

# A THEORY OF PUNISHMENT: THE USE OF MECHANICAL RESTRAINTS IN PSYCHIATRIC CARE

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## I. INTRODUCTION

Patients committed voluntarily or involuntarily to mental institutions place their trust and lives into the hands of their caretakers. When patients pose an imminent danger to themselves or others, many states permit their caretakers to mechanically restrain them. These procedures create perceptible damage to both patients and medical staff. While some professionals champion these methods as a form of treatment, mechanical restraints should instead be viewed as a form of punishment.<sup>1</sup> People with mental illness are an especially vulnerable group<sup>2</sup> and deserve protection from abuse. Because mental illness is an illness and not a form of behavior that deserves punishment, it is crucial that treatment for mental illness be delivered with kindness and understanding.

This Comment focuses on eliminating the use of mechanical restraints as a form of treatment and, more importantly, demonstrates the availability of other methods for handling dangerous behavior. First, I highlight some of history's more atrocious "treatments" for mental illness to help contextualize the discussion. Second, I describe the harm that mechanical restraints cause to patients and staff, as well as patients' views of

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<sup>1</sup> While I argue against the use of mechanical restraints, I acknowledge that working with patients who have mental illness can be an incredible challenge and that staff generally act with the best interests of their patients at the forefront.

<sup>2</sup> Laura E. Hortas, Note, *Asylum Protection for the Mentally Disabled: How the Evolution of Rights for the Mentally Ill in the United States Created a 'Social Group'*, 20 CONN. J. INT'L L. 155, 162 (2004).

restraints.<sup>3</sup> Third, after defining punishment and treatment, I review old but now controversial methods of treatment, which should be considered punishment. Fourth, in order to demonstrate problems with current “treatments,” I will illustrate the similarities between old treatment methods and those of today. Finally, I advocate for individual treatment plans focused on positive reinforcement, rather than punishment, and highlight institutions that successfully reduced or eliminated the use of restraints.

## II. A BRIEF HISTORY OF MENTAL HEALTH TREATMENTS NOW CONSIDERED PUNISHMENT

In order to fully understand today’s prevailing mental health treatments, it is important to review the past to analyze and consider decisions made today. In 1999, students from Marymount College touring Rockland Psychiatric Center handled old surgical instruments that had been used around the 1940s to treat patients with mental illness.<sup>4</sup> Today the use of these instruments is not regarded as treatment. Teachers explained to their students that the instruments were “all used [often with little anesthetic] . . . not out of cruelty but as part of what was then considered state-of-the-art treatment.”<sup>5</sup> One student observed, “We look on those treatments as barbaric now . . . . But years from now the treatments we use today might well be considered barbaric.”<sup>6</sup> The student’s observation is prescient because today’s use of mechanical restraints as a “treatment” should be considered as anything but.

In seventeenth-century America, doctors treating patients with mental illness “administered an assortment of concoctions made from such ingredients as human saliva and perspiration, earthworms, powdered dog lice, or crab eyes[, and] Saint-John’s-wort.”<sup>7</sup> Some patients even underwent bloodletting and blistering in line with phases of the moon.<sup>8</sup> Treatments were varied and seemingly unending. People were given “[h]ot human

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<sup>3</sup> It is important to note that there are two perspectives in which patients experience mechanical restraints: those being restrained and those witnessing the use of restraints on others. Only the former is discussed in this Note, though it seems clear that witnessing such an event would decrease feelings of both trust in staff and personal safety.

<sup>4</sup> Donna Cornachio, *Changes in Mental Care*, N.Y. TIMES, Jan. 3, 1999, at WE7 (instruments included tools used in lobotomies, electroshock therapy, insulin-shock therapy, and hydrotherapy).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> LELAND V. BELL, *TREATING THE MENTALLY ILL: FROM COLONIAL TIMES TO THE PRESENT* 2 (1980).

<sup>8</sup> *Id.*

blood, as well as pulverized human hearts or brains,” and other unthinkable combinations.<sup>9</sup> Further practitioners “treated” patients by terrorizing, beating, and restraining them with whips, chains, leg irons, iron rings, “madd shirts,” cold showers, emetics, cathartics, and sedatives.<sup>10</sup>

These professionals thought their management of mental illness was humane and therapeutically effective because “a calm, subdued patient was [seen as] saner than a violent one.”<sup>11</sup> Part of this barbaric treatment stemmed from the belief that individuals with mental illness “were not affected by extreme temperature and were indifferent to their physical existence[.]”<sup>12</sup> which illustrates the effect of dehumanization and stigma on this marginalized group of people.

In France, 1793, rather than using old treatments that he described as punishment, Philippe Pinel started removing patients’ restraints in order to treat the mentally ill with his version of compassion.<sup>13</sup> However, Pinel still valued control as he substituted “psychological coercion for the application of random force” by relying on cold showers, sprays, straitjackets, and intimidation to keep the ward milieu calm.<sup>14</sup> Similarly, also during the latter half of the eighteenth century, Benjamin Rush, a medical leader in the United States, relied on bloodletting and methods such as “dousing the patient with cold water, keeping the patient awake for 24 hours in a standing, erect position, applying ice to the shaven head, and instilling a feeling of terror with threats of corporal punishment and death.”<sup>15</sup> He also used both a “tranquilizing chair,” which completely bound the patient’s body and decreased blood flow to the brain, and a “purpose-built gyrator” that “twirled [patients] . . . until their noses bled,”<sup>16</sup> because he believed “that a doctor could use any technique so long as it enhanced the patient’s well-being.”<sup>17</sup>

Today, no ethical person would endorse any of these methods because we recognize the above “treatment” as torture. Accordingly, since

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<sup>9</sup> *Id.* at 2–3.

<sup>10</sup> *Id.* at 5.

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

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 6.

<sup>14</sup> *Id.* at 6–7.

<sup>15</sup> *Id.* at 8.

<sup>16</sup> MARY DE YOUNG, MADNESS: AN AMERICAN HISTORY OF MENTAL ILLNESS AND ITS TREATMENT, 173–74 (2010). At this time, the Association of Medical Superintendents of American Institutions for the Insane held the position that a mechanical restraint was a “moral instrument” whose use “is at once benevolent, enlightened, and practicable.” *Id.*

<sup>17</sup> BELL, *supra* note 7, at 8.

what is considered appropriate changes with time, we must constantly reevaluate today's treatments to ensure that we help patients—not torture or punish them.

Unfortunately, “[t]he history of mental health care is not a success story or a story of progress; it does not follow a straight-line development from grim, torture-like activities of early times to benign, enlightened practices of the present.”<sup>18</sup> Therefore, we must critically evaluate “treatments” for those with mental illness, keeping in mind that, as social perception of mental illness ebbs and flows, so does the perceived morality and appropriateness of treatments suggested by the medical field. In fact, Thomas Kirkbride, who practiced at the same time as Rush, was deeply troubled by mechanical restraints, stating that he never used them “without a feeling of mortification, [or] without asking [himself] if it was really necessary.”<sup>19</sup> When instinct tells us something is wrong, the search for other solutions must be at the forefront. Treatments should respect the patient's dignity in the most humane way fathomable. However, to do so requires that we constantly reevaluate our current methods.

### III. THE USE OF MECHANICAL RESTRAINTS TODAY CAUSES MORE HARM THAN BENEFIT

Mechanical restraints are defined in various ways.<sup>20</sup> One definition for mechanical restraints is a “manual method or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove and that restricts the patient's freedom or normal access to one's body.”<sup>21</sup> An example is when a patient is “tied spread-eagled to a bed with leather cuffs fastening each limb tightly to the bed and perhaps some body restraint (a net or sheet) as well.”<sup>22</sup> Other exam-

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<sup>18</sup> *Id.* at 3.

<sup>19</sup> DE YOUNG, *supra* note 16, at 175 (citation omitted).

<sup>20</sup> The lack of consensus about the definition of mechanical restraints contributes to the lack of adequate information about the rates and duration of using mechanical restraints on patients. In fact, “[i]n spite of the documented risk associated with their use, S/R [seclusion and restraint] remain the most erratically regulated, and under-reported of all the intrusive interventions used in the healthcare field today.” Kevin Ann Huckshorn, *Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint*, 33 ADMIN. & POL'Y MENTAL HEALTH SERVICES RES. 482 (2006) (citation omitted) (discussing problems with both seclusion and restraint). In this Comment, I only focus on problems associated with restraint, although many sources in this Comment also discuss seclusion.

<sup>21</sup> *Id.* at 483 (citation omitted).

<sup>22</sup> ELYN R. SAKS, *REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL* 122 (2002).

ples include “straightjackets, camisoles, and wet-sheet packs.”<sup>23</sup>

Using mechanical restraints creates a myriad of problems, not only for those restrained but also for those doing the restraining. While some actions that cause pain can create ascertainable and important benefits, such as health benefits following the pain of surgery,<sup>24</sup> use of mechanical restraints does not have beneficial effects and is not worth the harm caused.

#### A. MECHANICAL RESTRAINTS CAUSE INJURY, DEATH, AND DIGNITARY HARMS

In the spring of 2008, Jeffery was a hospitalized twenty-five-year old who was distressed about not being able to smoke a cigarette three minutes earlier than usual, and consequently knelt onto his knees.<sup>25</sup> Although his reaction did not appear to have rendered him dangerous, the medical staff gave him Ativan (an anti-anxiety medication) and then placed him in five-point restraints, belly-down,<sup>26</sup> which was followed by additional medication.<sup>27</sup> Tragically, while in this position—over drugged and restrained—Jeffery died of a heart attack.<sup>28</sup>

Most states allow the use of restraints when patients present a danger to themselves or others.<sup>29</sup> For example in California, “[r]estraint [is] used only when alternative methods are not sufficient to protect the patient or

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<sup>23</sup> *Id.* at 122.

<sup>24</sup> CAROLINE DUNN, *ETHICAL ISSUES IN MENTAL ILLNESS* 83 (1998).

<sup>25</sup> Lori Ashcraft, William A. Anthony & Shannon Jaccard, *Rein in Seclusion and Restraints: They Are Not Compatible with Recovery-Oriented Services*, 28 *BEHAV. HEALTHCARE* 6 (2008).

<sup>26</sup> *Id.*

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

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

<sup>29</sup> See, e.g., ALASKA STAT. § 47.30.825(d) (2004) (“A locked quiet room, or other form of physical restraint, may not be used, except as provided in this subsection, unless a patient is likely to physically harm self or others unless restrained.”); CONN. GEN. STAT. § 17a-544(a) (1978) (“No patient may be placed involuntarily in seclusion or a mechanical restraint unless necessary because there is imminent physical danger to the patient or others and a physician so orders.”); COLO. REV. STAT. § 26-20-103 (2010) (listing only instances when restraint may be used); DEL. CODE ANN. tit. 16, § 5161(b)(6)(c) (amended 2011) (“[R]estraint or seclusion may be administered pursuant to and documented contemporaneously by the written order of an authorized, licensed mental health professional to the extent necessary to prevent physical harm to self or others.”); GA. CODE ANN., § 37-3-165(b) (1997) (“Physical restraints shall not be applied unless they are determined by an attending physician . . . to be absolutely necessary in order to prevent a patient from seriously injuring himself or herself or others and are required by the patient’s medical needs.”).

others from injury.”<sup>30</sup> While the theory of protecting patients or others from injury is sound, standards written this way are both broad and vague. As a result, it is difficult to apply these standards to individual patients, and equally difficult to evaluate the appropriateness of past restraint episodes.

Though Jeffrey was not following rules, his actions did not pose any danger to himself or others, rendering the use of restraints unnecessary.<sup>31</sup> Allowing the use of restraints, especially with broad and vague standards, permits a venue for abuse. The consequences are heavy, as patients not reaching the standards’ intentions may be injured or die in a place where they are supposed to be safe and undergoing treatment.<sup>32</sup> Unfortunately, this result is not uncommon:

[In fact, a] significant number [of patients] die in restraints, typically because they aspirate their vomit and choke to death or have a heart attack. One study identified 142 deaths reported as occurring during or immediately after restraint between 1989 and 1999. A research specialist at the Harvard Center for Risk Analysis estimated many more unreported deaths—50 to 150 each year. That of course is 1 to 3 deaths per week.<sup>33</sup>

One aspect of the use of mechanical restraints that cannot be denied is that it is dangerous.

Death is not the only consequence from the use of mechanical restraints. The use of these methods greatly harms the patient’s dignity, as restraints “render[] one utterly helpless,” defenseless, and without the ability to use the restroom or eat. Furthermore, restraints are degrading, humiliating, and incredibly painful.<sup>34</sup> Mechanical restraints are especially problematic for patients who are also rape victims, as the restraint process can re-traumatize them, which often results in patients refusing to return to a psychiatric institution for necessary help.<sup>35</sup>

Additionally, patients complain about undue force and mistreatment

<sup>30</sup> CAL. CODE REGS. tit. 22, § 71545(a) (2010).

<sup>31</sup> Ashcraft et al., *supra* note 25, at 6.

<sup>32</sup> See Nancy K. Ray, Karen Myers & Mark E. Rappaport, *Patient Perspectives on Restraint and Seclusion Experiences: A Survey of Former Patients of New York State Psychiatric Facilities*, 20 PSYCHIATRIC REHABILITATION J. 11, 15 (1996).

<sup>33</sup> SAKS, *supra* note 22, at 147

<sup>34</sup> *Id.* at 147–48; see also Charles G. Curie, *SAMHSA’s Commitment to Eliminating the Use of Seclusion and Restraint*, 56 PSYCHIATRIC SERVICES 1139–40 (2005) (“[T]raumatic and harmful experiences are all too common [in restraint and seclusion] . . . and [patients] perceive these events to be humiliating, dehumanizing, unreasonable, and distressing.”).

<sup>35</sup> Sharyl B. Smith, *Restraints: Retraumatization for Rape Victims?*, 33 J. PSYCHOL. NURSING 23, 23–25 (1995) (“[Staff] punished [patient] for becoming manic[.]”).

or abuse while in restraints.<sup>36</sup> Patients also complain that the use of these restraints “negatively influence[d] . . . recollections of their overall inpatient hospital experiences.”<sup>37</sup> In fact, the use of restraints can cause “sanctuary harm,” which occurs when “events in psychiatric settings . . . involve insensitive, inappropriate, neglectful, or abusive actions by staff or associated authority figures and invoke in [patients] a response of fear, helplessness, distress, humiliation, or loss of trust in psychiatric staff.”<sup>38</sup> These feelings, resulting from the use of mechanical restraints, cause “reduced self-esteem and sense of self-worth, exacerbation of psychiatric symptoms, and reduced participation in psychiatric care.”<sup>39</sup> If individuals with mental illness are purportedly committed to be treated and assisted, using methods that exacerbate symptoms, reduce participation in services, and create loss of self-esteem does not advance those ends.

Furthermore, patients have reported that, in addition to having negative reactions to the use of restraints, the implementation of restraints often did not comply with state standards.<sup>40</sup> In other words, patients reported that they did not reach state-designated levels of dangerousness necessary for placement in restraints; and also, that patients were ignored and not monitored while in restraints.<sup>41</sup> A study of 1,040 responses from former psychiatric inpatients found that while a small minority of respondents reported that the use of restraints and seclusion was appropriate, because the inpatients themselves had been dangerous, “the most common complaint . . . was that use of these interventions was premature, not necessary, and/or punitive.”<sup>42</sup> In fact, seventy-three percent of respondents stated that they were not dangerous to self or others at the time of restraint or seclusion, and of those instances, staff admitted that the patient’s behavior was inap-

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<sup>36</sup> Ray et al., *supra* note 32.

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

<sup>38</sup> Cynthia S. Robins et al., *Consumers’ Perceptions of Negative Experiences and ‘Sanctuary Harm’ in Psychiatric Settings*, 56 PSYCHIATRIC SERVICES 1134, 1135 (2005).

<sup>39</sup> *Id.* at 1135.

<sup>40</sup> Ray et al., *supra* note 32, at 15.

<sup>41</sup> *Id.*; see also Wanda K. Mohr & Brian D. Mohr, *Mechanisms of Injury and Death Proximal to Restraint Use*, 14 ARCHIVES OF PSYCHIATRIC NURSING 285, 288 (2000) [hereinafter Mohr & Mohr, *Mechanisms*].

<sup>42</sup> Ray et al., *supra* note 32, at 14; see also Linda Cramer, Ginny McGrath & A.J. Ruben, *The End of Seclusion and Restraint*, 32 VT. B. J. & L. DIG. 28, 30 (2006) (“[E]xperience and training has [sic] shown that in these circumstances patients often are not actually dangerous; rather, it is the staff’s perceptions and fears that the patient may injure themselves or others, or that the staff will lose control over the situation, that dictates the use of seclusion and restraint and the violence associated with those measures.”).

propriate but not dangerous.<sup>43</sup> Moreover, many patients reported that they did not know why they were restrained, believing instead that the primary purpose was for staff control, and not patient well-being and treatment.<sup>44</sup>

These facts raise two separate problems. First, patients are at risk of many kinds of harm when placed in mechanical restraints, including risk of death, physical injury, and various dignitary harms. Second, even though states have attempted to limit the use of mechanical restraints to instances when patients are at risk of imminent danger to themselves or others, these standards are often not met, causing increased harm to the patients. As stated earlier, if these risks could be counterbalanced by positive outcomes that truly make the risks worth the benefits, such harm *might* be justified. However, “it is unclear, based on present literature, whether any benefit (good) accrues to the patient from the use of restraints that entails anything other than safety.”<sup>45</sup> There is no positive consequence that justifies this level of harm. Rather, using mechanical restraints looks much more like punishment than treatment.

#### B. STAFF ARE INJURED AND SUFFER ANXIETY WHEN USING MECHANICAL RESTRAINTS

The use of mechanical restraints is not only harmful to patients but also to staff.<sup>46</sup> In fact, “[n]urses report that they prefer to use other means to manage aggressive behavior, that they are not altogether comfortable with restraint use, and that the process is as painful for them as for their patients.”<sup>47</sup> This may be in part due to “[t]he nature of nursing as a humanistic and caring activity and the requirement to practice physical restraint clearly sets the scene for some personal and ethical conflicts.”<sup>48</sup> It may al-

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<sup>43</sup> Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 532 (2007).

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

<sup>45</sup> Wanda K. Mohr, *Restraints and the Code of Ethics: An Uneasy Fit*, 24 ARCHIVES OF PSYCHIATRIC NURSING 3, 7 (2010) [hereinafter Mohr, *Code of Ethics*]. Mohr’s article is geared towards the use of physical restraints. In her article, she defines physical restraints as both when staff members hold a patient with their own bodies and also when staff tie a person down. Because I categorize tying a person down as a use of mechanical restraint, Mohr’s discussion of the use of physical restraints remains relevant to the use of mechanical restraints.

<sup>46</sup> *Id.* at 3 (citation omitted).

<sup>47</sup> *Id.*

<sup>48</sup> Stuart Bigwood & Marie Crowe, *‘It’s Part of the Job, but It Spoils the Job’: A Phenomenological Study of Physical Restraint*, 17 INT’L J. OF MENTAL HEALTH NURSING 215, 216 (2008) (citation omitted) (This article does not make clear whether the use of physical restraints includes tying down a patient.); see also Sandy Marangos-Frost & Donna Wells, *Psychiatric Nurses’ Thoughts and Feelings About Restraint Use: A Decision Dilemma*, 31 J. OF ADVANCED



so be in part due to the fact that staff found the use of restraints was “unlikely to produce desired change.”<sup>49</sup> Staff also reported restraining patients as traumatic, even contributing to job dissatisfaction.<sup>50</sup>

While staff often feel that restraints are necessary, due to the unpredictability of the patient population, the threshold for when restraints are necessary is different for each staff member based on his or her tolerance, or rather intolerance, for lack of control.<sup>51</sup> In fact, some nurses reported that sometimes “[they] sort of feel uncomfortable because [they] don’t feel there has been enough negotiation beforehand,” while others feel that re-establishing control has a therapeutic role.<sup>52</sup> Some feel like bullies when they perceive that not all options are exhausted before the initiation of restraints, which causes a high level of stress and anxiety.<sup>53</sup>

Staff injuries are not infrequent, which include both actual injury and anticipatory fear whenever patients are out of control.<sup>54</sup> Such fears can be particularly present when working with children because they “are wounded and mistrustful, and their main mode of coping is to lash out in attack.”<sup>55</sup> In essence, because restraining a patient requires touching someone who is presumptively angry or out of control, staff are at risk of being injured when they approach and touch the patient in an effort to control his or her ability to move.<sup>56</sup>

In addition, there is no clear standard for determining when a patient has reached a point extreme enough to justify the use of restraints, which results in controversy between nurses and the larger medical community:

[I]t is true that most inpatient mental health staff have grown accustomed to having S/R [(seclusion and restraint)] available in the face of what is considered imminently dangerous behavior. However, it is equally true that the majority of S/R interventions are used prematurely and because staff lack the knowledge, skills, or abilities to proactively choose other, less restrictive interventions.<sup>57</sup>

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NURSING 362, 365–66 (2000).

<sup>49</sup> Suzanne Goren & W. John Curtis, *Staff Members’ Beliefs About Seclusion and Restraint in Child Psychiatric Hospitals*, 9 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 7, 11–12 (1996).

<sup>50</sup> Bigwood & Crowe, *supra* note 48, at 221–22.

<sup>51</sup> *Id.* at 219.

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

<sup>53</sup> *Id.*

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

<sup>55</sup> Mohr & Mohr, *supra* note 41, at 286.

<sup>56</sup> *See id.* at 285.

<sup>57</sup> Huckshorn, *supra* note 20, at 489.

Thus, while the use of restraints may be effective in temporarily controlling the situation, it has large costs such as psychological stresses and physical injury to patients and staff.

C.    HARMS FROM MECHANICAL RESTRAINTS ARE EXTENSIVE AND DO NOT ACCOMPLISH THERAPEUTIC GOALS

While restraints do succeed in protecting others from the immediate reach of a distressed patient, it does not appear that any therapeutic end is accomplished. The costs of experiencing and administering restraints are high. As discussed above, patients are at risk of death and suffer significant dignitary harms, including senses of helplessness, hopelessness, fear, degradation, and humiliation. Restraint episodes can further traumatize patients who are victims of abuse or are suffering from post-traumatic stress disorder. Further, staff must deal with the constant anxiety of wondering both whether the restraint is justified and about the possibility of incurring physical injury.

IV.   PUNISHMENT VERSUS TREATMENT: HOW TO ANALYZE CONTROVERSIAL TREATMENTS

A.    WHEN PUNISHMENT FAILS TO BE AN ELEMENT OF TREATMENT

Joel Feinberg defined punishment as “the infliction of hard treatment by an authority on a person for his prior failing in some respect (usually an infraction of a rule or command).”<sup>58</sup> It is “part of a system that involves conduct norms, an authoritative procedure for generating these norms, an authoritative procedure for decisions to impose sanctions, and some measure of practical power over persons or resources.”<sup>59</sup> Therefore, punishment is an act designed to discourage what we deem socially inappropriate behavior.

Punishment is composed of an unpleasant consequence coupled with condemnation.<sup>60</sup> An unpleasant consequence alone is not, in and of itself, punishment because sometimes unpleasantness is an “unfortunate contingent fact,” like the pain that accompanies surgery but which carries no

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<sup>58</sup> JOEL FEINBERG, *DOING & DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY* 95 (1970).

<sup>59</sup> Guyora Binder, *Punishment Theory: Moral or Political?*, 5 *BUFF. CRIM. L. REV.* 321, 321 (2002).

<sup>60</sup> Kent Greenawalt, *Punishment*, 74 *J. CRIM. L. & CRIMINOLOGY* 343, 344 (1983).

condemnation.<sup>61</sup> Thus, punishment requires condemnation or judgment in addition to an unwanted consequence. Anything considered “cruel and unusual punishment” should meet standards of condemnation because it is not only an unpleasant consequence, but is also “torturous, degrading, inhuman, grossly disproportionate [punishment] to the crime in question, or otherwise shocking to the moral sense of the community.”<sup>62</sup>

Prevailing definitions of punishment do not contain language geared toward teaching new behaviors or encouraging better behavior. Rather, the definitions focus on imposing a consequence for a past action. In effect, punishment is retrospective. It looks at a moment, behavior, or event that has occurred, labels it as a failure to conform to social norms, and metes out negative consequences to enforce the idea that the behavior should not be repeated.

Whether a procedure promotes a behavioral change through treatment or punishment depends on the goal of a procedure. The key inquiry is whether the procedure alters behavior or merely condemns prior behavior.<sup>63</sup> *Knecht v. Gillman*, a case that utilizes objective factors in its analysis, illustrates the line between treatment and punishment.<sup>64</sup> Prison inmates with behavioral problems were given injections, which caused them to vomit for a period between fifteen minutes and one hour, if they exhibited a behavior the institution deemed inappropriate.<sup>65</sup> The court held that:

[T]he act of forcing someone to vomit for a fifteen minute period for committing some minor breach of the rules can only be regarded as cruel and unusual unless the treatment is being administered to a patient who knowingly and intelligently has consented to it. To hold otherwise would be to ignore what each of us has learned from sad experience—that vomiting (especially in the presence of others) is a painful and debilitating experience. The use of this unproven drug for this purpose on an involuntary basis, is, in our opinion, cruel and unusual punishment prohibited by the [E]ighth [A]mendment.<sup>66</sup>

The court considered several factors in determining that such procedure was punishment rather than treatment. First, the inmates did not knowing-

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

<sup>62</sup> BLACK'S LAW DICTIONARY 1269 (8th ed. 2004).

<sup>63</sup> REED MARTIN, LEGAL CHALLENGES TO BEHAVIOR MODIFICATION: TRENDS IN SCHOOLS, CORRECTIONS, AND MENTAL HEALTH 71 (1975).

<sup>64</sup> *Knecht v. Gillman*, 488 F.2d 1136, 1137–38 (8th Cir. 1973).

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

<sup>66</sup> *Id.* at 1140.

ly and intelligently consent to the procedure.<sup>67</sup> Second, the procedure was coercive and imposed by force.<sup>68</sup> Third, the injection caused the physical pain of vomiting.<sup>69</sup> Fourth, the inmates suffered dignitary harm from being forced to vomit in front of others.<sup>70</sup> Finally, though some regarded the procedure to be a treatment, the court noted that characterizing it as treatment does not prohibit objective review of whether the procedure is actually punishment.<sup>71</sup> The negative aspects of this procedure, which imposed unwanted consequences in response to maladaptive behavior without teaching new behavior, completely outweighed any possible benefits. The procedure leaned so far towards punishment that, without proper consent, the court deemed it cruel and unusual.<sup>72</sup>

There are significant similarities between injecting prison inmates without their consent and the use of mechanical restraints on psychiatric patients. First, patients are often not asked permission before they are restrained.<sup>73</sup> Second, the procedure is coercive: it is the result of unwanted behavior and forced upon the patient.<sup>74</sup> Third, restraints are extremely painful, cause physical injuries, and have resulted in a significant number of deaths.<sup>75</sup> Fourth, patients in restraints suffer great dignitary harm,<sup>76</sup> arguably greater than that suffered by vomiting, as the patient is rendered absolutely motionless and defenseless. Lastly, though some might intend this procedure to be treatment, simply having the intent to treat is insufficient without also having objective facts to prove that the procedure provides some benefits.

Therefore, the analysis in *Knecht* is applicable to mechanical restraints. The court decided in *Knecht* that, though some believed uncontrolled vomiting might change a patient for the better, the procedure objectively constituted cruel and unusual punishment.<sup>77</sup> Similarly, though the

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<sup>67</sup> *Id.* at 1139–40.

<sup>68</sup> *Id.* at 1140.

<sup>69</sup> *Id.*

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

<sup>71</sup> *Id.* at 1138–39.

<sup>72</sup> *Id.* at 1140.

<sup>73</sup> There will be cases in which patients are not in a condition to consent. However, the historical record also makes it clear that restraints have been used inappropriately. One can presume that at times a patient's consent was not sought, nor was the patient given an opportunity to avoid restraints.

<sup>74</sup> SAKS, *supra* note 22, at 147

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

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

<sup>77</sup> *Knecht*, 488 F.2d at 1137–40.

use of mechanical restraints might be imposed with good intentions and prevent or stop the instant allegedly dangerous behavior, mechanical restraints are used to communicate to patients that their behavior is not socially acceptable. It does not teach patients to change their behavior, but instead causes far too much harm to be tolerated. Therefore, when assessing whether a procedure is punishment or treatment, it is “punishment” if it is an objectively unpleasant consequence couple with condemnation, implemented for behavior judged unacceptable, and does not teach new behavior.

B. TREATMENT REQUIRES OBJECTIVE BENEFICENCE AND TEACHING OF ALTERNATE BEHAVIOR

Punishment and treatment can share an element of coercion. Both can be “designed such that predetermined positive reinforcement or privilege is provided for desired behavior and undesired behavior results in a response cost (withholding positive reinforcers) or actual punishment.”<sup>78</sup> The difference between punishment and treatment is that, with treatment, caregivers act with “beneficence” or “a moral obligation . . . for the benefit of their patients.”<sup>79</sup> As Wanda K. Mohr aptly described, “Clinicians are rarely able to produce benefits without creating additional risks or incurring some costs. As a result, to act with beneficence, they must act only when the benefits warrant the risks and costs associated with a procedure or action . . . .”<sup>80</sup>

However, beneficence must be viewed objectively. For example, a school in Massachusetts for autistic children uses electric shocks activated remotely to modify behavior of autistic children and teens.<sup>81</sup> Electrodes “attached to students’ arms, legs, or torsos,” deliver a two-second shock of sixty or sixty-six volts transmitted by fifteen and forty-one milliamps on average.<sup>82</sup> “Tasers, by comparison, transmit between 2.1 and 3.9 milliamps on average” but for longer periods of time.<sup>83</sup> The school claimed that this method prevented students from harming themselves and others and is used as a last resort.<sup>84</sup> Parents stated that without such methods their

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<sup>78</sup> Mohr, *supra* note 45, at 5.

<sup>79</sup> *Id.* at 6.

<sup>80</sup> *Id.*

<sup>81</sup> Donovan Slack, *School Lobbied to Stop Electric Shock Ban: Canton Facility Spent \$100,000 on Effort*, BOS. GLOBE, Feb. 28, 2011.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

children would be dead or institutionalized.<sup>85</sup>

Conversely, a United Nations investigator called the practice “torture” and others said it was inhumane, especially in light of “positive behavioral supports” that have been successful for working with autistic children.<sup>86</sup> Further, shocks are sometimes used for minor infractions such as not paying attention, as opposed to imminently dangerous behavior.<sup>87</sup> Any benefits to these children must be evaluated objectively compared to the costs and without regard to the intention of those imposing the shocks. The benefit of changed behavior due to such aversive conditioning is not worth the costs inherent in repeatedly shocking a child.<sup>88</sup> Classifying such conditioning as punishment is not difficult.<sup>89</sup>

Behavior modification, which is the practice of attempting to change behavior, can be a form of treatment when it encourages people to react differently to situations and can benefit patients. The costs and benefits, however, must be carefully weighed. Further, to be effective, it must teach new behavior:

So reward and punishment is not new—but in its traditional use it does not teach behavior. Rewards are dispensed in the absence of bad behavior; punishments occur for what is perceived as bad behavior. But there is no consequence for learning a new behavior. It is as if the institution were established not to help people get better but just to see that they do not get worse [and] . . . what is being taught is docility, secretiveness, and even withdrawal.<sup>90</sup>

In addition to teaching new behavior, each procedure should be evaluated to determine whether it is successful: “If the stimulus were used repeatedly over a long period of time, ostensibly to change the same behavior, then it is certainly not effective therapy but is only unauthorized punishment.”<sup>91</sup>

It is often difficult to determine exactly what methods or practices fit into the category of objectively beneficent treatment. What is certain, however, is that restraints are not treatment. First, the only possible benefits of restraint are those accrued by other patients in the ward from having

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<sup>85</sup> *Id.*

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

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*; see also Lindsay Tanner, *Shocking Treatment*, BERKSHIRE EAGLE, Mar. 15, 2007 (discussing legislature and judiciary efforts to prevent parents from using an electrical prod on their son).

<sup>89</sup> Slack, *supra* note 81; Tanner, *supra* note 88.

<sup>90</sup> MARTIN, *supra* note 63, at 78–79.

<sup>91</sup> *Id.* at 76–77.

the “dangerous” patient removed, or by staff who no longer have to confront an out-of-control patient. For the restrained patient, however, no therapeutic benefit is gained simply by forcing him or her to submit or become subdued.<sup>92</sup> Second, restraining someone does not teach the patient new behavior.<sup>93</sup> In effect, restraint takes away the patient’s power to learn how to diffuse his or her own anger, thereby replacing lessons about internal control with lessons about external force.<sup>94</sup> Finally, continuing to use restraints, even when it does not change behavior, demonstrates that the point in restraining is not to prevent future undesirable behavior but only to stop the current incident through punishment. Though coercion, in and of itself, may not define a procedure as punishment, here it is not balanced with anything that benefits the patient. Therefore, restraints cannot be beneficent or appropriate treatment. In essence, treatment must involve objective beneficence, teach new behavior, and reflect actual outcomes.

#### C. TREATMENTS THAT ARE PUNISHMENT, DESPITE GOOD INTENTIONS

In general terms, punishment occurs when pain is inflicted to discourage improper behavior. American society as a whole has defined certain behavior attributed to a person with a mental illness as improper, whether involving delusions, hallucinations, or other manifestations of illness.<sup>95</sup> Any treatment method that lacks beneficence, fails to teach new behavior, and involves high costs and risks of harm can and probably should be categorized as a form of punishment. While there are various forms of “treatment” which straddle the line between treatment and punishment, before using any procedure, medical staff should ensure that the benefits outweigh the costs. Two medically used procedures, insulin-shock therapy and psychosurgery, are especially informative.

Insulin-shock therapy was a popular treatment in the 1930s and claimed to be the ultimate cure for schizophrenia.<sup>96</sup> This treatment has been described as follows:

The basic aim of Sakel’s treatment was to induce a state of hypoglycemia, a condition of abnormally low blood sugar, through doses of insulin. Increasingly large amounts were administered until the patient lapsed into a coma. Before the patient lost consciousness, the symptoms of hy-

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<sup>92</sup> Mohr, *supra* note 45, at 7.

<sup>93</sup> See Curie, *supra* note 34, at 1139.

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

<sup>95</sup> Hortas, *supra* note 2, at 157–162.

<sup>96</sup> Bell, *supra* note 7, at 137.

poglycemia intensified; they included increased perspiration and salivation, accompanied by complaints of hunger and thirst. Some patients became drowsy, while others grew restless, tossed and turned, and shouted. Alterations in perception were common; sucking movements, forced gasping, tremors, twitchings, and epileptic seizures were observed. The shock phase of the treatment occurred when the patient went into a coma, remaining totally unresponsive to outside stimuli. Hypoglycemia was terminated by administering a carbohydrate solution orally or intravenously. Sugar was used, dissolved in water, tea, or fruit juice. This whole procedure, from the initial injection to recovery from coma, took five or six hours. While the frequency and duration of the treatment varied with the patient's condition and the physician's opinion, it was usually given five times a week, with two rest days, until 50 or 60 comas had been applied . . . .<sup>97</sup>

For schizophrenic patients, this "treatment," which caused obvious and intense physical pain, as well as then-unknown complications from repeated comas, was nothing short of punishment. While this procedure was intended to cure an illness, it was championed as a cure far too soon. Later studies demonstrated that insulin-shock therapy had "little long-range sustaining effect" and caused "fatalities, cardiovascular and respiratory disturbances, vertebral fractures, and the occurrence of prolonged coma."<sup>98</sup> The potential short-term benefits to patients, as evidenced by more socially acceptable behavior, do not warrant the physical and emotional consequences of the procedure. Rather, it is an unpleasant consequence for maladaptive behavior whose benefits do not outweigh the costs.

Psychosurgery, like insulin-shock therapy, is another inappropriate form of so-called treatment. Psychosurgery, which first became controversial in the 1950s, is an experimental procedure whereby doctors operate on a patient's brain to cure or improve the symptoms of illness.<sup>99</sup> The results of lobotomy, one form of psychosurgery, are described by the following:

[T]he results of the operation were dramatic and concrete: a definite postoperative condition and personality emerged. In the days and weeks following surgery, the patient was confused and apathetic; blood pressure dropped, and body weight increased at a striking rate. The lobotomized patient ate ravenously and remained overweight; gave monosyllabic responses to questions in a flat tone; had a blank expression; lost control over bowel and bladder; had to be fed like an infant. During the daily routine of convalescence such a patient played aimlessly with a

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<sup>97</sup> *Id.* at 136.

<sup>98</sup> *Id.* at 137.

<sup>99</sup> Benedict Carey, *Wariness on Surgery of the Mind*, N.Y. TIMES, Feb. 14, 2011, at D5.



doll or a ball, or wrote a letter that simply repeated a phrase over and over. Many of these manifestations of lobotomy were transitory, disappearing or modifying sharply within a few months after surgery. However, the psychological changes were most obvious, more permanent, and often disheartening. The lobotomized patient lost something: soul, or spirit, or driving force, or sparkle; clearly some flavor of the personality was gone. That patient's interests narrowed; he or she procrastinated, lived without goals on a day-to-day basis in an euphoric state without rancor or emotional involvement, and was strikingly uninhibited. No longer self-conscious, his or her tactless, outspoken, childlike behavior irritated and embarrassed others. On the other hand, the lobotomized patient forgot insults, and angry flare-ups and other displays of aggression quickly dissipated.<sup>100</sup>

Despite these terrible results, lobotomy and other psychosurgery procedures are still used. For example in 2009, the Food and Drug Administration approved deep brain stimulation, a form of psychosurgery, for treatment of severe cases of obsessive-compulsive disorder.<sup>101</sup> This treatment is extremely controversial. Some doctors think the information known now about the procedure is sufficient for a patient to make an informed decision to undergo the procedure.<sup>102</sup> Others argue that the procedure needs further testing before becoming a widespread "therapy."<sup>103</sup> Dr. Joseph J. Fins, Chief of Medical Ethics at New York-Presbyterian/Weill Cornell hospital stated, "'We're not against the operation, we just want to see it tested adequately before it's called a therapy . . . . With the legacy of psychosurgery, it's important that we don't misrepresent things as therapy when they're not.'"<sup>104</sup> As Dr. Helen S. Mayberg aptly stated, "'Just because we recognize that there is a need for this doesn't mean we don't have to proceed in an agnostic, scientific manner to see whether, in fact, it improves people's lives.'"<sup>105</sup> Further, medical scientists have admitted to not fully understanding the dynamics of the brain.<sup>106</sup> As Caroline Dunn,

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<sup>100</sup> BELL, *supra* note 7, at 145.

<sup>101</sup> Carey, *supra* note 99.

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> Bill Birnbauer & Julie-Anne Davies, *How Melbourne Became a Centre of Mind Control; Insight: Doctors Who Play God*, SUNDAY AGE (Austl.), Feb. 14, 1999, at 1 ("A strong opponent to psychosurgery, Dr. Paul Mullen, professor of forensic psychiatry at Monash University, said . . . . 'We are not operating at the level where we are intervening delicately. We are going in there with the equivalent of a bulldozer to knock down roads and tear up rail lines and pull down telegraph exchanges. You have to ask, do we know enough to play these kinds of

one pro-psychosurgery author stated, "Nevertheless, the limitations of our current state of knowledge about the brain and its functioning must also be acknowledged; there is therefore a balance to be struck between undue reverence for the brain and foolhardy interference with it."<sup>107</sup> In essence, if it does not render more benefit than harm to patients, psychosurgery should be considered punishment, even if doctors and other professionals have the best of intentions. Further, psychosurgery, or at least lobotomy, does more than "treat" illness; it drastically alters a person's personality, essence, and well-being. When the costs outweigh the benefits of a particular procedure, it cannot be called a treatment. Therefore, drastic procedures must be evaluated critically, especially where they may seriously change a patient's personality and prevent him or her from participating in recovery.

In sum, treatment requires that the benefits to patients outweigh the risks of harm and any actual injury. The procedures outlined in these sections demonstrate that the line between punishment and treatment is not always clear. However, when patients are condemned due to bad behavior, they are punished, not treated. Procedures must be held to a high standard before they can be considered treatment. New methods with unknown consequences must be evaluated thoroughly before they are implemented.

## V. MECHANICAL RESTRAINTS SHOULD NOT BE UTILIZED

### A. MECHANICAL RESTRAINTS ARE PUNISHMENT, SIMILAR TO OLD VERSIONS OF TREATMENT

Some claim that restraints are a form of treatment, because the procedure ensures a patient's "behavior is under control and no longer poses a threat to self or others or a further disruption to the therapeutic milieu."<sup>108</sup> Once a restrained patient is under control, the treatment goals of the procedure are achieved.<sup>109</sup> Whether the "treatment" is effective depends upon whether the patient remains calm.<sup>110</sup>

This analysis is strikingly similar to the oldest forms of "treatment," where a torturous procedure was deemed effective when it resulted in a

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games with other people's brains.'").

<sup>107</sup> DUNN, *supra* note 24, at 83.

<sup>108</sup> John R. Lion & Paul H. Soloff, *Implementation of Seclusion and Restraint, in THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT* 19, 28-29 (Kenneth Tardiff ed.) (1984).

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

submissive and, therefore, saner patient.<sup>111</sup> Without teaching patients new behaviors, such “treatment” only punishes the patient for maladaptive behavior without treating the underlying problem. Punishment through methods of control should only have a role in treatment when it “weaken[s] or reduce[s] the likelihood of maladaptive behavior” and is coupled with instruction on new ways to react to situations that cause the maladaptive behavior.<sup>112</sup> When patients are mechanically restrained and are not released until they have “regained control,” they are not given tools with which to find alternative means to deal with their psychosis. Without a learning element, the use of restraints is nothing short of punishment for maladaptive behavior. Rather, these “attempts at the use of aversion are not really based on negative reinforcement but are pure punishment, hardening behaviors rather than teaching new ones, and inspiring more undesired behaviors.”<sup>113</sup>

Patients reported that use of restraints created “hopelessness and powerlessness, resulting in anger, resentment, and a breakdown in the therapeutic relationship with treatment staff.”<sup>114</sup> Given the lack of benefits of restraints, the destruction of the therapeutic relationship only makes patients worse off rather than better.

Even if the use of mechanical restraints, insulin-shock therapy, and psychosurgery provided some benefit, any procedure must be evaluated to ensure that the benefits outweigh the costs before it can be called treatment. Some articles proclaimed that restraint use was essential and “reduce[d] patient agitation and prevent[ed] patient injury.”<sup>115</sup> These articles were either “case reports . . . or are of poor quality . . . [In fact, r]ecent studies actually suggest that restraints can serve as positive reinforcers for aggression.”<sup>116</sup> One author explained that the idea that restraints are “helpful in learning self-control and building ego strength [is misguided] . . .

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<sup>111</sup> See Bell, *supra* note 7, at 5.

<sup>112</sup> Robert P. Linderman & Stephen E. Wong, *Behavior Analysis and Therapy Procedures Related to Seclusion and Restraint*, in THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT 35, 38 (Kenneth Tardiff ed., 1984) (arguing that the use of restraint in an emergency situation is not a form of treatment, but that restraint has a place in treatment when used as a form of behavior modification).

<sup>113</sup> MARTIN, *supra* note 63, at 74–75 (discussing how the use of aversive behavior in *Morales*, though called a behavioral modification, was actually pure punishment and not negative reinforcement) (“[The procedure in question] appear[ed] to be senseless, malicious harassment of juveniles.”).

<sup>114</sup> Huckshorn, *supra* note 20, at 485 (citation omitted).

<sup>115</sup> DE YOUNG, *supra* note 16, at 177.

<sup>116</sup> Mohr, *supra* note 45, at 6–7 (“[T]here is very limited empirical evidence to support the therapeutic utility of restrictive measures or research that could be used to inform practice.”).

[because t]here is no research whatsoever that supports these themes and, as such, these practices should not continue.”<sup>117</sup> It is clear, though, that these methods have caused physical injury, death, psychological degradation, and humiliation.<sup>118</sup>

Mechanical restraints do solve the immediate problem of containing an out of control patient and, therefore, prevent momentary potential harm. Any claim that this procedure is therapeutic by making patients feel safe or by reducing agitation lies in stark opposition to the facts. Before a method can be championed as a cure-all or an effective treatment for various maladies, it must demonstrate an ability to improve people’s well-being without being dehumanizing. Though a procedure may help explain changed behavior, it is not automatically justified as treatment. Procedures must be questioned and new solutions sought that do not simply impose consequences for unwanted behavior.

As will be shown below, research illustrates that mechanical restraints are unnecessary in nearly all circumstances and, with the right staff training and attitude, the same situations can be resolved in other ways. It is only by teaching new behaviors to patients and developing less intrusive techniques that individuals with mental illness are treated rather than punished.

#### B. THE USE OF MECHANICAL RESTRAINTS CAN BE REPLACED WITH OTHER METHODS

Various clinicians believe that the use of mechanical restraints should be considered “*therapeutic failure* and that such events signal the need to re-double efforts to avoid use in the future.”<sup>119</sup> Many institutions have reduced or eliminated their use of restraints.<sup>120</sup> The most successful programs have adopted a multi-faceted approach similar to that suggested by the National Association of State Mental Health Programs Directors. That program includes the following:

1. Leadership that sets the agenda for change, creates a climate for a new organizational culture, develops a clear plan, and assures broad inclusion of all stakeholders.

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<sup>117</sup> Huckshorn, *supra* note 20, at 489.

<sup>118</sup> See Saks, *supra* note 22, at 122; Mohr, *supra* note 45, at 3.

<sup>119</sup> Huckshorn, *supra* note 20, at 490 (citation omitted).

<sup>120</sup> Many institutions that reduced restraint also decreased their use of seclusion and discussed such reduction in the articles. When possible, I did not include the discussion of seclusion as I do not evaluate the use of seclusion in this Comment.

2. Facilities [that] systematically collect data on seclusion and restraint use and this data is used to inform staff and to evaluate incidents.
3. Creation of a therapeutic environment based on recovery and trauma informed care, individualized treatment planning, and responsiveness to client needs.
4. Use of available tools to reduce seclusion and restraint, including assessment tools, de-escalation plans, and the use of the physical environment.
5. Consumer [(patient)] involvement in multiple aspects of the organization's restraint reduction efforts.
6. Consistent use of debriefing tools to both analyze seclusion and restraint events and to mitigate the adverse effects of said events.<sup>121</sup>

There are many examples of successful institutions that do not use or have greatly reduced use of restraints. For example, a psychiatric inpatient setting created a Behavior Management Committee to review difficult cases in order to alter treatment plans to reflect the needs of a particular patient.<sup>122</sup> This process resulted in a decrease in overall average hours per month of restraint and seclusion episodes from 18.8 hours to 7.2 hours in six months.<sup>123</sup> A second facility decreased the use of restraint through "collaborative problem solving," which creates highly individualized treatments and increases patient and staff communication for adolescents and youth.<sup>124</sup> Similarly, the New York State Psychiatric Institute significantly reduced the use of restraints by implementing a program that set time limits for restraint use and educated staff about appropriate behaviors for restraint and how to find alternatives to restraint, like relaxing rules and allowing patients to leave the hospital with staff.<sup>125</sup> Between 1994 and 1998, Pennsylvania reduced hours of restraint by fifty-two percent in an ongoing effort to eventually eliminate the use of restraints and seclusion in

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<sup>121</sup> 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, 22 (2006) (citation omitted).

<sup>122</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, 14–16 (1998).

<sup>123</sup> *Id.* at 16.

<sup>124</sup> Ross W. Greene et al., *Innovations: Child and Adolescent Psychiatry: Use of Collaborative Problem Solving to Reduce Seclusion and Restraint in Child and Adolescent Inpatient Units*, 57 PSYCHIATRIC SERVICES 610, 610–12 (2006).

<sup>125</sup> David J. Hellerstein, Amy Bennett Staub & Elizabeth Lequesne, *Decreasing the Use of Restraint and Seclusion Among Psychiatric Inpatients*, 13 J. PSYCHIATRIC PRAC. 308, 308–15 (2007).

treating those with mental illness.<sup>126</sup> The Salem Hospital Psychiatry Inpatient Unit has nearly eliminated the use of mechanical restraints through a culture change towards one of non-violence, collaboration, and partnership, which resulted in “increased patient, family, staff, and physician satisfaction, reduction of patient and staff injury, and improved recruitment of staff and physicians.”<sup>127</sup> Finally, an adolescent ward implemented a program focused on communicating with patients at all stages of loss of control, giving positive reinforcement when patients calmed themselves down, and discussing the episodes afterwards.<sup>128</sup> This ward decreased episodes of seclusion and restraint by sixty-four percent.<sup>129</sup>

Dr. Saxe, Chair of Boston University’s Department of Child and Adolescent Psychiatry, upon reflecting on the process of restraining patients said that, “once he realized how he was conducting his clinical practice he could no longer reconcile the use of restraint with the value of the imperative, *to do no harm*.”<sup>130</sup> With creative thinking, it is possible to change the attitude of an entire institution, thereby succeeding in treating patients more humanely with practices that cause much less harm.

Investing in education is one of the most important techniques to successfully reduce the use of restraints in institutions. Teaching staff de-escalation skills and the damage caused by restraints allows them to change their attitudes regarding the use of restraints.<sup>131</sup> For example, in one instance, after a patient hit a psychiatric technician, some staff began to prepare the patient’s bed for the use of four-point restraints, while other staff continued to talk to the patient to try to calm her.<sup>132</sup> The staff was able to calm the patient down to the point that she no longer posed an imminent danger to herself or others.<sup>133</sup> Because she regained control, the staff member in charge chose not to restrain her.<sup>134</sup> However, this caused other staff to become uncomfortable.<sup>135</sup> Some staff felt that any violence

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<sup>126</sup> Cramer et al., *supra* note 42, at 30.

<sup>127</sup> *Id.*

<sup>128</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, 280–85 (1989).

<sup>129</sup> *Id.* at 284.

<sup>130</sup> Huckshorn, *supra* note 20, at 490.

<sup>131</sup> Staci Silver Curran, *Staff Resistance to Restraint Reduction: Identifying and Overcoming Barriers*, 45 J. PSYCHOSOCIAL NURSING 45, 46 (2007).

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

initiated toward staff should result in the use of restraints, regardless of whether the patient remained a danger to self or others.<sup>136</sup> The staff's desire to restrain the patient is clearly a method of punishment, rather than treatment, since staff that wanted to restrain her, despite successful de-escalation, had a desire to impose a serious consequence on the patient for endangering their safety.<sup>137</sup> However, by not restraining the patient, the staff successfully allowed the patient to de-escalate on her own, mitigated the possibility of further injury to staff or to the patient through the restraint process, and illustrated an ability to be responsive to the patient's needs.<sup>138</sup> Furthermore, it encouraged the patient to continue to work on de-escalating her own anger and violence, thus teaching her vital skills geared toward a more autonomous lifestyle. The call made to avoid restraints by the staff member in charge needs to be reinforced and explained to other staff members to encourage them to see the episode in a new light.<sup>139</sup>

It is also necessary to continue generating new ideas that can help patients without being abusive.<sup>140</sup> One such example is called "mindfulness training."<sup>141</sup> A study evaluating mindfulness training, while small, had positive results with three patients who had previously been unresponsive to other forms of treatment such as psychotropic medications and behavior management.<sup>142</sup> Mindfulness training taught the patients to manage their symptoms through extensive meditation so that they could "rapidly shift their focus from an event, such as rising anger, to a feature of the present moment which [was] neutral."<sup>143</sup> During a four-year follow-up period, physical aggression was not reported and verbal aggression was limited to a minimal, socially acceptable level.<sup>144</sup>

There is ample evidence that people with mental illness can be treated without the use of restraints:

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<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Id.* at 46–47.

<sup>139</sup> *Id.*

<sup>140</sup> Huckshorn, *supra* note 20, at 488; see also Dennis C. Donat, *Special Section on Seclusion and Restraint: Encouraging Alternatives to Seclusion, Restraint, and Reliance on PRN Drugs in a Public Psychiatric Hospital*, 56 PSYCHIATRIC SERVICES 1105 (2005) (outlining various ways to modify behavior to avoid the use of restraint and seclusion, including learning how to read behavior to ascertain the cause of disruption).

<sup>141</sup> Nirbhay N. Singh et al., *Individuals with Mental Illness Can Control Their Aggressive Behavior Through Mindfulness Training*, 31 BEHAV. MODIFICATION 313 (2007).

<sup>142</sup> *Id.* at 316.

<sup>143</sup> *Id.* at 319.

<sup>144</sup> *Id.* at 320–22.

If indeed we, in the state mental health arena are attempting at the least to do no harm, *and* we are aware of the prevalence of trauma histories in the lives of the children and adults that we serve, *and* we know of low cost, effective, and replicable interventions that can prevent and reduce the use of S/R [(seclusion and restraint)] . . . how can we morally and ethically continue to use these interventions?<sup>145</sup>

Other methods are replicable and do exist. Because medical professionals know that restraints are harmful and lack therapeutic benefit, and that reduction or even elimination of restraints may be possible, they are ethically obligated to eliminate the use of restraints, in favor of far more effective and humane methods.

## VI. CONCLUSION

When evaluating procedures that may be championed as treatment, it is crucial to examine the procedure both intuitively and objectively. Whether or not a form of treatment has been appropriately tested is especially important in light of the horrific lessons taught by old forms of treatment, such as insulin-shock therapy. If the treatment of those with mental illness is meant to reflect care and kindness alongside a mutual desire to better those afflicted, then treatment must encompass these values. Methods that prize control over teaching cannot be a form of treatment.

The operative word is “treatment.” The history of treatment for individuals with mental illness is dark and depressing. Cultural and sociological shifts over time have demonstrated that much of what was considered treatment in the past is no longer acceptable because doctors had completely disregarded patients’ humanity and dignity. Mechanical restraints, like many past treatments, do not benefit patients. Rather restraints, by completely impeding a patient’s ability to be autonomous, only succeed in securing a patient to benefit others who are trying to avoid harm. The benefits of securing a patient do not outweigh the costs, as mechanical restraints are not the only way to protect others, and objectively create painful, humiliating, and dehumanizing consequences for maladaptive behavior without providing benefits. Mechanical restraints fail to reinforce positive behavior and fail to teach patients how to maintain control. The use of mechanical restraints should, therefore, be considered a form of punishment and be eliminated.

Accordingly, I suggest we amend current law along the lines of the following proposed legislation:

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<sup>145</sup> Huckshorn, *supra* note 20, at 490.



- (1) Mechanical restraints are defined as a “manual method or mechanical device, material, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove and that restricts the patient’s freedom or normal access to one’s body.”
- (2) Mechanical restraints are not a form of treatment and have no place in the treatment of individuals with mental illness and should no longer be used for any purpose,
  - (A) Except as necessary
    - (i) in the transportation of persons, but then in the least restrictive manner possible for the least possible period of time, and shall not be considered treatment, or
    - (ii) for the implementation or duration of necessary medical procedures and, as such, shall be considered part of the procedure and not treatment.
- (3) When deemed a danger to self or others, patients must be treated with the least restrictive alternative possible, which includes reliance on de-escalation and other non-restrictive procedures. If all alternatives fail, as consistent with treatment plans motivated by a desire to treat patients with dignity and respect, staff may
  - (A) physically restrain (held by staff) the patient until the patient regains control,
  - (B) put patients in seclusion for the shortest possible period of time, and
    - (i) when secluded, patients must be monitored constantly based on circumstances but, in all events, no less than once every fifteen minutes, and the medical record for the patient shall include a contemporaneous notation of the date, time, name of staff, and detailed condition of the patient at the time of observation. If staff resources allow, patients should be constantly watched and accompanied while in seclusion;
    - (ii) when secluded, patients must be given adequate food, water, and access to restrooms; and
    - (iii) patients may not be secluded for more than one hour per instance unless a physician who has personally examined the patient determines that the patient be secluded for additional time. At no time, however, should a patient be in seclusion for more than two hours.
  - (C) use chemical restraints.
- (4) All institutions will compile and review data detailing each episode of

seclusion, chemical restraint, or physical hold. The information must include the circumstance that required such a response. The medical practice committees of the institution shall review each such episode for appropriateness and prepare a report of their conclusions and suggestions for alternative procedures for future situations.

- (5) After any incident requiring physical holding, seclusion, or chemical restraint, staff must include the patient, if possible, in a discussion of the incident. Such discussion must be aimed at finding solutions that will avoid such a procedure in the future, thereby restoring the therapeutic relationship between patient and staff.