

# The End of Seclusion and Restraint

This article is presented by the staff of Vermont Protection and Advocacy, Inc., Vermont's federally mandated and authorized disability watchdog organization, in order to broaden and intensify the discussion regarding the use of violent and coercive practices against people with disabilities.<sup>1</sup> The article will discuss the growing trend towards the elimination of violence and coercion on in-patient, locked psychiatric units around the country and in Vermont in terms of the substantive due process rights of involuntarily committed psychiatric patients to be free from the arbitrary and harmful use of coercion against them. It is the authors' hope that increasing awareness among Vermont attorneys of the rights of individuals on in-patient psychiatric units in Vermont will lead to more scrutiny over the use of such violent and coercive practices and speed the elimination of the use of seclusion and restraint and the violence associated with those measures against people with disabilities.

## **The Seminal Case:**

### **Youngberg v. Romeo**

For most of the history of mental health treatment the use of force, seclusion, and restraint, and the violence associated with those measures, was an accepted reality of day-to-day treatment milieus.<sup>2</sup> It was not until the 1982 seminal decision in *Youngberg v. Romeo* that Constitutional limits on the use of coercive practices in psychiatric and other treatment settings were clearly articulated.<sup>3</sup> In *Youngberg*, the mother of a man with profound retardation who was involuntarily institutionalized in Pennsylvania filed suit against state officials after her son suffered multiple injuries and lengthy restraint procedures. The Court agreed with the mother, finding that the Constitution requires that, once a state takes a person into custody, the person has a right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and to habilitation (training) that is minimally adequate as reasonably may be required by these interests.<sup>4</sup> In his opinion for a unanimous Supreme Court, Justice Powell wrote: "If it is

cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed—who may not be punished at all—in unsafe conditions."<sup>5</sup> The Court announced in *Youngberg* that the relevant question when analyzing whether the use of coercion and violence against involuntarily committed patients was unconstitutional was whether or not professional judgment had been exercised in the fact-specific situation. When determining whether the state has met its obligation to provide constitutionally adequate treatment—that is, freedom from unreasonable use of force or restraint—"decisions made by the appropriate professional are entitled to a presumption of correctness."<sup>6</sup>

The Court's decision in *Youngberg* clearly identified that there are Constitutional limits to the amount of force that can be used against an involuntary patient in a hospital or other treatment facility, yet it left the actual definition of what is excessive to the amorphous and potentially fluid determination of "professional judgment."

## **The Legal Standard:**

### **Professional Judgment**

There are several good reasons why the courts should require the input of medical professionals and defer, in part, to those medical professionals when they do exercise professional judgment in ordering coercive interventions against psychiatric patients. Use of seclusion and restraint and the violence associated with those measures poses serious health risks, both physical and psychological. Prone restraints, use of controlling agents like OC spray or Tasers, and even the neurobiological and psychological effects of trauma, can have life-threatening medical consequences. In May 2004 VP&A reported on the suicide death of a patient at the Vermont State Hospital in 2003 whose restraint experience the previous day appears to have been a precipitating factor for his completed suicide effort.<sup>7</sup> Medical professionals should have the training to understand if medications or other aspects of the

patient's illness may have symptoms or side effects, such as motor restlessness or tremors, that may increase the already notable pain, discomfort, and possibility of injury associated with the use of restraints. Often medications, known as chemical restraints, provide an alternative to physical restraints. Use of chemical restraint may appear more humane but often has equally adverse consequences. It is still not uncommon to find both mechanical and chemical restraints, and seclusion, all used concurrently on some units.

Medical professionals should also be in a position, based on experience, training, and level of responsibility, to insure that all less intrusive, restrictive, and potentially dangerous alternatives to the use of seclusion and restraint (and the violence associated with those measures) have been evaluated, attempted, and shown to be ineffective. However, it is not uncommon to find that the individuals on the units making the immediate decisions about the use of seclusion and restraint, and the violence associated with those measures, are not the doctors or psychiatrists contemplated by the judiciary's decisions, but rather the line staff—mental health workers and psychiatric technicians or, possibly, a nurse or a nurse manager. These staff members (especially those on the evening and night shifts), while quite likely working heroically under difficult circumstances, are also likely to have the least amount of training and experience in the use of alternative or non-violent strategies to de-escalate potentially out-of-control situations on in-patient units.

The standard used to determine if there has been a failure to use professional judgment in the use of seclusion and restraint (and the violence associated with those measures) on a person in the state's custody, and therefore a violation of a patient's substantive due process rights, is a high one. The fact that even an obviously better alternative treatment existed will not avoid a finding that a doctor or mental health worker exercised adequate professional judgment so long as the decision was not a substantial departure from accepted practice.<sup>8</sup> In some cases courts have

required convincing evidence that the defendant medical professional acted in a way that no competent medical professional would have acted in order to find a constitutional violation.<sup>9</sup> The standard requires more than simple negligence but less than the willful and malicious deliberate indifference required under the eighth amendment standard applicable to excessive force claims made by prisoners.<sup>10</sup> In one case involving allegations of failure to provide adequate medical care to a Virginia woman involuntarily in state custody, the court held that the actions of the state medical professional must be so far out of bounds as to make them explicable only as an arbitrary and unprofessional action, but recognized that courts have had some difficulty determining precisely how far the professional judgment standard falls from negligence on the culpability continuum.<sup>11</sup>

Nationally there are two major sets of regulations governing the use of seclusion and restraint against in-patient psychiatric patients. They are the Conditions of Participation for hospitals who accept Medicaid and Medicare funding, known as the CMS regulations, and the rules promulgated by the Joint Commission on Accreditation of Healthcare Organizations known as the JCAHO standards.<sup>12</sup> While these standards may not be dispositive in terms of whether or not a specific use of seclusion and restraint and the violence associated with it was an exercise of professional judgment or was unconstitutional, they are certainly relevant.<sup>13</sup> In Vermont, a court-ordered consent decree in the case of *Doe v. Miller* exists that governs the use of seclusion and restraint and the violence associated with those measures at the beleaguered Vermont State Hospital.<sup>14</sup>

All of these standards for in-patient psychiatric facilities have similar requirements both in terms of how seclusion and restraint is defined, when it is permissible, and what must happen after the initiation of coercive and violent procedures. For example, the standards all basically require that seclusion and restraint not be applied unless there is actually an imminent emergency in which a patient or someone else is about to be physically injured and all reasonable non-coercive alternatives have been attempted.<sup>15</sup> There are also limitations placed on the amount of time people of different age groups may be restrained before the situation is reviewed in person by a physician, ranging from

one to four hours.<sup>16</sup> In fact, all facilities and residential programs caring for individuals with disabilities, including mental health-related disabilities, have specific regulations relating to the use of coercive, violent, and involuntary practices against their residents.<sup>17</sup>

While the fourteenth amendment offers only minimum protections that do not establish standards of care themselves and require deference to professionals, the courts are clearly the final arbiters of when use of seclusion and restraint and the violence associated with those measures is unconstitutional. Courts have noted that the Constitution does not immediately fall into line behind the majority view of a committee appointed by the American Psychiatric Association.<sup>18</sup> The Constitution does require that punishment be avoided and medical judgment be exercised. As one court noted: "This a far cry from saying that anything goes—that if the holder of a masters degree in psychology were to decide that sex offenders should be lobotomized and subject to daily electroshock 'therapy,' no court could gainsay that decision."<sup>19</sup> These decisions imply that the courts are open to considering new and evolving standards of professional judgment.

### **The Changing Standard of Professional Judgment**

What constitutes the professional judgment of medical professionals has certainly changed over time. Just as the standard for what is cruel and unusual punishment has evolved over the last twenty years in terms of, for example, whether it is acceptable to execute inmates who were juveniles when they committed their offenses,<sup>20</sup> the standard for what a competent mental health professional considers to be the appropriate therapeutic response to a patient's self-harming or potentially dangerous behaviors has also changed. It is important to note that our experience and training has shown that in these circumstances patients often are not actually dangerous; rather, it is the staff's perceptions and fears that the patient may injure themselves or others, or that the staff will lose control over the situation, that dictates the use of seclusion and restraint and the violence associated with those measures. Often the lack of training and the lack of staff availability to provide one- or two-on-one supervision to a patient prevent giving the patient the time and space

needed to de-escalate. We do not want this article to perpetuate the stereotypical and invalid myth that people with a mental illness are more dangerous or violent than the general public.

Recent editions of the National Association of State Mental Health Program Directors (NASMHPD) publication *Networks* have indicated that eliminating coercive practices on in-patient psychiatric units is part of a larger, federally-approved, effort to reorient our mental health systems "toward a consumer-focused philosophy that emphasizes recovery and independence" and that "it is a hospital's culture more than clinical necessity that determines how often or even if coercive practices are used."<sup>21</sup> A number of hospitals, and even entire state systems, have drastically reduced or eliminated the use of seclusion and restraint.

Pennsylvania is one of several states leading the way in exploring strategies to reduce or eliminate the use of coercive measures in the mental health arena. According to data from the Pennsylvania Performance Measurement System, between 1994 and 1998 the number of hours of seclusion in the state's psychiatric hospitals dropped by 91 percent (from 32.5 hours to 2.9 hours per thousand patient hours). During the same period, hours of restraint fell by 52 percent (from 40 hours to 19 hours per thousand patient hours). This data, in addition to being closely monitored by the state, is made available to the patient and family organizations and the state's mental health planning and advisory council. The collection and provision of this data "has introduced accountability and a healthy competition among hospitals. Seclusion and restraint were symptoms of a whole approach to caring for patients. We felt that it was important to make it clear that these practices are not treatment interventions but treatment failures to be used only as a last resort," said Charles Currie, Pennsylvania's Deputy Secretary for Mental Health and Substance Abuse.<sup>22</sup>

Salem Hospital Psychiatry Inpatient Unit in Salem, Oregon, changed its environment of care beginning in 2001. According to the hospital's promotional materials, as a result of this change

use of locked seclusion and mechanical restraint has been nearly eliminated. Using a defined vision and strategy, the leaders of the unit sought to

change a traditional, involuntary, often coercive inpatient culture to one of non-violence, collaboration, and partnership. Unanticipated benefits include increased patient, family, staff, and physician satisfaction, reduction of patient and staff injury, and improved recruitment of staff and physicians. By focusing on respect and dignity, the environment became one of participation and healing. Staff time is used more efficiently and the program has improved financially.<sup>23</sup>

Recognizing the impact of trauma histories in institutionalized persons and designing treatment protocols to avoid re-traumatization has become the emerging new standard of care in the treatment of persons with disabilities generally.<sup>24</sup> Trauma survivors may be especially vulnerable to physician- or treatment-caused (iatrogenic) trauma that occurs within the psychiatric setting. For example, the routine use of seclusion, restraints, or handcuffs may serve to recapitulate previous traumatic experiences, and thereby exacerbate symptoms of PTSD.<sup>25</sup> The newly reorganized Vermont Agency of Human Services has created a "trauma coordinator" position staffed by a PhD.-level professional assigned to implement trauma-sensitive practices throughout the agency. As recently as August 2004 the Vermont Mental Health Performance Indicator Project noted: "Restraint and seclusion, which are currently accepted methods of management of psychiatric consumers in this country, meet DSM-IV definition of human-induced traumatic stressors. Both exert violent and absolute control while engendering utter helplessness and fear."<sup>26</sup> Newer systems for training staff, such as the MANDT system, emphasize the importance of trauma-sensitive responses to escalating behavior.<sup>27</sup> This acknowledgement of the consequences of the use of seclusion and restraint and the violence associated with those measures against patients is informing the trend towards eliminating the use of these coercive and violent practices in psychiatric facilities.

### Progress in Vermont

In the winter of 1999-2000, then Commissioner of the Vermont Department of Developmental and Mental Health Services (DDMHS), Rodney Copeland, issued a report entitled *Vermont's Vision of a Public*

*System for Developmental and Mental Health Services Without Coercion*. That report identified the need to "... eliminate the coercion experienced by our most vulnerable citizens."<sup>28</sup> The report described the DDMHS plan to provide a "... significant increase in our efforts to eliminate coercion from our systems of care."<sup>29</sup>

Currently, in Vermont, Retreat Healthcare has taken the lead in moving towards a seclusion and restraint-free facility by initiating its Trauma Informed Recovery and Resiliency Model (TIRRM). In March 2005, staff from Retreat attended a training seminar on "Creating Violence Free and Coercion Free Mental Health Treatment Environments" sponsored by the National Association of State Mental Health Program Directors (NASMHPD) National Executive Training Institute, where they developed the preliminary plan for implementation of the TIRRM initiative. Retreat has indicated that insidious paternalism and coercion too often characterize mental health treatment, leading to unnecessary and traumatic use of coercive practices against patients. The TIRRM initiative aims to reduce drastically the use of coercion against patients through comprehensive changes. More progressive training of staff on de-escalation practices are being provided. Changes to policies regarding information gathering and planning at admission aimed at being prepared to respond to situations that escalate to dangerous proportions are being implemented. By moving the overall treatment philosophy towards one that supports patients retaining power and control of their treatment choices, Retreat hopes to reinforce these changes. The TIRRM model recognizes that coercive interventions traumatize both patients and staff, and that reducing the incidence of coercive intervention best serves the interests of all.<sup>30</sup>

Both the Vermont State Hospital and Fletcher Allen Health Care have been considering making commitments and necessary changes to achieve less coercive and violent in-patient environments. Staff of the Vermont State Hospital attended a NASMHPD training in the spring of 2003 similar to the one attended by Retreat staff prior to their implementation of the TIRRM initiative. While both the Vermont State Hospital and Fletcher Allen Healthcare have begun efforts to reduce coercive and violent practices against psychiatric

patients, they have yet to implement a comprehensive, trauma-informed strategy to move closer to the elimination of such violent and coercive practices in their facilities. As more and more examples of successful implementation of coercion- and violence-free mental health environments are identified and noted, both within Vermont and around the country, facilities that are lagging behind in adapting to the new standard of care will have little choice but to make progress towards the elimination of seclusion and restraint and the violence associated with those measures in their facilities as well. In this way the standard for what constitutes the permissible use of seclusion and restraint against people with disabilities, both in and out of state's custody, will change as well. In the very near future it is likely that professional judgment will not condone the use of seclusion and restraint in the vast majority of situations in which such coercive and violent practices are used currently. Such a determination based on the evolving standards of medical treatment will have myriad positive benefits, from reducing re-traumatization of patients to reducing the number of staff injuries and related workers' compensation claims.<sup>31</sup>

For more information on the trend towards the elimination of seclusion and restraint against people with disabilities please contact us at 1-800-834-7890, 1-802-229-1355 or visit our website at [www.vtpa.org](http://www.vtpa.org) and click on the link "bibliographies."

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<sup>2</sup> While generally accepted, the use of coercive and violent measures against patients with mental illness was not universally agreed upon. "Concern about the ethics of restraint

reaches back a long way. In 1838, Hill wrote, 'In a properly constructed building, with a suitable number of attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of Lunacy whatever'" R.G. HILL, THE TOTAL ABOLITION OF PERSONAL RESTRAINT IN THE TREATMENT OF THE INSANE (1976; orig. publ. 1838). Anna Marsh founded the Brattleboro Retreat in 1870 based on a philosophy of humane treatment and the principles of respect for each individual.

<sup>3</sup> 457 U.S. 307 (1982). The *Youngberg* Court built on earlier decisions finding that even convicted prisoners had due process rights and that "liberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action," citing *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, (1979) (POWELL, J., concurring in part and dissenting in part).

<sup>4</sup> *Youngberg*, 457 U.S. at 325.

<sup>5</sup> *Id.* at 316.

<sup>6</sup> *Id.* at 324.

<sup>7</sup> See VP&A's website, [www.vtpa.org](http://www.vtpa.org), click on the *investigations* hyperlink to find "An Investigation Into the Circumstances Surrounding the Death of Christopher Fitzgerald on August 8, 2003 at the Vermont State Hospital."

<sup>8</sup> See *Kulak v. City of New York*, 88 F.3d 63 (2d. Cir.1996) (holding that use of a Haldol cocktail as emergency medication was not a constitutional violation even though providing just Ativan, a shorter acting drug with fewer side effects, would have been just as effective).

<sup>9</sup> *Lubera v. Jewish Ass'n for Services for Aged*, 1996 WL 426375, \*5+ (S.D.N.Y. Jul 30, 1996) (No. 95 CIV. 7845 (DLC)).

<sup>10</sup> *Estelle v. Gambel*, 429 U.S. 97, 105 (1976) (deliberate indifference to serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain forbidden by the eighth amendment).

<sup>11</sup> *Patten v. Nichols*, 274 F.3d 829 (4<sup>th</sup> Cir. 2001). Beyond recognizing that the standard requires proof of more than mere negligence, courts have had some difficulty determining precisely how far the professional judgment standard falls from negligence on the culpability continuum. Compare *Yvonne L. v. New Mexico Dep't of Human Servs.*, 959 F.2d 883, 894 (10<sup>th</sup> Cir.1992) (doubting whether "there is much difference" between the deliberate indifference standard and the *Youngberg* standard), with *Doe v. New York City Dep't of Soc. Servs.*, 709 F.2d 782, 790 (2d Cir.1983) (stating that in *Youngberg*, "the Court adopted what is essentially a gross negligence standard"). See also *Shaw v. Strackhouse*, 920 F.2d 1135, 1146 (3d Cir.1990) ("[p]rofessional judgment, like recklessness and gross negligence, generally falls somewhere between simple negligence and intentional misconduct").

<sup>12</sup> The CMS regulations can be found at 42 C.F.R. §482.13 *et seq.* The JCAHO standards on Behavioral Health can be found on their website <http://www.jointcommission.org/Standards/>. A complete copy of the 2006-2007 Standards for Behavioral Health Care and the 2006 Hospital Accreditation Standards can be purchased at the JCAHO website.

<sup>13</sup> See *Neiberger v. Hawkins*, 239 F.Supp.2d 1140, 1158 (D.Colo. 2002) (finding defendants have not established a *prima facie* showing of

present institutional exercise of professional judgment through their JCAHO accreditation, and citing *Woe v. Cuomo*, 729 F.2d 96, 106 (2d Cir.1984) ("JCAH[O] approval represents an 'exercise of professional judgment' to which we must defer under *Youngberg*.")).

<sup>14</sup> *Doe v. Miller*, Docket S-142-82 Wnc, Settlement Order, June 8, 1984. This Order is especially relevant now that the Vermont State Hospital is not allowed to receive CMS money directly and, consequently, technically is not governed by the CMS regulations.

<sup>15</sup> See CMS regulations 42 C.F.R. §482.13(e) and (f); JCAHO Standard PC 12.60; *Doe v. Miller*, *supra* note 14, at II (D), definition of "emergency."

<sup>16</sup> See CMS regulations 42 C.F.R. §482.13(f)(3) (D) and (f); JCAHO 12.70, 12.80, 12.100, and 12.110; *Doe v. Miller*, *supra* note 14, at II (B)(2).

<sup>17</sup> Here is a partial list of facilities providing services to individuals with disabilities in Vermont and the applicable licensing regulations: Residential Care Home Licensing Regulations, State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, effective 10/3/2000; Therapeutic Community Residences Regulations, State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, effective 06/10/1977; Licensing and Operating Rules for Nursing Homes Regulations, State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, effective 12/15/2001; Intermediate Care Facilities for the Mentally Retarded (ICF/MR), State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, certified for participation in the Medicaid program through the Division of Licensing and Protection; Homes for the Terminally Ill, State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, effective 10/01/2001; Assisted Living Residence, State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection, effective 03/15/2003; Residential Child Care Facilities, State of Vermont, Agency of Human Services, Department for Children and Families, Family Services Division, Residential Licensing Unit, effective 11/15/1992.

<sup>18</sup> *West v. Schwebke*, 333 F.3d 745 (C.A.7 2003).

<sup>19</sup> *Id.* at 749.

<sup>20</sup> *Roper v. Simmons*, 543 U.S. 551 (2005).

<sup>21</sup> "Focus on the States—Pennsylvania Leads the Way in Reducing the Use of Seclusion and Restraint," NETWORKS, Summer 1999; "Seclusion and Restraint Debate Gains Momentum," NETWORKS, Summer 1999.

<sup>22</sup> "Focus on the States—Pennsylvania Leads the Way in Reducing the Use of Seclusion and Restraint," *supra* note 21.

<sup>23</sup> Maggie Bennington Davis & Tim Murphy, *The Engagement Model, Evolutions in Healthcare*. See also Maggie Bennington Davis & Tim Murphy, *Restraint and Seclusion: The Model for Eliminating Their Use in Healthcare* (2005).

<sup>24</sup> T. Petti et al., *Perceptions of Seclusion*

*and Restraint by Patients and Staff in an Intermediate-Term Care Facility*, 4 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 115 (2001) ("When asked, individuals virtually always report experiencing seclusion and restraint as traumatic...").

<sup>25</sup> B.C. Frueh et al., *Trauma Within the Psychiatric Setting: Conceptual Framework, Research Directions, and Policy Implications*, 28 ADMIN. & POL'Y IN MENTAL HEALTH 147 (2000).

<sup>26</sup> Vermont Mental Health Performance Indicator Project Report, *Trauma-Involuntary Inpatient Interventions and Community Mental Health Service Utilization*, August 27, 2004, citing A. JENNINGS, THE DAMAGING CONSEQUENCES OF VIOLENCE AND TRAUMA: FACTS, DISCUSSION POINTS, AND RECOMMENDATIONS OF BEHAVIORAL HEALTH SYSTEMS (2004).

<sup>27</sup> Named for its founder, David Mandt, the MANDT System is based on treating people with dignity and respect. It teaches non-hands-on interventions and development of skills to identify and de-escalate potentially threatening/violent situations. The training includes a section on Trauma-Informed Services, which "incorporates knowledge about trauma, prevalence, impact and recovery in all aspects of service delivery. It minimizes re-victimization and leads to services that are hospitable and engaging to survivors." *MANDT System Manual*, January 2006, at 113.

<sup>28</sup> Rodney Copeland, *Vermont's Vision of a Public System for Developmental and Mental Health Services Without Coercion*, Vermont Department of Developmental and Mental Health Services, Fall-Winter 1999-2000, at ii.

<sup>29</sup> *Id.* at 3.

<sup>30</sup> Comments and quotations from Maria Besescu, VP of Communications and External Affairs, and Mary Trombley, Clinical Nurse Manager Tyler 3 & 4, Retreat Healthcare, 2005-2006.

<sup>31</sup> See Salem Hospital information, *supra* note 23.

