

PUTTING PATIENTS AT THE CENTER OF RESTRAINTS

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I. INTRODUCTION

Empowering patients with as much authority in the restraint context as we can is a noble goal.¹ At the very least, it restores some agency to patients rendered utterly helpless by the restraint process. There are many points at which patients might make choices among restraint modalities, which I will elucidate here. Indeed, each of the four student-scholar papers in this issue speaks of such.

Note also that I take current laws on restraint as a given. While I would outlaw full body restraints, they are permitted under current law, and I therefore include them as one of the modalities from which patients must/may choose.

After reviewing the four student-scholar papers on this issue, I will briefly note statutory and regulatory materials that speak to patient choice or involvement in the restraint process. I will then discuss the theoretical and policy matters behind placing patient choice at the center of the restraint process.

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¹ A number of years ago I suggested that patients be given a choice among different emergency modalities. See Elyn R. Saks, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836, 1853 (1986) [hereinafter Saks, *Mechanical Restraints*] (suggesting a model restraint statute that includes a rigorous “dangerousness” standard that distinguishes between restraints and seclusion, and that allows for patient choice and procedural safeguards); ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 146–72 (2002) [hereinafter SAKS: REFUSING CARE]. See *infra* note 49 for other commentators who have followed suit.

II. STUDENT-SCHOLAR VIEWS

Ms. Yumi Ahn notes that one item in the restraint recommendations of the National Association of State Mental Health Program Directors (NASMHPD) is “patient involvement.”² She operationalizes this as focusing on “verbal feedback between staff and patients”³ and getting a commitment from patients post-restraint not “to repeat [dangerous] behavior again.”⁴ She also speaks of a dialogue with consumer groups, identifying problems; de-escalation strategies devised with patients in small groups; tools to elicit patient feedback on what measures aggravate, frustrate, and calm them; and consumer anger management groups.⁵ She asks clinicians to register patients’ negative experiences and notes that patients rate restraints as the most restrictive emergency modality.⁶

In Ms. Jacqueline Klein’s comment, she points out the many reasons restraints should be considered punishment and not treatment.⁷ In addition to this interesting and careful exploration of the differences between treatment and punishment, Ms. Klein advocates that after a restraints episode there should be a discussion between patients and staff.⁸ In this discussion, solutions should be proposed for the future and an effort should be made to restore the therapeutic relation between patient and staff.⁹

In Mr. Nicholas Scurich’s comment, the restraints decision is formalized using decision theory.¹⁰ Mr. Scurich considers the relevant values at stake, as well as the appropriate threshold for false positives and false negatives.¹¹ Among the things he considers are the emotional side effects in restrained patients.¹² More important, he sketches out patient responses to restraints as one of the considerations to keep in mind when formulating

² Yumi Ahn, Comment, *Behavioral Intervention Programs As an Alternative to Mechanical Restraints: Cost-Benefit Analysis and Policy Recommendations*, 21 S. CAL. REV. L. & SOC. JUST. 21, 28 (2012).

³ *Id.* at 23.

⁴ *Id.* at 42.

⁵ *Id.* at 25–27.

⁶ *Id.* at 33.

⁷ Jacqueline Klein, Comment, *A Theory of Punishment: The Use of Mechanical Restraints in Psychiatric Care*, 21 S. CAL. REV. L. & SOC. JUST. 47, 47–48 (2012).

⁸ *Id.* at 72.

⁹ *Id.*

¹⁰ Nicholas Scurich & Richard S. John, Comment, *Constraints on Restraints: A Signal Detection Analysis of the Use of Mechanical Restraints on Adult Psychiatric Inpatients*, 21 S. CAL. REV. L. & SOC. JUST. 75, 90–103 (2012).

¹¹ *Id.* at 93–94, 102–106.

¹² *Id.* at 77–78.

restraint policy.¹³ He reports on patient responses in a short survey he designed of different stakeholders in the restraint context.¹⁴ Clearly, the patient's voice is important to him.

Ms. Zoe Sussman also sees a role for patient choice in the restraints context.¹⁵ Most particularly, she is very attentive to reports on how patients experience restraints and considers this to be one important factor as we evaluate whether restraints are acceptable.¹⁶ She also advocates that, in general, patients should be involved in their treatment,¹⁷ as greater respect for individual rights may lead to lessened restraint.¹⁸ She mentions that there are a variety of things that can lessen restraints use, such as anger management techniques, but that “[p]atients should be able to ‘choose how they want to manage their aggressive feelings.’”¹⁹ She cites one author as saying that “[w]hen patients are treated as people, with dignity and respect, they are less likely to become aggressive.”²⁰ Patient involvement also “produce[s] acknowledgment of self-worth.”²¹

Ms. Sussman also advocates for debriefing after a restraint episode with both patients and staff.²² Doing this for patients is “an important part of respecting patients, is a method for involving patients in their treatment, reducing their trauma, fear, and preventing confusion.”²³

Ms. Sussman also provides a model law²⁴ that refers to patient choice:

The model law should address the importance of respecting the patient's choices. If possible, the law should require staff to ask patients to indicate his or her preferences regarding restraint position and other treatment options. There are a variety of ways to give patients more choice, which include types of physical restraint preferred, preference for seclusion rather than physical restraint, and preference for medication in addition to or instead of restraints. If feasible, documentation of preferences

¹³ *Id.* at 103–104.

¹⁴ *Id.* at 97.

¹⁵ Zoe Sussman, Note, *Mechanical Restraints: Is This Your Idea of Therapy?*, 21 S. CAL. REV. L. & SOC. JUST. 109, 124 (2012).

¹⁶ *Id.* at 111.

¹⁷ *Id.* at 122–126.

¹⁸ *Id.* at 126.

¹⁹ *Id.* at 123 (citation omitted).

²⁰ *Id.*

²¹ *Id.*

²² *Id.* at 126–127.

²³ *Id.* at 126.

²⁴ *Id.* at 133–134.

and habits should be mandated upon arrival and admittance to an institution. Perceived problems associated with giving patients choices may be valid, but patients' liberty interest should be a priority.²⁵

Ms. Sussman also has an extensive discussion of some of the complications of giving patients a choice. It may be, for example, that a patient prefers being restrained faceup or facedown, but the opposite choice is safer.²⁶ In addition, giving patients a choice between two terrible alternatives may not protect autonomy well.²⁷ Some of these issues will be discussed below.

III. STATUTES AND REGULATIONS

I will now turn to the statutes and regulations that give patients choice over which restraint method—mechanical restraints, physical restraint, seclusion, or medication—should be used in emergencies. There are only three states that explicitly require, through statute or regulation, that patients be given choice among emergency modalities.²⁸

Alaska's regulation says that "[w]hen practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored."²⁹

Oregon's regulation says that, in an emergency, a member of the interdisciplinary team "shall, if practicable, ask the patient or resident for an expression of preference or aversion to the various forms of intervention."³⁰ The regulation goes on to say that the patient's parent or guardian should also be asked his or her preference.³¹ Clause (c) of this regulation says that "[t]he patient's or resident's wishes for or against particular forms of intervention shall be respected . . . , provided that primary consideration shall be given to the need to protect the patient or resident and others in the institution."³²

Virginia's regulation requires providers to meet the patient or his au-

²⁵ *Id.* at 133.

²⁶ *Id.* at 124.

²⁷ *Id.* at 125–126.

²⁸ ALASKA STAT. § 47.30.825(d) (2012); OR. ADMIN. R. 309-112-0015(2)(b) (2012); 12 VA. ADMIN. CODE § 35-115-110(C)(1) (2012).

²⁹ ALASKA STAT. § 47.30.825(d).

³⁰ OR. ADMIN. R. 309-112-0015(2)(b).

³¹ *Id.*

³² OR. ADMIN. R. 309-112-0015(2)(c) (2012).

thorized representative upon admission to discuss and document, among other things, “his preferred interventions in the event his behaviors or symptoms become a danger to himself or others and under what circumstance, if any, the intervention may include seclusion, restraint, or time out.”³³

Other jurisdictions give more tailored choices. For example, Michigan gives patients a choice between restraints while sitting or lying down.³⁴ New Hampshire requires that patients who “can make an informed decision to be voluntarily placed in an unlocked room . . . be offered that alternative, if feasible.”³⁵

As opposed to individual choice of modality, other jurisdictions require patient involvement in formulating the restraint regime in their hospital. For instance in California, the statute speaks of technical assistance and training programs, saying they should be “designed with the input of stakeholders, including clients and direct care staff.”³⁶ Furthermore, South Dakota speaks of written policies based on a comprehensive assessment, including an “involvement of the patient or resident in weighing the benefits and consequences.”³⁷

A number of jurisdictions prescribe that patients should be told why they are being restrained and what they need to do to get out, which restores some agency to them. Ohio, for example, requires staff to “[e]xplain to the individual the reason for the mechanical restraint or seclusion, and the required behaviors of the individual which would indicate sufficient behavioral control so that mechanical restraint or seclusion can be discontinued.”³⁸ Texas requires staff to provide the patient with “the reason for the medical order, the length of time restraint or seclusion has been ordered, and the behaviors necessary for the individual to be removed from restraint or seclusion.”³⁹ Virginia requires caregivers to explain to the patient, “in a way that he can understand, the reason for using mechanical restraint or seclusion, the criteria for its removal, and the individual’s right to a fair review of whether the mechanical restraint or seclusion was per-

³³ 12 VA. ADMIN. CODE § 35-115-110(C)(1).

³⁴ See MICH. COMP. LAWS ANN. § 330.1740 (West 2012) (“A restrained resident shall continue to receive food, shall be kept in sanitary conditions, shall be clothed or otherwise covered, shall be given access to toilet facilities, and shall be given the opportunity to sit or lie down.”).

³⁵ N.H. CODE ADMIN. R. ANN. HE-M 305.04 (2012). See also N.H. REV. STAT. ANN. § 135-C:57 (2012).

³⁶ CAL. HEALTH & SAFETY CODE § 1180.3(b)(2) (West 2004).

³⁷ S.D. ADMIN. R. 44:04:04:11.02 (2000).

³⁸ OHIO ADMIN. CODE 5122:26-161(L)(3) (2001).

³⁹ 25 TEX. ADMIN. CODE § 404.154(26) (1993).

missible.”⁴⁰ New Mexico’s law, which focuses on seclusion in the case of children, requires that the child placed in seclusion be provided with “(a) an explanation of the behavior that results in the seclusion; and (b) instructions on the behavior required to return to the environment.”⁴¹

A number of jurisdictions require a debriefing after a restraint episode that includes the patient. Massachusetts requires a facility’s plan to include “the regular use of debriefing activities” and a process “for addressing patient concerns and complaints about the use of restraint or seclusion.”⁴² Washington requires a post-intervention debriefing “to discuss precipitating factors leading to the need for intervention.”⁴³ New Mexico’s law, which applies to children with developmental disabilities, requires “a debriefing with the child in which the precipitating event, unsafe behavior and preventive measures are reviewed with the intent of reducing or eliminating the need for future restraint or seclusion.”⁴⁴ North Carolina requires debriefing “with the client and . . . staff to eliminate or reduce the probability of the future use of restrictive interventions.”⁴⁵ Ohio has a fairly extensive law in this regard:

[S]taff shall meet with the individual for the purpose of: (1) Assisting the individual to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of the intervention(s); (2) Assisting the individual to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again; and (3) Developing and documenting a specific plan of intervention(s) for inclusion in the ITP/ISP [Individual Treatment Plan/Individual Service or Support Plan], with the intent to avert future need for mechanical restraint and/or seclusion.⁴⁶

IV. THEORY/POLICY

In light of the above laws about involving patients centrally in the restraint decision, I will do a number of things in the following sections. First, I will talk about why giving patients maximal choice is important. Second, I will look at patient involvement in possible restraint decisions

⁴⁰ 12 VA. ADMIN. CODE § 35-115-110(C)(13)(e) (2012).

⁴¹ N.M. STAT. ANN. § 32A-6A-10(L)(2) (West 2008).

⁴² 104 MASS. CODE REGS. 27.12(1)(h)-(i) (2012).

⁴³ WASH. ADMIN. CODE § 246-337-110 (9)(h) (2005).

⁴⁴ N.M. STAT. ANN. § 32A-6A-10(F) (West 2007).

⁴⁵ 10 N.C. ADMIN. CODE 28D.0206 (2012).

⁴⁶ OHIO ADMIN. CODE 5122-26-16 (N)(1-3) (effective until Jan. 1, 2012).

on admission to the hospital, including the pros and cons of this approach and how it could be implemented. I will then look at patient choice at the moment an emergency modality is being applied to the patient, including how much choice he or she should have at that time. I will then look at debriefing restraint episodes with patients after the restraint has ended. Finally, I will discuss some complications that arise when the choices are unequal and/or the patient is incompetent.

A. GIVING PATIENTS MAXIMAL CHOICE

Why is it a good idea to give patients the maximal amount of choice in the restraint context? Putting patients at the center of a restraint decision may occur before, at the time of, or after a restraint episode.⁴⁷ Doing so

⁴⁷ Putting patients at the center of restraints also occurs when commentators study, or cite studies about, how patients respond to restraints. Their experience is clearly important as we deliberate about the best restraints policies. For articles that discuss psychological and physical effects of restraint on patients, see Kathleen R. Delaney, *Evidence Base for Practice: Reduction of Restraint and Seclusion Use During Child and Adolescent Psychiatric Inpatient Treatment*, 3 *WORLDVIEWS ON EVIDENCE-BASED NURSING* 19, 25 (2006); William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 *AM. J. PSYCHIATRY* 1584, 1588 (1994); B.C. Frueh et al., *Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting*, 56 *PSYCHIATRIC SERVICES* 1123, 1132–33 (2005); Suzanne Goren & W. John Curtis, *Staff Members' Beliefs About Seclusion and Restraint in Child Psychiatric Hospitals*, 9 *J. CHILD & ADOLESCENT PSYCHIATRIC NURSING* 7, 12 (1996); Kevin A. Huckshorn, *Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint*, 33 *ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVICES RES.* 482, 489–90 (2006); R. Kaltiala-Heino et al., *Reasons for Using Seclusion and Restraint in Psychiatric Inpatient Care*, 26 *INT'L J.L. & PSYCHIATRY* 139, 148 (2003); Steve Killick & David Allen, *Training Staff in an Adolescent Inpatient Psychiatric Unit in Positive Approaches to Managing Aggressive and Harmful Behavior: Does it Improve Confidence and Knowledge?*, 11 *CHILD CARE PRAC.* 323, 326 (2005); Margaret M. Knight, *Quality Improvement Initiative to Minimize Seclusion and Restraint*, 27 *J. FOR HEALTHCARE QUALITY* 20, 21 (2005); Pamela L. Lindsey, *Psychiatric Nurses' Decision to Restrain: The Association Between Empowerment and Individual Factors*, 47 *J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES* 41, 47 (2009); Andres Martin et al., *Reduction of Restraint and Seclusion Through Collaborative Problem Solving: A Five-Year Prospective Inpatient Study*, 59 *PSYCHIATRIC SERVICES* 1406, 1411 (2008); Robert J. Moss & John La Puma, *The Ethics of Mechanical Restraints*, 21 *HASTINGS CTR. REP.* 22, 23–24 (1991); Wanda K. Mohr & Brian D. Mor, *Mechanisms of Injury and Death Proximal to Restraint Use*, 14 *ARCHIVES PSYCHIATRIC NURSING* 285, 285–95 (2000); Marlene Nadler-Moodie, *Clinical Practice Guideline: 1-Hour Face-to-Face Assessment of a Patient in a Mechanical Restraint*, 47 *J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES* 37, 43 (2009); Linda Oberleitner, *Aversiveness of Traditional Psychiatric Patient Restriction*, 14 *ARCHIVES PSYCHIATRIC NURSING* 93, 95–96 (2000); Freida H. Outlaw & Barbara J. Lowery, *An Attributional Study of Seclusion and Restraint of Psychiatric Patients*, 8 *ARCHIVES PSYCHIATRIC NURSING* 69, 69–70, 75 (1994); Brodie Paterson & Joy Duxsburg, *Restraint and the Question of Validity*, 14 *NURSING ETHICS* 535, 542–43 (2007); Nancy K. Ray et al., *Patient Perspectives on Restraint and Seclusion Experience: A Survey of Former Patients of New York State Psychiatric Facilities*, 20 *PSYCHIATRIC REHABILITATION J.* 11, 11–18 (1996); Cynthia S. Robins et al., *Con-*

treats the patient with dignity and respect. This is especially important because restraints themselves render the patient utterly helpless and it is necessary to return some dignity back to the patient. Giving patients choice is also likely to lead to the best decisions: patients know themselves best and care about themselves most.

Indeed, the “Recovery Movement,”⁴⁸ a very prominent movement in

sumers' Perceptions of Negative Experiences and "Sanctuary Harm" in Psychiatric Settings, 56 *PSYCHIATRIC SERVICES* 1134, 1138 (2005); Eila Sailas & Kirstian Wahlbeck, *Restraint and Seclusion in Psychiatric Inpatient Wards*, 18 *CURRENT OPINION PSYCHIATRY* 555, 557 (2005); George M. Schreiner et al., *Decreasing the Use of Mechanical Restraints and Locked Seclusion*, 31 *ADMIN. & POL'Y MENTAL HEALTH* 449, 454, 461 (2004); Yvette Sheline & Teresa Nelson, *Patient Choice: Deciding Between Psychotropic Medication and Physical Restraints in an Emergency*, 21 *BULL. AM. ACAD. PSYCHIATRY & L.* 321, 326 (1993); Sheryl B. Smith, *Restraints: Retraumatization for Rape Victims?*, 33 *J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES* 23, 26 (1995); Ruby L. Steele, *Staff Attitudes Toward Seclusion and Restraint: Anything New?*, 29 *PERSP. PSYCHIATRIC CARE* 23, 23–28 (1993); B. Stubbs et al., *Physical Intervention: A Review of the Literature on its Use, Staff and Patient Views, and the Impact of Training*, 16 *J. PSYCHIATRIC & MENTAL HEALTH NURSING* 99, 101 (2009); Ann M. Sullivan et al., *Reducing Restraints: Alternatives to Restraints on an Inpatient Psychiatric Services—Utilizing Safe and Effective Methods to Evaluate and Treat the Violent Patient*, 74 *PSYCHIATRIC Q.* 51, 52 (2005); Elaine Walsh & Brooke R. Randell, *Seclusion and Restraint: What We Need to Know*, 8 *J. CHILD. & ADOLESCENT PSYCHIATRIC NURSING* 28, 34–35 (1995); Rolf Wynn, *Psychiatric Inpatients' Experiences with Restraint*, 15 *J. FORENSIC PSYCHIATRY & PSYCHOL.* 124, 124–44 (2004).

⁴⁸ See Frederick J. Frese III, Edward L. Knight & Elyn R. Saks, *Recovery from Schizophrenia: With Views of Psychiatrists, Psychologists, and Others Diagnosed with this Disorder*, 35 *SCHIZOPHRENIA BULL.* 370, 370–80 (2009). See also William A. Anthony, *Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990's*, 16 *PSYCHOSOCIAL REHABILITATION J.* 11, 11–23 (1993); Elizabeth A. Baxter & Sita Diehl, *Emotional Stages: Consumer and Family Members Recovering from the Trauma of Mental Illness*, 21 *PSYCHOSOCIAL REHABILITATION J.* 349, 349–55 (1998); Patricia E. Deegan, *Recovery: The Lived Experience of Rehabilitation*, 11 *PSYCHOSOCIAL REHABILITATION J.* 11, 11–19 (1988); Patricia E. Deegan, *Recovering Our Sense of Value After Being Labeled Mentally Ill*, 31 *J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES* 7, 7–11 (1993); SITA DIEHL & ELIZABETH BAXTER, *TENN. DEP'T OF MENTAL HEALTH & DEV. DISABILITIES, BACK FROM WHERE I'VE BEEN: STORIES FROM THE BRIDGES PROGRAM OF RECOVERY FROM MENTAL ILLNESS* (2001); Daniel B. Fisher, *The Empowerment Model of Recovery: Finding Our Voice and Having a Say*, NAT'L EMPOWERMENT CTR., http://www.power2u.org/articles/recovery/model_recovery.html (last visited Jan. 25, 2012); Daniel B. Fisher, *Health Care Reform Based On an Empowerment Model of Recovery by People with Psychiatric Disabilities*, 45 *HOSPITAL & COMMUNITY PSYCHIATRY* 913, 913–15 (1994); Daniel B. Fisher, *Hope, Humanity, and Voice in Recovery from Psychiatric Disability*, 5 *J. CAL. ALLIANCE FOR MENTAL ILLNESS* 7, 7–11 (1994); Fred J. Frese, *Advocacy, Recovery, and the Challenges of Consumerism for Schizophrenia*, *PSYCHIATRIC CLINICS N. AM.* 233, 233–49 (1998); Fred J. Frese et al., *Integrating Evidence-Based Practices and the Recovery Model*, 52 *PSYCHIATRIC SERVICES* 1462–68 (2001); KIM HOPPER ET AL., *RECOVERY FROM SCHIZOPHRENIA: AN INTERNATIONAL PERSPECTIVE* (2007); Anthony F. Lehman, *Putting Recovery into Practice: A Commentary on "What Recovery Means to Us,"*, 36 *COMMUNITY MENTAL HEALTH J.* 329, 329–31 (2000); Robert P. Liberman, *Recovery from Disability: Manual of Psychiatric Rehabilitation*, 166 *AM. J. PSYCHIATRY* 941, 941 (2009); U.S. DEP'T OF HEALTH & HUMAN SERVS., *NATIONAL CONSENSUS STATEMENT ON MENTAL*

the mental health arena, puts patients in the very center of their care. The movement is concerned with more than reduction or remission of symptoms; it cares about quality of life. Most important, it puts patients at the center of what quality of life means: patients get to determine what, *for them*, is quality of life. Giving patients maximal choice in the restraint context, then, is consistent with the Recovery Movement's focus on the patient's wishes and choices.

Giving patients choice among emergency modalities is also a way of stating that the "least restrictive alternative" is for the patient to determine.⁴⁹ What does the particular patient deem least restrictive? Particularly, when the choices equally serve relevant interests and the patient is competent, does giving choice make sense? I will parse out these different scenarios below.

It is worth noting that giving patients choice in this context is especially sensible because there is little consensus on how to rank physical controls in terms of restrictiveness.⁵⁰ Some say medication is most restrictive because it intrudes into one's mind and personality most. Some say it is the least restrictive because it restores the person to sanity quickest and helps his or her mental state. And what is more restrictive—being restrained to a chair in the lounge or placed in seclusion without restraints? Indeed, when I ask my students to rank the different emergency modalities in terms of restrictiveness they justify very different orderings—there is no consensus among them.

Given that there is no clearly correct ordering of emergency modalities, asking patients how they rank them makes sense because the least restrictive alternative is what the patient deems least restrictive. I will discuss complications with this view later.

A strong argument exists, however, that these choices are all so bad

HEALTH RECOVERY, available at <http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf> (last visited Jan. 25, 2012); Peter J. Weiden, Address at the American Psychiatric Association Annual Symposium: Is Recovery Attainable in Schizophrenia?: Biologic, Pharmacologic, and Psychologic Perspectives (May 5, 2008).

⁴⁹ I have made this point in the past. See Saks, *Mechanical Restraints*, *supra* note 1, at 1853. See also Sheline & Nelson, *supra* note 45, at 323–24, 327–28 (suggesting that patient choice should determine what the least restrictive alternative is for him or her).

⁵⁰ Several articles discuss the least restrictive alternative concept in this context. See Grant T. Harris et al., *Staff and Patient Perceptions of the Least Restrictive Alternatives for the Short-Term Control of Disturbed Behavior*, 17 J. PSYCHIATRY & L. 239, 239–63 (1989); Valerie Klinge, *Staff Opinions About Seclusion and Restraint at a State Forensic Hospital*, 45 HOSP. & COMMUNITY PSYCHIATRY 138, 138–41 (1994); Janice LeBel & Robert Goldstein, *The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination*, 56 PSYCHIATRIC SERVICES 1109, 1109–14 (2005).

that there is no real choice. Any choice the patient makes will be coerced. Asking patients to make a coerced choice is worse than denying them the choice altogether because it makes patients an instrument of their own maltreatment. To see this, we need not look just at truly horrible choices like “Sophie’s choice” (the choice of selecting one child to be killed versus allowing both to be killed). Even just telling patients that they can go peaceably into restraint or be put there with force may not be giving them a real choice. In fact, it may be asking them to do something that is ultimately demeaning as they are asked, again, to be the instrument of their own maltreatment.

This argument is deep and one that I cannot fully engage here. Even though there are such Sophie’s choices in the world, the restraint context is not one of them. Sophie’s choices were both horrible. However, choosing between putting oneself into restraints or being forced into them may be a choice that a person would want to have. The peaceable restraint might save the patient from additional trauma. Or choosing between seclusion and restraints may offer a true choice: one’s choices are narrowed, certainly, and take place between two unpleasant things, but are not so horrible as the choice Sophie faced. And again one might want to exercise even this narrow choice. It is true that a choice between methods of restraint is not like a choice between restraint and freedom, but it might still be a valuable choice.

B. THREE CHOICE POINTS

There are at least three places where patient choice could be elicited and followed: before any restraint episode—on admission to the hospital; at the moment of a restraint episode; and after a restraint episode.⁵¹ I assume that the choices are equal and the patients are competent.

⁵¹ I discuss providing patients with choices among various emergency modalities in an earlier article. See Saks, *Mechanical Restraints*, *supra* note 1, at 1853. See also SAKS, REFUSING CARE, *supra* note 1, at 146–72; Jane G. Dresser, *Wrapping: A Technique for Interrupting Self-Mutilation*, 5 J. AM. PSYCHIATRIC NURSES ASS’N 67, 67–70 (1999); David J. Hellerstein et al., *Decreasing the Use of Restraint and Seclusion Among Psychiatric Patients*, 13 J. PSYCHIATRIC PRAC. 308, 309 (2007) (noting that assessing patients’ preferred coping mechanisms has been utilized in efforts to reduce the use of restraint and seclusion); Sheline & Nelson, *supra* note 45, at 338–46 (discussing the importance of patient participation in determining the appropriate intervention in an emergency); Sullivan et al., *supra* note 45, at 63 (“A dramatic decrease in restraint and seclusion can occur, even on an acute care inner city psychiatric service, when administration, unit staff and patients join together to assess violent potential, develop alternatives for managing that violence and empower patients to truly participate in their treatment plan.”).

1. On Admission

When patients are first admitted to the hospital, whether voluntarily or involuntarily, should they be informed about possible responses to an emergency? Or should only potentially dangerous patients be so informed? If some or all patients should be informed, what would that look like?

The advantage of informing and receiving consent from patients at the moment of admission is that, in most cases, staff can obtain the required information prior to any emergency, when patients are more likely to be in a position to deliberate without stress. The different possible modalities—full or partial mechanical restraints, physical restraint, seclusion, and/or medication—would be described, with the pros and cons of each being spelled out. Staff can respond to the patient's initial reaction in a way that would allow the patient to process the information. Staff can tell patients that an emergency is an unlikely event, but that it is important to understand which means of restraint is least objectionable. Additionally, if staff can make reliable judgments about who is a likely candidate for restraint, they could choose to inform and elicit choice only from those patients.

However, there is a downside. The moment a patient is admitted to a psychiatric hospital, particularly on an involuntary basis, he or she is likely to be highly "activated"—that is stressed out, upset, or confused. Thus, it would generally be difficult for the patient to process information. Being told about highly intrusive and degrading things that may or may not happen to him or her may further activate the patient's already aggravated state. If the patient did not already need restraints, he or she may come to need them now! Of course, it is important to note that some patients may require an emergency intervention upon admission, and while staff should try to elicit which kind they prefer, it is more difficult to do so in the midst of an emergency.

Further, new patients will not have experienced the different control mechanisms, and may not even know what they look like as a bystander. Therefore, waiting to elicit a patient's preferred form of restraint until after the patient has experienced, or at least seen, the various control mechanisms would ensure the patient's choice is better informed. On the other hand, it is possible to elicit a choice on admission and then revisit the issue after the patient has had some experience. And of course, many patients will be "repeat players," and will have been subjected to, or seen, the different emergency modalities.

In addition to informing patients upon admission about the different

interventions, staff may also try to get other important information from patients.⁵² Staff could ask patients why they chose a particular control mechanism and have them rank other less restrictive interventions, such as behavioral intervention programs. Staff could also ask patients to identify what triggers them and what calms them down.

Although only three jurisdictions currently elicit patient choice,⁵³ giving patients choice makes sense and should be a feature of all restraint laws. And of course gathering more information from patients also makes sense.

2. At the Moment of an Emergency

The second moment in which patient choice could potentially be elicited is at the moment of an emergency that results in a restraint episode.⁵⁴ Staff should know which method the patient has chosen, and *must* remember this. The question then arises of what to do if, in the moment of an emergency, the patient changes his or her mind? For example, in the middle of a restraint episode, a patient may prefer to be restrained to a chair in a dayroom instead of seclusion, which he or she had originally chosen. Assuming, as we have been, that the patient is competent, it seems that the new choice should override the original choice. But what if the original choice was more thoughtfully made? Although in the moment of an emergency patients are less likely to be thinking clearly, they are also presently experiencing the restraint mechanisms and therefore know what feels better or worse. While it is a valid point that patients are more upset in the moment of an emergency, their most recent choice of restraint should non-

⁵² Other important information that should be sought include factors that aggravate or trigger the patient's condition, as well as approaches that calm the patient down. A number of commentators discuss the efforts to elicit this information from patients. See Christopher L. Coffin, *Case Law and Clinical Considerations Involving Physical Restraint and Seclusion for Institutionalized Persons with Mental Disabilities*, 23 MENTAL & PHYSICAL DISABILITY L. REP. 597, 597, 599–600 (1999); Joyce W. Grigson, *Beyond Patient Management: The Therapeutic Use of Seclusion and Restraints*, 22 PERSP. PSYCHIATRIC CARE 137, 137–38 (1984); Hellerstein, *supra* note 49, at 308–09; Richard H. Hunter et al., *The Multimodal Functional Model—Advancing Case Formulation Beyond the “Diagnose and Treat Paradigm”*: Improving Patient Outcomes and Reducing Aggression and the Use of Control Procedures in Psychiatric Care, 5 PSYCHOL. SERVICES 11, 11, 14–15 (2008); Jessica A. Jonikas et al., *Brief Reports: A Program to Reduce the Use of Physical Restraint in Psychiatric Inpatient Facilities*, 55 PSYCHIATRIC SERVICES 818, 818–20 (2004).

⁵³ Alaska, Oregon, and Virginia are the three jurisdictions that currently elicit patient choice. See ALASKA STAT. § 47.30.825 (2004); OR. ADMIN. R. 309-112-0015 (1982); 12 VA. ADMIN. CODE § 35-115-110 (2001).

⁵⁴ See *supra* note 45 for articles on this.

ethless be honored. Competent patients should be allowed to change their minds. Choices made by incompetent patients are discussed below in Part IV.D.

Another way to empower patients in the moment of an emergency is, as many of the statutes and regulations require, to tell them why they are being restrained and what they can do to be released.⁵⁵ For example, patients could be told that if they do not struggle or shout for fifteen minutes straight, they will be released from the restraints. This again is restoring some agency to patients, which can only be a good thing.

3. Debriefing After a Restraint Episode

The third point at which to involve patients in restraint decisions is after a restraint episode.⁵⁶ A number of statutes and regulations, as we have seen, require this.⁵⁷ Staff and the patient should review the reason the patient was restrained, and staff should also ask for the patient's own view on whether the restraint was needed. Studies have shown that patients often think they were not dangerous when staff believed them to be.⁵⁸ Helping staff to identify these times would be useful. The patient should also be asked how it felt to be restrained and what can be done to reduce or minimize the trauma. Trauma victims generally should be asked if the restraint was re-traumatizing and how to reduce or minimize that. Strategiz-

⁵⁵ See OHIO ADMIN. CODE 5122-26-161 (L) (3) (2001); 26 TEX. ADMIN. CODE § 404.154 (1993); 12 VA. ADMIN. CODE §35-115-110 (2001); N.M. STAT. ANN. § 32A-6A-10 (1978). See also Ikar J. Kalogjera et al., *Impact of Therapeutic Management on Use of Seclusion and Restraint with Disruptive Adolescent Inpatients*, 40 HOSP. & COMMUNITY PSYCHIATRY 280-82 (1989); Nadler-Moodie, *supra* note 45, at 37, 42; Gregory M. Smith et al., *Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, 56 PSYCHIATRIC SERVICES 1115, 1119 (2005).

⁵⁶ On debriefing patients, see Huckshorn, *supra* note 45, at 487; Kalogjera et al., *supra* note 53, at 282; Ali N. Khadivi et al., *Association Between Seclusion and Restraint and Patient-Related Violence*, 55 PSYCHIATRIC SERVICES 1311 (2004); Janice Lebel, *Regulatory Change: A Pathway to Eliminating Seclusion and Restraint or 'Regulatory Scotoma'?*, 59 PSYCHIATRIC SERVICES 194 (2008); Maureen Lewis et al., *Crisis Prevention Management: A Program to Reduce the Use of Seclusion and Restraint in an Inpatient Mental Health Setting*, 30 MENTAL HEALTH NURSING 159, 162 (2009); Andres Martin et al., *supra* note 45, at 1409; Sailas & Wahlbeck, *supra* note 45, at 556; Schreiner et al., *supra* note 45, at 453; Sullivan et al., *supra* note 45, at 57; Linda Witte, *Reducing the Use of Seclusion and Restraint: A Michigan Provider Reduced Its Use of Seclusion and Restraint by 93% in One Year on Its Child and Adolescent Unit*, 28 BEHAV. HEALTHCARE 54, 56 (2008).

⁵⁷ See *supra* text accompanying notes 40-43.

⁵⁸ For a number of articles noting differences in patients' and staffs' views on restraints, see Harris et al., *supra* note 48, at 257; Outlaw & Lowery, *supra* note 45, at 75; Ray et al., *supra* note 45, at 12-13; Wynn, *supra* note 45, at 124-44.

ing what can be done in the future would be the most important piece of the debriefing. Which interventions and in what order should be tried to calm the patient down? What kind of behavior should the patient exhibit in order to be released from restraints?

C. GIVING PATIENTS INPUT INTO GENERAL RESTRAINT POLICY

In addition to helping staff respond to patients in emergencies, feedback from patients/consumers should also be sought in formulating general restraint policy.⁵⁹ No one knows better how it feels to be restrained than someone who has actually experienced it. Even requiring staff to experience restraint is only second best because it would not be real and they would not have fantasies that the restraint will last a very long time. While staff still should be required to experience restraint themselves, they should solicit input from patients regarding their experiences for a more authentic understanding.

Patients in general should be used as an important resource to design restraint policies. We should elicit information from them that would be helpful in their treatment. We should ask questions such as: What is the range of possible triggers of violence? What often/usually helps to defuse and deescalate a situation? Are there occasions when we should not honor a choice in the moment of a restraint episode? What are the individual patients' rankings of emergency modalities? How should we rank these modalities if the patient will not provide a choice?

The last is especially important. If patients will not provide a choice, we need to have a default order of restrictiveness. Of course, I have my own ideas on this. However, I think it is best for research to be done on a large number of patients to see if there is any consensus in the patient community. This is another way of putting patients at the center of restraints.

D. COMPLICATIONS IN THE RESTRAINT SCENARIO: WHEN CHOICES ARE UNEQUAL AND/OR PATIENTS ARE INCOMPETENT

In the foregoing, we have taken the scenario where the choices are equal and the patient is competent, but what happens if we complicate this scenario—the choices are not equal and/or the patient lacks capacity?

⁵⁹ For some commentators suggesting this be done, see Frueh et al, *supra* note 45, at 1132–33; Huckshorn, *supra* note 45, at 490–93; Sailas & Wahlbeck, *supra* note 45, at 558; Schreiner et al., *supra* note 45, at 452; Sheline & Nelson, *supra* note 45, at 327; Smith, *supra* note 45, at 27.

Parsing out these situations is difficult, in part because the concept of the least restrictive alternative is complicated and potentially confounded by considerations other than physical restrictiveness, like treatment effects.⁶⁰

As our first example, let us take the case where the interventions are indeed equivalent in all dimensions—a patient is dangerous to others and there is a choice between restraint to a chair in a dayroom or seclusion. Assume both choices equally protect others and their treatment efficacy (if any) is equivalent. It seems clear in this scenario that there is no right answer as to which is preferable. Thus, what the patient prefers should be the barometer. Indeed, even if the patient lacks capacity, the patient's choice should arguably be honored. Again, there is no right answer, so we should go with what the patient prefers.

Of course, it is usually not the case that modalities are equivalent on all fronts. Consider again a patient who is dangerous to others. The patient could be “staff specialed,” put in seclusion, restrained to a chair in the ward, or have her wrists restrained to her belt.⁶¹ Clearly the hypothesis of equivalent effectiveness at preventing danger is not necessarily reality: the staff “specialing” the patient may turn away for a moment and violence may occur; the patient in seclusion could attack the person bringing him or her food; the patient in a chair could tip it over and hurt a staff member; and the patient with wrist restraints could run toward and forcefully ram into other patients or staff.

Thus, one issue is how well the intervention protects others, which is usually something one cannot completely know. Even if various interventions protect equally well, the concept of the least restrictive alternative seems to give insufficient guidance as to what that means. In the first instance, even if we are only measuring freedom of movement, difficult questions arise. If patients' wrists are restrained to their belts, they will have freedom of motion throughout the ward. In contrast, if patients are secluded, the space in which they can walk will be limited, but they will be free to move their arms.

Even more important, when one takes into account the therapeutic value of a measure, the concept of the least restrictive alternative gets even more complicated. What if a measure is more physically restrictive, but

⁶⁰ I do not address two especially difficult scenarios: (1) medication used as a treatment and not a chemical restraint and (2) patients choosing what is clearly a more restrictive intervention. See James K. Luiselli, *Behavioral Assessment and Analysis of Mechanical Restraint Utilization on a Psychiatric, Child and Adolescent Inpatient Setting*, 13 BEHAV. INTERVENTIONS 147, 152 (1998).

⁶¹ SAKS, REFUSING CARE, *supra* note 1, at 131.

highly therapeutic? A doctor may be able to say, although it is uncertain how reliably, that seclusion is better for a patient because it would help de-stimulate him or her, or that restraint to a chair in a day room is better because it would allow for socialization.

Is the least restrictive alternative the choice that is least restrictive of one's liberty, given equal therapeutic efficacy? Or is it the choice that is the best compromise in values of freedom and efficacy? For example, a little more efficacy would not justify much more physical restrictiveness.

In either event, it seems that a competent patient should be permitted to choose modalities that are less optimal in terms of therapeutic efficacy (or more restrictive otherwise). If a competent patient can choose to forego clearly efficacious treatment altogether, the patient should be allowed to choose a less optimal treatment.

What about incompetent patients? These patients do not understand all the issues at stake in the emergency context. Leaving aside medication, the likely small increment in efficacy in this context—ability to socialize versus some de-stimulation—does not seem to outweigh the patient's choice, even if he or she is incompetent and even if another intervention is better. Very large benefits may call for a different response.

Note that the incompetent patient scenario may be especially troubling when patients change their minds at the moment of the emergency. Staff has no way to gauge competency at this point. As noted above, staff may think that the choice patients made in advance, in a calm moment, is more likely to represent their true competent choice. On the other hand, they may think that patients in the process of being restrained have better information on what that is like, and so their contemporaneous choice may be better. Even if we introduce the complexity that the patient is incompetent, we should arguably respect most of their choices in this arena. In those cases in which capacity is important, we have no other choice but to try to assess it at the moment.

V. CONCLUSION

All of the foregoing means that statutes and regulations in the states should give patients the choice among emergency modalities, except in certain cases when patients lack capacity. However, even in the latter case, patients should still be permitted to choose, unless their choice is clearly substandard.

In addition, how staff approaches emergency treatment should change. They should elicit patient involvement on admission, at the mo-

ment of restraint, and afterwards. They should also consult patients about emergency measures in general, such as: (1) what should the choice be if patients will not make one (what as a general matter is the least restrictive alternative); (2) what are some plausible interventions prior to using restraint; (3) when should staff respect and not respect a patient's change of mind at the moment of intervention; (4) how do patients feel about the tradeoff between treatment efficacy and the degree of physical restrictiveness; and (5) are there ways patients can provide peer support around restraints?

Rather than seeing restraints as a treatment, there is a clear trend toward seeing it as a treatment failure. Soliciting patient involvement in restraint on many levels should lead to patients being shown greater dignity and respect. In many cases, this will also be cost effective and better for staff too.⁶² It is black letter law that autonomy must yield in an emergency, but there are ways in this context that we can honor patients' autonomy and let them make their own choices without endangering themselves or others.

⁶² See Huckshorn, *supra* note 45, at 488; LeBel & Goldstein, *supra* note 48, at 1109–10; U.S. DEP'T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., THE BUSINESS CASE FOR PREVENTING AND REDUCING RESTRAINT AND SECLUSION USE 13 (2011), <http://store.samhsa.gov/shin/content//SMA11-4632/SMA11-4632.pdf>.