

Human Services Restraint: Its Past and Future

David Ferleger

Restraints and seclusion are used on people in institutions, children in schools, nursing home residents, general hospital patients, and other locations, but most often with people who have disabilities. Questions regarding legality, morality, and efficacy abound. These questions, compounded by the serious possible adverse consequences of restraints and seclusion, have commanded wide-ranging attention from legislatures, government agencies, human service professionals, direct care staff, advocates, clients and families, and the public. This article addresses the use of physical restraints and seclusion. It does not address the use of drugs as a behavior restraint, although much of the discussion applies in that context as well.

Is the use of human services restraint therapeutic? Can restraint use be reduced or replaced with alternatives? Is it time to relinquish these practices, at least when incorporated in a treatment or habilitation plan?

In this article I begin with a look at the early institutional use of restraints and seclusion and, as a reminder of what may ultimately be at stake, I note some worst-case results in the United States. I then consider efficacy and risks of “human services restraint.” I review efforts to reform and reduce the use of restraint and address legal liability questions that impact on agency policy and professional behavior. I conclude with some thoughts on the current state of knowledge, policies, and practices regarding human services restraint and on the future of these techniques.

Restraints in the Early Institutions

Dr. John Conolly accepted the judgment of Dr. Robert Hill, who had experimented with nonrestraint at the Lincoln asylum. Dr. Hill had stated, “In a properly constructed building with [enough attendants], restraint is never necessary, never justifiable, and always injurious” (Ozarin, 2001, p. 27). That was 170 years ago.

Dr. Conolly was appointed superintendent of the Middlesex County asylum at Hanwell in Eng-

land in June 1839. Over 40 of the 800 patients were restrained at the time. Within 3 months, by September 21, all forms of mechanical restraint were gone (Hunter & Macalpine, 1963). Dozens of other facilities followed suit. As a modern commentator explained (Saks 1986),

Conolly was the most famous spokesperson for the non-restraint movement in Britain. His book, *THE TREATMENT OF THE INSANE WITHOUT MECHANICAL RESTRAINTS* (1856), thoroughly documented the salutary effects of removing patients’ shackles. Although Conolly did allow for the use of seclusion in some circumstances, he recommended a policy of forbearance toward patients’ inappropriate behavior, and managed to forego the use of restraints for over ten years. His accomplishment was even more remarkable in that he did not have antipsychotic drugs with which to calm his patients. . . . Forty other large public asylums quickly replicated Conolly’s success. (Uppercase in original) (Saks, 1986, p. 1845)

Dr. Conolly epitomized the no-restraint policy within the “moral treatment” movement influenced by the Quakers in England and post-French Revolution reformers in France in the late 1700s and into the 1800s. England’s 1854 Lunacy Acts prompted the reduction of restraint use as well. The names of Tuke, Pinel, and Kirkbride are a familiar part of this history (Ozarin, 2000; Tomes, 1984).

In the United States, psychiatric hospital superintendents in the mid- to late 1800s were divided on the use of restraints but generally opposed the no-restraint, English position. Physical restraint was viewed as a form of therapeutic treatment and was an accepted practice for dealing with violent patients. American psychiatrists extolled the value of restraint and seclusion, with one noting that these practices are required by a specific American violence. Eugene Grissom of the North Carolina state asylum argued “that the moderate use of mechanical restraint was therapeutic and morally sound, that it was required by the peculiar violence of American Insanity; and it that prevented tragic accidents and injuries” (Tomes, 1988, p. 190). John Gray, the editor of the *American Journal of Insanity* wrote, “We look upon restraint and seclusion, directed and controlled by a conscientious and intelligent medical man, as among the valuable allevi-

ating and remedial agents in the care and cure of the insane” (as cited in Tomes, 1988, p. 206).

In 1875, Dr. (Lord) John Buckmill, a former superintendent of an asylum in England, visited American public and private asylums. He disagreed with the American viewpoint. At the superintendents’ annual meeting that year, he invited any superintendent to visit England for a month, and he bet £100 that such a visitor could not find any form of restraint in British asylums. He had no takers. He later wrote, “[The American superintendents] will look back to their defense with the same wonderment . . . that has been said in defense of domestic slavery” (Ozarin, 2001, p. 27).

Worst-Case Stories

Although the vast majority of cases of restraint and seclusion do not result in physical harm or death, and for the most part shackles have given way to personal physical restraint, it is sobering to keep in mind at least some of the instances in which death during restraint has occurred recently. Contemplating these deaths assists in reflecting on how alternative practices might have affected the situation, if at all.

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

- Isaiah Simmons died January 23, 2007, at the Bowling Brook Preparatory School in Maryland. He allegedly acted out in the dinner line and was restrained. Four youths who witnessed the incident said staff sat on him for 3 hours until he passed out and died. The school has closed, the death was ruled a homicide, and indicted staff were charged with waiting 41 minutes before calling 911 about the unresponsive boy; they were later cleared of criminal charges (Nuchols, 2007).
- Cedric Napoleon, a 14-year-old special education student died March 7, 2002, after a teacher and a classroom aide restrained him in Killeen, Texas. He suffocated due to pressure on his chest. The school said he was disruptive. His foster parents said that when the restraint happened, their son was attempting to leave the classroom to look for food because school officials had limited his food ration as punishment. The boy was not fighting or involved in any violent act at the time of the restraint (*Associated Press*, 2002; Spencer, 2002).

- On February 15, 2007, Jonathan Carey, a boy with autism who was a resident at the O.D. Heck Developmental Center in New York was restrained in a van while staff were running errands for 1.5 hours. He could not be revived. Two staff are being charged (CAICA, 2007).
- On June 3, 2007, Omega Leach, Age 17, died at the Chad Youth Enhancement Center in Tennessee, a day after being restrained for 7 to 8 minutes for attacking a staff member. At the end of those minutes, staff could not find a pulse. The state found that the facility violated restraint policies (WTVF Nashville, 2007).
- Angelikka Arndt was 7 years old when she died in May 2006 while being restrained at the Northwest Counseling and Guidance Clinic in Wisconsin. She had been restrained nine times over a month. She died of “complications from chest compression asphyxiation” after being held face down on the floor by two staff. The restraint was due to her “gargling milk” (Reynolds, 2006b).
- In Ephrata, Pennsylvania, Giovanni Aletriz of Allentown, was 16 when he died on February 4, 2006, the second death in 2 months at SummitQuest Academy, a program for boys with mental health and sex offender problems. An independent forensic pathologist found that the death most likely resulted from being held face-down forcefully. SummitQuest officials said the staff follows a crisis management procedure developed by the University of Pittsburgh Medical Center’s West Psychiatric Institute. No charges were filed because he had an undiagnosed heart condition. The Department of Public Welfare put the facility on a 6-month provisional license (Stauffer, 2006a, 2006b).
- Mikie Garcia died on December 4, 2005, in Texas of “suffocation during physical restraint,” according to the medical examiner. He had been placed in “time out” for refusing to obey orders, and he started banging his head against concrete, so staff restrained him until he stopped breathing. Staff restrained the boy with his arms across his chest and his hands held behind him, in what is called a “basket hold.” He was 12 years old (Reynolds, 2006a).

Human Services Restraint Defined

Restraint is the use of force to limit another person’s movement. This may occur by physical contact among individuals, mechanically by devices to limit movement, or chemically by the use of drugs. *Seclusion*

is the involuntary placement of a person in a room, exit from which is not a permitted choice.

Human service restraint, a term taken from Tuminski (2005), is used here. The term encompasses both restraints and seclusion. It refers to restraint of a client under the mandate of a program or agency, public or private, by staff who are taught specific restraint techniques. We distinguish human service restraint from actions among parents, friends, and others in freely given relationships.

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

Restraints do not include orthopedically prescribed devices, protective helmets, holding someone to conduct routine physical examinations or tests, protections against one falling out of bed, or assistance to permit someone to participate in activities without risk of physical harm [42 C.F.R. 482.13 (e)(1)(i)(C)].

In hospitals, restraint appears to be allowed in nonemergency situations; in intermediate care facilities—mental retardation (ICF/MR) programs, physical restraint and time-out are specifically permitted in nonemergency situations and, when prescribed, must be included in a client's individual program plan for active treatment. The United States provides some regulatory definitions. These differ depending on the type of program and people served. Two examples are provided here.

For Medicare and Medicaid participating hospitals, including psychiatric facilities, the regulations are new. *Restraint* is “Any manual method, physical 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” [42 C.F.R. 482.13 (e) 2006]. Restraint is allowed in nonemergency situations. *Seclusion* is “The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. Seclusion may only be used for the management of violent or self-destructive behavior.”

The older ICF/MR regulations forbade “unnecessary” restraints and required that clients must be “provided active treatment to reduce dependency

on drugs and physical restraints” [42 C.F.R. 483.420(a)(6)]. The ICF/MR regulations permit the use of a time-out room as part of “an approved systematic time-out program” incorporated into the client's individual program plan. [42 C.F.R. 483.450(c)]. Physical restraints are permitted only:

1. As 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;
2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or
3. [As a health-related medical/surgical procedure]. [42 C.F.R. 483.450(c)]

Efficacy and Risks

The use of these human services restraint techniques is not simply a response to client behavior. There is an interplay among staff, setting, the characteristics of the individual, and the individual's behavior, which is perhaps best conceptualized, in the words of one researcher, within an “ecobehavioral” perspective (Day, 2000). Day noted, for example, that age and nature of disability may affect restraint use; there is a greater use of restraints for children with “lower intelligence or neurological impairments.” (Day, 2000, p. i). As discussed below, policy, training, and staff behavior greatly affect the extent of restraint use.

Fisher, in a review of the existing literature published in 1994, reached the conclusion that “[l]ocal non-clinical factors, such as cultural bias, staff role perceptions and the attitudes of hospital administrators, have a greater influence on the use of these practices than any clinical factors” (Fisher, 1994, p. 1590).

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

- It has harmful consequences to both staff and clients.
- It may reinforce aggressive behavior as a coping mechanism.
- It may not be clinically effective.
- It may humiliate clients.
- It may be countertherapeutic for individuals with an abuse history.

- It has been used for discipline, coercion, and convenience.
- It may be unethical.
- It may be unconstitutional.

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

NASMHPD [National Association of State Mental Health Program Directors] and NTAC [National Threat Assessment Center] forge ahead with advocating, influencing, and training to reduce and eliminate restraint and seclusion. The training manuals of these organizations are supported (or more precisely not supported) by the research outlined in this article. The authors believe that voices of protest must be raised to slow down the locomotive of opinions and pressure tactics that may lead mental health treatment in the wrong direction. (Zeigler & Silver, 2004, p. 7)

The discussion here focuses on what the author believes are two fundamental questions that are most likely to influence governmental, agency, and judicial decisions on restraint: (a) efficacy and (b) risk of harm. There is relatively little scientific investigation of the techniques’ efficacy, and no proof of their efficacy. There is, however, much evidence of their risks.

Efficacy

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

Planned human services restraint for treatment, to support positive behavior, or to reduce negative behavior has not been shown to be effective. For example, a review of 109 articles spanning 35 years between 1965 and 2000 on restraints and seclusion on children and adolescents found that the techniques have only “questionable efficacy” (Day, 2000, p. 28). Research on human services restraint is characterized as sketchy and inconclusive. Both governmental and professional reviews have found no therapeutic value in the practices. For example, the state of Wisconsin concluded,

The efficacy of the use of seclusion and physical restraint as behavior change techniques has not been documented, and re-

search on the use of these techniques in schools is sketchy. While the use of these techniques may not be empirically supported as positive behavioral interventions, their use may be necessary for safety reasons. (Wisconsin Department of Public Instruction, 2005, p. 4)

The National Alliance on Mental Illness (NAMI) stated:

Restraint and seclusion have no therapeutic value. They should never be used to ‘educate patients about socially acceptable behavior,’ for purposes of punishment, discipline, retaliation, coercion, and convenience; or to prevent the disruption of the therapeutic milieu. (NAMI, 2003, p. 15)

In a training manual, *A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages*, the U.S. Department of Health & Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA; 2006) set a goal

to reduce and ultimately eliminate the use of seclusion and restraint in behavioral healthcare settings. These practices are detrimental to the recovery of persons with mental illnesses. (U.S. Department of Health and Human Services 2006, p. 3)

Despite the absence of evidence of efficacy, there are volumes on proper procedures and criteria, minivolumes on documentation, and innumerable dollars spent annually on programs for staff training in techniques that have not been found to be effective.

Risks

It is difficult to evaluate the relative risks in the use of human services restraint. The absence of data on restraint use (including data on routine use as well as the frequency of untoward events) makes it extremely difficult to comment on the relative risks involved in restraint, the comparative risks involved across a wide range of individual procedures, and the relative risks involved in alternative interventions, including seclusion, mechanical restraint, or medication (Busch & Shore, 2000; Patterson, 2003).

Clients and staff may be injured during the imposition of restraint. The ultimate risk is death. In the professional literature, there has been discussion of the risk of death associated with the use of physical restraints since at least the 1980s. More recent research has focused on deaths and other adverse consequences in restraint (Fisher, 1994; Milliken, 1998; Mohr, 2003; Patterson, 2003). Although much of the research concerns psychiatric restraint use, the physiological effects of restraint are no different for individuals with intellectual and devel-

opmental disabilities. These risks exist with both mechanical restraint and with so-called personal restraint, where a staff person's body is used to impose the restraint.

Upset clients, when restrained, are held down or held tight, often with bodily organs and chest compressed; the heart begins to beat faster or out of rhythm, as the body attempts to obtain more oxygen to support itself (DiDino & Zaccardi, 2007). Restraints involving neck holds or obstruction of the nose or mouth have a high risk of fatality, as do mechanical restraints or prone tying, including "hobble tying." "Hobble tying is the term used to describe the prone positioning of a patient, following which their wrists are secured behind their back, their ankles are tied, and their wrists and ankles are subsequently secured together by pulling the shoulders back and bending the legs towards them" (Horsburgh, 2004, p. 8). In a series of 214 cases of hobble tying in agitated delirium, death occurred in nearly 12% of the cases (Stratton, 2001). Seated restraint is also risky; preexisting physical conditions, such as obesity, heart disease, general physical ill health, or exhaustion, are additional risks (Horsburgh, 2004).

It is fair to say that there is no way to predict who may die due to the use of physical restraint or who may be seriously injured. Almost 10 years ago, an editorial in the *Canadian Medical Association Journal* noted the asserted benefits of human services restraint and then reminded us, "However, restraint is not itself harmless; some proportion of those who are restrained may die. We do not know what this proportion is, or how many others will come near death and need to be revived" (Milliken, 1998, p. 1611).

Children appear to be particularly likely to be subjected to restraints and to die while restrained (Cotton, 1989; Delaney & Fogg, 2005; Earle & Forquer, 2005; Fassler & Cotton, 1992; Nunno, 2006). The use of restraints in schools is of increasing concern and is now the subject of specific research attention; restraint use in schools is often not subject to accreditation or regulatory control (Ryan & Peterson, 1992).

Reduction in Restraint and Seclusion Use

There is a great deal of evidence that the use of human services restraint can be dramatically reduced and, as some programs have shown, elimi-

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

Singh (1999) taught staff on an adolescent unit about behavioral principles and a treatment approach that focused on the patient's strengths. The investigators gradually reduced the number of acceptable hours of restraint and seclusion, setting progressively lower quarterly criterion levels. Staff met these levels, eventually reaching zero use. They maintained the gain at 1-year follow up (Singh 1999).

A study published in 2005 regarding Pennsylvania's reduction program examined the use of seclusion and mechanical restraint from 1990 to 2000 and the rate of staff injuries from patient assaults from 1998 to 2000 in Pennsylvania's state hospital system. From 1990 to 2000, the rate of seclusion decreased from 4.2 to 0.3 episodes per 1,000 patient-days. The average duration of seclusion decreased from 10.8 to 1.3 hours. The rate of restraint decreased from 3.5 to 1.2 episodes per 1,000 patient-days. The average duration of restraint decreased from 11.9 to 1.9 hours. No significant changes were seen in rates of staff injuries from 1998 to 2000 (Smith, 2005).

The National Association of State Mental Health Program Directors has conducted training on human services restraint reduction and has reported that seclusion/restraint hours were reduced by as much as 79%, the proportion of individuals in seclusion/restraint was reduced by as much as 62%, and the incidents of seclusion/restraint events in a month were reduced by as much as 68%. These data are based on 3- to 6-month posttraining evaluations of the first 12 states trained, with 8 hospitals sending data (Conley, 2004; Huckshorn, 2006).

As indicated, alternative approaches often encompass (a) organizational and policy changes, (b) quality assurance techniques, and (c) changes to clinical programming, such as prevention of the behavior or situation leading to restraints or seclusion, or the use of alternative procedures. Formulas for reduction typically include such elements as the fol-

lowing (American Academy of Child & Adolescent Psychiatry, 2002; Day, 2000; Delaney, 2006; Miller, 2006; Milliken, 1998; Petti, 2001; Sullivan, 2005):

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

There are other approaches to limiting human services restraint. These may be imposed by authorities outside the entity that is serving clients. These include the approaches discussed below.

Legislation and regulation. Proposed legislation in New Jersey would forbid the use of restraints or seclusion as planned interventions or treatment, recognizing only its emergency use. This is Matthew's Law, named after Matthew Goodman, a child with autism who died after use of restraints (New Jersey Bills No. A948, S71, 2006–2007). Various states have passed or are considering legislation limiting restraint use. Other legislation on restraints is in place (Children's Health Act, 2000).

Federal law regulates restraint use. Some examples are as follows: 42 U.S.C. §290jj (2002), regulating public or private, nonmedical, community-based facilities, guarantees a “right to be free from . . . any restraints or involuntary seclusions imposed for purposes of discipline or convenience.” The Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. §15009(3)(A)(3)] includes congressional findings that public funds should be for programs that meet minimum standards relating to “prohibition of the use of physical restraint and seclusion for such an individual unless absolutely necessary to ensure the immediate safety of the individual or others, and prohibition of the use of such restraint and seclusion as a punishment or as a substitute for a habilitation program.”

Policy change resulting from personal experience. Stefan (2006) reported that, after a state mental health department medical director spent the day in ambulatory restraints, he prohibited their use in state facilities. Court-appointed monitors and ex-

pert witnesses have also been affected by having institutional staff administer restraints to them.

Ban. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2006) seeks to “ultimately eliminate the use of seclusion and restraint in behavioral healthcare.” President George W. Bush's New Freedom Commission on Mental Health 2003 final report recommended that seclusion and restraint be used “only as safety interventions of last resort, not as treatment interventions” (U.S. Mental Health Commission, p. 9). The New York State Psychological Association's task force on the issue “recommends that aversive behavior interventions be prohibited, without exception, as part of a behavior intervention plan” (New York State Psychological Association, 2006, p. 6). A broader ban is urged by The Alliance to Prevent Restraint, Aversive Interventions and Seclusion (APRAIS). APRAIS (2005) was created by a number of professional and advocacy organizations.

Judicially determined legal standards. Legal decisions may have a significant effect. I turn to the law in the next section.

A Legal Perspective

Much contemporary discussion on the use of human services restraint focuses on legal liability. Professional standards of care are integral to grounds on which legal liability is based. When will staff, teachers, or an agency be liable for damages for using restraint at all, or for failing to use it? When is there liability for a restraint gone awry? When does it violate treatment rights to use, or not to use, restraint?

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

On the basis of how the cases have been tried and litigated thus far, the courts have generally been supportive of restraint use and have not established significant barriers to the use of programmatic restraint. It does not appear, however, that the courts (at least in their published opinions) have taken into account the professional research on efficacy and risks or the policies adopted by professional organizations and governmental agencies.

There is a constitutional right to be free from bodily restraint, with the right circumscribed by the “professional judgment” standard announced by the

Supreme Court 25 years ago in a case originating in the Pennhurst State School and Hospital restraint practices (*Youngberg v Romeo*, 1982). Legal discussions of restraint have been framed by the *Romeo* standard under the 14th Amendment, related decisions, and other legal principles (i.e., 4th Amendment, 8th Amendment) and statutes such as the Americans With Disabilities Act and education laws.

The extreme is clear. Where a patient is subjected to kicking, stomping, strangling, and twisting in the process of a takedown for restraint, the constitutional limits are breached, as a Minnesota federal court found recently (*Nicolaison v Brown*, 2007). A fair statement of the state of the law is found in that decision. “Constitutionally infirm practices are those that are punitive in intent, those that are not rationally related to a legitimate purpose or those that are rationally related but are excessive in light of their purpose.”

Under current court decisions, the legal standard cited above would likely tolerate restraint use when treatment professionals or teachers decided to restrain or seclude someone for safety or behavior control purposes, and the action is taken in at least arguable good faith. Even severe and injurious actions have not been condemned by the courts.

- In a 2002 decision, a 14-year-old public school student (“M.H.”) with Down syndrome sued for damages (*M.H. ex. Rel. Mr. H. v Bristol Board of Education*, 2002). M.H. misbehaved and a special education teacher spat water into his face, saying, “This is spitting.” The incident was not reported to school supervisors, and the staff who were present later falsely told the parents, who noticed M.H.’s soaked hair, that they had been “playing hairdresser.” On another day, a special education teacher held both the boy’s arms forcibly behind his back and directed him to a task. During a fire alarm, M.H.’s arms were bruised when staff physically removed him from the building. Teachers also used a chair restraint, which was written into a behavior plan. The court concluded that (a) the two incidents of physical restraint and the incident of spitting by a teacher did not rise to the level of constitutional violations, and (b) the defendants’ use of a chair restraint on the plaintiff did not violate the plaintiff’s substantive due process rights because the defendants exercised professional judgment.
- A 16-year-old public school student with Down

syndrome was subjected to restraint and isolation for behavioral outbursts. The appeals court held that there was no violation of the Individuals With Disabilities Education Act (IDEA) or her individualized education program (IEP), as she was not treated differently from other students with behavioral outbursts (*Melissa S. v School District of Pittsburgh*, 2006).

- A third-grade public school special education student with behavioral issues, including kicking and hitting others and striking his head on walls, was put in time-out and restrained repeatedly. The court noted that there was “an increased amount of restraint in his third-grade year, but that fact alone does not make his education inappropriate within the meaning of the IDEA” (*CJN v Minneapolis Public Schools*, 2003).
- A Texas court held that the wrapping of a first-grade student in sheet or blanket, adding tape to secure it, and on occasions taping the wrapped student to a cot, to prevent the student from harming herself or others while “raging,” did not violate any clearly established Fourth Amendment right to be free from such restraint (*Doe v S & S Consol. I.S.D.*, 2001).
- In a case involving a 9-year-old girl with severe intellectual disability, who was a student in a public school, the therapist recommended a “blanket wrap.” The court held this restraint to be “within the realm of professionally acceptable choices” (*Heidemann v Roether*, 1996).
- A court upheld placing a second-grade student in restraints to stop him from sliding on table tops (even though his parents had withdrawn consent to the use of restraints), concluding that restraints were needed for physical safety (*Alex G. ex rel. Dr. Steven G. v Bd. of Trustees of Davis Joint Unified School District*, 2005).

Arguably, some of these courts avoided specific rulings on the restraint techniques by making decisions based on immunity and other substance-avoiding principles. At the same time, it is noteworthy that the court decisions in these cases found nothing especially troubling in the particular use of restraint.

The courts have not been provided a full accounting of the history and nature of restraint, the dearth of evidence of efficacy, the high risk, or the weight of professional opinion. The law will likely evolve from its current state as courts receive that accounting. At that point, I expect the decisions to

take another direction. Courts will recognize the fragility of the prior decisions upholding restraint and will begin to examine claims that restraints are therapeutic with great skepticism.

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

Agency and Organizational Views

The use of restraint is increasingly subject to scrutiny and disfavor. Federal agencies and professional organizations in recent years have become very critical of any use of restraint and seclusion.

As already noted, President George W. Bush's New Freedom Commission on Mental Health final report (2003) advised, "Seclusion and restraint will be used only as safety interventions of last resort, not as treatment interventions" (U.S. Mental Health Commission, 2003, p. 9). The National Institute on Disability and Rehabilitation Research (NIDRR) provides research grants on positive behavioral supports as a way to reduce the use of restraint and seclusion. NIDRR has stated, "Unnecessary institutionalization remains a problem, as do the practices of seclusion, restraint, and forced treatment" (NIDRR, 2006, 71 Fed.Reg. 8183 [Feb. 15, 2006]). In 2003, SAMHSA reported established seclusion and restraint as a priority area and developed a National Action Plan to reach its vision of seclusion and restraint free mental health services" (U.S. Department of Health and Human Services, 2003).

Public attention has focused on the issue, both in the news and in response to government reports. The U.S. General Accounting Office (GAO) created a report, almost 10 years ago, titled *Improper Restraint or Seclusion Use Places People At Risk* (U.S. GAO, 1999). The National Technical Assistance Center for State Mental Health Planning recently issued a detailed white paper on the subject (Haimowitz, 2006).

Advocates, treatment professionals, and other organizations have pressed the issue, taking positions and issuing white papers. Among the groups who have done so are the American Academy of Child and Adolescent Psychiatry, American Acad-

emy of Pediatrics, American Psychiatric Association, American Association of Child and Adolescent Psychiatry, International Society of Psychiatric-Mental Health Nurses, NAMI, Autism National Committee, Child Welfare League, National Mental Health Association, and the New Jersey Council on Developmental Disabilities.

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

The Future of Human Services Restraint

In my view, the intense level of attention on restraint and seclusion stems from social and personal discomfort with the imposition of these involuntary measures on persons with disabilities and the great risks entailed by these techniques. Human services restraint negatively affects not just the individuals subjected to restraint but also staff, leadership, agency culture, families, and the public. Those wide-ranging effects have a substantial social cost that is often overlooked both in practice and in the published research.

It is valuable to consider whether the use of unproven human services restraint within planned treatment interventions is consistent with the values of our society, our treatment programs, and our personal ethics and morality. Many believe that it is immoral to impose restraint on people who are vulnerable and who have a devalued status. Some have gone further and urged that all use of human services restraint be prohibited simply on moral grounds.

If the justification for restraints is treatment, then its advocates cannot fairly show either that restraints are therapeutic or that the life-threatening risks can be credibly minimized.

What does the future hold? The use of human services restraint is moving into history. We now know that emergency restraint can be avoided in many instances through policy and organizational changes, adequate training, deescalation techniques, positive supports, debriefing, and other mechanisms. We know that restraint as part of a treatment program does not work and is extremely dangerous. There is a professional and governmental consensus against the use of restraints.

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

- There is a proven significant risk of death and other injuries. We are unable to predict who will die or be injured. It is not acceptable to maintain planned restraints in the face of such risk.
- Programmatic and planned restraint is not therapeutic or educational.
- The nonclinical factors leading to human services restraint will be increasingly recognized.
- Courts will prohibit planned restraint and any restraint as part of an habilitation or treatment plan, or in schools.
- Extraordinary reduction in the use of restraints and seclusion occurs when attention is paid to the issue.

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

These conclusions are neither new nor revolutionary. They date back to discussion in the field close to 200 years ago. What is new is that we now have research on efficacy and risk, and we have perhaps a more refined sense of the dignity due to those who might be at risk of restraint.

The renewal of a nonrestraint policy in human services will occur in an environment I call the “new moral treatment,” spearheaded by contemporary “John Conollys,” together with allied administrators, professionals, advocates, and clients. With the knowledge and skills gained in a 150 years of continued service to people with disabilities, hopefully we will do no worse than Dr. Conolly. Surely, we can do better.

References

- Alex, G. ex rel. Dr. Steven G. v. Board of Trustees of Davis Joint Unified School District. 387 F.Supp.2d 1119 (E.D. Cal. 2005).
- American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. The use of physical restraint interventions for children and adolescents in the acute care setting. *Pediatrics*, 99, 497–498.
- American Academy on Child & Adolescent Psychiatry. (2006). AACAP official action: Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special references to seclusion and restraint. *Journal of the American Academy on Child & Adolescent Psychiatry*, 44 (Suppl.).
- Autopsy: Restraint killed student at Killeen school. (2002, March 25). *Associated Press*. Retrieved from <http://www.texnews.com/1998/2002/texas/kill0325.html>
- Children’s Health Act of 2000. Pub L. 106-310, 42 U.S.C. § 290jj (2000).
- CJN v. Minneapolis Public Schools, 232 F.3d 63 (8th Circuit, 2003).
- Condition of Participation: Patients’ Rights. 42 C.F.R. 482.13 (e). (Final rule, published December 8, 2006) (hospitals).
- Conley, J. (2004). The NTAC training curriculum for the reduction of seclusion and restraint. *Evaluation Fast Facts from the Evaluation Center at HSRI*, 3, 1–4.
- Cotton, N. (1989). The developmental-clinical rationale for the use of seclusion in the psychiatric treatment of children. *American Journal of Orthopsychiatry*, 59, 442–250.
- Day, D. M. (2000, November). *A review of the literature on restraints and seclusion with children and youth: Toward the development of a perspective in practice*. The Intersectoral/Interministerial Steering Committee on Behaviour Management Intervention for Children and Youth in Residential and Hospital Settings, Toronto, Ontario, Canada.
- Delaney, K. R. (2006). Evidence base for practice: Reduction of restraint and seclusion use during child and adolescent psychiatric inpatient treatment. *Worldviews on Evidence-Based Nursing*, 3, 19–30.
- Delaney, K. R., & Fogg, L. (2005). Patient characteristics and setting variables related to use of restraint on four inpatient psychiatric units for youth. *Psychiatric Services*, 56, 186–192.
- Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §15009(3)(A) (3) (2000).

- DiDino, T., & Ziccardi, M. K. (2002, February 7). Advisory for care providers exploring the dangers of positional asphyxia. Retrieved from <http://pwsausa.org/CareProviders/Positional%20Asphyxia%20MA-50.pdf>
- Doe v. S&S Consol. I.S.D., 149 F. Supp 2nd 274 (E.D. Tx. 2001).
- Earle, K., & Forquer, S. (1995). Use of seclusion with children and adolescents in public psychiatric hospitals. *American Journal of Orthopsychiatry*, 65, 238–244.
- Fassler, D., & Cotton, N. (1992). A national survey on the use of seclusion in the psychiatric treatment of children. *Hospital and Community Psychiatry*, 43, 370–374.
- Fisher, W. A. (1994). Restraint and seclusion: a review of the literature. *American Journal of Psychiatry*, 151, 1584–1591.
- Haimowitz, S., Urff, J., & Huckshorn, K. A. (2006). Restraint and seclusion—A risk management guide (White Paper), citing Fisher, W. (1994). Restraint and seclusion: A review of the literature. *American Journal of Psychiatry*, 151, 1584–1591.
- Heidemann v. Rother, 84 F.3d 1021 (8th Cir. 1996).
- Horsburgh, D. (2004). How, and when, can I restrain a patient? *Postgraduate Medical Journal*, 80, 7, citing Patterson, B. (2003). Deaths associated with restraint use in health and social care, in the UK: The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*, 10, 3.
- Huckshorn, K. A. (2006, April 4). Creating violence-free mental health settings: Changing our cultures of care [PowerPoint presentation]. Austin, TX: Hogg Foundation for Mental Health.
- In the name of treatment: A parent's guide to protecting your child from restraint, aversive interventions, and seclusion.* (2005). Retrieved from www.aprais.org
- Melissa S. v. School District of Pittsburgh, 183 Fed Appx. 184, 2006 WL 1558900 (3rd Cir. 2006).
- M.H. ex. Rel. Mr. H. v. Bristol Board Of Education, 2002 WL 33802431 (D. Conn., Jan 9, 2002).
- Milliken, D. (1998). Death by restraint. *Canadian Medical Association Journal*, 158, 1611.
- Miller, J. A. (2006). Reduction of physical restraints in residential treatment facilities. *Journal of Disability Policy Studies*, 16, 202–208.
- Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with the use of physical restraints. *Canadian Journal of Psychiatry*, 48, 330–337.
- National Alliance on Mental Illness, Policy Research Institute. (2003, May). Seclusion and Restraints: Task force report. Retrieved from http://www.nami.org/Template.cfm?Section=Policy_Research&_Institute&Template=/ContentManagement/ContentDisplay.cfm&ContentID=10979
- National Institute on Disability and Rehabilitation Research. (2005). *Long range plan for fiscal years* Retrieved from <http://www.ncddr.org/new/announcements/lrp/fy2005-2009/index.html>
- National Technical Assistance Center for State Mental Health Planning. (2002). Eliminating the use of seclusion and restraint: Special edition of the NTAC networks. Alexandria, VA. Retrieved from http://www.nasmhpd.org/general_files/publications/ntac_pubs/networks/SummerFall2002.pdf
- New Jersey Bills No. A948, S71 2006–2007 Session.
- Nicolaison v. Brown, 2007 WL 851616, (D.Minn., February 6, 2007).
- Nuchols, B. (2007, April 17). Six indicted in juvenile offender's death. *Associated Press*. Retrieved from: http://caica.org/Isaiah_Simmons_restraint_death.htm#6%20indicted
- Nunno, M., Holden, M., & Tollar, A. (2006). Learning from tragedy: a survey of child and adolescent restraint fatalities. *Child Abuse & Neglect*, 30, 1333–1342.
- Ozarin, L., & Kirkbride, T. (2000, October 6). Hospital innovator. *Psychiatric News*.
- Ozarin, L. (2001, September 21). The question of restraint: 200 years of debate. *Psychiatric News*, 36, p. 27.
- Patterson, B. (2003). Deaths associated with restraint use in health and social care, in the UK: The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*, 10, 3–15.
- Perone, M. (2003, Spring). Negative effects of positive reinforcement. *The Behavior Analyst*, 26, 1.
- Petti, T., Mohr, W. K., Somers, J. W., & Sims, L. (2001). Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. *Journal of Child and Adolescent Psychiatric Nursing*, 14, 115–127.
- Protection of clients' rights. 42 C.F.R. 483.420(a)(6).
- Reay, D. T., Howard, J. D., Fligner, C. L., & Ward,

- R. J. (1988). Effects of positional restraint on oxygen saturation and heart rate following exercise. *American Journal of Forensic Medicine Pathology*, 9, 16–18.
- Regulations for Psychiatric Residential Treatment Facilities for Persons under 21. 42 C.F.R. 483.352 (ICF/MR) (2001).
- Report of the New York State Psychological Association Task Force on Aversive Controls with Children. (2006, August 22). Retrieved from http://72.14.253.104/search?q=cache:KCCO-HHG9pwJ:www.transparencyinpubliceducation.org/files/NYSPA_ExecSummary.pdf+time+out+seclusion+rooms+should+they+be+used&hl=en&ct=clnk&cd=10&gl=us&client=safari
- Reynolds, D. (2006, December 7). Clinic, staff convicted of abuse in Angellika Arndt's restraint death. *Inclusion Daily Express*. Retrieved from <http://inclusiondaily.com/archives/06/12/07/120706wiarndt.htm>
- Reynolds, D. (2006, March 1). No charges to be filed in boy's basket hold death. *Inclusion Daily Express*. Retrieved from <http://www.raggededgemagazine.com/departments/inclusion-dailynews/000816.html>
- Roberts, A. *The Inquiry Commission: 1842–1844, The treatment of lunacy in England and Wales*. Middlesex University. Retrieved from <http://www.mdx.ac.uk/WWW/STUDY/4.htm#4.1.2>, citing Hunter, R., & Macalpine, I. (1963). *Three hundred years of psychiatry, 1535–1860: A history presented in selected English texts*. London: Oxford University Press.
- Ryan, J. B., & Peterson, R. L. (2002). *Physical restraints in schools* [Draft]. Michigan Positive Behavioral Support Network—PBS. Retrieved from <http://www.bridges4kids.org/PBS/articles/RyanPeterson2004.htm>
- Saks, E. R. (1986). The use of mechanical restraints in psychiatric hospitals. *Yale Law Journal*, 95, 1836.
- Schmidt, P., & Snowden, T. (2000). The effects of positional restraint on heart rate and oxygen saturation. *Journal of Emergency Medicine*, 19, 289.
- Singh N. N., Singh S. D., Davis C. M., Latham, L. L., & Ayers J. G. (1999). Reconsidering the use of seclusion and restraints in inpatient child and adult psychiatry. *Journal of Child and Family Studies*, 8, 243–253.
- Smith, G. (2005). Special section on seclusion and restraint: Pennsylvania State Hospital System's seclusion and restraint reduction program. *Psychiatric Services*, 56, 1115.
- Spencer, J. (2002, March 9). Police: Restraint of pupil met rules. *Austin American-Statesman*.
- Stauffer, C. (2006, February 9). Initial autopsy: Restrained teen was suffocated. *Lancaster New Era*. Retrieved from <http://www.isaccorp.org/summitquest/summit-quest.02.09.06.html>
- Stauffer, C. (2006, March 31). Teen's death: No charges—DA says restraining of boy at Ephrata psychiatric facility followed state regulations. *Lancaster New Era*. Retrieved from <http://www.isaccorp.org/summitquest/summit-quest.03.31.06.html>
- Stefan, S. (2006, November 8). *Lessons from the successful reduction and elimination of restraint and seclusion in psychiatric settings*. Paper presented at The Association for the Severely Handicapped annual conference.
- Stratton, S. J., Rogers, C., & Brickett, K. (2001). Factors associated with sudden death in individuals requiring restraint for excited delirium. *American Journal of Emergency Medicine*, 19, 187–191.
- Substance Abuse and Mental Health Services Administration. (2003). *National call to action: Eliminating the use of seclusion and restraint*. Rockville, MD: Author.
- The National Institute on Disability and Rehabilitation Research. *Long range plan for Fiscal Years 2005-2009*. Retrieved from <http://www.ncddr.org/new/announcements/lrp/fy2005-2009/index.html>
- Tiffany, F. B. (1890). *Life of Dorothea Lynde Dix at 69*. Boston: Houghton, Mifflin.
- Tomes, N. (1984). *A generous confidence: Thomas Story Kirkbride and the art of asylum-keeping, 1840-1883*. London: Cambridge University Press.
- Tomes, N. (1988). The great restraint controversy: A comparative perspective an Anglo-American psychiatry in the nineteenth century. In P. R. Bynum & W. F. Shepherd (Eds.), *The anatomy of madness: Essays on the history of psychiatry*. London: Routledge.
- Tuke, S. (1815). *Practical hints on the construction and economy of pauper lunatic asylum*. York, England: Author.
- Tumeinski, M. (2005). Problems associated with use of physical and mechanical restraints in con-

- temporary human services. *Mental Retardation*, 43, 43–47.
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2006). *A roadmap to seclusion and restraint free mental health services for persons of all ages, training manual*. Rockville, MD: Author.
- The use of drugs to manage inappropriate behavior. 42 C.F.R. 483.450(c) (1995).
- U.S. General Accounting Office. (1999). *Improper restraint or seclusion use places people at risk* (GAO Publication HEH-99-176). Washington, DC: Author.
- Wisconsin Department of Public Instruction. (2005, September). *Guidelines for the appropriate use of seclusion and physical restraint in special education programs*. Madison, WI: Author.
- Youngberg v. Romeo, 457 U.S. 307 (1982).
- Young witness talks about youth center death. (2007, July 11). *WTVF Nashville*. Retrieved from <http://www.isaccorp.org/chad/chad-youth-enhancement.07.11.07.html>
- Zeidler, S. (2007). Death renews push for Jonathan's Law [CAICA Web site]. Retrieved from http://www.caica.org/JONATHAN_CAREY_death_renews_push_for_Jonathan's_Law_2-26-07.htm
- Ziegler, D. L. (2001). To hold or not to hold, is that the right question? *Residential Treatment for Children & Youth*, 18(4), 33–45.
- Ziegler, D. L., & Silver, D. (2004). Considering the literature on restraint and seclusion: Is there support that these interventions are harmful? Retrieved from <http://rccp.cornell.edu/pdfs/Zeigler.pdf>
- Ziegler, D. L. (2003). Is there a therapeutic value to restraint? *Child Welfare League of America's Children's Voice*, 13(4), 30–35.

Author:

David Ferleger, Esq., 10 Presidential Blvd., Bala Cynwyd, PA 19004. E-mail: david@ferleger.com