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Reference

1. Allen JG, Coyne L, Beasley C, et al: A conceptual model for research on required length of psychiatric hospital stay. *Comprehensive Psychiatry* 28:131-140, 1987

Physical Restraint

To the Editor: In the February issue, Dr. Fidone (1) correctly points out the risks of applying the baskethold to a patient in a supine position. The baskethold is properly applied only to a standing patient.

In response to Dr. Fidone's assertion that a substitute hold is not likely to be found, I would like to point out that restraint in a prone position is, in my experience, safer for both staff and patients. Movement is more naturally limited. The patient's arms may be held in a palms-up position at a 90-degree angle to the body, or at the sides, with the staff member pinning the patient's legs with his own if additional staff members are not available to hold the legs. This method is safer than the baskethold described and equally economical of staff.

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Mr. Steinfeld is a social worker with Putnam Community Services of Harlem Valley Psychiatric Center in Carmel, New York, and director of the Institute for Emergency Management in Pawling, New York.

Reference

1. Fidone GS: Risks in physical restraint (ltr). *Hospital and Community Psychiatry* 39:203, 1988

In Reply: Restricting application of the baskethold to standing patients would seriously limit its effectiveness as a restraint and significantly increase the risk of injury to all involved, particularly in attempts to subdue strong, violently aggressive patients. Neutralizing lower body strength and controlling kicking would be substantially more difficult in such situations.

Hypoxia and declining cardiac output could also occur in upright patients, especially if the struggling were prolonged and the patient's criss-crossed arms were held tightly, with the back pressed firmly against the attendants. As a consequence, inspiratory movements could be restricted, intrathoracic pressure raised, and venous return impeded. Additionally, patients who had recently consumed a full meal or were prone to vomit when intensely excited, from obturation, or as a side effect of medication could continue to pose a risk of sudden airway obstruction.

The prone position with arms held palms-up at 90 degrees to the torso results in severe restriction of shoulder motion and fixation of the upper arm. A patient's efforts to wrench free from such a position could result in serious injury to the shoulder or humerus. Additional disadvantages are the increased risk of facial injuries in self-abusive patients and the delay in recognition of pallor or cyanosis as a result of the patient's face being partially hidden from view.

GEORGE S. FIDONE, M.D.

CMHC Standards

To the Editor: As a professional working in community mental health for more than seven years, I read with great interest the report of the panel discussion on developing standards for psychiatric practice in community mental health centers in the November issue (1). I support their concerns and understand the complexities and binds we all face.

If, however, the physician members of the panel are truly concerned about standards of care and not just about what would enhance their own practices and livelihoods, their discussion of community mental health center standards should include other licensed professionals. I and other psychologists in community mental health centers face many of the same ethical and legal issues—issues involving signing insurance forms, responsibility versus authority for patient care, the degree of direct contact with patients under our supervisees' care, responsibility for decision making in multidisciplinary treatment teams, and so forth.

Sometimes the politics of all these issues becomes so frustrating that I find myself planning how to escape into my more lucrative, less bureaucratic private practice. But then my conscience reminds me that the frustrations I experience in community mental health are only a small reflection of what my patients face daily in their dealings with bureaucracies. I have more choices and options than they do. So I choose once again to make a commitment to the people who don't have the option to escape to a private practitioner.

I urge psychiatrists, psychologists, and social workers—in other words trained professionals—to establish a cooperative forum where we can all address these quality of care issues. Ideally, we can attempt to meet the ethical requirements and laws of our own professions, respect each other's professions, and help increase the quality of care our patients receive.

SHARON IRWIN AKAMATSU, PH.D.

Dr. Akamatsu is a staff psychologist at the Kevin Coleman Community Mental Health Center in Kent, Ohio.

Reference

1. Talbott JA, Clark GH Jr, Sharfstein SS, et al: Issues in developing standards governing psychiatric practice in community mental health centers. *Hospital and Community Psychiatry* 38:1198-1202, 1987