonetheless, the study shows

that 63 percent of the population in the emergency service had an opinion about which intervention they preferred in an emergency. Furthermore, those opinions were different for different patients. Although a majority of patients expressed a preference for medication, another large group expressed a preference for restraints. Ultimately, the determination of what treatment is less restrictive, like the determination of what treatment is most effective, is not entirely a legal nor clinical judgment. It is a subjective determination that may vary from individual to individual based on the specific circumstances. The concept of offering patients a role in deciding the treatment of choice in emergency situations is entirely consistent with the development of legal theories balancing individual rights with other societal interests, and reconciles legal obligations to provide least restrictive interventions by including the patient in that determination.

Patient involvement is consistent with yet another fundamental concept in mental health law—the requirement for individual diagnosis and treatment.[25] Furthermore, providing patients a mechanism for involvement in determining which intervention is used fulfills clinical objectives by engaging them in the treatment process. Studies have found that patients have a better outcome when treatments are tailored to their individual needs and when they are actively involved in the treatment planning with the treatment team.[26, 27] Given the different individualized treatment approaches required by different patients, it would be useful to further explore the reasons why some interventions are preferred over others. It would also be important to further examine specific strategies for gaining client input into the emergency treatment process in a format which is administratively feasible, safe, and meaningful to the client.

One such mechanism would be to query patients about their preferences regarding emergency interventions, as well as other options in their course of treatment as part of the treatment planning process conducted in outpatient settings. The responses could be incorporated into the outpatient chart and forwarded to emergency services and acute hospitals for their records on the patient. This information, like drug allergies and medical history, would be useful to the clinicians who assess and treat the patient in the emergency setting, as well as to the outpatient clinician who helps counsel the patient about avoiding problems of hospitalization and emergency settings.†

Another option for providing patients the opportunity to exercise choice in emergency decisions is to ask each patient, as part of the admission process, what their preferences would be regarding emergency interventions and the advantages and disadvantages of each intervention. This method is proposed by one legal author who includes patient

† This mechanism for prospective health care planning is consistent with the Federal Patient Self-Determination Act,[28] which requires that all inpatient facilities receiving Medicaid or Medicare funds provide patients information about their rights to make advance directives for treatment and assist them in the implementation of those directives.

choice as an important element of a model statute for use of seclusion and restraint.[24] At a minimum, this would inform patients about the possible consequences for out-of-control behavior; but it might also serve to ensure a level of patient compliance with the intervention that would enhance patient and staff safety and well-being.

The law requires the use of least restrictive interventions in psychiatric treatment, but it does not specify which intervention, physical restraints, or medication is least restrictive. Similarly, clinicians acknowledge the problems in determining least restrictive interventions in an absolute and generalizable sense. Our study shows that patients have preferences for different interventions in an emergency situation. Our discussion suggests that a particular patient's preference is an important factor in determining whether medication or physical restraint is the appropriate intervention for them in an emergency. Providing patients the opportunity for participation in making choices about emergency treatment provides a mechanism for reconciling legal concerns and clinical objectives.

References

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