MECHANICAL RESTRAINTS: IS THIS YOUR IDEA OF THERAPY?

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I. INTRODUCTION

> I screamed at the top of my lungs and struggled against the group of hands pinning me down, but I was no match for them, and soon the bands were fastened tight. Then it got worse . . . . They arranged a net over me—an actual net—from the top at my neck to the bottom at my ankles, covering my legs, my torso, my chest. And then they pulled it snug at the four corners. I couldn't move at all, and felt like all the breath was leaving my body. . . . No one I knew, . . . knew that I was here, tied to a bed with a net over my body. I was alone in the night . . . .[1]

The United States Supreme Court recognized in *Youngberg v. Romeo*[2] that a person has the right to be free from unnecessary restraint as part of the constitutional right to freedom of movement.[3] This right, however, competes with an institution's legal authority to mechanically restrain a patient in order to prevent injury to the patient or others.[4]

Not only are mechanical restraints generally ineffective in treating aggression and in preventing injury,[5] restraints can also cause extreme

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[1] ELYN R. SAKS, THE CENTER CANNOT HOLD 149–50 (2007) [hereinafter SAKS, CENTER CANNOT HOLD].

[2] 457 U.S. 307, 316 (1982).

[3] Daniel Chandler, Teresa Nelson & Colette I. Hughes, *Performance Administration Through Monitoring Seclusion and Restraint Practices,* 25 ADMIN. MENTAL HEALTH, 525, 526 (1998).

[4] *See* Children's Health Act of 2010, 42 U.S.C.A. § 290ii (2000).

[5] Robert J. Moss & John La Puma, *The Ethics of Mechanical Restraints,* 21 HASTINGS CTR. REP. 22, 23 (1991).

harm.[6] Reported problems caused by restraints include "agitation, pressure ulcers, contractures, infections, incontinence, functional impairment, accidental strangulation and asphyxiation, oedema, cyanosis and necrosis."[7] Mechanical restraints can even cause death, which "raises doubts about the use of mechanical restraints to protect patients from self-harm."[8] In addition to causing physical harm, mechanical restraints can be viewed as "the most severe assault . . . on dignity ever allowed in a civilized society."[9] The potential for harm inherent in restraint use has led states to implement regulations permitting restraints only to prevent harm to the patient or others, and only after other less restrictive measures have been considered.[10] Nonetheless, restraint use continues to be a problem in hospitals and mental health institutions.[11]

In this Comment, I first discuss the use of restraints from the perspectives of mechanically restrained consumers,[12] mental health staff, and hospitals or institutions. I explain how each perspective supports the conclusion that restraint use should be stringently limited. I then discuss past attempts at restraint reduction and highlight what I find to be the most important recurrent themes in successful restraint reduction programs.[13] After a discussion of each theme, I compare my findings to the guidelines suggested by the American Psychiatric Association (APA), American Psychiatric Nurses Association (APNA), and the National Association of Psy-

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[6] *See* Leyla Ozdemir & Erdem Karabulut, *Nurse Education Regarding Agitated Patients and Its Effects on Clinical Practice*, 34 CONTEMPORARY NURSE 119 (2009).

[7] *Id.* at 120.

[8] ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND RIGHTS OF THE MENTALLY ILL 147 (2002) [hereinafter REFUSING CARE].

[9] *Id.*

[10] *See* 12 VA. ADMIN. CODE § 35-115-10(C)(6) (2011) ("Providers shall not use seclusion or restraint for any behavioral, medical, or protective purpose unless other less restrictive techniques have been considered and documentation is placed in the individual's service plan . . . ."); 440 IND. ADMIN. CODE 1.5-3-13(3) (2008) ("Restraint or seclusion may be used only when less restrictive interventions have been determined to be ineffective to protect the consumer, a staff member, or others from harm.").

[11] Moss & La Puma, *supra* note 5, at 22.

[12] For the purposes of this paper, "consumer" refers to a patient who is or has been subject to mechanical restraints.

[13] In compiling this data, I aimed to review literature and studies from hospitals and institutions that have already implemented successful restraint reduction programs. Thus, I based my review on studies that have been effective in practice, rather than on articles that offer only theoretical suggestions. Further, the focus of this Comment is mechanical restraints in adult populations, but some articles I referenced or based my arguments on include or refer to adolescent populations.

chiatric Health Systems (NAPHS).[14] I next illuminate complications that arise when we give patients choice over medical decisions in the restraint context. Finally, I present suggestions for a model statute regarding restraint use.[15]

II. PERSPECTIVES ON RESTRAINT USE

A. HOW PATIENTS VIEW RESTRAINTS

> "I was not told why or given an opportunity to object verbally [to restraint/seclusion] . . . it was out of my hands."[16]

Despite the intention of psychiatric hospitals throughout the country to reduce the use of mechanical restraints, the patient's subjective experience has been overlooked.[17] Robins et al. noted that consumers have "lacked a voice for their experiences."[18] Yet knowing how consumers view restraints is a fundamental and integral part of understanding how and why we must reduce the use of restraints. Examining restraint use from a consumer's perspective also allows us to better evaluate the "treatment" rationale, often cited as a justification for restraint use.[19] Ray et al.'s study examined over 1,000 previously restrained patients' opinions

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[14] AM. PSYCHIATRIC ASS'N, AM. PSYCHIATRIC NURSES ASS'N & NAT'L ASS'N OF PSYCHIATRIC HEALTH SYS., LEARNING FROM EACH OTHER: SUCCESS STORIES AND IDEAS FOR REDUCING RESTRAINT/SECLUSION IN BEHAVIORAL HEALTH (2003), *available at* http://www.naphs.org/rscampaign/learning.pdf [hereinafter LEARNING FROM EACH OTHER]. I compiled my list of findings from literature prior to looking at the guidelines suggested by the APA, APNA, and NAPHS to provide an objective review.

[15] For purposes of this paper, the words "restraint," "restraints," and "mechanical restraints" refer to holding or tying a patient down with a device (for example cuffs and ties). I use the word "seclusion" to mean the "isolation of a patient in a locked area, for the purpose of modifying a behavior," as defined by the California Code of Regulations. CAL. CODE REGS., tit. 22, § 77029. Thus, "restraint" means something different from "restraint by seclusion," although California regulations consider seclusion a form of restraint. Some of the articles that I discuss studied restraints and seclusion together, so I often use evidence based on information containing efforts at reducing both restraints and seclusion. The focus of this paper, however, is a reduction of mechanical and physical restraint.

[16] Nancy K. Ray, Karen J. Myers & Mark E Rappaport, *Patient Perspectives on Restraint and Seclusion Experience: A Survey of Former Patients of New York State Psychiatric Facilities*. 20 PSYCHIATRIC REHABILITATION J. 11, 15 (1996) (alteration in original).

[17] *Id.* at 12.

[18] C.S. Robins et Al., *Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experience and "Sanctuary Harm" in Psychiatric Settings*, 56 PSYCHIATRIC SERVICES 1134, 1135 (2005).

[19] *See* REFUSING CARE, *supra* note 8, at 127.

of their experience with restraint use.[20] Approximately 73% of the responding patients indicated that, at the time of restraint or seclusion, the patient did not believe that he or she was a danger to themselves or others.[21] Moreover, 50% of the patients stated that unnecessary force was used in restraining or secluding them.[22] One patient complained, "When I could not sleep, I was put in restraints and given a needle."[23] Another patient said, "I wish people would have talked to me instead of restraining me."[24] These comments illustrate that consumers believe restraints are often used preemptively and when not necessary.

Consumers frequently feel that staff members use restraints in order to "demonstrate power to patients that did not follow staff directions."[25] Despite the fact that many state laws ban restraint use in this manner,[26] patients felt that "seclusion and restraint were used to intimidate and frighten and not for protection of patients and others."[27] Ray et al. noted that the former patients' feelings about their restraints and seclusion episodes "were significantly associated with their belief that hospital staff had or had not first tried less restrictive interventions, prior to resorting to the use of restraint and seclusion."[28] Trout's review of the qualitative literature on patients' perspectives confirms that patients often feel that staff members use restraints in an unethical manner.[29]

The preemptive and unnecessary use of restraints causes harsh repercussions for the patient. Smith posited that using restraints on rape victims

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[20] Ray et al., *supra* note 16, at 13–14.

[21] *Id.* at 14.

[22] *Id.* at 15.

[23] *Id.*

[24] *Id.*

[25] Rolf Wynne, *Psychiatric Inpatients' Experiences with Restraint*, 15 J. FORENSIC PSYCHIATRY & PSYCHOL. 124, 135 (2004) (citing M.E. Johnson, *Being Restrained: A Study of Power and Powerlessness*, 19 ISSUES MENTAL HEALTH NURSING 124, 191–206 (1998)).

[26] *See* 22 CAL. CODE REG. tit. 22, § 77103(c) ("Behavioral restraint and seclusion shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff."); ARK. CODE ANN. § 20-47-229(e) (2009) ("The restraint shall not be used as a means of coercion, discipline, convenience, or retaliation by staff."); N.M. Code R. § 7.26.2.75(A)(1)–(3) (2001) ("The facility may not use physical restraint: (1) as punishment; (2) for the convenience of the staff; (3) as substitute for activities or treatment.").

[27] Ray et al., *supra* note 16, at 15.

[28] *Id.* at 17.

[29] *See* Tania D. Strout, *Perspectives on the Experience of Being Physically Restrained: An Integrative Review of the Qualitative Literature*, 19 INT'L J. MENTAL HEALTH NURSING 416, 418–27 (2010).

might recreate their traumatic experiences.[30] While restraints may be used in some hospitals as a form of treatment, this alleged "treatment" could actually cause harmful symptoms rather than treat the patient.[31] Smith cited a number of case studies that provide a look at the consumer's experiences while in restraints as well as the consumer's feelings about restraints after use.[32] Throughout the interviews, patients often compared being restrained with their experiences of being raped.[33] One patient recalled being restrained because she tried to hurt herself.[34] The staff pulled her pants down and placed her in five-point restraints, facedown, which brought back vivid images of when she was raped at the age of twelve.[35] She recalled her thoughts: "'Why are you torturing me?' . . . I wanted death, an end to the pain I was suffering . . . . 'Please, God, let my heart stop beating. Let the torture end!'"[36] After this incident, the patient raised her hand to request a teddy bear and was once again violently restrained against her will.[37]

It is easy to see why being restrained can cause profound distrust for doctors.[38] Patients come to the hospital expecting treatment—not pain.[39] Their distrust is problematic as it can lead patients to hide their feelings and thoughts from doctors,[40] which may interfere with successful treatment. Restraints also cause a consumer to feel hopelessness that may result in the deterioration of the therapeutic relationship with nurses and doctors. Research shows that being hopeful is a necessary part of a patient's recovery.[41] Trust is especially important in the healthcare context, because of the patient's vulnerability to pain.[42]

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[30] S.B. Smith, *Restraints: Retraumatization for Rape Victims?*, 33 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 23, 23 (1995).

[31] *Id.*

[32] *Id.* at 23–26.

[33] *Id.*

[34] *Id.* at 24–25

[35] *Id.*

[36] *Id.* at 24.

[37] *Id.* at 25.

[38] *See id.*; Wynne, *supra* note 25, at 135.

[39] Smith, *supra* note 30, at 27.

[40] *See* S.D. Goold, *Trust and the Ethics of Health Care Institutions*, 6 HASTINGS CTR. REP. 26, 30 (2001).

[41] Kevin Ann Huckshorn, *Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint* 33 ADMIN. & POLICY MENTAL HEALTH 482, 485 (2006).

[42] Wanda K. Mohr, *Restraints and the Code of Ethics: An Uneasy Fit,* 44 ARCHIVES PSYCHIATRIC NURSING 3, 3 (2010) (citing Goold, *supra* note 40, at 26–33).

Review of patients' perspectives urges the conclusion that all institutions should make a concerted effort to minimize restraint use. Proponents of the "restraint as treatment" school of thought would point to the small percentage of patients in Ray et al.'s study who responded positively to their restraints and seclusion experiences.[43] Positive comments may provide support for laws allowing restraint use in certain circumstances as opposed to an outright ban of mechanical restraints.[44] However, the overwhelming number of negative comments made by patients show that restraints should only be permitted as a last resort, *after* the failure of less restrictive alternatives.

B. HOW MENTAL HEALTH STAFF VIEW RESTRAINTS

> "It's not like we wander around waiting to use [mechanical restraints], you know."[45]

Emphasis on the harm that restraints cause places nurse staff in a highly unfavorable light. Yet accusing mental health staff of callously overusing restraints may be unjustified. Attempts to reduce seclusion and restraint use have been associated with a higher risk of harm to patients and staff.[46] Staff in overcrowded hospitals may not have the knowledge or ability to reduce restraint use. Staff members expressed that they are as upset by the restraining process as their patients.[47] Given the general consensus of consumers that restraints are used too readily, too often, and when not necessary, it is imperative to view restraint use from those who decide to restrain and/or implement the restraints.

What are the most common reasons cited by staff for using restraints? A study analyzing the reasons for the use of restraints and seclusion found that 11.2% of the time, such episodes occurred because of actual violence by patients.[48] Patients threatening violence was the reason for restraints

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[43] Ray et al., *supra* note 16, at 14.

[44] One patient recollected having positive experiences with restraints and seclusion: "I was threatening others; out of control; I was not hurt; [the restraint] helped me think about what I needed to do." *Id.*

[45] 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. MENTAL HEALTH NURSING 215, 219 (2008).

[46] Ali None Khadavi et al., *Association Between Seclusion and Restraint and Patient-Related Violence*, 55 PSYCHIATRIC SERVICES 1311, 1311 (2004).

[47] Mohr, *supra* note 42, at 3.

[48] R. Kaltiala-Heino et al., *Reasons for Using Seclusion and Restraint in Psychiatric Inpatient Care*, 26 INT'L J. L. & PSYCHIATRY 139, 144 (2003).

and seclusion use 25.1% of the time.[49] "Agitation/disorientation" was the most common reason cited by staff for restraints and seclusion use at 43.6% of the time.[50] Another study found that "perceived danger to self or others" was the most frequent reason for restraint.[51] Still other studies found that restraints were used to facilitate implementation of treatments and to prevent patients from wandering and falling out of bed.[52] Moss and Puma suggested that restraints are used in lieu of nurse supervision and to shield the institution from liability after a patient's fall.[53]

The next step is to consider how staff members actually feel about using restraints. One study examined mental health nurses' perceptions of the restraint experience in an acute setting.[54] Nurses viewed restraints as a "highly therapeutic practice"[55] and "a necessary therapeutic tool."[56] They generally viewed the use of physical restraint as an "integral, essential, and unavoidable part of acute mental health nursing practice."[57] Interestingly, however, certain problems with restraint use, previously identified by consumers, were echoed in the nurse's comments.[58] For instance, the use of restraints to establish control was a common theme in the nurses' statements.[59] Nurses agreed with patients that implementation of restraints is often emotionally taxing. One nurse commented, "[Sometimes] I sort of feel uncomfortable because I don't feel there has been enough negotiation beforehand." [60] Another nurse said, "I felt instantly like a bully. I felt instantly like, I am awful . . . look what I have done to this man."[61] Other studies confirmed that nurses might feel intense discomfort when consi-

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[49] *Id.*

[50] *Id.* at 144–45.

[51] Moss & La Puma, *supra* note 5, at 22 (citing Laurence Robbins et al., *Binding the Elderly: A Prospective Study of the Use of Mechanical Restraints in an Acute Care Hospital* 35 J. AM. GERIATRIC SOC. 290–96 (1987)).

[52] *Id.* (citing Rubenstein et al., *Standards of Medical Care Based on Consensus Rather than Evidence: The Case of Routine Bedrail Use for the Elderly*, 11 J.L. MED. & ETHICS 271, 271–76 (1983)).

[53] *Id.*

[54] Bigwood & Crowe, *supra* note 45, at 217.

[55] *Id.* at 216 (citing T. Meehan, H. Bergen & K. Fjeldsoe, *Staff and Patient Perceptions of Seclusion: Has Anything Changed?*, 47 J. ADVANCED NURSING 33, 33–38 (2004)).

[56] *Id.* at 219.

[57] *Id.* at 218.

[58] *Id.* at 218–20.

[59] *Id.* at 219–20.

[60] *Id.* at 219.

[61] *Id.* at 220.

dering restraints.[62] Some nurses truly dread the thought of using restraints and find themselves in a dilemma when alternatives to restraint are unsuccessful.[63] A nurse may not feel that restraining a patient is significantly more acceptable than "risking harm to a patient."[64] Moreover, some nurses find restraining patients conflicts with their therapeutic role.[65] They struggle when deciding if restraints are necessary and feel uneasy if they believe, post-use of restraints, that the restraints were not justified or that all other options had not been explored.[66]

Some nurses did also acknowledge some positive results of restraint use.[67] These nurses explained that they believed using restraints fosters a therapeutic relationship between themselves and the patients.[68] Staff also mentioned that restraint use fosters team bonding between staff members by creating a sense of trust and safety.[69]

Because staff members' feelings and reactions vary, broad generalizations regarding staff perceptions of restraint use may be inaccurate. It is valuable to consider staff characteristics that may contribute to differences in opinions regarding restraints because these differences can lead to variations in restraint use.[70] One study focused on staff opinions of seclusion and restraints in a state hospital found that the difference in opinion was at least partly correlated with levels of education.[71] The more educated staff thought that restraints were overused and supported checking restrained patients more frequently.[72] They also believed that restraints were effective 81% of the time, compared to less educated staff, who believed restraints were effective 94% of the time.[73] The study also found that male and female staff viewed the restraint process differently; female staff members considered attention given to patients by peers during restraint as

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[62] Mohr, *supra* note 42, at 3; Bigwood & Crowe, *supra* note 45, at 220; Sandy Marangos-Frost & Donna Wells, *Psychiatric Nurse's Thoughts and Feelings About Restraints Use: A Decision Dilemma*, 31 J. ADVANCED NURSING 362, 366 (2000).

[63] Marangos-Frost & Wells, *supra* note 62.

[64] *Id.*

[65] Bigwood & Crowe, *supra* note 45, at 220.

[66] *Id.*

[67] *Id.* at 219.

[68] *Id.*

[69] *Id.*

[70] *See* Valerie Klinge, *Staff Opinions About Seclusion and Restraint at a State Forensic Hospital*, 45 HOSP. & STAFF COMMUNITY PSYCHIATRY 138 (1994).

[71] *Id.*

[72] *Id.* at 140.

[73] *Id.*

positive, while male staff members considered this attention negative.[74] Do female staff members view attention during restraint as positive[75] because they believe that they personally would appreciate attention if restrained? Reasons for inter-staff differences merit further research.[76]

In sum, staff members seem to hold two overarching and somewhat conflicting views on restraints. On the one hand, staff may perceive restraints as a positive bonding experience for the nurse, patient, and staff team.[77] They feel a duty to their patients to keep the hospital safe and attempt to achieve this through restraints.[78] On the other hand, staff may feel consumed with guilt if they feel that restraints are not necessary.[79] These conflicting findings may support the view that, when restraints are absolutely necessary, we can justify their use as a last resort, because restraints promote feelings of safety for staff and other patients.[80] However, the uneasiness that staff members feel suggests that when restraints are not used as a last resort, and when less restrictive alternatives are not attempted, restraints are improper and should not be used.

There seems to be a disconnect between consumer perceptions about staff rationale for using restraints (to exercise control in the absence of real danger)[81] and actual reasons why staff resort to restraints (to keep the ward safe by maintaining control and to protect consumers).[82] Perhaps some staff members use restraints improperly to exercise control when patients are not dangerous, while others use restraints only when absolutely necessary. Perhaps staff use restraints properly and consumers misunderstand the reason for the restraint and underestimate the danger they are presenting. Perhaps after restraints are used, or when confronted with a questionnaire, staff members explain their use with a more justifiable and admirable rationale than their true rationale. These differing reasons could be caused by cognitive dissonance, because staff may try to justify use of restraints in hindsight.

Based on the overwhelming consensus of consumers that restraints are used unnecessarily, and since staff members strongly dislike using re-

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[74] *Id.*

[75] *See id.*

[76] *Id.* at 141.

[77] Bigwood & Crowe, *supra* note 45, at 219.

[78] *Id.*

[79] *Id.* at 220.

[80] *Id.* at 219.

[81] *See* Ray et al., *supra* note 16, at 14.

[82] Bigwood & Crowe, *supra* note 45, at 219; R. Kaltiala-Heino, *supra* note 48, at 142–43.

straints, it appears most likely that staff members might use restraints improperly because they feel they have no alternative. Thus, to further reduce mechanical restraint use, we should provide staff members the tools to reduce restraint use, allowing them to use restraints only when absolutely necessary.[83]

In sum, from the perspective of mental health staff, restraints are not pleasant but are sometimes needed.[84] Staff members would be happier, less stressed, and more comfortable if they could reduce restraint use, but they fear that they cannot do this without placing patients or others in danger.[85] The fact that staff members express great discomfort with restraint use[86] indicates that they would be highly incentivized to comply if a reduction program is implemented. Even if staff do perceive some benefits to restraint use, minor benefits (such as team bonding) are not sufficient to justify depriving patients of their liberty. It is illegal and morally unjust for patients' liberty interest to be infringed for any reason other than preventing harm to themselves or others.[87] When forming a restraint reduction plan, we should incorporate patients' perspectives, because patients are usually those harmed by restraints[88] and are likely to be the best judges of their experiences.

C. HOW THE MENTAL HEALTH INSTITUTION VIEWS RESTRAINTS

Not only are restraint reduction programs achievable without a significant financial outlay, but these programs also improve staff morale, which can increase productivity and efficiency. In terms of funding, staffing, and patients, facilities that achieve restraint reduction are not significantly different than other facilities.[89] Lebel and Goldstein studied the economic cost of restraint reduction.[90] They discovered that when an adolescent inpatient service decreased its use of time devoted to utilizing restraints

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[83] *Id.* at 221.

[84] *Id.* at 219.

[85] *Id.* at 221.

[86] Mohr, *supra* note 42, at 3.

[87] BAZELON CTR. FOR MENTAL HEALTH L., FEDERAL STANDARDS FOR USE OF RESTRAINT AND SECLUSION 1 (2010), *available at* http://www.bazelon.org/LinkClick.aspx?fileticket=omYbFQEMJkY%3d&tabid=321.

[88] *Id.* at 23.

[89] Elia S. Cohen & Ann L. Kruschwitz, *Restraint Reduction: Lessons from the Asylum*. 3 J. ETHICS L. & AGING 25, 39 (1997).

[90] Janice LeBel & Robert Goldstein, *The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination*, 56 PSYCHIATRIC SERVICES 1109 (2005).

from 23% to 4% of the time, staff members increased their availability for other tasks.[91] In addition, staff members used less sick days and enjoyed decreases in severity of staff injuries, use of replacement staff, costs to fill shifts, and advertisement costs, given the decreased demand for replacement staff.[92] Therefore, a restraint reduction program can potentially decrease hospital costs by increasing staff efficiency. This highlights that staff members should use restraints only when absolutely necessary. Thus, from the hospital's perspective, a successful restraint reduction program could be beneficial by increasing patient and nurse comfort level and satisfaction.

Restraint reduction has additional benefits. Federal laws require facilities to comply with certain regulations in order to receive Medicare and Medicaid reimbursement.[93] Additionally, a facility can reduce its liability risk when it reduces restraint use, because the number of patient injuries and deaths may decrease.[94] A focus on restraint and seclusion reduction can "provide early warning of system-wide problems that need attention" and assist in "recruit[ing] and retain[ing] high-quality staff."[95] Restraint reduction also has benefits for public relations.[96] Due to the public's growing concern regarding restraint use in hospitals, "it is likely that . . . [a] facility's track record will come under increasing public scrutiny."[97] Finally, and most importantly, reducing restraint use is ethically necessary in order to fully respect each patient.[98] The APA, APNA, and APHS list many other benefits for hospitals in reducing seclusion and restraint.[99] Moreover, a successful restraint reduction program can positively affect an institution in ways that may not be apparent at first glance; hospitals should make a concerted effort to implement such a program.

III. RESTRAINT REDUCTION: WHAT WORKS?

The above sections examined the subjective experience of restraint use from various parties and confirmed the conclusion that restraints should only be used when absolutely necessary to ensure the safety of pa-

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[91] *Id.* at 1113.

[92] *Id.*

[93] *See* LEARNING FROM EACH OTHER, *supra* note 14, at 5.

[94] *Id.* at 4.

[95] *Id.*

[96] *Id.* at 5.

[97] *Id.*

[98] *See id.* at 3–5.

[99] *Id.*

tients and staff when less restrictive alternatives have failed. Many institutions have successfully implemented programs that reduce restraint use. The following is a discussion of aspects of effective restraint reduction programs.

A. RESTRAINTS AS TREATMENT FAILURE

Successful reduction programs consider restraint use not as a treatment option but as treatment failure. Literature analyzing successful reduction programs suggests that, rather than attributing success to financial resources, success should instead be attributed to "deeply committed professional leaders and clinicians who have undertaken to provide care without resort to restraint."[100] Drastic reduction of restraint use has occurred in hospitals that are "significantly similar to most others . . . not . . . distinguished by extraordinary funding, staffing ratios, unusually high-quality physical arrangements, or a special group of patients."[101] Unexpectedly, restraint reduction can and does occur in overcrowded hospitals with low resources and staff.[102] Their success eliminates the excuse that restraints are used as tools to cope with low funding and low staffing. It is commonly accepted that "expectations of behavior (by caregivers and those directing policy) generally [yield] the expected behavior."[103] Consequently, a change in attitude may be the most important aspect of a reduction program. Studies documenting effective programs confirm the importance of changing attitudes about restraints: "It is a hospital's culture more than clinical necessity that determines how often or even if coercive practices are used."[104] Change stems from no longer thinking of restraints as a treatment or solution, but instead as treatment failure.[105]

An important caveat to the restraints-as-treatment-failure model is that administrators should be cautious not to cause fear in staff for improper use of restraints.[106] Fear of wrongly using restraints can stifle disclo-

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[100] Cohen & Kruschwitz, *supra* note 89, at 39.

[101] *Id.*

[102] *Id.*

[103] *Id.* at 29.

[104] Linda Cramer, Ginny McGrath & A. J. Ruben, *Special Focus: The End of Seclusion and Restraint*, 32 VER. B.J. & L. DIG. 1, 5 (2006).

[105] Gregory Smith et al., *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, 56 Psychiatry Online 1115, 1121 (2005).

[106] *See* Staci Silver Curran, *Staff Resistance to Restraint Reduction, Identifying and Overcoming Barriers*, 45 J. PSYCHOSOCIAL NURSING 45, 48 (2007).

sure and prevent honesty, thus precluding effective change.[107] For this reason, staff members should not be punished for expressing their feelings and fears.[108] Rather, institutional cultures that reinforce the idea of restraints as treatment failure have effectively provided staff incentives to reduce the use of restraints.[109] One such program was used by a multidisciplinary team convened by Robert E. McCue, which gave a "Crisis Prevention Award" to the unit in the hospital with the lowest number of restraint uses.[110]

Indeed, the APA, APNA, and NAPHS guidelines recommend and acknowledge that actual change "[is] related to the priority and understanding of the facility's clinical and administrative leadership,"[111] which underscores the importance and necessity of culture change.[112] Therefore, in lieu of immediately resorting to restraining a patient who is acting out, staff should ask, "[W]hat is happening and what does the patient need?"[113]

B. EFFECTIVELY TRAIN STAFF

In an effective reduction program, it is necessary to train staff on how to reduce restraint use and utilize alternatives. Specialized staff training alone may reduce the use of restraints.[114] For example, one study found that after nurses attended an education program, no nurses from the post-test group utilized physical restraint, while the pre-test group used physical restraint on seventeen out of forty agitated patients.[115] Practicing nurses acknowledged that continued training on restraint practices is needed.[116] Sensitivity training,[117] education on prevention, milieu management, crisis intervention, and treatment [118] are fundamental to all such

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[107] *See id.*

[108] *Id.*

[109] Robert E. McCue et al., *Reducing Restraint Use in a Public Psychiatric Inpatient Service.* 31 J. BEHAV. HEALTH SERVICES & RES. 217, 220 (2004).

[110] *Id.*

[111] LEARNING FROM EACH OTHER, *supra* note 14, at 6.

[112] *Id.*

[113] *Id.* at 7.

[114] Ozdemir & Karabulut, *supra* note 6, at 123.

[115] *Id.*

[116] *See* Strout, *supra* note 29, at 417.

[117] Hank Visalli & Grace McNasser, *Reducing Seclusion and Restraint: Meeting the Organizational Challenge*, 14 J. NURSING CARE QUALITY 35, 37 (2000).

[118] Christopher Coffin, *Case Law and Clinical Considerations Involving Physical Restraint and Seclusion for Institutionalized Persons with Mental Disabilities*, 23 MENTAL & PHYSICAL DISABILITY L. REP. 597, 599 (1999).

training programs. Some facilities have utilized training manuals, videos, and hands on training sessions.[119] Successful staff trainings do not need to be extremely time consuming. One reduction program reduced restraint use by 98% by creating a unique crisis management plan for each patient and trained staff via a comprehensive manual, ninety-minute video,[120] and one-day training session.[121]

Accordingly, the APA, APNA, and NAPHS guidelines emphasize the importance of staff education.[122] They recommend that staff be continually educated in the following areas:

> [A]ssessment and crisis prevention techniques, use of least restrictive methods, how to employ restraint and seclusion safely (including understanding the risks and benefits of either intervening or not intervening), a process for continuously reevaluating the need for restraint or seclusion, a process for continuous monitoring to ensure the patient's safety[,] and other needs.[123]

The guidelines recognize that adequate staffing and training may be costly, but support the investment because "[s]taffing to acuity pays off" and "[i]nvesting in training makes a difference in restraint/seclusion rates."[124] The guidelines suggest a two-stage initial training process in which staff members are first given extensive orientation training and then are retrained after a few months of hands-on experience, so that they may better understand how to apply their new tools.[125]

C. INVOLVE PATIENTS IN THEIR TREATMENT

Research suggests that involving patients in their treatment by training them and individualizing their treatment is effective for restraint reduction.[126] Involving patients in their treatment plans shows respect to patients. "Greater respect for individual rights and interventions like simple positive reinforcement and encouragement, staff-patient interaction, even

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[119] Jessica A. Jonikas et al., *A Program to Reduce Use of Physical Restraint in Psychiatric Inpatient Facilities*, 55 PSYCHIATRIC SERVICES 818, 819 (2004); McCue et al. *supra* note 108, at 220.

[120] The head nurse and director of quality assurance were available at the meetings to answer questions and provide further information.

[121] Jonikas et al., *supra* note 119, at 819.

[122] *See* LEARNING FROM EACH OTHER, *supra* note 14, at 13.

[123] *Id.*

[124] *Id.* at 14.

[125] *Id.* at 15.

[126] *See* Visalli & McNasser, *supra* note 117, at 39.

going for a walk off the unit, can be effective in reducing or eliminating the use of (or claimed need for) seclusion or restraint."[127] A focus on teaching patients how to control their feelings has also been successful.[128] The Mohawk Valley Psychiatric Center used tools such as behavior mapping, Anger Management Assessment, and the Triangle of Choices to teach patients how to "develop healthy styles of interacting."[129] Another effective reduction program used a stress and anger management group that focused on "changing the cycle of anger" and "learning coping skills."[130] Patients should be able to "choose how they want to manage their aggressive feelings."[131] Some successful reduction programs included "discussion[s] with clients about indicators of risk and identification of thinking errors."[132] Coffin suggests that these tools are successful because they allow patients to be involved in their own treatment program: "When patients are treated as people, with dignity and respect, they are less likely to become aggressive."[133] Patient involvement in treatment "produce[s] acknowledgement of self-worth."[134] Not only does respecting the patient by involving them in their treatment decrease the need for restraints, [135] it is also the most ethical way to treat a patient.

Again, the APA, APNA, and NAPHS guidelines echo the importance of patient involvement by recommending patient-specific approaches and patient involvement in both staff training and treatment planning.[136] These guidelines also emphasize that every patient "deserves highly individualized treatment."[137]

Which is the best restraint position? Should patients have a choice? If restraint use is unavoidable, hospital staff should aim to use restraints in the most ethical and respectful manner possible. The feeling of powerless-

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[127] Coffin, *supra* note 118, at 600 (quoting ROBERT M. LEVY & LEONARD S. RUBENSTEIN, THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES 301 (Norman Dorsen ed., 1996)).

[128] Visalli & McNasser, *supra* note 117, at 39.

[129] *Id.*

[130] McCue et al., *supra* note 109, at 219.

[131] Coffin, *supra* note 118, at 599.

[132] C. Larue et al., *Factors Influencing Decisions on Seclusion and Restraint*, 16 J. PSYCHIATRIC & MENTAL HEALTH NURSING 440, 444 (2009).

[133] Coffin, *supra* note 118, at 600 (quoting Hank Visalli, *Striving Toward a Best Practice Model for a Restraint-Free Environment*, 6 J. NURSING CARE QUALITY 1, 4 (1997)).

[134] *Id.*

[135] *See id.* at 599–600.

[136] *Id.*

[137] LEARNING FROM EACH OTHER, *supra* note 14, at 19.

ness was a "main objection" voiced by patients.[138] Patient aversion to powerlessness suggests the importance of allowing patients as much choice as possible within the restraint process. If restraint use is absolutely necessary, giving patients a choice in restraint position seems to be the most respectful way to restrict their freedom of movement. In addition, providing patients with a choice may foster compliance. Moreover, considering the patient's choice is also consistent with the legal requirement for "individual diagnosis and treatment" established in *Wyatt v. Stickney*.[139] If possible, a patient's choice can be documented upon admission to an institution before restraint use becomes necessary so that they can make their choice while calm. Yet while giving patients a choice seems to be the easy answer, as we see below, potential complications arise.

Patients can be restrained in a supine (faceup) or prone (facedown) position.[140] The use of the supine position may make a patient "feel more vulnerable and sexually exposed."[141] Patients, especially females, restrained in the prone position, "found the experience far more tolerable" than restraint in the supine position; they also did not "feel as sexually vulnerable."[142] In addition, patients' feelings of "anger, fear, and anxiety" decreased more rapidly when restrained in the prone position.[143] Moreover, patients in the prone position were restrained for less time than patients in the supine position. Patients restrained in a supine position were confined an average of 8.2 hours, compared to patients restrained in a prone position, whose average time of restraint was five hours.[144]

However, while these findings suggest that we use the prone position rather than the supine position, the majority of mental health advocates and practitioners urge that we should never use prone restraints,[145] because patients placed facedown have an increased risk of suffocation.[146] Paterson

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[138] *See* Sharon R. Aschen, *Restraints: Does Position Make a Difference?* 16 ISSUES MENTAL HEALTH NURSING 87, 90 (1995).

[139] 344 F. Supp. 373 (M.D. Ala. 1972).

[140] Aschen, *supra* note 138, at 89.

[141] *Id.*

[142] *Id.* at 90.

[143] *Id.*

[144] *Id.*

[145] *See* Kristi D. Aalberg, *An Act Concerning Physical Restraints of Persons with Disabilities: A Legislative Note on Connecticut's Recent Ban of the Use of Life-Threatening Restraints on the Mentally Ill*, 4 QUINNIPIAC HEALTH L.J. 211, 227 (2001); G. A. Lancaster et al., *Does the Position of Restraint of Disturbed Patients Have Any Association with Staff and Patient Injuries?*, 15 J. PSYCHIATRIC & MENTAL HEALTH NURSING 306, 307 (2008).

[146] Aschen, *supra* note 138, at 89.

et al.'s study shows that out of twelve cases of restraint-related deaths in the United Kingdom, the majority occurred while the patient was in the prone position.[147]

Aside from the specific problems with each restraint position, there are further logistical complications from allowing patients to choose their position.[148] Riley's explanation about why different positions are used in practice suggests that the safety of a position may be dependent on the situation and the placement of the patient prior to being restrained.[149] For example, when staff members are warned of a patient's dangerous activity, but de-escalation is ineffective, the prone position is used more often.[150] This is because after unsuccessful face-to-face attempts to de-escalate, "controlled descent to the floor in the prone position [would be the] safer option because the member of staff at the front is best placed to protect the face."[151] However, if a patient is "withdrawn and uncommunicative" and is turned away from staff, it may be safer to secure the patient's head and lower the patient onto his or her back, or into the supine position. [152] Thus, perhaps we should not preemptively balance the advantages and disadvantages of different restraint positions prior to the event because the safest choice may be best determined on a case-by-case basis.[153]

Moreover, both the prone and supine positions have specific concerns associated with them.[154] As explained above, one position may be safer depending on the particular situation.[155] If one restraint position is considered safer in a specific circumstance, but the patient has not chosen the safer option, which restraint position should staff choose? What if a patient chooses a particular position under a masochistic desire to feel pain? Should we assume that every patient has the ability to balance the advantages and the disadvantages of the various positions? What if a patient

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[147] David Riley, *Patient Restraint Positions in Psychiatric Inpatient Service*, 102 NURSING TIMES 42 (2006), *available at* http://www.nursingtimes.net/nursing-practice/clinical-specialisms/mental-health/patient-restraint-positions-in-a-psychiatric-inpatient-service/203421.article (citing Brodie Paterson et al., *Restraint-Related Deaths in Health and Social Care in the UK: Learning the Lessons*, 6 MENTAL HEALTH PRAC. 10, 12 (2003), *available at* http://www.nm.stir.ac.uk/documents/ld-restraint-related-deaths-mh.pdf)).

[148] *See id.*

[149] *Id.*

[150] *Id.*

[151] *Id.*

[152] *Id.*

[153] *See id.*

[154] *Id.*

[155] *Id.*

changes his or her mind at the moment the patient becomes dangerous? Is it best for the patient to choose a particular position when another may be significantly safer? Having to choose between the safety and the liberty of the patient may be an unfair burden on staff. Furthermore, is the patient receiving a true choice when we are only offering the ability to choose how their freedom is restricted? Because findings show that most patients negatively view being restrained,[156] allowing patients to choose their own restraint position may be no choice at all. Moreover, it is possible that the consequences of being restrained are not fully comprehensible to the patient prior to the actual restraint experience. Based on the possibility of patients having masochistic desires, the extreme harm that restraints can cause,[157] and patients' potential inability to comprehend this harm, perhaps we should not allow patients the choice over their form of restraint.

Although these complications highlight how difficult it can be to incorporate a patient's choice of restraint implementation, giving patients choices is an important step toward fully respecting the patient.[158] These complications also emphasize how the extreme measure of restraint should *only* be used after careful consideration and when absolutely necessary. In the case that there are equivalent choices in terms of risk and benefit to the patient, denying a patient this choice is inexcusably paternalistic and disrespectful.

D. DISCUSS EVERY RESTRAINT EPISODE WITH PATIENTS AND STAFF

If restraint is inevitable, debriefing patients becomes an important part of a reduction program.[159] Explaining to patients what occurred and why restraints were used is an important part of respecting patients, is a method for involving patients in their treatment, reducing their trauma, fear, and preventing confusion.[160] Intra-staff review of restraints episodes is also important and useful.[161] One hospital set up a standard meeting time and place to review every episode of restraint and seclusion.[162] The meetings "led to exploration of ways to improve collaborative symptom

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[156] Ray et al., *supra* note 16, at 14.

[157] *See* Ozdemir & Karabulut, *supra* note 6, at 120.

[158] *See supra* Part II.C.

[159] *See* Gregory Smith et al., *supra* note 105, at 1119.

[160] *See id.*

[161] Diane E. Allen, Alexander de Nesnera & Justin W. Souther, *Executive-Level Reviews of Seclusion and Restraint Promote Interdisciplinary Collaboration and Innovation*, 15 J. AM. PSYCHIATRIC NURSES ASS'N 260, 261 (2009).

[162] *Id.*

assessment, timely intervention, and effective pharmacological treatment of violent patients."[163] Another study confirmed the value of daily review of restraint, citing as helpful discussions of "the events leading to the restraint, alternative actions that could have been taken, and strategies to prevent future restraints in the patient." [164]

In agreement, the APA, APNA, and NAPHS guidelines consider debriefing to be essential for many of the same reasons listed above.[165] Additionally, "[d]ebriefing is a teaching moment"[166] and must provide staff with an occasion to learn from the event but, at the same time, remain tailored to the patient.[167]

E. CONSIDER USING MEDICATION

Administering psychotropic[168] medication to reduce restraint use is a highly debated topic.[169] Physicians generally prefer the use of psychotropic medication to physical restraint, because medication offers the benefit of continued "chemical alteration for a period of time following administration" and promotes the patient's ability to interact socially and live without delusions.[170] The use of drugs like clozapine has been associated with "a significant reduction in the use of seclusion and restraint"[171] and a considerable reduction in the duration of restraint and seclusion use.[172] Clozapine has even been shown sufficiently effective to permit a patient to be released from the hospital.[173] However, opponents of using psychotropic medication used in lieu of restraints fear overmedication and seda-

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[163] *Id.* at 263.

[164] McCue et al., *supra* note 109, at 220.

[165] *See* LEARNING FROM EACH OTHER, *supra* note 14, at 30.

[166] *Id.*

[167] *Id.*

[168] Because most, but not all, patients in this context use antipsychotic drugs, I use the term "psychotropic," which includes antipsychotic medication.

[169] Yvette Sheline & Teresa Nelson, *Patient Choice: Deciding Between Psychotropic Medication and Physical Restraints in an Emergency*, 21 BULL. AM. ACAD. PSYCHIATRY L. 321, 322 (1993).

[170] *Id.*

[171] John A. Chiles, Peter Davidson & Dennis McBride, *Effects of Clozapine on Use of Seclusion and Restraint in a State Hospital*, 45 HOSP. & COMMUNITY PSYCHIATRY 269, 270 (1994).

[172] Ashok R. Mallya, Phillip D. Roos & Kathleen Roebuck-Colgan, *Restraint Seclusion and Clozapine*, 53 J. CLINICAL PSYCHIATRY 395, 396 (1992).

[173] *Id.*

tion.[174] They stress negative symptoms caused by drugs such as clozapine.[175] Some of the possible side effects, such as tardive dyskinesia,[176] are significant and could be permanent.[177]

Assuming that medication such as clozapine is generally effective for reducing restraint use and purportedly improving patients' quality of life by reducing delusions or hallucinations, we must ask whether patients should have a choice in taking the medication. The fear is that physicians may be acting paternalistically by assuming that medication is preferable to alternatives. One study found that 36% of patients preferred physical restraints to psychotropic medication.[178] Should we ignore the patient's preference in favor of what we objectively consider to be the patient's well-being? After considering the potential negative side effects of medication, the answer is not apparent.[179] In her book, *Refusing Care*, Elyn R. Saks suggests that we should forcibly medicate a patient who is incompetent to make a decision only if that patient "would have decided on medication if competent."[180] Moreover, while the patient's right to refuse medication is a complicated issue, and outside the scope of this paper, the use of drugs, such as clozapine, has been found to reduce the need for restraint use.[181]

Furthermore, the APA, APNA, and NAPHS guidelines suggest having a "clear plan for adequate and appropriate psychopharmacology."[182] They see medication as "a part of a highly individualized, integrated treatment plan."[183]

F. CREATE A CRISIS RESPONSE TEAM

Many successful restraint reduction programs utilize a crisis response team, sometimes called a psychiatric emergency response team.[184] The

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[174] *See* Chiles, Davidson & McBride, *supra* note 171, at 270.

[175] *Id.*

[176] Tardive dyskinesia is a disorder resulting in involuntary repetitive body movements and has a slow or belated onset.

[177] Sheline & Nelson, *supra* note 169, at 322.

[178] *Id.* at 325.

[179] *See* REFUSING CARE, *supra* note 8, at 89.

[180] *Id.*

[181] Chiles, Davidson & McBride, *supra* note 171, at 270; Mallya, Roos & Roebuck-Colgan, *supra* note 172, at 399.

[182] LEARNING FROM EACH OTHER, *supra* note 14, at 28.

[183] *Id.*

[184] McCue et al., *supra* note 109, at 220; Gregory Smith et al., *supra* note 105, at 1119.

purpose of the team is to assist inpatient staff when dealing with an aggressive patient in order to avoid restraint use.[185] Absent immediate danger, protocol calls for the team to clear the area and "engage the person in a therapeutic conversation directed at identifying the underlying reasons for the crisis" in order to "help the [patient] understand what needs to occur for him or her to regain control."[186] This is yet another opportunity to prevent restraint use by involving the patient in treatment.

The APA, APNA, and NAPHS recognize the importance of staff support and discuss Crisis Intervention Specialists, who identify and help diffuse potential crisis situations.[187]

G. DATA MANAGEMENT AND DOCUMENTATION

Organizing data is an important part of restraint reduction at patient, staff, institution, and broader community levels. At the patient level, effective individualized treatment requires proper documentation.[188] The availability of patient-specific data, such as the patient's preferences, habits, history, and method of preferred anger de-escalation, allows staff to tailor treatment to the individual patient.[189] In one program, "[a]ll information from all staff, either verbal or through progress notes, [went] back to get incorporated into the treatment plan."[190] "The empirical information gathered from working with patients [was] used to help the person resolve the situation in the least restrictive manner."[191] At the staff level, proper documentation is necessary in order to comply with a doctor's legal duty to his or her patient.[192] Requiring documentation also promotes accountability in mental health staff and consequently may increase incentives to use restraints only when absolutely necessary. At the level of the institution, restraint use can vary greatly by institution and by departments within an institution. Documentation of restraint use within an individual hospital thus permits identification of problem areas, "pattern[s,] and opportunities for improvement."[193] At the broader community level, the

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[185] McCue et al., *supra* note 109, at 220.

[186] Gregory Smith et al., *supra* note 105, at 1119.

[187] LEARNING FROM EACH OTHER, *supra* note 14, at 16, 28.

[188] *See* Visalli & McNasser, *supra* note 117, at 43.

[189] *Id.*

[190] *Id.*

[191] *Id.*

[192] Coffin, *supra* note 118, at 599 (citing Ronald W. Scott, LEGAL ASPECTS OF DOCUMENTING PATIENT CARE 32 (1994)).

[193] Visalli & McNasser, *supra* note 117, at 38, 43.

effectiveness of a national restraint reduction movement is furthered by the ability to compare the results of different reduction programs in institutions throughout the country. Documentation also permits publication of restraint rates, which can increase public awareness of restraint misuse. Increased public awareness of the high rate of restraint use has been shown to lead to legislative changes focused on restraint reduction.[194] Thus, publication of restraint rates may affect practice by increasing staff accountability.

The APA, APNA, and NAPHS recommendations agree and discuss the importance of documenting and managing data.[195] "All aspects of the seclusion and restraint episode, including the behaviors and events leading up to it, the less restrictive interventions employed, the care provided during the episode and the form of seclusion or restraint[,] are recorded in the clinical record."[196]

H. ACHIEVING RESTRAINT REDUCTION FROM A LEGISLATIVE STANDPOINT

Federal standards regarding the use of restraints establish a protective floor for patients' rights.[197] Staff must use restraints only to ensure the physical safety of the patient or others, and only upon a written order by a physician or other licensed practitioner permitted by the facility and state law.[198] These national standards do not preempt federal or state regulations that are more protective of patients' rights, "such as the rules promulgated . . . by the Health Care Financing Administration . . . for hospitals participating in the Medicaid or Medicare program."[199]

A possible route to incentivize restraint reduction nationwide is to implement a more rigorous national standard that withholds federal funding from states and facilities that fail to meet the standard. However it may be impossible to determine when restraints are overused due to the varied spectrum of patient needs. Some hospitals may have a greater percentage of dangerous patients, which may necessitate more restraint use. Addition-

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[194] *See* Dwight F. Blint, *Facilities Lose Medicaid over Restraint Use*, HARTFORD COURANT, Sept. 4, 1999, *available at* http://articles.courant.com/1999-0904/news/9909040093_1_new-restraint-patient-restraints-inspectors.

[195] LEARNING FROM EACH OTHER, *supra* note 14, at 19.

[196] AM. PSYCHIATRIC NURSES ASS'N, AMERICAN PSYCHIATRIC NURSES ASSOCIATION STANDARDS OF PROFESSIONAL PERFORMANCE 19–20 (May 2000).

[197] BAZELON CTR. FOR MENTAL HEALTH L., *supra* note 87.

[198] *Id.*

[199] *Id.*

ally, a more specific or rigorous national standard may unconstitutionally usurp the state's police power. Thus, the complexity of restraint reduction may make implementing a program that establishes a procedure to judge the success of a hospital extremely complicated. Nonetheless, the ability to withhold federal funding is so powerful that working through the complexities of this problem may be worthwhile.

It is generally established that restraints should only be used when absolutely necessary—after less restrictive alternatives have been attempted and have failed.[200] At first glance, state laws are consistent with this ideal.[201] California regulations, similar to laws in other states,[202] mandate that restraints be used "only when alternative methods are not sufficient to protect the patient or others from injury."[203] However a law that mandates restraints only when absolutely necessary may not be effective. Policy efforts to reduce restraint use have not always been successful.[204] One study found that almost 10% of episodes were pro re nata or as needed, although these episodes were, and still are, "specifically prohibited under California law."[205] The lack of compliance may suggest that changing the law alone may not be sufficient to cause a reduction in restraint use. As discussed above, it may be that adopting a different attitude toward restraints and staff training at the facility level, rather than or in addition to adopting more rigorous state or federal laws, will lead to significant reductions.[206] This theory has been confirmed in one hospital that had for many years maintained "strict regulations on the type and use of restraint and seclusion, clearly for emergent safety purposes only."[207] This significant decrease seemed to stem from "adopt[ing] the philosophy that alternative methods [to restraints] could be highly effective."[208] Thus, a key to reduction may be to implement laws to change attitudes.

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[200] *See* LEARNING FROM EACH OTHER, *supra* note 14, at 2.

[201] *See* CAL. CODE. REGS., tit. 22, § 71545(a) (2011); 440 IND. ADMIN. CODE 1.5-3-13 (2008); 12 VA. ADMIN. CODE § 35-115-110 (2007).

[202] *Id.*

[203] CAL. CODE REGS. tit. 22, § 71545(a) (2011).

[204] *See* Wesley B. Crenshaw & Paul S. Francis, *An Updated National Survey on Seclusion and Restraint in State Psychiatric Hospitals*, 48 PSYCHIATRIC SERVICES 395, 397 (1997).

[205] Chandler, Nelson & Hughes, *supra* note 3, at 532; *see* CAL. CODE REGS. tit. 22, § 77103(e) (2011).

[206] Ann M. Sullivan et al., *Reducing Restraints: Alternatives to Restraints on an Inpatient Psychiatric Service—Utilizing Safe and Effective Methods to Evaluate and Treat the Violent Patient*, 76 PSYCHIATRIC Q. 51, 53 (2005).

[207] *Id.*

[208] *Id.* at 53.

IV. SUGGESTIONS FOR A MODEL LAW TO REDUCE MECHANICAL RESTRAINT USE IN INSTITUTIONS

A model law should be clear and unambiguous. Often, laws regarding mechanical restraints are not specific enough. For example, as discussed above, California law, similar to laws in other states,[209] mandates restraint use "only when alternative methods are not sufficient to protect the patient or others from injury."[210] While a good attempt at reduction, it is vague, and provides little guidance. Does this mean that restraint use should only apply to the threat of severe injury? What about a minor injury? Is a 60% chance that the patient will not be dangerous sufficient to protect the patient or others? Every institution, situation, and patient is different. What constitutes an emergency may differ in each community and hospital, and to every doctor, nurse, and medical staff. Accordingly, under a law like California's statute, there is uncertainty as to whether restraint use is justified. Thus, clear standards for what constitutes proper use of restraints should be spelled out and determined by experts.

The model law should also include a staff education requirement. A clearer law will not automatically lead to a fundamental change in staff attitudes and views on restraints, which is necessary for restraint reduction.[211] Mental health staff should be taught, while in school or once employed by an institution, that restraints are treatment *failures*—only to be used when absolutely necessary to prevent harm to a patient or to staff. A law should mandate staff education on the dangers of restraint use and the alternatives.

The law should bolster accountability measures, and every restraint occurrence should be documented. Statutes and regulations already list documentation requirements and doctors have legal duties pertaining to documentation, which include documenting restraint use and the surrounding circumstances,[212] but perhaps we should require the documentation to be more detailed. What led you to restrain the patient? How did the patient feel about being restrained? Was it helpful? How long was the patient restrained and why was that specific time period necessary? Did you consider the patient's preferences? How often did you check on the restrained patient? Regulations should also provide guidance on how to deal with

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[209] *See* 440 IND. ADMIN. CODE 1.5-3-13 (2008); 12 VA. ADMIN. CODE § 35-115-110 (2007).

[210] CAL. CODE REGS. tit. 22, § 71545(a) (2011).

[211] *See* Cramer, McGrath & Ruben, *supra* note 104, at 5.

[212] *See* Coffin, *supra* note 118, at 599.

staff members who overuse restraints. If a staff member continually misuses restraints, administrators should take action to help the staff member and require improvement. Also, the burden of strict documentation standards may discourage nurses from using restraints. Some literature suggests that a video surveillance system is necessary in institutions "because many aggressive episodes can be predicted."[213] A surveillance system may also increase staff accountability and lead to a more efficient, peaceful, and respectful institution with fewer restraint episodes. However, surveillance systems could be costly and present privacy issues. Further research is needed to determine if a surveillance system would be both ethical and cost-effective.

The model law should address the importance of respecting the patient's choices. If possible, the law should require staff to ask patients to indicate his or her preferences regarding restraint position and other treatment options. There are a variety of ways to give patients more choice, which include types of physical restraint preferred, preference for seclusion rather than physical restraint, and preference for medication in addition to or instead of restraints. If feasible, documentation of preferences and habits should be mandated upon arrival and admittance to an institution. Perceived problems associated with giving patients choices may be valid, but patients' liberty interest should be a priority.

V. EXAMPLE MODEL LAW

Bearing in mind the above considerations, a possible model regulation could be as follows: "Mechanical restraints may be used, if and only if, absent being restrained, the patient is *certain* to cause *great* harm to his/herself or *likely* to harm another person."[214]

We should promulgate regulations that include the following: (1) a definition and examples of "certain," "great harm," and "likely to harm"; (2) tools for guaranteeing competence and licensing of staff who utilize restraints, which require staff to understand the risks of restraints and become fluent in utilizing less restrictive alternatives; (3) a maximum time period for how long a patient may be restrained without being checked; (4) a requirement that staff must explain to the patient the conditions of re-

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[213] Angela M. Gerolamo, *The Conceptualization of Physical Restraint as a Nursing-Sensitive Adverse Outcome in Acute Care Psychiatric Treatment Setting*, 20 ARCHIVES PSYCHIATRIC NURSING 175, 182 (2006).

[214] The threshold for likelihood and amount of harm required for restraint use should be greater in the case of self-harm, because as discussed above, the harm that restraints can cause a patient decreases the rationale for using restraints to prevent self-harm.

lease from restraints, such that if the patient remains calm for a certain period of time while being restrained, the patient will be released; (5) a review procedure for a patient who wants to appeal the use of restraints; (6) a requirement that staff *consider* the patient's choice of preferred restraints, which include restraint position or type of mechanical restraint as previously documented or as indicated by the patient at the time of restraint, and this choice should not be mandatory because doctors should decide which position is the safest for the patient; and (7) a strict documentation requirement, which includes information including but not limited to (A) the reason for restrain; (B) the patient's reaction to restraint, (C) the total number of minutes restraints were used, (D) the frequency of checking on the patient, and (E) whether the patient was given any choice in the type of restraint.

VI. CONCLUSION

Our goal should be to reduce our use of restraints. Overusing restraints simply does not make sense. Evidence shows that restraints both fail to provide therapeutic value and prevent injury.[215] As discussed, restraint reduction benefits patients, staff, the institution, and the community, and can be achieved without significant financial cost. Considering these facts, and based on the examination of restraints from the points of view of those involved, there is no valid explanation for continued overuse of restraints. Because we have seen that mental health staff members do not actually want to use restraints, we must give them the tools to eliminate all unnecessary restraint occurrences. Finally, a law regarding restraint use should focus on affecting staff *attitudes*, since such a change may be an essential factor in restraint reduction.

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[215] Moss & La Puma, *supra* note 5, at 23.