ECT As A Form of Restraint*

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ECT is controversial as a form of therapy, with lay and psychiatric objectors. Restraint is also controversial, though often necessary. The Ontario Mental Health Act of 1978 allows the psychiatrist to restrain patients without consent if there is risk of physical danger. The act mentions "chemical and mechanical" means. ECT is not dealt with as a form of restraint. A case is described of a manic male who during 2 episodes of psychosis presented a serious threat of assault to staff. The next of kin was reluctant to sign consent for "treatment" because of fear of the patient's later resentment. An application to the Review Board for permission to treat would have taken a week. On both occasions attempts to control the patient with chemotherapy were totally unsuccessful despite the use of rapid neuroleptization, paraldehyde, barbiturates and mechanical restraints. In both admissions 4 ECT given over 2 days produced rapid behavioural control. ECT was then discontinued because the patient declined to give consent for ECT as treatment and he no longer presented a threat. Medical and legal consultation were necessary and the consensus was that ECT as restraint may be justified on the basis of clinical judgment. In such cases ECT is safer, more reliable and more humane than chemotherapy or mechanical restraints. The authors discuss the current public and professional antipathy towards ECT. There is risk of death for the patient in circumstances where legal barriers prevent the appropriate use of electro-shock and a U.S. case is mentioned. There is a clear need for further public and professional education. Provincial legislation should be drafted so as to clearly permit the use of ECT in involuntary patients who present an acute, severe risk of injury to themselves or others.

In recent decades there has been a decrease in the use of physical restraints and it is a rarity now to read of the use of wet packs, dry packs or straight-jackets. However, it appears that many psychiatric units still make infrequent use of cuffs. The reduction in the use of physical restraint does not, however, reflect a decrease in restraint per se. Instead chemical restraint is used frequently. It too has become controversial, and the term "chemical straight-jacket" is used pejoratively. Nevertheless, it is clear that there are patients whose level of uncontrolled physical violence is so high that there is urgent need for external control to prevent harm to the agitated patient or to others.

Some civil libertarians have been concerned about the abuse of such restraints by psychiatrists. The Ontario Mental Health Act of 1978 (1) gives psychiatrists permission to limit the freedom and actions of a patient whom they consider "likely to cause serious bodily harm to themselves or to another or who is at risk of imminent and serious physical impairment." Although a patient may be held in the hospital involuntarily, the physician has no mandate to treat that patient against his will. There is, however, a legal process available through which the physician may apply to a provincial review board which will assess the physician's arguments and may give him the right to treat the patient in spite of the latter's protests. Under section 13(3a) "an involuntary patient may be detained, restrained, observed and examined in a psychiatric facility, for not more than 2 weeks under a certificate of involuntary admission." Under section 1(Ma) which is called "interpretation" it states "restraint means keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient."

While matters are relatively clear with regard to chemicals, the use of ECT is more controversial. The question arises whether ECT can reasonably (and legally) be considered a form of restraint. Guirguis and Durost in their paper on mechanical restraints (2) do not include ECT in their comprehensive list. Also, Guirguis does not refer to ECT in his paper on alternatives to the use of mechanical restraints in the management of disturbed patients (3). In the particular case under consideration in this paper, legal opinion was sought and the opinion given was that this was primarily an issue of clinical judgement, in circumstances where ECT might be considered safer and more humane than chemical or cuff restraint. The patient's mother could legally have given permission for us to proceed with ECT as treatment. She did not wish to do this because, although she felt that the treatment might very well be helpful, she was afraid her son would bear a grudge against her afterwards because of her signa-

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ture on the consent. We respected this as a reasonable judgement by the mother.

Case Report

The patient who works as a clerk was born September 1953, in Yugoslavia. He has a history of bipolar affective disorder going back to December 1974. He was admitted to the Clarke Institute for the fifth time November 1, 1981. He had previously been discharged 32 weeks earlier. He had been taking lithium and oral fluphenazine at the time of his discharge but had stopped taking these medications about 2 months before his admission. He was first assessed at another hospital where he was described as being "aggressive and abusive physically and verbally." There, because of the physical risk he was given 20 mgs. diazepam I.V. which produced sedation for a short time. Twenty minutes later he was given haloperidol 10 mgs., p.o. After transfer to the Clarke Institute, he was treated vigorously, receiving 6 doses of paraldehyde, with brief sedative effect and a program of rapid neuroleptization, receiving 9 doses of 10 mgs. I.M. haloperidol and 4 doses of 15 mgs. I.M. haloperidol, total 150 mgs., over the next 8 1/2 hours. Despite these large doses of medication, he had to be placed in restraints because of the threat to others.

It became apparent that he was not responding to the neuroleptic quickly enough and a decision was made to use ECT on an emergency basis. He received 2 bilateral treatments on the morning of November 4, the first seizure lasting 25 seconds and the second one 180 seconds. His medications were switched to chlorpromazine and that day he received three 100 mg injections and two 400 mg oral doses. He was markedly improved that day, immediately after waking post-ECT and it was possible to take him out of restraints. He was still spitting at staff but not striking at them. That night he received a single dose of paraldehyde and the next morning had one ECT lasting 65 seconds. He did not respond to an attempt to induce a second seizure.

His p.r.n. medication on November 5 consisted of one 100 mgs injection of chlorpromazine and two 400 mgs oral doses. That night he did not need paraldehyde and the following morning he had two more ECT's lasting 45 seconds and 95 seconds. Subsequently his behaviour was quite well controlled and he presented no serious management problems. The emergency ECT was therefore discontinued.

Although we recommended a full course of ECT to him as treatment, he did not agree to this and as he no longer presented a threat there were no grounds to use ECT as a form of restraint. With his consent he was treated with chlorpromazine 2400 mgs daily in divided doses.

His subsequent course was relatively uneventful but unfortunately on December 7 he left the hospital without any warning to staff. He was readmitted to the hospital on December 15 when he was once again agitated saying that he felt he might kill someone. At one point he became so angry that he pulled a picture and some wallpaper off the wall. After admission he was rapidly neuroleptized being given haloperidol 10 mgs I.M. q. 30 minutes. After receiving 60 mgs over 3 1/2 hours he settled and slept through the night. By the next morning he appeared to be under better control, and even though he expressed delusional ideas and was restless and disorganized he did not appear aggressive. It was planned to give him injections of 10 mgs 4-hourly and he received one at 0900. However, by noon he was once again agitated and threatening. Rapid neuroleptization was reinstituted and he received a further 15 injections between 1220 and 2115. The injections produced no effect and the dose was increased to 20 mgs I.M. and he received a further 5 injections in the next 2 1/2 hours so that in a period of 12 hours he had received 250 mgs. He then slept but had to receive three further 20 mgs injections between 0700 and 0900 on December 17. When a consulting psychiatrist was brought in to see him he attempted to kick the physician.

Once again it was decided that he was not responsive to neuroleptics, having received 310 mgs of I.M. haloperidol in a 21-hour period, and it was again decided that ECT was needed. As in the first instance, consent was not available but this did appear to present a psychiatric emergency in which control was necessary to protect others from the patient. He received 2 bilateral ECT which lasted 150 seconds and 30 seconds. Subsequently, he settled for about 6 hours but then became verbally abusive once more. Over a 12-hour period he received 70 mgs of I.M. haloperidol plus 50 mgs of I.M. chlorpromazine. He slept for 4 hours but awoke verbally abusive. Shortly thereafter he received 2 further ECT lasting 90 seconds and 30 seconds. Thenceforth he was well controlled and quite pleasant in his interactions. His I.M. medication was discontinued and his ECT was discontinued because he would not give consent for treatment with ECT. He was started on fluphenazine 40 mgs b.i.d. His subsequent course was not remarkable. It should be noted that as on previous occasions, he refused lithium prophylaxis.

Discussion

There are some patients who do not settle with physical restraints (in this case, cuffs) or sedatives (in this case paraldehyde). Such patients may also fail to respond to rapid neuroleptization. This particular patient received 250 mgs of haloperidol in a 12-hour period and 310 mgs over a 21-hour period with a minimal reduction of his agitation. This technique is not without risk of respiratory arrest and serious heart block. He was known to respond to ECT. Furthermore, he suffered from a syndrome — extreme agitation and aggressiveness occurring in the context of a manic illness — that is known to respond to electroconvulsive treatment. He was unwilling to give consent and it was inappropriate for his mother to do so and a clinical decision was made that ECT for this patient constituted "restraint." Indeed, the clinical course was even more gratifying than one could have optimistically predicted and suggests that for this particular patient (and perhaps others like him) ECT should be considered the "restraint of choice." Physicians may, however, be unwilling to use this particular approach because it is not dealt with in the current Ontario Mental Health Act. This case strongly suggests that use of ECT as restraint is warranted and should be legalized when there is convincing clinical evidence to support

such action. A recent U.S. case ended in the patient's death when legal barriers prevented the appropriate use of ECT (4). Ambivalence in psychiatric staff is accentuated because ECT given as restraint for a manic is also singularly effective treatment, like rapid neuroleptization but unlike paraldehyde.

In the case cited in this paper a particular, safe and useful application of ECT is described. Its use fits the requirements of American Psychiatric Association's task force on Electroconvulsive Therapy (5) which states that ECT should not be used to control behaviour in the absence of severe, intractible, dangerous behaviour occurring in the context of a major psychosis. The reservation against the use of ECT to control violent behaviour by Kendell (6) is also met in this instance; the patient had a history of bipolar affective disorder, and his behaviour was a disabling consequence of his illness. There can, in short, be little doubt that the ineffectiveness of medication, the history of previous response to treatment, the grave danger to the patient and others, places the ECT he was given in the category of medical treatment. It was clearly not used as a device to limit inconvenient, difficult behaviour unconnected with a psychotic illness. While the authors emphasize that ECT used simply to restrain difficult people constitutes a misuse of an effective medical treatment, it nevertheless has a carefully defined place in the armamentarium of safe and humane techniques of restraint.

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Résumé

Les électrochocs constituent une forme de thérapie controversée dont les opposants se retrouvent tant dans le monde psychiatrique que dans le grand public. Les contraintes font aussi l'objet de controverses bien qu'elles soient souvent nécessaires. La Loi sur la santé mentale de l'Ontario de 1978 permet au psychiatre d'imposer des contraintes aux patients, sans leur consentement, si ceux-ci présentent des risques de danger physique. La Loi utilise les termes "moyens chimiques et mécaniques". Pourtant la Loi ne fait pas mention de l'électrochoc comme forme de contrainte. Dans cet article, l'auteur décrit un patient atteint de manie qui, pendant deux crises psychotiques représentait une menace de violence grave pour le personnel. Son plus proche parent se montrait hésitant à signer la formule de consentement au "traitement" parce qu'il craignait le ressentiment futur du patient. Il aurait fallu une semaine pour obtenir de la Commission d'examen la permission de traiter ce patient. À ces deux occasions, les tentatives faites pour contrôler le patient par la chimiothérapie étaient demeurées sans succès malgré l'utilisation de neuroleptiques à activité rapide, de paraldéhydes, de barbituriques et d'instruments de contrainte mécanique. Lors des deux admissions, les quatre électrochocs administrés sur une période de deux jours ont permis de contrôler rapidement ce patient. Pourtant ce genre de traitement ne fut pas poursuivi parce que le patient a refusé par la suite de donner le consentement nécessaire et parce que, de toute façon, le patient ne représentait plus un danger. On a jugé nécessaire de prendre conseil, tant sur le plan médical que juridique et le consensus fut à l'effet que la contrainte exercée au moyen de l'électrochoc peut être justifiée lorsqu'à la suite d'une évaluation clinique, on le juge nécessaire. Dans ce genre de situations, l'électrochoc est plus sûr, plus fiable et plus humain que la chimiothérapie ou que les moyens de contrainte mécanique. Les auteurs discutent dans cet article de l'antipathie que suscite l'électrochoc dans le monde professionnel et dans le grand public. Il existe certains risques de décès lorsque les obstacles juridiques empêchent l'utilisation appropriée de l'électrochoc; les auteurs illustrent cette possibilité au moyen d'un exemple américain. Les auteurs constatent également qu'il existe un grand besoin d'éducation à ce sujet tant dans le monde professionnel que dans le grand public. La Loi provinciale devrait être rédigée de façon claire et permettre l'utilisation de l'électrochoc pour les patients qui refusent ce genre de traitement et qui présentent des risques graves et immédiats pour eux-mêmes ou pour les autres.

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Use of electrical therapy outrages patients' groups

By JOCK FERGUSON

Several lawyers and patients' rights activists are outraged over the use of electric shock therapy to subdue an unruly male patient at the Clarke Institute of Psychiatry.

In late 1981, Dr. Joel Jeffries, faced with what he said was an uncontrollable patient who couldn't be subdued with drugs, consulted other doctors and the hospital's lawyer before deciding to give the man jolts of electricity.

In an interview he said the procedure, while not specifically authorized by the Ontario Mental Health Act as a restraint technique, was legally justified by clinical circumstances.

He said he wrote an article in the Canadian Journal of Psychiatry, along with Dr. Vivian Rakoff, in part to persuade the Ontario Government to amend the Mental Health Act to allow the use of electroconvulsive therapy as a restraint technique in specific cases.

Dr. Jeffries said that large doses of drugs, 250 milligrams of Haloperidol in one 12-hour period and 310 milligrams in another 21-hour period, proved ineffective in reducing the man's agitation and there was a danger he would hurt others as well as himself.

The shocks were administered without the consent of the patient or his mother, who was afraid that agreeing to the shock procedure would alienate her son from her, according to Dr. Jeffries.

In writing about the case in the December, 1983, issue of the Canadian Journal of Psychiatry, he said he was persuaded to try the ECT procedure because the administration of large doses of tranquillizing drugs "is not without risk of respiratory arrest and serious heart block."

"The doctors knowingly ignored the Mental Health Act and are trying to justify it by claiming there were clinical reasons," said David Baker, a lawyer and executive director of the Advocacy and Resource Centre for the Handicapped.

"It's an act of civil disobedience on their part . . . and I think we have a right to expect more from people as powerful as psychiatrists."

Carla McKague, a Toronto lawyer active in patients' rights issues, said in an interview that she would have advised the doctors "to tread carefully" had they consulted her about using ECT to subdue a patient.

The man was strapped to a table and electrodes were attached to either side of his head and, on 10 separate occasions, electricity pulsed through his brain, producing convulsions or seizures lasting as long as three minutes, according to Dr. Jeffries. The charges were administered to the man over several days during two separate bouts of manic behavior in November and December, 1981.

However, Dr. Jeffries stressed, once the patient became coherent, he refused a shock therapy program to treat his problem, and no more shocks were administered. Dr. Jeffries said it was important to understand that the nine shocks (a 10th failed to produce a seizure) were only to restrain the man, not to treat his problem.

"In such cases," he said, "ECT is safer, more reliable and more humane than chemotherapy or mechanical restraints."

However, others strongly disagree.

Miss McKague and Mr. Baker said the Ontario Mental Health Act is very specific on what can be used to restrain a patient. "Restraint means keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable, having regard to the physical and mental condition of the patient."

Mr. Baker said that if the procedure were used today, it would, in his mind, violate Section 7 of the Charter of Rights and Freedoms, which guarantees the right to life, liberty and the security of the person.

Gilbert Sharpe, a lawyer with the Ministry of Health, said that in his view the use of ECT to restrain a patient wasn't prohibited by the act, but that as far as he was aware the technique had never been used to restrain patients in psychiatric hospitals run by the province.

Dr. Jeffries said "this case strongly suggests that the use of ECT as restraint is warranted and should be legalized when there is convincing clinical evidence to support such action. But Mr. Sharpe said "a change in the act isn't warranted to specify it as a restraint technique."

Dr. Jeffries said he was well aware that publishing the article would spark a controversy. "I hope it won't be blown up into something gross . . . and play into the hands of the anti-psychiatry lobby (who have) gone wild on ECT. They are going to use this to fuel their fire."

The man given the shock treatment is now on a drug therapy program to treat his condition and, according to Dr. Jeffries, has not undergone any further shock treatment.

In a closing cautionary note the authors said: "ECT used simply to restrain difficult people constitutes a misuse of effective medical treatment, (but) it nevertheless has a carefully defined place in the armamentarium of safe and humane techniques of restraint."

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