Psychiatric Nurses' Attitude and Practice toward Physical Restraint

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A B S T R A C T

Aim: This study was to assess psychiatric nurses' attitude and practice toward physical restraint among mentally ill patients. Methods: A descriptive research design was used to achieve the study objective. The present study was carried out in three specialized governmental mental hospitals and two psychiatric wards in general hospital. A convenient purposive sample of 96 nurses who were working in the previously mentioned setting was included. The tool used for data collection was the Self-Administered Structured Questionnaire; it included three parts: The first comprised items concerned with demographic characteristics of the nurses, the second comprised 10 item measuring nurses' attitudes toward physical restraint, and the third was used to assess nurses' practices regarding use of physical restraint. Results: There were insignificant differences between attitudes and practices in relation to nurses' sex, level of education, years of experience and work place. Moreover, a positive significant correlation was found between nurses' total attitude scores, and practices regarding use of physical restraint. Conclusion: Psychiatric nurses have positive attitude and adequate practice toward using physical restraints as an alternative management for psychiatric patients. It is important for psychiatric nurses to acknowledge that physical restraints should be implemented as the last resort. The study recommended that it is important for psychiatric nurses to acknowledge that physical restraints should be implemented as the last resort.

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In psychiatric hospitals, patients' violence and threats of violence constitute serious emergencies that may be difficult to handle by staff. Physical restraints (PRs) refer to any physical methods of restricting a person's freedom of movement, physical activity or normal access to his or her body (Martin, 2002). Moreover it is used in psychiatric health care settings as one of the psychiatric management to reduce the risk of harm among psychiatric patients whether it is directed toward self or toward others (Gelpkopt Roffe, Behrbak, Melamed, Werbloff et al., 2009). The use of PR as an intervention in the care of psychiatric patients goes back to the beginning of the science of psychiatry. However, it is still one of the challenging questions in the psychiatric services and has always been considered as a moral argument (Iversen, 2009; Steinert, Lepping, Bernhardsgütter, et al., 2010). Physical restraint includes devices designed to limit a patient's physical movements such as limb holders, safety vests and bandages. It is used to handle violent and maladaptive behaviors, manage patients with severe mental disorders, prevent injury and reduce agitation and aggression (Capezuti, 2004; Chien, Chan, Lam, & Kam, 2005; Akansel, 2007).

Nurses are closely involved in caring for restrained patients. The common absence of medical orders for starting or removing physical restraints indicates that the nurses mostly make these decisions. Their roles start with the selection of the least restricting arm restraint device available, followed by ones responsible and ending with modifying the patient care plan based on an hourly assessment of the patient’s response and physical condition (De Jonghe et al., 2013).

Several attempts have been made to reduce the integration of restraints in the clinical practice, as most studies used educational approaches in order to encourage nurses to use alternative measures instead of physical restraint. All studies delivered intensive training sessions and introduced a nurse specialist as a consultant; however, the success rate of these interventions in different countries has been variable; for example a successful educational intervention applied on nurses working in the USA proved to be ineffective in The Netherlands (Huizing, Hamers, Gulpers, Berger, 2006; Becker, Kocy, & Klie, 2007; Capezuti et al., 2007).

In general, research findings revealed that patients as a result of being restrained reported that they felt angry, helpless, sad, and powerless, punished, embarrassed, and that their right to autonomy and privacy has been violated, in addition to a feeling of loss of self worth, degradation, demoralization and humiliation while they are restrained (The American Psychiatric Nurses Association, 2001; The JOANNA Briggs Institute, 2002; Elgamal, 2006). Most of the patients' subjective experiences highlight the negative impact of physical restraint on the patients. These experiences were summarized in two themes: restriction and discomfort. Restriction relates to loss of freedom and control over what is happening during hospitalization, while discomfort is...
caused by enforced immobility, i.e. from patient narrative comment: “I felt like a dog and cried all night, it hurts me to have to be tied up, and I’m in a jail stuck, I couldn’t even bring my hands together” (Sailas and Wahlbeck, 2005; Suen et al., 2006).

A study about psychiatric staff’s thoughts and feelings about restraint use, found that the risk of harm and the use of restraint conflicted with nurses’ role to protect. Nurses did not want to use restraints as a first option (Aschen, 1995; Hennessy, McNeely, Whittington, Strasser, & Archea, 1997; Karlsson, 2000; Hantikainen & Ka¨ppeli, 2000). In most of the studies the nursing staff reported a range of emotional reaction felt while doing restraint procedure, including anxiety, anger, feeling bored or distressed, crying, inadequacy, hopelessness, frustration, fear, guilt, dissatisfaction, isolation, being overwhelmed, feeling drained, vengeance and repugnance (Kamel, Maximos, & Gaafar, 2007).

In another study the nursing staff described how they had come hardened to the experience of restraint. Some of them reported that they had no emotional reaction and many reported automatic responding during restraint event in which they did not feel any emotion. This lack of feeling among nurses might be due to the fact that the practice had become so ritualized that it does not provoke any reaction (Sequeira & Halstead, 2004). Nurses’ attitudes toward physical restraints described as ambivalent, characterized by respect for a person’s dignity and by anxiety and the responsibility for the resident’s safety. Nurses described feelings of frustration and guilt when they used physical restraints against the will of a resident (Hantikainen & Ka¨ppeli, 2000; Karlsson, 2000).

Attitudes toward physical restraint can affect on nurses’ performance and behavior, especially psychiatric patients who already confronting and discrimination, which may express also by professionals and the general public (Emrich, Thomson, & Moore, 2003). Getting in touch with psychiatric patients and getting knowledge can help in replacing the myths with facts, decreasing stigma and affecting attitudes positively (Halters, 2004).

Physical restraints are a common practice in psychiatric hospitals, with prevalence rates ranging between 33% and 68% in hospital settings (Hamers & Huizing, 2005). Since nurses’ attitude and practice play an important role in psychiatric health care setting, it was deemed important to develop a restraint policy and educate nurses how to implement it because hospitals in Sudan do not have policies and there are illegal uses of restraint recorded.

AIM OF THE STUDY

The Aim of This Study Was to

Assess psychiatric nurses’ attitude and practice toward physical restraint among mentally ill patients.

Objective of the Present Study Was to

• identify psychiatric nurses attitudes toward restrained patients.
• evaluate psychiatric nurses practices regarding physical restraint.

SUBJECTS AND METHODS

Research Design

A descriptive research design was used in the study.

Setting

The present study was carried out in Khartoum-Republic of Sudan hospitals. It included three specialized governmental mental hospitals (Abdalal Aleedreece, Taha Bahser and Altegani Almahi) and two Psychiatric wards in two general hospitals (Alselah Altibi and Khartoum Teaching Hospital).

Subjects

The study was conducted on a convenient purposive sample consisting of 96 nurses who were working in these hospitals in the time of data collection according to following criteria: from both sexes and working in different psychiatric departments. Any deviations from these criteria were excluded. The questionnaire was distributed to all nurses with mentioned criteria, and the response rate was 63% with 96 nurses from all respondents.

Tools of Data Collection

Data Were collected through

Self-Administered Structured Questionnaire, which aimed to assess nurses’ attitude and practice regarding use of physical restraints. It was adopted from Janelli, Kanski, Scherer, and Neary (1992) and adapted by researchers in Arabic format in order to have a suitable language to suit the nurses’ level of understanding. Then, it was revised by using of panel of experts for the content validity. It included three parts as follows:

The first part:

It comprised items concerned with demographic characteristics of the nurses such as age, sex, qualifications, educational level, years of experience and work place.

The second part:

It comprised 10 items measuring nurses’ attitudes toward using of physical restraint, rated on a 4-point Likert scale in which four = ‘strongly agree’ and one = ‘strongly disagree’. Thus, high scores with cutoff point 24–40 reflected positive attitudes and low scores with cut-off point 10–23 reflected negative attitudes (potential range: 10–40).

The third part:

It was used to assess nurses’ practices regarding the use of physical restraint, which comprised 18 items assessing the issues in nursing care provided to patients immediately, before or during restraint such as ‘explain procedures to patient and significant others.’ The items reported to be done were scored “1” and the items not done were scored “0”. For each area, the scores of the items were summed-up and the total divided by the number of the items, giving a mean score for the part. These scores were converted into a percent score, and means and standard deviations were computed. The nurses’ practice was considered adequate if the percent score was 60% or more and inadequate if less than 60.

The Cronbach’s alpha coefficients of parts two and three were 0.73 and 0.78.

Pilot Study

A pilot study was conducted after the development of the tools and before starting the data collection. It included 10% from nurses’ works in the previously mentioned settings and then excluded from the study sample. The purpose of the pilot study was to test the applicability, feasibility and clarity of the tools, and it served to estimate the time needed to complete the tools. Simple modifications of the tools were done.

Field Work

The data were collected from 20 February to 30 July 2014. Two days per week were specified for data collection. The days were Sunday and Thursday from 9.30 to 12.30 p.m. The investigator interviewed, observed and filled in the tools from each nurse individually. The approximate time spent with each nurse during the interview was 30 to 45 min; nurses interview number ranged from 1 to 6 nurses per day.
An official permission was granted by the hospitals and the Ministry of Health in Khartoum City.

Ethical Consideration

The aim of the research was explained to the head nurses and nurses. Verbal consent was obtained from each nurse to participate in the study after clarifying the procedure of the study. Nurses were informed about their right to refuse participation and to withdraw at any time without any consequences. Confidentiality of data was ensured.

Statistical Analysis

Data were collected and fed into the computer for analysis and presentation. Data were entered and analyzed using SPSS 20.0 statistical software package. Data were presented using descriptive statistics in the form of frequencies and percentages for qualitative variable, Chi-square and Pearson correlation coefficient. Statistically significant difference was considered when P-Value ≤0.05.

RESULTS

The respondents in this study were 96 nurses with a mean age 34.5 ± 2.5 years, 45.8% of nurses were aged between 30 and 50 years old, more than half of them were female (53.1%), and the largest group of the study nurses (74.0%) studied in nursing secondary school. Most of nurses had period of experience 4–8 years (37.5%), and 53.1% of them work in male ward.

Table 1 describes the nurse’s attitude toward the physical restraint. More than half of them disagreed with the statement that “the main reason for restraints are used in the hospital is shortage of staff” (58.3%), while less than half of them “feel embarrassed when the family enters the room of patient who is restrained” (47.9%) and the patient suffers from loss of dignity when placed in restraints” (47.9%), followed by “feels that placing a patient in restraints can decrease nursing care time” (42.7%), and “feel guilty when placing a patient in restraints” (39.6%). About two thirds of nurses try to use alternative nursing measures before restraining the patient (61.4%) followed by 46.9% who apply restraints to assure legal protection for nurses and hospital and 45.8% who feel bad if the patient gets more upset after restraints are applied.

Table 2 reflects that more than half of the nurses have no sufficient staff during physical restraints (65.6%), do not assess patient condition every 10–15 min (56.3%) and do not document the patient intervention (39.6%); 46.9% of the nurses do not monitor patient skin frequently in restrained extremities and do not talk with the client during the procedure (38.5%), while about one third of nurses do not involve the patient in making decisions (33.3%).

Table 3 revealed that 53.8% of female nurses and, 44.9% aged between 30 and 50 years were holding more positive attitudes toward physical restraints. In addition, nurses who had nursing secondary school (73.1%) experience the positive attitudes toward physical restraint, and nurses working in male wards (50.0%) for the years of experience 8 years (35.9%) and more had positive attitudes. Also, the table indicated that the female nurses (54.8%) with age group from 30 to 50 years (46.6%), nurses who had nursing secondary school (73.9%), those working in male wards (50.7%), and those with years of experience 8 years and more (35.6%) had inadequate practices toward physical restraint. Moreover, there are insignificant differences between attitudes and practices in relation to nurses’ sex, level of education, years of experience and work place.

Table 4 shows that there is a positive significant correlation between nurses’ total attitude and practices regarding use of physical restraint.

DISCUSSION

Traditionally, the burden of keeping patients safe and their medical equipment intact has been left to the nurses. Using restraints to prevent
It is important to note that if restraint is an important intervention that requires recording and communication plans to meet the needs of individual clients (Suen et al., 2006).

Less than half of the respondent nurses in this study indicated that they do not record data about PR use in patient’s chart (type of restraint used, indication for use, time of application and the related nursing care). Because of this insufficient practice, it is hard to say why patients are being physically restrained, or what kinds of results were observed. This result is consistent with Choi and Song (2003) and Azab and Abu Negm (2013) who found that there was no documentation in nursing notes on PR in three quarter of the studied restrained cases. This was attributed to the consideration of PR by health professionals as not being an important intervention that requires recording and communication (Macpherson, Lofgren, Granieri, & Myllenbeck, 1990). However, the recent regulatory standards of PR use raised the importance of its documentation due to its legal and ethical implications.

It has been known from the present results that psychiatric nurses have positive attitudes toward using of physical restraints. This finding of nurses’ attitudes reflects their agreement about using of physical restraint for psychiatric patients, and such finding could be explained by the fact that nurses perceive agitated psychiatric patients as dangerous and consequently, they agree with the use of restraint because they perceive that restraint may reduce the complications that might occur. On the other hand, nurses think that controlled patients should be released from restraint. Further studies supporting this evidence were found by Elgamal (2006) and Wai-Tong and Isabella (2007); additional supportive evidence was found by Sajat (2008) and Mohammed (2015).

Our results revealed that female nurses with age group of 30 to 50 years are holding positive attitudes than male nurses and other nurses from other age groups. The positive attitudes toward physical restraint are experienced by nurses who had diploma and were working in male wards for the years of experience 8 years and more. The findings above indicated that psychiatric nurses are influenced by their experiences which they have learned during the period of their employment as psychiatric nurse; this explanation proves the theory of attitude change. According to Tyler and Schuller (2012), the attitudes that are demonstrated by young individuals are less than those demonstrated by older persons. The interpretation of this differentiation is in two ways: the first one is a “psychological explanation” which sees that younger individuals are open to change their attitudes; the second one is a “life style explanation” which sees that young individuals

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Table 3
Comparison between Nurses’ Attitude and Practices toward Use of Physical Restraint in Relation to Socio-Demographic Characteristics (n = 96).

<table>
<thead>
<tr>
<th>Age (years):</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>χ² Test</th>
<th>P</th>
<th>Practice</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>χ² Test</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 Years old</td>
<td>33</td>
<td>42.3</td>
<td>7</td>
<td>38.9</td>
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<td>.585</td>
<td>Adequate (23)</td>
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<td>43.5</td>
<td>30</td>
<td>41.1</td>
<td>.231</td>
<td>.891</td>
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<td>30-</td>
<td>35</td>
<td>44.9</td>
<td>10</td>
<td>55.6</td>
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<td>11</td>
<td>47.8</td>
<td>34</td>
<td>46.6</td>
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<td>50+</td>
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<tr>
<td>Male</td>
<td>42</td>
<td>53.8</td>
<td>9</td>
<td>50.0</td>
<td>.087</td>
<td>.486</td>
<td>Inadequate (73)</td>
<td>11</td>
<td>47.8</td>
<td>40</td>
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<td>.341</td>
<td>.635</td>
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<td>46.2</td>
<td>9</td>
<td>50.0</td>
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<td>12</td>
<td>52.2</td>
<td>33</td>
<td>45.2</td>
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<tr>
<td>Bachelor</td>
<td>21</td>
<td>26.9</td>
<td>4</td>
<td>22.2</td>
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<td>.468</td>
<td></td>
<td>5</td>
<td>21.7</td>
<td>21</td>
<td>28.8</td>
<td>.611</td>
<td>.737</td>
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<td>Nursing Secondary School</td>
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<td>17</td>
<td>73.9</td>
<td>54</td>
<td>73.9</td>
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<td>Years of experience:</td>
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<tr>
<td>&lt;4 years</td>
<td>24</td>
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<td>2</td>
<td>11.1</td>
<td>4.04</td>
<td>.133</td>
<td></td>
<td>10</td>
<td>45.5</td>
<td>26</td>
<td>35.6</td>
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<td>4-</td>
<td>26</td>
<td>33.3</td>
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<td>8</td>
<td>34.8</td>
<td>26</td>
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<td>8-</td>
<td>28</td>
<td>35.9</td>
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<td>33.3</td>
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<td></td>
<td>8</td>
<td>34.8</td>
<td>26</td>
<td>35.6</td>
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<td>Work places:</td>
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<tr>
<td>Emergency</td>
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<td>28.2</td>
<td>3</td>
<td>16.7</td>
<td>1.69</td>
<td>.428</td>
<td></td>
<td>5</td>
<td>21.7</td>
<td>20</td>
<td>27.4</td>
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<td>Female word</td>
<td>17</td>
<td>21.8</td>
<td>3</td>
<td>16.7</td>
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<td></td>
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<td>4</td>
<td>17.4</td>
<td>16</td>
<td>21.9</td>
<td>.729</td>
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<td>50.0</td>
<td>12</td>
<td>66.7</td>
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<td></td>
<td></td>
<td>14</td>
<td>60.9</td>
<td>37</td>
<td>50.7</td>
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<tr>
<td>Mean ± SD</td>
<td>26.864 ± 3.529</td>
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<td>6.343 ± 3.862</td>
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<td>Min. and Max.</td>
<td>20–35</td>
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<td>0–14</td>
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</tbody>
</table>

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Table 4
Correlation between Nurses’ Total Scores of Attitudes and Practices toward Use of Physical Restraint (n = 96).

<table>
<thead>
<tr>
<th>Total Practices Score</th>
<th>Total Attitudes Score</th>
<th>r</th>
<th>.266</th>
<th>p</th>
<th>.009*</th>
</tr>
</thead>
</table>

Injury is a long lasting practice; nurses reported feelings of guilt over this practice yet they felt they had no options (Lusis, 2000). Despite growing literature about restricting the use of restrain, this practice is common in acute or residential settings and prevalence of physical restraint use is high (Evans, Wood, & Lambert, 2002; Irwing, 2002). The psychiatric care setting is perhaps the last major health care setting in which PR remains common and perceived as an unquestioned practice, in which it is used as a protective intervention in psychiatric settings (Petti, Mohr, Somers, & Sims, 2001). The findings of the present study revealed that, one quarter of nurses disagreed with the statement that ‘family members have the right to refuse the use of restraints’. This revealed the need to increase awareness of patient’s rights and ethical issues related to use of PR to avoid allegations of assault. This result is consistent with Azab and Abu Negm (2013) who did a study to assess ICU nurses’ knowledge, attitude and practice regarding use of PR in the ICU settings at Ain Shams University Hospitals and factors influencing it and Suen et al. (2006) who studied factors influencing practices of staff with regard to the use of restraints in rehabilitative settings and found that most of the respondent nurses disagreed with the statement that ‘Family members have the right to refuse the use of restraints.’ It is important to note that if restraint is decided to be done for individuals without capacity, it must be the least restrictive of their basic rights and freedoms, in their best interests and after failure of other alternative non-restrictive methods (Hine, 2007). The result of the current study is consistent with Azab and Abu Negm (2013) who mentioned several alternative methods that could be used before applying PR, such as providing companionship and supervision, offering physical and diversional activities, playing soft background music, manipulating environments, evaluating the effects of drugs that may be contributing to a patient’s agitation and using care plans to meet the needs of individual clients (Suen et al., 2006).
have more change-inducing experiences than older persons but Mohammed (2015) disagreed with this result.

In addition, the present results revealed that there are insignificant differences between nurses’ attitudes in relation to nurses’ sex, level of education, years of experience and work place. The finding above could be explained by psychiatric nurses’ experience in this area of work that reflects the insignificant relationship in spite of the positive attitudes that they hold toward using of restraint. On the other hand, the insignificant relationship may be due to decreased conditions that need restraints in some of psychiatric wards considering that some of families did not admit their agitated patients to hospital due to stigmatization. A study presented supportive evidence that found Hamers et al. (2009) and Huang, Chuang, and Chiang (2009) who found that there is no association with nurses’ characteristics.

The present study revealed that about half of nurses with age group of 30 to 50 years perform physical restraints inadequately, in which, it was found that the level of nurses’ practice concerning physical restraints increased with older nurses. These findings are generally in line with McMillan and Jane (2004) and Al-Khaled, Zahrani, and El-Soussi (2011) who concluded that professionals mature age wise nurses who have experience tend to make a better adjustment when compared with younger peers.

The results of current study indicated that most of nurses who had diploma are applying restraining adequately. This can be explained by the fact that diploma nurses apply restraints frequently while, B.Sc. nurses frequently work as a supervisor than as a staff nurse. Al-Khaled et al. (2011) disagreed with this result.

In relation to nurses’ experience, this study showed that nurses with a higher experience are performing the procedure of restraining better than others. This could be explained by the fact that experiences and continuous training enhance personal performances and practices. These findings are congruent with Gillis (1997) and Al-Khaled et al. (2011) the fact that experiences and continuous training enhance personal performances and practices.

There are insignificant differences between nurses’ practices in relation to years of experience and work place. These results disagree with Al-Khaled et al. (2011) who found that there is a significant relation between nurses’ practices and years of experience.

The present study revealed that there is a positive significant correlation between nurses’ total attitude, and practices regarding use of physical restraint. These findings are generally in line with Karlsson, Bucht, Eriksson, and Sandman (2001) who concluded that the attitudes of Swedish nursing staff toward the use of physical restraints were strongly connected to their use in practice.

CONCLUSIONS

“Psychiatric nurses have positive attitude and adequate practice toward using physical restraints as an [alternative management for aggressive psychiatric patients and not for all the patients]”. The study recommended that it is important for psychiatric nurses to acknowledge that physical restraints should be implemented as the last resort. That psychiatric nurses either have or do not have the knowledge on the application of how physical restraints should be implemented as the last resort is not at all addressed within the body of this work. As written “Since nurses’ attitude and practice play an important role in psychiatric health care setting, it was deemed important to develop a restraint policy and educate nurses how to implement it because hospitals in Sudan do not have policies and there are illegal uses of restraint recorded”.

References


