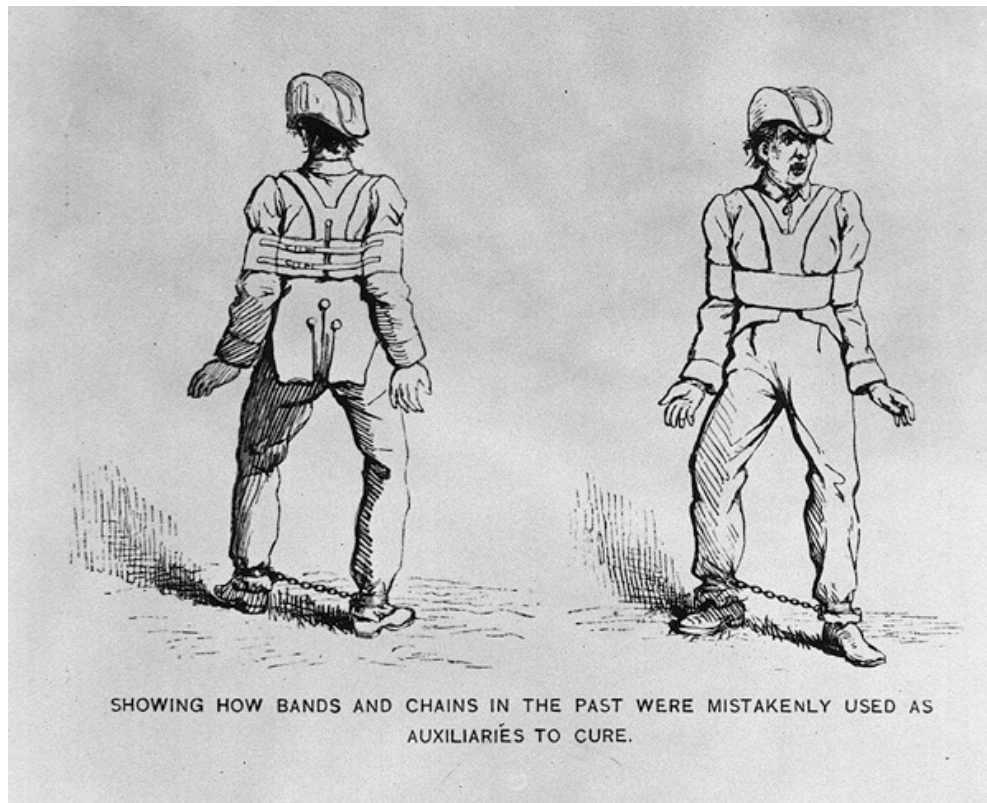


## HUMAN SERVICES RESTRAINT: REDUCE, REPLACE, OR RELINQUISH?



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Restraints and seclusion are used on people in institutions, children in schools, nursing home residents, general hospital patients, and other locations, most often on people with disabilities. Questions regarding legality, morality and efficacy abound. These questions, compounded by the serious possible adverse consequences of restraints and seclusion, have commanded wide-ranging attention from legislatures, government agencies, human service professionals and direct care staff, advocates, clients and families, and the public.

Can the use of human services restraint be reduced? Replaced with alternative approaches? Or is it time to relinquish these practices, at least when incorporated in a treatment or habilitation plan?

This article begins with a brief look back at the institutional use of restraints and seclusion, and then notes some worst case results in the United States, as a reminder of what is at stake. The efficacy and risks of “human services restraint” are then considered. Efforts to reform and reduce the use of restraint are reviewed. Legal liability questions which impact on agency policy are addressed next. The article concludes with some thoughts on the necessity of human services restraint and its future.

## Restraints in the Early Institutions

To those who favored restraints, Dr. John Conolly argued, "In a properly constructed building with [enough attendants], restraint is never necessary, justifiable, and always injurious." That was 170 years ago. The discussion continues today.

Dr. Conolly was appointed Superintendent of the Middlesex County Asylum at Hanwell in England in June 1839. Over 40 of the 800 patients were restrained at the time. Within three months, by September 21, all forms of mechanical restraint were gone. Dr. Conolly epitomized the “no restraint” policy within the “moral treatment” movement influenced by the Quakers in England and post-French Revolution reformers in France in the late 1700s and into the 1800s. England’s 1854 Lunacy Acts prompted the reduction of restraints as well. The names of Tuke, Pinel and Kirkbride are a familiar part of this history.

In the United States, psychiatric hospital superintendents in the mid- to late 1800s were divided on the use of restraints but generally opposed the “no restraint” English position. Physical restraint was viewed as a form of therapeutic treatment and was an accepted practice for dealing with violent patients. American psychiatrists extolled the value of restraint and seclusion, with one noting that is required by “the peculiar violence of American Insanity.”

In 1875, Dr. (Lord) John Buckmill, a former superintendent of an asylum in England, visited American public and private asylums. He disagreed with the American viewpoint. At the superintendents’ annual meeting that year, he bet £100 that an American superintendent could not find any form of restraint in British asylums in a month-long tour. He had no takers. He later wrote, “[The American superintendents] will look back to their defense with the same wonderment. . .that has been said in defense of domestic slavery.”

## Worst Case Stories

While the vast majority of instances of restraint and seclusion do not result in physical harm or death, it is sobering to keep in mind at least some of the instances in which death occurred, to assist in thinking through how any alternative policies might have affected their experience, if at all.

It is sometimes said that the use of restraints represents a treatment failure. Here are seven stories which represent a tragic failure in the use of restraints.

- Isaiah Simmons died January 23, 2007 at the Bowling Brook Preparatory School in Maryland. He allegedly acted out in the dinner line and was restrained. Four youths who witnessed the incident said staff sat on him for three hours until he passed out and died. The school has closed, the death was ruled a homicide and indicted staff were charged with waiting 41 minutes before calling 911 about the unresponsive boy.
- Cedric Napoleon, a 14 year old special education student died March 7, 2002 after a teacher and a classroom aide restrained him in Killeen, Texas. He suffocated due to pressure on his chest. The school said he was disruptive. His foster parents said that

when the restraint happened, their son was attempting to leave the classroom to look for food because school officials had limited his food ration as punishment. The boy was not fighting, or involved in any violent act at the time of the restraint.

- On February 15, 2007, Jonathan Carey, an autistic boy who was a resident at the O.D. Heck Developmental Center in New York, was restrained in a van while staff were running errands for 1 ½ hours. He could not be revived. Two staff are being charged.
- On June 3, 2007, Omega Leach, age 17, died at the Chad Youth Enhancement Center in Tennessee, a day after being restrained for seven to eight minutes for attacking a staff member. At the end of those minutes, staff could not find a pulse. The state found that the facility violated restraint policies.
- Angelikka Arndt was seven years old when she died May 2006 while being restrained at the Northwest Counseling and Guidance Clinic in Wisconsin. She had been restrained nine times over a month. She died of "complications from chest compression asphyxiation" after being held face down on the floor by two staff. The restraint was due to her "gargling milk."
- In Ephrata, Pennsylvania, Giovanni Aletriz of Allentown, was 16 when he died on Feb. 4, 2006, the second death in two months at SummitQuest Academy, a program for boys with mental health and sex offender problems. An independent forensic pathologist found that the death most likely resulted from behind held face down forcefully. SummitQuest officials said the staff follows a crisis management procedure developed by the University of Pittsburgh Medical Center's West Psychiatric Institute. No charges were filed because he had an undiagnosed heart condition. DPW put the facility on a six month provisional license.
- Mikie Garcia died on Dec. 4, 2005, in Texas of "suffocation during physical restraint," according to the medical examiner. He had been placed in "time out" for refusing to obey orders, and he started banging his head against concrete, so staff restrained him until he stopped breathing. Staff restrained the boy with his arms across his chest and his hands held behind him, in what is called a "basket hold." He was twelve.

In 1998, the Hartford Courant published the stories of dozens of people who died in restraints. Many of them were children. Some had developmental disabilities. Many died in “community” settings.

## Human Services Restraint Defined

Restraint is the use of force to limit another person's movement. This may occur by physical contact among individuals, mechanically by devices to limit movement, or chemically by the use of drugs. Seclusion is the involuntary placement of a person in a room, exit from which is not a permitted choice.

In hospitals, restraint appears to be allowed in non-emergency situations; in ICF/MR programs, physical restraint and time-out are specifically permitted in non-emergency situations and, when prescribed, must be included in a client’s individual program plan for active treatment.

“Human service restraint,” a term taken from Marc Tumeinski, is used here. It encompasses both restraints and seclusion. It refers to restraint of a client under the mandate of a program or agency, public or private, by staff who are taught specific restraint techniques. We distinguish human service restraint from actions among parents, friends and others in freely given relationships.

Human services restraint is used in response to, or to control, injury to others, self-injury, property damage, resistance to behavior control, inappropriate behavior, rule-breaking, and the like. It may or may not be used solely in emergency situations. It may or may not be used for treatment, as part of a planned behavioral intervention, or as an aversive consequence for a target behavior.

Restraints do not include orthopedically prescribed devices, protective helmets, holding someone to conduct routine physical examinations or tests, protections against one falling out of bed, or assistance to permit someone to participate in activities without risk of physical harm.

The use of these human services restraint techniques is not simply a response to client behavior. There is an interplay among staff, setting, the characteristics of the individual, and the individual's behavior, which is perhaps best conceptualized, in the words of one researcher, within an "ecobehavioral" perspective. For example, age and nature of disability may affect restraint use; there is a greater use of restraints for children with "lower intelligence or neurological impairments." As discussed below (Section V), policy, training and staff behavior affect the extent of restraint use.

A review of the existing literature published in 1994 reached the conclusion that "[l]ocal non-clinical factors, such as cultural bias, staff role perceptions and the attitudes of hospital administrators, have a greater influence on the use of these practices than any clinical factors."

## Efficacy and Risks

There is a vast literature on these practices, much of it simply descriptive, policy-oriented, and useful in training staff in techniques. There is also what might be called a "negative literature" and a "positive literature." Critiques of restraint use have been made on multiple grounds:

- it has harmful consequences to both staff and clients.
- may reinforce aggressive behavior as a coping mechanism
- may not be clinically effective,
- may humiliate clients,
- may be countertherapeutic for individuals with an abuse history,
- has been used for discipline, coercion, and convenience,
- may be unethical, and
- may be unconstitutional.

There are a small number of self-described “voices of protest” who defend restraint and seclusion and seek to “slow down the locomotive of opinions and pressure tactics that may lead mental health treatment in the wrong direction.”

NASMHPD and NTAC forge ahead with advocating, influencing, and training to reduce and eliminate restraint and seclusion. The training manuals of these organizations are supported (or more precisely not supported) by the research outlined in this article. The authors believe that voices of protest must be raised to slow down the locomotive of opinions and pressure tactics that may lead mental health treatment in the wrong direction.

The discussion here focuses on what the author believes are two fundamental questions which are most likely to influence governmental, agency and judicial decisions on reduction, replacement or relinquishment of restraint: efficacy and risk of harm. There is relatively little scientific investigation of the techniques’ efficacy, but much evidence of their risks.

## Efficacy

Rapid intervention limited to protecting someone from immediate harm is obviously sometimes necessary; in such cases, the intervention is limited to the least duration and to the least risky method, and must be accomplished by specially trained personnel. “Emergency restraint” is not planned and is not for the purpose of treatment or reduction of harmful behavior.

Planned human services restraint for treatment, to support positive behavior or reduce negative behavior, have not been shown to be effective. For example, a review of 109 articles spanning 35 years between 1965 and 2000 on restraints and seclusion on children and adolescents found that the techniques have only “questionable efficacy.” Research on human services restraint is characterized as sketchy and inconclusive. Both governmental and professional reviews find no therapeutic value in the practices.

Despite the absence of evidence of efficacy, there are volumes on proper procedures and criteria, mini-volumes on documentation and millions of dollars are spent on programs for staff training in techniques which may or may not work.

## Risks

It is quite difficult to evaluate the relative risks in the use of human services restraint.

The absence of data on restraint use (including data on routine use as well as the frequency of untoward events) makes it extremely difficult to comment on: the relative risks involved in restraint; the comparative risks involved across a wide range of individual procedures; and the relative risks involved in alternative interventions, including seclusion, mechanical restraint or medication.

Clients and staff may be injured during the imposition of restraint. The ultimate risk is death. In the professional literature, there has been discussion of the risk of death associated with the use of physical restraints since at least the 1980s. More recent research has focused on deaths and other adverse consequences in restraint.

Upset clients, when restrained, are held down or held tight, often with bodily organs and chest compressed; the heart begins to beat faster or out of rhythm, as the body attempts to obtain more oxygen to support itself. Restraints involving neck holds or obstruction of the nose or mouth have a high risk of fatality, as do mechanical restraints or prone tying, including "hobble tying." "Hobble tying is the term used to describe the prone positioning of a patient, following which their wrists are secured behind their back, their ankles are tied, and their wrists and ankles are subsequently secured together by pulling the shoulders back and bending the legs towards them." In a series of 214 cases of hobble tying in agitated delirium, death occurred in nearly 12% of the cases.

Seated restraint is risky, and pre-existing physical conditions, such as obesity, heart disease, general physical ill health, or exhaustion, are additional risks.

It is fair to say that there is no way to predict who may die due to the use of physical restraint, or who may be seriously injured. Almost ten years ago, an editorial in the Ca-

nadian Medical Association Journal noted the asserted benefits of human services restraint and then reminded us: “However, restraint is not itself harmless; some proportion of those who are restrained may die. We do not know what this proportion is, or how many others will come near death and need to be revived.”

Children appear to be particularly likely to be subjected to restraints, and to die while restrained. Restraints in schools is of increasing concern, and is now the subject of specific research attention; restraint use in schools is often not subject to accreditation or regulatory control.

## Reduction in Restraint and Seclusion Use

There is a great deal of evidence that the use of human services restraint can be dramatically reduced and, in some programs, eliminated.

A major technique for achieving this result is the wisdom and technology of positive behavioral supports, harking back, in spirit at least, to the approaches pioneered by Pines, Tuke, Conolly and the moral treatment movement, and American institutional reformers such as Dorothea Dix. Dedicated leadership, improved policies, acquisition and distribution of restraint data, explicit goals, careful debriefing of incidents, and specially designed staff training, have all contributed to successful reduction efforts.

Nirbhay Singh taught staff on an adolescent unit about behavioral principles and a treatment approach that focused on the patient’s strengths. The investigators gradually reduced the number of acceptable hours of restraint and seclusion, setting progressively lower quarterly criterion levels. Staff met these levels, eventually reaching zero-use. They maintained the gain at one year follow-up.

A study published in 2005 regarding Pennsylvania’s reduction program examined the use of seclusion and mechanical restraint from 1990 to 2000 and the rate of staff injuries from patient assaults from 1998 to 2000 in Pennsylvania’s state hospital system. From 1990 to 2000, the rate of seclusion decreased from 4.2 to 0.3 episodes per 1,000 patient-days. The average duration of seclusion decreased from 10.8 to 1.3 hours. The rate of restraint decreased from 3.5 to 1.2 episodes per 1,000 patient-days. The average duration

of restraint decreased from 11.9 to 1.9 hours. No significant changes were seen in rates of staff injuries from 1998 to 2000.

The National Association of State Mental Health Program Directors (NASMHPD) has conducted training on human services restraint reduction and reports that seclusion/restraint hours were reduced “by as much as 79%, the proportion of consumers in seclusion/restraint was reduced by as much as 62%, and the incidents of seclusion/restraint events in a month were reduced by as much as 68%.” This data is based on three to six month post-training evaluation of the first 12 states trained, with 8 hospitals sending data.

As indicated, alternative approaches often encompass (a) organizational and policy changes; (b) quality assurance techniques; and (c) changes to clinical programming, such as prevention of the behavior or situation leading to restraints or seclusion, or the use of alternative procedures. There is no magic prescription, of course. The many formulae for reduction typically include such elements as:

- Leaders who set an organizational culture change agenda;
- Systematic collection of seclusion and restraint data;
- Use of data to inform staff and evaluate incidents;
- Improvement in environmental conditions;
- Individualized treatment and responsiveness to clients;
- De-escalation tools;
- Debriefing to both analyze seclusion and restraint events and to mitigate their adverse effects;
- Staff training.

There are other approaches to limiting human services restraint which have their origin outside the entity serving clients. These include:

Legislation. Proposed legislation in New Jersey would forbid the use of restraints or seclusion as planned interventions or treatment, recognizing only its emergency use. This is Matthew's Law, named after Matthew Goodman, a child with autism who died after use of restraints. Other legislation on restraints is in place or in process.

Policy change resulting from personal experience. Susan Stefan reports that, after Dr. Ken Mitchell, former Medical Director of the Department of Mental Health in Massachusetts, spent the day in ambulatory restraints, he prohibited their use in DMH facilities.

Ban. The U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration (SAMSHA) seeks to "ultimately eliminate the use of seclusion and restraint in behavioral healthcare." The President's New Freedom Commission on Mental Health 2003 final report recommends that seclusion and restraint be used "only as safety interventions of last resort, not as treatment interventions." The New York State Psychological Association's task force on the issue "recommends that aversive behavior interventions be prohibited, without exception, as part of a behavior intervention plan." A broader ban is urged by The Alliance to Prevent Restraint, Aversive Interventions and Seclusion, <http://www.aprais.org>. The Alliance is created by a number of professional and advocacy organizations.

Judicially Determined Legal Standards. Legal decisions may have a significant effect. We turn to the law in the next section.

## A Legal Perspective

In our time, much discussion on the use of human services restraint focuses on legal liability. When will staff, teachers or an agency be liable for damages for using restraint at all? For a restraint gone awry? Does it violate treatment rights to use, or not to use, restraint?

Because liability considerations may affect agency and professional behavior, it is appropriate to consider the current state of the law in this regard.

At least based on how the cases have been tried and litigated thus far, the courts have generally been supportive of restraint use, and have not established significant barriers to the use of programmatic restraint.

There is a constitutional right to be free from bodily restraint, with the right circumscribed by the “professional judgment” standard announced by the Supreme Court 25 years ago in *Youngberg v. Romeo*, 457 U.S. 307 (1982), the case originating in the Pennhurst State School and Hospital restraint practices. The Romeo standard under the Fourteenth Amendment, related decisions, and other legal principles (Fourth Amendment, Eighth Amendment), and statutes (ADA, IDEA, for example), have framed the legal discussions.

The extreme is clear. Where a patient is subjected to kicking, stomping, strangling, and twisting in the process of a takedown for restraint, the constitutional limits are breached, and so a Minnesota federal court found in early 2007.

A fair statement of the state of the law is found in that decision. “Constitutionally infirm practices are those that are punitive in intent, those that are not rationally related to a legitimate purpose or those that are rationally related but are excessive in light of their purpose.”

That standard is not likely to be met where treatment professionals or teachers decide to restrain or seclude someone for safety or behavior control purposes, and the action is taken in at least arguable good faith. Even severe and injurious actions have not been condemned by the courts.

- In *M.H. ex rel. Mr. H. v. Bristol Bd. of Educ.*, 2002 WL 33802431 (D. Conn., Jan. 9, 2002), a 14 year old public school student with Down’s Syndrome sued for damages. M.H. misbehaved and a special education teacher spat water into his face, saying “This is spitting.” The incident was not reported to school supervisors and the staff who were present later falsely told the parents, who noticed M.H.’s soaked hair, that they had been “playing hairdresser.” On another day, a special education teacher held both the boy’s arms forcibly behind his back and directed him to a task. During a fire alarm,

M.H.'s arms were bruised when staff physically removed him from the building. Teachers also used a chair restraint which was written into a behavior plan. The court concluded that: 1) the two incidents of physical restraint and the incident of spitting by a teacher do not rise to the level of constitutional violations; and 2) the defendants' use of a chair restraint on the plaintiff did not violate the plaintiff's substantive due process rights because the defendants exercised professional judgment.

- Melissa S. v. School District of Pittsburgh, 183 Fed.Appx. 184, 2006 WL 1558900 (3d Cir. 2006) (16 year old public school student with Downs Syndrome was subjected to restraint and isolation for behavioral outbursts. Held: no violation of IDEA or her IEP as she was not treated differently from other students with behavioral outbursts)
- CJN v. Minneapolis Public Schools, 323 F.3d 63 (8th Cir. 2003) (third grade public school special education student with behavioral issues including kicking and hitting others, striking head on walls, was put in "time out" and restrained repeatedly. Held: "an increased amount of restraint in his third-grade year, but that fact alone does not make his education inappropriate within the meaning of the IDEA.").
- Doe v. S & S Consol. I.S.D., 149 F.Supp.2d 274 (E.D. Tx. 2001) (wrapping, of first-grade student in sheet or blanket, taping wrapping to secure it, and on occasions taping wrapped student to cot, to prevent student from harming herself or others while "rag-ing," did not violate clearly established Fourth Amendment right to be free from such restraint)
- Heidemann v. Rother, 84 F.3d 1021 (8th Cir. 1996) (9 year old girl with severe retardation in public school; therapist-recommended "blanket wrap" held to be "within the realm of professionally acceptable choices").
- Alex G. ex rel. Dr. Steven G. v. Board of Trustees of Davis Joint Unified School Dist., 387 F.Supp.2d 1119 (E.D. Cal. 2005) (upholding placing second grade student in restraints to stop him from sliding on table tops, even though parents had withdrawn consent to use of restraints; restraints were needed for physical safety).

In another decision, a court implied that had chair-tying been for punishment or discipline, it would have been acceptable. Jefferson v. Ysleta Sch. Dist., 817 F.2d 303 (5th Cir. 1987) (8 year old public school student, not handicapped, was tied to a chair for a day and part of a second day as an ‘instructional technique.’” Held: the chair-tying violated child’s constitutional rights as it was not for punishment or discipline).

The law will evolve from its current state. I believe that a full rendering of the nature, the evidence regarding, and the risks of human restraint has not yet been presented to a court. When that occurs, I expect that the caselaw to take another direction and that courts will begin to recognize the fragility of the prior decisions upholding restraint.

Restraints presented by a school or facility as an efficacious treatment for inclusion in a treatment or as an educational technique will likely be rejected by courts. The specific ICF/MR regulations which permit time-out and restraint as part of an individual active treatment plan would likewise be rejected, initially as applied in individual cases.

## Conclusion

Federal law, federal agencies, and professional organizations repeatedly express concern regarding the use of restraint and seclusion. In 2003, the United States HHS Substance Abuse and Mental Health Services Administration (SAMHSA) reported that it had “established seclusion and restraint as a priority area and has developed a National Action Plan to reach our vision of seclusion and restraint free mental health services.”

Public attention has focused on the issue, both in the news and in government reports. Advocacy, treatment professional and other organizations have pressed the issue, taking positions and issuing white papers. The National Technical Assistance Center for State Mental Health Planning (NTAC) recently issued a detailed “white paper” on the subject.

Web sites are now devoted to the issue. There is an organization named, “Children Injured by Restraint and Aversives” and one sponsored by multiple national groups to end the use of seclusion and restraints. Citizens Against Restraint, Toronto, Canada, seeks to ban all restraint use.

I suggest that the intense level of attention on restraint and seclusion stems from social and personal discomfort with the imposition of these involuntary measures on persons with disabilities, and the great risks entailed by these techniques. Many believe that it is just not right to impose restraint on people who are vulnerable and who have a devalued status. Human services restraint affects not just the individuals subjected to restraint, but also staff, leadership, agency culture, families and the public.

It is valuable to consider whether the use of unproven human services restraint within planned treatment interventions is consistent with the values of our society, our treatment programs, and our personal ethics and morality. Many have concluded that such restraint violates these values. Some have gone further and urged that all use of human services restraint be prohibited.

Can human services restraint practices be fixed? Is there a remedy for restraint abuse? Are there process improvements which can be made? Or should such restraint use be ended and restraint-free human services become the norm?

What does the future hold?

The use of human services restraint is moving into history. Emergency restraint can be avoided in many instances, we now know.

I believe that all programmatic restraint will be prohibited, and that restraint will not be permitted in a habilitation plan or as an acceptable aversive consequence for a target behavior. I believe this will occur for several reasons:

- There is a proven risk of death and other injuries. We are unable to predict who will die or be injured.
- Programmatic and planned restraint is not therapeutic or educational.
- The non-clinical factors leading to human services restraint will be increasingly recognized.
- Extraordinary reduction in the use of restraints and seclusion occurs when attention is paid.

Where there is a need for restraint or seclusion in an emergency to prevent immediate harm to a person, the techniques may be allowed subject to extensive limitations such as those in the latest federal regulations (applicable to hospitals), except that only vertical person-to-person restraint should be permitted (due to the special death risk of prone restraint), and for a very limited time.

I also believe that, in future cases, courts will be provided with a detailed record and expert opinion, and on that basis will begin to

- Limit the range of permissible emergency restraint and impose substantial safeguards,
- Forbid the use of human services restraint for therapy, treatment or education,
- In damage cases, impose liability on agencies and staff,
- In injunction and reform cases, impose standards consistent with the above.

These developments in human services will occur in an environment I will call the “new moral treatment,” spearheaded by our century’s new Pinels, Conolly’s and Kirkbrides, together with consumers and clients seeking these changes.

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