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PSYCHIATRIC RESTRAINT AND SECLUSION: RESISTING LEGISLATIVE SOLUTION

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I. INTRODUCTION

The use of restraint¹ and seclusion² in the American psychiatric setting has a rich history—rich in medical, ethical, legal, and social controversy.³ For centuries, mental

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1. Governmental and legal definitions of restraint vary. The Government Accountability Office defines a restraint as a “partial or total immobilization of a person through the use of drugs, mechanical devices such as leather cuffs, or physical holding by another person.” U.S. GEN. ACCOUNTING OFFICE, MENTAL HEALTH: IMPROPER RESTRAINT OR SECLUSION USE PLACES PEOPLE AT RISK, GAO/HEHS-99-176, at 1 n.1 (1999) [hereinafter GAO REPORT]. Federal regulations that apply to Medicare-participating hospitals define restraint as follows:

Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or [a] drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

42 C.F.R. §§ 482.13(e)(1)(i)(A)-(B) (2007).

2. Federal regulations that apply to Medicare-participating hospitals define seclusion as the “involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.” 42 C.F.R. § 482.13(e)(1)(ii).

3. See, e.g., John Julian Allen, *Seclusion and Restraint of Children: A Literature Review*, 13 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 159, 159 (2000) (“There is widespread concern and ethical debate about the use of these controversial, untested, and questionably effective interventions”); Nancy

health care providers used movement restrictions and solitary confinement to manage psychiatric patients.⁴ Superintendents of eighteenth and early nineteenth century insane asylums and other institutions of confinement believed that strait-waistcoats, “tranquilizer chairs,” “maniac beds,” chains, shackles, and “quiet rooms” deescalated agitation and promoted self-control.⁵ Reforms beginning in the nineteenth century helped make some psychiatric institutions more

S. Cotton, *The Developmental-Clinical Rationale for the Use of Seclusion in the Psychiatric Treatment of Children*, 59 AM. J. ORTHOPSYCHIATRY 442, 442 (1989) (“Ethically, [seclusion] seems to run counter to our humanistic intuitions about . . . proper treatment Legally, it poses a serious challenge to the most basic tenets of our system, focused as it is on the protection of rights and freedom. If the practice of seclusion is to be justified, one would expect that justification to come from clinicians, those who prescribe its implementation. Yet even in this realm many are troubled; the practice of seclusion in our profession of seclusion seems to be an anomaly in our profession of care and protection.”); J. Carole Taxis, *Ethics and Praxis: Alternative Strategies to Physical Restraint and Seclusion in a Psychiatric Setting*, 23 ISSUES IN MENTAL HEALTH NURSING 157, 158 (2002) (“An ethical quagmire often arises when the nurse, faced with a decision to seclude or restrain a patient, must balance factors of autonomy, beneficence, and nonmaleficence with therapeutic goals.” (citing ELISE BANDMAN & BERTRAM BANDMAN, *NURSING ETHICS THROUGH THE LIFE SPAN* (4th ed. 2001); TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5th ed. 2001))).

4. See, e.g., David Macbride, *A Methodical Introduction to the Theory and Practice of Physick*, in *THREE HUNDRED YEARS OF PSYCHIATRY, 1535-1860: A HISTORY PRESENTED IN SELECTED ENGLISH TEXTS* 449, 449-50 fig. 90 (Richard Hunter & Ida Macalpine eds., 1963) [hereinafter *THREE HUNDRED YEARS*] (illustrating the straight-waistcoats and “maniac beds” used to restrain patients in eighteenth-century England).

5. John Haslam, *Observations on Madness and Melancholy*, in *THREE HUNDRED YEARS*, *supra* note 4, at 633, 635 (“In the most violent state of the disease, the patient should be kept alone in a dark and quiet room so that he may not be affected by the stimuli of light or sound, such abstraction more readily disposing to sleep.”); Macbride, *supra* note 4, at 449-50; Benjamin Rush, *Medical Inquiries and Observations, Upon the Diseases of the Mind*, in *THREE HUNDRED YEARS*, *supra* note 4, at 662, 668, 671 (illustrating Rush’s “tranquilizer” chair); Thomas Willis, *Two Discourses Concerning the Soul of Brutes Which Is That of the Vital and Sensitive of Man*, in *THREE HUNDRED YEARS*, *supra* note 4, at 188, 191 (“For by this means, the Corporeal Soul being in some measure depressed and restrained, is compell’d to remit its pride and fierceness; and so afterwards by degrees grows more mild, and returns in order: Wherefore, Furious Mad-men are sooner, and more certainly cured by punishments, and hard usage, in a strait room, than by Physick or Medicines.”). See generally Nancy Tomes, *The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the Nineteenth Century*, in 3 *THE ANATOMY OF MADNESS: ESSAYS IN THE HISTORY OF PSYCHIATRY* 190, 202-03 (Roy Porter et al. eds., 1988) (discussing the early American belief in the therapeutic use of restraints).

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humane, in part because staff members were trained to find ways to calm potentially violent patients without imposing holds or isolation.⁶ With the advent of Freud's psychoanalysis, advances in microbiology in the late nineteenth and early twentieth centuries, as well as the explosion of psychotropic drugs in the latter half of the twentieth century, many traditional uses of restraint and seclusion became unnecessary.⁷ Federal and state legislatures and administrative agencies responded to these philosophical, scientific, and medical developments by restricting restraint and seclusion to emergency situations and forbidding their imposition as a means of coercion, discipline, or convenience.⁸

Although restraint and seclusion are used less frequently in the twenty-first century, they persist as methods of behavior management.⁹ A number of recent injuries and deaths associated with these interventions have refueled the

6. Cece Lentini, *Fight Against Restraints Goes to Capitol Hill*, KEY, Spring 1999, at 1, 8 ("To be sure, reforms that began in the 19th century have helped make psychiatric institutions much more humane than they once were. With appropriate training, staff members often can find ways to deescalate a potentially violent situation without using restraints at all."); Philippe Pinel, *A Treatise on Insanity*, in THREE HUNDRED YEARS, *supra* note 4, at 602, 606 (examining mid-nineteenth century efforts to abandon coercive and repressive measures in insane asylums).

7. See generally FRANZ G. ALEXANDER & SHELDON T. SELESNICK, THE HISTORY OF PSYCHIATRY: AN EVALUATION OF PSYCHIATRIC THOUGHT AND PRACTICE FROM PREHISTORIC TIMES TO THE PRESENT 181-210, 271-96 (1966) (examining the impact of Freud, microbiology, and psychopharmacology on psychiatry).

8. See *infra* Parts IV.B-C.

9. See, e.g., Cal. Dep't of Mental Health, Seclusion and Restraint Data: State Hospitals and Psychiatric Programs (Jan. 2007), <http://www.dmh.cahwnet.gov/Statehospitals/S&R/default.asp> (follow "S/R Data" hyperlink; then follow "Number of Seclusion Episodes" and "Number of Restraint Episodes" hyperlinks in "(Click on Image to Open Report)" column of "Seclusion and Restraints Data Charts" table) (documenting the occurrence of 1546 restraint episodes and 541 seclusion episodes in California state mental hospitals and correctional facility psychiatric programs between January and March 2006); G. Kullgren et al., *Practices and Attitudes Among Swedish Psychiatrists Regarding the Ethics of Compulsory Treatment*, 16 MED. & L. 499, 501-04 (1997) (examining the extent to which psychiatrists recommend compulsory interventions, including restraint and seclusion, in various clinical situations; finding that sixty-one percent of the respondents order restraint in cases of threatening and violent paranoid psychosis and that seventy-six percent of the respondents believed that physically restraining out-of-control patients is ethical).

dialogue regarding their appropriate use, bringing centuries-old questions to the fore.¹⁰ Some stakeholders, who believe that the use of restraint and seclusion are evidence of patient warehousing, institutional abuse and neglect, and human rights violations, support legislation that would further reduce restraint and seclusion use or eliminate it altogether.¹¹ Other stakeholders, who believe that restraint and seclusion can be used to prevent violent or assaultive patients from harming themselves and others, are questioning the scientific basis, cost, and feasibility of restraint-and-seclusion-free initiatives.¹² In recent legislative sessions, federal and state

10. See, e.g., Walter Goodman, *Restraint as a Euphemism in Psychiatric Hospitals*, N.Y. TIMES, Apr. 21, 1999, at E8 (reviewing a *60 Minutes II* segment that covered the story of a sixteen-year-old boy who was asphyxiated by a towel while he was being “therapeutically restrained” at a for-profit psychiatric hospital); *Hospital and Employees Cited in Death of Child*, N.Y. TIMES, May 8, 1998, at B5 (reporting the death of an eleven-year-old boy who suffocated while being restrained at a Connecticut psychiatric facility); JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., THE JOINT COMMISSION’S SENTINEL EVENT DATABASE: 10 YEARS OF DIGGING AT THE ROOTS 3 (2005) (identifying 124 deaths of restrained patients from data collected from 1995 to 2004); Tina Kelley, *Center for Disabled Children Agrees to Improve Medical Care*, N.Y. TIMES, July 7, 2005, at B2 (discussing the 2002 death of fourteen-year-old Matthew Goodman after he was restrained at a center for developmentally disabled children); Encarnacion Pyle, *Reformers Push to End Restraint, Seclusion; Death, Injuries Prompt Training of Workers in More Positive Methods*, COLUMBUS DISPATCH, Apr. 24, 2005, at A15 (reporting additional restraint and seclusion deaths); Heather Vogell, *Safer Restraints in Group Homes? Proposed Rules Would Ban Workers from Sitting on Children*, KATHI’S MENTAL HEALTH REV., Apr. 28, 2005, at <http://www.toddlertime.com/advocacy/hospitals/restraints/restraints-051405-2.htm> (reporting the deaths of a twelve-year-old girl and a nine-year-old boy after mental health care workers laid on the children to restrain them).

11. See, e.g., NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS., POSITION STATEMENT ON SECLUSION AND RESTRAINT (1999) [hereinafter POSITION STATEMENT] (“It is NASMHPD’s goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint”); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T HEALTH & HUMAN SERVS., A NATIONAL CALL TO ACTION: ELIMINATING THE USE OF SECLUSION AND RESTRAINT 5 (2003) [hereinafter NATIONAL CALL] (“It is now a priority for SAMHSA to . . . ultimately eliminate the use of seclusion and restraint. . . . Research shows that physical force, mobilization, and isolation are dehumanizing. Seclusion and restraint . . . risk lives and inflict emotional and physical trauma.”); Janice LeBel & Kevin Ann Huckshorn, *Elimination of Seclusion and Restraint: A Reasonable Goal?*, 57 PSYCHIATRIC SERVS. 576, 577 (2006) (“The assertion that seclusion and restraint can ultimately be eliminated . . . stands squarely on its own merits.”); cf. Akihito Suzuki, *The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum*, 39 MED. HIST. 1 (1995) (examining the non-restraint movement of Victorian psychiatry).

12. See, e.g., News Release, Am. Hosp. Ass’n, *Guiding Principles on*

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lawmakers have attempted to respond to these seemingly irreconcilable concerns.¹³ Many commentators believe that heightened awareness of inappropriate restraint and seclusion practices and more intense education and regulation will resolve these concerns.¹⁴ I argue instead that

Restraint and Seclusion for Behavioral Health Services, Feb. 29, 1999, at <http://www.naphs.org/news/guidingprinc.html> (arguing that “[r]estraint and seclusion, when used properly, can be life-saving and injury-sparing interventions,” and that overregulation of restraint and seclusion policies “could divert limited resources to bureaucratic activities” when such monies should be dedicated to clinical care); Andrés Martin et al., Letter to the Editor, *Seclusion and Restraint “One-Hour Rule,”* 43 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 1322, 1322 (2004) (stating that particular restraint and seclusion regulations “strain available human resources,” are “logistically burdensome,” and “may be of limited clinical utility”).

13. *Compare* Child and Adolescent Mental Health Resiliency Act of 2006, S. 3449, 109th Cong. § 110 (2006) (proposing the development and dissemination of educational materials that would encourage ending the use of restraint and seclusion in all facilities or programs that care for children and adolescents, as well as the training of mental health professionals and others on alternatives to restraint and seclusion), *and* 104 MASS. CODE REGS. 27.12(1) (2006) (requiring private, county, and municipal mental health facilities in Massachusetts to develop a plan to eliminate, wherever possible, the use of restraint and seclusion), *and* S.B. 325, 75th Leg., 2005 Tex. Gen. Laws 698 (requiring state administrative agencies to adopt rules defining acceptable restraint holds, governing the use of seclusion, and developing methods for lowering the frequency of restraint and seclusion practices), *with* 70 Fed. Reg. 67,093, 67,093 (Nov. 4, 2005) (clarifying that any authorized licensed health care professional may order the use of restraint and seclusion when necessary), *and* A. 9986, 2006 Leg. Sess. (N.Y. 2006) (proposing that New York physician assistants and nurse practitioners be permitted to order restraint), *and* S. 683, 2005 Leg., 116th Sess. (S.C. 2005-2006) (proposing that South Carolina licensed independent practitioners be permitted to order restraint).

14. *See, e.g.,* Joyce Jorgenson & Carol Geisler, *Education Is Key to System-Wide Change*, NETWORKS, Summer/Fall 2002, at 9, 9 (“Education . . . is a cornerstone to changing the cultural environment that tolerates the practice of restraints and seclusion.”); NAT’L ASS’N OF PSYCHIATRIC HEALTH SYS., GUIDING PRINCIPLES ON RESTRAINT AND SECLUSION FOR BEHAVIORAL HEALTH SERVICES 1 (1999) (recommending the sharing of guidelines and information on inappropriate restraint and seclusion techniques); Eric M. Weiss, *Hundreds of the Nation’s Most Vulnerable Have Been Killed by the System Intended to Care for Them*, HARTFORD COURANT (Conn.), Oct. 11, 1998, at A1, *available at* http://www.pcma.com/crisis_intervention_news/deadly_restraint/day1.stm (part of the newspaper’s five-part investigative series “Deadly Restraint: A Nationwide Pattern of Death,” published October 11-15, 1998) (“Yet the great tragedy is that many of the deaths could have been prevented by setting standards that are neither costly nor difficult: better training in restraint use; constant or frequent monitoring of patients in restraints; the banning of dangerous techniques such as face-down floor holds; CPR training for all direct-care workers.”).

the psychiatric¹⁵ restraint and seclusion controversy¹⁶ resists legislative solution because it is a function of more fundamental problems relating to mental health care access and finance. The controversy persists because of these practical problems, and because the use of restraint and seclusion implicate seemingly competing goals of patient safety and individual autonomy and, more broadly, the philosophical doctrines of legalism and medicalism.

Future restraint and seclusion policy must continue to address the significant dangers associated with these interventions by requiring the use of alternative de-escalation strategies, less restrictive measures consistent with patient and ward safety, and advanced monitoring of restrained and secluded patients. Our health care policy also must address the root causes of restraint and seclusion use. By providing earlier intervention and care for individuals with mental illness, we can reduce the incidence of violent and aggressive behavior that traditionally precedes restraint and seclusion. We also must recognize the liberty interferences and psychological injuries that are associated with the use of restraint and seclusion and should incorporate within each restrained or secluded patient's plan of care measures to respond to such interferences and injuries.

This article proceeds as follows. Part II provides an abbreviated American history of care for mental illness and a contextual framework for understanding current restraint and seclusion use. Part II places today's restraint and seclusion controversy in its proper historical context. Part III

15. This Article examines the use of restraint and seclusion in the psychiatric context. Outside the scope of this Article is the use of restraint and seclusion with other populations, including individuals with intellectual and developmental disabilities and individuals that require acute-level medical and surgical care.

16. Historians, clinicians, policymakers, and others refer to recurring questions regarding the appropriateness of restraint and seclusion use as the "restraint controversy." See, e.g., Joseph K. Mullen, *The Physical Restraint Controversy*, 9 RECLAIMING CHILD. & YOUTH 92, 92 (2000); Tomes, *supra* note 5 (examining "The Great Restraint Controversy"); Dave Ziegler, *Is There a Therapeutic Value to Physical Restraint?*, CHILD. VOICE, July/Aug. 2004, available at <http://www.cwla.org/articles/cv0407myturn.htm> ("This exposé of injuries and deaths reported caused by the use of restraint and seclusion is often credited with starting the current wave of criticism of restraint and seclusion. The controversy has run the gambit from media coverage to policy change and new federal legislation.").

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carefully examines the scientific literature supporting and opposing the use of psychiatric restraint and seclusion. This section compares late twentieth century studies that conclude that restraint and seclusion have a wide range of accepted and appropriate uses to recent “survivor” studies and sentinel event data, which link these interventions to increased patient agitation, injury, and death. By providing a balanced review of the relevant medical literature and available data, Part III attempts to dispose of one-sided arguments about restraint and seclusion and encourages a more complete dialogue regarding the criteria (if any) that justify their use.

Part IV examines federal and state efforts to regulate the use of restraint and seclusion in the psychiatric context. This section shows how lawmakers struggle to establish appropriate restraint and seclusion boundaries hundreds of years after the introduction of these interventions as methods of behavior management.

Part V places the restraint and seclusion controversy within the broader context of the mental health care system. Americans generally do not have a constitutional, statutory, or common law right to voluntary, non-emergency mental health care and available care is under-funded.¹⁷ The lack of access to, and funding for, basic mental health care contributes to emergency, inpatient, and acute mental health care, contexts in which restraint and seclusion are used more frequently.¹⁸ Although federal and state laws prohibit the use of restraint and seclusion as a substitute for adequate staffing, these mandates are unfunded.¹⁹ While the current restraint and seclusion discourse correctly considers the interventions’ significant risks and liberty interferences, it fails to give proper weight to their role in preventing violence and patient self-injury in psychiatric emergencies that result from unstabilized psychiatric conditions and a lack of access to mental health care, not a lack of training regarding alternative de-escalation strategies.

I thus recommend the following approach. In addition to requiring the use of alternative de-escalation strategies if the benefits of those strategies outweigh the physical and

17. See discussion *infra* Part V.A.

18. See discussion *infra* Part V.A.

19. See discussion *infra* Parts IV.B-C.

psychological risks posed by restraint and seclusion to the patient and third parties, my approach would: (1) address the root causes of the use of restraint and seclusion; (2) require health care providers who use restraint and seclusion to use the safest techniques and the most advanced methods of patient monitoring; and (3) require health care providers who use restraint and seclusion to acknowledge the liberty interferences and psychological injuries that result from these interventions and incorporate within each restrained or secluded patient's plan of care measures to respond to such interferences and injuries. I conclude that the current non-restraint movement has important and laudable goals; however, lawmakers need to consider a more complete dialogue regarding the root causes, implementation, and effects of these interventions before adopting blanket elimination policies.

II. CARE FOR MENTAL ILLNESS: A BRIEF AMERICAN HISTORY

Mental illness posed few significant problems for American communities before 1800.²⁰ One theory is that the settlers of the English colonies did not encourage individuals with mental illness to join them on the Atlantic passage.²¹ A second theory relates to demographics. The colonist population was relatively scattered, and no urban area had more than 50,000 residents, and only two areas had 25,000 or more residents as late as 1790.²² The number of mentally ill colonists was correspondingly small.²³ A study of the frequency of mental abnormality, including insanity, in the official records of the British American and Caribbean colonies from 1607 to 1700 identified eighty-two cases of mental abnormality among a total population of approximately 300,000.²⁴ The study concluded that mental illness was not widespread in the early colonies.²⁵

20. Gerald N. Grob, *The Severely and Chronically Mentally Ill in America: Retrospect and Prospect*, in *SICKNESS & HEALTH IN AMERICA: READINGS IN THE HISTORY OF MEDICINE AND PUBLIC HEALTH* 334, 335 (Judith Walzer Leavitt & Ronald L. Numbers eds., 3rd rev. ed., 1997).

21. E. FULLER TORREY & JUDY MILLER, *THE INVISIBLE PLAGUE: THE RISE OF MENTAL ILLNESS FROM 1750 TO THE PRESENT* 193 (2001).

22. Grob, *supra* note 20, at 335.

23. *Id.*

24. TORREY & MILLER, *supra* note 21, at 194.

25. *Id.*

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Until the late nineteenth century, the only recognized form of mental illness was “insanity,” loosely defined as a condition in which an individual is “unable to function in society because of delusions, hallucinations, incoherent speech, paranoia, depression, or withdrawal from social relationships.”²⁶ The colonists believed that the cause of insanity rested with God and could not be eliminated.²⁷ The result was that the biological and social sources of insanity received little attention during the colonial period.²⁸ Non-institutional methods for responding to insanity seemed appropriate, and the colonists generally left the insane in the care of their families and supported them, in case of need, as one of the poor.²⁹ Poorhouses, almshouses, and even prisons provided institutional support when necessary.³⁰

Family, poorhouse, and almshouse support gave way to hospitals and insane asylums in the late eighteenth century.³¹ The first American’ hospitals, the Pennsylvania Hospital (1751) and the New York Hospital (1791), had as a primary goal the care of the insane.³² At first, the Pennsylvania Hospital provided care to the insane in the basement of its main building.³³ In 1841, the hospital opened a new building

26. William G. Rothstein, *A Historical Analysis of the Treatment of the Mentally Ill*, in READINGS IN AMERICAN HEALTH CARE: CURRENT ISSUES IN SOCIO-HISTORICAL PERSPECTIVE 281, 281 (William G. Rothstein ed., 1995).

27. DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* 109 (1971).

28. *Id.*

29. Grob, *supra* note 20, at 335; ROTHMAN, *supra* note 27, at xiii; EDWARD SHORTER, *A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC* 49 (1997); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 72 (1949); TORREY & MILLER, *supra* note 21, at 194.

30. ROTHMAN, *supra* note 27, at xiii-xix.

31. Andrew Scull, *The Discovery of the Asylum Revisited: Lunacy Reform in the New American Republic*, in MADHOUSES, MAD-DOCTORS, AND MADMEN: THE SOCIAL HISTORY OF PSYCHIATRY IN THE VICTORIAN ERA 144, 145 (Andrew Scull ed., 1981) [hereinafter MADHOUSES]. *But see* MENTAL HYGIENE TASK FORCE, N.Y. STATE ASSEMBLY, *AN EVALUATION OF THE DELIVERY OF MENTAL HYGIENE SERVICES IN NEW YORK STATE* 8 (2005), *available at* <http://www.assembly.state.ny.us/comm/Mental/20050303/> (noting that New York State permitted the confinement of individuals with mental illness in jails and poorhouses until the late nineteenth century).

32. CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA’S HOSPITAL SYSTEM* 33 (1987); Morris J. Vogel, *The Transformation of the American Hospital*, in INSTITUTIONS OF CONFINEMENT: HOSPITALS, ASYLUMS, AND PRISONS IN WESTERN EUROPE AND NORTH AMERICA, 1500-1950, at 39, 41 (Norbert Finzsch & Robert Jutte eds., 1996).

33. Scull, *supra* note 31, at 145.

that was designed exclusively for the care of the insane.³⁴ The New York Hospital housed its “maniacs” first in the basement and then in a new third story³⁵ until 1808, when a separate building for the insane was constructed on the hospital’s grounds.³⁶ This separate building, which later moved to a different part of the city, became known as the Bloomington Asylum.³⁷

The first American hospital devoted exclusively to the care and cure of the insane opened in Williamsburg, Virginia, in 1773.³⁸ Williamsburg’s “Public Hospital for Persons of Insane and Disordered Minds”³⁹ was the only facility of its kind until 1824, when the state of Kentucky established its Eastern Lunatic Asylum.⁴⁰ By 1861, forty-eight asylums had been established in the United States, including thirty-two public asylums in twenty-five states, one federal asylum for the District of Columbia, and fifteen small private asylums devoted to paying patients.⁴¹ By 1880, approximately eighty public institutions for the mentally ill existed in the United States.⁴² By 1920, approximately 521 mental hospitals had been established.⁴³ Known as the “age of the asylum,” some historians interpret this period as one of medical reform.⁴⁴ Others believe that mental illness was socially, and not just medically, constructed,⁴⁵ and that the insane asylum was an attempt to restore a necessary social balance to the new

34. ROSENBERG, *supra* note 32, at 33.

35. Scull, *supra* note 31, at 146.

36. ROSENBERG, *supra* note 32, at 33-34.

37. *Id.* at 34.

38. SHORTER, *supra* note 29, at 45.

39. Colonial Williamsburg, Public Hospital, <http://www.history.org/Almanack/places/hb/hbhos.cfm> (last visited Feb. 25, 2007).

40. EDWARD B. BEIS, MENTAL HEALTH AND THE LAW 4 (1984).

41. Rothstein, *supra* note 26, at 282; *see also* Grob, *supra* note 20, at 335 (“[B]y the Civil War, almost every state had established one or more public institutions for [the mentally ill].”).

42. BARBARA SICHERMAN, THE QUEST FOR MENTAL HEALTH IN AMERICA: 1880-1917, at 13-14 (1980).

43. STARR, *supra* note 29, at 169.

44. ROTHMAN, *supra* note 27, at xiv (coining the period “age of the asylum”); *see also* Clive Unsworth, *Law and Lunacy in Psychiatry’s ‘Golden Age,’* 13 OXFORD J. LEGAL STUDS. 479, 481 (1993) (“With the arrival of the carceral era, . . . [a] new system combined an extensive network of lunatic asylums, public and private, in which patients were legally detained . . .”).

45. ROTHMAN, *supra* note 27, at xv.

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republic.⁴⁶

A. *Physical Care*

At the time of the opening of the Williamsburg facility, mental illness was considered a disease of the brain and the nervous system, and individuals who were mentally ill were treated as though they chose to be irrational.⁴⁷ Treatments were primarily physical and medical, and consisted of seclusion, mechanical and medicinal restraints, plunge baths and other “shock” water treatments, bleeding, and blistering salves.⁴⁸ By modern standards these treatments undoubtedly seem cruel. But at a time when the mysteries of schizophrenia, bipolar disorder, depression, anxiety, and agitation had yet to be unlocked, these treatments were considered humane. Seclusion, or the solitary confinement of individuals in “quiet rooms,” was believed to be particularly effective in calming severely agitated individuals.⁴⁹ In 1799, two dungeon-like cells were dug under the first floor of the Williamsburg facility.⁵⁰ Patients who experienced “state[s] of raving phrenzy”⁵¹ were involuntarily maintained in the dark and gloomy⁵² cells for hours, days,⁵³ months,⁵⁴ years⁵⁵ and, sometimes, on a permanent basis.⁵⁶

46. *Id.* at xviii.

47. Colonial Williamsburg, *supra* note 39.

48. *Id.*

49. See Cotton, *supra* note 3, at 443-44 (discussing the use of quiet rooms).

50. Colonial Williamsburg, *supra* note 39.

51. *Id.*

52. ROBERT WALN, JR., AN ACCOUNT OF THE ASYLUM FOR THE INSANE 3, 6 (Phila., Benjamin & Thomas Kite, 1825), available at http://www.ncbi.nlm.nih.gov/books/bookres.fcgi/history/pdf_waln.pdf (describing the dark and gloomy solitary confinement chambers at Philadelphia’s Friends Asylum in 1825).

53. See GAO REPORT, *supra* note 1, at 8 (reporting the seclusion of a Missouri man for thirty days in 1999).

54. WALN, *supra* note 52, at 23-24 (reporting the eighteen-month seclusion of a patient at Philadelphia’s Friends Asylum in the first quarter of the nineteenth century).

55. Elizabeth Stawicki, *A Haunting Legacy: Canton Insane Asylum for American Indians* (Minnesota Public Radio broadcast Dec. 9, 1997) (audio and transcript available at http://news.minnesota.publicradio.org/features/199712/09_stawickie_asylum/) (reporting the three-year seclusion of a patient at South Dakota’s Canton Insane Asylum).

56. WALN, *supra* note 52, at 24 (reporting the “permanent” seclusion of a Friends Asylum patient).

Mechanical restraints, including straitjackets, muffs, leg-locks, handcuffs, and “coercion chairs,” were also popular.⁵⁷ These mechanisms were believed to help agitated patients regain their self-control.⁵⁸ Straitjackets (cloth or canvas coats that crossed patients’ hands or arms in front of their bodies and secured them to the opposite sides) were believed to be particularly humane, and far gentler than the shackles and chains used in prisons.⁵⁹ Straitjackets applied no weighted pressure to the arms or body, caused fewer skin abrasions, and allowed some form of movement.⁶⁰

Benjamin Rush, the father of American psychiatry, developed in 1811 his famous “tranquilizer chair,” considered by some to be the most complete human restraint ever devised.⁶¹ The tranquilizer chair featured a wooden chair with an adjustable backboard.⁶² At the top of the backboard was a wooden box lined with stuffed linen that secured the patient’s head and prevented it from moving from side to side.⁶³ Chest, belly, arm, and hand bands, made of flat pieces of strong leather, limited movement, and wood ankle bracelets confined the feet.⁶⁴ To the underside of the chair was fastened a half water-filled stool pan that could be emptied and replaced without disturbing the patient. The legs of the chair were fastened to the floor.⁶⁵ Some patients reportedly were strapped to tranquilizer chairs for as long as six months.⁶⁶

B. Moral Treatment

Less physical methods of treating insanity grew in popularity after the American Revolution, in part because of the influential writings of Philippe Pinel in France and

57. See JOHN CONOLLY, *THE TREATMENT OF THE INSANE WITHOUT MECHANICAL RESTRAINTS* (Arno Press 1973) (1866).

58. Kansas State Historical Society, Straitjacket, <http://www.kshs.org/cool3/straitjacket.htm> (last visited Feb. 25, 2007).

59. *Id.*

60. *Id.*

61. Rush, *supra* note 5, at 671, fig.134.

62. *Id.* at 671.

63. *Id.*

64. *Id.*

65. *Id.*

66. See *Legends of Am.*, Glore Psychiatric Museum in St. Joseph, MO, <http://www.legendsofamerica.com/MO-PsychiatricMuseum2.html> (last visited Feb. 25, 2007).

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Samuel Tuke in England.⁶⁷ Pinel and Tuke insisted that kind and gentle treatment, known as “moral treatment,” could cure insanity.⁶⁸ Moral treatment was based on the idea that a beautiful location and an appropriate social and physical environment could have curative powers.⁶⁹ American insane asylums in the mid-nineteenth century adopted the philosophy of moral treatment and emphasized kindness over coercion.⁷⁰ The daily routine of patients treated in accordance with this philosophy included occupational therapy, religious exercises, “amusements,” “games,”⁷¹ and plenty of rest in cells furnished with beds and other comforts.⁷² T. Romeyn Beck, a New York physician, explained the trend towards moral treatment: “Coercion by blows, stripes and chains, although sanctioned by the authority of Celsus and Cullen, is now justly laid aside”⁷³

Consistent with the philosophy of moral treatment, in 1851 the Association of Medical Superintendents of American Institutions for the Insane (AMSII), the predecessor of the American Psychiatric Association, adopted twenty-six standards (Standards) relating to the location and construction of asylums.⁷⁴ The Standards required insane asylums to be “located in the country, not within less than two miles of a large town, and easily accessible at all

67. Robert Gardiner Hill, *A Lecture on the Management of Lunatic Asylums, and the Treatment of the Insane*, in *THREE HUNDRED YEARS*, *supra* note 4, at 886, 887. See generally Pinel, *supra* note 6, at 602-13 (discussing the pioneering work of Pinel); Samuel Tuke, *The Retreat: An Institution in New York*, in *THREE HUNDRED YEARS*, *supra* note 4, at 684, 684-90 (discussing the work of Tuke).

68. ROTHMAN, *supra* note 27, at 109-10; Rothstein, *supra* note 26, at 281.

69. See, e.g., SICHERMAN, *supra* note 42, at 15; Grob, *supra* note 20, at 336 (“There were to be no threats of physical violence; and only rarely were mechanical means of restraint to be employed.”); Note, *Liability of Mental Hospitals for Acts of Their Patients Under the Open Door Policy*, 57 VA. L. REV. 156, 158 (1971) (discussing the tolerating and accepting attitudes that characterized the moral treatment philosophy); Rothstein, *supra* note 26, at 281-82 (“Moral treatment consisted of a morally and religiously uplifting environment and care by compassionate attendants who treated the patients with persuasion and sympathy rather than coercion, although restraint was employed when necessary.”).

70. See, e.g., SICHERMAN, *supra* note 42, at 15.

71. Grob, *supra* note 20, at 336.

72. Colonial Williamsburg, *supra* note 39.

73. ALEX BEAM, *GRACEFULLY INSANE: THE RISE AND FALL OF AMERICA'S PREMIER MENTAL HOSPITAL* 11 (2001).

74. SARAH C. SITTON, *LIFE AT THE TEXAS STATE LUNATIC ASYLUM: 1857-1997*, at 11 (1999).

seasons.”⁷⁵ The Standards also required insane asylums to devote not less than fifty acres to pleasure gardens for use by patients.⁷⁶ The stated reasons for the geographic and garden requirements were to remove patients from the stress of urban living while ensuring, through proximity to town, ease of provisioning and access for visitors.⁷⁷ Three years after AMSAII adopted these Standards, Dr. Thomas Kirkbride, superintendent of the prestigious Pennsylvania Hospital for the Insane, published his famous linear plan for the construction of insane asylums.⁷⁸ The plan, which featured a central structure with wings on the side, was believed to contribute to the restoration of sanity.⁷⁹

C. Custodial Care

The successive philosophies of physical treatment and moral treatment eventually gave way to custodial care.⁸⁰ After the middle of the nineteenth century, the asylum superintendents’ administrative duties overwhelmed their medical duties.⁸¹ As a result, custodial care, also called patient warehousing, became commonplace.⁸² The asylums lacked adequate staff to provide treatment, and asylum attendants were not properly trained to work with

75. *Id.* at 12.

76. *Id.*

77. *Id.*

78. ROTHMAN, *supra* note 27, at 134; SITTON, *supra* note 75, at 4; Kenneth D. Gaver, *Mental Illness and Mental Retardation: The History of State Care in Texas*, IMPACT, July/Aug. 1975, at 5. Although Kirkbride and his followers believed that the structure of the asylum contributed to mental health, others believe that the imposing structure of the asylum was needed to convince the public of the importance of the emerging specialty of psychiatry. See, e.g., Nancy J. Tomes, *A Generous Confidence: Thomas Story Kirkbride’s Philosophy of Asylum Construction and Management*, in MADHOUSES, *supra* note 31, at 121, 123 (“In the campaign to promote the asylum and the medical specialty associated with it, asylum construction and management played a key role. The hospital’s unique appearance and regimen offered proof to the families of the afflicted that these doctors were making use of a radical new treatment for a dreaded ailment. In distinguishing themselves from competitors, the asylum was by far the most impressive item in the superintendents’ therapeutic armamentarium. The mental hospital served as their professional showcase, their most effective public advertisement.”).

79. SITTON, *supra* note 75, at 4.

80. Rothstein, *supra* note 26, at 282.

81. *Id.* at 283.

82. *Id.*

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individuals who suffered from mental illness.⁸³ Restraints, which were supposed to be used only occasionally under the philosophy of moral treatment, were used more frequently to maintain order.⁸⁴ Some patients remained in restraints for days.⁸⁵

A belated example of patient warehousing involved Osawatomie State Hospital, which was established in Kansas in 1866. Osawatomie State Hospital had twelve beds at the time of its opening.⁸⁶ By the end of 1867, the Hospital had twenty-two patients with fifty more desiring admission.⁸⁷ A ratio of one physician per 845 patients had developed by 1945.⁸⁸ To manage the large patient body, attendants resorted to the use of force with male patients, and straitjackets and wrist-cuffs with female patients.⁸⁹ In 1950, the *Kansas City Star* published a series of articles on the conditions at Osawatomie and other state hospitals. According to these reports, up to one-half of the Osawatomie patient population was straitjacketed at any given time.⁹⁰ Documentation shows that Osawatomie State Hospital continued to straitjacket its patients until at least 1956.⁹¹

D. *Community Care*

By the late nineteenth century, the majority view was that insane asylums did not cure mental illness.⁹² Pliny Earle, psychiatrist and co-founder of the American Medical Association, documented his belief as early as 1887 that asylum superintendents had greatly exaggerated their earlier recovery rates, thus contributing to the cult of curability.⁹³ This changing perspective resulted in a reexamination of the methods of treating mental illness.⁹⁴ In 1880, one group of

83. Kansas State Historical Society, *supra* note 58.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*

89. Kansas State Historical Society, *supra* note 58.

90. *Id.*

91. *Id.*

92. SICHERMAN, *supra* note 42, at 12.

93. PLINY EARLE, *THE CURABILITY OF INSANITY* 22 (Arno Press Inc. 1972) (1887).

94. SICHERMAN, *supra* note 42, at 12.

psychiatrists, neurologists, and lay individuals who believed that the then-current system of providing mental health care was deficient organized the National Association for the Protection of the Insane and the Prevention of Insanity (NAPIPI).⁹⁵ The primary purpose of NAPIPI was to improve conditions within insane asylums and to reverse the growing trend of insanity through preventive treatment.⁹⁶

At the turn of the century, insane asylums began to lose their centrality and identity as the best means of treating insanity.⁹⁷ As America became more industrialized, new outpatient centers began to replace the asylum as a means for dealing with mental health conditions.⁹⁸ At the same time, the concept of mental illness began to expand due, in part, to World War I and the mental hygiene movement.⁹⁹ World War I transformed views of mental illness from a “vague abstraction into a meaningful illness” as soldiers suffered from “shell shock” and “war neurosis.”¹⁰⁰ In addition, the science of promoting mental health and preventing mental illness through the application of psychiatry and psychology emerged in part as a result of Clifford W. Beers’s 1908 autobiography, *A Mind That Found Itself*, which described his experiences in institutions for the insane.¹⁰¹ Using the phrase “mental hygiene” to describe his ideas,¹⁰² Beers founded the Connecticut Society for Mental Hygiene (1908) and the National Committee for Mental Hygiene (1909).¹⁰³ The goals of both groups were to improve the quality of care for the mentally ill, to prevent mental illness when possible, and to ensure the availability of accurate information relating to mental health.¹⁰⁴

By the 1940s, few individuals believed that the

95. *Id.*

96. *Id.* at 12-13.

97. See ROTHMAN, *supra* note 27, at xvi-xvii (stating that “new methods replaced the asylum for dealing with social problems”).

98. *Id.*

99. Rothstein, *supra* note 26, at 284-85.

100. *Id.*

101. See generally MIRIAM SIEGLER & HUMPHRY OSMOND, MODELS OF MADNESS, MODELS OF MEDICINE 147 (1974) (discussing Beers’ contributions to the community mental health movement).

102. *Id.*

103. See Clifford Beers Found. Home Page, <http://www.cliffordbeersfoundation.co.uk/> (last visited Mar. 21, 2007).

104. Rothstein, *supra* note 26, at 284-85.

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structured environment of the asylum could cure mental illness.¹⁰⁵ Some individuals even doubted the custodial benefit of the asylum.¹⁰⁶ The national census of mental hospitals declined from a peak of 634,000 in 1954 to 579,000 in 1963.¹⁰⁷ One prominent, though contested, explanation for the census drop was the discovery of psychopharmacology,¹⁰⁸ including medicinal tranquilizers, neuroleptics, and antidepressants. Under this theory, “patients who were previously hospitalized ‘could now be safely treated, or at least more safely ignored,’ on an outpatient basis.”¹⁰⁹ Another explanation for the decline in number of mental hospitals lies in Congress’ 1965 amendments to the Social Security Act, which provided greater aid to states to support aged individuals in nursing homes.¹¹⁰ By transferring patients from mental hospitals to nursing homes, states could obtain more reimbursement from the federal government.¹¹¹ A final explanation was provided by the new “community psychiatry” advocates, who argued that “state hospitals reinforced disability and isolation, [but that] local services and halfway houses could help return the mentally ill to normal roles in society.”¹¹²

By the mid-1900’s, a combination of forces likely caused the “near emptying” of state mental hospitals.¹¹³ Many asylum patients were discharged and individuals who would have been admitted to an asylum in the past were referred to community centers.¹¹⁴ The initial trends in American mental health care (physical, moral, and custodial) gave way to the current philosophy of community mental health care.¹¹⁵ With

105. SITTON, *supra* note 75, at 132.

106. *Id.*

107. STARR, *supra* note 29, at 365.

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. SITTON, *supra* note 75, at 7.

114. *Id.*

115. *Cf.* Unsworth, *supra* note 44, at 479 (dividing the history of the provision for individuals with mental disorders into three eras: (1) pre-carceral—“before the mass consignment of the mentally disordered to specialized institutions had taken place”; (2) carceral—characterized by the powerful insane asylum; and (3) post-carceral—“encompassing the transformation in legal relations which has accompanied the attempt to close

the advent of deinstitutionalization¹¹⁶ and the growth of community support programs, fewer psychiatric patients are restrained or secluded for behavior management.¹¹⁷ Many believe, however, that the “deinstitutionalization of individuals with less serious illness has resulted in an inpatient population with more severe mental illness.”¹¹⁸

III. THE CURRENT RESTRAINT AND SECLUSION CONTROVERSY

Although used less frequently in the twenty-first century, restraint and seclusion persist as methods of behavior management.¹¹⁹ Current methods of restraint include drugs, mechanical devices, and physical holding by another person.¹²⁰ Drugs fall within the definition of “restraints” when they are used “to manage the patient’s behavior or restrict the patient’s freedom of movement and [are] not a standard treatment for the patient’s condition.”¹²¹ They include sedatives (such as Ativan), antipsychotic drugs (such as Haldol), and other drugs usually given by injection that alter mood, mental status, or behavior.¹²² Mechanical devices used to restrain patients include two-point restraints (which immobilize an individual’s hands using a nylon, cotton, fur-lined, quilted, or leather cuff around each wrist),¹²³ four-point

the asylum and substitute non-institutional alternatives”).

116. See Meredith Karasch, Note, *Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: An Overview of California’s Mental Illness System*, 54 HASTINGS L.J. 493, 495 (2003) (discussing deinstitutionalization in the mid-twentieth century).

117. Lentini, *supra* note 6, at 8.

118. GAO REPORT, *supra* note 1, at 4; see also Steven S. Sharfstein, *Seclusion and Restraint*, 16 PSYCHIATRIC TIMES 1, 1 (1999) (“Deinstitutionalization of the mentally ill over the last 30 years has created a public health crisis across the country.”).

119. See generally Kim J. Masters, *Modernizing Seclusion and Restraint*, May 28, 2005, at 2 (noting the similarity between current and old methods of restraint and seclusion: “Very little fundamental change has occurred to restraint and seclusion devices and monitoring equipment since 1794, when Philippe Pinel developed humane practices for helping psychiatric patients manage episodes of violence.”).

120. GAO REPORT, *supra* note 1, at 1 n.l.

121. 42 C.F.R. § 482.13(e)(1)(i)(B) (2007).

122. Daniel Watson, *The Crazy Shift*, PSYCHOL. TODAY, Sept./Oct. 2000, at 68, 69, available at <http://psychologytoday.com/articles/pto-20000901-000037.html> (describing the chemical restraint of an emergent psychiatric patient using Ativan and Haldol).

123. See, e.g., EMS Medical Products, Posey Restraints, <http://www.emsmedicalproducts.com/b20.htm> (last visited Feb. 25, 2007)

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restraints (which immobilize a person on a bed or gurney with a cuff around each wrist and each ankle), and five-point restraints (which add an additional belt around the waist), as well as a variety of finger-control mitts, vests, jackets, body nets, and tightly-tucked sheet wraps.¹²⁴ Physical holds usually involve one or more staff members holding a patient's arms; or lying across, sitting across, or straddling a patient's body while the patient is in a prone (face-down), supine (face-up), or seated position.¹²⁵ Physical holds traditionally included "basket holds" (in which the patient's arms were crisscrossed over her chest and held from behind while the patient was eased to the ground) as well as a variety of other aptly-named holds.¹²⁶ Modern seclusion usually involves an involuntary confinement of an individual in a small room or a single bedroom.¹²⁷

A. Restraint and Seclusion Perspectives

Perspectives regarding psychiatric restraint and seclusion vary. One traditional position is that restraint and seclusion may be used to calm violent and assaultive patients, teach patients how to control themselves, and preserve the calm of the psychiatric ward. A second position is that restraint and seclusion carry significant physical and

(illustrating a variety of wrist and ankle cuffs).

124. See, e.g., Rehabmart Discount Medical Equipment, Restraints, <http://www.rehabmart.com/category/Restraints.htm> (last visited Feb. 25, 2007) (illustrating a variety of wrist and ankle cuffs, belts, finger-control mitts, vests, jackets, and body nets).

125. Letter from Wan J. Kim, Assistant Attorney General, to the Honorable Rick Perry, Governor of Texas 23-26 (Dec. 11, 2006), available at http://www.usdoj.gov/crt/split/documents/lubbock_sch_findlet_12-11-06.pdf (describing incidents of physical restraint, including staff members lying on top of face-down and side-lying residents); David M. Day, A Review of the Literature on the Effectiveness of Physical Restraints in Children and Youth, at slide 9 (June 1-4, 2005), available at <http://rccp.cornell.edu/pdfs/dday.pdf> (describing the prone and supine holds).

126. See GAO REPORT, *supra* note 1, at 7 (describing the basket hold); Rhonda Bodfield, *CPS Finds 4 Cases of Abuse at Desert Hills in 5 Years*, ARIZ. DAILY STAR, Mar. 4, 1998, at 1A (describing a number of instances in which physical holds were used to control youths at an Arizona behavioral treatment facility); David Allen, Risk & Prone Restraint: Reviewing the Evidence, at <http://rccp.cornell.edu/pdfs/allen.pdf#search=%22physical%20holds%20used%20to%20restrain%20children%22> (last visited Feb. 25, 2007) (illustrating how asphyxia can occur during various physical holds).

127. Pyle, *supra* note 10.

psychological risks, although they may be used in some emergency situations. A third position is taken by some individuals who have survived incidences of restraint and seclusion, but not without physical or psychological injury. Called "survivor literature," these reports emphasize patients' unfavorable views of their restraint and seclusion experiences. A fourth position is that psychiatric restraint and seclusion are inherently dangerous and should be eliminated. Each of these positions is discussed in more detail below.

The first position is that restraint and seclusion have a wide range of accepted and appropriate uses, including calming violent and assaultive patients, teaching patients how to control themselves and preserving the psychiatric ward milieu.¹²⁸ Support for this traditional position is found in a number of scientific studies and medical journal articles published in the 1970s, 1980s, and early 1990s. For example, one study argued that seclusion does obtain desired behavioral results, including control of violence and reduction of anxiety.¹²⁹ Other studies emphasize that restraint and seclusion are necessary for sustaining the "smooth functioning" of the ward minisociety and can help agitated individuals calm themselves.¹³⁰ Another study justified the use of restraint and seclusion for patients who, without such interventions, may have engaged in deliberate self-injury.¹³¹ Yet another study firmly concluded that the use of restraint and seclusion offer therapeutic and control functions for patients and staff.¹³² A final illustrative study concluded

128. See, e.g., Renee L. Binder & Susan M. McCoy, *A Study of Patients' Attitudes Toward Placement in Seclusion*, 34 HOSP. & COMMUNITY PSYCHIATRY 1052, 1052 (1983) ("[S]eclusion is an accepted treatment modality on many psychiatric inpatient units . . ."); Cotton, *supra* note 3, at 442 (discussing at length the psychiatric benefits of seclusion); Harriet Wadson & William T. Carpenter, *Impact of the Seclusion Room Experience*, 163 J. NERVOUS & MENTAL DISEASE 318, 318 (1976) ("The seclusion room is an important, but ambivalently perceived aspect of psychiatric inpatient units.").

129. Wadson & Carpenter, *supra* note 129, at 318.

130. Donald S. Gair, *Limit-Setting and Seclusion in the Psychiatric Hospital*, 17 PSYCHIATRIC OPINION 15, 15 (1980); Robert H. Plutchik et al., *Toward a Rationale for the Seclusion Process*, 166 J. NERVOUS & MENTAL DISEASE 571, 571 (1978).

131. Kenneth Tardiff, *Emergency Control Measures for Psychiatric Inpatients*, 169 J. NERVOUS & MENTAL DISEASE 614, 618 (1981).

132. Paul H. Soloff & Samuel M. Turner, *Patterns of Seclusion: A Prospective*

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that seclusion is one intervention that “can be effective in treating . . . impulsive, relationship-resistant children who have been unable to learn internal control from other socialization interactions.”¹³³

A second perspective recognizes the value of restraint and seclusion in some emergency situations, but emphasizes the significant physical and psychological risks associated with these interventions. For example, the author of one review article found that it was “nearly impossible” to operate a program for severely symptomatic individuals without the use of some form of restraint or seclusion, and that restraint and seclusion are efficacious in preventing injury and reducing agitation.¹³⁴ The author also found, however, that restraint and seclusion can have substantial deleterious physical and (more often) psychological effects on both patients and staff.¹³⁵ The author of a second review article agreed that “[t]he clinical reality is that an acutely assaultive and violent patient risks his or her safety and that of other patients and staff.”¹³⁶ The author also found, however, that: (1) staff decision making regarding restraint and seclusion was inconsistent and that the gender, education level, and clinical experiences of the staff affected their ordering decisions; (2) “nonpharmacologic, programmatic changes can be implemented that diminish dramatically the use of restraint and seclusion in child/adolescent, and adult populations”; and (3) “when control of patient aggression is needed acutely, there are no data to guide clinical decisions as to which combination of [restraint and seclusion] . . . would be better in specific patient populations.”¹³⁷

A third perspective is found in the “survivor literature,” which collects patients’ unfavorable reports of their experiences with restraint and seclusion.¹³⁸ One study

Study, 169 J. NERVOUS & MENTAL DISEASE 37, 37 (1981).

133. David Fassler & Nancy Cotton, *A National Survey on the Use of Seclusion in the Psychiatric Treatment of Children*, 43 HOSP. & COMMUNITY PSYCHIATRY 370, 373 (1992).

134. William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 AM. J. PSYCHIATRY 1584, 1590 (1994).

135. *Id.* at 1584, 1590.

136. Alisa B. Busch & Miles F. Shore, *Seclusion and Restraint: A Review of Recent Literature*, 8 HARV. REV. PSYCHIATRY 261, 262 (2000).

137. *Id.* at 268.

138. See Patricia A. Amos, *New Considerations in the Prevention of Aversives*,

examining such literature found that “patients presented a universally negative view of the seclusion experience when reacting directly to the event,”¹³⁹ and concluded that greater care is required in the imposition of seclusion.¹⁴⁰ A second study found that patients retrospectively viewed their seclusion experiences as negative and anxiety-provoking.¹⁴¹ A third study found from patient descriptions that seclusion was a “painful experience associated with feelings of helplessness, fear, sadness, and anger.”¹⁴² A widely-cited study reporting the responses of 1040 former psychiatric patients regarding their experiences in inpatient psychiatric treatment facilities in New York State found that the vast majority of the respondents who had been restrained or secluded viewed the experience negatively.¹⁴³ Ninety-four percent of these respondents noted at least one complaint about their restraint and seclusion experience¹⁴⁴ and seventy-three percent of the respondents stated that they were not dangerous to themselves or others at the time they were restrained or secluded.¹⁴⁵ The New York patients also indicated that they: (1) did not know the reason for their restraint or seclusion; (2) felt that the interventions were humiliating, punishing, and depressing; and (3) thought that staff control of patients was a primary factor in the use of restraint and seclusion.¹⁴⁶ Patient narratives are prominent in the survivor literature:

I can't bring myself to describe the moment-by-moment struggles and shear gut-wrenching terror of being put into

Restraint, and Seclusion: Incorporating the Role of Relationships into an Ecological Perspective, 29 RESEARCH & PRACTICE FOR PERSONS WITH SEVERE DISABILITIES 263, 266 (2004).

139. Wadeson & Carpenter, *supra* note 129, at 327.

140. *Id.* at 328.

141. Binder & McCoy, *supra* note 129, at 1053. The study also found, however, that seclusion remains a necessary method of dealing with violent and agitated patients. *Id.*

142. Kathryn Hammill et al., *Hospitalized Schizophrenic Patient Views About Seclusion*, 50 J. CLINICAL PSYCHIATRY 174, 174 (1989) (finding that patients believed seclusion was “necessary” for the “control of disruptive aggressive patient behaviors”).

143. Nancy K. Ray et al., *Patient Perspectives on Restraint and Seclusion Experiences: A Survey of Former Patients of New York State Psychiatric Facilities*, 20 PSYCHIATRIC REHABILITATION J. 11, 11 (1996).

144. *Id.*

145. *Id.* at 14.

146. *See id.* at 15.

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five-point restraint. . . . I don't feel comfortable wearing watches any more and for a long time belts were out of the question. . . . The terror of confinement, the pain of the restraint, and the wound to my soul made me want to stay as far away from the mental health system as possible.¹⁴⁷

A final perspective is that restraint and seclusion should be prohibited in the psychiatric setting.¹⁴⁸ This position, which is supported by research showing that physical force, immobilization, and isolation are dehumanizing and that seclusion and restraint risk lives and significant emotional injury,¹⁴⁹ is discussed in more detail later in this article.¹⁵⁰

The reasons for these varying scientific opinions regarding restraint and seclusion also have been studied.¹⁵¹ One author suggests that scientific attitudes depend on the context in which the research was conducted.¹⁵² Authors who support the use of restraint and seclusion may conduct their research in public psychiatric facilities, while opponents of these interventions conduct their research in private or university hospitals.¹⁵³ A second pair of co-authors suggests that attitudes about the use of restraint and seclusion depend on the particular scientific inquiry.¹⁵⁴ Scientific inquiries into the efficaciousness of restraint and seclusion for preventing violence and aggression tend to support their use, whereas studies that examine the experience and opinions of patients who have been restrained and secluded tend to oppose their use.¹⁵⁵

147. William Pflueger, *Consumer View: Restraint Is Not Therapeutic*, NETWORKS, Summer/Fall 2002, at 7, 7, available at http://www.nasmhpd.org/general_files/publications/ntac_pubs/networks/SummerFall2002.pdf.

148. LeBel & Huckshorn, *supra* note 11, at 577.

149. NATIONAL CALL, *supra* note 11, at 5; POSITION STATEMENT, *supra* note 11.

150. *See infra* Part III.C.

151. *See, e.g.*, Sam Tsemberis & Cornelius Sullivan, *Seclusion in Context: Introducing a Seclusion Room into a Children's Unit of a Municipal Hospital*, 58 AM. J. ORTHOPSYCHIATRY 462 (1988).

152. *Id.* at 462.

153. *See id.*

154. Dave Ziegler & Dan Silver, *Considering the Literature on Restraint and Seclusion: Is There Support That These Interventions Are Harmful?* 3-4, available at <http://rccp.cornell.edu/pdfs/Zeigler.pdf> (last visited Feb. 26, 2007).

155. *See id.*

B. Data Linking Restraint and Seclusion to Injury and Death

In the past decade, data regarding the use of restraint and seclusion and related injuries and deaths has been collected and reported by the media as well as a number of private and governmental organizations. The most prominent of these reports surfaced in 1998, when the *Hartford Courant* issued a week-long investigative report into the number and types of deaths of individuals with psychiatric or developmental disabilities that occurred across the nation or shortly after these individuals were restrained or secluded in psychiatric hospitals, psychiatric units of general hospitals, group homes, residential facilities for troubled youths, or centers and group homes for individuals with intellectual disabilities.¹⁵⁶ Many of the 142 deaths identified by the *Courant* were caused by asphyxiation, suffocation, strangulation, smothering, a broken neck, cardiac arrest, blunt trauma to the head, stress due to restraint, shock, or dehydration.¹⁵⁷ Twenty-three of the 142 individuals, according to the report, died after staff restrained them by crossing the individuals' arms across their chests and placing them in prone floor holds.¹⁵⁸ Another twenty individuals died after they were tied up in leather wrist and ankle cuffs or vests, having been ignored for hours.¹⁵⁹ The report suggested that federal and state regulators, health officials, and the legal system "failed to observe" or "willfully ignored" these deaths, and recommended mandatory reporting of deaths that occur during or following restraint or seclusion.¹⁶⁰ According to the *Courant* report, the mandatory reports should form the bases of alerts sent to the health care provider community

156. See, e.g., *For the Record: 11 Months, 23 Dead*, HARTFORD COURANT (Conn.), Oct. 11, 1998, at A11, available at http://www.pcma.com/crisis_intervention_news/deadly_restraint/faces.stm (part of the newspaper's five-part investigative series "Deadly Restraint: A Nationwide Pattern of Death," published October 11-15, 1998); Weiss, *supra* note 14 (same).

157. Weiss, *supra* note 14.

158. *Id.*

159. *Id.*

160. *Id.*

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regarding unsafe restraint and seclusion practices.¹⁶¹

Even before the *Courant* report, state agencies were collecting and analyzing data regarding the dangers of the use of psychiatric restraint and seclusion. In 1994, for example, the New York State Commission on Quality of Care issued two reports examining restraint and seclusion practices in New York's state psychiatric facilities.¹⁶² The second report surveyed former psychiatric patients and found that "patients who were restrained or secluded during their inpatient stays "overwhelmingly report[ed] [that] these interventions were used illegally and that they were often poorly treated, abused or injured when restrained or secluded."¹⁶³ Approximately one-third of the respondents also reported that they were concerned for their safety and well-being while inpatients, and that their basic rights of dignity and privacy were violated.¹⁶⁴ Other respondents reported unnecessary force, psychological abuse, physical abuse, sexual abuse, and ridicule and threats by staff during restraint and seclusion.¹⁶⁵ Still other respondents reported that restraint and seclusion were used as punishments for not taking medication or obeying staff.¹⁶⁶ Reports regarding the lack of periodic bathroom, exercise, meal, and water breaks during episodes of restraint and seclusion also were noted.¹⁶⁷

Health care accreditation agencies also have collected and analyzed data regarding the use of restraint and seclusion and related injuries and deaths.¹⁶⁸ The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) found that the cause of death in forty percent of the

161. *See id.*

162. *See* N.Y. STATE COMM'N ON QUALITY OF CARE, RESTRAINT AND SECLUSION PRACTICES IN NEW YORK STATE PSYCHIATRIC FACILITIES (1994); N.Y. STATE COMM'N ON QUALITY OF CARE, VOICES FROM THE FRONTLINE: PATIENTS' PERSPECTIVES OF RESTRAINT AND SECLUSION USE (1994).

163. N.Y. State Comm'n on Quality of Care, (2 Reports) Restraint and Seclusion Practices in New York State Psychiatric Facilities, and Voices from the Frontline: Patients' Perspectives of Restraint and Seclusion Use, Sept. 1994, <http://www.cqcapd.state.ny.us/publications/pubvoice.htm>.

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.*

168. *See, e.g., Preventing Restraint Deaths*, SENTINEL EVENT ALERT (Joint Comm'n on Accreditation of Healthcare Orgs.), Nov. 18, 1998, available at http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_8.htm.

cases reported was asphyxiation, including asphyxiation due to staff placing excess weight on the back of patients restrained in the prone position, placing towels or sheets over patients' heads to protect against spitting or biting, and obstructing patients' airways when pulling the patients' arms across their necks.¹⁶⁹ JCAHO's sentinel event alert identified several strategies for reducing these risks, including more thorough patient assessments, earlier interventions with less restrictive measures, adequate staff-to-patient ratios, and the continuous observance of restrained patients.¹⁷⁰

Mental health consumer advocacy organizations such as the National Alliance on Mental Illness (NAMI) have collected restraint and seclusion use, injury, and death data and have publicized dangerous restraint and seclusion practices and incidents.¹⁷¹ According to NAMI, an Oregon woman was secluded for more than thirty hours in an Oregon hospital in December 1998 without being allowed to use the restroom or to contact relatives.¹⁷² A man in Missouri was restrained for twenty-one days and secluded for thirty days in a state psychiatric hospital in February 1999, resulting in kidney problems and lost muscle tone.¹⁷³

In 1999, the United States Government Accountability Office (GAO) issued a report summarizing many of these data collection efforts and highlighting the risks associated with improper restraint and seclusion practices.¹⁷⁴ The GAO also recognized, however, the existence of varying attitudes regarding the appropriateness of restraint use (including disagreement about whether restraints are only appropriate during an emergency and as a response of last resort to a treatment failure),¹⁷⁵ as well as the need for restraint and seclusion when patients lose control and place themselves or others at imminent risk of physical harm,¹⁷⁶ and the appropriateness of seclusion in reducing overstimulation, teaching self-control, and protecting others.¹⁷⁷ The GAO

169. *Id.*

170. *Id.*

171. GAO REPORT, *supra* note 1, at 7-9.

172. *Id.* at 8.

173. *Id.*

174. *Id.*

175. *Id.* at 4.

176. *Id.*

177. GAO REPORT, *supra* note 1, at 4.

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found that no comprehensive reporting system to track injuries and deaths involving the use of restraint and seclusion existed and that federal and state regulations governing restraint and seclusion in the psychiatric and intellectual disability settings were inconsistent across facility type.¹⁷⁸ The ultimate recommendation of the GAO was to reduce the use of restraint and seclusion by adopting policies identifying permissible restraint and seclusion practices, reporting instances of restraint and seclusion, training staff regarding safe use of and alternatives to restraint and seclusion,¹⁷⁹ and maintaining adequate staff-to-patient ratios.¹⁸⁰

Private and governmental organizations continue to collect data regarding inappropriate restraint and seclusion practices and the dangers associated with these interventions. Patients reportedly continue to be restrained for “trivial offenses,” such as failing to sit at a particular dining room table.¹⁸¹ Nurses apparently agree only eight percent of the time regarding whether a particular situation will escalate into violence or destruction of property and, thus, whether restraints or seclusion should be ordered.¹⁸² Many restrained and secluded patients report feeling punished, humiliated, and de-humanized.¹⁸³ A culture of control and force reportedly continues to pervade psychiatric facility management and staff, and the use of restraint and seclusion is believed to be evidence of the down-flow of that culture to patient care.¹⁸⁴ Fifty to 150 American deaths each year reportedly are caused by the use of restraint and seclusion.¹⁸⁵

178. *Id.* at 3.

179. *Id.* at 3-4.

180. *Id.* at 20.

181. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., *OVERCOMING BARRIERS AND PROTECTING CONSUMER RIGHTS* (2003), *available at* <http://alt.samhsa.gov/seclusion/SRMay5report6.htm> [hereinafter *OVERCOMING BARRIERS*].

182. *Id.*

183. *Id.*

184. *See id.*

185. *Id.*

C. The Current Restraint- and Seclusion-Free Discourse

It is not surprising that the current restraint and seclusion discourse focuses on the reduction and elimination of the use of restraint and seclusion in the psychiatric setting. The underlying themes of this discourse are that restraint and seclusion are neither positive nor therapeutic interventions; that restraint and seclusion are labor-intensive acts of violence that are less effective than alternative de-escalation strategies; that restraint and seclusion themselves (and not just their inappropriate use) are the cause of physical and psychological injury and death; and that the use of restraint and seclusion is evidence that the mental health care system is not working correctly.¹⁸⁶

These themes are communicated through the literature of both private and governmental organizations. In 1999, the National Association of State Mental Health Program Directors (NASMHPD) issued a formal statement clarifying its position that restraint and seclusion are safety interventions of last resort, not treatment interventions, and stating its goal of reducing “and ultimately eliminating” restraint and seclusion use.¹⁸⁷ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2003 formally stated its goal of “ultimately eliminating the use of restraint and seclusion in behavioral healthcare settings.”¹⁸⁸ In 2005, SAMHSA issued as part of its National Action Plan a training manual designed to achieve “restraint-free mental health care.”¹⁸⁹ The Alliance to Prevent Restraint, Aversive Interventions, and Seclusion (APRAIS) formally stated in 2005 its vision that “children with disabilities should grow up “free from the use of restraint and seclusion . . . and from the fear that these forms of behavior management will be used on themselves, their siblings or their friends.”¹⁹⁰ The rhetoric of restraint- and seclusion-free

186. *See, e.g., id.*

187. *See* POSITION STATEMENT, *supra* note 11.

188. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEPT OF HEALTH & HUMAN SERVS., ROADMAP TO SECLUSION AND RESTRAINT FREE MENTAL HEALTH SERVICES 3 (2005).

189. *See id.* at 5 (“The goal of this curriculum is to provide direct care staff the tools and knowledge needed to improve their skills in preventing and ultimately eliminating the use of seclusion and restraint.”).

190. ALLIANCE TO PREVENT RESTRAINT, AVERSIVE INTERVENTIONS, & SECLUSION, IN THE NAME OF TREATMENT: A PARENT’S GUIDE TO PROTECTING

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mental health care continues today, with organizations such as the Hogg Foundation for Mental Health hosting training institutes for organizations committed to eliminating the use of restraint and seclusion use¹⁹¹ and with federal and state lawmakers attempting to establish restraint- and seclusion-free psychiatric environments.¹⁹²

In summary, perspectives regarding the use of restraint and seclusion vary. Searching for ways to prevent patient self-injury and violence to others in acute inpatient populations, clinicians and scientists in the mid-to-late twentieth century studied the efficacy of restraint and seclusion and concluded that these interventions had a wide range of accepted and appropriate uses.¹⁹³ Additional studies conducted at the turn of the twentieth century focus less on the efficacy of restraint and seclusion for preventing self-injury and violence and more on patients' perspectives of their past restraint and seclusion experiences. From this patient perspective, restraint and seclusion are viewed as psychologically harmful. Finally, the collection and analysis of restraint and seclusion data in the late 1900s and early 2000s shows that the use of restraint and seclusion can and has caused significant harm, including death, in child, adolescent, and adult psychiatric populations. Critics of the latter two perspectives argue that the one hundred-plus

YOUR CHILD FROM THE USE OF RESTRAINT, AVERSIVE INTERVENTIONS, AND SECLUSION 2 (2005).

191. See Hogg Found. for Mental Health, Seclusion & Restraint Reduction: Training Institute Instructional Materials, http://www.hogg.utexas.edu/programs_S&Rtraining_docs.html (last visited Feb. 26, 2007) (noting that a training institute was held in September 2006 for organizations committed to the ultimate elimination of restraint and seclusion use).

192. See, e.g., Child and Adolescent Mental Health Resiliency Act of 2006, S. 3449, 109th Cong. (2006) (introducing a federal bill that would require the development and dissemination of educational materials that encourage ending the use of restraint and seclusion in all facilities or programs that care for children and adolescents, as well as the training of mental health professionals and others on alternatives to restraint and seclusion); 104 MASS. CODE REGS. 27.12(1) (2006) (requiring private, county, and municipal mental health facilities in Massachusetts to develop a plan to eliminate, wherever possible, the use of restraint and seclusion).

193. See, e.g., Binder & McCoy, *supra* note 129, at 1052 (“[S]eclusion is an accepted treatment modality on many psychiatric inpatient units”); Cotton, *supra* note 3, at 442 (discussing at length the psychiatric benefits of seclusion); Wadson & Carpenter, *supra* note 129, at 318 (“The seclusion room is an important, but ambivalently perceived aspect of psychiatric inpatient units.”).

restraint- and seclusion-related deaths is unfortunate, but pales in comparison to other causes of death in the health care context and has been over-dramatized by the media.

Part III thus provides a balanced review of the relevant medical literature and available data. A dialogue regarding the criteria, if any, that justify the continued use of these interventions must take into account both their risks and benefits. Relying on the persuasive survivor literature and sentinel event data, although somewhat downplaying the studies showing that restraint and seclusion are efficacious in preventing patient self-injury and violence in psychiatric emergencies, many mental health consumer advocacy organizations are lobbying to eliminate the use of restraint and seclusion in the psychiatric setting. The question thus becomes whether legislative adoption of these elimination strategies will solve the restraint and seclusion controversy once and for all.

IV. RESTRAINT AND SECLUSION LEGISLATION AND REGULATION

A. *Human Rights Principles*

To address this question, an understanding of current restraint and seclusion regulation is necessary. The bulk of this Part focuses on federal and state law; however, it is important to note that restraint and seclusion are considered important international human rights issues as well. During the last century, human rights organizations have found patients in international psychiatric facilities caged on their beds (via metal frames built two to three feet over the bed with a wire or net mesh enclosing the sides and the top) for hours and days, lying in their own urine and feces.¹⁹⁴ At one facility, staff reportedly locked patients in their rooms from the afternoon until the next morning whenever staffing levels were insufficient.¹⁹⁵ In response to these and other concerns,

194. ERIC ROSENTHAL & CLARENCE J. SUNDRAM, WORLD HEALTH ORG., THE ROLE OF INTERNATIONAL HUMAN RIGHTS IN NATIONAL MENTAL HEALTH LEGISLATION 59 (2004); see also Oliver Lewis, *Mental Disability Law in Central and Eastern Europe: Paper, Practice, Promise*, 8 J. MENTAL HEALTH L. 293, 299 (2002) (describing the use of caged beds in Hungary, Bulgaria, Slovakia, the Czech Republic, and Slovenia).

195. ROSENTHAL & SUNDRAM, *supra* note 195, at 59.

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the United Nations General Assembly in 1991 adopted the “Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care” (MI Principles).¹⁹⁶ Although the MI Principles are a non-binding resolution of the United Nations General Assembly, they are used as a guide to the interpretation of related provisions of international human rights conventions.¹⁹⁷ Under MI Principles, patients in mental health facilities have the right to be treated in the least restrictive environment appropriate to the patient’s health needs and the need to protect the physical safety of others.¹⁹⁸ The MI Principles also contain a number of procedural safeguards designed to prevent abuse. Practitioners working in mental health facilities must record each use of restraint or seclusion in the patient’s record along with an explanation of the clinical justification for the intervention.¹⁹⁹

B. Federal Law

Restraint and seclusion practices are an international and national concern. Following years of overcrowded, understaffed, dangerous, and dehumanizing conditions at Bryce Hospital in Tuscaloosa, Alabama, the United States District Court for the Middle District of Alabama issued its seminal opinion in *Wyatt v. Stickney*.²⁰⁰ Among other things, *Wyatt* established three important common law principles relating to the use of restraint and seclusion. First, patients with mental health conditions generally have the right to be free from restraint and seclusion.²⁰¹ Second, restraint and seclusion may be used in an emergency situation, defined as a situation in which a patient might harm himself or others,

196. Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, G.A. Res. 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc. A/46/49 (1991) [hereinafter MI Principles].

197. Angelika C. Moncada, Comment, *Involuntary Commitment and the Use of Seclusion and Restraint in Uruguay: A Comparison with the United Nations Principles for the Protection of Persons with Mental Illness*, 25 U. MIAMI INTER-AM. L. REV. 589, 593 (1994); Eric Rosenthal & Leonard S. Rubenstein, *International Human Rights Advocacy Under the “Principles for the Protection of Persons with Mental Illness,”* 16 INT’L J.L. & PSYCHIATRY 257, 257 (1993).

198. MI Principles, *supra* note 198, at princ. 9(1).

199. *Id.*

200. *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff’d in part, rev’d in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

201. *Stickney*, 344 F. Supp. at 379-80.

but only if less restrictive methods of preventing such harm are not feasible.²⁰² Third, if a patient is to be restrained or secluded, a qualified mental health professional²⁰³ must have personally seen the episode justifying the restraint or seclusion, evaluated the patient, and ordered in writing the restraint or seclusion for no more than a short, finite period of time.²⁰⁴

Subsequent federal decisions clarified that restraints may be imposed only in conjunction with treatment (in other words, treatment is society's quid pro quo for the deprivation of personal liberty)²⁰⁵ and that institutional residents have a constitutional right to be free from unreasonable restraints²⁰⁶ and seclusion.²⁰⁷ The determination of whether a restraint is reasonable, according to the U.S. Supreme Court, depends on whether professional judgment was exercised when the restraint was ordered.²⁰⁸

Wyatt was very influential at the national level. Among other things, the opinion influenced the Task Force on Legal and Ethical Issues of the President's Commission on Mental Health (Commission), which in turn motivated Congress' enactment of the Bill of Rights section of the Mental Health Systems Act (MHSA) in 1980.²⁰⁹ The MHSA states that

202. *Id.* at 380.

203. *Id.* at 379 (defining a qualified mental health professional as a psychiatrist, a psychologist with a doctoral degree, certain social workers with master's degrees and additional psychiatric clinical experience, and certain registered nurses with graduate degrees in psychiatric nursing and additional psychiatric clinical experience).

204. *Id.* at 380.

205. *Aderholt*, 503 F.2d at 1312 (citing *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974)).

206. *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982) (quoting *Greenholtz v. Neb. Penal Inmates*, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part)).

207. *Rogers v. Okin*, 478 F. Supp. 1342, 1374 (D. Mass. 1979) (enjoining a state institution for individuals with mental illness from placing patients in seclusion except in emergency situations in which there is an occurrence or serious threat of extreme violence, personal injury, or attempted suicide), *aff'd in part, rev'd in part, vacated in part, and remanded*, 634 F.2d 650 (1st Cir. 1980), *vacated by* *Mills v. Rogers*, 457 U.S. 291 (1982).

208. *Youngberg*, 457 U.S. at 324 ("The State also has the unquestioned duty to provide reasonable safety for all residents and personnel within the institution. And it may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety or to provide needed training.").

209. RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL

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persons receiving mental health services have the right to treatment in a setting and under conditions that are most supportive of their personal liberty and restrict such liberty only to the extent necessary consistent with such person's treatment.²¹⁰ The Commission also recommended that individuals have the right to be free from restraint or seclusion imposed for reasons other than treatment or in an emergency situation.²¹¹ Restraint and seclusion imposed for treatment or in an emergency situation, according to the Commission, should require the written order of a mental health professional.²¹² Congress restated these rights in 1986 in its Bill of Rights for Mental Health Patients (Bill of Rights).²¹³ Although the MHSA and the Bill of Rights indicate Congress' concern regarding inappropriate use of restraint and seclusion, these provisions have little teeth. Neither the MHSA nor the Bill of Rights establishes any enforceable rights or duties, including a private right of action.²¹⁴ The MHSA and the Bill of Rights are merely precatory; they do no more than express a Congressional preference for appropriate use of restraint and seclusion.²¹⁵

Although federal administrative agencies have attempted to impose enforceable duties relating to the use of restraint and seclusion on various types of health care providers, these efforts lacked specific applicability to the psychiatric setting until 1999. The Health Care Financing Administration (HCFA)²¹⁶ in 1988 adopted final regulations governing the use of restraint and seclusion in intermediate care facilities for

AND CRIMINAL ASPECTS 1093 (4th ed. 2004).

210. Mental Health Systems Act, 42 U.S.C. §§ 9501(1)(A)(i)-(ii) (2000).

211. *Id.* § 9501(1)(F).

212. *Id.*

213. *Id.* § 10841.

214. *Monahan v. Dorchester Counseling Ctr., Inc.*, 770 F. Supp. 43, 47 (D. Mass. 1991), *aff'd*, 961 F.2d 987 (1st Cir. 1992); *Brooks v. Johnson & Johnson, Inc.*, 685 F. Supp. 107, 109 (E.D. Pa. 1988).

215. *See Brooks*, 685 F. Supp. at 108.

216. On July 1, 2001, the federal agency known as the Health Care Financing Administration (HCFA) became the Centers for Medicare and Medicaid Services (CMS). *CTRS. FOR MEDICARE & MEDICAID SERVS., 2002 FACT SHEET: FOR PHYSICIANS AND OTHER PROVIDERS: KEY NEWS FROM MEDICARE FOR 2002*, at 1, *available* at <http://www.cms.hhs.gov/Transmittals/downloads/B0165.pdf> (last visited Feb. 17, 2007).

individuals with mental retardation.²¹⁷ These regulations restrict the use of restraints to an “integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied” and to emergency measures that are necessary to protect the individual or others from injury.²¹⁸ In 1991, HCFA adopted final regulations governing the use of restraint and seclusion in nursing homes that participate in the Medicare and Medicaid programs.²¹⁹ These regulations ban all non-medical use of restraint²²⁰ and all use of seclusion²²¹ in covered nursing homes. Although both sets of regulations clarify the appropriate use of restraint and seclusion in a range of long-term care settings, they fail to address the use of restraint and seclusion in behavior management in the psychiatric setting.²²²

As part of its ongoing revisions to its Conditions of Participation for Hospitals (COPs), HCFA adopted in 1999 an interim final rule governing the use of restraint and seclusion for behavior management in public and private psychiatric hospitals and psychiatric units in general hospitals that participate in the Medicare Program.²²³ The 1999 interim final rule, which was inspired in part by the *Hartford Courant* report identifying 142 restraint- and seclusion-related deaths,²²⁴ acknowledged that in some emergency situations the use of restraint may be the least harmful way to protect an individual’s safety and the safety of others.²²⁵

217. 42 C.F.R. §§ 483.450(c)-(d) (2006). The phrase “intellectual disability” is preferable to “mental retardation.” I use “mental retardation” here to ensure consistency with the regulations.

218. *Id.* §§ 483.450(d)(1)(i)-(ii).

219. *Id.* §§ 483.13(a)-(b).

220. *Id.* § 483.13(a).

221. *Id.* § 483.13(b).

222. GAO REPORT, *supra* note 1, at 3 (“The federal government regulates the use of restraint and seclusion in nursing homes and Intermediate Care Facilities for the Mentally Retarded, but until recently, no federal regulations governed their use in other facilities, such as psychiatric hospitals . . .”).

223. 42 C.F.R. § 482.13(f).

224. 64 Fed. Reg. 36,070, 36,070 (July 2, 1999) (codified at 42 CFR pt. 482) (discussing why HCFA needed to issue the patients’ rights COP); *id.* at 36,078 (discussing the heightened awareness of unsafe restraint and seclusion practices due to media attention).

225. *Id.* at 36,078.

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The interim final rule thus required a balancing of interests:

[W]e believe that it is critical to reinforce appropriate restraints reduction by acknowledging the patient's right to be free from restraints except when the use of a restraint is the least restrictive option that will provide the greatest benefit to the patient (that is, the risks associated with the use of the restraint are outweighed by the risk of not using it).²²⁶

This balancing was formally codified in the COPs as a regulatory permission to use restraint²²⁷ and seclusion,²²⁸ but only if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.²²⁹

In 2000, Congress enacted The Children's Health Act (CHA), one section of which amended part of the Public Health Service Act to establish minimum requirements regarding the use of restraint and seclusion in health care facilities that receive federal funds.²³⁰ To conform the 1999 interim final rule to the requirements set forth in the CHA, the Centers for Medicare and Medicaid Services (CMS) issued new restraint and seclusions regulations in December 2006.²³¹ Effective January 2007, the new regulations emphasize that patients in Medicare-participating hospitals have the right to be free from unnecessary restraint²³² or seclusion,²³³ and that convenience, punishment, retaliation and coercion are not

226. *Id.* at 36,080.

227. The COPs define restraint as a physical restraint or a drug that is used as a restraint. 42 C.F.R. §§ 482.13(e)(1)(i)(A)-(B). Physical restraints include any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that the patient cannot easily remove that restricts the patient's freedom of movement or bodily access. *Id.* at § 482.13(e)(1)(i)(A). Drugs used as a restraint include medications used to control behavior or to restrict the patient's freedom of movement that are not part of the standard treatment for the patient's medical or psychiatric condition. *Id.* at § 482.13(e)(1)(i)(B).

228. The COPs define seclusion as the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. *Id.* at § 482.13(e)(1)(ii).

229. *Id.* at §§ 482.13(e)(2)-(3).

230. Children's Health Act of 2000, Pub. L. No. 106-310, § 3207 (codified as amended at 42 U.S.C. § 290ii (2000)).

231. Patients' Rights Conditions of Participation, 71 Fed. Reg. 71,378, 71,379 (Dec. 8, 2006) (codified at 42 C.F.R. § 482.13(e) (2007)).

232. *See supra* note 1 (providing the new regulatory definition of restraint).

233. *See supra* note 2 (providing the new regulatory definition of seclusion).

acceptable reasons to use these interventions.²³⁴ The new regulations contain several subtle and not-so-subtle changes from the 1999 interim final rule. Like the 1999 interim final rule, the new regulations establish a laundry list of requirements that must be satisfied before restraint or seclusion may be imposed on a patient receiving care at a Medicare-participating hospital.²³⁵ First and foremost, restraint or seclusion only may be used when a physician or other licensed independent practitioner (LIP) determines that less restrictive interventions have been ineffective to protect the patient, a staff member, or others from harm.²³⁶ Unless superseded by a more stringent state law, “each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others” is limited to four hours for adults eighteen years of age or older, two hours for children and adolescents nine to seventeen years of age, and one hour for children under nine years of age.²³⁷ When restraint and seclusion are used for the management of violent or self-destructive behavior, a physician, other LIP, registered nurse, or physician assistant with appropriate training must see the patient face-to-face within one hour after the intervention and must evaluate, among other things, the patient’s reaction to the intervention, the patient’s medical and behavioral condition, and the need to continue or terminate the intervention.²³⁸ Regardless of the length of time identified in the initial order, the practitioner must discontinue the intervention at the earliest possible time.²³⁹

The new regulations strengthen the training requirements applicable to physicians and other LIPs who order restraint and seclusion. Patients now have the right to safe implementation of restraint or seclusion by a trained staff member.²⁴⁰ Hospital policies must specify applicable

234. 42 C.F.R. § 482.13(e) (2007); Patients’ Rights Conditions of Participation, 71 Fed. Reg. at 71,380.

235. See 42 C.F.R. § 482.13(e).

236. *Id.* § 482.13(e)(2).

237. *Id.* § 482.13(e)(8)(i).

238. *Id.* §§ 482.13(e)(12)(i)-(ii).

239. *Id.* § 482.13(e)(9).

240. *Id.* § 482.13(f).

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training requirements, and physicians and LIPs must have a working knowledge of their hospital's policies regarding restraint and seclusion.²⁴¹ Staff must be able to demonstrate competency in the application of restraints, the implementation of seclusion, and the monitoring and assessment of patients on whom restraint and seclusion have been imposed as part of their initial workplace orientation and subsequently on a periodic basis.²⁴² The training must address the use of nonphysical intervention skills, behavioral changes that indicate that restraint and seclusion is no longer necessary, and staff and patient behaviors, events, and environmental factors that trigger instances of restraint and seclusion.²⁴³

The new regulations also impose more stringent reporting requirements. Hospital must report to CMS each death that occurs while a patient is in restraint or seclusion, each death that occurs within twenty-four hours after the patient has been removed from restraint or seclusion, and each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death.²⁴⁴ Hospitals must make the required reports no later than the close of the next business day following knowledge of the patient's death.²⁴⁵

In summary, the new regulations attempt to minimize unsafe restraint and seclusion practices by: (1) establishing criteria for the imposition of restraint and seclusion; (2) identifying the individuals who are permitted to order restraint and seclusion; (3) limiting the length of time for which restraint and seclusion may be imposed; (4) strengthening the training requirements applicable to health care professionals involved in the imposition of these interventions; and (5) requiring the reporting of a broader class of patient deaths. The COPs do not, however, require Medicare-participating hospitals or psychiatric facilities to establish restraint- and seclusion-free environments.²⁴⁶

241. 42 C.F.R. § 482.13(e)(11).

242. *Id.* § 482.13(f)(1).

243. *Id.* § 482.13(f)(2).

244. *Id.* § 482.13(g)(1).

245. *Id.* § 482.13(g)(2).

246. Hospitals, behavioral health care providers, and other health care

C. State Law

States have long been interested in the regulation of restraint and seclusion use. Like other state legislatures during the early twentieth century, the Texas Legislature enacted in 1925 House Bill 249 (HB 249), a then-comprehensive piece of mental health legislation, one purpose of which was to regulate the restraint of state hospital patients who were classified as insane, mentally ill, or mentally defective.²⁴⁷ HB 249 defined restraint to include both “therapeutic and chemical restraint[s]” and “confinement in a strong room as well as seclusion in solitary confinement,” although it excepted from the definition “the prolonged bath, the hot or cold pack, or a medication when it is used as a remedial measure and not as a form of restraint.”²⁴⁸ HB 249 restricted state hospitals from imposing restraints in the form of “muffs, waist straps, wristlets, anklets, camisoles, lock chairs, lock cribs, protection sheets or other devices

organizations that have received accreditation by a national accreditation body, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), generally are considered to be in compliance with the relevant COPs. *See Nat'l Ass'n of Psychiatric Health Sys. v. Shalala*, 120 F. Supp.2d 33, 35 (D.D.C. 2000). JCAHO accredits approximately eighty percent of the hospitals that participate in the Medicare program. GAO REPORT, *supra* note 1, at 16. JCAHO standards relating to restraint and seclusion are thus relevant. JCAHO has and enforces both hospital and behavioral health care standards. *See* JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS. [JCAHO], 2006 HOSPITAL ACCREDITATION STANDARDS (2006), *available at* http://www.jointcommission.org/NR/rdonlyres/F42AF828-7248-48C0-B4E6-BA18E719A87C/0/06_hap_accred_stds.pdf; JCAHO, APPROVED STANDARDS ADDITIONS FOR BEHAVIORAL HEALTH SERVICES (2006), *available at* http://www.jointcommission.org/NR/rdonlyres/09CDAFFB-D502-40C7-973C-A935DF05BC5C/0/bhc_recovery_oriented_stds.pdf. Like the COPs, the JCAHO standards attempt to minimize unsafe restraint and seclusion practices by regulating the individuals who can order restraint and seclusion, the criteria for the imposition of restraint and seclusion, and the maximum length of time for which restraint and seclusion may be ordered, as well as establishing administrative and reporting requirements. *See, e.g.*, JCAHO, 2006 HOSPITAL ACCREDITATION STANDARDS, *supra*. JCAHO's revised restraint and seclusion standard, effective January 1, 2001, allows restraint and seclusion to be used, but “only in an emergency, when there is an imminent risk of an individual physically harming himself or herself or others, including staff.” *See* JCAHO, SETTING THE STANDARD 8 (2007), *available at* http://www.jointcommission.org/NR/rdonlyres/6C33FEDB-BB50-4CEE-950B-A6246DA4911E/0/setting_the_standard.pdf. The JCAHO standards do not require the elimination of restraint and seclusion in the psychiatric setting.

247. H.B. 249, 1925 Leg., 1925 Tex. Gen. Laws 407.

248. *Id.* § 21, 1925 Tex. Gen. Laws at 414.

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interfering with free movement” unless the restraints were applied in the presence of the superintendent of the hospital, or of a physician, or an assistant physician employed by the institution, or on his written order preserved in the records of the institution. In addition, the case must have involved “extreme violence, active, homicidal and suicidal condition, physical exhaustion, infectious disease or following an operation or acts which have caused serious bodily injury.”²⁴⁹ HB 249 did carve out an emergency exception permitting the use of restraints without the presence of the superintendent or a physician and without a written order if, after the imposition of the restraint, the use of the restraint was immediately reported to the superintendent or to a physician who immediately investigated the case and approved or disapproved of the restraint imposed.²⁵⁰

HB 249 further required the superintendent, physician, or assistant physician to personally keep under lock and key all implements or devices of restraint not in actual use,²⁵¹ to document all cases of restraint use, and to make such records available to the governing body of mental hospitals in the state (the Board of Control) upon request.²⁵² The records were required to include “the cause for [the restraint], the form used, the name of the patient, the time when the patient was placed under restraint and the time when released.”²⁵³ State hospitals and employees who knowingly violated or willingly permitted the violation of the prohibitions against restraint were subject to fines of \$50 to \$300.²⁵⁴

In the mid-twentieth century, state legislatures codified their various mental health laws, including their restraint and seclusion laws, into separate mental health codes.²⁵⁵ For example, faculty members of The University of Texas School of Law, with help from the Hogg Foundation for Mental

249. *Id.* § 19, 1925 Tex. Gen. Laws at 413-14.

250. *Id.*

251. *Id.* § 20, 1925 Tex. Gen. Laws at 414.

252. *Id.* § 21, 1925 Tex. Gen. Laws at 414.

253. Tex. H.B. 249.

254. *Id.* § 22.

255. See, e.g., MICH. COMP. LAWS § 330.1740 (2005), available at http://www.michigan.gov/documents/mentalhealthcode_113313_7.pdf (pertaining to restraint); *Id.* § 330.1742, available at http://www.michigan.gov/documents/mentalhealthcode_113313_7.pdf (pertaining to seclusion).

Health and other public advocacy groups, drafted in 1957 the basis of Texas House Bill 6 (HB 6). When passed by the Texas Legislature, HB 6 established Texas' new Mental Health Code.²⁵⁶ One purpose of the Mental Health Code was to protect "the rights and liberty of every one." To that end, the Mental Health Code generally prohibited physical restraint use, although it did contain an exception for restraints that were prescribed by a physician, removed as soon as possible, and documented in the patient's medical record under the signature of the ordering physician.

Other states' mental health codes similarly regulated the use of restraint and seclusion²⁵⁷ and, today, many states limit these interventions to "behavioral emergencies."²⁵⁸ A behavioral emergency is defined as a situation in which preventive, de-escalative, or verbal techniques have been considered and determined to be ineffective and it is necessary to prevent an individual from imminent death and substantial bodily harm to either himself or others.²⁵⁹ Most states also expressly prohibit the use of restraint or seclusion as a form of discipline or punishment, for convenience, as a substitute for effective treatment, or to compensate for inadequate staffing.²⁶⁰ These latter provisions perhaps are a response to statements in mandatory annual reports drafted by state insane asylums during the nineteenth century²⁶¹ indicating that restraints were imposed notwithstanding the prevailing theory of moral treatment when an insufficient

256. Tex. Mental Health Code, ch. 243, § 1, 1957 Tex. Gen. Laws 505.

257. See, e.g., MICH. COMP. LAWS § 330.1740.

258. 25 TEX. ADMIN. CODE § 415.261 (2006).

259. *Id.* § 415.253(a)(2) (2006).

260. See, e.g., COLO. REV. STAT. § 27-10.5-115(8) (2005) ("Physical restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports."); CONN. GEN. STAT. § 19a-550(b)(8) (2006) (stating that each patient shall be "free from mental and physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms"); FLA. STAT. ANN. § 394.459(4)(c) (West 2006) ("A facility may not use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff.").

261. As an example, an 1858 Texas law made it the duty of the superintendent of the State's Lunatic Asylum to "keep a register of all patients received and discharged, and of the operations of the Asylum, . . . and report the general results to the Governor on the first day of October of each year." 1858 Tex. Gen. Laws 117, ch. 93 § 10.

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number of attendants were responsible for supervising too large a number of highly excited patients.²⁶² Many states now prohibit the use of restraint and seclusion to compensate for inadequate staffing,²⁶³ although their legislatures have not provided the requested appropriations that would secure an adequate number of trained staff members.

For some states, regulations limiting the use of restraint and seclusion to behavioral emergencies were insufficient. The Commonwealth of Pennsylvania became so concerned about the dangers associated with restraint and seclusion that a representative of the Pennsylvania Department of Public Welfare announced in 1997 and that restraint use should be eliminated altogether.²⁶⁴

262. One such annual report stated:

In the thing of RESTRAINT, MECHANICAL AND CHEMICAL, one about as bad as the other—neither to be thought of in a properly organized, well conducted hospital for the insane. All authorities upon the management of the insane condemn both. . . . It might be stated that as the quality of personal attendance improves the record will show a diminished amount of mechanical restraint, so that the latter may be regarded in some degree a gauge or measure of the former. . . .

. . . .

. . . Although the medical officers of the Institution are as much opposed to mechanical restraint as any one can be, and reprobate its use as strongly, yet, owing to the lack of suitable attendants upon an excited household, have been compelled to hold recourse to it, in some of its most objectionable forms. Between 50 and 60 patients, all more or less and not a few highly excited, in wards with their gallery attachments over 200 feet long, with two attendants to look after them, besides the ward work to do, what was to be done? Sleeves, muffs, wristlets, crib-beds and other relics of barbarism in the treatment of the insane—“tell if not in Gath, publish it not in the streets of Askelon, lest the uncircumcised rejoice”—have been freely used; no help for it. But where there are but two attendants on such wards, the dining room attendant who properly keeps a dining room for fifty patients—the china closet, knives, forks, spoons, crockery and glassware—in the condition they are required to be kept in this Institution, finds little time for ward work. On Sundays, when one of the ward attendants has an *off*, as is the custom of all institutions of this kind, there is but one attendant most of the time on the ward.

N. TEX. HOSP. FOR THE INSANE, FOURTH ANNUAL REPORT 12-13 (1888) (internal citations omitted); *see also* ROTHMAN, *supra* note 27, at 149 (“Attendants were too few—only one for every fifteen patients—to allow close supervision to obviate mechanical restraints.”).

263. *See, e.g., supra* note 263.

264. Susan Stefan, *Successful Restraint and Seclusion Reduction Programs as Quality Indicators for Psychiatric Services*, MEDSCAPE, Apr. 10, 2006, http://www.medscape.com/viewarticle/528949_2 (last visited Mar. 1, 2007). More recently, New Jersey Assemblyman Eric Munoz introduced in 2006 a bill

Other lawmakers appear less certain about the need to completely eliminate the use of restraint and seclusion in the psychiatric context. In February 2006, New York Assemblyman Peter Rivera introduced a bill that would loosen his state's Mental Hygiene Law to permit certain physician assistants and nurse practitioners to order the restraint of a patient.²⁶⁵ South Carolina Senator Thomas Alexander introduced similar legislation in March 2005 that would amend his state's Rights of Mental Health Patients Act to permit licensed independent practitioners to order restraint or seclusion in a mental health or alcohol and drug abuse facility.²⁶⁶

Still other states are taking a middle position that supports more stringent regulation designed to reduce unsafe restraint and seclusion practices, while not eliminating the interventions altogether. In 2005, the Texas Legislature clarified that mental hospitals, mental facilities, and several other classes of institutions may not administer a restraint that obstructs a patient's airway, impairs a patient's breathing, or interferes with the patient's ability to communicate.²⁶⁷ The Texas Legislature further clarified that prone (face-down) or supine (face-up) holds may be used only for certain limited periods of time, as a last resort when other less restrictive interventions have proven to be ineffective, and when a trained observer ensures that the patient's

limiting the use of restraint and seclusion in state facilities servicing individuals with developmental disabilities. H.B. 948, 2006 Leg., 212th Assemb. (N.J. 2006). Outside the psychiatric and developmental disability context, a number of state legislatures recently have considered bills that would regulate the use of restraint and seclusion in public schools. *See, e.g.*, S.B. 906, 2005 Gen. Assemb. Sess. (N.C. 2005); H.B. 1792, 59th Leg., Reg. Sess. (Wash. 2005). Over the last ten years, Pennsylvania's goal of restraint and seclusion elimination was incorporated at the federal level, including by Senator Chris Dodd's Child and Adolescent Mental Health Resiliency Act of 2006. *See* Child and Adolescent Mental Health Resiliency Act of 2006, S. 3449, 109th Cong. (2006). Introduced to Congress on June 6, 2006, Senate Bill 3449 would amend the Public Health Service Act to require the Secretary of the Department of Health and Human Services to develop and disseminate educational materials that encourage eliminating the use of restraint and seclusion in all facilities or programs that care for children and adolescents, and to train mental health professionals and others on alternatives to restraint and seclusion. *Id.*

265. A. 9986, 2006 Leg. Sess. (N.Y. 2006).

266. S. 683, 2005 Leg., 116th Sess. (S.C. 2005-2006).

267. S.B. 325, 79th Leg., Reg. Sess. (Tex. 2005) (codified at TEX. HEALTH & SAFETY CODE § 322.051(a) (Vernon 2005)).

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breathing is not impaired.²⁶⁸ The legislation also charges Texas' administrative agencies with adopting implementing regulations that define acceptable restraint holds, address the use of seclusion, and develop practices to decrease the frequency of the use of restraint and seclusion.²⁶⁹

Other states continue to study the best legislative direction. Connecticut, for example, introduced a bill in 2006 that would require two state commissioners to review the extent to which individuals with psychiatric disabilities are afforded certain rights required by statute, including the right to restrictions on the imposition of mechanical restraint and seclusion.²⁷⁰ The commissioners are to report their findings and recommendations to the Connecticut General Assembly no later than July 1, 2007.²⁷¹

V. CONTEXTUALIZING THE RESTRAINT AND SECLUSION PROBLEM

I now return to the question of whether the centuries-old restraint and seclusion controversy will be solved by legislation, as proposed by mental health consumer advocacy organizations, eliminating the psychiatric use of these interventions. Here I argue that blanket elimination strategies should not be adopted without first disentangling more fundamental problems relating to mental health care access and finance.

A. *Lack of Access to and Financing for Basic Mental Health Care*

Studies show that the factors that contribute to the use of restraint and seclusion are similar to the factors that lead to inpatient psychiatric admission.²⁷² These factors include extreme aggression, assaultive behavior, attempted suicide,

268. TEX. HEALTH & SAFETY CODE § 322.051(b) (Vernon 2005).

269. *Id.* § 322.052(a).

270. H.B. 5542, Gen. Assem., Feb. Sess. (Conn. 2006).

271. *Id.*

272. See Cotton, *supra* note 3, at 443-45; William T. Garrison, *Aggressive Behavior Seclusion and Physical Restraint in an Inpatient Child Population*, 23 J. AM. ACAD. CHILD PSYCHIATRY 448, 448 (1984); Paramjit T. Joshi et al., *Use of the Quiet Room on an Inpatient Unit*, 27 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 642, 642 (1988); Paul H. Soloff, *Seclusion and Restraint in 1985: A Review and Update*, HOSP. & COMMUNITY PSYCHIATRY 652, 652 (1985).

self-injury including cutting, and destruction of property using fire, feces, and other means.²⁷³ Individuals who engage in these behaviors frequently have pathological family histories, attentional and learning problems, poor self-esteem and impulse control, maladaptive coping strategies, and immature defenses.²⁷⁴ Socially, these individuals tend to “live in poverty with family histories of loss, violence, neglect, and abuse.”²⁷⁵ The therapeutic management of these individuals requires basic mental health care interventions that can help stop these maladaptive cycles and initiate healthier processes of adaptation and development.²⁷⁶

Early detection, assessment, and linkage with mental health treatment and support can prevent mental health problems from compounding into conditions that may lead to restraint and seclusion.²⁷⁷ Early mental health interventions may lessen long-term conditions that breed violent and assaultive behavior.²⁷⁸ On the other hand, “untreated and undertreated” mental illness, especially paranoid schizophrenia, predisposes individuals to attempted suicide, homicide, and other aggressive behaviors that can lead to the use of restraint and seclusion.²⁷⁹

All of these studies suggest that access to basic mental health care can help individuals avoid more serious mental health conditions, the symptomatic behaviors of which may lead to the use of restraint and seclusion. Unfortunately, it goes without saying that not all Americans have access to basic mental health care. Although one in five American children have a mental disorder,²⁸⁰ and between five and nine

273. See Cotton, *supra* note 3, at 444.

274. *Id.*

275. *Id.*

276. *Id.*

277. PRESIDENT’S NEW FREEDOM COMM’N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 57 (2003) [hereinafter PRESIDENT’S NEW FREEDOM].

278. *Id.* at 60 (citing JACK P. SHONKOFF & DEBORAH A. PHILLIPS, FROM NEURONS TO NEIGHBORHOODS: THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT (2000)).

279. Sharfstein, *supra* note 119, at 1.

280. BAZELON CTR. FOR MENTAL HEALTH LAW, FAST FACTS ON INSURANCE COVERAGE AND ACCESS TO SERVICES FOR CHILDREN WITH SERIOUS MENTAL HEALTH NEEDS (2004), *available at* <http://www.bazelon.org/issues/insurance/factsheets/children.pdf> [hereinafter BAZELON] (citing U.S. DEP’T OF HEALTH AND HUMAN SERVS., MENTAL HEALTH:

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percent of children have a serious emotional disturbance,²⁸¹ approximately twelve percent of American children are uninsured.²⁸² Seventy-nine percent of children and adolescents who have mental health conditions that require evaluation did not receive any evaluation or mental health treatment in 1997.²⁸³ Twenty percent of non-elderly adults are uninsured, and the majority of adults with mental health problems also did not receive a mental health evaluation or treatment in the previous year.²⁸⁴ According to the U.S. Surgeon General, less than one-third of adults with a diagnosable mental disorder, and even a smaller proportion of children, receive mental health services in a given year.²⁸⁵ In summary, access to basic mental health care can help individuals avoid more serious conditions that may lead to the use of restraint and seclusion.

Unfortunately, it goes without saying that even for those children and adults who are insured, mental health coverage is not always obtainable.²⁸⁶ Access to mental health care is restricted by private health insurance coverage limits, public insurance eligibility restrictions, and shortfalls in state budgets.²⁸⁷ Notwithstanding federal and state laws that attempted to ensure parity in mental health care coverage,²⁸⁸ eighty-seven percent of health plans that complied with these laws place limits on mental health coverage that they do not place on medical or surgical care.²⁸⁹ Of these health plans,

A REPORT OF THE SURGEON GENERAL (1999)).

281. *Id.* (citing PRESIDENT'S NEW FREEDOM, *supra* note 278).

282. *Id.* (citing KAISER COMM'N ON MEDICAID AND THE UNINSURED, HEALTH COVERAGE IN AMERICA: 2002 DATA UPDATE (2003)).

283. *See id.*

284. *See id.* ("Adults are more likely to be uninsured than children because public coverage is designed primarily to help low-income children.").

285. NAT'L MENTAL HEALTH ASS'N, A CALL FOR INVESTMENT: EXPANDING COMMUNITY-BASED MENTAL HEALTH SERVICES 2 (2000).

286. BAZELON, *supra* note 281, at 2 (citing Ctr. on an Aging Soc'y, Georgetown Univ., *Issue Brief: Child & Adolescent Mental Health Services: Whose Responsibility is it to Ensure Care?*, DATA PROFILES (2003), available at <http://ihcrp.georgetown.edu/agingsociety/pdfs/mentalhealth.pdf>).

287. *Id.*

288. *See* Mental Health Parity Act of 1996, 42 U.S.C. § 300gg-5 (2001); NAT'L MENTAL HEALTH ASS'N, WHAT HAVE STATES DONE TO ENSURE INSURANCE PARITY? (2005), available at http://www1.nmha.org/state/parity/state_parity.pdf (summarizing state mental health parity laws).

289. U.S. GEN. ACCOUNTING OFFICE, No. GAO/HEHS-00-95, MENTAL HEALTH PARITY ACT 5 (2000), available at

sixty-six percent have lower outpatient office visit limits, sixty-five percent have lower hospital day limits, twenty-seven percent have higher outpatient office visit co-payments, and twenty-five percent have higher outpatient office visit co-insurance.²⁹⁰ These statistics are significant given the expense of mental health care.²⁹¹ Just one outpatient therapy session can cost more than one hundred dollars, and residential treatment facilities that provide twenty-four-hour-a-day, seven-day-a-week, mental health care can cost more than \$250,000 per year.²⁹²

Public mental health insurance coverage does not ensure access to all types of mental health care delivery programs.²⁹³ Although State Child Health Insurance Program (S-CHIP) plans do pay for mental health care, the care that is covered is inpatient and outpatient care, not school-based and residential care.²⁹⁴ And, although the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program mandates the provision of all necessary medical services (including mental health services) to Medicaid-eligible children, many of these children are not receiving the screenings for which they are eligible.²⁹⁵ State budget cuts also may continue to reduce access to mental health care.²⁹⁶ Over a recent ten-year period, expenditures for mental health and substance abuse decreased relative to overall healthcare expenditures by thirteen percent.²⁹⁷ State budget shortfalls combined with skyrocketing medical costs may cause some children from low-income families to lose their health care coverage while other children may experience a reduction in coverage.²⁹⁸

<http://www.gao.gov/new.items/he00095.pdf>.

290. BAZELON, *supra* note 281, at 2 (citing U.S. GEN. ACCOUNTING OFFICE, *supra* note 292).

291. *Id.* at 2.

292. *Id.* (citing U.S. GEN. ACCOUNTING OFFICE, NO. GAO-03-397, CHILD WELFARE AND JUVENILE JUSTICE (2003), *available at* <http://www.gao.gov/new.items/d03397.pdf>).

293. *Id.* at 3.

294. *Id.* (citing Center on an Aging Society, *supra* note 289).

295. *Id.*

296. BAZELON, *supra* note 281, at 3 (citing Center on an Aging Society, *supra* note 289).

297. NAT'L MENTAL HEALTH ASS'N, *supra* note 289, at 2.

298. BAZELON, *supra* note 281, at 3 (citing Center on an Aging Society, *supra* note 289).

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The legal system provides little assistance to individuals who cannot afford basic mental health care services and who do not have health insurance. Americans generally do not have a constitutional, statutory, or common law right to voluntary, non-emergency mental health care. States do not have a constitutional duty to provide voluntary mental health care services for those within its borders,²⁹⁹ and the failure to provide basic voluntary psychiatric care and treatment does not “shock the conscience” as would be necessary to establish a due process violation.³⁰⁰ Although Congress and many state legislatures have enacted mental health patient bills of rights that speak to mental health patients receiving the services they require,³⁰¹ these bills generally do not establish a private cause of action that would support a patient’s claim for basic mental health care services.³⁰² Congress, through the federal Emergency Medical Treatment and Active Labor Act (EMTALA), requires Medicare-participating hospitals with dedicated emergency departments to provide necessary stabilizing treatment to individuals who request emergency treatment; however, this requirement only applies when the individual is determined to have an emergency medical or psychiatric condition.³⁰³ A suicidal patient thus has a limited right under EMTALA to emergency room treatment sufficient to stabilize her current psychiatric emergency, but not to basic mental health care services that may help prevent the next psychiatric emergency. The lack of access to, and funding for, basic mental health care contributes to emergency, inpatient, and acute mental health care, contexts

299. See, e.g., *Monahan v. Dorchester Counseling Ctr.*, 770 F. Supp. 43, 46-47 (D. Mass. 1991).

300. See, e.g., *id.* at 46 (“In essence, Plaintiff claims that the state failed to provide him with adequate psychiatric care and treatment . . . these shortcomings . . . are not so egregious as to shock the conscience” (quoting *Pittsley v. Warish*, 927 F.2d 3, 6 (1st Cir. 1991) (internal citations omitted))).

301. See, e.g., 42 U.S.C. § 10841 (2001) (“It is the sense of the Congress that, . . . each State should review and revise [its laws as] necessary to ensure that mental health patients receive the protection and services they require”).

302. See, e.g., *Monahan*, 770 F. Supp. at 47 (“Congress did not intend to create a private right of action [in 42 U.S.C. § 10841].”).

303. 42 U.S.C. § 1395dd(b)(1)(A) (2006) (Emergency Medical Treatment and Active Labor Act stabilization requirement); 42 C.F.R. § 489.24(a)(ii) (2006) (regulatory stabilization requirement).

in which restraints and seclusion are used more frequently.³⁰⁴

Understaffing of facilities, caused by a lack of funding, has been one of the most persistent barriers to appropriate treatment, including appropriate use of restraint and seclusion.³⁰⁵ Studies routinely show that increased staff-to-patient ratios reduce the use of restraint and seclusion. A 2002 study, for example, found that increases in the number of staff members relative to the number of patients receiving care at a public psychiatric hospital were significantly related to decreases in reliance on restraint and seclusion for managing challenging behavioral problems.³⁰⁶ Although federal and state laws prohibit the use of restraint and seclusion to compensate for inadequate staffing, this mandate is unfunded. Stated another way, Congress and state legislatures traditionally have not appropriated the funds to ensure adequate staff-to-patient ratios as part of the same legislation prohibiting the use of restraint and seclusion as a substitute for adequate staffing.

B. The Conflict Between Patient Safety and Autonomy

Restraint and seclusion questions also implicate competing goals of patient safety and autonomy.³⁰⁷ Today,

304. See, e.g., U.S. PUB. HEALTH SERV., DEP'T OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, at ch. 2 (1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/home.html> (lack of access to mental health care contributes to emergency and inpatient health care).

305. See, e.g., Walter E. Barton, *Hospital Services for the Mentally Ill*, 286 ANNALS AM. ACAD. POLITICAL & SOC. SCI. 107, 113 (1953) ("Hospitals have been so preoccupied with problems of short staff and overcrowding that they have had little time to develop programs for the early recognition, diagnosis, treatment, and prevention of psychiatric disorders."); Beverly Winkels, *Seclusion Rooms and Other Restraints*, NURSING, Mar. 2004, at 12, 12 ("[I]f a patient needs 1:1 care as a substitute for restraints, adequate staff isn't always available.").

306. Dennis C. Donat, *Impact of Improved Staffing on Seclusion/Restraint Reliance in a Public Psychiatric Hospital*, 25 PSYCHIATRIC REHAB. J. 413, 415 (2002) ("This confirmed that as the staff:patient ratio gradually increased, the reliance on seclusion and restraint in this hospital gradually decreased.").

307. See, e.g., Lorraine Cecilia Mion et al., *Physical Restraint Use in the Hospital Setting: Unresolved Issues and Directions for Research*, 74 MILBANK Q. 411, 420 (1996) ("Clinicians typically focus on the ethical principles of beneficence and nonmaleficence when caring for hospitalized patients, which leads to a frequent medical moral dilemma: how to prevent harm to the patient and simultaneously preserve the patient's autonomy." (citing Arthur Schafer, *Restraints and the Elderly: When Safety and Autonomy Conflict*, 132 CAN. MED.

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hospitals admit psychiatric patients almost exclusively on criteria designed to determine whether they are dangerous to themselves or others.³⁰⁸ Although the current restraint and seclusion rhetoric correctly considers the all-too-real dangers of restraint and seclusion, the role of these interventions in preventing violence and patient self-injury in psychiatric emergencies also must be taken into account.

Common law requires institutional health care providers to protect patients against harm from themselves and others. In the long-term care context, the Texas Supreme Court recently held that a nursing home is legally required to prepare a comprehensive care plan for the medical and mental needs of its patients, and clarified that this plan may “require enhanced supervision and additional staff or physical restraints to protect them from injuring themselves and others or to protect them from other patients.”³⁰⁹ This case builds on the common law principle that hospitals, including hospitals treating patients with mental health conditions, have a duty to prevent patients from harming themselves and others, and that this duty may include the imposition of restraints: “The hospital’s responsibility to its patient extended to the taking of such measures as were necessary to

ASS’N J. 2157 (1985), available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1346330&blobtype=pdf>); A. Sourander et al., *Use of Holding, Restraints, Seclusion and Time-out in Child and Adolescent Psychiatric In-Patient Treatment*, 11 EUR. CHILD & ADOLESCENT PSYCHIATRY 162, 162 (2002) (“[T]he use of restraints . . . poses a conflict between a patient’s clinical needs and legal rights.”); Thomas S. Szasz, *Hospital Refusal to Release a Mental Patient*, 9 CLEV.-MARSHALL L. REV. 220, 220 (1960) (“The double role of the institutional psychiatrist—consisting on the one hand of being a therapist to his patient, and on the other of being a protector of society against the patient—is one of the major dilemmas facing contemporary psychiatry.”); Tardiff, *supra* note 132, at 614 (“In an age of concern about the rights and freedom of the individual, the use of coercive measures of control in psychiatric hospitals has come under intense scrutiny by the legal and medical professions.”); Taxis, *supra* note 3, at 158 (“[N]urses [and other staff members] are clearly responsible for the safety of patients, [but codes of ethics such as] the American Nurses Association . . . also require[] that the nurse provide care that is respectful of the dignity and individuality of each patient. . . . An ethical quagmire often arises when the nurse, faced with a decision to restrain or seclude a patient, must balance factors of autonomy, beneficence, and nonmaleficence with therapeutic goals.” (citing BANDMAN & BANDMAN, *supra* note 3; BEAUCHAMP & CHILDRESS, *supra* note 3)).

308. Sharfstein, *supra* note 119, at 1.

309. *Diversicare Gen. Partner, Inc. v. Rubio*, 185 S.W.3d 842, 850 (Tex. 2005).

prevent the patient from hurting himself if the hospital knew or, in the exercise of reasonable care, should have known that the patient's mental incapacity might lead to his own injury."³¹⁰

Many times, however, a health care provider's common law duty to prevent violent and assaultive patients from harming themselves and others will conflict with the provider's ethical and legal duty to promote patient autonomy. The word "autonomy" derives from the Greek *autos* ("self") and *nomos* ("rule," "governance," or "law").³¹¹ Although the word *autonomy* traditionally referred to the self-rule of independent city-states, bioethicists, lawyers, and others since have extended the word to refer to the related concepts of personal liberty, self-governance, and individual choice.³¹² An autonomous individual self-rules and is free from controlling interference by others.³¹³ An individual who has diminished autonomy, on the other hand, may be controlled by others or may be incapable of deliberating about or acting upon her personal desires and goals.³¹⁴ Individuals who are incarcerated in jails and individuals who have intellectual disabilities that interfere with decision-making capacity frequently are referred to as having diminished autonomy.³¹⁵ Physically and chemically restrained and secluded patients who lack freedom of movement and the ability to control their behavior also have diminished autonomy.³¹⁶

In situations in which a health care provider has attempted to, but cannot, calm a violent patient using less restrictive de-escalation techniques, and where the provider reasonably believes that significant patient self-injury or death, or injury to or the death of a third-party is imminent, the health care provider may restrain or seclude the patient

310. *Harris v. Harris County Hosp. Dist.*, 557 S.W.2d 353, 355 (Tex. Civ. App.-1st 1977).

311. BEAUCHAMP & CHILDRESS, *supra* note 3, at 57.

312. *Id.* at 57-58.

313. *Id.* at 58.

314. *Id.*

315. *Id.*

316. *See id.* ("Even autonomous persons with self-governing capacities sometimes fail to govern themselves in particular choices because of temporary restraints caused by illness or depression . . . or other conditions that restrict their options.").

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as a means of preventing violence.³¹⁷ In these situations, the intervention appears to be consistent with the provider's common law duty to prevent patients from injuring themselves and others. By ordering the intervention, the provider also, however, has diminished the autonomy of the restrained or secluded patient.³¹⁸

The question becomes how a provider's common law duty to prevent patient self-injury and harm to others should be balanced with the duty to promote patient autonomy in a psychiatric emergency. Those in favor of policies that would eliminate the use of psychiatric restraint and seclusion weigh the patient's right to autonomy more heavily than the provider's duty to prevent patient self-injury and harm to others.³¹⁹ Indeed, the patient's right to autonomy (to the exclusion of patient and community safety) tends to be featured prominently in the materials of many psychiatric patient advocacy organizations: "Seclusion and restraint procedures . . . represent a significant infringement of an individual's right to autonomy and self-determination . . ." ³²⁰ Positions such as these are not surprising considering the high value our culture places on individual autonomy.³²¹

Unfortunately, reductions in the use of restraint and seclusion also have been associated with injury to or the death of the violent patient, another patient, an employee, or a third party.³²² And this potential for injury or death cannot be ignored. Recent studies show that approximately eighteen to twenty-five percent of psychiatric inpatients exhibit violent behavior while in the hospital.³²³ Approximately seventy-

317. Sharfstein, *supra* note 119, at 1 ("At times, it is necessary to restrain or isolate individuals to prevent them from harming themselves or others.")

318. See BEAUCHAMP & CHILDRESS, *supra* note 3, at 58 ("Personal autonomy is . . . self-rule that is free from both controlling interference by others and from limitations.")

319. PSYCHIATRIC PATIENT ADVOCATE OFFICE, REVIEW OF SECLUSION AND RESTRAINT PRACTICES IN ONTARIO PROVINCIAL PSYCHIATRIC HOSPITALS: PERSPECTIVES OF PATIENTS, CLINICIANS, AND ADVOCATES 3 (2001).

320. *Id.*

321. See, e.g., DANIEL B. SINCLAIR, JEWISH BIOMEDICAL LAW: LEGAL AND EXTRA-LEGAL DIMENSIONS 174 (2003) ("In modern common-law systems, the concept of autonomy is at the centre of the physician-patient relationship, and constitutes a value to which the courts attempt to give as full expression as possible."); Schafer, *supra* note 308, at 1258.

322. Note, *supra* note 64, at 156.

323. Michele Raja & Antonella Azzoni, *Hostility and Violence of Acute*

eight percent of violent acts committed by psychiatric inpatients are directed toward “nurses, with other targets being (in descending order of frequency) fellow patients, property, [the patient himself or herself], physicians, psychologists, family members, and housekeeping staff.”³²⁴ “Ten to 45% of patients with schizophrenia exhibit aggressive or threatening behavior during hospitalization.”³²⁵ Approximately ten percent of individuals diagnosed with schizophrenia commit suicide,³²⁶ many during young adulthood, and some of these young adults make suicide attempts shortly before and even during psychiatric admissions.³²⁷ Although physicians and other mental health care providers sometimes can predict which threats will turn to actual violence based on diagnosis, the patient’s current behavior, the patient’s previous history, and the provider’s previous experience with the patient, the unpredictability of mental illness and its various manifestations prevents

Psychiatric Inpatients, 1 CLINICAL PRAC. & EPIDEMIOLOGY IN MENTAL HEALTH 1, 1 (2005) (citing C. Arango et al., *Violence in In-Patients with Schizophrenia: A Prospective Study*, 25 SCHIZOPHRENIA BULL. 493 (1999); McNeil et al., *Predictors of Violence in Civilly Committed Acute Psychiatric Patients*, 145 AM. J. PSYCHIATRY 965 (1988)).

324. *Id.*; see also Richard A. Friedman, *Violence and Mental Illness: How Strong is the Link?*, 355 NEW ENG. J. MED. 2064, 2064 (2006) (discussing the death of Wayne Fenton, associate director of the National Institute for Mental Health, who was killed by a violent patient with schizophrenia on September 3, 2006).

325. Raja & Azzoni, *supra* note 324, at 1 (citing T. Craig, *An Epidemiological Study of Problems Associated with Violence Among Psychiatric Problems*, 139 AM. J. PSYCHIATRY 1262 (1982); M. Rossi et al., *Violent or Fear-Inducing Behavior Associated with Hospital Admission*, 36 HOSP. COMMUNITY PSYCHIATRY 643 (1985); K. Tardiff et al., *Violence by Patients Admitted to a Private Psychiatric*, 154 AM. J. PSYCHIATRY 88 (1997); K. Tardiff & A. Sweillam, *Assault, Suicide, and Mental Illness*, 37 ARCHIVES GEN. PSYCHIATRY 164 (1980)); see also Friedman, *supra* note 325, at 2065 (providing additional statistics regarding assaultive patients).

326. Alan Breier, *Introduction: A New Era in the Pharmacotherapy of Psychotic Disorders*, 62 J. CLINICAL PSYCHIATRY 3, 3 (2001) (citing Alan Breier & B.M. Astrachan, *Characterization of Schizophrenic Patients Who Commit Suicide*, 141 AM. J. PSYCHIATRY 206 (1984)).

327. See, e.g., S. Cohen et al., *Rates and Correlates of Suicide Attempts in First-Admission Psychotic Patients*, 90 ACTA PSYCHIATRICA SCANDINAVICA 167 (1994) (documenting patient suicide attempts during the episode for which they were hospitalized); H. Spie l et al., *Suicidal Behavior of Psychiatric In-Patients*, 106 ACTA PSYCHIATRICA SCANDINAVICA 134 (2002) (examining suicidal behavior before and during psychiatric inpatient stays).

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providers from accurately identifying all violent patients.³²⁸

I do not believe that ethical interpretations or laws that would completely eliminate restraint and seclusion as an option are supportable in this context. By “this context,” I mean a situation in which: (1) all patients do not have access to basic mental health care; (2) a lack of access to and funding for such care contributes to the use of emergency, inpatient, and acute mental health care; (3) a mental health care provider working in this environment reasonably believes that a psychiatric patient may seriously injure or kill him or herself or another person; and (4) less restrictive de-escalation measures have been tried and have proven ineffective. Instead, the violent patient’s right to autonomy must be balanced against the interest in maintaining the life and safety of the patient and third parties. A policy that would eliminate the use of restraint and seclusion as an option in this context would focus too narrowly on the question of whether the violent patient’s liberty interest has been infringed. Instead, the question should be whether the nature or extent of the liberty violation is reasonable in light of the imminent threat to health or safety.³²⁹

328. Note, *supra* note 70, at 162.

329. See *Youngberg v. Romeo*, 457 U.S. 307, 322-24 (1982). In *Youngberg*, the Court said:

We have established that Romeo retains liberty interests in safety and freedom from bodily restraint. Yet these interests are not absolute In operating an institution such as Pennhurst, there are occasions in which it is necessary for the State to restrain the movement of residents—for example, to protect them as well as others from violence. . . . The question then is not simply whether a liberty interest has been infringed but whether the extent or nature of the restraint or lack of absolute safety is such as to violate due process. . . . In determining what is “reasonable”—in this and in any case presenting a claim for training by a State—we emphasize that courts must show deference to the judgment exercised by a qualified professional.

Id. at 319-20, 322. Since *Youngberg*, many courts have applied the professional judgment standard to restraint and seclusion cases. See, e.g., *Heidemann v. Rother*, 84 F.3d 1021, 1029-31 (8th Cir. 1996) (holding plaintiff’s evidence was “insufficient to create a genuine dispute as to whether the blanket wrapping treatment represented a substantial departure from accepted professional judgment, practice, or standards”); *Subacz v. Sellars*, No. CIV.A.96-CV-6411, 1998 WL 720822, at *9-10 (E.D. Pa. Sept. 21, 1998) (two physicians’ reports could be a basis for finding that professional judgment was not exercised in the use of bodily restraints); *United States v. Pennsylvania*, 902 F. Supp. 565, 631-40 (W.D. Pa. 1995) (finding the institutional defendant had exercised professional judgment in attempting to treat residents’ behavior problems).

In light of the significant dangers of restraint and seclusion, I think that the restraint and seclusion-free movement has important and laudable goals. However, lawmakers need to consider a more balanced and complete dialogue regarding the root causes of violence and aggression before adopting policies that would completely prohibit the use of restraint and seclusion. Attempts to eliminate factors within the mental health care system that contribute to mental health conditions that manifest in violence and aggression should precede, or at least accompany, attempts to eliminate the use of restraint and seclusion.

C. A Note About Legalism Versus Medicalism

Before discussing my approach to the restraint and seclusion controversy, I would like to suggest a final reason for the persistence of the controversy, which relates to legalism and medicalism. One theme in the psychiatry and the law literature is legalism versus anti-legalism, or medicalism. This theme views the reform of mental health legislation and its history in terms of a pendulous movement between the two extremes of stringent mental health regulation, on the one hand, and unchecked medical discretion on the other.³³⁰ The legalism versus medicalism theme is a useful tool for exploring opposing attitudes towards the use of restraint and seclusion.

The philosophical doctrine of legalism has been equated with formalism (a mechanistic approach) that many believe is too rigid to regulate the unpredictable field of psychiatry.³³¹ According to the doctrine of legalism, moral conduct is “a matter of rule following rather than individual conscience.”³³² Legalism also suggests rigid adherence to the form of the law, rather than its spirit or intended purpose.³³³ However defined, one frequent criticism of legalism when applied to the field of psychiatry is that psychiatric decision-making is better left to professional ethics, not stringent regulation. Legalism also has been blamed for attempting to limit

330. Phil Fennell, *Law and Psychiatry: The Legal Constitution of the Psychiatric System*, 13 J.L. SOC'Y 35, 37-38 (1986).

331. *Id.* (citing K. Jones, *The Limitations of the Legal Approach to Mental Health*, 3 INT'L J.L. & PSYCHIATRY 10, 10-11 (1980)).

332. *Id.* at 38.

333. *Id.*

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medical discretion by enhancing patients' rights.³³⁴

Anti-legalism, or medicalism, focuses on freeing of psychiatry from excess regulation.³³⁵ Medicalism highly values the independent medical judgment of psychiatrists and other mental health professionals, and encourages professionals to make decisions that will minimize harmful physical effects.³³⁶ Proponents of medicalism value compassion and a desire to protect patients from harm.³³⁷ As expected, opponents view the medical model as paternalistic and outdated.³³⁸

Viewed through the lens of legalism versus medicalism, the controversy surrounding psychiatric restraint and seclusion use is better understood. The goal of many psychiatric patient consumer advocates is to reduce the use of restraint and seclusion because their use has caused psychological harm, serious physical injury, and even death.³³⁹ One option for meeting this goal is to establish, by means of statute or regulation, the right of mental health patients to be free from dangerous holds and psychologically harmful isolation practices.³⁴⁰ Because of the difficulty of distinguishing between safe and unsafe methods of restraint and seclusion, as well as the administrative and judicial oversight needed to determine which ordering physicians were behaving carefully or dangerously vis-à-vis these interventions, consumer advocates instead decide to support a formal and absolute right of patients to be free from all restraints and seclusion.³⁴¹ Mental health care providers who use alternative de-escalation strategies are viewed as complying with the law, whereas providers who use restraint and seclusion are viewed as violating human rights.

The goal of many mental health care professionals also is to prevent psychological harm, physical injury, and death. Mental health care professionals use their education and clinical training to weigh factors such as diagnosis, current

334. *See id.* at 39-40.

335. *Id.* at 37.

336. Schafer, *supra* note 308, at 1257.

337. *Id.*

338. *See id.*

339. *See supra* Parts III.B-C.

340. *See supra* Parts IV.B-C.

341. *See supra* note 11 and accompanying text.

behavior, and past experience with the patient to determine, when all less restrictive measures have been tried and have failed, whether to restrain or seclude the patient.³⁴² Although formal rules permitting or prohibiting restraint and seclusion are nice, they are not altogether useful in balancing the interests of the psychiatric patient and third parties when the unpredictable behavior of a patient is at issue. A medicalist might view the psychiatrist's application of professional judgment to the emergency situation as an act of compassion and a desire to protect patients and third parties from harm; a legalist, however, might interpret the decision to order restraint or seclusion as controlling and demeaning.³⁴³

Although mental health consumer advocates and the medical profession both have patient health as their goal, they differ regarding the best means of accomplishing it. The momentum of the current non-restraint movement shows the value our culture places on autonomy and reminds us of our mandate to respect and promote the rights of individuals with disabilities, including individuals with mental illness.³⁴⁴ But I worry that the realities of our mental health care system (including a lack of access to basic mental health care, which contributes to the need for emergency, inpatient, and acute mental health care, the necessity of which is determined based on criteria including the dangerousness of the patient to self and others) have not yet caught up with the goals of the non-restraint movement. When a physician or other licensed independent practitioner reasonably believes that a patient's behavior poses an imminent threat to the life or health of the patient or a third party and all less restrictive measures have proven ineffective, the option to use restraint or seclusion should be preserved.

D. Future Restraint and Seclusion Policy

Existing federal and state laws governing psychiatric restraint and seclusion regulate the individuals who can order restraint and seclusion, the length of time for which restraint and seclusion may be ordered, the criteria for the imposition of restraint and seclusion, the use of restraint and

342. See *supra* note 12 and accompanying text.

343. Schafer, *supra* note 308, at 1257.

344. See *supra* Part V.B.

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seclusion to compensate for inadequate staffing, the education of health care professionals regarding the dangers of restraint and seclusion, and the reporting of adverse events that occur during or as a result of these interventions.³⁴⁵ So, what should be the direction of future restraint and seclusion policy?

Our health care policy must address the root causes of the use of restraint and seclusion. The studies discussed in Part V.A suggest that we can reduce the incidence of the violent and aggressive behavior that traditionally has preceded the use of restraint and seclusion by providing earlier intervention and care for individuals with mental illness. The studies discussed in Part V.B further suggest that higher staff-to-patient ratios can reduce the use of restraint and seclusion.³⁴⁶ Additional studies suggest that more detailed patient assessments at the time of admission may increase health care providers' ability to identify those patients who may resort to violence and those who will not, thus reducing unnecessary use of restraint and seclusion.³⁴⁷ Of course, earlier intervention and care for individuals with mental illness, higher staff to patient ratios, and more detailed violence screening require more time and human resources and greater funding of mental health care. In a perfect world with limitless funds, our health care policy would appropriate more funds for basic mental health care, increased staffing of emergency and inpatient mental health care, and more detailed inpatient assessments. Such a policy would prospectively minimize the factors that actually give rise to psychiatric violence and aggression, instead of responding to violence and aggression that already has occurred or is about to occur.

In an imperfect world in which additional funding for basic mental health care and increased staffing of emergency and inpatient psychiatric units is not forthcoming, our health care policy should continue to require the use of alternative

345. See *supra* Parts III.B-C.

346. Donat, *supra* note 307, at 415 ("This confirmed that as the staff:patient ratio gradually increased, the reliance on seclusion and restraint in this hospital gradually decreased.")

347. See, e.g., Dale E. McNeil & Renee L. Binder, *Screening for Risk of Inpatient Violence: Validation of an Actuarial Tool*, 18 *LAW & HUM. BEHAV.* 579, 580 (1994).

de-escalation strategies if the benefits of these strategies outweigh the physical and psychological risks to the patient and third parties from restraint and seclusion. Laws and regulations should continue to require health care providers to incorporate the least restrictive techniques into their de-escalation strategies, thereby limiting the use of restraint and seclusion to extreme situations involving imminent violence that are unresponsive to alternative de-escalation strategies. In these extreme situations, our laws and regulations should continue to permit the use of restraint and seclusion on the grounds that the life of the patient and third parties outweighs the liberty interference and physical and psychological injuries that may result from restraint and seclusion use.

Our current laws do not, however, provide specific guidance regarding safe methods of restraint and seclusion. For example, the Conditions of Participation require Medicare-participating hospitals to implement restraint and seclusion in the least restrictive manner possible and in accordance with safe appropriate restraining techniques.³⁴⁸ However, neither the Conditions of Participation nor any guidance adopted thereunder specify the relative safety of various methods of restraint and seclusion. To ensure that health care providers are using only the safest methods of restraint and seclusion, a Congressional committee, a federal agency or subagency such as SAMHSA, or the Government Accountability Office could research, identify, and publish as guidance the safest methods of restraint and seclusion. Depending on the research findings, the guidance may, for example, prohibit health care providers from administering restraints (identified in the guidance by name and picture) that obstruct a patient's airway, impair a patient's breathing, or interfere with a patient's ability to communicate. The guidance may permit health care providers to use prone and supine holds only as a transition to another hold and only when an observer who has been trained to identify the risks associated with positional, compression, or restraint asphyxiation and with prone and supine holds, and who is not involved in the restraint, is ensuring that the patient's

348. 42 C.F.R. § 482.13(f) (2007).

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breathing is not impaired.³⁴⁹

Although many laws, including the COPs, establish maximum time limits for which restraint and seclusion may be imposed, and require the continual assessment, monitoring, and reevaluation of restrained or secluded patients,³⁵⁰ neither the COPs nor any guidance adopted thereunder specify exactly how restrained or secluded patients should be monitored. Because JCAHO data shows that one of the most significant risks to individuals who are restrained is suffocation, our health care policy should consider requiring the use of pulse oximetry during episodes of restraint.³⁵¹ Pulse oximetry is a noninvasive direct measure of the oxygen saturation of hemoglobin.³⁵² Modern, portable oximeters are considered accurate and reliable.³⁵³ More importantly, recent studies conclude that oximetry may be a “viable, cost-effective tool that could protect persons who are subjected to physical restraint from respiratory embarrassment, suffocation, and death”³⁵⁴ by alerting health care professionals to situations in which an individual’s oxygen is dangerously low.

Although many laws, including the COPs, permit restraint or seclusion to be used only when “less restrictive measures have been found to be ineffective to protect the patients or others from harm,”³⁵⁵ and require all staff who have direct patient contact to have ongoing education and training in “alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion,”³⁵⁶ neither the COPs nor any guidance adopted thereunder specify the least restrictive alternatives to restraint and seclusion nor do they rate the relative effectiveness of alternative, named de-

349. Recent Texas legislation may be helpful in this regard. See TEX. HEALTH & SAFETY CODE ANN. § 322.052 (Vernon 2006).

350. 42 C.F.R. §§ 482.13(f)(3)(ii)(D), (f)(5).

351. See, e.g., Masters, *supra* note 120, at 18; Kim James Masters & Deborah Wandless, *Use of Pulse Oximetry During Restraint Episodes*, 56 PSYCHIATRIC SERVS. 1313, 1313 (2005).

352. Masters & Wandless, *supra* note 352, at 1313.

353. *Id.* (citing R.R. Reeves & M.E. Ladner, *Screening for Decreased Oxygen Saturation During Medical Evaluations*, 56 PSYCHIATRIC SERVS. 108 (2005)).

354. Masters & Wandless, *supra* note 352, at 1313.

355. 42 C.F.R. § 482.13(f)(3)(i).

356. *Id.* § 482.13(f)(6).

escalation strategies. Federal and state legislatures and administrative agencies may wish to take notice of the existence of alternative distraction aids, including virtual reality techniques, that are being considered by behavioral psychologists who study the effectiveness of de-escalation strategies.³⁵⁷ Given JCAHO's finding that seclusion is twenty times safer than restraint, lawmakers also may wish to consider the effectiveness of prioritizing seclusion in the intervention sequence.³⁵⁸

Finally, the survivor studies discussed in Part III show that even "safe" restraint and seclusion practices can cause psychological harm. Additional literature written by patients who have been restrained or secluded further detail the liberty interferences and negative psychological effects, including embarrassment, humiliation, and dehumanization, that can result from the use of restraint and seclusion.³⁵⁹ Even though our laws permit the use of restraint and seclusion on the grounds that these interventions may save the life of the patient or third parties in a psychiatric emergency that is non-responsive to alternative de-escalation strategies, our mental health care providers should recognize the significant liberty interference and the potential for negative psychological effects and incorporate measures to counteract these injuries into the patient's treatment plan. The impact of restraint and seclusion on psychiatric patients should be "acknowledged and addressed therapeutically."³⁶⁰

For centuries, restraint and seclusion have been overused as methods of psychiatric behavior management.

357. See, e.g., Masters, *supra* note 120, at 19.

358. See *id.* at 20.

359. STEPHANIE HAIMOWITZ ET AL., RESTRAINT AND SECLUSION – A RISK MANAGEMENT GUIDE 11 (Sept. 2006), available at <http://www.power2u.org/downloads/R-S%20Risk%20Manag%20Guide%20Oct%2006.pdf> (noting that restraint and seclusion can be humiliating); OHIO LEGAL RIGHTS SERV., A CLOSER LOOK: SECLUSION AND RESTRAINT PRACTICES IN CHILDREN'S RESIDENTIAL FACILITIES IN OHIO (Apr. 2002), available at http://www.olrs.ohio.gov/asp/pub_3_PhysicalRestraint.asp (noting that it is embarrassing to be restrained and secluded); Lisa W. Foderaro, *Hospitals Seek an Alternative to Straitjacket*, N.Y. TIMES, Aug. 1, 1994, at A1 (noting that physical restraints can be dehumanizing).

360. OVERCOMING BARRIERS, *supra* note 182 ("The impact of abuse and trauma on the lives of consumers and staff must be acknowledged and addressed therapeutically.").

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Acknowledgement of both the physical and psychological dangers of restraint and seclusion as well as the realities of our modern mental health care system may take us to the next step in the restraint and seclusion controversy.