Breaking the Restraints
Four-Limbs Restraining of Patients in Psychiatric Wards in Israel
An Account of Systematic Human Rights Violations
March 2016

Executive Summary

“I was crying, screaming, banging on the doctor’s door. They threatened to tie me up if I didn’t stop. But other than threatening, no one did anything to try to calm me down, to see what was bothering me. They did tie me up in the end. You lie tied to the bed, in complete helplessness, looking at the door, waiting for someone to come in and let you out, holding it in so as not to soil yourself with your urine and feces, doing mind exercises, trying not to go mad. At first, you’re sure you’re going to be released any minute, that they were just trying to teach you a lesson, but no one comes. And, in the end, you give up, and it becomes all murky. You dissociate from your body. There’s no beginning and no end. Well, actually, there is an end, the end of you trusting that anyone in this place will ever help you.

Yarden, 30, bound in four-point limb restraints in a psychiatric hospital in central Israel.

Over the last few years, Bizchut – The Israel Human Rights Center for People with Disabilities, has received many complaints regarding people in psychiatric care who have been tied up in four-point limb restraints for many hours by hospital staff. People have reported being forcibly led into an isolated room where there was a bed fixed to the floor, to which they were tied using four, sometimes five straps made of synthetic fabric or leather cuffs, locked with screws. They were left there, confined to the bed, unable to move, scratch an itch or go to the bathroom. Some have reported being tied up for several hours. Others reported being tied to the bed for a whole night and some for many days consecutively. When we began looking into this practice and the reasons that lead medical staff to decide to restrain their patients, we discovered that the problem is both deep-rooted and much neglected. There has been no public discussion on the subject and there is almost no official data.

The research we conducted over the last few months, the results of which appear in a report published in March 2016 (in Hebrew), exposed us to hundreds of stories from people who have been mechanically restrained. These, in conjunction with figures we received from the Ministry of Health, lead us to conclude that the use of mechanical restraints on patients is routine practice in psychiatric care wards across the country. According to an estimate based on the figures provided by the Ministry of Health, in 2014, the average rate for use of mechanical restraints was approximately 23%, in other words, one in four patients were tied up during their hospital stay, or around 4,000 people every year. This is an alarming figure, and apparently extremely high compared to other western countries. The practice of tying patients is highly prevalent and strongly felt in all psychiatric care facilities in Israel. Even patients who have not themselves been restrained, are likely to have seen other patients who have thus been threatened. The experience of being tied up and the fear of it remain with thousands of individuals who are placed in psychiatric care every year, and form a significant element of how these patients, and the public at large, view psychiatric hospitalization.
The figures are particularly disturbing, given the fact that restraining patients is an injurious and dangerous act, as evidenced in many studies cited in the report. There are known cases of death as a direct result of patient restraints in Israel. Cases of physical harm or injury, as well as mental harm, including trauma, resurgence of past trauma and exacerbation of existing mental symptoms, are quite common. 80% of the persons who responded to an online questionnaire initiated by Bizchut, reported that they had been subjected to physical force while being restrained. About 40% of respondents said they had suffered harm or injury while tied up.

In addition, use of mechanical restraints is a demeaning act and a severe violation of human dignity. About 70% of the persons who responded to Bizchut’s questionnaire said they felt humiliated as a result of being restrained. About 30% reported they could not go to the bathroom during the entire time they were tied up and had to wait for hours. About 25% said they had to urinate or defecate on themselves. Patients spoke of experiencing helplessness, frustration, rage, violation of privacy and abandonment. Most mentioned being tied up as the worst experience they had during their hospitalization.

The report also reveals the prevalence and pervasiveness of the practice. About half the people who responded to Bizchut’s questionnaire noted they had been restrained more than once during their hospitalization. Patients remained tied up for many hours at a time. Bizchut’s questionnaire reveals that about half of those restrained were held this way for more than eight hours. Several people said they had been tied up for more than 24 hours consecutively. Children and youths are also held in limb restraints for hours. The figures show that the amount of time a patient remains restrained is not just an outcome of the patient’s behavior, but also of the staff’s approach and attitudes as well as the circumstances in the ward at the time. Surprisingly, and despite the inherent human rights violation, the decision as to whether to restrain someone and for how long is in the hands of a ward orderly. The report reveals that in most cases, in contravention of the law, physicians approve the initial decision to use mechanical restraints and any extensions based on the nurses’ request and without having examined the patient at all. 74% percent of the respondents said they had not been seen by a physician prior to being tied up and even more noted that they were not examined while they were restrained. Most hospitals do not have protocols for real-time reporting on incidents of mechanical restraint use to ward directors and certainly not to hospital management. The Ministry of Health does not collect systemic figures on this at all.

The report further reveals that patients are disproportionately restrained for reasons exceeding those specified by law. According to the figures presented in the report, and in contravention of the law itself, most people are not tied up due to real concerns related to levels of danger. In most cases patients are tied-up because they are in a state of agitation; for example, they speak incessantly, yell or move restlessly. While these behaviors are typical and common in patients who are in a state of crisis, they are often viewed as a ‘nuisance’ by staff members and, in their eyes, justify restraining a patient. This is especially evident in short-staffed wards and those lacking in a patient centred approach. Threats made by staff members, such as ‘Stop running (or yelling or pestering), or I’ll tie you up’ were often mentioned by questionnaire respondents. Restraining also appears to be used as a means of establishing authority or punishment. About 25% of the respondents said they had been tied up as punishment for their behavior. About 15% said they had been tied up for disobeying the orders of a staff member and 10% for a prohibited act. Patients reported situations such as: “I was tied up as a punishment and to discipline me”, and “I swore loudly at a staff member and they wanted to punish me and teach me a lesson”. Some staff members resort to mechanical restraints because they believe it has therapeutic value. However, this approach is considered anachronistic around the world and research has shown that its effects in
terms of therapy are in fact negative. Rather than calming patients down, restraining actually increases agitation, undermines trust and interferes with recovery and rehabilitation.

Even when restraints are used according to the specifications in the law, and to prevent danger, the report shows that in a significant number of cases, the severity of the situation does not justify using four-point limb restraints. Verbal abuse and damage to property generally do not justify restraining a patient. Even physical assaults do not justify hours and certainly not days of restraints, especially since many types of behaviour considered aggressive are actually the result of the ‘pressure cooker’ conditions in the ward and the staff’s approach. The use of coercive measures in these cases only aggravates the situation. However, in most inpatient care wards, mechanical restraints are the default practice in stressful situations. Staff members receive no training on non-coercive alternatives and there are not enough personnel nor awareness to implement these alternatives.

In light of all this, Bizchut claims that the use of mechanical restraints in Israel, certainly in its current scope, amounts to a breach of law and a disproportionate violation of the constitutional human rights of patients.

Calls to stop the practice have increased around the world, both because the practice is considered injurious and inhumane and because it is anachronistic. Bizchut’s report details how over the past twenty years, many western nations have implemented programs and initiatives aimed at putting a stop to the practice, or at least, reducing it to negligible rates. Different countries around the world have reduced use of mechanical restraints by scores of percentage points, to the point of effective elimination in some places. All this demonstrates that a dramatic reduction of the practice of restraining patients, to the point of near elimination of this practice, is a practical, viable goal. There are encouraging signs in Israel as well. Management at the Beer-Sheva Mental Health Center has undertaken an independent project to reduce use of four-limb restraints. Over the course of 2014-2015, the center, which serves a general population of 1.5 million people, achieved a 70% drop in the duration of mechanical restraint use and close to a 60% drop in cases of restraints.

Tying patients in inpatient care wards is preventable. It is an anachronistic tool that was meant to subdue and trample people with psychosocial disabilities in the bygone days of the mental asylums. Over the years, the practice was couched in a variety of therapeutic justifications, and anchored in various legal and administrative procedures. As such, most staff members do not resort to it out of malice, but because it is viewed as legitimate and because it is easy to administer. This is the message they get during their training. Those at the helm have chosen not to address the issue for decades, and have ignored past recommendations to significantly decrease its current usage, made in the past by their own expert committees.

In summation, over the years, patients have often complained about being frequently tied up for long periods of time, but there has been little response. The time has come to face reality. Bizchut’s report calls on the Ministry of Health to send a clear, binding message to everyone in the field that restraining patients is no longer legitimate therapy in a psychiatric care ward. The report also calls on the ministry to put together a comprehensive, detailed national plan, accompanied by a pilot project and assessment research, that will lead to establishing protocols and guidelines, developing alternative therapies, training staff members and ensuring monitoring mechanisms in order to uproot this practice and provide care staff with good, readily available alternatives. The report provides a list of research-based
recommendations designed to prevent a situation where these steps remain no more than theoretic declarations.

The report paints a bleak picture that may be distressing to some readers. The issue is clearly not black and white. Professionals in mental health inpatient care have taken on a complex, challenging vocation. However, everyone can agree that a hospital is a place for care and recovery, a place for rehabilitation, growth and human empathy. A patient is a person who needs all of these in a time of crisis and a care giver is a person who has chosen to dedicate his or her professional life to assisting in providing just that. Tying up patients subverts each and every one of these values. It hurts and damages both the patient and the care giver.

**Bizchut report calls: Let’s “Break the Restraints” and together, find a way to ensure care without tying up patients.**

“I felt like I was screaming, but it’s clear to me that I was completely silent. I was screaming about the abuse, the pain, the humiliation of being tied up, the injustice of it, my loneliness, that no one could save me from. No one could come and advocate for me, tell them there was no need to tie me up because I’d never been violent toward anyone, not in that state, and not in any other.

They untied me after two days. Two days of being restrained, of urinating and defecating on myself, of silhouettes passing by the room window and shouting unintelligible things at me, of a bright fluorescent light in the room that won’t let you sleep. Two days of intense humiliation, of my self-respect being taken from me and crushed, only because I might be violent once I came out of this state.

After they untied me, I slowly became myself again. I remember a line from a David Broza song constantly playing in my head “shouting at the walls”, or something like that.

My cry was intense, but no one heard it. To this day, I keep waking up at night from nightmares about the humiliating experience I had, the huge pain, the terrible loneliness, the helplessness that allows people to take away your liberty just because of a vague chance that maybe... I’ll be violent. And I wonder: Was there another way? Was it possible to get me out of that state without the terrible humiliation I went through?

Orit, 30, bound in four-point limb restraints in a psychiatric hospital in central Israel.

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1 First-person quotes in the report were mostly taken from an internet survey conducted by Bizchut from October 2015 to January 2016, which is explored in the report, and from communications to Bizchut in writing and over the telephone. Some of the identifying elements in the communication, including specifics about the facts, were altered to prevent exposing the patient. Note that patients were generally apprehensive about exposing their stories because many believed they would have to return to the same hospital where they were bound, and feared the ramifications. First names in this report are in most cases not the real names. The age cited is the approximate age at the time the person was tied, unless the person asked to hide this detail. Some people asked to note the name of the hospital where they had been tied up and others asked to withhold it, which is why both options appear in the report.