

# BEHAVIORAL INTERVENTION PROGRAMS AS AN ALTERNATIVE TO MECHANICAL RESTRAINTS: COST-BENEFIT ANALYSIS AND POLICY RECOMMENDATIONS

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## I. INTRODUCTION

A number of behavioral intervention programs have been used to reduce restraint and seclusion use in inpatient psychiatric facilities.<sup>1</sup> Despite their proven effectiveness, behavioral intervention programs are still underused or ineffectively employed in many inpatient settings.<sup>2</sup> If we take it that minimizing and eventually eliminating the use of mechanical restraints is a primary goal of treating violent patients, legislators should make these intervention programs mandatory in all inpatient facilities. These therapeutic programs to curb inpatient violence are often criticized as too costly. However, I am not aware of any no financial data that directly compares the cost of implementing behavioral intervention programs to the cost of using mechanical restraints. Nevertheless, economic considerations should not suffice to dismiss intervention programs as an alternative to mechanical restraints because sound mental health policymaking should involve an evaluation of patients' rights, the therapeutic efficacy of a pro-

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<sup>1</sup> See, e.g., Dennis C. Donat, *Encouraging Alternatives to Seclusion, Restraint, and Reliance on PRN Drugs in a Public Psychiatric Hospital*, 56 PSYCHIATRIC SERVICES 1105, 1105 (2005) [hereinafter Donat, *Encouraging Alternatives*]; Andrés Martin et al., *Reduction of Restraint and Seclusion Through Collaborative Problem Solving: A Five-Year Prospective Inpatient Study*, 59 PSYCHIATRIC SERVICES 1406 (2008).

<sup>2</sup> Donat, *Encouraging Alternatives*, *supra* note 1, at 1105.

gram, and public safety.<sup>3</sup> This Comment argues that mechanical restraints should be outlawed and behavioral intervention programs should become mandatory in inpatient settings to prevent violence and to therapeutically treat violent behavior. Through a cost-benefit analysis, I dispel the view that behavioral intervention programs are too costly to be a viable alternative to mechanical restraints. In addition, this Comment presents a model law in the area of mechanical restraints.

## II. BEHAVIORAL INTERVENTION PROGRAMS AS AN ALTERNATIVE TO MECHANICAL RESTRAINTS

Various measures are used to control patient violence in inpatient settings.<sup>4</sup> The most commonly used are mechanical restraints, seclusion, and medication.<sup>5</sup> While there is a wealth of research comparing these three control mechanisms, scholars have only considered behavioral intervention programs as a temporary measure to reduce restraint or seclusion.<sup>6</sup> Yet behavioral intervention programs are worth investigating as a sustainable alternative to these control methods because they could reduce the use of all three.<sup>7</sup> Since mechanical restraints are the most restrictive and ethically objectionable method of controlling patient violence,<sup>8</sup> this paper will only focus on behavioral intervention programs as an alternative to mechanical restraints. For our purposes, we will define behavioral intervention programs as any method, program, action, or initiative that is designed to prevent violence among mental health patients, without using restraint, seclusion, or medication.

### A. EXAMPLES OF INTERVENTION PROGRAMS

Since flexibility is one of the key advantages of behavioral intervention programs, there are an infinite variety of programs that can be used to mitigate inpatient violence. The following are some empirically successful

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<sup>3</sup> See David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225, 225 (1992).

<sup>4</sup> See Donat, *Encouraging Alternatives*, *supra* note 1, at 1105.

<sup>5</sup> See *id.*; see also Harvey Gordon et al., *The Use of Mechanical Restraint in the Management of Psychiatric Patients: Is It Ever Appropriate?*, 10 J. FORENSIC PSYCHIATRY 173, 177-79 (1999).

<sup>6</sup> See Donat, *Encouraging Alternatives*, *supra* note 1, at 1107.

<sup>7</sup> Restraint, seclusion, and medication all pose unique ethical and treatment problems, but a comparison of these three methods is beyond the scope of this Comment.

<sup>8</sup> See Donat, *Encouraging Alternatives*, *supra* note 1, at 1105; see also Gordon et al., *supra* note 5, at 177.

programs worth examining.

### 1. Token Economy

Token economies have been used since the 1970s to modify a range of undesirable behaviors, by using reinforcement.<sup>9</sup> For every desirable behavior, patients earn a token which they can later exchange for rewards, such as cigarettes, candy, personal televisions, single rooms, and other activities or privileges desired by patients.<sup>10</sup> Token economies are proven to be effective “in a wide variety of settings and for many patient populations, including children in special education classrooms, the mentally retarded, adolescents with conduct disorders in residential care homes, and psychiatric patients in day hospitals.”<sup>11</sup> In one study of a token economy in an inpatient psychiatric unit, researchers found a positive long-term effect on reducing violence against staff and other patients.<sup>12</sup> Interestingly, in this study the token economy reduced violence in the unit even though it had originally been implemented to target other desirable behaviors.<sup>13</sup> The targeted behaviors included being on time, taking medication without reminders, showering, attending group activities, and cleaning.<sup>14</sup>

### 2. “ABCD” Program

The “ABCD” program, instituted by the largest public child and adolescent psychiatric hospital in Connecticut, stands for four core elements: autonomy, belonging, competence, and doing for others.<sup>15</sup> The program focuses on verbal feedback between staff and patients, which forms positive relationships and promotes autonomy.<sup>16</sup> By fostering staff-patient coaching relationships, the program seeks to promote a sense of community by teaching patients that violent and aggressive behaviors are not ac-

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<sup>9</sup> See, e.g., Robert P. Liberman, *The Token Economy*, 157 AM. J. PSYCHIATRY 1398, 1398 (2000).

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> James P. LePage et al., *Reducing Assaults on an Acute Psychiatric Unit Using a Token Economy: A 2-Year Follow-Up*, 18 BEHAV. INTERVENTIONS 179, 179 (2003) (finding a 33% reduction in staff and patient injuries over two years).

<sup>13</sup> *Id.* at 183.

<sup>14</sup> *Id.*

<sup>15</sup> Abigail Donovan et al., *Seclusion and Restraint Reform: An Initiative by a Child and Adolescent Psychiatric Hospital*, 54 PSYCHIATRIC SERVICES 958, 958 (2003).

<sup>16</sup> *Id.*

ceptable.<sup>17</sup> The children are also given schoolwork, artwork, and group projects to help them feel a sense of accomplishment and build competence.<sup>18</sup> Also, the children are taught to contribute to the facility by mentoring new patients and engaging in activities involving shared responsibility.<sup>19</sup> Accordingly, the program reduced the unit's seclusion and restraint rates by 26% and 38% in two consecutive years.<sup>20</sup>

### 3. Stages-Based Therapeutic Management Programs

One therapeutic management program used in a public adolescent inpatient unit divided aggressive behavior into four stages: verbal, motor, property damage, and attack.<sup>21</sup> In the verbal stage, patients use abusive language and make non-specific threats.<sup>22</sup> In the motor stage, threats are more specific and patients are significantly more agitated.<sup>23</sup> In the property damage stage, patients damage property or handle it dangerously.<sup>24</sup> In the attack stage, patients attack themselves or others.<sup>25</sup> As a patient's behavior escalates to each stage, immediate and specific interventions are applied, using both verbal and behavioral approaches.<sup>26</sup> In the verbal and motor stages, staff communicate clearly to patients that they are losing control.<sup>27</sup> In the property damage and attack stages, staff members tell patients that they have lost control.<sup>28</sup> During these stages, it is important to tell patients that they are provoking anxiety in others so that they do not increase their disruptive behavior.<sup>29</sup> Next, staff members assure patients that they want to help the patients regain control.<sup>30</sup> If patients regain control, staff members positively reinforce the renewed self-control.<sup>31</sup> Although the program

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<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.* at 959.

<sup>21</sup> Ikar J. Kalogjera et al., *Impact of Therapeutic Management on Use of Seclusion and Restraint with Disruptive Adolescent Inpatients*, 40 HOSP. & COMMUNITY PSYCHIATRY 280, 281 (1989).

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.* at 281–82.

<sup>27</sup> *Id.* at 282.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

involves some use of seclusion and restraint,<sup>32</sup> some valuable ideas can be taken from it. Staff members avoid positive or negative reinforcement of disruptive behavior after a dangerous episode.<sup>33</sup> For example, staff members do not comfort patients by touching or making sympathetic statements, nor do they express anger or disappointment.<sup>34</sup> After a dangerous episode, patients are asked to make a commitment not to repeat the behavior again.<sup>35</sup> A follow-up session should take place an hour after the episode so that patients can discuss alternatives to losing control, but they are not asked why they lost control in the first place.<sup>36</sup> Patients continue to work with their therapist to understand the behavior.<sup>37</sup> In one instance, a youth patient acted out violently because he was anxious about an impending court hearing, was afraid that the staff would reject him, and wanted reassurance that they cared about him.<sup>38</sup> It was discovered that in the past his father often abused and then subsequently nurtured him.<sup>39</sup> Thus, he learned to associate being nurtured with acting out violently.<sup>40</sup> Accordingly, he worked with his therapist to correct this pattern of behavior, and was not subject to seclusion or restraint for the rest of his stay in the facility.<sup>41</sup>

#### 4. Anger Triggers and De-Escalation Strategies

It is important for staff and clinicians to find out what causes or triggers aggression among patients, rather than assuming that patients have an inherent propensity to aggression. Staff must understand that anger is a normal feeling that everyone experiences, and is often caused specifically by others' actions or by situations. Open dialogue with patient advocates would therefore be helpful, as they can identify specific problem areas, such as perceptual differences between staff and patients, inconsistent application of rules, changes in personnel, and difficulty accessing care.<sup>42</sup> A dynamic view of disruptive adolescent behavior propounds that adoles-

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<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.* at 283.

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 281–83.

<sup>42</sup> Hank Visalli & Grace McNasser, *Striving Toward a Best Practice Model for a Restraint-Free Environment*, 11 J. NURSING CARE QUALITY 1, 2 (1997).

cents act out violently due to internal conflicts, not overflowing energy.<sup>43</sup> If adolescents find that their disruptive behavior eases tension, violence is likely to recur.<sup>44</sup> Adolescents also use disruptive behavior to control their environment when they find that a predictable pattern of events occurs in response to their acting out.<sup>45</sup> Often their disruptive behavior is a mode of communication, so any intervention program must be focused on forming a working alliance with the adolescent.<sup>46</sup> This theory could also apply to adult patients, as they most likely experience similar internal struggles.

Reviewing de-escalation strategies with patients in small group settings was helpful in a twenty-three-bed inpatient unit for adolescents with developmental disabilities.<sup>47</sup> In these group sessions, staff members reviewed de-escalation strategies—such as anger management techniques, correct use of time-out, and self-talk with the patients—to reduce disruptive and aggressive behavior.<sup>48</sup> In the same study, a token economy was also adopted in which the patients could earn a special group activity of their choice—such as a pizza day or a gym day—if they achieved reduction of restraint or seclusion use by 25%.<sup>49</sup> Individualized plans were implemented for patients with a higher rate of restraint or seclusion.<sup>50</sup> Patients were taught specific anger management techniques during non-crisis periods—such as going to their room, sitting on their bed, taking five deep breaths, or thinking about a pleasant event—rather than merely being told to calm down.<sup>51</sup> During a crisis, patients would be reminded of these specific skills, and ample time would be given for the patients to follow the instructions, as they often had difficulties processing verbal communications quickly.<sup>52</sup> Also, staff members who had the best rapport with specific patients would give the instructions one-on-one because patients with developmental disabilities find it hard to understand information coming from multiple people.<sup>53</sup> In addition, staff noticed that seclusion and restraint episodes occurred more frequently during shift changes. So they

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<sup>43</sup> Kalogjera et al., *supra* note 21, at 281.

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> See George M. Schreiner et al., *Decreasing the Use of Mechanical Restraints and Locked Seclusion*, 31 ADMIN. & POL'Y MENTAL HEALTH 449, 457 (2004).

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.* at 458.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.* at 457–58.

changed their routine during this time of the day to eliminate the crisis-ridden period.<sup>54</sup> Other early intervention strategies were also emphasized to staff. Staff members gave positive instructions in a neutral tone of voice, such as “remember, your goal is to stop hitting and to go on pass this weekend.”<sup>55</sup> These strategies, along with other systematic changes in the unit, resulted in a 35% reduction of seclusion and restraint use during the intervention phase of six months.<sup>56</sup>

## 5. Other Innovative Ideas

There are various other innovative ideas to ensure restraint-free environments in inpatient facilities. Quiet zones can be established, as louder than normal communications can create tension among patients.<sup>57</sup> Another example is a “Nursing Anger Management Assessment Tool,” which was developed in a New York hospital to help staff more effectively assist patients with anger management. On admission, patients are asked to fill out a form indicating what aggravates them and what helps them calm down.<sup>58</sup> There are nineteen items on the list of coping skills, such as going for a walk, talking to a family member, and breathing exercises.<sup>59</sup> Patients are asked to check the boxes for coping skills that work for them and are encouraged to list other effective skills that do not appear on the list.<sup>60</sup> If patients become aggressive, their anger management skills and responses to treatment should be reassessed periodically.<sup>61</sup> Another innovative alternative to restraints is patient-run anger management group discussions.<sup>62</sup> In these meetings, patient advocates with psychiatric diagnoses and experience in inpatient settings can help patients and staff to understand the pattern of how angry feelings arise and the subsequent behaviors that follow.<sup>63</sup> The meetings tend to make patients feel safe discussing their issues, and the dialogue can help the parties come to a mutually agreeable solution.<sup>64</sup> Another idea is the “comfort wrap,” which is when patients volun-

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<sup>54</sup> *Id.*

<sup>55</sup> *Id.* at 456.

<sup>56</sup> *Id.* at 459–60.

<sup>57</sup> Visalli & McNasser, *supra* note 42, at 2.

<sup>58</sup> *Id.* at 2–3.

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* at 3.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

tarily roll themselves into bed sheets or blankets to form a cocoon shape, which reduces anxiety and restores boundaries.<sup>65</sup> Having access to additional staff was also found to be effective in deterring aggression.<sup>66</sup>

#### B. FEATURES OF AN EFFECTIVE INTERVENTION PROGRAM

From the examples above, it is clear that a holistic approach towards intervention programs that include certain cultural changes is essential for a successful intervention program. First, a good monitoring and data collection system is necessary for patients with a high number of violent episodes.<sup>67</sup> Second, all levels of management and staff must be involved<sup>68</sup>; management must help plan and implement the program, and there must be adequate administrative support from clinical leaders.<sup>69</sup> Third, direct-care staff must be trained on the concepts and procedures of behavioral programs.<sup>70</sup> Fourth, pointing out positive results to staff is helpful, such as posting results in a centrally located staff area.<sup>71</sup> This process allows for timely feedback and continuous program improvement.<sup>72</sup> These four features overlap significantly with the six core strategies for restraint and seclusion reduction from the National Association of State Mental Health Program Directors (NASMHPD): (1) leadership that sets the agenda for change; (2) data collection; (3) creation of a therapeutic environment based on recovery, trauma informed care, and individualized treatment; (4) use of assessment tools, de-escalation plans, and changes to the physical environment; (5) patient involvement; and (6) consistent use of debriefing tools to both analyze each event and mitigate any adverse effects.<sup>73</sup>

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<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> Dennis C. Donat, *Impact of a Mandatory Behavioral Consultation on Seclusion/Restraint Utilization in a Psychiatric Hospital*, 29 J. BEHAV. THERAPY & EXPERIMENTAL PSYCHIATRY 13, 15 (1998) (explaining the procedure used to reduce seclusion and restraint).

<sup>68</sup> *See id.* For example, in a mandatory behavioral consultation program instituted in a public psychiatric hospital in Virginia, a Behavioral Management Committee consisted of one clinical social worker, one psychiatric nurse, a patients' rights advocate who is independent of the hospital, and five clinical psychologists. *Id.*

<sup>69</sup> *See* Donat, *Encouraging Alternatives*, *supra* note 1, at 1107–08.

<sup>70</sup> *Id.* at 1106.

<sup>71</sup> Donovan et al., *supra* note 15, at 959.

<sup>72</sup> *Id.*

<sup>73</sup> Kevin A. Huckshorn, *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* (Nat'l Technical Assistance Ctr. for State Mental Health Planning, draft 2005), available at [http://www.nasmhpd.org/general\\_files/publications/ntac\\_pubs/SRPlanTem\\_plate-withcover7-05.pdf](http://www.nasmhpd.org/general_files/publications/ntac_pubs/SRPlanTem_plate-withcover7-05.pdf).



### III. COST-BENEFIT ANALYSIS OF USING MECHANICAL RESTRAINTS

#### A. COSTS

##### 1. Ethical Concerns

The use of mechanical restraints infringes upon patients' dignity and freedom. Under typical four or six point restraints, which are often applied in a forceful and condemning manner, patients are immobilized on a bed or gurney with no freedom of bodily movement.<sup>74</sup> Although proponents often argue that this extreme measure is to protect staff and patients from imminent physical harm, studies show that hospital staff often use restraints to punish or discipline patients in non-emergency situations.<sup>75</sup> In addition, some staff members use restraints out of fear or anger.<sup>76</sup> Aside from the fact that restraints make it physically impossible for patients to harm others, what is most troubling is that the efficacy of mechanical restraints has never been proven. In fact, literature on this issue points out that the use of restraints is not therapeutic but a failure in the treatment process.<sup>77</sup>

Since a decision to restrain patients restricts their freedom and undermines their dignity, with no proven clinical efficacy, the decision is more ethical than medical or administrative.<sup>78</sup> Thus, the decision is fundamentally different than prescribing drugs or performing procedures. Proponents of therapeutic jurisprudence warn courts not to blindly trust clinical expertise when mental health issues are at stake: "Many of the issues at the heart of mental health law are legal, not clinical, in nature. Legal issues should not be permitted to masquerade as clinical ones; indeed, rather than deference, the law should adopt a healthy skepticism toward claims of clinical expertise."<sup>79</sup>

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<sup>74</sup> Gordon et al., *supra* note 5, at 174.

<sup>75</sup> *Id.* at 176.

<sup>76</sup> *Id.*

<sup>77</sup> Janice LeBel & Robert Goldstein, *The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination*, 56 PSYCHIATRIC SERVICES 1109, 1110 (2005).

<sup>78</sup> Elyn R. Saks, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836, 1849–50 (1986) [hereinafter Saks, *Mechanical Restraints*] (criticizing the "intrusion" justification for allowing liberal use of restraints).

<sup>79</sup> Wexler & Winick, *supra* note 3, at 226.

Courts have, however, historically earmarked the decision to restrain patients as a medical one reserved for doctors. In the landmark case of *Youngberg v. Romeo*,<sup>80</sup> the Supreme Court established patients' right to be free of unnecessary and excessive restraint, but gave much deference to professionals in state hospitals by stating that their "professional judgment" to restrain patients is presumed valid.<sup>81</sup> Accordingly, professionals are only liable when they depart substantially from accepted professional judgment, practice, or standards.<sup>82</sup> The Court gave little guidance on the meaning of "professional judgment," and almost deliberately let it remain vague. The Court reasoned that, "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions."<sup>83</sup> Accordingly, the Court's reluctance to oversee the professionals' decisions serves as an extra shield for professionals against liability. The Court should have recognized that medical professionals are not any better qualified than judges or juries to make such ethical decisions. Professionals have indeed failed to make ethically sound decisions in restraint practices, causing injuries and death to many patients.<sup>84</sup> The Court seemed to be conscious of budget constraints in state hospitals when explaining the rationale for the professional judgment standard: "Such a presumption is necessary to enable institutions of this type—often, unfortunately, overcrowded and understaffed—to continue to function."<sup>85</sup> Furthermore, even if medical professionals failed to satisfy professional standards, they would escape liability if their failure was due to budgetary constraints.<sup>86</sup> While this policy may seem fair for doctors, it could serve as a bulletproof shield against liability at the expense of patients' rights to redress for abusive use of restraints. It is not clear from the Court's opinion whether doctors are more likely to restrain patients because of budget constraints. Hypothetically, doctors may increase or decrease their use of restraints due to budget constraints. Lawsuits involving a decrease in the use

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<sup>80</sup> 457 U.S. 307 (1982).

<sup>81</sup> *Id.* at 323.

<sup>82</sup> *Id.* at 323 n.30 ("By 'professional' decisionmaker, we mean a person competent, whether by education, training or experience, to make the particular decision at issue.").

<sup>83</sup> *Id.* at 322–23.

<sup>84</sup> The Hartford Courant investigative report in 1998 reported 142 patient deaths as a result of abusive seclusion and restraint practices. Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 534–35 (2007). The New York State Commission on Quality of Care also issued reports in 1994, which revealed incidences of physical abuse, psychological abuse, sexual abuse, ridicule, and threats by staff during restraint and seclusion. *Id.*

<sup>85</sup> *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982).

<sup>86</sup> *Id.* at 323.

of restraints are unlikely, since patients' dignity would be preserved by not using mechanical restraints. However, if the current budget cuts in psychiatric hospitals nationwide were to increase the use of restraints,<sup>87</sup> it is possible for doctors to *always* escape liability for abusive use of restraints because budget constraints, as mentioned above, would serve as a complete defense from liability.

Obtaining consent from patients in advance is one possible way to alleviate some of the ethical concerns. Many authors have emphasized giving patients choice over the types of control measures to be used in emergencies.<sup>88</sup> However, even if patients consent to being mechanically restrained during violent episodes, there is still the danger that staff may over-predict violence and unnecessarily restrain patients when a less restrictive means would be sufficient.<sup>89</sup>

## 2. Financial Costs

It is nearly impossible to quantify the costs of using mechanical restraints in an inpatient facility without having standardized procedures in place. However, it is generally accepted that the cost of administering restraints is substantially high, particularly when considering staff time as a cost.<sup>90</sup> For example, the cost of administering restraints in an adolescent inpatient unit in Massachusetts took up almost one third of its annual budget in 2000. A study conducted in the same unit found that, from 2000 to 2003, a restraint reduction initiative reduced the cost of restraints by 92%, from \$1,446,740 to \$117,036.<sup>91</sup> The study measured this cost by multiplying the amount of time staff spent on restraint-related activities by their wages.<sup>92</sup> Another significant source of financial cost that is overlooked in this type of analysis is the potential financial liability faced by hospitals for patient and staff injuries as a result of restraints.

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<sup>87</sup> See, e.g., Kristen Wyatt, *State Budget Cuts Decimate Mental Health Services*, CNSNEWS.COM (Mar. 9, 2011), <http://www.cnsnews.com/news/article/state-budget-cuts-decimate-mental-health-services>. Between 2008 and March 2011, thirty-two states and Washington, D.C. cut funding for mental health services. *Id.* California reduced funding by more than \$587 million or by 16%. *Id.* Kentucky reduced its funding by 47% over the two years since 2009. *Id.* Arizona cut its budget by more than \$57 million between 2009 and 2010. *Id.*

<sup>88</sup> See, e.g., Gordon et al., *supra* note 5, at 176; Saks, *Mechanical Restraints*, *supra* note 78, at 1853.

<sup>89</sup> Since nurses agree only 8% of the time whether a particular situation will escalate into violence, their decision to restrain patients is highly error-prone. Tovino, *supra* note 84, at 537.

<sup>90</sup> LeBel & Goldstein, *supra* note 77, at 1113.

<sup>91</sup> *Id.* at 1112.

<sup>92</sup> *Id.*

### 3. Staff-Related Costs

Staff turnover rates are high in facilities that regularly use restraints.<sup>93</sup> This means that the cost of training new staff would also be higher in facilities that use restraints. Use of restraints also creates a hostile unit environment, which would increase the staff turnover rate. The Massachusetts study cited above found that in a facility that used restraints, staff spent a substantial amount of their time doing non-therapeutic activities, thereby defeating the purpose of care facilities.<sup>94</sup> In contrast, when a restraint reduction initiative was in place, staff could focus more on building relationships with patients, understanding patients' needs, planning for pre-crisis intervention, and developing de-escalation skills.<sup>95</sup>

### 4. Patient-Related Costs

First, restraint can cause injuries to patients, and even death in extreme cases.<sup>96</sup> Reported injuries from patients struggling to remove restraints include strangulation, pressure sores, nosocomial infection, and falls.<sup>97</sup> These injuries may pose more serious problems for mentally retarded patients who are unable to communicate their physical distress because some injuries may not be addressed in time and left unchecked.<sup>98</sup>

Second, restraints can trigger past traumas in patients, and thus exacerbate their symptoms.<sup>99</sup> It has been shown that rape victims are especially damaged because being restrained can resurrect their trauma, as they feel out of control and betrayed by the people they trust.<sup>100</sup> The triggering of past trauma causes patients to distrust hospital staff, and consequently causes milieu instability, which is detrimental to both patients and staff. For some patients, re-traumatization is so severe that they vowed never to receive hospital treatment again.<sup>101</sup>

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<sup>93</sup> See *id.* at 1113.

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> Gordon et al., *supra* note 5, at 178.

<sup>97</sup> *Id.*

<sup>98</sup> William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 AM. J. PSYCHIATRY 1584, 1587 (1994).

<sup>99</sup> Jeffrey J. Borckardt et al., *Enhancing Patient Safety in Psychiatric Settings*, 13 J. PSYCHIATRIC PRAC. 355, 355 (2007).

<sup>100</sup> See Sharyl Brase Smith, *Restraints: Retraumatization for Rape Victims?*, 33 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 23, 23 (1995).

<sup>101</sup> *Id.* at 24.

Third, restraints suppress unwanted behavior instead of teaching new behavior, which is counter-therapeutic for patients.<sup>102</sup> If restraints are overused or used regularly for a prolonged period of time, it is harder for patients to develop daily living skills outside of an inpatient setting.<sup>103</sup>

Fourth, witnessing other patients being mechanically restrained, or even hearing about it, may cause anxiety, rebellion, and violence among patients and staff.<sup>104</sup>

Fifth, there is potential for discrimination against patients with a history of restraint episodes.<sup>105</sup> The staff may feel more justified or comfortable with restraining certain restraint-prone patients, leading to repressive or punitive use of restraints.<sup>106</sup> This could in turn make the patient feel defensive and helpless, inciting more violence.<sup>107</sup> This pattern of behavior could perpetuate the vicious cycle of recurring restraints and regression.<sup>108</sup> Also, there is a high risk that patients will be put under restraint when it is unnecessary because violence cannot always be accurately predicted.<sup>109</sup>

Lastly, patients' negative experiences with restraints must be considered. Patients have also ranked restraint as the most restrictive control mechanism, and have expressed that they felt agitated, unable to calm down, disoriented, and humiliated while being placed under restraints.<sup>110</sup> Some of them were able to calm down,<sup>111</sup> but this does not necessarily explain the treatment efficacy of restraints, because an alternative intervention program could have calmed down the patients. One patient said that being left alone in his or her room would have been more calming than being restrained.<sup>112</sup> Because patients value freedom and dignity, just like everyone else, the subjective views of patients must be taken seriously.<sup>113</sup>

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<sup>102</sup> Gordon et al., *supra* note 5, at 178.

<sup>103</sup> Eila Sailas & Kristian Wahlbeck, *Restraint and Seclusion in Psychiatric Inpatient Wards*, 18 CURRENT OPINION PSYCHIATRY 555, 557 (2005).

<sup>104</sup> LeBel & Goldstein, *supra* note 77, at 1111.

<sup>105</sup> Barbara Berland et al., *Patient Characteristics Associated with the Use of Mechanical Restraints*, 5 J. GEN. INTERNAL MED. 480, 484 (1990).

<sup>106</sup> Leslie Stilling, *The Pros and Cons of Physical Restraints & Behavioral Controls*, 30 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 18, 18 (1992).

<sup>107</sup> *Id.*

<sup>108</sup> See Rolf Wynn, *Psychiatric Inpatients' Experiences with Restraint*, 15 J. FORENSIC PSYCHIATRY & PSYCHOL. 124, 137 (2004) (stating regression of psychotic patients as a result of being restrained).

<sup>109</sup> Fisher, *supra* note 98, at 1585.

<sup>110</sup> See Wynn, *supra* note 108, at 132.

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 131.

<sup>113</sup> Saks, *Mechanical Restraints*, *supra* note 78, at 1848.

Further, their emotions and feelings should be respected more than those without mental illness because patients' emotions are inextricably linked to their treatment process.

### B. BENEFITS

Proponents of mechanical restraints claim several benefits. First, proponents claim that restraints can reduce violence against staff and other patients, as it can help patients control their assaultive urges and help preserve the calm of a psychiatric ward.<sup>114</sup> The use of restraints is based on the notion that restriction of one's freedom can be justified if that person's exercise of liberty would harm others.<sup>115</sup> Second, proponents argue that mechanical restraints can prevent patients from harming themselves. This is perhaps the least controversial use of mechanical restraints, as seclusion could be a dangerous option for patients that are prone to harming themselves. Conversely, though, coercive measures such as restraints may cause patients to feel like they have lost control, which can cause them to act out violently.<sup>116</sup> Third, research shows that restraints can reduce agitation and can even be viewed as therapeutic.<sup>117</sup> However, what is not clear from this research is whether the patients would have calmed down in the absence of being restrained. Still, the benefits claimed by proponents can be countered by conflicting research that shows restraints are counter-therapeutic and may increase violence and agitation among patients.<sup>118</sup>

### C. ANALYSIS

On balance, it is clear that the costs of mechanical restraints greatly outweigh its benefits. Research supporting the benefits of restraints is mostly inconclusive, and directly conflicting research makes its benefits less tenable.<sup>119</sup> From both utilitarian and ethical standpoints, restraint is an undesirable activity with negative utility, and should be avoided if other

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<sup>114</sup> Fisher, *supra* note 98, at 1588.

<sup>115</sup> Stilling, *supra* note 106, at 19.

<sup>116</sup> *Id.* at 18. One interesting study done on this issue found that restraint was an effective positive reinforcer to reduce self-harming behavior in three profoundly mentally retarded patients. See Judith E. Favell et al., *The Use of Physical Restraint in the Treatment of Self-Injury and As Positive Reinforcement*, 11 J. APPLIED BEHAV. ANALYSIS 225, 225 (1978). However, this research was conducted in the late 1970s, and given the small sample size, one should question its validity.

<sup>117</sup> See Gordon et al., *supra* note 5; Fisher, *supra* note 98.

<sup>118</sup> LeBel & Goldstein, *supra* note 77, at 1110.

<sup>119</sup> See *id.*

alternatives exist.

#### IV. COST-BENEFIT ANALYSIS OF IMPLEMENTING BEHAVIORAL INTERVENTION PROGRAMS

##### A. COSTS

###### 1. Ethical Concerns

Behavioral intervention programs pose few ethical problems because they do not infringe on patients' bodily movement and freedom. However, some intervention programs are criticized for being paternalistic and coercive. For example, token economies are criticized for failing to give patients autonomy, respect, and empowerment, and for having no lasting effects.<sup>120</sup> However, the same criticisms can be leveled at mechanical restraints, as they also do not promote patients' autonomy and do not produce long-term benefits. If both measures share these ethical concerns, the one with less physical restriction and coercion should be adopted.

Patients should be free to refuse intervention programs as long as their decisions are not based on delusions.<sup>121</sup> Patients should be allowed to refuse intervention programs based on their feelings.<sup>122</sup> For example, they should be able to refuse to take part in a program because they do not like the person who is running it. In such a case, hospital staff should engage in a conversation with the patient to find out how they can best accommodate the patient's needs and wishes. Similarly, patients should be allowed to refuse a program if they believe that it would not work for them, as long as they have a logical reason for their refusal and are willing to participate in another program that fits their preferences.<sup>123</sup>

###### 2. Financial Costs

It is again difficult to quantify how much a proposed intervention

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<sup>120</sup> Robert W. Glover, *Reducing the Use of Seclusion and Restraint: A NASMHPD Priority*, 56 PSYCHIATRIC SERVICES 1141, 1142 (2005). There is conflicting research showing that token economies had a long-term effect of reducing aggression among patients. See LePage et al., *supra* note 12.

<sup>121</sup> Delusion is a belief for which there is no evidence. See Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 962–65 (1991) (delusion as the standard for incompetence).

<sup>122</sup> See *id.* at 984–85 (refusing treatment based on feelings such as hatred).

<sup>123</sup> See *id.* at 987–88 (refusing treatment based on belief about its effectiveness).

program would cost because it would depend largely on the size of the unit, patients' conditions, quality of existing facilities, and qualifications of the staff. Nevertheless, it must be noted that certain intervention programs can be adopted without incurring much extra cost. For example, token economies require few additional monetary or staff resources to implement or sustain.<sup>124</sup> Also, many intervention programs involve cultural changes within a unit—such as improving communication and rapport between staff and patients—which requires a change of attitude more than extra money. Further, many changes would require little staff training time, such as giving specific instructions to patients in a neutral tone of voice.

The cost of setting up intervention programs may seem substantial at first glance, but much of the cost is likely to be front-loaded, including the cost of training staff, paying outside consultants, hiring more staff to improve patient-staff ratios, and paying for structural environmental changes.<sup>125</sup> The cost of hiring outside personnel would likely decrease over time, as staff members become more familiar with programs and standard protocols develop within units. Also, successful implementation of intervention programs would shorten patients' stays and lower staff turnover rates. Therefore there would be economic benefits in the long-term.

### 3. Staff-Related Costs

First, staff would have to take on the burden of educating themselves on different aspects of behavioral therapy and interacting more closely with patients and other parties involved in programs. However, there is no evidence that shows staff training for intervention programs would be more burdensome or more costly than staff training for mechanical restraints. Second, there may be increased violence against staff if mechanical restraints are banned. However, intervention programs should be targeted at intervening early before the onset of violence. So if such intervention programs are run successfully, increased violence should not be a problem. In fact, the intervention programs would probably decrease violence.

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<sup>124</sup> LePage et al., *supra* note 12, at 188.

<sup>125</sup> Borckardt et al., *supra* note 99, at 359.



#### 4. Patient-Related Costs

There are no known harmful effects of intervention programs on patients because there is no increased risk of injury, retraumatization, discrimination, hostile environment, or emotional damage. One possible detrimental effect on patients is loss of autonomy, as certain programs require them to follow orders and comply with rules. However, autonomy can be developed by other means, such as taking part in group activities and peer mentoring as part of intervention programs.

### B. BENEFITS

Most notably, behavioral intervention programs would produce better treatment results for patients in the long-term by improving their autonomy and communication skills, and by training them to become participating members of the community outside of inpatient settings.<sup>126</sup> Moreover, intervention programs target patients' behavioral problems head-on, rather than only physically stopping violent acts the way mechanical restraints do. There is a wealth of research that shows that these intervention programs significantly help reduce the use of restraints on patients.<sup>127</sup> Whether this reduction is due to cultural change or other factors, this is strong evidence that these intervention programs have clinical efficacy. If intervention programs are used in the regular course of treatment for all patients, instead of as merely temporary measures, the inpatient rehabilitation efforts would be more fruitful. In addition, if intervention programs replace restraints for treating inpatient violence, the unit culture will improve greatly, as unnecessary tension between the patients and hospital staff would be minimized.<sup>128</sup>

### C. ANALYSIS

The benefits of behavioral intervention programs outweigh its costs, even if the financial costs of setting up the programs may be substantial. If

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<sup>126</sup> See *supra* Part II.A.

<sup>127</sup> See Donat, *Encouraging Alternatives*, *supra* note 1, at 1107; Donovan et al., *supra* note 15, at 959; Kalogjera et al., *supra* note 21, at 284; Martin et al., *supra* note 1.

<sup>128</sup> See generally Donovan et al., *supra* note 15, at 958 (behavior intervention programming aimed at fostering "positive relationships" and "collaboration" between patients and staff); LeBel & Goldstein, *supra* note 77, at 1114 ("[Decreasing mechanical restraints had a] positive impact on staff"); LePage et al., *supra* note 12, at 187 ("[The implementation of token economies affected] the attitude of the staff [because the] staff became more convinced that the program was effective . . . and worked with the patients with more confidence.").

we compare the results from the cost-benefit analysis of each measure, mechanical restraints entail more costs and ethical concerns than intervention programs.<sup>129</sup> Mechanical restraints have little treatment efficacy,<sup>130</sup> whereas empirical studies show that intervention programs curb inpatient violence.<sup>131</sup> Most important, we should aim to choose a measure that is least restrictive of patients' liberty and dignity,<sup>132</sup> even if the cost of using that measure may be higher. Therefore, when addressing inpatient violence, intervention programs should replace mechanical restraints.

## V. MODEL LAW IN THE AREA OF MECHANICAL RESTRAINTS

Formulating policy on mechanical restraints requires a delicate balancing of preserving patients' liberty and dignity, treating their conditions effectively, and protecting the public and related parties from harm. Legislation in this area poses particular challenges because legislators must go beyond making mere value judgments and address the practical problems of accessibility to mental healthcare and finance, which lie at the core of the controversy.<sup>133</sup>

### A. THREE LEGISLATIVE OPTIONS<sup>134</sup>

As shown above, the current liability scheme for medical professionals is grossly deficient, and, as a result, abusive restraint practices are prevalent.<sup>135</sup> The following are three possible solutions to this shortcoming. One, we could levy a more hefty liability on doctors to match the excessive power given to them under the shield of the professional judgment

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<sup>129</sup> See *supra* Part III.A.

<sup>130</sup> LeBel & Goldstein, *supra* note 77, at 1110, 1112 (discussing two studies conducted by the National Association of State Mental Health Program Directors and finding behavior intervention decreased recidivism rates in re-hospitalizations) ("[T]he use of seclusion and restraint was not therapeutic and reflected a failure in the treatment process[.]"); Martin et al., *supra* note 1, at 1406 ("[A] review of 36 published studies concluded that there is insufficient evidence to support an association between patient safety and use of restraint and seclusion."); Saks, *Mechanical Restraints*, *supra* note 78, at 1841, 1843, 1846.

<sup>131</sup> See LePage et al., *supra* note 12, at 186; Tovino, *supra* note 84, at 516.

<sup>132</sup> Saks, *Mechanical Restraints*, *supra* note 78, at 1841. Professor Saks emphasizes the need to protect the "liberty and dignity of the patient" as the basis of her argument for limited use of mechanical restraints. *Id.* at 1837.

<sup>133</sup> Tovino, *supra* note 84, at 515–16.

<sup>134</sup> These options are not mutually exclusive. If the third option is not adopted, both the first and the second options should be implemented.

<sup>135</sup> See *supra* Part III.A.1.

standard.<sup>136</sup> Two, we could combat abusive restraint practices with regulations that encourage safe practices.<sup>137</sup> Three, we could abolish restraints and use other means available to control inpatient violence, such as behavioral intervention programs.

### 1. Statutory Damages Scheme

We can create a statutory remedy to compensate patients who have been subject to unreasonable or unnecessary restraint. A two-tier remedy scheme should be created: (1) the doctor's personal liability and (2) the hospital's vicarious liability for the doctor's negligence. This damages structure would encourage hospitals to supervise how doctors exercise their powers to control patient violence. The hospital's vicarious liability should extend to the actions of all its agents, including hospital staff. The amount of damages should be fixed to avoid expensive litigation: neither too low so that the statutory damages merely become a cost of doing business, nor too high to unduly burden the healthcare industry.<sup>138</sup> If any injury requires medical expenses over a certain minimum amount, or if death occurs as a result of restraint use, the statute should establish a rebuttable presumption of liability against the doctor and the hospital, unless they can effectively establish an affirmative defense.

### 2. Safe Practice Standards for Mechanical Restraints

Efforts to regulate the safe practice of mechanical restraints should contain concrete rules and guidelines. Setting regulatory standards for safe mechanical restraints use poses numerous challenges because enforcement would be extremely difficult and expensive.<sup>139</sup> If the safe practice standard of mechanical restraints use were vaguely formulated—such as the standard of reasonableness—we would add nothing to the current vague professional judgment standard.

Safe practice standards should include certain limitations. For example, we could require a limit of thirty minutes of restraint time with staff supervision throughout, and permission from a doctor to continue the restraint after the first fifteen minutes.<sup>140</sup> Also, there should be a limit on

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<sup>136</sup> See Saks, *Mechanical Restraints*, *supra* note 78, at 1855.

<sup>137</sup> See *id.* at 1853–54.

<sup>138</sup> See *id.* at 1848 n.86 (discussing specific statutory damages for doctors' liability).

<sup>139</sup> See Donovan et al., *supra* note 15, at 959.

<sup>140</sup> See Saks, *Mechanical Restraints*, *supra* note 78, at 1853–54.

how often a patient can be restrained within a specified time period, such as no more than three times per month. In addition, certain types of restraints could be banned, such as a ban on four or more point restraints.

Every institution that uses restraints should register with and report every incidence of restraint use to a nationally linked database. This nationally linked database can be used to create a healthy competition between the hospitals to minimize restraint use.<sup>141</sup> The Centers for Medicare & Medicaid Services can offer grants to those hospitals that remain restraint-free and achieve certain treatment goals. As hospitals may under report their uses of restraint, an auditing body should be established to incentivize accurate reporting and good record keeping. We should also impose appropriate sanctions, such as removal of grants or fines against violating hospitals.

### 3. Abolition of Mechanical Restraints and Mandatory Intervention Programs

As the enforcement of the previous two alternatives might be too costly, this paper endorses a third option: eliminate mechanical restraints altogether. As a practical concern, enforcing the other proposals may be so expensive that their costs may exceed the cost of setting up and operating intervention programs in inpatient units.<sup>142</sup> The model law should provide that behavioral intervention programs with specific de-escalation strategies become mandatory in inpatient units that either: (1) admit patients with any history of violent behavior or (2) have had any violent inpatient episodes in the past two years.<sup>143</sup> Consent should be obtained from all patients upon admission, and if they refuse to follow the program, the program should be altered within reason to meet their needs. If patients refuse to take part in any of the programs, their decision should be honored.<sup>144</sup> However, if they refuse to join all programs, and consequently become

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<sup>141</sup> Cf. Donovan et al., *supra* note 15, at 959 (discussing the benefits of a standardized curriculum for restraint reduction) (“[The standardized curriculum should be] linked nationally to determine which curriculum components are most effective. As data are gathered, a national curriculum can be created[.]”).

<sup>142</sup> See Tovino, *supra* note 84, at 514 n.12 (citing Am. Hosp. Ass’n, Guiding Principles on Restraint and Seclusion for Behavioral Health Services (Feb. 29, 1999) (model guidelines on mechanical restraints), (“[Overregulation of restraint and seclusion policies] could divert limited resources to bureaucratic activities [when such monies should be dedicated to clinical care.]”), available at <https://www.naphs.org/news/guidingprinc>).

<sup>143</sup> See Huckshorn, *supra* note 73, at 7.

<sup>144</sup> See Saks, *Mechanical Restraints*, *supra* note 78, at 1853 (discussing the patient’s right to choose psychiatric treatment).

violent during their stay, they should be required to comply with the program either for the rest of their stay, or until they remain calm for a certain period of time, such as two months, whichever is shorter.

The legislation should design a program with minimum guidelines that all qualified facilities must follow. The guidelines should include a minimum amount of time for staff training and patient participation. Certain cultural changes, which require little extra budgeting, can be recommended, such as implementing a no gossip policy, designating a quiet zone, and communicating hopeful messages to the patients.<sup>145</sup> Group activities within the unit, such as peer mentoring and forming sports teams to develop patient autonomy, should be encouraged. Token economies should also be encouraged, as they can help patients learn valuable everyday living skills.<sup>146</sup> But if patients have ethical problems with the program, they should be free to refuse to take part in it or to withdraw anytime. Intervention programs should also include regular workshops to teach de-escalation strategies with patient advocates, who have psychiatric diagnoses and experience in inpatient settings.

Every six months, each facility should sign a commitment form that certifies that they have conformed to all program requirements. If they decide to withdraw from the program, they should be required to give a valid reason, such as there having been no violence in the unit for the past two years. A team of committees should be established to conduct annual checks on each unit. In cases where units grossly violate requirements, a fine can be levied against them or their funding may become conditional on meeting certain program goals.<sup>147</sup> Additionally, they may be subject to more rigorous reporting duties for a specified period, such as ten months.

The legislation should ban the use of all mechanical restraints in inpatient units, apart from the use of helmets or finger control mitts to prevent self-injury. Seclusion should be used as a last resort and the use of alternative means, such as time-outs or comfort wraps, should be recommended.<sup>148</sup> If active violence occurs, patients should be manually restrained.<sup>149</sup> After a violent episode, patients should be required to meet

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<sup>145</sup> These policies have been effective in eliminating restraint use in a facility in Arizona. Lori Ashcraft, Address at the Saks Institute for Mental Health Law, Policy, and Ethics Spring Symposium: An Organization Eliminates Seclusion and Restraint (Apr. 23, 2011) (video available at <http://lawmedia.usc.edu/mediasite/Viewer/?peid=5fbddefbfa7146219fc654a86f64993d>).

<sup>146</sup> See LePage et al., *supra* note 12, at 183.

<sup>147</sup> See Schreiner et al., *supra* note 47, at 461.

<sup>148</sup> See, e.g., *supra* Part II.A.5.

<sup>149</sup> See *infra* Part V.A.3.c.

with staff members to debrief the event and make a commitment not to repeat the behavior. The meeting should take place no longer than an hour after the episode has ended.<sup>150</sup>

*a. The United Kingdom Model*

The U.K. model of restraint use should teach us that abandoning mechanical restraints would not increase the use of seclusion or medication.<sup>151</sup> Historically, U.K. mental health authorities have been opposed to using mechanical restraints, although the case of *Pountney v. Griffiths* gave psychiatric hospitals the authorization to use “more force than is really necessary” to control patients in some circumstances.<sup>152</sup> Section 145(1) of the Code of Practice of the Mental Health Act of 1983 defines medical treatment for mental illness as “care, habilitation and rehabilitation under medical supervision aimed at alleviating or preventing a deterioration of the patient’s mental disorder.”<sup>153</sup> In the U.K., mechanical restraints as well as physical restraints and seclusion are not considered medical treatments because they are not applied to treat the mental disorder itself, but instead are considered mechanisms to deal with certain behaviors resulting from the disorder.<sup>154</sup> Although British courts have started to widen the scope of medical treatments,<sup>155</sup> their hospitals are still reluctant to use mechanical restraints, fearing the “slippery slope,”<sup>156</sup> as using mechanical restraints on one patient could result in increased use or abuse in the future.<sup>157</sup>

*b. Rehabilitation*

The American psychiatric community should insist on rehabilitation. Although there is no constitutional right to rehabilitation or voluntary

<sup>150</sup> See Tovino, *supra* note 84, at 546.

<sup>151</sup> See Saks, *Mechanical Restraints*, *supra* note 78, at 1845–48. Professor Saks discusses the British model, where “[d]espite the absence of mechanical restraints, the British use seclusion less often than American psychiatrists, and there is no evidence that they use medication or physical restraint more than American psychiatrists.” *Id.* at 1846.

<sup>152</sup> [1976] A.C. 314 (H.L.) 328 (appeal taken from Eng.). Though the House of Lords stated that hospital staff should use reasonable force against patients, *id.* at 318, “[i]n securing someone who is escaping it is possible that more force than is really necessary may be used.” *Id.* at 328. See also Gordon et al., *supra* note 5, at 175.

<sup>153</sup> Gordon et al., *supra* note 5, at 175.

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.* at 180–81.

<sup>157</sup> *Id.* at 181.

mental healthcare in the United States, when alternatives exist, hospital staff should use treatment methods that are least restrictive and most effective. At the very least, doctors or hospital staff should not cause patients' conditions to deteriorate by putting them in mechanical restraints when their aggression could be controlled by intervention programs. This view is echoed by the Supreme Court's opinion in *Youngberg v. Romeo*:

[T]he State is under a duty to provide [the patient] with such training as an appropriate professional would consider reasonable to ensure his safety and to facilitate his ability to function free from bodily restraints. It may well be unreasonable not to provide training when training could significantly reduce the need for restraints or the likelihood of violence.<sup>158</sup>

As various intervention programs are proven to significantly reduce the need for restraints or the likelihood of violence,<sup>159</sup> it would be unreasonable for state hospitals not to provide intervention programs to patients. This is consistent with the new standard set by federal regulation<sup>160</sup> that requires restraint and seclusion to be authorized only when a "physician or other licensed independent practitioner (LIP) determines that less restrictive interventions have been ineffective to protect the patient, a staff member, or others from harm."<sup>161</sup> In other words, medical professionals should choose a treatment method that is less restrictive and more effective than another.

Accordingly, mechanical restraints should disappear from the U.S. psychiatric landscape because they are less effective and excessively more restrictive than intervention programs, and have no rehabilitative effects on patients. Abolition of mechanical restraints in psychiatric hospitals is not an unrealistic goal because seclusion, medication, and restraints are still available in emergency situations. In an ideal world, all forms of restrictive control measures would be eliminated. However, limited access to mental healthcare leaves many Americans' mental disorders untreated,<sup>162</sup> which can lead to "attempted suicide, homicide, and other aggressive behaviors once admitted to psychiatric hospitals, thus making use of restraint or seclusion necessary."<sup>163</sup> Furthermore, lack of funding for inpatient and acute mental health units causes overcrowding in facilities,

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<sup>158</sup> 457 U.S. 307, 324 (1982).

<sup>159</sup> Donat, *Encouraging Alternatives*, *supra* note 1, at 1105.

<sup>160</sup> 42 C.F.R. § 482.13(e) (2011).

<sup>161</sup> Tovino, *supra* note 84, at 546.

<sup>162</sup> *Id.* at 554.

<sup>163</sup> *Id.* at 554–55.

which may lead to inevitable use of seclusion or restraint.<sup>164</sup>

*c. Manual Restraint*

In case of emergencies that call for the patient to be restrained, manual restraint should be used instead of mechanical restraints. This is because manually holding someone can be less dehumanizing<sup>165</sup>: we use this method in everyday situations, for example holding people manually to stop them from fighting in a bar. Furthermore, staff cannot manually hold patients for as long as they can with mechanical restraints.<sup>166</sup> Many deaths have occurred because staff neglected patients who were under mechanical restraints for a prolonged period of time.<sup>167</sup> Moreover, patients must not be put on the floor facedown while being restrained because some deaths have occurred due to asphyxiation during manual restraint.<sup>168</sup> In addition, staff members must be trained well to restrain patients safely as staff injuries are fairly common.<sup>169</sup>

## B. PATIENT AND FAMILY INVOLVEMENT

Treatment providers, both in the private and public sectors, naturally err on the side of protecting their own interests of cost reduction and liability minimization. Thus, input from mental health patients, their advocates, and their family members is crucial for sound policy making in mental health law. Finally, family members or guardians should be present when patients give consent for a treatment.

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<sup>164</sup> *Id.* at 557–58.

<sup>165</sup> For this reason, among others, manual restraint is preferred to mechanical restraints in the U.K. See Professor Phil Frennell, Cardiff Law School, Address at the Saks Institute for Mental Health Law, Policy, and Ethics Spring Symposium: A Comparative Discussion of the Views in the U.K. on Use of Mechanical Restraints (Apr. 22, 2011) (video recording and scholarly article available at <http://lawweb.usc.edu/centers/saks/restraintsProgram.cfm> (last visited Sept. 23, 2011)).

<sup>166</sup> Duncan Stewart et al., *Manual Restraint of Adult Psychiatric Inpatients: A Literature Review*, 16 J. PSYCHIATRIC & MENTAL HEALTH NURSING 749, 751 (2009).

<sup>167</sup> Tovino, *supra* note 84, at 534 (“Twenty-three of the 142 individuals reported in the Hartford Courant report died because they were restrained with their arms crossed across their chests and placed in prone position. Another twenty of them died after being tied up in leather wrist and ankle cuffs or vests, having been ignored for hours.”).

<sup>168</sup> Stewart et al., *supra* note 166, at 751.

<sup>169</sup> *Id.* at 752.



## VI. CONCLUSION

The abolition of mechanical restraints is a bold step towards protecting patients' freedom and liberty. This is the surest way to end current abusive practices in mechanical restraints use because enforcement of safe practices would be too costly. Mandatory behavioral intervention programs would ensure that patients develop autonomy, so that they can become valuable members of the community outside of inpatient settings. However, behavioral intervention programs can have positive long-term effects only if they become a permanent part of treatment in inpatient units. A lesson learned from the U.K. model is that use of mechanical restraints is not necessary to preserve the milieu in inpatient units. Further, the use of seclusion or medication would not increase as a result of the ban if we invest in resources that help curb patients' violence. Hospital staff could spend their time engaging in therapeutic activities in lieu of enforcing coercive measures that result in patient regression and injury. Even with nationwide budget cuts to state hospitals, a significant number of intervention programs can be implemented without extra costs. Therefore mandatory intervention programs in inpatient units are a realistic solution to patient violence.