

# MENTAL HEALTH LAW & POLICY JOURNAL

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VOLUME 1

WINTER 2012

NUMBER 1

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## SPECIAL ISSUE: THE USE OF RESTRAINTS AND SECLUSION IN PSYCHIATRIC SETTINGS

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THE “PROFESSIONAL JUDGMENT” STANDARD  
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Website: <http://www.memphis.edu/law/currentstudents/mentalhealthjournal/index.php> Email: [mhlpjournal@gmail.com](mailto:mhlpjournal@gmail.com)

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**SUBSCRIPTIONS AND SINGLE ISSUES:** The subscription rate for domestic subscribers is \$30.00 per annum. Single issues are \$15.00 per issue. Rates may vary for overseas subscribers. Tennessee residents should add a sales tax of 9.25%. Please enclose a check with single issue orders. All subscriptions are renewed automatically unless timely notice of cancellation is given. Please direct all correspondence regarding subscriptions to the Business Editor at the above address.

**POSTMASTER:** Send address changes to The Mental Health Law & Policy Journal, Cecil C. Humphreys School of Law, 1 North Front Street, Memphis, TN 38103. Periodicals postage paid at Memphis, Tennessee, and at additional mailing offices.

**Cite as: 1 Mental Health L. & Pol'y J. \_\_ (2012)**

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## **SPECIAL ISSUE: THE USE OF RESTRAINTS AND SECLUSION IN PSYCHIATRIC SETTINGS**

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# Mechanical Restraints: The “Professional Judgment” Standard

BY ELYN R. SAKS<sup>\*</sup>

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## I. INTRODUCTION

The *Youngberg v. Romeo* “professional judgment” standard says that a hospital patient’s right against improper mechanical restraints under the due process clause is protected if a professional’s decision is not “such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”<sup>1</sup> The purpose of this essay is to attempt to understand what this means and to evaluate whether or not it is a good standard. First, I lay out why restraints decisions are consequential. Then, after giving some background on what courts are actually doing regarding restraints post-*Romeo*, I lay out several different interpretations of the standard, as well as their pros and cons. I conclude by proposing that a more protective standard be adopted.

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1. *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982).

## II. WHY ARE RESTRAINTS DECISIONS CONSEQUENTIAL?

A number of courts and commentators have compared medication and restraints decisions under *Romeo*. They distinguish the two on the basis that the respondent in *Romeo* lacked capacity,<sup>2</sup> and that “soft restraints” are not as intrusive as forcible medication. The first point is important. The second is perhaps misguided. Most medication, especially when used short term, is fairly benign—the risks and side effects are minimal. By contrast, restraints not infrequently lead to death—one estimate was one to three restraints deaths per week in this country.<sup>3</sup> People who are restrained may aspirate their vomit, strangle themselves, or have a heart attack.<sup>4</sup> Restraints are meant to keep people safe, yet it is unclear if they are actually saving or costing lives. Certainly states that have undergone restraint reduction programs have not seen a significant increase in injury or death.<sup>5</sup>

One might also say that medication intrudes deeply into one’s mind, and changes how one thinks. But perhaps the better

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2. *Id.* at 309 (stating that Nicholas Romeo was diagnosed with profound mental retardation, had “the mental capacity of an 18-month-old child, with an I.Q. between 8 and 10, and [could not] talk and lack[ed] the most basic self-care skills.”).

3. Eric M. Weiss, *Hundreds of the Nation’s Most Vulnerable Have Been Killed by the System Intended to Care for Them*, HARTFORD COURANT, Oct. 11, 1998, at A1.

4. See Wanda K. Mohr, *Adverse Effects Associated with Physical Restraint*, 48 CANADIAN J. PSYCHIATRY 330 (2003); Eric M. Weiss, *Deadly Restraint: A Nationwide Pattern of Death*, HARTFORD COURANT, Oct. 11, 1998, at A1; Eric M. Weiss, *Little Training, Few Standards, Poor Staffing Put Lives at Risk*, HARTFORD COURANT, Oct. 12, 1998, at A1; Eric M. Weiss, *Patients Suffer in a System Without Oversight*, HARTFORD COURANT, Oct. 13, 1998, at A1; Eric M. Weiss, *People Die and Nothing is Done*, HARTFORD COURANT, Oct. 14, 1998, at A1; Eric M. Weiss *From “Enforcer” to Counselor*, HARTFORD COURANT, Oct. 15, 1998, at A1.

5. Indeed, there is evidence there are decreases in injuries and deaths; and that costs do not increase either. Susan Stefan, *Successful Seclusion and Restraint Reduction Programs as Quality Indicators for Psychiatric Services*, MEDSCAPE PSYCHIATRY (Mar. 26, 2010, 1:15 P.M), <http://www.medscape.org/viewarticle/528949>; JANICE LEBEL, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *The Business Case for Preventing and Reducing Restraint and Seclusion Use* (2011); Janice LeBel & Robert Goldstein, *The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination*, 56 PSYCHIATRIC SERVICES 1109 (2005).

view is that it restores people to normalcy. It is important to acknowledge that restraints too can have a severe impact on one's mind. Patients who are restrained feel degraded, helpless, and in pain. The event becomes a trauma and can have the serious impact that trauma so often has on the mind. At the least, the practice of restraint use may prevent patients (certainly I am in this category) from ever accepting treatment in a hospital, even when it would be in their interests.

### III. POST-*ROMEO* RESTRAINT CASES

There have not been many cases addressing a facility's restraints practices under *Romeo*. Indeed, only a single case actually finds a constitutional violation under *Romeo*. *Brooks v. Flaherty* was a class action suit in which many individuals had been restrained, despite the fact that the staff had not documented any evidence of these individuals acting aggressively.<sup>6</sup> The *Flaherty* decision found that:

[t]he . . . decision to seclude and mechanically restrain the plaintiffs without employing behavioral treatment programs is such a substantial departure of accepted professional judgment, practice, and standards as to demonstrate that the decision is not a function of independent professional judgment within the meaning of [*Romeo*].<sup>7</sup>

Moreover, the court found that the plaintiffs were "mechanically and chemically restrained beyond the extent necessary to assure their safety or to provide needed training."<sup>8</sup>

Several other cases have found a material issue of fact as to whether professional judgment was exercised by the professionals who made the decision to implement restraint. For example, the court in *Armstead v. Pingree* found that allegations by plaintiffs of improper restraints are sufficient under *Romeo* to state a claim for relief under the due process clause.<sup>9</sup> A number of other courts have rejected motions for summary judgment because there was a

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6. *Brooks v. Flaherty*, 699 F.Supp. 1178, 1201 (W.D.N.C. 1988).

7. *Id.* at 1202.

8. *Id.*

9. *See Armstead v. Pingree*, 629 F.Supp. 273 (M.D. Fla. 1986).

material question of fact as to whether or not the judgment of the professional to use restraints was justifiable.<sup>10</sup>

Many restraint cases have found that professional judgment was in fact exercised by the defendants. *Abdul-Matiyan v. Allen* was a case that involved the use of restraint in the context of transportation.<sup>11</sup> The *Allen* court applied both a rational basis test and the professional judgment standard and found that both were satisfied.<sup>12</sup> Another case, *Doe v. Gaughan*, involved a Massachusetts Department of Corrections facility for violently mentally ill men.<sup>13</sup> The trial court found that “[r]estraint and seclusion may be imposed . . . only upon authorization of the professional staff, or in case of emergency” and that “[c]orrection officers may not institute seclusion or restraint on their own initiative, but may remove previously authorized restraints if it appears that restraints are no longer necessary.”<sup>14</sup> In response to the plaintiffs’ claims that alternative treatments could have lessened the amount of time spent in restraint, the appellate court held that the decisions were based upon professional judgment and that it is not enough to say that there may be different or better ways to provide treatment.<sup>15</sup> A series of additional cases concerning the use of restraints suggests that courts are often quite

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10. *West v. Schwabke*, 333 F.3d 745, 749 (7th Cir. 2003) (denying motion for summary judgment because there was disagreement among the experts as to whether or not long-term restraint and seclusion was outside the realm of professional judgment and therefore there was a material issue as to whether defendant’s judgment was justified); *Feagley v. Waddill*, 868 F.2d 1437 (5th Cir. 1989) (rejecting defendant’s summary judgment motion in case involving an eleven year old girl with mental retardation who was restrained and who ultimately died); *Gilbert v. Texas Mental Health and Mental Retardation*, 919 F.Supp. 1031, 1038 (E.D. Texas 1996) (denying summary judgment motion because material facts existed as to whether defendants conduct amounted to an exercise of professional judgment).

11. *See Abdul-Matiyan v. Allen*, No. 06-CV-1503 (GTS/DRH), 2010 WL 3880687 (N.D.N.Y. Mar. 4, 2010).

12. *Id.*

13. *Doe v. Gaughan*, 808 F.2d 871, 873 (1st Cir. 1986) (finding that the use of restraints and seclusion is based on professional judgment, and appellants suffered no constitutional violation of right to freedom from restraint).

14. *Doe v. Gaughan*, 617 F.Supp. 1477, 1482 (D. Mass. 1985).

15. *Doe*, 808 F.2d at 885.

willing to give great deference to restraint decisions through application of the professional judgment standard.<sup>16</sup>

Finally, even post-*Romeo* there are cases that are brought under alternate theories. In *Lucero v. City of Albuquerque*, a substantive due process challenge was brought after a man with severe mental illness was restrained in flexi-cuffs around his wrists and ankles by hospital staff and police for several hours.<sup>17</sup> Another case, *Melancon v. County of Los Angeles*, involved a claim of deliberate indifference to a patient's medical needs that was filed after the petitioner's son died from pulmonary embolism while being restrained in a correctional psychiatric facility.<sup>18</sup> A number of other restraint cases have been brought as tort actions,<sup>19</sup> as

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16. See, e.g., *Cole v. Fromm*, 94 F.3d 254 (7th Cir. 1996) (explaining that medical professional must balance need for treatment against competing concerns, i.e., preventing unnecessary treatment and need for freedom from unnecessary restraints); *Shaw by Strain v. Strackhouse*, 920 F.2d 1135 (3rd Cir. 1990) (finding that restraint used was not enough to trigger due process protection); *United States v. Arkansas*, 794 F.Supp.2d 935 (E.D. Ark. 2011) (holding that a facility with a restraints policy incorporating multiple safeguards did not violate resident's Fourteenth Amendment rights and that professional judgment was exercised); *Jacobs v. McAdory*, No. 09-3138, 2011 WL 1045053, at \*5 (C.D. Ill. Mar. 23, 2011) ("If professional judgment leads to the conclusion that restraints are necessary for the wellbeing of the detainees (or others), then the constitution permits those devices."); *Williams v. Wasserman*, 164 F.Supp.2d 591 (D. Md. 2001) (denying motion for summary judgment because the plaintiffs had not proven that the State did not appropriately rely on the recommendations of the hospital doctors in secluding or restraining the patients, nor that the recommendations substantially deviated from any accepted professional standards); *Alello v. Smith*, 94-103 (La. App. 5 Cir. 7/26/94); 641 So.2d 664 (finding that professional judgment exercised by doctor when medication failed to control patient); *Wisconsin Dep't of Corrections v. Lilly*, 804 N.W.2d 489 (Wis. Ct. App. 2011) (finding that professional judgment was exercised where a prisoner was restrained to a chair to address a hunger strike).

17. *Lucero v. City of Albuquerque*, 77 F. App'x. 470, 477 (10th Cir. 2003) (stating that "the test for establishing a substantive due process challenge is "whether the behavior of the governmental officer is so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience") (quoting *Cnty. of Sacramento v. Lewis*, 523 U.S. 833, 847-48 n. 8 (1998)).

18. *Melancon v. County of Los Angeles*, No. B152446, 2002 WL 1824962 (Cal. Ct. App. Aug. 9, 2002) (deciding that actions of the medical professionals did not rise to deliberate indifference to patient's medical needs).

19. See *Jaramillo v. Kellogg*, 966 P.2d 792 (N.M. Ct. App. 1998) (holding that expert testimony indicating possible negligence by nonparties was not sufficient to warrant a special verdict form on comparative negligence); *Alt*

violations of state statutes,<sup>20</sup> as a violation of the Patient's Bill of Rights,<sup>21</sup> and even as a challenge to a United States Department of Health and Human Services rule.<sup>22</sup>

#### IV. THE MEANING AND DESIRABILITY OF THE PROFESSIONAL JUDGMENT STANDARD

Our question is what the professional judgment standard means; and whether it is a good standard. I look first at the most thoughtful challenge to the professional judgment standard, that proposed by Susan Stefan.<sup>23</sup>

Stefan has indeed written a thoughtful and comprehensive article on the professional judgment standard, first articulated in the context of a claim of right to treatment and rights governing the use of mechanical restraints. She argues that in the former context a professional judgment standard makes sense but in the latter it does not. In the former, the context of positive liberties, professionals set the standard for what is credible and acceptable treatment. In the context of negative liberties, they do not have the expertise to weigh values when a person's liberties collide with, for example, her treatment interests.<sup>24</sup> Moreover, we do not let

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v. John Umstead Hosp., 479 S.E.2d 800, 804 (N.C. Ct. App. 1997) (holding that nurses' care towards patient was not within the applicable standards of practice); Clark v. Ohio Dep't of Mental Health, 573 N.E.2d 794, 796 (Ohio Misc. 2d 1989) (stating that restraints are "nothing more than punishment" and in situation where less restrictive measures could have been utilized, but court only awarded nominal damages).

20. See O'Sullivan v. Sec'y of Human Servs., 521 N.E.2d 997, 1002 n.10 (1988) (holding that a violation of statute constituted a deprivation of statutory rights).

21. See Benge v. Pounds, Civil No. 07-cv-01849-REB-MEH, 2008 WL 384567 (D. Colo. Feb. 7, 2008) (holding this Bill does not create a private cause of action).

22. See Nat'l Ass'n of Psychiatric Health Systems v. Shalala, 120 F.Supp.2d 33 (2000).

23. Susan Stefan, *Leaving Civil Rights to the "Experts:" From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639 (1992).

24. See J. Richard Ciccone et al., *Medication Refusal and Judicial Activism: A Reexamination of the Effects of the Rivers Decision*, 44 HOSP. & COMMUNITY PSYCHIATRY 555, 557 (1993); J. Richard Ciccone et al., *Right to Refuse Treatment: Impact of Rivers v. Katz*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 203, 208 (1990) [hereinafter Ciccone II]; Patrick Wiseman, *Deferring to*

police officers decide what is acceptable practice in the search and seizure context—what they tend to do, or would tend to do absent other regulation, does not set the constitutional standard.<sup>25</sup>

Stefan, in the course of making her argument, discusses what a “professional” is—someone with expert knowledge and also a fiduciary duty to protect someone else’s interests. She notes that, in the context of hospitalization in a public hospital, the “professionals” at issue often do not meet this standard. She also sketches out how the professional judgment standard is being illegitimately extended to arenas where the pretense of professionalism—for example, putting the regulated person’s interests first—are clearly not met, as in the case of guards in a prison.

Stefan proposes that in the restraints context, a “rational basis” standard be applied. It is ironic that this standard, deplored by many in this context, is deemed more protective than the professional judgment standard. Indeed, other commentators suggest that the two standards are basically equivalent.

To look a little at the logic of the professional judgment standard, it should be noted that it is not equivalent to the standard that a professional made the judgment.<sup>26</sup> It speaks rather to “such a grave departure from professional standards, practices, or norms as to lead to the inference that professional judgment wasn’t acted on at all.” It is not the case that one must prove professional judgment was not exercised. This is conclusively presumed if the act is a “grave departure.” Of course this makes one’s constitutional liberties receive less protection than common law rights to acceptable treatment. There, one’s rights are to treatment that doesn’t depart from the professional standard of care—the departure need not be a “grave departure.”<sup>27</sup>

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*the Judgment of Mental Health and Related Professionals in Striking the Constitutional Balance Between Individual Liberty and the Interests of the State*, 19 COLUM. HUM. RTS. L. REV. 281 (1988); Note, Herbert A. Eastman, *Metaphor and Madness, Law and Liberty*, 40 DEPAUL L. REV. 281 (1991).

25. See Stefan, *supra* note 23.

26. See *id.*; Wiseman, *supra* note 24.

27. See, e.g., *Shaw v. Strackhouse*, 920 F.2d 1135 (3d Cir. 1990) (holding that the professional judgment standard is greater than negligence and less than deliberate indifference). Other cases in this context refer to protecting against arbitrary and capricious acts, believing that judgment exercised by a professional offers sufficient protection. See, e.g., *United States v. Charters*, 863

What shall we make of Stefan's central argument: that professionals are not the right people to judge when liberty may be deprived? There are at least three arguments against this view.

One is that medical doctors and psychologists are indeed trained in balancing liberty and treatment interests.<sup>28</sup> For example, doctors must judge whether patients have the capacity to consent to treatment if that is at all in question. It will be their normative judgment in the first instance that at least the person's capacity should be evaluated—whether their choice should be accepted. The capacity question in part also involves a judgment that a particular person lacks particular abilities to understand, the level of the abilities often varying depending on how important the choice is. Some standards try to specify this in advance, while others leave it to evaluators to make this normative judgment.

In addition, in making recommendations to patients, doctors will often be balancing different kinds of interests. For example, a procedure might hurt one's ability to ambulate but keep one cognitively intact. Should that procedure be recommended or performed? Or it might hurt one's cognitive ability, but keep one's ability to ambulate intact. A particular kind of surgery may involve more pain but give greater longevity. How much more pain is too much not to balance it against the longevity? Or a particular procedure will involve tremors and the doctor knows the patient is a pianist but the alternatives won't work as well.

To underscore these value judgments, think of what are called "consultation-liaison psychiatrists." They are called in to evaluate whether the patient has the right and ability to make a choice. This again is a judgment that is permeated through and through with value choices.

In other words, doctors are balancing interests and values all the time. Their exercising professional judgment means balancing wellbeing against liberty, because part of the professional judgment involved in making medical recommendations means doing such balancing.

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F.2d 302, 305 (4th Cir. 1988); *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987).

28. Others suggest that doctors are socialized in a way that makes them especially bad at making judgments involving loss of liberty. *See* Ciccone II, *supra* note 24.

This argument does make sense, but doesn't really carry the day. Doctors do make value judgments with non-mentally ill people, but they are, as it were, reviewed by the patient. If a doctor feels cognitive ability is more important than gross motor skills, he would do well to put the value choice on the table and let the patient decide. If the doctor makes a recommendation but does not know the patient is a pianist, it is good that his balancing of values is spelled out so the patient may weigh in and inform the doctor how important it is that he not suffer tremors.

Doctors, of course, do not defer to patients' wishes if they deem the patient lacks capacity. While making a capacity judgment does involve balancing interests, many of the value choices are made in advance, with the doctor applying a norm rather than developing it.

Finally, we could also say that other state actors, for example the police, do make some value judgments in the context of searches and seizures, but the most important judgments are made by the courts and legislators, with the police simply applying the standard. Yet if we defer to doctors on these major issues, it is not clear why we would not defer to the police. Doctors, of course, have a kind of fiduciary duty to their patients, but police are actors with their own professional norms and standards too, and arguably care about the social weal as much as anyone.

A second way to understand the professional judgment standard is that the states (courts) decide what the patient's interests are and professionals provide procedural protection by looking to the norms of their profession in applying the courts' standard.<sup>29</sup> Indeed, there is some language in *Youngberg v. Romeo* that suggests this interpretation.<sup>30</sup> So, for example, the state decides that incompetency is required to act without the patient's consent in cases where there is no danger, but professional judgment must be exercised in making this judgment about competency. Or the court decides that danger is required for the doctor to act, but he must exercise professional judgment in identifying that danger. This interpretation returns the judgment about proper balancing to the courts and sees the standard as an

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29. See, e.g., Ciccone II, *supra* note 24.

30. See *Youngerberg v. Romeo*, 457 U.S. 307, 324 (1982) (The state "may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety or to provide needed training").

adequate procedural protection. The interpretation may be problematic in resting only on very slight language.

There is a third way to understand the professional judgment standard in the context of restraints and forced treatment. This is that the court's adoption of the professional judgment standard is to say that one's liberty interests are adequately protected if doctors exercise professional judgment. That is, freedom from restraints is protected if applying the restraints is a credible medical/professional judgment that it is in the patient's medical interests. If one is being cared for in a medically appropriate manner, one's liberty interests are being adequately protected.<sup>31</sup>

On this view, it is not that the courts are saying that professionals have expertise in making these value judgments, but their—the courts'—judgment is that professionals making credible medical decisions satisfies patients' liberty interests. If the patient is going to be benefitted medically, then infringements on his liberty are justified. In short, due process is satisfied if a sound enough treatment decision is made.

This seems like a more plausible argument than simply delegating the liberty determination to professionals. Still, we may not agree with the judgment that if someone is benefitted medically, their liberty interests are sufficiently constitutionally protected.

Indeed, to see the difficulties with this view, why, if the argument above is right, is it not the case that professionals can impose physical treatment on a person if it is in her best medical interests? Like the hospitalized psychiatric patient, she would be medically benefitted. Why doesn't this adequately protect her liberty interests?

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31. Commentators who seem to be making this point include Brooks, Ciccone II, and Coffin. They suggest that *Romeo* strikes the right balance between liberty and the "demands of organized society." Or as another commentator puts it, "liberty is outweighed by the state's interest in restoring people's behavior to what it should be." See, e.g., Kathryn L. Brooks et al., *Patient Overcrowding in Psychiatric Hospital Units: Effects on Seclusion and Restraint*, 22 ADMIN. & POL'Y MENTAL HEALTH 2, 133 (1994); Ciccone II, *supra* note 24; and Christopher L. Coffin, *Case Law and Clinical Considerations Involving Physical Restraint and Seclusion for Institutionalized Persons with Mental Disabilities*, 23 MENTAL & PHYSICAL DISABILITY L. REP. 597 (1999).

I can think of a number of reasons to distinguish these cases. First, if someone is in a psychiatric hospital, he has lost a lot of liberty already. In the context of having little choice already, removal of this choice is just less significant. Perhaps more important, the treatment is designed to help one reclaim liberty. The advantages of credible treatment are liable to be greater—getting out of the hospital with all one's decisional authority being restored.

If this argument is right, then, what should we say and do about the case of someone who is physically ill who cannot take care of himself as a result? If some kind of physical treatment is provided, he will be able to take care of himself and regain his liberty. Would forcible treatment then be constitutionally authorized? He is being medically benefited though treated against his will.

One might say this person has consented to being in the hospital, and can conceivably leave and therefore avoid the forced treatment. Also, he has not already had liberty taken away as had the psychiatric patient. On the other hand, perhaps he *should* be forcibly treated, just like the psychiatric patient.

Indeed, the argument above that we don't allow forcible treatment of people without mental illness even if it medically benefits them does not prove the professional judgment standard is inappropriate because it would authorize forcible treatment of people without mental illness. It may mean, rather, that the non-ill person's treatment is constitutionally acceptable, but on state law grounds—battery for example—is actionable. The constitutional standard is low. In the same way, the Eighth Amendment "deliberate indifference" standard to judge the constitutionality of substandard medical treatment is a lower standard than a medical malpractice standard. The person has common law protected interests that are higher than the rights afforded by the federal constitution.

Another issue to note is that professional standards can change, and may have done so in the restraints context.<sup>32</sup> Many people now think that restraints represent "treatment failure," and not "treatment." It may be that professional norms are not to restrain, and when someone does so in the context of other

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32. Linda Cramer et al., *The End of Seclusion and Restraint*, 32 VT. B.J. 28 (Summer 2006).

modalities being appropriate they are departing greatly from professional norms. Indeed, the Court says “minimally adequate treatment” must be geared toward keeping people out of restraints, so one would also be departing from professional judgment in the “providing treatment” prong of due process.<sup>33</sup>

Even if there is a growing norm that restraints represent treatment failure, there still is at least a substantial minority that think restraints are appropriate, even outside the context of severe danger. For example, great agitation could warrant restraints in some professionals’ eyes. That restraint reduction efforts have occurred only in a small number of places underscores that it is not the overwhelming standard of care not to use restraints. Still, the trend is in this direction and we may soon be at a place where the professional judgment standard almost always says no restraints.

Perhaps more important, one might argue that if a person can be maintained without restraints—that if we don’t literally need restraints to keep someone safe—then even if a substantial minority would restrain, restraints are impermissible. It would violate the professional judgment standard, because a true professional judgment wouldn’t risk a patient’s safety from restraints dangers in contexts where other things than restraints would suffice. In other words, professional judgment is not a matter of sheer number of people who would do something, but a matter of what a true professional—one who cares about his patient, both his interests in treatment and his interests in safety—would do.

One might think of this as a matter of what the reasonable professional would do—i.e. he wouldn’t risk death from restraints for the sake of modest treatment gains that could be achieved in other ways. The “substantial departure,” then, would be from what a reasonable professional would do. And restraining in many cases might then fail the professional judgment standard.

Indeed, it should also be noted, again, that there is a relationship, under *Romeo*, between the right to treatment and the right to be free of restraints: one has a right to such treatment as will prevent unnecessary mechanical restraints. Use of restraints may then violate professional standards around the use of restraints and professional standards around what is done, therapeutically, before the use of restraints to try to prevent them. That is, earlier

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33. See *Youngberg v. Romeo*, 457 U.S. 307, 319, 322–23 (1982).

treatment choices may be substandard under a professional judgment standard governing the treatment choices.

Another point is that the professional judgment standard is made more palatable even to some who think the standard inappropriately lodges constitutional authority in an unsuited professional; these people will temper their complaints about the standard by suggesting that professional judgment is definitely not present if restraints are used for punishment or the convenience of staff; and that a professional judgment must take into account whether there were less restrictive alternatives.

As a final point, what is the relationship of the professional judgment standard to a state's restraints statutes? Suppose a state allows restraints only in situations of danger and not for treatment. Does a professional in such a state fail not only the statute but also the due process clause if he uses restraints for treatment? Or, contra the statute, uses them for agitation and not danger? One argument is that professionals practice within the bounds of the law, so that departing from a statute is outside the range of acceptable professional judgment. Another argument, though, is that not abiding by a statute may give rise to damages for that, but is not so extreme as to be a *grave* departure from professional standards. One has been wronged, but not constitutionally.

#### V. TOWARDS A SOUND POLICY FOR THE USE OF RESTRAINTS

So where does all of this leave us? There are different interpretations of the professional judgment standard—how we should understand its meaning and force. Some of these do not improperly delegate interpretation of constitutional rights to people not likely authoritative on this issue. One, for example, uses the standard as a procedural device. Another adopts the standard because its own judgment of liberty verses treatment says that protecting treatment interests is sufficient protection of liberty as well.

Even if the Court's standard does not fail to make sense, it is arguably not an appropriate standard. The Court has said that civil patients are entitled to better treatment than convicts in another closed institution, namely prisons. Yet, in this context, they are giving them no better treatment. The professional judgment standard is at best a gross negligence standard, and this is not that far from a "deliberate indifference" standard. Indeed, the

Court takes the standard to identify judgments that are so deficient that they suggest that they weren't based on professional norms at all. A deliberately indifferent professional doesn't care; a person who is not acting as a professional may positively harm someone in the name of care. The person's actions are not justified professionally.

Many articles have been written justifying a different constitutional standard—arguing, essentially, that one needs an important or even compelling interest to justify such a grave intrusion on liberty. In the medication context, a standard that requires incompetency to justify *parens patriae* forcible medication, or an emergency to justify police power forcible medication, makes a great deal of sense, and has been adopted by many states on state constitutional, common law, or statutory grounds.

In the restraints context, we might want to allow restraints only in the context of serious and imminent harm. Treatment interests should not justify restraints and neither should an interest in “preserving the milieu” or punishing people. In another article, I will lay out the components of a sound model law. We may want the constitution to protect people from improper restraints under this statute. Of course, even with the professional judgment standard, we should also be open to changes in professional trends. As noted, many jurisdictions now view restraints as a treatment failure and not treatment. Restraining people in certain circumstances today may meet the professional judgment standard, but in the future be considered substandard.

A strict restraints standard is sound. Essentially, it allows forcible restraint only in contexts when it would be justified for people who don't have mental illness. In other emergencies, doctors may act without patient consent. And in ordinary life, people may restrain others (say in a bar fight) to protect other people from harm. Unless there are other reasons to treat patients with psychiatric disorders differently, this should be the standard in this context as well.

The professional judgment standard, then, while it makes sense as a conceptual matter, may be wrong as a normative matter on most interpretations. State courts should allow restraints only if there is a compelling interest in using them.

# **An Overview of Historical and Current Trends in the Use of Mechanical Restraints in Psychiatric Settings**

BY JOHN JIMENEZ<sup>\*</sup>

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## **I. INTRODUCTION**

From the earliest times in recorded history, those who have been labeled as “insane” have been physically restrained in some manner — locked up in small spaces, fettered, chained, tied with ropes or cloth. Over time, the methods changed, but an element of coercion and the perceived need for some form of involuntary commitment or treatment have remained a consistent part of psychiatric treatment.

The history of psychiatry is the story of an emerging science of the mind, evolving from assumptions that insanity was the manifestation of demonic possession to a view of illness mediated by abnormalities in brain structure and function. It is a story that is inextricably linked with society’s sense of spirituality,

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morality, justice, and culture. One of those crossroads is the question of coercion: to what extent and under what circumstances is it justifiable to limit the liberties of another person because that individual has a mental illness? Neither clinicians nor ethicists have been able to fully answer this question.

Over the past half-century, the practice of mechanically restraining psychiatric patients has been challenged, to the extent that some regard restraint under any circumstances as a “treatment failure.”<sup>1</sup> Legal and ethical arguments supporting patient autonomy and dignity abound. Governmental, regulatory, and institutional policies place significant pressure on clinicians to reduce the use of restraints. Yet, despite widespread criticism and vilification of such practices, most psychiatric institutions have not been able to function without some form of restraint, whether mechanical or physical.

The purpose of this article is to provide a historical context on the use of mechanical restraints, and to then move to a discussion of the current use of restraints in psychiatric settings, including an overview of research concerning the reduction and elimination of mechanical restraints. It is important to note that this article is concerned primarily with the use of *mechanical*, as opposed to *physical*, restraints. Mechanical restraint involves the use of equipment or devices in order to control freedom and movement.<sup>2</sup> Physical restraint, on the other hand, involves people manually holding, moving, or otherwise controlling the movement of an individual.<sup>3</sup>

## II. HISTORICAL OVERVIEW

Anecdotal reports have survived from as far back as ancient Greece, describing the management of people with mental

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1. *Breaking the Bonds*, SAMSHA News (SAMSHA, Rockville, MD.), 2003, [http://www.samhsa.gov/samhsa\\_news/Volume\\_XI\\_2/article6.htm](http://www.samhsa.gov/samhsa_news/Volume_XI_2/article6.htm); Dep’t Pub. Welfare, Commonwealth of Pennsylvania, Mental Health & Substance Abuse Services Bulletin, (July 1, 2001).

2. Duncan Stewart et al., *Manual Restraint of Adult Psychiatric Inpatients: A Literature Review*, 16 J. PSYCHIATRIC & MENTAL HEALTH NURSING 749, 750 (2009); E. Sailas & M. Fenton, *Seclusion and Restraint for People with Serious Mental Illnesses* (The Cochrane Database Systematic Reviews 2000 CD-ROM 001163 3 2009).

3. Stewart et al., *supra* note 2.

illnesses.<sup>4</sup> Labeled “insane,” these individuals were physically restrained by a variety of methods, including being placed into stocks, fettered, or guarded at home.<sup>5</sup> While the Greeks described a system of “humors” which became imbalanced in mental illness, prior to the age of scientific medicine, mental illness was typically ascribed to demonic possession, witchcraft or other religious transgression.<sup>6</sup> Typically, the burden of caring for these individuals fell to family members, and the abusive treatment of the mentally ill in the home was frequently no better than later institutional care.<sup>7</sup> In cases where families were not able or willing to care for them, the mentally ill were abandoned, left to wander as beggars and outcasts — the “ships of fools” of legend were real boats, filled with madmen relegated to wandering from one port to another.<sup>8</sup>

The first incarnation of institutionalized mental health care was at the Bethlem Royal Hospital of London.<sup>9</sup> At first a medical hospital, Bethlem Royal began caring for “insane” individuals in the 14th century.<sup>10</sup> Conditions and treatments were by all accounts deplorable. Accommodations were filthy, and residents had little access to hygiene, clean clothing, or fresh air.<sup>11</sup> Shackles, manacles, leg irons, and other restraints were a common part of daily life.<sup>12</sup> By the 19th century, the spectacle of confined madmen at what had become known as “Bedlam” drew over 90,000 visitors yearly, who paid a penny to walk through the hospital and behold the “freaks.”<sup>13</sup>

In the 16th century, the evolution of the English Poor Laws, initially enacted to deal with the larger social problem of vagrants

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4. EDWARD SHORTER, *A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC 1* (John Wiley & Sons 1997).

5. Paul H. Soloff, *Historical Notes on Seclusion and Restraint*, in *THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT* (Kenneth Tardif ed., 1984); SHORTER, *supra* note 4, at 2.

6. Soloff, *supra* note 5, at 2.

7. SHORTER, *supra* note 4, at 2–3.

8. MICHEL FOUCAULT, *MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON 8* (Routledge Classics eds., 2001) (1961).

9. SHORTER, *supra* note 4, at 4

10. *Id.*

11. *Id.*

12. FOUCAULT, *supra* note 8, at 71–72.

13. *Id.* at 68.

and beggars, helped bring into focus the challenges of managing the mentally ill within a larger society.<sup>14</sup> As a result, almshouses and workhouses began to emerge, functioning essentially as combined shelters, care homes, and prisons.<sup>15</sup> As such, these facilities took in those deemed incapable of productive work or unable to provide self-care, such as the infirm, blind, and deaf, as well as the insane.<sup>16</sup> Of note, these arrangements created the first specialized institutions for the mentally ill, and they also signaled the start of congregating lunatics with criminals and vagrants.<sup>17</sup> No distinctions were made between the insane and the otherwise unfit.<sup>18,19</sup>

In the 18th century, the Enlightenment heralded a more scientific approach to the human condition. Physicians, as well as society at large, began to consider that mental illness might have roots in a physical disturbance, rather than having religious or demonic connotations.<sup>20</sup> With little empirical data, physicians began to develop complex theories on the origins of insanity. Benjamin Rush, known for his contributions to early American medicine and government, theorized that insanity stemmed from disturbances of blood flow in the vessels at the base of the brain.<sup>21</sup> The English psychiatrist William Battie postulated that insanity began with muscular spasms, which in turn led to laxity in the nerves of the brain.<sup>22</sup> Johann Christian Reil, a German physician, theorized that irritable nerve fibers led to a predisposition to mental disorders.<sup>23</sup> Interestingly, most of these clinicians believed that mental illness was at some level heritable.<sup>24</sup> Despite these advancements, there was no consensus on the origins of mental

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14. William L. Parry-Jones, *Asylum for the Mentally Ill in Historical Perspective*, PSYCHIATRIC BULL., Oct. 1988, at 407.

15. *Id.*

16. FOUCAULT, *supra* note 8, at 43–44.

17. *Id.*

18. *Id.* at 50.

19. Parry-Jones, *supra* note 14.

20. SHORTER, *supra* note 4, at 27.

21. *Id.*

22. *Id.*

23. *Id.* at 28.

24. *Id.* at 29.

illness.<sup>25</sup> As such, institutions were charged with controlling and containing aberrant behaviors.<sup>26</sup>

Concurrently, the late 1700s saw the rise of “Romantic” Psychiatry, whose proponents contended that social circumstances, inner corruption, and “passions of the soul” were causative of mental illness.<sup>27</sup> The only treatment was strict adherence to moral precepts; in this vein, terror, vexation, or even disappointment could precipitate illness.<sup>28</sup> “Moral” treatment, then, focused on self-control and discipline — in fact the French concept of “moral” might more appropriately be captured in the term “mental” or “psychological,” although the word was not used in that time period.<sup>29</sup>

The specialized asylum rose to prominence in the 19th century.<sup>30</sup> In both Europe and the United States (“U.S.”), the number of asylums grew rapidly.<sup>31</sup> While initially intended to be places of rest and recovery, along the Moral Treatment model, these institutions quickly became overcrowded.<sup>32</sup> Such names as the Pitié-Salpêtrière Hospital and the Bicêtre Hospital in Paris, in addition to the expanded Bethlem Hospital in London, became infamous.<sup>33</sup> Estimates are that there were at least 150,000 individuals in U.S. asylums by the year 1900 (approximately 0.2% of the population), and similar numbers across Europe.<sup>34</sup>

There are multiple etiologies to explain the dramatic increase in hospitalization for the mentally ill. With the advent of the Industrial Age, and the growth of urban culture, society became increasingly less tolerant of deviant behavior.<sup>35</sup> Thus, the locus of care for the mentally ill gradually shifted away from families

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25. SHORTER, *supra* note 4, at 26–29.

26. *Id.* at 7; FOUCAULT, *supra* note 8, at 38–40.

27. SHORTER, *supra* note 4, at 30.

28. *Id.* at 31.

29. *Id.* at 20.

30. *Id.* at 46.

31. *Id.*

32. *Id.* at 46–47.

33. Soloff, *supra* note 5, at, 3–5.

34. Jeffrey L. Geller, *Excluding Institutions for Mental Diseases From Federal Reimbursement for Services: Strategy or Tragedy?*, PSYCHIATRIC SERVICES, Nov. 2000, at 1398; SHORTER, *supra* note 4, at 35.

35. SHORTER, *supra* note 4, at 48.

towards hospitals.<sup>36</sup> Similarly, the workhouses and almshouses began to distinguish between the insane and those otherwise needing assistance, moving their mentally ill populations to the asylums.<sup>37</sup> Concomitantly, there was a rise in the prevalence of medical conditions with behavioral and cognitive manifestations. The nineteenth century witnessed an epidemic of syphilis, with devastating neuropsychiatric consequences.<sup>38</sup> Similarly, the in the same time period there was a remarkable increase in the per capita consumption of alcohol, both in the United States and Europe, (in UK, consumption rose 57 percent, and in France, production of alcohol increase by a multiple of fourteen) leading to an increase in the incidence of alcohol-induced toxicity and psychosis.<sup>39</sup> These redistributions likely caused a collective surge in the asylum population.

Interestingly, the increase in numbers of hospitalized mentally ill begs the question of whether the incidence of psychiatric illness itself was increasing. Several researchers have argued that schizophrenia is a “new” disease, rather than a syndrome that has always plagued humanity.<sup>40</sup> However, caution must be exercised when making assumptions based on hospital admission data of the time, as the practice of psychiatry was devoid of any regulatory oversight or systematic criteria. Decisions regarding admission to the asylums were left to the discretion of physicians with, on occasion, involved family.<sup>41</sup>

The dramatic trend of increasing psychiatric commitment continued into the 20th century, and by 1955 an estimated 560,000 patients were housed in asylums in the United States, now representing 0.3% of the population.<sup>42</sup> Ironically, the inhumane conditions were little better than those offered to the mentally ill six centuries earlier. In May 1946, Life Magazine published an expose entitled “Bedlam 1946: Most U.S. Mental Hospitals are a

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36. *Id.* at 41.

37. *Id.* at 49.

38. *Id.* at 53–58.

39. *Id.* at 59.

40. *Id.* at 63.

41. *Id.* at 50–51.

42. John A. Talbott, *Deinstitutionalization: Avoiding the Disasters of the Past*, 30 HOSP. & COMMUNITY PSYCHIATRY, Sept. 1979, 621–24.

Shame and a Disgrace.”<sup>43</sup> Based on the reports of conscientious objectors who worked as attendants in the asylums, this seminal investigation included graphic descriptions and photos of overcrowding, understaffing, abusive treatment of patients, and the cruel use of sedative medications and restraints.<sup>44</sup> Further, the article called for an end to “concentration camps that masquerade as hospitals.”<sup>45</sup> The ensuing public outcry helped prompt government involvement, and the increased scrutiny that followed contributed to the gradual release of patients from state mental health facilities. A similar pattern was seen in Europe, and over the following decades the asylum populations on both sides of the Atlantic were reduced by almost sixty percent.<sup>46</sup>

### III. EARLY PSYCHIATRIC TREATMENTS

The evolution of treatments for mental illness has paralleled the growth of psychiatric and medical knowledge. In the 18th century, common interventions included flogging, cleansing/showering, water therapy, bloodletting, induced purging, the application of caustic compounds on the skin to produce blistering, and the use of laxatives.<sup>47</sup> While these practices seem barbaric and bizarre to modern sensibilities, many of them were based on the prevailing but limited science of the time.<sup>48</sup> Thus, in order to release the negative humors causing mental imbalance, bloodletting, blistering, and other forms of cleansing were considering therapeutic. The tranquilizer chair, in which patients were immobilized with the head covered, was used to restore appropriate blood flow to the brain and thus ameliorate insanity.<sup>49</sup>

Beginning in the 18th and continuing through the 19th centuries, Quaker groups established treatment centers based on “Moral Treatment,” countering the increasing appreciation of

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43. Albert Q. Maisel, *Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace*, LIFE MAGAZINE, May 1946, at 102–18.

44. *Id.*

45. *Id.* at 118.

46. Talbott, *supra* note 42, at 621.

47. Janet Colaizzi, *Seclusion & Restraint: A Historical Perspective on Restraints & Ethics in Psychiatry*, 43 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 31, 36 (2005); FOUCAULT, *supra* note 8, at 162–65.

48. FOUCAULT, *supra* note 8, at 162.

49. Colaizzi, *supra* note 47, at 35.

mental illness as a form of physical ailment with the notion that psychiatric disturbances were caused by inner corruption that could be countered by living a life of rigid standards and individual self-control.<sup>50</sup> Both in the U.S. and in England, Quaker communities established dedicated residences that sought to instill such virtues in the mentally ill by adhering to a strict daily schedule of productive work, healthy diet and exercise, and frequent education on discipline.<sup>51</sup> These methods were an attempt to deviate from the coercive practices of the asylums, but a reliance on seclusion and, at times, eventual physical restraint, demonstrated that moral treatment was not a cure for behavioral disturbances.<sup>52</sup> In fact, the Quakers were responsible for the development of the straightjacket, which became a widely used method of controlling violent behavior.<sup>53</sup> Its intended purpose was to assist with self-control, but ultimately the straightjacket became a coercive measure.<sup>54</sup> Although the Quaker institutions set the standards for institutional care of the mentally ill, the ideal of bucolic, homelike settings rapidly deteriorated as hospitals became overcrowded, and their function moved from therapeutic to purely custodial.<sup>55</sup> The Asylums are generally regarded as a failure, as Shorter remarks, “That the dreams of the early psychiatrists failed is unquestionable.”<sup>56</sup>

Pharmacological agents for the treatment of the mentally ill were introduced in the 19th century.<sup>57</sup> Early medications included opiates, alcohol, bromide salts, and chloral hydrate.<sup>58</sup> These were largely used to sedate, rather than treat symptoms.<sup>59</sup> By 1900, the use of barbiturates, also as sedatives, had become common practice.<sup>60</sup> And by the 1930s, electroconvulsive therapy (“ECT”)

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50. *Id.* at 32.

51. FOUCAULT, *supra* note 8 at 242 .

52. Gary S. Belkin, *Self-restraint, Self-examination: A Historical Perspective on Restraints and Ethics in Psychiatry*, 53 PSYCHIATRIC SERVICES 663, 663–64 (2002).

53. Colaizzi, *supra* note 47, at 35.

54. *Id.*

55. SHORTER, *supra* note 4, at 33.

56. *Id.*

57. Colaizzi, *supra* note 47, at 36.

58. *Id.*

59. *Id.*

60. *Id.*

had been developed;<sup>61</sup> its arrival heralded another significant battleground in psychiatric care. In the 1950s, the introduction of antipsychotics, the first class of medications that effected change in both behaviors and psychiatric symptoms, helped usher in the period of scientific psychiatry.<sup>62</sup> It is worth noting that antipsychotics are currently the top-selling class of medications in the U.S.<sup>63</sup>

#### IV. MECHANICAL RESTRAINTS IN HISTORICAL PERSPECTIVE

The forms of mechanical restraint used in early mental health settings, as mentioned above, differed little from those used in the punishment of criminals, or in torture. Handcuffs and leg locks were used liberally, fashioned out of metal, leather, or cloth; metal neck collars and chest harnesses were chained to the wall, leaving no room for movement; straightjackets, originally intended to displace the use of chains, were used almost universally.<sup>64</sup> Other primitive devices were invented specifically for use with the mentally ill. The tranquilizer chair, in which the patient was restrained upright, with a box placed over the head, and a bucket underneath the seat to capture waste, was intended, ironically, to be a humane method of controlling behavior.<sup>65</sup> It was designed by Benjamin Rush, often called the “father” of American psychiatry, and a proponent of Moral Treatment.<sup>66</sup> The crib bed, a low narrow bed with rails along the sides and a lid over the top, trapped the patient supine in a tight cage.<sup>67</sup>

The controversy over the ethics and efficacy of restraint began in the late 18th century.<sup>68</sup> Legends grew around Philippe Pinel, credited with the removal of chains from patients at Bicetre

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61. SHORTER, *supra* note 4 at 218.

62. *Id.* at 249–50.

63. Press Release, IMS Health, *IMS Health Reports U.S. Prescription Sales Grew 5.1 Percent in 2009, to \$300.3 Billion* (Apr. 1, 2010) (available at <http://www.imshealth.com/portal/site/imshealth/menuitem> (last visited Nov. 7, 2011)).

64. Colaizzi, *supra* note 47, at 34.

65. *Id.*

66. *Id.*

67. *Id.* at 36.

68. Soloff, *supra* note at 5, at 2; Prinsen & van Delden, *infra* note 72, at 69.

Hospital in 1795 — yet history notes that he used other forms of physical restraint liberally.<sup>69</sup> Thus, while the Enlightenment heralded a trend away from the use of chains and shackles to contain patients, other forms of restraint such as straightjackets, physical containment, and threats of escalating punishment were utilized in lieu of irons.<sup>70</sup> In the U.S., asylum directors often touted the bucolic settings of their institutions and the elimination of antiquated restraints, but in actuality they relied heavily on other forms of control such as isolation and forcible manual restriction.<sup>71</sup>

Modern psychiatry continues to grapple with the ethics and utility of physically restraining patients, compounded further by the need to balance personal autonomy and dignity with safety.<sup>72</sup> Perhaps the most restrictive of the methods used in modern settings is the 4-point restraint, in which hard or soft cuffs are attached to the wrists and ankles and then secured to a stationary bed.<sup>73</sup> Posey restraints — closed vests that are tied to the patient's bed — are used more rarely in psychiatric settings, and most commonly seen in medical settings, especially geriatrics and critical care.<sup>74</sup> Ambulatory restraints, involving a secured belt to which wrist and/or ankle cuffs are attached, allowing a restricted range of motion for both arms and legs, are often used in transporting patients, or to prevent escape or elopement from inpatient wards.<sup>75</sup> Other restrictive measures at first may not appear to be restraints, but nonetheless coerce behavior. Examples include the wheelchair belt, which can be used to limit an individual's voluntary movements.<sup>76</sup> A desk or tray attached to a wheelchair achieves the same ends.<sup>77</sup> Pocket mittens, used especially in pediatric settings

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69. Soloff, *supra* note 5, at 3–4.

70. Colaizzi, *supra* note 47, at 53.

71. Gary S. Belkin, *Self-restraint, Self-examination: A Historical Perspective on Restraints and Ethics in Psychiatry*, 53 PSYCHIATRIC SERVICES 663, 663–64 (2002).

72. Elnathan J.D. Prinsen & Johannes J.M. van Delden, *Can We Justify Eliminating Coercive Measures in Psychiatry?*, 35 J. MED. ETHICS, 69–73 (2009).

73. Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 528–29 (2007).

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

or other circumstances that involve deleterious behaviors, can effectively limit an individual's free interactions when attached in a secure way.<sup>78</sup>

## V. JUSTIFYING THE USE OF RESTRAINTS

Why are patients restrained? Justifications for resorting to their use vary according to the clinical scenario and the clinicians involved. Indications cited in the literature include: (1) to prevent self-harm (including suicidal behavior, cutting or other parasuicidal acts, and behaviors that threaten to interrupt medical treatments, such as attempting to remove intravenous access lines or mechanical ventilation tubes);<sup>79</sup> (2) to prevent violent behavior/harm to others;<sup>80</sup> (3) to prevent behaviors that threaten the therapeutic milieu, such as uncontrollable screaming, damage to property, fecal smearing, exposure of genitals, or masturbating;<sup>81</sup> (4) to prevent elopement/absconding;<sup>82</sup> (5) to decrease stimulation;<sup>83</sup> (6) to limit the physical agitation that may result from severe disorganization, intoxication, or other organic brain syndromes or delirium states;<sup>84</sup> (7) as a response to verbal threats;<sup>85</sup> (8) to address patients' refusal of medication;<sup>86</sup> (9) as a consequence of breaking unit rules;<sup>87</sup> (10) as part of a behavioral therapy program;<sup>88</sup> or (11) at the patient's request.<sup>89</sup>

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78. *Id.*

79. T.G. Gutheil & K. Tardiff, *Indications and Contraindications for Seclusion and Restraint*, In Tardiff K. (Ed) *The psychiatric uses of seclusion and restraint*. Washington, DC, Am. Psychiatric Pub. 12 (1984).

80. *Id.* at 12.

81. *Id.* at 12–13.

82. C. Ryan & L. Bowers, *An Analysis of Nurses' Post-Incident Manual Restraint Reports*, 13 J. Psychiatric & Mental Health Nursing 527, 529 (2006); L. Bowers et al., *Patient-staff Conflict: Results of a Survey of Acute Psychiatric Wards*, 38 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 402, 403 (2003).

83. Gutheil & Tardiff, *supra* note 79, at 12.

84. *Id.* at 13.

85. William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 AM. J. PSYCHIATRY 1584, 1587 (1994).

86. Ryan & Bowers, *supra* note 82; Bowers et al., *supra* note 82.

87. Ryan & Bowers, *supra* note 82.

88. Gutheil & Tardiff, *supra* note 79, at 14.

89. *Id.* at 12.

## VI. CURRENT DATA ON RESTRAINTS

Restraint research is beset by a number of challenges, and overall, both the quality and generalizability of available studies are limited. Most notably, both this author, and two recent systematic review of the literature<sup>90</sup> located no randomized trials testing the hypothesis that the use of restraints is an effective intervention. Further, currently there is no uniform method for collecting restraint data: statistics may be reported variably as an individual's restraint episodes during a single hospitalization or during a specified period of time, the number of restraint episodes over a period of time for a single hospital unit, or total hours spent in restraints per a specified period of time.<sup>91</sup> The definition of a restraint episode is not standard — for example, institutions use different time thresholds to determine whether a restraint episode has occurred.<sup>92</sup>

Few study designs utilize randomization or control groups, whereas others may be criticized for selection bias or limited sample pool sizes. In addition, few control for confounding variables such as overcrowding, medication given, and readmissions or re-restraint episodes,<sup>93</sup> and multiple studies present data in confusing ways, or are unclear regarding stated outcome.<sup>94</sup> Therefore, it is difficult to come to generalizable conclusions, given the wide variance in utilization, apparent need, and reported outcomes of seclusion/restraint measures. As stated by Sailas & Fenton, “[t]here is a surprising and shocking lack of published trials assessing the effects of secluding or restraining people with schizophrenia or similar psychotic illnesses.”<sup>95</sup>

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90. Louise Nelstrop et al., *A Systematic Review of the Safety and Effectiveness of Restraint and Seclusion as Interventions for the Short-term Management of Violence in Adult Psychiatric Inpatient Settings and Emergency Departments*, 3 WORLDVIEWS ON EVIDENCE-BASED NURSING 8, 10 (2006); Sailas & Fenton, *supra* note 2, at 2.

91. Stewart et al., *supra* note 2, at 750–51.

92. *Id.* at 751.

93. *Id.* at 752.

94. Nelstrop et al., *supra* note 90, at 11.

95. Sailas & Fenton, *supra* note 2, at 7.

The meticulous records of the St. Louis Insane Asylum from 1885 provide an illustrative historical perspective.<sup>96</sup> Over a six-month period at the institution, there was an average census of 450 patients, and a restraint rate of 9.7% each month.<sup>97</sup> It is notable that although fifty-three different patients were restrained, only ten patients were responsible for almost half of the total number of episodes.<sup>98</sup> Almost all of the episodes involved conflicts or violence, and the most common diagnoses were mania and psychosis.<sup>99</sup>

Interestingly, modern restraint rates are not dissimilar. In a one-month study of a general hospital emergency room in 1983, 24% of 697 admissions were restrained, and of those 60% required immediate restraint, applied before any other intervention was possible.<sup>100</sup> Patients who were restrained were more likely to be male, intoxicated, and psychotic.<sup>101</sup> In a similar study from 1999, 8.5% of admissions to psychiatric emergency services were restrained, but those restraint episodes were not associated with census volumes or assaults.<sup>102</sup> However, this particular data set originates from an unpublished review, and there is no direct access to this data.<sup>103</sup> Surprisingly, these are the most recent published emergency room data to be found at the time of writing this article. In the literature examining inpatient settings, there is again wide variability, and there is again a dearth of recent data to be found at the present date: overall restraint rates range from 66% of patients on a National Institute for Mental Health research unit; 15-51% in state hospitals; 3.6% in military hospitals; and 26% in municipal hospitals.<sup>104</sup>

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96. Robert J. Esther, *Use of Physical Restraints in a Nineteenth-Century State Hospital*, 8 HIST. PSYCHIATRY 83, 83-93 (1997).

97. *Id.* at 91.

98. *Id.* at 88-89.

99. *Id.* at 92.

100. Suzanne Telintelo et al., *A Study of the Use of Restraint in a Psychiatric Emergency Room*, 34 HOSP. COMMUNITY PSYCHIATRY 164, 164 (1983).

101. *Id.*

102. Glenn W. Currier & Michael H. Allen, *Emergency Psychiatry: Physical and Chemical Restraint in the Psychiatric Emergency Service*, 51 PSYCHIATRIC SERVICES 717, 717 (2000).

103. *Id.*

104. Fisher, *supra* note 85, at 1586.

The demographics of patients who are restrained yield little consistent data. Perhaps the only consistently reproducible observation is that age correlates negatively with restraint usage, with younger patients being restrained more often than older patients.<sup>105</sup> Gender correlations have not been consistent, as some studies indicate men are restrained more often than women, others show no difference, and at least one shows higher restraints among women.<sup>106</sup> Racial demographics are similarly difficult to correlate. Several studies suggest that African American patients are restrained at higher rates, but these numbers may reflect regional differences.<sup>107</sup> No one diagnosis is associated with restraint – studies show that individuals with a wide range of diagnoses, including psychosis, mania, personality disorder, and mental retardation, are restrained in psychiatric settings.<sup>108</sup>

Environmental factors are generally thought to have implications for restraint rates, but the data are frequently contradictory. Length of stay, time of day, and census volume have all been both positively and negatively associated with restraint episodes.<sup>109</sup> However, given the paucity of data, the discrepancies may suggest more about the inconsistency of data collection than the observations themselves. One environmental factor, the introduction of a separate seclusion room, did not correlate with a decrease in restraint usage.<sup>110</sup> Interestingly, a Finnish study has suggested that immigrant status may correlate with restraint rates, with those born in Finland restrained at lower rates.<sup>111</sup>

Data from outside the U.S. show a similar pattern of variability. A 2010 statistical examination of restraint rates range from 35% in Austria, to 7.3% in the U.K., and a reported 0% in

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105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.* at 1587.

109. *Id.*

110. *Id.*; 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, 462–65 (1988).

111. Maria Knutzen et al., *Characteristics of Psychiatric Inpatients Who Experienced Restraint and Those Who Did Not: A Case-Control Study*, 62 PSYCHIATRIC SERVICES 492, 495 (2011).

Iceland.<sup>112</sup> A conclusion from of this paper was the consensus that there are few robust studies examining restraint use.<sup>113</sup> Furthermore, the lack of consistency in how restraint data are collected and reported complicated any reliability of an overall analysis.<sup>114</sup>

In the United Kingdom (“U.K.”), mechanical restraints are used only in very limited settings and circumstances.<sup>115</sup> The cultural bias is against the use of mechanically restraining patients, and although papers report that it is used in certain limited settings, there are no data on where or when this occurs, and what the numbers are.<sup>116</sup> However, physical or “manual” restraint, often described as a “hands-on” forceful restriction of movement, is used with relative frequency, as is seclusion.<sup>117</sup>

In 2004, the British National Institute for Clinical Excellence (“NICE”) established guidelines for the management of disturbed and violent behavior in psychiatric inpatient settings.<sup>118</sup> These guidelines emphasize de-escalation methods in response to problematic behavior.<sup>119</sup> They identify physical or manual intervention as a management strategy that should be considered only when other solutions have failed.<sup>120</sup> A 2010 review of such manual restraint techniques provides an interesting perspective on the view that mechanical restraints should be eliminated in favor of physical methods.<sup>121</sup> In this examination of forty-five papers, on average there were two to five restraint episodes per month in a twenty bed psychiatric unit, and that overall, around one in eight or 12.5% of patients were restrained.<sup>122</sup> Half of all restraint episodes

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112. Tillman Steinert et al., *Incidence of Seclusion and Restraint in Psychiatric Hospitals: A Literature Review and Survey of International Trends*, 45 SOC. PSYCHIATRY & EPIDEMIOLOGY 889, 892 (2010).

113. *Id.* at 894.

114. *Id.* at 895.

115. Stewart et al., *supra* note 2, at 754.

116. *Id.* at 750.

117. *Id.*

118. *Violence: The Short-Term Management of Disturbed Violent Behaviour in Psychiatric In-Patient Settings and Emergency Departments*, NICE 3 (Feb. 2005) <http://www.nice.org.uk/nicemedia/live/10964/29716/29716.pdf>.

119. *Id.* at 7.

120. *Id.* at 16.

121. Stewart et al., *supra* note 2, at 751.

122. *Id.* at 750–51.

involved patients being held prone on the floor, prompting concerns regarding potential for injury from positional asphyxia.<sup>123</sup> In addition, the authors note the high incidence of staff injuries during restraint events, reporting that on average 17% of restraint episodes resulted in a staff injury.<sup>124</sup> While the variability in methods of data collection and definitions of restraint episodes in the U.K. studies mirror the challenges in restraint research in the U.S., as discussed above, this review does illustrate the risks inherent in assuming that manual or physical methods are necessarily preferable to mechanical restraint.<sup>125</sup>

## VII. RESTRAINT REDUCTION

One of the primary motivations behind the movement to reduce the use of mechanical restraint episodes is to reinforce the focus on treatment and rehabilitation of patients.<sup>126</sup> A number of studies have demonstrated the negative impact of seclusion and restraint on patients, including perceptions of the quality of treatment, re-experiencing of past traumas, and attitudes towards staff and hospitals.<sup>127</sup>

To this end, several themes have been identified as instrumental or significant in effecting change. In a 2003 publication describing the successful reduction of seclusion and restraint episodes in a large, state psychiatric facility, six elements were incorporated into an aggressive approach: (1) active administrative endorsement;<sup>128</sup> (2) patient participation;<sup>129</sup> (3) a culture change within the facility;<sup>130</sup> (4) extensive staff training;<sup>131</sup>

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123. *Id.* at 751.

124. *Id.* at 752.

125. *Id.* at 755.

126. B. Christopher Freuh et al., *Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting*, 56 PSYCHIATRIC SERVICES 1123, 1124 (2005).

127. Tom Meehan et al., *Perceptions of Seclusion: A Qualitative Investigation*, 31 J. Advanced Nursing 370, 370–77 (2000); Freuh, *supra* note 126, at 1123.

128. William A. Fisher, *Element of Successful Restraint and Seclusion Reduction Programs and Their Application in a Large Urban, State Psychiatric Hospital*, 9 J. PSYCHIATRIC PRAC. 7, 7 (2003).

129. *Id.* at 8

130. *Id.*

131. *Id.*

(5) frequent data analysis;<sup>132</sup> and (6) individualized treatment.<sup>133</sup> The cultural shift was accomplished by encouraging a widespread policy of respect and by dispelling the belief that restraints reduce staff injuries.<sup>134</sup> Increased training focused on the early detection and de-escalation of violence, heightened sensitivity to the patients' perspectives, and including patients and other allied healthcare team members in debriefings.<sup>135</sup> Frequent data analysis helped identify sentinel cases for prompt formal review, and also provided more productive real-time feedback.<sup>136</sup> Treatment plans were elaborated to include more behavioral and psychotherapeutic interventions, as well as the aggressive use of clozapine,<sup>137</sup> an effective antipsychotic medication that is often underutilized due to its very rare but dangerous side effects.<sup>138</sup> When these changes were implemented, restraint and seclusion episodes were reduced by 67% over a three year time period.<sup>139</sup> Another facility implemented administrative endorsement as the single most potent predictor of success, reducing episodes by 75% over five years.<sup>140</sup>

Other studies have focused on red-flag situations. One report identified internal circumstances that would increase the likelihood of seclusion or restraint: ineffectual management of problematic behaviors, and inadequate surveillance of patients.<sup>141</sup> In their policy review, the National Association of State Mental Health Program Directors identified several elements that helped to reinforce reliance on seclusion and restraint measures.<sup>142</sup> Among others, these included a lack of adequate attention to safety issues

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132. *Id.*

133. *Id.*

134. Fisher, *supra* note 128, at 10.

135. *Id.* at 9.

136. *Id.* at 10.

137. *Id.* at 11.

138. *Id.*

139. *Id.* at 12.

140. Dennis C. Donat, *An Analysis of Successful Efforts to Reduce the Use of Seclusion and Restraint at a Public Psychiatric Hospital*, 54 PSYCHIATRIC SERVICES 1119, 1120 (2003).

141. Barbara M. D'Orio et al., *Reduction of Episodes of Seclusion and Restraint in a Psychiatric Emergency Service*, 55 PSYCHIATRIC SERVICES 581, 581-83 (2004).

142. NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS., MED. DIRS. COUNCIL, REDUCING THE USE OF SECLUSION AND RESTRAINT, PART I: FINDINGS, STRATEGIES, AND RECOMMENDATIONS (1999).

and risk factors at the intake point of admission, the resistance of staff to believe what patients say, and the assumption that “compliance” and “structure,” in and of themselves, are important for recovery.<sup>143</sup>

One of the more systematic and thorough reviews of the restraint literature synthesized several conclusions across various studies.<sup>144</sup> Despite repeated attempts, a majority of inpatient facilities surveyed were unable to eradicate reliance on some form of physical or mechanical restraint or seclusion.<sup>145</sup> However, intensive training of healthcare team members was generally effective at reducing numbers and inappropriate instances of episodes, and at reducing injury rates.<sup>146</sup> Furthermore, although rates of seclusion and restraint can be influenced by clinical factors such as age or diagnosis, they are also substantially affected by nonclinical variables, such as staff role perceptions and the attitudes of hospital administrators.<sup>147</sup>

What remains unclear, on a macro level, is whether the national push to reduce coercive practices in psychiatry has resulted in decreased numbers of restraint episodes across different settings and institutions. At the time of publication of this article, no review has systematically evaluated the overall effects of restraint reduction efforts.

### VIII. CONCLUSION

Perhaps the most striking inference to be drawn from the above literature is that, having reviewed the often-contradictory data, one might draw a variety of conflicting conclusions. For example, Fisher observes that “although it appears to be reasonably well-established that seclusion and restraint ‘work,’ i.e., they provide an effective means for preventing injury and reducing agitation, it is at least equally well-established that these procedures can have serious deleterious physical and (more often) psychological effects on patients.”<sup>148</sup> In their Cochrane review,

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143. *Id.*

144. Fisher, *supra* note 85, at 1590.

145. *Id.*

146. *Id.* at 1589.

147. *Id.* at 1590.

148. *Id.*

however, Sailas and Fenton state that, “[n]o controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness.”<sup>149</sup> They go on to observe that “[i]n the absence of any controlled trials in those with serious mental illness, no recommendation can be made about the effectiveness, benefit or harmfulness of seclusion or restraint.”<sup>150</sup> Moreover, the literature has not clearly indicated which interventions (restraints, seclusion, medication administration), and in which combinations, are the most effective in reducing violent or other extreme behaviors.<sup>151</sup> As Prinsen and van Delden note, “[a]n obvious hiatus in the total discussion about coercive measures is the lack of clear definitions and data of its use, and the total lack of trials in which different measures are compared and effects are investigated.”<sup>152</sup>

Despite the ambivalence in the literature around the subject of restraints and coercion, regulation has become increasingly restrictive. U.S. federal rules state that, “[t]he decision to use restraint or seclusion nearly always is arbitrary, idiosyncratic, and generally avoidable,” and go on to direct, “[r]estraint and seclusion can only be used in emergency situations if needed to ensure physical safety and if less restrictive interventions have been determined to be ineffective.”<sup>153</sup>

Such guidelines ultimately establish a potentially oxymoronic standard for the use of restraints. For the individual clinician making an in-the-moment decision about restraining an individual, the balance between the conflicting principles of personal liberty and safety is at its most tenuous. In each decision, this balance inevitably tips in favor of one ideal over the other. This fundamental dilemma is at the crux of research into the use of restraints. Further study will need to evaluate more definitively the clinical efficacy of restraints, as well as continuing to investigate the ethics of coercive management in psychiatry.

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149. Sailas & Fenton, *supra* note 2, at 8.

150. *Id.*

151. *Id.*

152. Prinsen & van Delden, *supra* note 72, at 72.

153. Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient Rights, 64 Fed. Reg. 36,070 (July 2, 1999) (to be codified 42 C.F.R. pt. 481).

The history of restraints is inextricably tied to the history of psychiatry; any thorough examination of restraints in modern psychiatry would not be complete without a perspective that includes the history of psychiatry and its institutions. As discussed above, the lessons of history are alive and well in the current debate over the use of restraints and other forms of coercion in psychiatry, and the questions to be answered regarding the appropriateness of such measures remain as pressing as ever.

# Careless Deference: The Professional Judgment Standard and the Mechanical Restraint of the Mentally Ill

JAYSEN S. CHUNG<sup>\*</sup>

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## I. INTRODUCTION

Deference is generally and justifiably given to medical professionals in the decisions they make in treating their patients. As such, the law and society should not interfere too greatly with their medical decisions. With that said, given that not necessarily all of the decisions of these professionals are medical decisions,

nor do the actions they undertake always necessarily constitute treatment,<sup>1</sup> such deference should be limited.

The United States Supreme Court in *Youngberg v. Romeo* presumptively held valid the decision to restrain the liberties of mental health patients and other institutionalized individuals,<sup>2</sup> assuming that restraint is for the purpose of medical treatment.<sup>3</sup> The mechanical restraint of mental health patients should not receive such deference because it neither constitutes treatment nor does it involve a medical decision. This article argues that the mechanical restraint of a mental health patient when she poses an imminent threat of harm to herself or others is not a form of treatment and does not involve a medical decision because: (1) it is only a safety measure incidental to the course of treatment;<sup>4</sup> (2) it is potentially counter-therapeutic<sup>5</sup> and poses a serious risk of physical<sup>6</sup> and psychological harm;<sup>7</sup> (3) the decision to mechanically restrain is often influenced by the medical professional's personal emotions<sup>8</sup> and distinct level of tolerance for aggressive behavior<sup>9</sup> as well as by environmental<sup>10</sup> and

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1. See Elaine Walsh & Brooke P. Randell, *Seclusion and Restraint: What We Need to Know*, 8 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 28, 34 (1995).

2. *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982).

3. *Lanman v. Hinson*, 529 F.3d 673, 681 (6th Cir. 2008).

4. See Charles G. Curie., *SAMHSA's Commitment to Eliminating the Use of Seclusion and Restraint*, 56 PSYCHIATRIC SERVICES 1139, 1139 (2005).

5. Sharyl B. Smith, *Restraints: Retraumatization for Rape Victims?*, 33 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 23, 28 (1995).

6. See ELYN R. SAKS, *REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL* 155–56 (2002); Wanda K. Mohr, & Brian D. Mohr, *Mechanisms of Injury and Death Proximal to Restraint Use*, 14 ARCHIVES OF PSYCHIATRIC NURSING 285, 285 (2000); Robert J. Moss & John La Puma, *The Ethics of Mechanical Restraints*, 21 HASTINGS CENTER REP. 22 (1991).

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

8. Sandy Marangos-Frost & Donna Wells, *Psychiatric Nurses' Thoughts and Feelings About Restraint Use: A Decision Dilemma*, 31 J. ADVANCED NURSING 362, 366 (2000).

9. Terry L. Terpstra et al., *Nursing Staff's Attitudes Toward Seclusion & Restraint*, 39 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 20, 24 (2001).

10. Robert W. Glover, *Reducing the Use of Seclusion and Restraint: A NASMHPD Priority*, 56 PSYCHIATRIC SERVICES 1141, 1141 (2005).

administrative factors;<sup>11</sup> and (4) because the aggressive behavior that leads to the mechanical restraint may not necessarily be the result of the patient's illness, but that of other external factors.<sup>12</sup>

## II. BACKGROUND

### *A. The Use of Mechanical Restraints in Mental Hospitals*

Mechanical restraints involve the use of restraining straps, belts, and/or other equipment to restrict freedom of movement or normal access to one's body.<sup>13</sup> Such restraint is often used to restrain limbs on a bed in a "four-point" or "five-point" restraint, or to a chair.<sup>14</sup> Other forms include straitjackets, muffs, leg-locks, and handcuffs.<sup>15</sup> It has been estimated that mechanical restraints are used as many as 500,000 times a day in the United States and that there are at least fifty to 150 deaths caused by the use of mechanical restraints or seclusion every year.<sup>16</sup>

### *B. The Flawed Professional Judgment Standard*

In *Youngberg*, the Supreme Court held that, under the Due Process Clause of the Fourteenth Amendment, psychiatric patients and other institutionalized individuals have a right to be free from unreasonable bodily restraints and the right to reasonably safe conditions of confinement.<sup>17</sup> However, in the same breath, the Court limited this right by adopting a professional judgment standard to determine whether those liberty interests were

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11. William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 AM. J. PSYCHIATRY 1584, 1585 (1994).

12. See Linda L. Oberleitner, *Aversiveness of Traditional Psychiatric Patient Restriction*, 14 ARCHIVES PSYCHIATRIC NURSING 93, 94 (2000).

13. See Len Bowers et al., *Student Psychiatric Nurses' Approval of Containment Measure: Relationship to Perception of Aggression and Attitudes to Personality Disorder*, 44 INT'L J. NURSING STUD. 349, 359 (2007); Judy J. Regan et al., *The Use of Restraints in Psychiatric Settings*, 99 TENN. MED. 41, 41 (2006).

14. Mohr & Mohr, *supra* note 6, at 285.

15. Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 522 (2007).

16. See Moss & La Puma, *supra* note 6, at 22; Robert E. McCue et al., *Reducing Restraint Use in a Public Psychiatric Inpatient Service*, 31 J. BEHAV. HEALTH SERVICES & RES. 217, 217 (2004).

17. *Youngberg v. Romero*, 457 U.S. 307, 319–20 (1982).

violated.<sup>18</sup> Under the professional judgment standard, the Court regarded the decisions of “medical professionals” presumptively valid, and liability would only be imposed when the decision was “such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”<sup>19</sup> The Court reasoned that there is “no reason to think judges or juries are better qualified than appropriate professionals in making such decisions.”<sup>20</sup>

Moreover, the Court left many aspects of the professional judgment standard vaguely defined or undefined, which have been subsequently interpreted by lower courts.<sup>21</sup> The Court loosely defined the term “professional” as a “person competent, whether by education, training or experience, to make the particular decision.”<sup>22</sup> The term has subsequently been extended to hospital case managers and administrators<sup>23</sup> as well as nurses and line staff,<sup>24</sup> with whom the Court did not necessarily envision when it used the term “professional.”<sup>25</sup> The Court also failed to define what exactly “professional judgment” is, or what would constitute a “substantial departure” from such judgment.<sup>26</sup> Most importantly, with regard to mechanical restraints, the professional judgment standard focuses only on whether professional judgment *has been used* in the decision to place a patient in restraints, while failing to ask the preliminary question of whether that decision even

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18. *Id.* at 319–20,

19. *Id.*

20. *Id.* at 322–23.

21. Christopher L. Coffin, *Case Law and Clinical Considerations Involving Physical Restraint and Seclusion for Institutionalized Persons with Mental Disabilities*, 23 MENTAL & PHYSICAL DISABILITY L. REP. 597, 598 (1999).

22. *Youngberg* at 323 n. 30.

23. Coffin, *supra* note 21, at 598.

24. Therefore, the use of the term “medical professional” in this article will refer to doctors, nurses, case managers, administrators, and other staff with similar responsibilities in mental health hospitals. It is not disputed that nurses and other staff often need to make decisions to mechanically restrain in emergencies.

25. Linda Cramer et al., *The End of Seclusion and Restraint*, 32 VT. B.J. 28, 28 (2006).

26. Coffin, *supra* note 21, at 598.

amounts to a medical decision or treatment, to which deference that the Court contemplated is actually owed.

### III. THE DYNAMIC BETWEEN THE PATIENT'S INTERESTS AND THE MEDICAL PROFESSIONAL'S DUTIES

The main justification for the use of mechanical restraints — the safety of the patient and others<sup>27</sup> — must be balanced against the patient's interests and professional and moral obligations that the medical professional owes to the patient.

Indeed, medical professionals are obligated to protect other patients, themselves, and other individuals from harm by a patient's dangerously aggressive behavior.<sup>28</sup> This obligation bolsters the argument that it may be justified to mechanically restrain a patient in order to protect her from harming herself. Nonetheless, the counterargument has also been made that mechanical restraint should never be used in such instances because there is almost always less-restrictive alternative methods available and because the patient can harm herself in restraints almost just "as easily as out of restraints."<sup>29</sup> Regardless of the position that one takes regarding this debate, deference to the medical profession should not be carelessly brushed aside.<sup>30</sup> However, such deference should only be given to the *medical* decisions of these professionals because the deference given to the profession is predicated upon the expectation for their *technical competence* to make such decisions and nothing more.<sup>31</sup>

Though safety is certainly a vital concern, a patient's right to autonomy, dignity, and safety from others is just as important, if not more. Autonomy is based on two fundamental components: (1) liberty, or the right to self-determination without interference or control from others; and (2) agency, or the ability to make

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27. George M. Schreiner et al., *Decreasing the Use of Mechanical Restraints and Locked Seclusion*, 31 ADMIN. & POL'Y MENTAL HEALTH 449, 449 (2004).

28. Saks, *supra* note 6, at 155–56.

29. *Id.* at 151.

30. *Youngberg v. Romero*, 457 U.S. 307, 323 (1982).

31. See Pam Lings et al., *The Doctor-Patient Relationship in U.S. Primary Care*, 96 J. ROYAL SOC'Y MED. 180, 180–81 (2003).

decisions and purposefully act upon those decisions.<sup>32</sup> Thus, “by their very definition, restraints are incompatible with the principle of autonomy insofar as . . . [it] involve[s] restricting a patient or limiting their freedom in some way against their will.”<sup>33</sup> There is “no reason to believe that the mentally [ill] think less of their freedom” than any other individual.<sup>34</sup> Although it may be justified to so drastically restrict the freedom of criminals, mental health patients are guilty of nothing more than that they are suffering from an illness, just like a cancer patient would suffer from a malignant tumor. Furthermore, unlike a criminal,<sup>35</sup> mental health patients often experience uncontrollable behavior and do not voluntarily choose to endanger themselves or others in these emergency situations.<sup>36</sup> There is also no reason to believe that mental health patients value their dignity any less than the next person. Among other negative emotions, patients report feelings of the loss of dignity, humiliation, helplessness, demoralization, and decreased self-esteem after being mechanically restrained.<sup>37</sup>

Mechanical restraints also pose serious physical and psychological risks to patients. Physical risks include compromised circulation, decreased vital capacity, contractures, muscle weakness, and nerve compression.<sup>38</sup> Patients have even died from aspirating their vomit, choking to death, or suffocating while in mechanical restraints.<sup>39</sup> Though mechanically restraining a patient *might* protect her from herself, it only does so by

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32. Wanda K. Mohr, *Restraints and the Code of Ethics: An Uneasy Fit*, 24 ARCHIVES OF PSYCHIATRIC NURSING 3, 4–5 (2010).

33. *Id.* at 5.

34. Laura R. Biddle, *Heller v. Doe: Freedom From Bodily Restraint and Associated Stigma—A Fundamental Interest*, 12 J. CONTEMP. HEALTH L. & POL’Y 239, 262 (1995).

35. Of course, while it may be true that criminals might exhibit more controllable or rational behavior than a mental health patient, the more important distinction here is that criminals have committed a crime or otherwise *done something wrong* that warrants restraint, whereas mental health patients have not.

36. See Freida H. Outlaw & Barbara J. Lowery, *An Attributional Study of Seclusion and Restraint of Psychiatric Patients*, 8 ARCHIVES PSYCHIATRIC NURSING 69, 75 (1994).

37. See Oberleitner, *supra* note 12, at 94; Walsh & Randell, *supra* note 1, at 34.

38. Moss & La Puma, *supra* note 6, at 23.

39. Saks, *supra* note 6, at 147; Mohr & Mohr, *supra* note 6, at 289.

simultaneously placing her in a high risk of external danger from the mechanical restraints. Therefore, replacing a risk of danger with just another, possibly higher, risk of danger seems senseless and unjustified, especially in light of the autonomy and dignity interests involved.

Furthermore, medical professionals owe a duty of beneficence and nonmaleficence to their patients.<sup>40</sup> Although the principle of beneficence confers a moral obligation on caregivers to act for the benefit of their patients, the principle of nonmaleficence means to “do no harm, prevent harm, and facilitate good.”<sup>41</sup> Certainly, a medical professional must act for the benefit of all their patients, which includes protecting them from harm from others. However, with such a high risk of physical and psychological harm associated with mechanical restraints, it is questionable as to whether such action can be considered for the benefit of the mechanically restrained patient. It is also quite uncertain as to whether restraining the patient actually facilitates the good of other patients, because it has been shown that the stressful nature of restraining a patient can agitate *other* patients who witness the restraint and therefore increase the risk of those other patients being restrained as well.<sup>42</sup>

#### IV. DEFINING TREATMENT

What exactly does treatment mean? Does an act in the course of treatment, having no therapeutic benefit, constitute treatment? Medical dictionaries have defined treatment as “the medical or surgical care of a patient; the institution of measures or the giving of remedies designed to cure a disease,”<sup>43</sup> or “the care of a sick person, and the remedies or means employed to combat the disease affecting him.”<sup>44</sup> A non-medical dictionary defined treatment as the “administration or application of remedies to a

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40. Mohr, *supra* note 32, at 6.

41. *Id.* at 6–7.

42. Marangos-Frost & Wells, *supra* note 8, at 366.

43. WILLIAM H.L. DORNETTE,, STEDMAN’S MEDICAL DICTIONARY 1473 (1976).

44. BERNARD S. MALOY, THE SIMPLIFIED MEDICAL DICTIONARY FOR LAWYERS 434 (1942).

patient for a disease or injury; medicinal management; therapy.”<sup>45</sup> According to these definitions, the use of mechanical restraints would not be considered treatment because it does not involve the “giving of remedies . . . to cure” the patient’s mental illness or “combat[ing] the disease” affecting her.

On the other hand, one medical dictionary defined treatment as “management, medical, or surgical care of a patient,”<sup>46</sup> and another non-medical dictionary defined it as “car[ing] or deal[ing] with a [health problem] surgically or medically.”<sup>47</sup> According to these definitions, the use of mechanical restraints would perhaps be considered treatment even if it had no therapeutic benefit because it could be said to “manage” the patient or “deal with” her health problem.

What definitions should apply? The discrepancy can conceivably be reconciled by examining the definitions in light of some asserted goals of treatment. It has been stated that the goals of treatment include recovery,<sup>48</sup> optimizing function, and rehabilitation.<sup>49</sup> There must also be trust between the patient and the medical professional where the patient believes that the professional has the patient’s best interests in mind, as well as the technical competence to provide beneficial treatment.<sup>50</sup> The deference given to medical professionals is at least partly predicated on this trust.<sup>51</sup> The first set of definitions appear to be more aligned with these goals of treatment, which focus more on remedies, rehabilitation, and a solution to the illness rather than on mere management of or “dealing with” a patient.

Whatever the definition may be, simply labeling something as “treatment” does not necessarily mean it actually *is* treatment.<sup>52</sup> In addition, “such a euphemism” could be dangerous because it

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45. AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1838 (2000).

46. CLARENCE W. TABER, TABER’S CYCLOPEDIA MEDICAL DICTIONARY T-46 (1955).

47. MERRIAM-WEBSTER COLLEGIATE DICTIONARY 1333 (2003).

48. Curie, *supra* note 4, at 1139.

49. Moss & La Puma, *supra* note 6, at 24.

50. Lings et al., *supra* note 31, at 183–84; See Susan Stefan, *Leaving Civil Rights to the “Experts”: From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 644 (1992).

51. See Lings et al., *supra* note 31, at 181.

52. Mohr, *supra* note 32, at 6.

“has the capacity to convince people that something is what it is not.”<sup>53</sup> The professional judgment standard should not allow medical professionals to violate an individual’s rights in the *name* of treatment.<sup>54</sup> Thus, in light of the various definitions and goals of treatment, a proposed definition of treatment could be that which includes: (1) a remedy designed to cure an illness; (2) a method or procedure that facilitates recovery, rehabilitation, or, at the very least, optimizes function; and (3) a maintenance of trust between the patient and medical professional.<sup>55</sup>

#### V. THE USE OF MECHANICAL RESTRAINTS DOES NOT CONSTITUTE TREATMENT NOR DOES IT INVOLVE A MEDICAL DECISION

With this proposed definition of treatment in mind, there are several reasons that suggest the use of mechanical restraints on mental health patients does not constitute treatment and does not involve a medical decision. Rather, it is merely the product of treatment *failure*.<sup>56</sup>

##### A. Lack of Therapeutic Benefit

Though it has been claimed that the use of mechanical restraints can help to promote an individual’s self-control<sup>57</sup> and

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53. *Id.*

54. Stefan, *supra* note 50, at 640.

55. Indeed, the general idea that a “professional” possesses a higher level of or specialized expertise in a particular industry than others could also play a role in our determination of the level of deference owed to medical professionals as discussed in this article. For example, prison guards might be considered professionals regarding the enforcement of security measures in a prison. However, this article chooses to focus solely on the definition of treatment—and not the definition of a professional—because it is the *fundamental* basis of the Court’s reasoning in *Youngberg* in contemplating the professional judgment standard. If mechanical restraints do not constitute treatment, then the question of whether the individual imposing mechanical restraint on a patient is a professional becomes *irrelevant*. That is, deference is, and *should only* be, given to a professional in making decisions for which she has that *higher level of or specialized expertise* and nothing else. In turn, a medical professional should generally receive deference for making *medical* or *treatment* decisions, and nothing else.

56. Staci S. Curran, *Staff Resistance to Restraint Reduction: Identifying and Overcoming Barriers*, 45 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES May 2007, at 45, 47.

57. Tovino, *supra* note 15, at 530.

help an out-of-control patient feel safe, therefore reconstituting herself, the data supporting this claim are “not very reliable,” and there will generally be less restrictive alternatives to accomplish the same goal.<sup>58</sup> It seems counterintuitive to help a patient regain self-control by taking away her self-control with mechanical restraints at the same time. There is little data to support both the efficacy and safety of mechanical restraints as a treatment,<sup>59</sup> and proponents have failed to provide convincing data that the use of restraints does “any more than contain behavior.”<sup>60</sup> Thus, it does not appear that mechanical restraints provide a remedy for mental illness, nor does it provide an opportunity for rehabilitation or even optimization of function.

### *B. Incidental to Treatment*

Simply because a procedure or action is made in the course of treatment does not necessarily mean that it is treatment or that it confers any therapeutic benefit. As mentioned in the previous section, mechanical restraints provide little to no therapeutic benefit.<sup>61</sup> With that in mind, the fact that mechanical restraints are commonly referred to as serving a function other than treatment<sup>62</sup> suggests that their use should not be considered treatment.

#### 1. Administrative Function

The use of mechanical restraints is commonly referred to as an administrative function,<sup>63</sup> safety measure of the last resort,<sup>64</sup> a control procedure,<sup>65</sup> or an “extreme response to an emergency situation.”<sup>66</sup> It has also been stated that it can be used to “maintain

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58. Saks, *supra* note 6, at 149.

59. Moss & La Puma, *supra* note 6, at 23.

60. Walsh & Randell, *supra* note 1, at 34.

61. See *supra* Part V.A. and notes 59–60.

62. Howard Bath, *The Physical Restraint of Children: Is It Therapeutic?*,

64 AM J. ORTHOPSYCHIATRY 40, 43 (1994).

63. *Id.*

64. Curie, *supra* note 4, at 1139.

65. Christopher B. Frueh et al., *Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting*, 56 PSYCHIATRIC SERVICES 1123, 1123 (2005).

66. Raymond B. Flannery et al., *Characteristics of Patients in Restraints: Six Year Analysis of Assaulted Staff Action Program*, 3 INT'L J. EMERGENCY MENTAL HEALTH 155, 155 (2001).

the therapeutic milieu.”<sup>67</sup> The American Psychiatric Association advocates the use of restraint to prevent: (1) imminent harm to self or others; (2) substantial damage to the physical environment; or (3) serious disruption to the treatment program.<sup>68</sup> However, these uses all seem to fit neatly under the category of “*in the course of treatment*” rather than actual treatment. A procedure merely used *in the course of* treatment is not treatment. Even if the use of restraints were *necessary* to implement treatment, it would still be improper to carelessly sweep it into the definition of treatment. It would be improper to consider giving a patient a sponge bath or changing a patient’s bedpan as treatment because they are merely conducted *in the course of* treatment. The use of mechanical restraints should be treated in the same fashion.

## 2. Other Functions

In addition to the use of restraints as an emergency safety measure, restraints have been used as punishment for not following staff directions,<sup>69</sup> to “get [patients] out of the way,” and to “intimidate and frighten” patients into behaving.<sup>70</sup> These asserted uses of restraints do not appear to constitute treatment or involve medical decisions whatsoever.

### *C. Physical and Psychological Risks of Harm and Potentially Counter-therapeutic*

The use of mechanical restraints poses high risks of physical and psychological harm that can ultimately be counter-therapeutic. Physical risks include compromised circulation, decreased vital capacity,<sup>71</sup> aspirating vomit, or choking to death.<sup>72</sup> Patients have also died from asphyxiation, or a lack of oxygen due

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67. Walsh & Randell, *supra* note 1, at 28.

68. Peter L. Forster et al., *Staff Training Decreases Use of Seclusion and Restraint in an Acute Psychiatric Hospital*, 13 ARCHIVES OF PSYCHIATRIC NURSING 269, 269 (1999).

69. Rolf Wynn, *Psychiatric Inpatients’ Experiences with Restraint*, 15 J. FORENSIC PSYCHIATRY & PSYCHOL. 124, 134 (2004).

70. Nancy K. Ray et al., *Patient Perspective on Restraint and Seclusion Experience: A Survey of Former Patients of New York State Psychiatric Facilities*, 20 PSYCHIATRIC REHABILITATION J. 11, 15 (1996).

71. Moss & La Puma, *supra* note 6, at 23.

72. SAKS, *supra* note 6, at 147; Mohr & Mohr, *supra* note 6, at 289.

to the inability to breathe normally.<sup>73</sup> Patients commonly experience psychological distress such as anxiety, anger, and fear when mechanically restrained.<sup>74</sup> Feelings of humiliation, loss of dignity, and helplessness have also been reported.<sup>75</sup> It seems uncommon for a “treatment” to impose such serious risks of harm.

The traumatic experience can also be counter-therapeutic to the patient in several ways. Indeed, a procedure that is considered to be counter-therapeutic cannot logically also be considered as treatment. Many mental health patients already suffer from posttraumatic stress disorder or acute stress disorder due to past traumatic experiences, or have a prior history of rape or abuse.<sup>76</sup> Therefore, the very experience of being mechanically restrained can cause patients to re-experience her traumas, which could have been part of the reason for treatment in the first place.<sup>77</sup> By causing patients to re-experience their trauma, or by exposing them to brand new experiences of trauma, the mechanical restraints only exacerbate their existing symptoms.<sup>78</sup> The experience may also provide “immense masochistic gratification that the patient wishes to re-create.”<sup>79</sup> Patients may alternatively create hallucinations to deal with the stress and trauma of being placed in restraints.<sup>80</sup> In addition to potentially producing more negative symptoms and more pathology, the use of mechanical restraints may also lead to regressive behavior, which causes them to further withdraw from reality.<sup>81</sup> The use of mechanical restraints can also lead to “an atrophy of [the patient’s] internal controls...and thus can increase his violence” which can “provoke further episodes of mechanical restraint.”<sup>82</sup> This would seem to simply create a vicious, never-ending cycle of restraint and aggressive behavior.

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73. Regan et al., *supra* note 13, at 41.

74. Aschen, *supra* note 7, at 90.

75. SAKS, *supra* note 6, at 147–48.

76. See Huckshorn, Kevin A., *Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint*, 33 ADMIN. & POL’Y MENTAL HEALTH 482, 490 (2006); Smith, *supra* note 5, at 28.

77. See Smith, *supra* note 5, at 28.

78. See *id.*

79. SAKS, *supra* note 6, at 148.

80. Oberleitner, *supra* note 12, at 95.

81. Smith, *supra* note 5, at 23.

82. SAKS, *supra* note 6, at 148.

Indeed, most types of any kind of medical treatment will often involve physical and counter-therapeutic risks, and sometimes psychological risks. Open-heart surgery, for instance, involves a risk of serious complications that can even result in death.<sup>83</sup> However, a successful open-heart surgery can repair or replace valves that control blood flow through the heart or repair abnormal or damaged structures in the heart, which ultimately improve or save a person's life.<sup>84</sup> On the other hand, as explained in Section A, mechanical restraints lack therapeutic benefit.<sup>85</sup> Thus, unlike other forms of medical treatment that involve risks, the physical and psychological risks, as well as the potential for counter-therapeutic effects, involved in the use of mechanical restraints grossly *outweigh* any possible benefit that it could provide a mental health patient.

*D. Mechanical Restraints Do Not Facilitate Rehabilitation or Optimization of Function*

The use of mechanical restraints is not a method by which medical professionals are teaching their patients to deal with aggressive behavior. Indeed, they are not teaching mental health patients that, in the event they experience agitation or uncontrollable aggression in everyday life, they should place themselves in mechanical restraints. That would be absurd. The use of restraints simply furthers the patient's dependence and isolation, which in turn leads to helplessness and hopelessness.<sup>86</sup> The patients cannot "learn to manage their illness and their lives" on their own "when they are under external control."<sup>87</sup> Though mechanical restraints may lead to "superficial compliance" by the patient, they do not achieve the "behavioral changes and internal controls" that are supposed to be the goals of treatment.<sup>88</sup> Although mechanical restraints may suppress the problem behavior

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83. *Risks and Complications of Heart Surgery*, <http://surgery.about.com/od/beforesurgery/a/OpenHeartSurgeryComplications.htm> (last visited Apr. 10, 2012).

84. *What is Heart Surgery?*, [http://www.nhlbi.nih.gov/health/dci/Diseases/hs/hs\\_what.html](http://www.nhlbi.nih.gov/health/dci/Diseases/hs/hs_what.html) (last visited Apr. 10, 2012).

85. Moss & La Puma, *supra* note 6, at 23.

86. Curie, *supra* note 4, at 1139.

87. *Id.*

88. Walsh & Randell, *supra* note 1, at 35.

at that time, they cannot teach new behavior in the long run.<sup>89</sup> It has also been asserted that “a lifelong pattern of dyscontrol cannot be modified by restraints.”<sup>90</sup> Thus, mechanical restraints do not have any direct rehabilitative effect for mental health patients, nor do they aid in facilitating optimization of function.

*E. Causes of Mental Health Patients’ Aggressive Behavior Other Than Their Illness*

If the aggressive behavior of a patient that ultimately leads to the use of mechanical restraints is not the result of the patient’s mental illness, but rather other factors, then the mechanical restraint could not be said to be treatment because it would not be “remedying” the illness for which the patient has been hospitalized for in the first place. Add a transition sentence or sentences that mentions and introduces environmental factors and behavior that is not associated with the mental illness and lack of nutrition.

1. Environmental Factors in the Hospital

It is possible that the aggressive behavior for which a mental health patient is mechanically restrained is caused by external or environmental factors, and is not even a result of the patient’s illness. In that case, even if mechanical restraints constituted treatment, it would not have any specific therapeutic effect on the mental illness. Studies have shown that overcrowding and aggressive behaviors are significantly related.<sup>91</sup> Such aggressive behavior may also be triggered by an institution’s “focus on control, organizational rules, directions to staff to ‘keep order,’ a homogenized ‘one size fits all’ treatment approach, and poor staff supervision”<sup>92</sup> or lack of leadership on the unit.<sup>93</sup> Patients may also be affected and agitated by witnessing or being

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89. Harvey Gordon et al., *The Use of Mechanical Restraint in the Management of Psychiatric Patients: Is It Ever Appropriate?*, 10 J. FORENSIC PSYCHIATRY 173, 178 (1999).

90. Walsh & Randell, *supra* note 1, at 34.

91. Kathryn L. Brooks et al., *Patient Overcrowding in Psychiatric Hospital Units: Effects on Seclusion and Restraint*, 22 ADMIN. & POL’Y MENTAL HEALTH 133, 142 (1994).

92. Glover, *supra* note 10, at 1141.

93. Oberleitner, *supra* note 12, at 95.

within earshot of the restraint of another patient.<sup>94</sup> The necessary resolution to the external or environmental issues mentioned above has less to do with the patient's illness — and therefore less to do with treating the patient — than it has to do with issues within the institution itself.

## 2. Behavior Not Associated With the Mental Illness

Aggressive behavior leading to the use of restraints may sometimes be the result of a patient's genuine dissatisfaction with something or personal conflicts with the staff or others, and not the patient's actual mental illness.<sup>95</sup> In such cases, restraints would not be "treating" the patient for the illness for which she has been committed, but rather only preventing what would otherwise be feelings that any ordinary person may experience.

## 3. Lack of Nutrition, Fluid Imbalance, and Other Somatic Complications

Moreover, a "lack of nutrition, fluid [im]balance, [poor] hygiene, and other somatic complications . . . could cause the patient's disorientation or agitation."<sup>96</sup> The precipitating factor causing the aggressive behavior in these cases is not the patient's illness. Mechanical restraints by themselves will not restore a nutrition or fluid balance. Thus, the appropriate treatment would be prophylactic efforts aimed at more carefully supervising the patient's nutrition, hygiene, and somatic complaints, so that the aggressive behavior would not arise in the first place.

### *F. Systematic Issues That Influence the Decision to Mechanically Restrain*

#### 1. Hospital Initiatives to Reduce the Use of Mechanical Restraints

Systematic and administrative changes that have resulted in the reduction of the use of mechanical restraints in some hospitals

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94. Marangos-Frost & Wells, *supra* note 8, at 366.

95. Brodie Paterson & Joy Duxbury, *Restraint and the Question of Validity*, 14 NURSING & ETHICS 535, 539 (2007).

96. R. Kaltiala-Heino et al., *Reasons for Using Seclusion and Restraint in Psychiatric Inpatient Care*, 26 INT'L J. L. & PSYCHIATRY 139, 140 (2003).

also suggests that the use of restraints has more to do with the external and environmental issues of the hospital rather than the patient's mental illness. Culture change within the hospital and hospital leaders who emphasize the importance of reducing restraint have proven to be an effective factor in initiatives to reduce the use of mechanical restraints.<sup>97</sup> Team building among the medical staff and improved supervision of the staff have also been initiatives taken in the successful reduction of the use of restraints.<sup>98</sup> In addition, hospitals have successfully implemented a procedure to convene as soon as possible after a patient has been put into restraints to think of ways to have prevented the situation in the first place and alternative procedures to have dealt with the emergency.<sup>99</sup> Other hospitals have emphasized the importance of actively maintaining their database, analyzing the records on a regular basis, periodic modification of strategies, or addressing different contributing factors of aggression in particular patients.<sup>100</sup>

## 2. Education of Staff and Other Medical Professionals

It has been reported that the majority of instances of the use of mechanical restraints "are used prematurely and because staff lack the knowledge, skills, or abilities to proactively choose other, less restrictive interventions."<sup>101</sup> One study attributed the use of restraint to particular staff's low levels of knowledge and competence in behavioral technology.<sup>102</sup> Thus, staff education has been emphasized by hospitals that have been successful in reducing rates of restraint.<sup>103</sup> Staff education can include teaching

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97. David J., Hellerstein et al., *Decreasing the Use of Restraint and Seclusion Among Psychiatric Inpatients*, 13 J. PSYCHIATRIC PRAC. 308, 309 (2007).

98. Hank Visalli & Grace McNasser, *Reducing Seclusion and Restraint: Meeting the Organizational Challenge*, 14 J. NURSING CARE QUALITY 35, 41 (2000).

99. Hank Visalli & Grace McNasser, *Striving Toward a Best Practice Model for a Restraint-Free Environment*, 11 J. NURSING CARE QUALITY 1, 3 (1997).

100. Schreiner et al., *supra* note 27, at 458.

101. Huckshorn, *supra* note 76, at 489.

102. Dennis C. Donat, *Impact of a Mandatory Behavioral Consultation on Seclusion/Restraint Utilization in a Psychiatric Hospital*, 29 J. BEHAV. THERAPY & EXPERIMENTAL PSYCHIATRY 13, 14 (1998).

103. Curran, *supra* note 56, at 48–49.

staff to divide aggressive behavior into four stages of appropriate responses.<sup>104</sup> Workshop training on trauma theory and the serious risks of the use of mechanical restraints has also proven effective.<sup>105</sup>

There also appears to be no national curriculum for medical professionals in providing training in prevention and management regarding the use of mechanical restraints.<sup>106</sup> One study cited psychology students who reported their “training in management of potentially violent patients was inadequate nor are important practice parameters or position statements included in major textbooks.”<sup>107</sup> This raises an important question. How medically informed are the decisions to use mechanical restraints? Of course, it could be said that such issues are learned through experience and “on the job.” However, if that is the case, how could the medical profession ever truly step away from the use of mechanical restraints if the philosophy continues to be perpetuated “on the job” by the more senior professionals? Indeed, the use of mechanical restraints is a “standard of care by consensus rather than by scientific data.”<sup>108</sup> As the abovementioned initiatives suggest, that standard of care may be outdated.

#### *G. Non-Medical Decisions*

Part of the reason that deference is given to the medical professionals in the first place is that, due to their position, training, and experience, they are better equipped than the ordinary person to make *medical* decisions.<sup>109</sup> However, as discussed below, medical professionals often make the decision to employ mechanical restraints for reasons having nothing to do with their medical expertise.<sup>110</sup>

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104. Oberleitner, *supra* note 12, at 96.

105. Sandra A. Barton et al., *Achieving Restraint-Free on an Inpatient Behavioral Health Unit*, 47 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH UNIT 34, 36 (2009).

106. Mohr, *supra* note 32, at 10.

107. *Id.*

108. Moss & La Puma, *supra* note 6, at 22.

109. See Lings, *supra* note 31, at 180–81.

110. See e.g., Fisher, *supra* note 11, at 1585.

### 1. Administrative Decisions

It has been shown that mechanical restraints are often used out of administrative convenience rather than for the actual treatment of the patient.<sup>111</sup> One study showed that increases in the number of staff members relative to the number of persons receiving care were significantly related to decreases in reliance on mechanical restraint for managing challenging behavior problems.<sup>112</sup> It has been stated that mechanical restraints may be overused if there are staffing shortages or if there is overcrowding.<sup>113</sup> These reasons for the use of restraint appear to be the result of administrative decisions rather than the informed, medical decisions to which the Court in *Youngberg* intended to give deference.<sup>114</sup>

### 2. Emotional Decisions

Decisions based on personal emotions and levels of tolerance for certain behaviors should also not be considered medical decisions. It has been reported that staff often use mechanical restraints out of fear for themselves, frustration, fear of losing control of a situation, anger,<sup>115</sup> hopelessness, and helplessness.<sup>116</sup> Perceptions and attitudes of nursing staff influence not only their interactions with patients but also their choice of interventions when responding to an identified need or problem.<sup>117</sup> One study showed how different nurses explain the same patient's behavior differently, resulting in variations in intervention choices to manage aggression.<sup>118</sup> It has also been noted that when mechanical restraints are employed, patients are

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111. *Id.* at 1585.

112. Dennis C. Donat, *Impact of Improved Staffing on Seclusion/Restraint Reliance in a Public Psychiatric Hospital*, 25 PSYCHIATRIC REHAB. J. 413, 413 (2002).

113. Gordon et al., *supra* note 89, at 178.

114. *See Youngberg v. Romeo*, 457 U.S. 307, 322–23.

115. Fisher, *supra* note 11, at 1585.

116. Marangos-Frost & Wells, *supra* note 8, at 363.

117. Terpstra et al., *supra* note 9, at 24.

118. Pamela L. Lindsey, *Psychiatric Nurses' Decision to Restrain: The Association Between Empowerment and Individual Factors*, 47 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES 41, 48 (2009).

often not dangerous, and it is in reality the staff's perceptions or fears that dictate the use of restraint.<sup>119</sup> If the use of mechanical restraints has nothing to do with the patient's illness, but rather is the result of the caregiver's emotions or tolerance levels, such use should not be considered treatment.

### 3. Human Instinct

As can often be seen in the news, in the event of an aggressive fight or altercation between people, other individuals often try to "break up" the fight by separating the fighting parties or restraining one of them.<sup>120</sup> It could be said that human instinct is what influences a person's attempt to "break up" such an altercation where people might get hurt. How is the act of "breaking up" a fight by restraining or separating the individuals so different from restraining a patient who may cause imminent harm to herself or others? The ultimate goal of both forms of restraint is to prevent harm and maintain peace. In that case, the use of mechanical restraints on mental health patients, similar to the restraint involved in "breaking up" fight, would tend to be more the result of human instinct than of medical decision-making.<sup>121</sup>

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119. Cramer et al., *supra* note 25, at 30.

120. *Hotel Guest Shot by Man Who Broke Up Fight*, CRIME VOICE, Jan 5, 2011, available at <http://crimevoice.com/hotel-resident-shot-by-man-who-broke-up-fight-4757/> (2011); *3 Men Stabbed in Macon Nightclub Fight*, available at <http://www.macon.com/2011/01/20/1417006/3-men-stabbed-in-macon-nightclub.html> (2011); Melissa Hawkes, KATC.COM, Jan 19, 2011. *Ten Arrested at Northside High for Fighting*, available at <http://www.katc.com/news/ten-arrested-at-northside-high-for-fighting/> (2011); *Rochester Woman Charged in Fatal Party Stabbing*, THE WALL STREET JOURNAL, available at <http://online.wsj.com/article/AP21f59a8653674816a73a07fc31693043.html> (2011); Donna Hales *Weekend Fight Ends With One Man Stabbed, One Man Hospitalized*, MUSKOGEE PHOENIX, Jan. 15, 2011, available at <http://muskogee phoenix.com/local/x233961719/Weekend-fight-ends-with-one-man-stabbed-one-man-hospitalized> (2011).

121. Conversely, it could be argued that because society generally accepts "breaking up" a fight as something tolerable because it is both egosyntonic and meant to "keep the peace," the use of mechanical restraints should similarly be accepted as something tolerable because it also could be said to "keep the peace." However, holding an individual back during a bar fight, for example, would be a much lesser restriction on individual freedom compared to the mechanical restraint of a mental health patient.

*H. Mechanical Restraints Diminish the Trust Between the Patient and Medical Professional*

Though by itself it does not discount the use of mechanical restraints as a form of treatment, a deterioration of the trust between the patient and medical professional as a result of mechanical restraint at the very least calls into question the claim that such restraint constitutes treatment. Mental health patients have reported that, after being mechanically restrained, they feel distrustful of their caregivers.<sup>122</sup> Also, though staff “may expect patients to believe they will be helped by being placed in restraints, the subjective experience of the patient may be far different.”<sup>123</sup> Trust cannot be established with this kind of disagreement and dysfunction regarding the use of mechanical restraints, treatment options, and compliance.<sup>124</sup> A deterioration of trust may not necessarily mean that the medical professional no longer has the patient’s best interests in mind. Indeed the medical professional may very well still engage in conduct wholly beneficial to the patient. However, if a patient does not trust a professional, then she likely will not believe that the professional has either the technical competence to provide her treatment or her best interests in mind. As mentioned earlier, the deference given to medical professionals is predicated on the expectation that they have the technical competence to provide treatment.<sup>125</sup> Although this diminished trust does not in itself mean that mechanical restraints do not constitute treatment, it further reinforces how tenuous claims of mechanical restraints as a form of treatment really are.

*I. Alternative Behavioral Treatments of Aggression in Mental Health Patients*

The therapeutic potential of mechanical restraints wanes in light of alternative behavioral treatments of aggression in mental health patients. For instance, an advance crisis management

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122. Wynn, *supra* note 69, at 138.

123. Sue Hardesty et al., *Evaluating Initiatives to Reduce Seclusion and Restraint*, 29 J. FOR HEALTHCARE EQUALITY 46, 48 (2007).

124. Outlaw & Lowery, *supra* note 36, at 75–76.

125. Lings et al., *supra* note 31, at 183–84.

program<sup>126</sup> or an assessment tool<sup>127</sup> requires a medical professional to work with a patient in advance to determine personal stress triggers and strategies that they personally prefer to manage their agitation and anger.<sup>128</sup> This method is also useful because it “communicates the [medical professionals’] expectation about their conduct and the fact that this area may become part of the treatment plan.”<sup>129</sup> If the patient begins to feel agitated or disoriented, the medical staff could immediately implement the strategies to avert the crisis.<sup>130</sup> If it could be performed by the patient by herself, she would be reminded of the strategy and encouraged by the staff to use it.<sup>131</sup> This type of program has proven successful in decreasing the use of mechanical restraints, partly because it helps patients learn how to better manage their behavior before it escalates to a level where restraints might otherwise be used.<sup>132</sup> Moreover, this approach is more aligned with the definition and goals of treatment, including rehabilitation and optimizing function, because it helps the patient learn how to manage herself in a way that is personal, preferable, and unique to her.

Another strategy is wrapping, which patients can learn to do by themselves both in the hospital and at home. Wrapping employs the use of a blanket, sheet, or comforter, which is placed on a bed before the client lies down in it and wraps herself in it in a swaddling style. This technique has been shown to prevent numbing and escalation of aggressive behavior and agitation.<sup>133</sup> Other techniques that appear to be more in line with the proposed definition and goals of treatment include teaching patients self-management strategies, including anger control, adaptive

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126. Jessica A. Jonikas et al., *Brief Reports: A Program to Reduce Use of Physical Restraint in Psychiatric Inpatient Facilities*, 55 PSYCHIATRIC SERVICES 818, 818 (2004).

127. Visalli & McNasser, *supra* note 99, at 2.

128. *See id.*; Jonikas et al., *supra* note 126, at 818.

129. Visalli & McNasser, *supra* note 99, at 2.

130. Jonikas et al., *supra* note 126, at 818.

131. *Id.*

132. *See id.* at 819; Visalli & McNasser, *supra* note 98, at 43–44.

133. Jane G. Dresser, *Wrapping: A Technique for Interrupting Self-Mutilation*, 5 J. AM. PSYCHIATRIC NURSES ASS’N 67, 69 (1999).

behaviors, and interpersonal self-awareness and symptom reduction.<sup>134</sup>

These abovementioned alternatives are meant to stop aggressive behavior *before* it escalates to the level where mechanical restraints need to be used to prevent harm, whereas mechanical restraints are used when the behavior has *already* reached that level. Consequently, these strategies might not be considered “alternatives” in the exact sense of the word. However, they do suggest that the appropriate treatment should be targeted at the behavior *before* it escalates to a level where a risk of danger is posed rather than *at the time* the behavior has already escalated to that level. After all, once mechanical restraints are used, the harm has already been done. As mentioned earlier, there is little data supporting mechanical restraints as a form of treatment, nor does there appear to be any evidence that their use on a patient ever leads to a reduced need for the use of restraints.<sup>135</sup> Instead, there appears to be a self-perpetuating cycle of aggressive behavior and restraint. These alternatives could not only reduce the use of restraints, but also provide patients with the ability to manage their own aggression and other personal difficulties. Unlike mechanical restraints, the alternatives provide better opportunities for rehabilitation and optimization of function and therefore fulfill the goals and proposed definition of treatment.

#### VI. ALTERNATIVES TO THE PROFESSIONAL JUDGMENT STANDARD

Given that the use of mechanical restraints does not constitute treatment and consequently the professional judgment standard should not govern the appropriate use of mechanical restraints, alternative standards should be explored. Certainly, due process liberty rights to be free from unreasonable bodily restraints should continue to be recognized, as was in *Youngberg*.<sup>136</sup> In addition to this, proposed standards applied in cases involving different areas of law or rights could perhaps be applicable to protecting such rights. Because the deference otherwise given to medical professionals in making treatment decisions should not apply to the use of mechanical restraints, the alternative standards

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134. Jonikas et al., *supra* note 126, at 818.

135. See Walsh & Randell, *supra* note 1, at 34.

136. See *Youngberg v. Romeo*, 457 U.S. 307, 319–20.

could be gleaned from non-medical contexts where individuals' bodily freedom is infringed upon. Taking guidance from other areas of law would not be extreme, because even the professional judgment standard, as contemplated in *Youngberg*,<sup>137</sup> appears to have some of its foundations in tort law and medical malpractice.

### A. Tort Law

#### 1. Medical Malpractice

In medical malpractice, a physician or doctor has breached her duty of care only if she has departed or deviated "from the standard of care or from good, sound medical practice."<sup>138</sup> Like the professional judgment standard, typical medical malpractice assumes that the doctor or medical professional is making decisions with regard to actual medical treatment.<sup>139</sup>

The main difference between the medical malpractice standard and the professional judgment standard is that the latter requires a *substantial* departure from the standard of practice.<sup>140</sup> Simply taking out the word "substantial," and requiring a mere departure from the standard of practice (medical malpractice) to impose liability could provide a higher level of protection. However, this would still assume that the use of mechanical restraint constitutes treatment. Because, as discussed earlier, the use of mechanical restraints do not constitute treatment,<sup>141</sup> the individuals using mechanical restraints on mental health patients should be treated just as any other individual under tort law and should not be afforded the shield of a standard of care that would otherwise protect medical professionals. At the very least, the medical malpractice standard still affords more protection to patients — albeit, only a limited amount more — than does the professional judgment standard as it stands today.

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137. See *id.* at 319–20, 323.

138. Steven E., Pegalis, *Standard of Care, Generally*, 1 Am. Law Med. Malp. § 3:3.

139. *Id.*

140. *Youngberg*, 457 U.S. at 323.

141. See *supra* Part V.

## 2. Duty to Aid Another Harmed by Actor's Conduct

Because the use of mechanical restraints does not involve a medical decision and does not constitute a form of medical treatment, other negligence doctrines that apply to the common individual could be applied in the context of mechanical restraints. The principle imposing a duty to aid another who is harmed by one's conduct could apply.<sup>142</sup> According to this principle, "if the actor knows or has reason to know that by his conduct, whether tortious or innocent, he has caused such bodily harm to another as to make him helpless and in danger of further harm, the actor is under a duty to exercise reasonable care to prevent further harm."<sup>143</sup> As mentioned earlier, by mechanically restraining patients, medical professionals can cause serious physical and psychological harm.<sup>144</sup> Accordingly, imposing a duty on medical professionals to "exercise reasonable care to prevent further harm" from the mechanical restraints could provide more adequate protection for patients.

Moreover, Restatement (Second) of Torts § 286 reads as follows:

The court may adopt as the standard of conduct of a reasonable man the requirements of a legislative enactment or an administrative regulation whose purpose is found to be exclusively or in part to protect: (1) a class of persons which includes the one whose interest is invaded; (2) the particular interest which is invaded; (3) that interest against the kind of harm which has resulted; and (4) that interest against particular hazard from which the harm results.<sup>145</sup>

## 3. A Standard Borrowed From Tort Law

The principles from tort law mentioned above could thus be assimilated into the context of mechanical restraints as follows:

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142. See RESTATEMENT (SECOND) OF TORTS § 322 (1965).

143. *Id.*

144. See SAKS, *supra* note 6, at 147; Mohr & Mohr, *supra* note 6, at 289; Aschen, *supra* note 7, at 90.

145. RESTATEMENT (SECOND) OF TORTS § 286 (1965).

The use of mechanical restraints creates a risk of physical and psychological harm. Doctors, physicians, and other medical professionals have a duty to protect patients from the risk of harm from the use of mechanical restraints, which includes exercising reasonable care when placing the patient in mechanical restraints and to prevent any further risk of harm that may arise when the patient is mechanically restrained.<sup>146</sup>

If this standard were codified in the statute such as the model statute proposed below, then a court could adopt it as a standard of conduct pursuant to Restatement (Second) of Torts § 286.<sup>147</sup>

*B. The Fourth Amendment Right Against Unreasonable Seizures & Excessive Force*

Furthermore, the Fourth Amendment right to be free from unreasonable seizures and excessive force by the state should also apply to the use of mechanical restraints on mental health patients. Such restraint on the freedom of movement of an individual could not be a clearer example of a seizure, which could potentially be unreasonable and involve the use of excessive force, under the Fourth Amendment. However, though the Fourth Amendment right has been applied to “seizures of individuals for psychiatric evaluations or involuntary commitment,” it has not yet been recognized regarding the use of mechanical restraints on mental health patients.<sup>148</sup>

1. The Applicability of the Fourth Amendment to the Context of Mechanical Restraints

In *Lanman v. Hinson*, which involved the allegations of unreasonable bodily restraint of a mental health patient who had *voluntarily* committed himself, the Sixth Circuit held that the Fourth Amendment would not apply because: (1) Fourth

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146. This article has chosen the principle of the duty to aid another harmed by one's conduct over a basic medical malpractice standard because it provides more protection to the patient and because the medical malpractice standard still would assume mechanical restraints are a form of treatment.

147. See *infra* Part VIII (Proposed Model Statute).

148. *Lanman v. Hinson*, 529 F.3d 673, 680.

Amendment protection against unreasonable seizures “seems primarily directed to the *initial* act of restraining an individuals’ liberty”; and (2) under *Youngberg*, because the restraint of a patient is “for the purpose of medical treatment.”<sup>149</sup> Here, the court seemed to imply that the Fourth Amendment did not apply simply because due process rights have already been said to apply.<sup>150</sup> What prevents both rights from simultaneously applying? The court further stated that “if a reasonable person in the patient’s position would believe” the restraint “was not medical treatment . . . then the patient has been seized within the meaning of the Fourth Amendment.”<sup>151</sup>

The court’s reasoning in holding that Fourth Amendment rights do not apply with regard to the mechanical restraint of mental health patients is flawed, for three reasons. First, to hold that the right against unreasonable seizures only applies to the initial act essentially means that once a person has been “seized,” she cannot be subsequently “seized” again or in a different way. For mental health patients, this would mean that once an individual is committed, she is in effect stripped of her Fourth Amendment rights from unreasonable seizures. This seems preposterous, especially in light of the fact that the use of mechanical restraints may pose an even greater, direct intrusion upon the person’s liberties than the initial act commitment. Second, the court stated that Fourth Amendment rights do not apply if the use of mechanical restraints constitutes treatment. Thus, it should logically follow that if the use of mechanical restraints does *not* constitute treatment, Fourth Amendment rights *should* apply.

Finally, as mentioned earlier, because the majority of mental health patients do not believe restraint is medical treatment,<sup>152</sup> the Fourth Amendment should apply pursuant to the Court’s very own assertion. Indeed, some may argue that mental health patients cannot be reasonable, and because the standard is a reasonable person *in the patient’s position*, the fact that the

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149. *Id.* at 680–81.

150. *See id.* at 681.

151. *Id.*

152. *See* Ray, Myers, & Rappaport, *supra* note 70, at 14; Outlaw & Lowery, *supra* note 36, at 75; Wynn, *supra* note 69, at 138; Hardesty et al., *supra* note 117, at 48.

majority of patients do not believe restraint is medical treatment<sup>153</sup> is tenuous evidence. However, such a view would completely disregard the notion that there is “no reason to believe that the mentally [ill] think less of their freedom”<sup>154</sup> than the rest of the population. Just as it would be wrong under U.S. law to state that a person is guilty until proven innocent of a crime,<sup>155</sup> it is fundamentally unfair to assume that mental health patients are unreasonable until proven reasonable. Thus, there must be a shift in attitude to recognize that mental health patients are entitled to the self-determination of their own freedom, just as any other individual. With such recognition, evidence that the majority of mental health patients do not believe restraint is medical treatment<sup>156</sup> is incredibly significant.

## 2. A Fourth Amendment Factors Test

If the Fourth Amendment right against unreasonable seizures and excessive force exists in addition to the due process rights recognized in *Youngberg*, then perhaps Fourth Amendment standards could provide guidance for an alternative to the professional judgment standard. The United States Supreme Court and other courts have applied a nonexclusive list of factors to determine whether police officers have used excessive force or otherwise violated an individual’s Fourth Amendment right against unreasonable seizures. From the perspective of a reasonable officer on the scene, factors include: (1) whether the suspect posed an immediate threat to the safety of officers or others; (2) the severity of the crime and the need for the application of force; (3) the relationship between that need and the amount of force that was used;<sup>157</sup> and (4) whether the officer considered less intrusive means or tactics before the use of force.<sup>158</sup> Though these cases involved the use of excessive force by officers against a criminal suspect, these factors seem quite pertinent in the context of

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153. See Ray et al., *supra* note 70, at 14; Outlaw & Lowery, *supra* note 36, at 75; Wynn, *supra* note 69, at 138; Hardesty et al., *supra* note 123, at 48.

154. Biddle, *supra* note 34, at 262.

155. See Coffin v. U.S., 156 U.S. 432, 453 (1895).

156. See Ray et al., *supra* note 70, at 14; Outlaw & Lowery, *supra* note 36, at 75; Wynn, *supra* note 69, at 138; Hardesty et al., *supra* note 123, at 48.

157. Graham v. Connor, 490 U.S. 386, 390, 396 (1989).

158. Bryan v. MacPherson, 630 F.3d 805, 828–29 (9th Cir. 2010).

mechanical restraints.<sup>159</sup> Just as the use of mechanical restraints can cause serious harm to the patient,<sup>160</sup> the unreasonable seizure and use of excessive force of a criminal suspect can also involve injuries to the suspect, such as a broken foot, cuts on wrists, bruised forehead, and an injured shoulder.<sup>161</sup> Ultimately, the same interests of freedom from unreasonable seizures and the use of excessive force exist in both contexts.

### 3. A Standard Borrowed From the Fourth Amendment Right Against Unreasonable Seizures

These factors could be assimilated into the context of the mechanical restraints as follows:

Whether the Fourth Amendment right against unreasonable seizures of a mental health patient has been violated by the use of mechanical restraint will be examined by the consideration of the following non-exclusive list of factors from the objective standpoint of the medical professional: (1) whether the patient posed an immediate threat to the safety of herself, the medical professionals, or others; (2) the level of harm posed and the need for the application of restraints; (3) the relationship between that need and the amount of restraint applied; and (4) whether the medical professional considered less intrusive means or tactics before the use of restraint.

Such a standard would appear to provide a greater level of protection for the patient under the Fourth Amendment than the professional judgment standard currently provides under the Due Process Clause of the Fourteenth Amendment. Further, if it is true that the due process liberty rights that the Court in *Youngberg* contemplated are meant to protect the same basic interests as the Fourth Amendment right against unreasonable seizures and use of

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159. By no means do I intend to equate mental health patients with criminal suspects, nor do I intend to equate police officers with medical professionals.

160. SAKS, *supra* note 6, at 147; Mohr & Mohr, *supra* note 6, at 289.

161. *Graham*, 490 U.S. at 390.

excessive force — that is, freedom from bodily restraints and intrusions — then perhaps the standard could apply in the context of both constitutional rights simultaneously.

## VII. CONCLUSION

The professional judgment standard as contemplated under *Youngberg* does not adequately protect the liberties of mental health patients and incorrectly assumes that the use of mechanical restraints on mental health patients constitutes treatment.<sup>162</sup> Mechanical restraints provide little to no therapeutic benefit, are merely incidental to treatment,<sup>163</sup> are potentially counter-therapeutic<sup>164</sup> and poses a great risk of physical<sup>165</sup> and psychological harm,<sup>166</sup> and are ultimately the result of decisions that are often highly influenced by personal emotion,<sup>167</sup> tolerance,<sup>168</sup> and environmental<sup>169</sup> and administrative factors.<sup>170</sup> Therefore, the use of mechanical restraints cannot be defined or considered as treatment because it does not remedy or cure the patient's mental illness nor does it facilitate rehabilitation, recovery, or the optimization of the patient's function. It appears to have quite the opposite effect. In finding an alternative of the professional judgment standard, tort law and the Fourth Amendment right against unreasonable seizures and excessive force may provide guidance and alternative standards that better protect the liberties of mental health patients from mechanical restraints. Ultimately, because the use of mechanical restraint does not constitute treatment and does not involve a medical decision, the professional judgment standard should not and cannot continue to be upheld.

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162. See *supra* Part II.B.

163. See Curie, *supra* note 4, at 1139.

164. Smith, *supra* note 5, at 28.

165. See SAKS *supra* note 6, at 155–56; Moss & La Puma, *supra* note 6, at 22; Mohr & Mohr 6, at 285.

166. Aschen, *supra* note 7, at 90.

167. Marangos-Frost & Wells, *supra* note 8, at 366.

168. Terpstra et al., *supra* note 9, at 24.

169. Glover, *supra* note 10, at 1141.

170. Fisher, *supra* note 11, at 1585.

## VIII. PROPOSED MODEL STATUTE

HEALTH & SAFETY CODE § X: Mechanical Restraint of Mental Health Patient

(A) Patients have the right to be free from unreasonable restraint, seizures, and excessive use of force from doctors, physicians, and other medical professionals. The use of mechanical restraints must only be used when the need to prevent imminent danger from the patient outweighs the ability to prevent the danger with alternative methods.<sup>171</sup>

(B) The use of mechanical restraints creates a risk of physical and psychological harm. When mechanical restraint is justified pursuant to section (C), doctors, physicians, and other medical professionals have a duty to protect patients from the risk of harm from mechanical restraints, which includes exercising reasonable care when placing the patient in mechanical restraints and to prevent any further risk of harm that may arise when the patient is mechanically restrained.<sup>172</sup>

(C) A “mechanical restraint” is one placed on an individual to restrict that individual from causing harm to himself/herself or others. Examples of mechanical restraints include: restraint sheets, camisoles, belts attached to cuffs, leather armlets, restraint chairs, and shackles.

(D) Mechanical restraints shall only be used as a last resort and in the event of an emergency, where an imminent danger is presented to others in the following three circumstances<sup>173</sup>:

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171. Based on the Fourth Amendment right to be free from unreasonable seizures and the use of excessive force, and standards from *Graham v. Connor*, 490 U.S. 386, 390, 396 (1989) and *Bryan v. MacPherson*, 630 F.3d 805, 828–29 (9th Cir. 2010).

172. Based on RESTATEMENT (SECOND) OF TORTS § 322 (1965): “[I]f the actor knows or has reason to know that by his conduct, whether tortious or innocent, he has caused such bodily harm to another as to make him helpless and in danger of further harm, the actor is under a duty to exercise reasonable care to prevent further harm.”

173. Adopted from SAKS, *supra* note 6, at 155–57.

- (1) On ambulance rides transporting a patient to emergency rooms or from emergency rooms to psychiatric hospitals;
- (2) In emergency rooms, only if the hospital does not have — at the time — sufficient space for a seclusion room; or
- (3) On psychiatric wards:
  - (a) In order for a doctor to safely examine a patient;
  - (b) In order to safely move a patient to a seclusion room; or
  - (c) If, at the time, there is an insufficient number of seclusion rooms.

(E) Use as a “last resort” in section (D) means that less restrictive alternatives, such as seclusion,<sup>174</sup> must be explored or reasonably attempted before use of mechanical restraints. Administrative deficiencies, such as a understaffing,<sup>175</sup> does not constitute as a reasonable justification for waiver of the requirement to seek and attempt less restrictive alternatives. If the patient presents and imminent danger to himself or herself, this will not constitute an emergency allowing for mechanical restraints to be applied.<sup>176</sup>

(F) In the event that circumstances necessitate mechanical restraints in the absence of the attending doctor or physician, only a certified nurse or trained staff member will be allowed to order the use of mechanical restraints, pursuant to the limitations of section B.

- (1) The certified nurse or trained staff member must have attended and passed 20 hours in a training program for mechanical restraints.<sup>177</sup>
  - (a) The certified nurse or trained staff member must complete the 20 hours in a training program annually.
- (2) If a certified nurse or trained staff member places a patient in mechanical restraints, the attending doctor or

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174. Or even restraint to a chair in the ward, so that the patient can still interact with her friends and other patients.

175. Example taken from Gordon et al., *supra* note 89, at 178.

176. Mechanically restraining a patient to protect from danger to herself is useless because the patient can hurt herself just as easily in restraints as out of restraints; SAKS, *supra* note 6, at 151.

177. Improved staff education can reduce the use and need for the mechanical restraint of mental health patients; Huckshorn, *supra* note 76, at 489.

physician must be notified within 10 minutes of restraint. Once the doctor or physician is notified, he must provide confirmation in the form of a written order within 15 minutes of notification.<sup>178</sup>

(a) The total amount of time as it applies toward section (F)(3) begins from the moment the patient is placed in mechanical restraints, not when the attending doctor has provided confirmation in a written order.

(G) The mechanical restraints shall be placed in the least restrictive way possible, so as to assure the comfort of the individual to the greatest extent possible.<sup>179</sup>

(1) Restraints shall not be placed on the individual in a way that restricts breathing.

(2) If the patient's symptoms worsen with the restraints, restraints may need to be changed or relieved.

(3) Patients shall not be abused or wrongfully touched or mishandled while they are being placed in restraints.

(H) Once placed in mechanical restraints, patients must be monitored not less than once every 10 minutes, to assure their safety, by a certified health professional.

(1) No patient shall stay in restraints for more than one hour before being re-evaluated for a decision on whether restraints will remain in place.<sup>180</sup>

(a) If the patient remains in restraints after being re-evaluated, that patient must be re-evaluated by a doctor every 20 minutes from thereon.

(i) During each re-evaluation, the doctor must explain to the patient the reasons for the use of mechanical restraints and the

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178. Given the serious risks of harm posed by the use of mechanical restraints, the most qualified medical professional should be involved in every decision to mechanically restrain a patient.

179. Mechanical restraints pose a serious risk of physical harm to the patient; Moss & La Puma, *supra* note 6, at 23; SAKS, *supra* note 6, at 147; Mohr & Mohr, *supra* note 6, at 289.

180. After one hour, if the patient's aggressive behavior has not subsided, it suggests that mechanical restraints are of no use to calm the aggressive behavior and an alternative should be applied.

reason for why the mechanical restraints remain on.<sup>181</sup>

(2) Proper documentation must be made as to the monitoring of the patient and the status of the patient.<sup>182</sup>

(a) Documentation must provide clear, complete, accurate information of any circumstances surrounding the use of mechanical restraint.

(b) A information management system must be maintained to track such documentation mentioned in section (F)(2)(a).<sup>183</sup>

(3) If determined by the attending doctor that it is safe to do so, the patient must be given food and/or water every 20 minutes.<sup>184</sup>

(4) No patient may remain in restraint for more than 2 consecutive hours.<sup>185</sup>

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181. Trust is a fundamental part of treatment, and that such trust be maintained. Also, by explaining the reasons for restraint, the patient may be less likely to feel humiliated or undignified; *See Lings et al., supra* note 31, at 183-84.

182. To assure that mechanical restraints remain necessary and to assure the safety of the patient.

183. Based on initiatives to reduce the use of mechanical restraints; Schreiner et al., *supra* note 27, at 458.

184. Agitation and disorientation can be caused by lack of nutrition; Kaltiala-Heino et al., *supra* note 96, at 140.

185. The requirement to first explore the use of a less restrictive alternative before employing mechanical restraints, as mentioned in sections (D) and (E) still remains. However, if after two hours the patient's aggressive behavior has not subsided, it is *more likely than not* that the mechanical restraints have proven ineffective at calming the aggressive behavior and a less restrictive alternative should be applied. Therefore, a less restrictive alternative must be explored both: 1) before the use of mechanical restraints; and 2) after the use of mechanical restraints has been employed for two hours and shows no signs of improving the patient's condition. Indeed, the actual use of mechanical restraints necessarily means that the first attempts of a less restrictive alternative were unsuccessful. However, simply because the first attempts of a less restrictive alternative were not successful before mechanical restraint, it does not automatically negate the possibility that a subsequent attempt of a less restrictive alternative (after mechanical restraint has proven unsuccessful after two hours) *could* be successful. The less restrictive alternative could of course include increased medication (assuming one agrees that medication is in fact less restrictive than mechanical restraint), or perhaps what the patient personally regards as less restrictive; *See SAKS, supra* note 6, at 147.

(I) After release from mechanical restraint, the attending doctor or physician must explain to the patient the reasons for the use of the restraint and record any and all feedback from the patient as to the experience.<sup>186</sup>

(1) The attending doctor and staff must convene not later than 48 hours after the restraint of the patient to discuss the occurrence and to determine alternatives to restraint for patient in the future.<sup>187</sup>

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186. Based on the idea that a fundamental part of treatment is the maintenance of trust between the patient and the doctor; *See Lings et al., supra* note 31, at 183–84.

187. Based on the initiatives to reduce the use of mechanical restraints; Visalli & McNasser, *supra* note 99, at 3.

# The Consumer's Right: An Expanded Role for Psychiatric Advance Directives in Reducing Coercive Intervention in Mental Health Care

JOSHUA D. CRABILL<sup>\*</sup>

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## I. INTRODUCTION

A series of investigative reports in the *Hartford Courant* in the fall of 1998, detailing a number of fatalities resulting from restraint use in Connecticut mental health facilities, is often cited as the pivotal moment that brought significant public attention in the United States to the overuse and abuse of mechanical restraints in mental health settings as a contemporary problem.<sup>1</sup> In both the voluminous empirical literature and policy papers on the topic since then, however, the focus is frequently centered on what can be done by either government officials and regulators, or staff and administrators of mental health facilities, to reduce the use of restraints and seclusion. Certainly, there is much to be said for this, and each of these important roles is recognized in the outline of a Model Law on restraints in the final section of this article. But what role is there for the so-called “consumer” to play in this?

Plausibly, no one is in a better position than the mental health consumer — the person potentially on the receiving end of coercive interventions — to set policy and guidelines for her own treatment. The consumer can do just that by completing a psychiatric or mental health advance directive. By allowing the mental health consumer to specify preferences in advance of the onset of acute symptoms or lost decision-making competence, psychiatric advance directives (“PADs”) are an essential instrument in protecting and extending patient autonomy. They accomplish this in the same way that other health care advance directives do (in particular those involved in end-of-life decisions). The scope of PADs can include, but is not limited to, the following areas: specifying preferred or familiar treatment facilities, and preferred or familiar staff at a given facility; designating a surrogate decision maker sympathetic to one’s interests, and the

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1. E.M. Weiss, *A Nationwide Pattern of Death*, HARTFORD COURANT, Oct. 11, 1998, at A1; E.M. Weiss, *Little Training, Few Standards, Poor Staffing Put Lives at Risk*, HARTFORD COURANT, Oct. 12, 1998, at A1; E.M. Weiss, *Patients Suffer in a System Without Oversight*, HARTFORD COURANT, Oct. 13, 1998, at A1; E.M. Weiss, *People Die and Nothing is Done*, HARTFORD COURANT, Oct. 14, 1998, at A1; E.M. Weiss, *From “Enforcer” to Counselor*, HARTFORD COURANT, Oct. 15, 1998, at A1.

extent of that surrogate's authority; specifying visiting permissions during one's treatment; informing staff of potential behavior that might be mistaken for aggression and how best to respond or engage with the patient in such situations; alerting staff to potential sources of trauma (or re-trauma) for the patient; noting general and situation-specific treatment and therapy preferences; giving recommendations of effective and ineffective methods of de-escalation; listing preferred or known medications (both efficacious and not); and conditions for revocation of the PAD itself.<sup>2</sup>

This paper argues that part of a comprehensive solution to the problem of improper, unnecessary and violative uses of coercive intervention against mental health patients must include effective, widespread completion and use of psychiatric advance directives (PADs). The single most important piece of evidence in making this case is the fact that increased completion of PADs has a significant statistical link with reduced incidence of coercive crisis interventions, including the use of restraints and seclusion. Dramatically, in one study those who completed a PAD were found to experience less than a third of the coercive crisis interventions than those in the no-PAD group during the first six months after completing a PAD (6.5% vs. 19.7%), and nearly a third fewer overall after two years (18.8% in the PAD group, compared to 27.3% for non-PAD patients).<sup>3</sup>

Determining the precise reasons for this link requires further empirical investigation, and the contributing factors are likely to be complex and varied. I will, however, attempt to identify a few of them. It has been shown, for instance, that facilitated completion of PADs improves competence on the part of many patients to make treatment decisions for themselves.<sup>4</sup>

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2. A sample PAD, which does not include all of these aspects, but which is nonetheless in many ways an excellent example of what can and should be part of a PAD, is available from the Bazelon Center for Mental Health Law website. BAZELON CENTER FOR MENTAL HEALTH LAW, <http://www.bazelon.org/Where-We-Stand/Self-Determination/Advance-Directives.aspx> (last visited Feb. 20, 2012).

3. Jeffrey W. Swanson et al., *Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions*, 17 J. MENTAL HEALTH 255, 261 (2008).

4. See, e.g., Eric B. Elbogen et al., *Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making*, 31 LAW & HUM.

Moreover, respect for the patient's autonomy and preferences may be an essential part of the recovery process and reduction of hospitalization. The role of a PAD is to put the patient, to the greatest extent possible, in control of her own treatment and recovery.<sup>5</sup> In general, mental health consumers engaged in their own treatment are less prone to disruptive or violent behavior, have an increased likelihood of adherence to treatment plans and medication use, and thus are less likely to relapse and have coercive methods used against them by staff.<sup>6</sup> PADs also evince strong clinical utility, in part by including references to available services and preferred treatments.<sup>7</sup> What all of this demonstrates is that patients are, in too many cases, an untapped resource for staff decision-making and treatment-planning. Indeed, by consulting patients' wishes, some of the more counterproductive effects of forced treatment — which might range from coercion discouraging patients from seeking treatment again, to the undermining of the therapeutic relationship during treatment itself — can be avoided. By promoting communication and working alliances between patients and staff, increased use of advanced directives can and does contribute, directly and indirectly, to lowering the incidence of restraint and seclusion.

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BEHAV. 275, 284–86 (2007). In a randomized controlled trial, psychiatric patients with a pre-morbid General Intelligence Quotient score below the median of 100 showed significantly greater improvement in their treatment reasoning ability following a brief intervention to facilitate PAD completion than did patients assigned to a non-treatment control group. *Id.*

5. Anna M. Scheyett & Mimi M. Kim, *Psychiatric Advance Directives: A Tool for Consumer Empowerment and Recovery*, 31 PSYCHIATRIC REHABILITATION J. 70, 70–71 (2007).

6. This finding is robust with regard to PADs. *See* Swanson, *supra* note 3, at 261. This, however, should not be surprising, given that other research has reached similar conclusions with regard the link between self-determination in mental health treatment and both public safety and treatment adherence in patients. *See e.g.*, E. B. Elbogen et al., *Effects of Legal Mechanisms on Perceived Coercion and Treatment Adherence Among Persons with Severe Mental Illness*, 191 J. OF NERVOUS & MENTAL DISEASES, 629–37, (2003); J. W. Swanson et al., *Effects of Involuntary Outpatient Commitment on Subjective Quality of Life in Persons with Severe Mental Illness*, 21 BEHAV. SCI. & L. 473–91 (2003).

7. Debra S. Srebnik et al., *The Content and Clinical Utility of Psychiatric Advance Directives*, 56 PSYCHIATRIC SERVICES 592 (2003).

In short, advance directives have a crucial role to play as an intermediary between a patient who may no longer be competent to make treatment decisions and those responsible for the patient's treatment. In the end, it is imperative for the sake of patient dignity and autonomy that the creation, transmission, and enforcement of PADs be promoted and that obstacles to these be reduced as far as possible, if not outright eliminated. The solution is not an easy one. It both requires patients to complete PADs and demands that mental health providers obtain them, read them, and take them seriously. But if, as the data indicate, between one and two-thirds of coercive interventions involving mental health patients can be eliminated with a simple legal document that seeks to involve patients in their own treatment, then it would be both irresponsible and unreasonable not to take a very close look at these legal instruments and how their role in mental health care might be expanded.

In what follows, I sketch a framework for enlarging the place of PADs in mental health care. This framework simultaneously takes the vulnerability of patients in a mental health setting into account, while also respecting the need for clear standards as to what the appropriate conditions are for setting up, enforcing and revising advance directives. Finally, I consider what form a standard PAD can and should take, what the consumer can include or not in a PAD, and what the extent of its power and conditions of enforcement should be.

## II. BARRIERS THAT LEAD TO FAILURE TO *COMPLETE* PADs

Although the Patient Self-Determination Act ("PSDA"), which was passed in the U.S. in 1990 and became effective in 1991, mandates that health care providers ask patients if they have an advance directive,<sup>8</sup> this does little good if the patient does not have one. Unfortunately for the consumer, completing a PAD can be a complex and sometimes arduous process, involving multiple steps, multiple parties, requiring information that may not always be easily accessible, and using language that is not always easily decipherable. This section looks at some of the leading factors that

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8. Patient Self-Determination Act, 42 U.S.C. §§ 1395cc (2006). Health care providers are required to ask patients if they have an advance directive in accordance with 42 U.S.C. § 1395cc(f)(1)(B) (2006).

prevent or discourage patients from completing a PAD. In each case I offer recommendations for how to ameliorate the problem.

#### *A. Poor Readability of PAD Forms*

One central problem that inhibits the completion of PAD forms is the language of the form itself. The text may present itself in difficult ways, and readability issues can include the following: complex organization; multiple or unclear forms; technical medical and/or legal language; professional jargon; and others. Frequently, this stems from a requirement in many states that the language of an acceptable PAD form must closely mirror that of either the relevant advance directive statute or the state's own advance directive form.<sup>9</sup> Moreover, this is a problem not only for consumers, but also for some physicians seeking to interpret the specific preferences and instructions contained in advance directives.<sup>10</sup>

This is not an entirely unfamiliar problem, and the poor readability of patient materials has been noted as an issue in discussion of end-of-life situations in particular.<sup>11</sup> It has also been observed that advance directive forms issued in the United States — which include health care powers of attorney, living wills, and forms that combine the two — generally fail to meet the fifth-grade reading level recommended by the National Work Group on Literacy and Health.<sup>12</sup> It would be a reasonable and easily enacted measure to bring the mandatory readability of PAD forms in line with the mean reading level of adults in the United States. A similar barrier exists regarding the availability of forms to patients in their native languages. Some states, such as California, already

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9. Lesley S. Castillo et al., *Lost in Translation: The Unintended Consequences of Advanced Directive Law on Clinical Care*, 154 ANNALS INTERNAL MED. 121, 122 (2011).

10. See Joan M. Teno et al., *Role of Written Advance Directives in Decision Making: Insights from Qualitative and Quantitative Data*, 13 J. GEN. INTERNAL MED. 439, 441 (1998).

11. See K.A. Ache & L.S. Wallace, *Are End-of-Life Patient Education Materials Readable?*, 23 PALLIATIVE MED. 545, 547 (2009).

12. See Luke A. Mueller et al., *Readability of State-Sponsored Advance Directive Forms in the United States: A Cross Sectional Study*, 11 BMC MED. ETHICS 1, 2 (2010).

provide multiple language options for end-of-life directive forms.<sup>13</sup> Nevertheless, more can be done to make this the case in all states, and with all relevant advance directive forms, including PADs.

The implications of these findings are important, for at least two reasons. First, the purpose of advance directives in general is to promote and to preserve patient autonomy, and a barrier to readability of an advance directive form is, to the extent that it discourages or prevents completion, a threat to autonomy and control over one's future situation. Second, the impact of poor readability will not be equal across society. Those who are discouraged from completion of a PAD due to readability will be disproportionately tend to be either those who lack general literacy skills, and who are consequently already among the least advantaged members of society, or those who lack a more specialized "health literacy."<sup>14</sup>

*RECOMMENDATION:* Simplify and standardize a clear, easy-to-read PAD form, and make this form available in multiple languages. Complex legal and medical language should either be explained or eliminated. The overall reading level should not exceed that of the national average for adults (at present, 5<sup>th</sup> grade).

### *B. Interstate Variations*

Moving or traveling to another state may create the need to complete a new and perhaps very different PAD. Legal requirements and standards, the nature of the specific forms to be completed, and reciprocity agreements for enforcement of PADs can all vary from state to state within the United States.<sup>15</sup> One's PAD from a given state may not be accepted by another state, or

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13. See CALIFORNIA DEPARTMENT OF DEVELOPMENT SERVICES, THINKING AHEAD: MY WAY, MY CHOICE, MY LIFE AT THE END (Sacramento, CA: California Department of Developmental Services) (2009), available at <http://www.dds.ca.gov/consumercorner/thinkingahead.cfm> (last visited Jan. 22, 2012).

14. See Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *Health Literacy: Report of the Council on Scientific Affairs*, 281 J. AM. MED. ASS'N 552 (1999).

15. The National Resource Center on Psychiatric Advance Directives (NRC-PAD) maintains a helpful and continuously updated list of state-by-state information on current PAD law. National Resource Center on Psychiatric Advanced Directives – State By State Info, NCR-PAD.ORG, <http://www.nrc-pad.org/content/view/282/83/> (last visited on Jan. 2, 2012).

not in its entirety, and a different form, which may be more or less similar and more or less complex, may have to be completed to ensure full execution of one's advance directive.<sup>16</sup> The result is that fewer enforceable PADs are completed by patients than would be the case if the validity of one's advance directive did not depend on whether one has moved to or spends significant time in another state. Moreover, improved clarity and ease of transfer would not only help the consumer, but would allow easier communication of preferences to health care providers (which is discussed more at length in Section III).

Once again, this is not an entirely unfamiliar issue, and has been discussed in regard to advance directives for the elderly and in end-of-life situations more generally.<sup>17</sup> In the same vein, one proposal to remedy the problem is the implementation of a national standard for advance directives.<sup>18</sup> Something similar is doubtlessly appropriate in the case of mental health and PADs. While it has been the province of individual states to regulate advance directive law for their own residents, it is the judgment of the author that the patchwork nature of the system at present does more to create confusion, obstruct autonomy, and impair the exercise of patient rights than it does to protect the rights of the residents of various states to determine their own laws.

The problem could be solved in one of two basic ways: (1) the more desirable option is the establishment of a national standard for advance directive law in the United States, or at the very least the creation of a nationally accepted form, enforceable and transferable from state to state; (2) a second-best alternative, but one which expresses respect for the value of state sovereignty, is for those states which have not yet done so<sup>19</sup> to adopt widespread reciprocity agreements with all or nearly all other

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16. See Lesley S. Castillo et al., *Lost in Translation: The Unintended Consequences of Advanced Directive Law on Clinical Care*, 154 ANNALS INTERNAL MED. 121, 121, 125 (2011).

17. See Charles P. Sabatino, *National Advance Directives: One Attempt to Scale the Barriers*, 1 NAT'L ACAD. ELDER L. ATTY'S 131, 133 (2005); Charles P. Sabatino, *De-Balkanizing State Advance Directive Law*, 25 B. ASS'N FOCUS ON AGING & L. 1 (2003).

18. See Sabatino, *supra* note 17, at 154.

19. Kentucky, Michigan, and Wyoming in particular have yet to adopt advance directive reciprocity agreements of the sort which have been enacted by 47 states and the District of Columbia. Castillo et al., *supra* note 16, at 124.

states; perhaps even adopting some variation of a model law on restraints, in order to ensure full enforceability of advanced directives completed in other states, so that patient autonomy is not threatened by one's interstate movements. Between the two options, the author prefers the former due to the impracticality of implementing an agreement that standardizes a form for, or equally empowers patients in, all 50 states.

*RECOMMENDATION:* Legislate a nationwide standard for the type, or types, of PAD form that will be acceptable nationwide. This needn't invalidate or override existing forms completed under previous standards, and patients should be able — but not required — to use more complex forms if they choose, as long as those forms conform to the standards for transmissibility (which might include, among other things, readability, as discussed in III.1).

### *C. Notary and Witness Requirements*

In essentially all states,<sup>20</sup> the presence of a licensed notary or of one or two witnesses (and, in some states, of both a notary and witnesses) is required to enact advance directives, including PADs.<sup>21</sup> In addition, some states require that the witness or witnesses be “impartial,” that is, not a close relative or a medical professional. The aim of this clearly seems to be protecting the consumer from being pressured to complete an advance directive, the content of which he or she doesn't necessarily agree with, by medical staff or family members whose interests in doing so may diverge from or even be opposed to those of the patient. It should be granted that this threat to patient self-determination from witnesses' potential conflicts of interest is real, and that the grounds for such concern are not unreasonable. For this reason, a limited form of impartiality is useful and should be preserved, especially with regard to medical staff or professionals in a position of authority over patients in terms of their care and treatment.

At the same time, strict impartiality requirements of the sort now in place in many states serve to create barriers and make it more difficult (perhaps prohibitively so) to complete an advance

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20. The exception here is New Mexico, where two witnesses are recommended but not required for advance directives. N.M. Stat. Ann. § 24-7A-4 (West 2012).

21. Castillo et al., *supra* note 16, at 123–24.

directive. Thus, although there must be limits — in particular, restricting medical staff and immediate family from acting as witnesses — it is not clear that many states' requirements optimally serve the interests of the consumer, which is presumably their primary if not sole justification. Not only do onerous notary and impartiality requirements in many cases not promote autonomy (with the exceptions noted), but actually restrict it by making a central instrument of autonomy — the advance directive — more difficult to access. While a limited impartiality requirement (e.g., one non-family, non-healthcare witness) clearly limits the ability of those who wish the consumer ill or seek to override or disregard her wishes for treatment, these well-motivated restrictions may on balance do more harm than good, by effectively inhibiting many patients from completing a PAD at all.

*RECOMMENDATION:* Given that a broad requirement for impartiality of witnesses or certification by a notary public would restrict the autonomy of the consumer by limiting her ability to control her own treatment — for reasons such as limited availability of a notary, cost of transportation, access to impartial witnesses, etc. — such requirements should be reformed. A limited impartiality requirement in some form should be retained to protect consumers, notably a prohibition on health care staff and immediate family acting as witnesses to an advance directive.

#### *D. Types of PADs Recognized*

Another difficulty that may present itself is the completion of a PAD in written form at all. This may be true for isolated or disabled individuals, for non-native speakers, or for other groups. Some have suggested that this is a problem, and that, moreover, the solution is to accept various types of PAD, including oral directives.<sup>22</sup>

Certainly, insofar as exclusion of different forms of PAD leads to non-completion of a PAD, and to the non-exercise of a patient's autonomy, this counts as a *prima facie* strike against such a barrier. Nevertheless, caution is required. The recognition of oral PADs, in particular, seems to present a grave risk to patients. The risk here stems primarily from difficulties with verification of the oral directive and its contents. How might oral instructions, preferences, consent, approval, and so on be demonstrated? Unless

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22. See *id.*

the contents of such a directive are recorded in such a way that it can be accessed and played back, the risk is that the report of the contents of the oral directive — and hence the autonomy of the patient and her future treatment — will rest with those in receipt of the oral directive, who may include health care professionals, family members, or others whose interests, for various reasons, might diverge from those of the consumer.

A worry of this sort arose in the discussion above regarding the alleged safeguard of requiring impartial witnesses in the case of written PADs.<sup>23</sup> Consequently, it might seem that a similar argument should apply here, namely, that the possible benefits of oral PADs outweigh the risks. There is, however, an important difference that should not be overlooked. When it came to the question of whether or not to require the impartiality of witnesses to a written directive, the potential benefits to the patient outweighed the slight, albeit genuine, risk of coerced signing of a document whose content one does not in fact approve. The risks of allowing oral PADs, however, in terms not only of verification of one's approval of the directive, but also in terms of its very existence as well as abridgments or additions to its contents, appear sufficiently weighty, give their open-ended and therefore potentially drastic nature, to override potential benefits from increased completion. Thus, this author disagrees with the position advocated by other commentators<sup>24</sup> who suggest that non-recognition of oral directives is ethically problematic, and that such recognition should be expanded to include all 50 states.

*RECOMMENDATION:* The risks justify keeping in place requirements banning the use of oral directives as well as removing the recognition of such directives in the 16 states where they are currently accepted. The sole exception would be where these directives are substantiated via being recorded in some permanent, standardized and distributable medium. The further removal of barriers to PADs in permanent and stable media is to be encouraged.

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23. See Section II.C.

24. *Id.*; BERNARD LO, *RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS* (4th ed. 2009).

*E. Prompting and Facilitation*

Empirical studies have demonstrated an enormous latent disposition of mental health consumers to complete PADs when prompted, and this result is robust.<sup>25</sup> One study found that simple, two-hour structured interventions in facilitating PAD completion for those who desire it can increase completion by over twenty times versus that of a control group (61% vs. 3%).<sup>26</sup> Another study conducted in five major urban areas in the United States found that, although only 4%–13% of consumers had already completed a PAD, between 70%–83% expressed interest in completing one if someone helped them to do so.<sup>27</sup>

These are deeply encouraging results, and the potential for expanded completion of PADs using simple methods of facilitation is dramatic. Likewise, the implications for all of the various benefits of PADs, from clinical utility to reduced coercion, are equally dramatic. PAD facilitation in particular has been shown to be “an effective method to boost competence of cognitively-impaired clients to write PADs and make treatment decisions within PADs, thereby maximizing the chances their advance directives will be valid.”<sup>28</sup> At the same time, the results are also heartbreaking, insofar as they demonstrate the large numbers of mental health consumers who have not completed PADs, perhaps for the simple reason that no one has ever offered to assist them in doing so. This function is particularly important for patients with communication barriers, including patients who are deaf, blind, elderly, non-English speakers, or who speak English as a second language. In fact, the strong disposition mental health consumers evince to take charge of their own treatment via PADs may lead one to wonder whether widespread or systematic facilitation of

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25. See *infra* notes 29 and 30 and accompanying text.

26. J. Swanson et al., *Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons with Severe Mental Illness*, 163 AM. J. PSYCHIATRY 1943, 1947 (2006).

27. Jeffrey Swanson et al., *Psychiatric Advance Directives Among Public Mental Health Consumers in Five U.S. Cities: Prevalence, Demand, and Correlates*, 34 J. AM. ACAD. PSYCHIATRY L. 43 (2006).

28. Eric B. Elbogen et al., *Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making*, 31 LAW & HUM. BEHAV. 275, 275 (2007).

PAD completion, especially if combined with some or all of the other recommendations above, might not result in near-universal completion of PADs by mental health consumers.

Given these results, it might seem to be appropriate to go so far as to require all competent patients to complete (or have completed) some form of advance directive as a standard component of admission to a mental health facility, and even for outpatient care. While there is some merit to this proposal, two worries present themselves. First, this proposal is currently illegal. The Patient Self-Determination Act (PSDA) requires that health care providers never discriminate against patients based on whether they have an advance directive.<sup>29</sup> Thus, for all intents and purposes, “it is against the law . . . to require either that you have or not have an advance directive.”<sup>30</sup>

Second, even if it were not against the law, it is probably a good idea not to actively *require* completion of a legally binding advance directive, given that the legal criteria for *revocation* of advance directives are sometimes unclear. Consider a patient who likes and trusts her doctor and, because she is required to complete an advance directive, signs a legally binding document that in effect, with a few qualifications, authorizes her treatment providers to do whatever they judge to be best for her welfare. The problem is that this may commit the patient to the content of the advanced directive, which in this case grants extremely broad and open-ended decision-making powers to others on her behalf, even if she were to later regain competence (perhaps following a relapse or a period of incompetence due to acute symptomatology). If the treatment decisions she would then competently make differ significantly either from the judgment of her care providers or from what is specified in the PAD, this would amount to forced treatment of a competent patient against her will — a very unfortunate consequence.

Other reasons not to allow facilities to require advance directives stem from the statistics concerning who is likely to have completed a PAD. Given the risks discussed in the previous

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29. See AmericanBar.org, *Health Care Advance Directives: What Is the Patient Self-Determination Act?*, [http://www.americanbar.org/groups/public\\_education/resources/law\\_issues\\_for\\_consumers/patient\\_self\\_determination\\_act.html](http://www.americanbar.org/groups/public_education/resources/law_issues_for_consumers/patient_self_determination_act.html) (last visited Jan. 2, 2012).

30. *Id.*

paragraph, a policy requiring that new patients must possess a PAD, for instance, would likely discriminate starkly and unjustly against poorer, less educated, minority, and disabled mental health consumers who are less likely to have completed a PAD in the first place. A final reason not to require completion of an advance directive, even if doing so is easily accessible and in such a way that is non-discriminatory, is that some patients may simply be more circumspect or have less confidence in their own ability to vividly and accurately imagine what they would want for themselves in any possible set of circumstances that might arise. Autonomy requires that consumers have the right to decline completion of a PAD, instead of articulating and committing themselves to, say, treatment preferences that turn out to be opposed to their own interests later on and to which they would otherwise not be bound.

Thus, while requiring a PAD would be both illegal and ill-advised, requiring health facilities to inform consumers of their rights and to offer advance directive completion services — even if such services are ultimately refused by the consumer — would be a boon to mental health. Unfortunately, even mere facilitation for those who want it is not standard practice in most health care settings. Outside of very limited circumstances, such as in the experiments mentioned above, most mental health care providers do little to promote facilitation of PADs in a meaningful way. One option might be the appointment of a particular governmental agency, on either the state or the federal level, either to promote or actively provide this service to consumers.<sup>31</sup> Facilitation of this sort might take different forms. It could perhaps involve something as simple as asking competent patients what their preferences are, using thought experiments to elicit those

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31. Although governmental entities at the national level seem to recognize the problem, such as the Substance Abuse and Mental Health Services Administration, such that SAMHSA's website claims that part of its response to the problem of seclusion and restraint use in mental health facilities is "to promote the increased use of advance directives," it is not clear what if any concrete efforts or funding is being directed toward this aim. United States Department of Health and Human Services Substance and Mental Health Services Administration, *Seclusion and Restraint: Statement of the Problem and SAMHSA's Response*, (Mar. 20, 2011), [http://www.samhsa.gov/seclusion/sr\\_handout.aspx](http://www.samhsa.gov/seclusion/sr_handout.aspx).

preferences, and making proactive completion assistance services much more widely available.

There is also much to be said for the role of peer facilitation in encouraging PAD completion. Scholars in the field have mentioned several of the potential benefits of peer support in this process.<sup>32</sup> For instance, consumers may be more comfortable conversing with, asking questions of, taking suggestions from, and even completing a PAD with their peers than with a health care provider. Peer training sessions, either volunteer or sponsored, are thus an attractive option for increasing consumer knowledge of PADs, as well as encouraging completion thereof.

On the other hand, health care providers themselves also seem to be well positioned to play a facilitative role in PAD completion. They possess the relevant familiarity with patients, their treatment options, and the relevant medical terminology; in addition, they are likely to regularly see and meet with patients. This last point is of special significance, because studies show that simply making information on advance directives available to consumers in a passive manner is not effective in increasing rates of completion.<sup>33</sup> Instead, the most effective way of increasing their use “is the combination of informative material and repeated conversations over clinical visits . . . .”<sup>34</sup> “[W]hen interactive informative interventions are employed, the PAD completion rate increases and the majority of the studies identify multiple sessions as the most effective method for direct interaction between patients and health care professionals.”<sup>35</sup> Thus, a multi-track approach to PAD facilitation may be called for, with the aim of reaching as many mental health consumers as possible through these various means.

Finally, before summarizing the recommendations in regard to facilitation of PADs, it is important to point out that the service is likely to be of most benefit to: (a) those who are most

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32. See Anna M. Scheyett et al., *Psychiatric Advance Directives: A Tool for Consumer Empowerment and Recovery*, 31 PSYCHIATRIC REHABILITATION J. 70, 73 (2007).

33. See Maria-Isabel Tamayo-Velazquez et al., *Interventions to Promote the Use of Advance Directives: An Overview of Systematic Reviews*, 80 PATIENT EDUC. & COUNSELING 10, 10–20 (2010).

34. *Id.*

35. *Id.*

vulnerable to the use of restraint and seclusion, such as the deaf and hard-of-hearing;<sup>36</sup> and (b) those who are least likely otherwise to complete a PAD, such as elderly and socially isolated individuals.<sup>37</sup> Other groups that fall under one or both of these headings include, but are not limited to: patients who are unaware of their rights as health care consumers, including those ignorant of the availability instruments like PADs or skeptical of their legal validity or usefulness; ESL or non-native speakers of other languages; the homeless; and the cognitively impaired. A model for one type of facilitation comes from procedures already used in obtaining informed consent for certain medical and surgical procedures among patients who suffer from cognitive impairment. Various methods, including computer-aided repetition, can significantly improve patient comprehension, such that in some cases consent can be given for procedures on impaired patients who are as informed, or nearly so, as that of otherwise unimpaired patients.<sup>38</sup> This and similar forms of consent-enhancement deserve wider implementation. In general, given that facilitating patient autonomy, in particular through PAD completion, will often do the most good for the most vulnerable patients, its promotion is encouraged most emphatically.

*RECOMMENDATION:* Put in place procedures, on a national scale, to facilitate widespread PAD completion by mental health consumers. Recognizing the differences in patients' circumstances and needs, a multifarious approach is recommended, including a combination of passively available information, peer counseling sessions, and multi-session facilitation by health care providers themselves. Provision of these services in a way likely to reach the vast majority of mental health consumers should be mandated at

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36. Brian Hartman & Ann Blalock, *Comparison of Seclusion and Restraint Prevalence Between Hearing Patients and Deaf or Hard of Hearing Patients in a State Hospital Setting*, 32 ISSUES MENTAL HEALTH NURSING 42, 42-43 (2011).

37. Naomi Karp & Erica Wood, *Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly*, AM. BAR ASS'N, 2004, <http://www.abanet.org/irr/hr/spring04/incapacitated.html>.

38. See generally A. Fernandez, et al., *Interventions to Improve Patient Comprehension in Informed Consent for Medical and Surgical Procedures: A Systematic Review*, 31 MED. DECISION MAKING, no. 1 Jan./Feb. 2011, 151 (providing a helpful recent review of studies of "enhanced consent").

either the state or federal level, although participation will (for the reasons discussed above) be optional.

### III. BARRIERS THAT LEAD TO FAILURE TO *RECEIVE* COMPLETED PADs

While completion of PADs is rightly viewed as a central issue (if not *the* central issue) in empowering and involving mental health consumers in their own care, it is not the only issue — for a PAD is, at heart, a communicative act. It is both informative and directive, and neither function can be accomplished if the intended recipients never see it or take it into account. In this section, I discuss some of these concerns, both those that are legal in nature and those that are a function of the health care system in the United States, that impact the accessibility and transmission of PADs, even after completion.

#### *A. Not Requested*

While the Patient Self-Determination Act requires that health care providers ask whether you *have* an advance directive, and if so to document that fact in your medical record, they are not legally required to obtain a copy of it. In many cases there is simply no imperative on staff to obtain a copy of a patient's advance directive, nor any standardized or widespread mechanism for locating and obtaining it should they wish to do so.

Complicating matters is the fact that attitudes about the importance and efficacy of PADs vary widely among mental health staff, social workers, and others. For instance, a survey<sup>39</sup> conducted in the UK showed that only “28% of psychiatrists thought advance directives were needed.”<sup>40</sup> Unfamiliarity or lack of experience with such health care powers of attorney or PADs might contribute to skepticism, though experience with such instruments does have a positive correlation with pro-attitudes

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39. Jacqueline M. Atkinson et al., *Models of Advance Directives in Mental Health Care: Stakeholder Views*, 39 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 673 673–75 (2004).

40. *Id.* at 673. For an in depth discussion of the contours of clinicians' views on and doubts about PADs, see E. B. Elbogen et al., *Clinical Decision Making and Views about Psychiatric Advance Directives*, 57 PSYCHIATRIC SERVICES, 350 (2006).

toward their use.<sup>41</sup> Thus, part of the barrier to providers receiving PADs can be the providers themselves. Consequently, it is important for education about, among other things, the clinical utility of PADs and how such instruments work to be a part of the training of all mental health staff.

In short, the current situation is one in which it is the patient's responsibility to ensure timely and effective transmission of their PAD to their health care providers, many of whom do not see the need for PADs to begin with. Given the difficulty of completing and having on file a PAD, it should be the responsibility of health care providers to obtain and familiarize themselves with the contents of their patients' PADs. To have it otherwise would be to place an unfair burden on the already vulnerable mental health consumer.

*RECOMMENDATION:* Require all institutions and treating staff to obtain a copy of the consumer's PAD, beyond the mere acknowledgment of its existence. Additionally, mandatory education about the structure and benefits of PADs will help familiarize, and thus change attitudes of, mental health staff, social workers, and others.

#### *B. Available Only with Difficulty or Delay*

If obtaining a patient's PAD is to be mandated (as recommended in the previous section), a reliable and timely method of delivery is certainly an important issue to consider. Requiring a written request to a patient's lawyer to obtain a PAD before treatment could potentially lead to delays in obtaining information that may be relevant to a patient's treatment. On the other hand, this delay must be weighed against the privacy concerns involved with what seems to be the most salient alternative, namely, digital delivery. A reasonable way to address such concerns is to have an opt-in system of digital delivery, combined with a requirement of explicit authorization of each request for those who opt-in to such a method. In this way, digital copies of one's PAD will have the potential to speed up transmission times, thereby putting needed information in the hands of staff promptly and efficiently. In particular, this would be

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41. See Mimi M. Kim et al., *Front Line Workers' Attitudes Towards Psychiatric Advance Directives*, 44 COMM. MENTAL HEALTH J., 28, 35 (2008).

a benefit in cases involving long-distance transmission, between states for instance.

*RECOMMENDATION:* Allow digital delivery of PADs, although only where authorized by the patient (or by the patient's designated legal representative). Require mental health facilities to have the relevant capabilities to request and access these documents, which may require both equipment and training with regard to digital health records. Implement security measures to ensure the privacy of the patient's information.

### *C. State-To-State Transmission Problems*

Distinct from non-application or validity of one's PAD in other jurisdictions<sup>42</sup> is the problem of obtaining an existing PAD, even from another state with which the requesting state has a reciprocity agreement. Mental health providers are not legally required to obtain a patient's PAD. Nor are they required to obtain the relevant information (e.g., a lawyer's phone number or address) which would allow them to do so. Further complicating matters is the fact that consumers themselves may be unsure about this information, or may not always have it at hand. Thus, requiring providers simply to request this information from consumers, in addition to asking whether they have an advanced directive, seems clearly insufficient to ensure a high likelihood of delivery, let alone timely delivery.

*RECOMMENDATION:* Privacy concerns related to the creation of a national digital database involving consumer information should always be taken seriously. Nevertheless, a database involving either (a) mere contact information for obtaining a given patient's PAD, or (b) the actual PAD available only to authorized users and as a strictly opt-in possibility for the consumer (and perhaps involving a nationally standardized format, as suggested in Section II above), would allow for swift communication and receipt of PADs regardless of location, thereby encouraging communication between consumer and provider and promoting patient involvement in treatment.

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42. For a more in depth discussion see Section IV.A.

#### IV. BARRIERS THAT LEAD TO FAILURE TO *ENFORCE* COMPLETED PADS

Some of the barriers to enforcement of a consumer's PAD, and hence restrictions on her autonomy, come from the fragmentation of mental health care law among the fifty states.<sup>43</sup> Other barriers come from mental health staff themselves, who are either unwilling to implement an advanced directive or, in some cases, unsure of how to do so.<sup>44</sup> And still others stem from legal ambiguities, confusions, or misunderstandings concerning the conditions for creation, enforcement, and revision of PADS.<sup>45</sup> These issues are discussed in turn.

##### *A. Enforceability in Other States*

The single greatest obstacle to enforcement of PADS is their non-existence. This might be as a result of non-completion, which was the topic of Section II, but the problem also may be that PADS are simply not among one's legal options in the state where one resides. In fact, currently only 25 states have made specific legal provision for PADS, although residents of other states typically have access to health care powers of attorney (HCPAs), or other similar legal instruments. In other words, half of American states deny their residents access to this vital tool and the expression of self-determination that accompanies it. And even among states that have provisions for PADS in some form or other, other states one is traveling to or spending time in may fail to have clear or well-worked out (or, for that matter, any) reciprocity agreements with the state in which one is a legal resident. In addition, requirements on the nature and wording of the PAD form in a given state may vary from that of other states, and in such a

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43. State-by-state information on current PAD law is available from the National Resource Center on Psychiatric Advance Directives. National Resource Center on Psychiatric Advance Directives, <http://www.nrc-pad.org/content/view/282/83/> (last visited Jan. 2, 2012).

44. See Debra Srebnik & Lisa Brodoff, *Implementing Psychiatric Advance Directives: Service Provider Issues and Answers*, J. BEHAVIORAL HEALTH SERVICES. & RES. 253, 260 (2003).

45. See e.g., Lesley S. Castillo et al., *Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care*, 154 ANNALS INTERNAL MED. 121, 125 (2011).

way that it is invalid or its validity is indeterminate, and therefore its enforceability cannot be relied upon.

*RECOMMENDATION:* As in Section II.1, the creation and implementation of a national form, or national standards for PAD forms, are recommended, in order to ensure that the patient's wishes can be articulated, made known, and respected regardless of jurisdiction or movement within the United States.

### *B. Overridability*

Discussed in Section III.A were some of the rather skeptical attitudes on the part of mental health providers concerning the importance and usefulness of PADs. There, these attitudes and aspects of staff culture were discussed with an eye to the proclivities of staff to obtain a PAD when not required to. It was suggested that part of the solution surely lies in education of staff as to the benefits of PADs, as well as a gradual shift toward a culture that embodies the ideal of collaborative treatment. The potential impact of these attitudes in terms of a patient's treatment is, however, even more serious when it comes to the willingness of staff to respect and enforce the provisions in a PAD.

Admittedly, the consumer is rarely a medical professional herself. Moreover, one of the most frequently expressed worries on the part of medical staff is to question the decision-making capacity of mental health patients to complete advance directives, even when patients' acute symptoms are in remission.<sup>46</sup> Thus, if there is a conflict between the instructions in the PAD and the opinion of medical experts or the professional community as to what would be best for the patient's health and recovery, there is a strong temptation toward paternalism — that is, to override the patient's wishes for her own good.

Most states grant providers the right not to act contrary to the standard of care. A recent survey of state laws shows that, although the criteria for refusal vary considerably from state to

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46. See Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say?*, 89 K.Y. L.J. 327 (1995); see generally Srebnik & Brodoff, *supra* note 44 (arguing mental health caregivers may also tend to question whether a patient in remission has sufficient competence to *revoke* a properly enacted PAD already in effect). Interestingly, mental health caregivers may also tend to question whether a patient in remission has sufficient competence to *revoke* a properly enacted PAD already in effect. See *id.* at 260.

state, nineteen states and the District of Columbia “have entirely open-ended criteria that permit providers to decline to comply with patients’ wishes for any reason.”<sup>47</sup> Although such a policy may sometimes be in the patient’s interest, especially if a surrogate decision maker appointed by a PAD is advocating treatment options contrary to the patient’s best interest, it also represents a significant liability in terms of patient autonomy and gives health providers almost unlimited scope to override the informed, competent, and sincere wishes of the patients under their care.

The central question here is essentially how far the autonomy and authority of the patient over her own treatment ought to extend. Should it be essentially unlimited? Could the state ever have a legitimate interest in a patient’s treatment, such that a PAD can or should be overridden? It is important to note, too, that the set of concerns at stake here involves all types of forced or coercive treatment — including forced hospitalization, forced medication, restraint and seclusion, stripping, etc. To put this question in context, a bit of case history is helpful.

A landmark case in the right of mental health consumers to determine their treatment is *Hargrave v. Vermont*.<sup>48</sup> The plaintiff, Nancy Hargrave, challenged a law that allowed a doctor to nullify mental health provisions in a durable power of attorney if the treatment choices made by the agent did not result in improvement of the declarant’s condition — even in non-emergency situations (i.e., where the patient did not present an immediate danger to herself or others).<sup>49</sup> The law in question was determined to be discriminatory, in light of the Americans with Disabilities Act, since it deprived individuals with mental illnesses from executing a durable power of attorney for health care with the same recognition and enforcement as the advance directive instruments executed by people who do not have mental illnesses.<sup>50</sup> The *Hargrave* decision thus represents an important principle in determining the scope of a

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47. Castillo et al., *supra* note 9, at 125 (discussing the obligations of a provider who refuses to comply with a patient’s wishes also vary depending on the state, with some states requiring that the provider either comply or arrange for the transfer of the patient to another facility and others simply requiring that the provider not interfere with such a transfer).

48. *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003).

49. *Id.* at 32.

50. *Id.* at 38.

PAD's enforceability; the conditions must be the same as those for other health care advance directives.

At the same time, it is important to recognize reasonable limits to the scope of a PAD's authority. Genuine emergencies, such as imminent danger to oneself or others, present a plausible justification for overriding the provisions of a PAD when doing so is the only means of reducing the danger or preventing harm. On that point, there is likely to be minimal controversy.<sup>51</sup>

But where should the line be drawn? Is, for instance, a total refusal of medication acceptable, such that strictly following the directives outlined in a patient's PAD might result in someone who turns out to be (in a far-fetched but frequently-cited type of scenario) both permanently untreatable and permanently undischARGEABLE? Alternatively, should the power of a PAD be limited, say, to a preference ranking among treatment options that are considered viable or necessary for treatment that is likely to improve one's condition? To answer these questions, it is appropriate here to advert to the guiding thought with which this article began, namely, that (*ceteris paribus*) the competent mental health consumer is best situated to set the guidelines for her own treatment. At the (very minimal) risk of condemning a patient without foresight to an ill-conceived set of advance directives of her own choosing, taking patient autonomy seriously seems to demand that — with the sole exception of genuine emergencies — the patient's wishes and instructions be respected to the fullest extent possible, and that both medical staff culture and the law itself ought to reflect this stance.

*RECOMMENDATION:* Although there are questions about whether a person can imagine with enough vivacity and detail all of the possible circumstances to which their advance directive might apply, lawmakers and health care providers should always (with the exception of imminent and serious threats to oneself or others) err on the side of autonomy. The benefit of the doubt

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51. There is, admittedly, some room for debate as to the extent to which risks to *oneself* ought to be allowed, if explicitly provided for in the consumer's PAD. While I feel the force of this consideration, I still want to suggest that if the threat to oneself is serious enough to threaten permanent irreparable injury (e.g., loss of limb or life), paternalism in overriding one's express wishes is to that extent—but *only* to that extent—justified.

should be afforded and coercive paternalism avoided whenever possible.

## V. SUMMARY OF RECOMMENDATIONS AND MODEL LAWS

### *A. Recommendations for a Model Advance Directive Law*

The ideal law on restraints in the United States will be national in scope, thereby solving several important problems at once.

First, it will solve the problem of readability, which may be due to various factors including: complex organization of the PAD form, multiple or unclear forms to fill out, technical medical and/or legal language, and difficulty reading English. I recommend a national standard requiring that the reading level of PAD forms not exceed the recommended fifth-grade level.

Second, a model PAD law would address multiple problems at the interstate level, including creating a universal basic PAD form that, upon completion, will be both valid and recognized as such, as well as being fully enforceable, in all fifty states. I recommend setting up an opt-in national electronic database that will facilitate the easy location and transmission of patient PADs, on both intra- and interstate levels, for those patients who wish to participate (recognizing that some may not due to privacy concerns).

Third, it will go a long way toward encouraging increased, if not almost universal, completion of PADs by mental health consumers by establishing — and funding — PAD facilitation services, on both the consumer-peer and the health provider level, utilizing multiple sessions if necessary. Impartial witness requirements will be eliminated (except for medical staff and immediate family), as well as notary requirements, which, although aimed at protecting autonomy, may in fact do more harm than good. Due to reliability and verification concerns, oral directives will be discouraged and largely banned.

Finally, expanding on the Patient Self-Determination Act of 1990,<sup>52</sup> any mental health provider offering services to a consumer will be required not only to ask whether a patient has a PAD and to

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52. Patient Self-Determination Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388-115, 1388-204 (1991).

note this, but to actively seek out and obtain a copy of the document within a specified period (facilitated by electronic delivery options), and to make this document available to all treating staff. Education about the format and benefits of PADs will be included in the recommended curriculum in educating all mental health workers.

In conclusion, while these recommendations are not easy to implement or easily agreed to, they are in many ways long overdue. PADs, as a legal instrument, afford patients a significant degree of control over their future and the opportunity to collaborate in their own treatment. This last fact is not to be neglected, not least of all because of the clinical utility PADs display, including aiding in recovery, avoiding (re-)trauma, reducing coercive interventions, and improving both perceived and actual treatment efficacy. The rights of patients and standard of care itself demand that nothing short of comprehensive, national reform be enacted now.

### *B. Model Restraint Law*

The aim of a model advance directive law is ultimately the empowerment of patients and the reduction of coercion in mental health care settings. In line with this aim, I sketch in this section a *model restraint law* and note the way in which a model advance directive law fits in as part of an overall policy to maximize and protect patient autonomy, dignity, and rights.

#### 1. Reporting

Standardized, detailed data reporting from all mental health facilities and providers, public and private, to both local and national agencies should be mandatory. Data should include the number and types of coercive interventions, the number of hours spent in seclusion or restraints, any injuries that result from coercive interventions, what provoked the interventions, any medications administered, and other information that might be deemed relevant. In addition, situations that seemed likely or possible to lead to the use of seclusion or restraints but are successfully de-escalated should be recorded.

In addition to mere data collection, it should also be the role of the collecting agencies to *interpret, summarize, review, and disseminate* the results of this collection. This further data can be

made available both as a tool for lawmakers and officials to shape policies. Also, this data could be linked to funding or other resources dedicated to the reduction of coercive interventions. Finally, it could serve as a resource for mental health consumers who, among other things, can use this information to specify preferred treatment facilities through advance directives.

## 2. Training and Education

Uniform minimal criteria for mental health care education and regular workforce development should be adopted. These criteria should be regularly reviewed and should, as a rule, be highly sensitive to developments in empirical research into what constitute effective methods of limiting and reducing coercion, including (but not limited to) training in violence prevention, de-escalation techniques, collaborative therapy, and trauma-informed care.

## 3. Preventive Measures

Staff should be required to perform risk assessments of mental health patients, to include treatment history, previous trauma, possible behavioral triggers for aggression that staff should avoid, and the like. The involvement of the consumer, the consumer's family, or a surrogate decision maker is both appropriate and necessary, and should involve regular contact and consultation with all of the parties mentioned.

An essential follow-up to this process will be the development of individualized treatment plans, based crucially, though obviously not exclusively, on the consumer's input, including the contents of her PAD if she has one. In this way, receipt and review of PADs, where they exist, will form a vital part in efforts to prevent coercive inventions.

In addition, strict patient-staff ratios, which already exist in many places, should be maintained, in order to promote the ability of staff to truly individualize care and respond to crises most effectively when they arise.

#### 4. Regulation

The use of restraints and seclusion should be strictly regulated, as should all coercive measures in health care. Use of such measures should be restricted to urgent, genuine emergencies only involving imminent danger to self or others. Moreover, coercive measures should be administered only by properly trained staff, ideally those in a position to be familiar with the patient's preferences (for instance, through having read his or her PAD).

Clear, strict guidelines for maximal time limits on the use of restraints and seclusion should be in place, with severe penalties (perhaps to be determined internally at different facilities) for violations of these limits. Any patient in restraints or seclusion should be frequently if not continuously monitored, both visually and verbally, and vital signs should be checked at least every fifteen minutes. Any use of pressure or weight on a patient's chest, lungs, sternum, diaphragm, back, neck or throat must be prohibited for the sake of patient safety and dignity. Likewise, proper use of restraints and seclusion will disallow their use as punishment, for the convenience of staff or other patients, or as part of any "treatment" regimen.

#### 5. Oversight and Review

Coercive measures such as mechanical restraints should always require regular in-person approval and regular (at minimum, hourly) re-approval from doctors, administrators, or both. Follow-up to staff having employed such measures, even when done properly, should include a mandatory debriefing of staff and review of all such incidents by administrators. Patients who are willing should be debriefed as well, and their perspective on the use of the measures should be actively elicited, recorded, and reviewed. Finally, the patient's PAD should be consulted, and its instructions and directives be compared by all relevant staff to what actually took place. Any discrepancies should be recorded and require an explanation from, and administrative review of, any party responsible for overriding a patient's PAD.

# Seclusion and Mechanical Restraints Among Ethnic Minorities: Understudied and Needed Area of Research

BY ARMANDO BARRAGÁN, JR.\*

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## I. INTRODUCTION

The use of seclusion and mechanical restraints (“S&R”) has been a contentious area of debate since its implementation in Western medicine hundreds of years ago. Seclusion and mechanical restraints are most commonly used in psychiatry for the management of violence and self-directed aggression.<sup>1</sup> Although there is broad consensus that coercion in psychiatry is sometimes indispensable,<sup>2</sup> it is commonly agreed that these interventions can “have deleterious physical and psychological effects on patients.”<sup>3</sup> For many individuals who undergo this practice, the long-term implications can be severe, causing emotional trauma, injuries, and death.<sup>4</sup> Even if the S&R is conducted correctly, fatal complications or injuries caused by restraints are still likely.<sup>5</sup>

Given the clear negative implications that S&R has for individuals and the differential impact this has on a given population,<sup>6</sup> it is surprising that ethnic minorities, accounting for

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1. See Alisa B. Busch & Miles F. Shore, *Seclusion and Restraint: A Review of Recent Literature*, 8 HARV. REV. PSYCHIATRY 261 (2000); W.A. Fisher, *Restraint and Seclusion: A Review of Literature*, 151 AM. J. PSYCHIATRY 1584 (1994).

2. See Lloyd Griffiths, *Does Seclusion Have a Role to Play in Modern Mental Health Nursing?*, 10 BRIT. J. NURSING 656 (2001); Ian Needham et al., *Coercive Procedures and Facilities in Swiss Psychiatry*, 132 SWISS MED. WKLY. 253 (2002); Mosunmola Tunde-Ayinmode & John Little, *Use of Seclusion in a Psychiatric Acute Patient Unit*, 12 AUSTRALASIAN PSYCHIATRY 347 (2004).

3. Fisher, *supra* note 1, at 1584.

4. See B. Christopher Frueh et al., *Patients' Reports of Traumatic or Harmful Experiences within the Psychiatric Setting*, 56 PSYCHIATRIC SERVICES 1123 (2005); Erlend Hem et al., *Thrombosis Associated with Physical Restraints*, 103 ACTA PSYCHIATRICA SCANDINAVICA 73 (2001); Wanda K. Mohr et al., *Adverse Effects Associated with Physical Restraints*, 48 CANADIAN J. PSYCHIATRY 637 (2003); B. Paterson et al., *Deaths Associated with Restraint Use in Health and Social Care in the UK: The Results of a Preliminary Survey*, 10 J. PSYCHIATRIC & MENTAL HEALTH NURSING 3 (2003).

5. See Hem et al., *supra* note 4; Mohr et al., *supra* note 4; Paterson et al., *supra* note 4.

6. See Kathleen R. Delaney, *Evidence Base for Practice: Reduction of Restraint and Seclusion Use During Child and Adolescent Psychiatric Inpatient Treatment*, 3 WORLDVIEWS ON EVIDENCE-BASED NURSING 19 (2006); Abigail Donovan et al., *Two-year Trends in the Use of Seclusion and Restraint Among*

40.6% of the American population (over 122 million people),<sup>7</sup> have not received the level of attention concerning this topic that they merit. A body of research has established the impact that ethnicity and culture have on the treatment and rehabilitation of individuals with mental health problems.<sup>8</sup> The differential effects associated with ethnicity and culture has influenced our understanding of how illnesses are expressed, how treatment providers perceive patients and how they ultimately decide to treat patients.<sup>9</sup> Accordingly, it is surprising that there has been such a lack of studies that explore and attempt to explain the phenomenon of one of the most contentious forms of patient intervention in the health field among ethnic minorities.

In an effort to shine light on this important issue, this article will discuss the magnitude of problems surrounding the use of

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*Psychiatrically Hospitalized Youths*, 54 PSYCHIATRIC SERVICES 987 (2003); Abigail Donovan et al., *Seclusion and Restraint Reform: An Initiative by a Child and Adolescent Psychiatric Hospital*, 54 PSYCHIATRIC SERVICES 958 (2003); Ross W. Greene et al., *Use of Collaborative Problem Solving to Reduce Seclusion and Restraint in Child and Adolescent Inpatient Units*, 57 PSYCHIATRIC SERVICES 610 (2006); Janice LeBel et al., *Child and Adolescent Inpatient Restraint Reduction: A State Initiative to Promote Strength-based Care*, 43 J. AM. ACAD. CHILD. & ADOLESCENT PSYCHIATRY 37 (2004); Kathleen R. Delaney & Louis Fogg, *Patient Characteristics and Setting Variables Related to Use of Restraint on Four Inpatient Psychiatric Units for Youths*, 56 PSYCHIATRIC SERVICES 186 (2005); Sheila S. Kennedy & Wanda K. Mohr, *A Prolegomenon on Restraint of Children: Implicating Constitutional Rights*, 71 AM. J. ORTHOPSYCHIATRY 26 (2001).

7. United States Census Bureau (2009) *2005-2009 American Community Survey*. Washington, DC.

8. See, e.g., William A. Vega & Steven R. Lopez, *Priority Issues in Latino Mental Health Services Research*, 3 MENTAL HEALTH SERVICE RES. 223-28 (2008); S.R. Lopez et al., *Ethnicity, Expressed Emotion, Attributions, and Course of Schizophrenia: Family Warmth Matters*, 197 J. ABNORMAL PSYCHOL. 428-39 (2004); M. Barrera Jr., *Mexican-American Mental Health Services Utilization: A Critical Examination of Some Proposed Variables*, 14 COMMUNITY MENTAL HEALTH J. 35-45 (1978); William A. Leigh, et al., *Managed Care in Three States: Experiences of Low Income African Americans and Hispanics*, 36 INQUIRY 318-31 (1999); Robert E. Roberts & Mahboob Sobhan, *Symptoms of Depression in Adolescence: A Comparison of Anglo, African and Hispanic Americans*, 21 J. YOUTH & ADOLESCENCES 639-51 (1992).

9. See Vega & Lopez, *supra* note 8; Lopez et al., *supra* note 8; Barrera, *supra* note 8; Leigh et al., *supra* note 8; Roberts & Sobhan, *supra* note 8.

S&R as it relates to ethnic minority populations, the organizations that track and regulate S&R, and their limitations as they relate to ethnic minorities. Additionally, this paper will review older and more recent studies concerning the use of S&R with ethnic minorities, and the limitations of those studies. Finally, the article will discuss the need for future studies in the area of ethnic minority mental health research.

## II. HOW BIG IS THE PROBLEM?

### A. Ethnic Disparities in Inpatient Settings

Historically, epidemiologists and ethnic minority researchers have noted ethnic and racial differences within inpatient mental health settings.<sup>10</sup> For example, Fried identified eight reports, including data from the early twentieth century describing African American and Caucasian differences.<sup>11</sup> These reports indicated higher rates of hospitalization for African Americans than for their Caucasian counterparts.<sup>12</sup> Other studies have also reported overrepresentation among African Americans in inpatient care.<sup>13</sup> This overrepresentation is not limited to African Americans. Latinos are also more likely than Caucasians to be admitted for inpatient hospitalization, showing a similar mental health utilization pattern to that of African Americans.<sup>14</sup> One

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10. Lonnie R. Snowden, *Psychiatric Inpatient Care and Ethnic Minority Populations*, in CROSS CULTURAL PSYCHIATRY 261 (William B. Lawson et al., eds., 1999). Asian Americans were not discussed in this report. Asian Americans are faced with similar challenges as those faced by Latinos and African Americans, especially in regards to use of inpatient services and the stigma associated with having a mental illness and their use of mental health treatment. Unfortunately, the level of inquiry is not at the level as seen among African Americans and Latinos.

11. Marc Fried, *Social Differences in Mental Health*, in POVERTY & HEALTH: A SOCIOLOGICAL ANALYSIS 157, 157 (John Kosa & Irving Kenneth Zola eds., 1975).

12. *Id.*

13. E.g., Freda K. Cheung & Lonnie R. Snowden, *Community Mental Health and Ethnic Minority Populations*, 26 COMMUNITY MENTAL HEALTH J., 277-91 (1990); Julian Chun-Chung Chow et al., *Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas*, 93 AM. J. PUB. HEALTH, 792 (2003); Jeffery D. Blum et al., *Equity and the Psychiatric Care of the Black Patient, 1950 to 1975*, 168 J. NERVOUS & MENTAL DISEASE, 279 (1980).

14. Chun-Chung Chow et al., *supra* note 13.

study found that Caucasians at state and county mental hospitals were admitted at a rate of 136.8 per 100,000, Latinos at 146 per 100,000, and African Americans at 364.2 per 100,000.<sup>15</sup>

The disparities inherent among ethnic minority inpatients have been associated with social level factors that may help to understand the mechanisms that drive racial disparities in the mental health profession.<sup>16</sup> Ethnic minorities, especially African Americans and Latinos, are at high risk for involuntary hospitalization and are likely to be referred to mental health services by law enforcement officials.<sup>17</sup> This phenomenon takes on a more complex nature as socioeconomic status is consistently shown to have a strong relationship with individuals who receive inpatient services. Individuals suffering from mental illness are overrepresented in high-poverty neighborhoods. Ecological studies in the geographic distribution of people with mental illnesses indicate that ethnic minorities suffering from a severe mental illness are disproportionately concentrated in high-poverty areas.<sup>18</sup>

Impoverished communities generally have a high proportion of ethnic minorities who cannot get access to less intrusive outpatient services. Lack of transportation, communication difficulties, and no permanent living address are chronic barriers that make it difficult for both the clients and the treatment providers to maintain regular engagement of outpatient services. This is often exacerbated as many homeless individuals also suffer from substance abuse disorders. Case managers, who

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15. Robin L. MacAskill et al., *Use of Inpatient Services by Special Populations*, in MENTAL HEALTH, UNITED STATES, 1987, 59 (1987).

16. See Blum et al., *supra* note 13; Cheung & Snowden *supra* note 13; Chun-Chung Chow et al., *supra* note 13; MacAskill et al., *supra* note 15; Snowden, *supra* note 10.

17. See Chun-Chung Chow et al., *supra* note 13; Sarah Rosenfield, *Race Differences in Involuntary Hospitalization: Psychiatric vs. Labeling Perspectives*, 25 J. HEALTH SOC. BEHAV. 14, 14–23 (1984).

18. See generally Chun-Chung Chow et al., *supra* note 13; Michael J. Dear & Jennifer R. Wolch, LANDSCAPES OF DESPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS (1987); Robert E. L. Faris & Warren H. Dunham, MENTAL DISORDERS IN URBAN AREAS: AN ECOLOGICAL STUDY OF SCHIZOPHRENIA AND OTHER PSYCHOSES (1960); Leo Srole et al., MENTAL HEALTH IN THE METROPOLIS: THE MIDTOWN MANHATTAN STUDY (1962); Michael J. Dear & Jennifer Wolch, MALIGN NEGLECT: HOMELESSNESS IN AN AMERICAN CITY (1993).

often serve as the link toward outpatient treatment, have been effective in assisting homeless clients in obtaining outpatient treatment,<sup>19</sup> but homeless ethnic minorities continue to suffer at high rates.<sup>20</sup> High-poverty areas contain a scarcity of necessary resources, thus leading to an increased probability of exacerbated symptoms. Consequently, public hospitals and mental health centers become the primary source of care in low-income and immigrant communities.<sup>21</sup>

Due to the increased level of demands placed upon inpatient centers, the limited resources these centers have, and the intrusive nature of acute intervention, the propensity for elevated stress levels among patients and providers is real. This has the potential to affect the quality and effectiveness of treatment. Furthermore, the sociocultural implications of poverty can be detrimental, as they may exacerbate already established misconceptions of inpatient mental health treatment.<sup>22</sup> African Americans and Latinos often report experiencing significant embarrassment and stigma related to mental illness.<sup>23</sup> Many ethnic minorities prefer seeking and receiving informal counseling for mental health services from ministers, family members or other trusted members of the community or family members.<sup>24</sup> This

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19. Gary Morse, *A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy and Research*, in PRACTICAL LESSONS: THE 1998 NATIONAL SYMPOSIUM ON HOMELESSNESS RES. 7 (Linda B. Fosburg & Deborah L. Dennis eds., 1999).

20. See Faris & Dunham, *supra* note 18; Srole et al., *supra* note 18; Dear & Wolch, *supra* note 18; Dear & Wolch, *MALIGN* *supra* note 18; Chun-Chung Chow et al., *supra* note 13.

21. AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED, (Marion Lewin & Stuart Altman eds., 2000); Chun-Chung Chow et al., *supra* note 13.

22. Lois Bolden & Mona N. Wicks, *Length of Stay, Admission Types, Psychiatric Diagnoses, and the Implication of Stigma in African Americans in the Nationwide Inpatient Sample*, 26 ISSUES IN MENTAL HEALTH NURSING 1043, 1043-59 (2005).

23. *Id.*; Erum Nedeem et al., *Does Stigma Keep Poor Young Immigrants and U.S.-Born Black and Latina Women From Seeking Mental Health Care?*, 58 PSYCHIATRIC SERVICES 1547, 1554 (2007); W.A. Vega et al., *Help Seeking for Mental Health Problems Among Mexican Americans*, 3 J. IMMIGRANT HEALTH 133, 133-40.

24. Bolden & Wicks *supra* note 22; Lonnie R. Snowden, *Barriers to Effective Mental Health Services for African Americans*, 3 MENTAL HEALTH

may prolong much needed early clinical treatment that can help to prevent eventually hospitalization (e.g., outpatient treatment at the development of first-rank psychotic symptoms).<sup>25</sup>

Ethnic disparities within inpatient settings, which show a disproportionate amount of ethnic minority youth who become patients, are an alarming concern. In the past decade, several studies have demonstrated an increase in pediatric psychiatric visits in emergency settings,<sup>26</sup> suggesting that hospitalization is the likely point of entry for many youth inducted into the mental health system, especially ethnic minority youth.<sup>27</sup> Few studies have focused specifically on the ethnic characteristics of children and adolescents in psychiatric emergency settings.<sup>28</sup> Although previous studies have examined the clinical and socio-cultural factors associated with adults in inpatient settings,<sup>29</sup> even fewer studies have specifically examined the role of socio-demographic factors.<sup>30</sup> A study of adolescent ethnic minorities within inpatient settings found that African Americans and Latino youth were more likely to be diagnosed with psychotic disorders and behavioral problems, while Caucasian youth were more likely to be diagnosed

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SERVICES RES. 181, 181–87 (2001); Philip S. Wangea al., *Adequacy of Treatment for Serious Mental Illness in the United States*, 92 AM. J. PUB. HEALTH 92, 92–98 (2002).

25. Bolden & Wicks, *supra* note 22; Snowden, *supra* note 24.

26. Gail A. Edelsohn et al., *Predictors of Urgency in Pediatric Psychiatric Emergency Service*, 42 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1197, 1197–202 (2003); Mary E. Evans & Roger A. Boothroyd, *A Comparison of Youth Referred to Psychiatric Emergency Services: Police Versus Other Sources*, 30 J. AM. ACAD. PSYCHIATRY 74, 74–80 (2002); Jordana Muroff et al., *The Role of Race in Diagnostic and Disposition Decision-Making in a Pediatric Psychiatric Emergency Service*, 30 GEN. HOSP. PSYCHIATRY 269, 269–76 (2008); Laura E. Thomas, *Trends and Shifting Ecologies: Part I.*, 12 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM. 599, 599–611 (2003); Damon Page, *Pediatric Psychiatry: More Blues in ED?*, 74 HOSP. HEALTH NETWORK 24, 24 (2000).

27. Muroff et al., *supra* note 26; Saul Sadka, *Psychiatric Emergencies in Children and Adolescents*, 67 NEW DIRECTIONS FOR MENTAL HEALTH SERVICES 65, 65–74 (1995).

28. Evans & Boothroyd, *supra* note 26.

29. Cheung & Snowden, *supra* note 13; Leigh et al., *supra* note 8; Rosenfield, *supra* note 17; Snowden, *supra* note 10.

30. Muroff et al., *supra* note 26.

with depressive disorders and bipolar disorder.<sup>31</sup> Although psychotic disorders are less common among youths than adults, they have been diagnosed in children with greater frequency in the recent past.<sup>32</sup>

### *B. Prevalence of Severe Mental Illnesses*

#### 1. African Americans

Between 2001 and 2003, the National Survey of American Life ("NSAL") completed the most comprehensive and detailed study of mental health among Americans of African descent.<sup>33</sup> With a sample that included 3,570 African Americans, 1,623 blacks of Caribbean descent and 1,006 non-Hispanic whites, it is one of the most nationally representative samples of African Americans in the United States.<sup>34</sup> The purpose of this study was to explore ethnic differences in mental health disorders, distress and other mental health issues that have historically affected Americans of African descent in the United States.<sup>35</sup> Issues such as use of health services within the context of a variety of presumed risk and protective factors among African Americans was also assessed and compared with non-Hispanic white respondents.<sup>36</sup>

Studies from the NSAL found that African Americans suffer from various types of disorder symptoms in their lifetime, with some rates greater than Caucasians.<sup>37</sup> However, when taking

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31. *Id.* at 270.

32. Sadka, *supra* note 27, at 67.

33. James S. Jackson et al., *The National Survey of American Life: A Study of Racial Ethnic and Cultural Influences on Mental Disorders and Mental Health*, 13 INT'L J. METHODS PSYCHIATRIC RES. 196 (2004).

34. *Id.* at 196.

35. *Id.*

36. *Id.*

37. *Id.*; Briggett C. Ford et al., *Lifetime and 12-Month Prevalence of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Disorder Among Older African Americans: Findings From The National Survey of American Life*, 15 AM. J. GERIATRIC PSYCHIATRY 652 (2007); Jacquelyn Y. Taylor et al., *Prevalence of Eating Disorders Among Blacks in The National Survey of American Life*, 40 INT'L J. EATING DISORDERS S10-S14 (2007); David R. Williams et al., *Prevalence and Distribution of Major Depressive Disorder In African Americans, Caribbean Blacks, and Non-Hispanic Whites*, 64 ARCHIVES GEN. PSYCHIATRY 305 (2007).

into account the differences in age, gender, marital status, and socioeconomic status, the differences between African Americans and Caucasians were eliminated.<sup>38</sup> Although these results indicate that the prevalence of mental illnesses for African Americans is similar across ethnic groups, African Americans are overrepresented in high-need populations.<sup>39</sup> Additionally, African Americans have been susceptible to inaccurate diagnoses.<sup>40</sup> Evidence suggests that African Americans are less accurately diagnosed than Caucasians when suffering from depression and seen in primary care facilities,<sup>41</sup> or when they are seen for psychiatric evaluation in an emergency room.<sup>42</sup>

There have been consistent reports on the over-diagnosis of schizophrenia among African Americans, especially the paranoid subtype.<sup>43</sup> Moreover, it has been found that African Americans suffering from bipolar disorder were more likely to be misdiagnosed with paranoid schizophrenia.<sup>44</sup> The disproportional diagnosis of paranoid schizophrenia in African Americans suffering from a mental illness that cannot be accounted for by symptom differences may be explained by cultural factors. Over-

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38. Darrell L. Hudson et al., *The Relationship Between Socioeconomic Position and Depression Among a U.S. Nationally Representative Sample of African Americans*, 47 SOC. PSYCHIATRY PSYCHIATRIC EPIDEMIOLOGY 373; DEPT. OF HEALTH & HUMAN SERV., *Mental Health: Culture, Race, and Ethnicity — A Supplement to Mental Health: A Report of the Surgeon General*, (2001), <http://www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf>. [hereinafter SURGEON GENERAL REPORT].; Briggett C. Ford et al., *supra* note 37.

39. SURGEON GENERAL REPORT, *supra* note 38, at 61.

40. *Id.* at 60.

41. Stephen J. Borowsky et al., *Who Is at Risk of Nondetection of Mental Health Problems in Primary Care?*, 15 J. GEN. INTERNAL MED. 381, 381 (2000).

42. Stephen M. Strakowski et al., *The Effects of Race and Information Variance on Disagreement Between Psychiatric Emergency Service and Research Diagnoses in First-Episode Psychosis*, 58 J. CLINICAL PSYCHIATRY 457 (1997).

43. James L. Collins et al., *Frequency of Schizophrenia and Depression in a Black Inpatient Population*, 72 J. NAT'L MED. ASS'N 851 (1980); S. Mukherjee et al., *Misdiagnosis of Schizophrenia in Bipolar Patients: A Multiethnic Comparison*, 140 AM. J. PSYCHIATRY 1571 (1983); Hans Toch et al., *Ethnicity, Disruptiveness, and Emotional Disorder Among Prison Inmates*, 14 CRIM. JUST. & BEHAV. 93 (1987).

44. Mukherjee et al., *supra* note 43.

diagnosis of paranoid schizophrenia may be explained by clinicians' lack of awareness of different cultural norms for paranoid ideations within the African American population.<sup>45</sup> Often times, idiomatic expressions among African Americans make it sound as if their intense ruminations are a form of psychosis.<sup>46</sup> Clinicians that do not take the time to diligently unravel what and how experiences are expressed may misdiagnose individuals.<sup>47</sup> These cultural factors are nuanced. An individual may be suffering from some form of mental illness that may be psychotic, but that illness may not be schizophrenia.<sup>48</sup> It could be depression with psychotic features, symptoms of Bipolar Disorder or may be an expression of distress not associated with a mental illness.<sup>49</sup> Interestingly, when structured procedures were used during individual assessments, or retrospective assessments were used via chart review, disparities were no longer present.<sup>50</sup>

## 2. Latinos

Equivalent to the NSAL and completed around the same year, the National Latino and Asian American Study ("NLAAS") was conducted with the same goal the NSAL had outlined in its

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45. Victor R. Adebimpe, *Overview: White Norms and Psychiatric Diagnosis of Black Patients*, 138 AM. J. PSYCHIATRY 279 (1981); David Baskin, *Cross-cultural Categorizations of Mental Illness*, 12 PSYCHIATRIC F. 36 (1984); Billy E. Jones & Beverly A. Gray, *Problems in Diagnosing Schizophrenia and Affective Disorders Among Blacks*, 37 PSYCHIATRIC SERVICES 61 (1986); Charles R. Ridley, *Clinical Treatment of the Nondisclosing Black Client: A Therapeutic Paradox*, 39 AM. PSYCHOLOGIST 1234 (1984).

46. Lesley M. Arnold et al., *Ethnicity and First-Time Symptoms in Patients with Psychosis*, 67 SCHIZOPHRENIA RES. 207, 207–12 (2004); F. M. Baker & Carl C. Bell, *Issues in the Psychiatric Treatment of African Americans*, 50 PSYCHIATRIC SERVICES 362, 363–64 (1999).

47. See Arnold et al., *supra* note 46; Baker & Bell, *supra* note 46 at 364–67.

48. See Arnold et al., *supra* note 46; Baker & Bell, *supra* note 46 at 364–67.

49. See Arnold et al., *supra* note 46; Baker & Bell, *supra* note 46 at 364–67; David Baskin, *Cross-cultural Conceptions of Mental Illness*, 56 PSYCHIATRIC Q., 45 (1984); Kazushige Ihara et al., *The Prevalence, Diagnostic Significance and Demographic Characteristics of Schneiderian First-Rank Symptoms In An Epidemiological Sample of First-Episode Psychoses*, 42 PSYCHOPATHOLOGY 81 (2009); Jones & Gray, *supra* note 45.

50. Baker & Bell, *supra* note 46 at 364–67.

study.<sup>51</sup> Like the prevalence rates of African Americans, Mexican Americans and Caucasians have similar rates of psychiatric disorders.<sup>52</sup> Interestingly, this phenomenon changes significantly when the sample is separated into two subgroups: those born in Mexico and those born in the United States. Those native to Mexico had lower rates of depression and phobias than those born in the United States.<sup>53</sup> A large-scale, landmark study examined the rates of psychiatric disorders in a large sample of Mexican Americans in Fresno County, California.<sup>54</sup> The study found that the lifetime prevalence rates of mental disorders among Mexican Americans immigrants born in Mexico were significantly lower compared to those who were born in the United States.<sup>55</sup> Approximately 25% of the Mexican immigrants had either a mental and/or substance abuse disorder, whereas 48% of the U.S.-born Mexican Americans had a disorder.<sup>56</sup> Additionally, the length of time immigrants spent in the United States was an important factor in predicting the development of mental illnesses.<sup>57</sup> For example, immigrants who lived in the United States for at least 13 years had higher prevalence rates of mental health disorders than those who had lived in the country for fewer than 13 years.<sup>58</sup>

Epidemiological and clinical researchers have raised questions about the relationship between individuals acknowledging psychotic symptoms and diagnoses of psychotic

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51. Margarita Alegria et al., *Considering Context, Space and Culture: The National Latino and Asian American Study*, 13 INT'L J. METHODS IN PSYCHIATRIC RES. 208 (2004).

52. *Id.*; Margarita Alegria et al., *Prevalence of Psychiatric Disorders Across Latino Subgroups in the United States*, 97 AM. J. PUB. HEALTH, 68 (2007).

53. M. Audrey Burnam et al., *Six-month Prevalence of Specific Psychiatric Disorders Among Mexican American and Non-Hispanic Whites in Los Angeles*, 44 ARCHIVES GEN. PSYCHIATRY, 687 (1987).

54. William A. Vega et al., *Lifetime Prevalence of DSM-III-R Psychiatric Disorders Among Urban and Rural Mexican Americans in California*, 55 ARCHIVES GEN. PSYCHIATRY, 771 (1998).

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

disorders among culturally diverse groups, especially Latinos.<sup>59</sup> Several studies have recorded higher rates of acknowledged putative psychotic experiences among Latinos than other U.S. ethnic groups.<sup>60</sup> However, the majority of Latinos who endorse psychotic symptoms do not meet the criteria for psychotic disorders when subjected to a standardized diagnostic assessment.<sup>61</sup> In a study that examined the prevalence of psychotic symptoms and their relationship to psychotic disorders among Latinos, the results showed that 9.5% of participants endorsed one or more lifetime psychotic symptom, yet 93% of those who endorsed one or more psychotic symptoms did not meet the criteria for a psychotic disorder.<sup>62</sup> Endorsement of psychotic symptoms was more closely associated with physical and emotional distress, particularly lifetime anxiety and substance use, than as an indicator of a psychotic disorder. According to Lewis-Fernandez et al., Latinos who endorse these symptoms constitutes more as a marker of general psychiatric vulnerability than a sign of a psychotic disorder.<sup>63</sup>

These studies demonstrate that the endorsement of behaviors that may be considered psychotic does not necessarily indicate an underlying psychotic illness.<sup>64</sup> Additionally, they illustrate that ethnocultural diversity challenges clinicians to accurately interpret the clinical significance of the presentation of patients' symptoms.<sup>65</sup> Consequently, studies that involve nosologic developments, and the evaluation and treatment of

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59. R. Lewis-Fernandez et al., *Significance of Endorsement of Psychotic Symptoms by US Latinos*, 197 J. NERVOUS MENTAL DISORDERS 337 (2009).

60. See, e.g., Ann M. Yamada et al., *Selecting an Acculturation Measure for use with Latino Older Adults*, 28 RES. ON AGING 519 (2006); Mark Olfson et al., *Psychotic Symptoms in an Urban General Medicine Practice*, 159 AM. J. PSYCHIATRY 1412 (2002); Shula Minsky et al., *Diagnostic Patterns in Latino, African American, and European American Psychiatric Patients*, 60 ARCHIVES GEN. PSYCHIATRY 637 (2003); Kenneth S. Kendler et al., *Lifetime Prevalence, Demographic Risk Factors, and Diagnostic Validity of Nonaffective Psychosis as Assessed in a US Community Sample*, 53 ARCHIVES GEN. PSYCHIATRY 1022 (1996).

61. Olfson et al., *supra* note 60; Minsky et al., *supra* note 60.

62. Lewis-Fernandez et al., *supra* note 59.

63. *Id.*

64. *Id.*; Minsky et al., *supra* note 60; Vega & Lopez, *supra* note 8 at 189–200; Lewis-Fernández et al., *supra* note 59.

65. Lewis-Fernández et al., *supra* note 59, at 223–28.

apparent psychotic symptoms, highlight the complexities of developing assessment tools that can accurately diagnose individuals from different cultural backgrounds.<sup>66</sup>

There is general consensus among mental health professionals that schizophrenia related disorders usually develop in late adolescence and into early adulthood.<sup>67</sup> In a recent survey of Latinos in the United States, the median age of participants was only 28 years old, placing Latinos among the youngest ethnic groups in the nation.<sup>68</sup> Accordingly, there is a high concentration of Latinos residing in the United States that are currently in the typical age range for the development of schizophrenia. With the growing saturation of Latinos who may develop this illness and no recent epidemiological studies available, there may be a sharp rise in prevalence within this ethnic group in the United States.<sup>69</sup> Consequently, there is a valid concern that we may be faced with a growing number of Latinos developing new cases of psychotic illnesses.<sup>70</sup>

### *C. Potential Ramifications of S&R on Ethnic Minority Groups*

When looking at S&R and its use among American ethnic minorities, it is important to consider how this portion of the American population ends up in inpatient settings. Given the influence that cultural and socioeconomic factors have on the behaviors of both the patients and clinicians in the treatment process, individual perceptions and understandings of how

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66. *Id.*

67. *Schizophrenia*, NATIONAL INSTITUTE OF MENTAL HEALTH, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES (2009), <http://www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booklet-2009.pdf>.

68. 2005-2009 *AMERICAN COMMUNITY SURVEY*, U.S. CENSUS BUREAU (2009).

69. *Data Collection, COLLABORATIVE PSYCHIATRIC EPIDEMIOLOGY SURVEYS*, <http://www.icpsr.umich.edu/icpsrweb/CPES/>. The Collaborative Psychiatric Epidemiological Survey (CPES) has conducted national scale surveys (which include the NSAL and the NLAAS) in recognition for the need of comprehensive epidemiological assessment on the distributions, correlates and risk factors of mental disorders with a special emphasis on ethnic minority groups. However, the study did not collect data on individuals who suffered from schizophrenia.

70. Minsky et al., *supra* note 60, at 471-77; U.S. CENSUS BUREAU, 2005-2009 *AMERICAN COMMUNITY SURVEY*, (2009).

illnesses are viewed and constructed vary greatly.<sup>71</sup> Subsequently, these differences in perception affect not only the rates of admission to hospitalized settings, but also the individual pathways people take to get to these settings. The consequences of such differences in perception can increase misunderstandings, reinforce misperceptions, and exacerbate health conditions on already disadvantaged individuals and are ultimately detrimental to the public health of ethnic minority populations.<sup>72</sup>

Many studies have provided mental health professionals and researchers with a greater understanding of the factors associated with disparities in inpatient care.<sup>73</sup> Large-scale studies like the NSAL and NLAAS demonstrate that the prevalence of mental illness is similar across all ethnic groups.<sup>74</sup> When not controlling for socioeconomic and cultural factors, however, there is variability between these groups.<sup>75</sup> The effects of these factors are so entrenched in the mental health treatment process that mental health professionals would be remiss to not consider their effects in other areas of the treatment process. Clearly, the practice of S&R is an area that involves the social interaction of patient and practitioner. Given our understanding of clinician bias in the treatment process,<sup>76</sup> the stressful conditions found in inpatient settings,<sup>77</sup> and the misunderstandings inherent between patients and practitioners,<sup>78</sup> the increased likelihood of disparities in S&R practice is real. The credible risk that clinicians may

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71. Baker & Bell, *supra* note 46; Minsky et al., *supra* note 60, at 471–77; Vega & Lopez, *supra* note 8 at 189–200.

72. Baker & Bell, *supra* note 46; Minsky et al. *supra* note 60, at 471–77; Vega & Lopez, *supra* note 8 at 189–200.

73. See Blum et al., *supra* note 13; Cheung & Snowden, *supra* note 13, at 277–91; Chun-Chung Chow et al., *supra* note 13; Snowden, *supra* note 10, at 261–74.

74. Alegria et al., *supra* note 51; Jackson et al., *supra* note 33.

75. Alegria et al., *supra* note 51; Jackson et al., *supra* note 33; SURGEON GENERAL REPORT, *supra* note 36; Minsky et al., *supra* note 60, at 471–77.

76. Baker & Bell, *supra* note 46; Vega & Lopez, *supra* note 8, at 189–200.

77. Blum et al., *supra* note 13; Freda K. Cheung & Snowden, *supra* note 14, at 277–91; Chun-Chung Chow et al., *supra* note 13; Snowden, *supra* note 10.

78. Baker & Bell, *supra* note 46; Vega & Lopez, *supra* note 8, at 189–200.

disproportionally subject ethnic minorities to S&R has negative implications in the advancement of clinical practice.<sup>79</sup>

Given the heterogeneous nature of ethnic minority groups in the country and the ever-changing clinical practice guidelines, research in many areas of minority mental health have received the attention they merit.<sup>80</sup> However, in the past decade, the use of S&R across ethnic groups has not been given adequate attention. In 2001, the Surgeon General released his report on mental health care as it relates to ethnic and cultural minorities.<sup>81</sup> The report stated that the mental health needs of ethnic minorities remain largely unmet, and that many facets of minority mental health are deserving of increased attention.<sup>82</sup> As a call to action, researchers throughout the nation have taken up the mantle in an endeavor to address the disparities in mental health care for ethnic minorities.<sup>83</sup>

#### *D. Limitations in Organizations' Regulation of S&R*

Perhaps as a result of the coercive nature of S&R practice and the history of deaths, injuries and malpractice, several organizations maintain mechanisms for tracking and reviewing incidents of S&R throughout the nation.<sup>84</sup> These organizations also provide accreditation services and guidelines for the practice of S&R. The Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare and Medicaid Services each maintain mechanisms for tracking and reviewing rates of S&R.<sup>85</sup> Data on information such as time spent in S&R, documentation describing the situations in which S&R was used, and other interventions that have been implemented are among the

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79. Baker & Bell, *supra* note 46; Vega & Lopez, *supra* note 8 at 189–200.

80. For example, culturally adapted interventions, idiomatic expressions of distress, psychiatric inpatient treatment, etc.

81. SURGEON GENERAL REPORT, *supra* note 38.

82. *Id.*

83. *Id.* at 23–25.

84. JOINT COMM'NS ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS (2009) [hereinafter JOINT COMM'NS]; U.S. DEP'T OF HEALTH AND HUMAN SERVS.: CENTER FOR MEDICARE AND MEDICAID SERVS., APPENDIX A – SURVEY PROTOCOL, REGULATIONS AND INTERPRETIVE GUIDELINES FOR HOSPITALS (2009) [hereinafter SURVEY PROTOCOL].

85. See JOINT COMM'NS, *supra* note 84; SURVEY PROTOCOL, *supra* note 84.

important information collected for critical review.<sup>86</sup> However, this data fails to provide comprehensive clinical information and other critical practice data necessary to allow evaluation of S&R incidents.<sup>87</sup> When considering ethnic minorities in the S&R treatment process, the lack of such comprehensive information makes it difficult to critically examine patterns of action that may provide information on the potential disparities found within inpatient psychiatric centers.<sup>88</sup>

A review of the Center for Medicare and Medicaid Services' State Operations Manual shows that efforts have been made to clearly establish procedures that are not only intended to increase the therapeutic value of S&R, but to help identify patterns in S&R practice.<sup>89</sup> For example, excerpts of Survey Procedures §482.13(e) list efforts to identify: What evidence is there that hospital staff identified the reason for the restraint or seclusion; "Does the number of patients who are restrained or secluded increase on weekends, on holidays, at night, or on certain shifts?"; "Were the reasons for the use of a restraint to manage non-violent, non-self-destructive behavior explained to the patient in understandable terms?"; "and whether the patient could articulate his/her understanding?"<sup>90</sup>

Although the State Operations Manual has made a clear effort to layout comprehensive procedures which would seemingly increase the quality of care provided by mental health care professionals, the procedures do not go far enough. They do not record the context in which individuals end up in S&R, or allow for examination of possible differences between and across ethnic groups. There are no clearly established procedures through which reviewers and researchers can critically evaluate the patterns of S&R practice between, and within, ethnic groups.<sup>91</sup> Without such limited information, it remains difficult to pinpoint where disparities of treatment may exist, as well as the identity of the

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86. Margaret M. Knight, *Quality Improvement Initiatives to Minimize Seclusion and Restraint*, 27 J. HEALTHCARE QUALITY, 20 (2005).

87. *Id.*

88. JOINT COMM'NS, *supra* note 84; SURVEY PROTOCOL, *supra* note 84.

89. SURVEY PROTOCOL, *supra* note 84.

90. *Id.*

91. *Id.*; JOINT COMM'NS, *supra* note 84.

individuals who are the recipients of S&R and to what frequency or degree they receive this intervention.

### III. PREVIOUS RESEARCH ON S&R AMONG ETHNIC MINORITIES

#### *A. Studies in Support of S&R Disparities*

Over the past twenty to thirty years, few studies have evaluated S&R among ethnic minorities. Much of the literature from the late 1970's to the 1980's focused on studying the social interactions between clinicians and patients in treatment based settings.<sup>92</sup> The importance of these examinations is twofold. First, they are the pioneering research concerning the differential effects of S&R practice among ethnic groups.<sup>93</sup> Second, they provide insight into the bias that is prevalent in the treatment process.<sup>94</sup> This section will provide additional review of the research that has specifically aimed to further understanding of the differential use of S&R among ethnic groups.<sup>95</sup>

Empirical examinations completed in the 1980's found that there was a greater incidence of seclusion of African American patients than other ethnic groups.<sup>96</sup> This research suggested that

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92. Birt L. Duncan, *Differential Social Perception and Attribution of Intergroup Violence: Testing the Lower Limits of Stereotyping of Blacks*, 34 J. OF PERSONALITY & SOC. PSYCHOL. 590 (1976); Charles F. Bond Jr. et al., *Responses to Violence in a Psychiatric Setting: The Role of Patient's Race*, 14 PERSONALITY & SOC. PSYCHOL. BULL. 448 (1988); Andrew H. Sagar & Janet W. Schofield, *Racial and Behavioral Cues in Black and White Children's Perceptions of Ambiguously Aggressive Acts*, 39 J. PERSONALITY & SOC. PSYCHOL. 590 (1980); Paul H. Soloff & Samuel M. Turner, *Patterns of Seclusion: A Prospective Study*, 169 J. NERVOUS & MENTAL DISEASE 37 (1981).

93. See, e.g., Duncan, *supra* note 92; Bond et al., *supra* note 92; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

94. See, e.g., Duncan, *supra* note 92; Bond et al., *supra* note 92; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

95. See Bond et al., *supra* note 92; Donovan, *supra* note 6; Duncan, *supra* note 92 at 590–98; Matthew Hoptman et al., *Clinical Prediction of Assaultive Behavior Among Male Psychiatric Patients at a Maximum-Security Forensic Facility*, 50 PSYCHIATRIC SERVICE 1461 (1999); Dale E. McNiel & Renee L. Binder, *Correlates of Accuracy in the Assessment of Psychiatric Inpatients' Risk of Violence*, 152 AM. J. PSYCHIATRY 901 (1995); Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

96. See Bond et al., *supra* note 92, at 448–58; Sagar & Schofield, *supra* note 92.

African American patients during that time may have been secluded, in greater numbers than Caucasians, as a result of how clinicians interpreted behaviors of African Americans.<sup>97</sup> In a study of clinicians' responses to violence in psychiatric settings, researchers found no significant differences when comparing the number of offenses African Americans and Caucasians committed in inpatient settings.<sup>98</sup> However, there were differences in the sanctions applied to violence.<sup>99</sup> African Americans were four times more likely to be secluded and restrained following violent episodes than were Caucasians.<sup>100</sup> This expanded upon previous studies<sup>101</sup> comparing African Americans' and Caucasians' admission into psychiatric hospitals due to abnormal behavior. When Caucasians behaved ambiguously, their behavior was not treated seriously.<sup>102</sup> In contrast, when African Americans behaved similarly, their behavior was interpreted as aggressive in intent.<sup>103</sup>

To truly understand and interpret these findings, one must consider the social context in which these studies were conducted.<sup>104</sup> One such study was an archival review of patients at a Connecticut state psychiatric hospital, which was operated by an all-Caucasian staff.<sup>105</sup> Perhaps as a result of the tumultuous history of African American/Caucasian relations in the history of the United States, there was an element of distrust resulting from the notable contrast in power and authority among ethnic groups in mental health institutions.<sup>106</sup> African American patients had difficulty adapting to the predominantly Caucasian institution, and often felt threatened.<sup>107</sup> Exacerbated by the acute and stressful conditions of inpatient settings, it is understandable that African

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97. Bond et al., *supra* note 92 at 448–58.

98. *Id.*

99. *Id.*

100. *Id.*

101. Duncan, *supra* note 92 at 590–98; Sagar & Schofield, *supra* note 92.

102. Duncan, *supra* note 92 at 590–98; Sagar & Schofield, *supra* note 92.

103. Duncan, *supra* note 92 at 590–98; Sagar & Schofield, *supra* note 92.

104. See Bond et al., *supra* note 92; Duncan, *supra* note 92 at 590–98; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

105. Bond et al., *supra* note 92.

106. *Id.*; Duncan, *supra* note 92 at 590–98; Sagar & Schofield, *supra* note 94; Soloff & Turner, *supra* note 92.

107. Bond et al., *supra* note 92; Duncan, *supra* note 92 at 590–98; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

American patients reacted with fear and hostility. As Caucasian staff members intervened to abort friction, African American patients' violence escalated, rendering seclusion insufficient, thereby prompting the imposition of restraints.<sup>108</sup>

These studies are significantly limited because of the insufficient efforts made to control for extraneous demographic variables that may otherwise explain the ethnic disparities found in S&R practice.<sup>109</sup> However, one study did make extra efforts to control for demographic variables.<sup>110</sup> That project found that African Americans were disproportionally represented in their secluded sample of psychiatric units of a university-based hospital.<sup>111</sup> After controlling for the effects of chronicity, legal status, mental status, and diagnostic considerations, race itself, however, was not a factor.<sup>112</sup> Since race was not related to diagnosis at either the time of seclusion or at final discharge, this finding could not be attributed to a systematic bias in diagnosis.<sup>113</sup> One possible explanation is that there may have been a failure to establish effective communication between the predominantly Caucasian psychiatric staff and the African-Americans patients.<sup>114</sup> Attribution of violent traits, prejudice, fear, and general distrust of power and authority are factors that may contribute to barriers between clinicians and patients.<sup>115</sup>

Although the findings made by these studies are over thirty years old, the differential treatment of ethnic minority patients in S&R has consistently demonstrated itself to be a powerful and invasive social phenomenon.<sup>116</sup> Several recent inquiries

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108. Bond et al., *supra* note 92; Duncan, *supra* note 92, at 590–98; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

109. Bond et al., *supra* note 92; Duncan, *supra* note 92, at 590–98; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

110. See Soloff & Turner, *supra* note 92.

111. *Id.*

112. *Id.*

113. *Id.*

114. Bond et al., *supra* note 92; Duncan, *supra* note 92, at 590–98; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

115. Bond et al., *supra* note 92; Duncan, *supra* note 92, at 590–98; Sagar & Schofield, *supra* note 92; Soloff & Turner, *supra* note 92.

116. Donovan, *supra* note 6; Hoptman et al., *supra* note 95; McNiel & Binder, *supra* note 95.

corroborate findings made over thirty years ago.<sup>117</sup> Additionally, these more recent studies have expanded our understanding in the differential treatment of ethnic minorities into facets of S&R previously unexplored, such as, the use of S&R among minors.<sup>118</sup>

*B. Studies Which Support Disparities in the Use of S&R Amongst Ethnic Minorities*

In an effort to evaluate the impact that new administrative reforms and clinical practices have on minors, one study examined demographic characteristics associated with the use of S&R on minors over a two-year period.<sup>119</sup> The study found a steady reduction over time in the number and duration of S&R on minors.<sup>120</sup> This may be related to the newly instituted federal regulations.<sup>121</sup> The findings not only confirmed that younger patients are more likely to experience S&R than their older counterparts,<sup>122</sup> but that ethnic minority youth are more likely to undergo S&R than their Caucasian peers.<sup>123</sup> Although contextual factors may provide a partial explanation of the higher risk of S&R among ethnic minorities, this study suggests that ethnic minority youths may have more serious symptoms upon entering the hospital, placing them at a higher risk of undergoing S&R.<sup>124</sup> Additionally, this study hints that, despite measures implemented to modify clinical practices, the Center for Medicare and Medicaid Services have not gone far enough in addressing potential for discrimination, biased perception of assault risk, and the need for improved cultural competence training among staff.<sup>125</sup>

*C. Studies Not Supporting S&R Disparities*

Although many studies have provided support for disparities in S&R practice, several studies have critically tested

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117. Donovan, *supra* note 6; Hoptman et al., *supra* note 95; McNiel & Binder, *supra* note 95.

118. Donovan, *supra* note 6; Hoptman et al., *supra* note 95; McNiel & Binder, *supra* note 95.

119. Donovan, *supra* note 6.

120. *Id.*

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

that assertion, especially regarding ethnicity.<sup>126</sup> The authors of these studies have argued that when certain demographic variables are controlled for, ethnicity no longer plays a role in the use of S&R.<sup>127</sup> In one such examination, African American patients were more likely than Caucasian patients to be given emergency medication and to be secluded after a violent incident.<sup>128</sup> However, after controlling for extraneous demographic factors, such as age, gender, the target of the assault, and the status of the patient, the effect of ethnic background was no longer significant.<sup>129</sup> The most confounding variable was the age of the patient, indicating that age is a stronger predictor of S&R than the ethnicity of the participant.<sup>130</sup> Several other studies have reported similar findings.<sup>131</sup>

Differences in the treatment of patients may be confounded by a wide range of variables, including the ethnicity of the patients, demographic variables, the nature of the mental illnesses, and the various legal grounds on which they have been detained.<sup>132</sup> Focusing solely on ethnicity overlooks these other factors that in some instances may better explain the pattern of S&R among individuals.<sup>133</sup> Factors such as gender and legal basis for inpatient treatment are, according to some research, stronger

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126. See, e.g., G.H. Gudjonsson et al., *Management of Psychiatric In-Patient Violence: Patient Ethnicity and the Use of Medication, Restraint, and Seclusion*, 184 BRIT. J. PSYCHIATRY 285 (2004); Gregory M. Smith et al., *Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, 56 PSYCHIATRIC SERVICES 1115 (2005); Mary D. Carpenter et al., *Ethnic Differences in Seclusion and Restraint*, J. NERVOUS & MENTAL DISEASE, 176, 726–31 (1988); N.L. Sohler et al., *Are There Racial Differences in the Way Patients with Psychotic Disorders Are Treated at Their First Hospitalization?*, 34 PSYCHOL. MED. 705–18 (2004).

127. Sohler et al., *supra* note 126.

128. Gudjonsson et al., *supra* note 126.

129. *Id.* at 258–62.

130. *Id.*

131. See, e.g., Carpenter et al., *supra* note 126; Sohler et al., *supra* note 126; Kenneth Tardiff, *Emergency Control Measures for Psychiatric Inpatients*, 58 J. CLINICAL PSYCHIATRY 616–24 (1981).

132. Gudjonsson et al., *supra* note 126 at 261.

133. *Id.* at 261–62.

determinants of who will be considered for S&R than ethnicity will be.<sup>134</sup>

*D. Limitations on Studies Evaluating the Use of S&R Amongst Ethnic Minorities*

Previous research findings, both in support of ethnic disparities in S&R and against, illustrate that the nature of disparities in S&R is complex and requires an assessment of many demographic factors to ensure a comprehensive evaluation of the phenomenon.<sup>135</sup> In the past ten years, researchers have been especially diligent and comprehensive in their effort to control for a range of social and demographic constructs when examining rates of S&R among ethnic groups.<sup>136</sup> Many of these recent studies have found that factors other than race play a more significant role in S&R practice.<sup>137</sup> However, these studies do not consider the ethnic background of the clinicians who provide the treatment. Previous studies have indicated the profound effect a clinician's ethnicity has in the treatment of ethnic minorities. This is especially true among African American patients who, as a group, are faced with greater misunderstandings in the context of nuanced aggressive behavior,<sup>138</sup> and the element of distrust present under acute conditions.<sup>139</sup> Considering the influence this has in the health/mental health care practice, researchers in the field of S&R would be remiss to not include the race of the clinician when studying S&R practice among ethnic groups. This project was unable to locate any previous studies that controlled for this factor.

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134. *Id.* at 261.

135. *See, e.g.,* Bond et al., *supra* note 92; Carpenter et al., *supra* note 126; Donovan, *supra* note 6; Duncan *supra* note 92 at 590–98; Gudjonsson et al., *supra* note 126; McNiel & Binder, *supra* note 95; Sagar & Schofield, *supra* note 92; Smith, *supra* note 128; Sohler et al., *supra* note 126; Soloff & Turner, *supra* note 92; Tardiff, *supra* note 133, at 616–24.

136. *E.g.,* Donovan, *supra* note 6; Gudjonsson et al., *supra* note 126; Smith et al., *supra* note 126; Sohler et al., *supra* note 126.

137. *E.g.,* Donovan, *supra* note 6; Gudjonsson et al., *supra* note 126; Smith et al., *supra* note 126; Sohler et al., *supra* note 126.

138. *See* Bond et al., *supra* note 92; Tracy Benford Price et al., *The Use of Restraint and Seclusion in Different Racial Groups in an Inpatient Forensic Setting*, 32 J. AM. ACAD. PSYCHIATRY & L. 163, 163–68.

139. *See* Bond et al., *supra* note 92; Price et al., *supra* note 138, at 163–68; Duncan, *supra* note 92; Sagar & Schofield, *supra* note 92.

A further limitation is the inadequate representation of Latinos in the previously examined groups.<sup>140</sup> Several of the studies that have included Latinos either included only small samples of Latinos, or Latinos were combined into other categories such as Caucasian or Other.<sup>141</sup> Some authors have defended combining Latinos with Caucasians or Others as a necessary practice because of protocol central to their research objectives, or sample characteristics that justified merging Latinos into a larger group.<sup>142</sup> Needless to say, the absence of Latinos, or the integration of Latinos into other groups, undermines the heterogeneity and unique cultural characteristics present in this population. Although these studies were successful in achieving their objectives, sociocultural/contextual factors unique among Latinos (e.g., English language proficiency, immigration status, etc.) is not recognized when aggregating into larger groups. Substantiating any differential effects of S&R practice among this ethnic group is severely restricted and any inferences made to the Latino population would be severely limited.<sup>143</sup>

Although the general immigrant population does present with fewer overall health problems than those native to this country, efforts made to address this population have been scarce, especially in the area of S&R practice.<sup>144</sup> The diversity of ethnic groups in the United States is matched in part by the myriad of individuals who differ in their national origins, migration, and regional settlement patterns. As mentioned previously, immigrants differ socially and present with unique health issues and mental

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140. See, e.g., Carpenter et al., *supra* note 126; Gudjonsson et al., *supra* note 126, at 258–62; Soloff & Turner, *supra* note 92 at 37.

141. See, e.g., Carpenter et al., *supra* note 126; Gudjonsson et al., *supra* note 126, at 258–62; Soloff & Turner, *supra* note 92, at 37.

142. Carpenter et al., *supra* note 126; Soloff & Turner, *supra* note 92, at 37.

143. See, e.g., Carpenter et al., *supra* note 126; Gudjonsson et al., *supra* note 128 at 258–62; Soloff & Turner, *supra* note 92, at 37–44.

144. J.E. Berg & E. Johnsen, *Innlegges Innvandrere Oftere Enn Etniske Nordmenn I Akuttpsykiatriske Avdelinger?*, 124 TIDSSKR NOR LÆGEFOREN 634, 634–36 (2004) (Nor.); M. Knutzen et al., *Association Between Patients' Gender, Age and Immigrant Background and Use of Restraint: A 2-year Retrospective Study at a Department of Emergency Psychiatry*, 61 NORDIC J. PSYCHIATRY 201, 201–06 (2007); Sohler et al., *supra* note 126; Vega et al., *supra* note 54, at 771–78.

health difficulties and patterns.<sup>145</sup> This project was unable to locate any studies that incorporated a subsample of immigrants. One study actually excluded participants who were not able to speak English, which is a characteristic commonly shared by immigrants.<sup>146</sup> There have only been two studies that assessed the differential use of S&R among immigrants.<sup>147</sup> Those studies found that there is a greater prevalence of S&R use with immigrant patients because of communication and comprehension problems arising between clinicians and the patients.<sup>148</sup> Both of these studies, however, were conducted in Europe and therefore cannot provide insight into the patterns of S&R practice among immigrant groups in the United States.

#### IV. WHERE DO WE GO FROM HERE?

##### *A. Recommendations*

Although there have been efforts in recent years to increase the quality of research completed regarding the use of S&R in an inpatient setting, there are many important questions that remain unanswered. The role of clinician bias in the context of S&R among ethnic minority groups is complex, multifaceted, and intertwined with other demographic characteristics that pose a challenge for empirical inquiry. Relations and interactions between clinicians and patients do not occur in a vacuum, and it is important that future research is also able to ascertain the degree of bias in S&R treatment that is not better explained by other factors. Although systematic bias related to ethnic groups for decisions to institute confinement may not exist in some psychiatric hospitals, this does not rule out the possibility that other types of bias may exist, or that such bias might remain in other psychiatric hospitals.<sup>149</sup>

In 2008, the National Institute of Mental Health (“NIMH”) released its Strategic Plan with the expressed mission to “transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and

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145. Vega et al., *supra* note 54, at 771–78.

146. Sohler et al., *supra* note 126.

147. Berg & Johnsen, *supra* note 144; Knutzen et al., *supra* note 144.

148. Berg & Johnsen, *supra* note 144; Knutzen et al., *supra* note 144.

149. Carpenter et al., *supra* note 126, at 726–31.

cure.”<sup>150</sup> The plan required the development of innovative interventions, and designs for intervention studies specifically focusing on accelerating research that “maximizes the ability of current treatments to reduce symptoms, improve adherence and functioning, and minimize side-effects...account[ing] for cultural/ethnic diversity.”<sup>151</sup> As researchers in the area of ethnic disparities in mental health care consider areas of inquiry, it is necessary to consider S&R practice across ethnic groups.

There are areas of empirical inquiry that have not been comprehensively explored, but will advance our understanding of S&R practice among ethnic minorities. For example, a temporal evaluation of clinical and behavioral patterns can provide researchers with insights that are otherwise not observable using cross-sectional analysis.<sup>152</sup> Development patterns, rapport building, intervention effects and contextual analysis provide a level of understanding that has not been thoroughly assessed among ethnic minorities.<sup>153</sup> Changes in how clinicians treat African Americans have occurred over time, but follow-up empirical inquiries are lacking.<sup>154</sup> A multilevel analysis across different levels of S&R practice would provide clinicians, policy makers, and scholars with a wealth of information. Such a study would entail an assessment of how mental health institutions implement S&R policy over time, as it relates to ethnic minority groups. Secondly, several factors effecting clinicians, such as the assessment of how clinicians implement their practice, and how their interpretation transforms or reinforces clinical culture and their understandings of illness and treatment, should be considered. Finally, there should be an assessment of patient-level factors concerning the impact that clinical transformations have on patients’ treatment outcomes and the subjective experiences of their mental health treatment. Any policy changes made at the macro level for S&R interventions would be opportunities in which to conduct an empirical examination, allowing for the

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150. *Strategic Plan*, NATIONAL INSTITUTE OF MENTAL HEALTH, at iv (2008), <http://www.nimh.nih.gov/about/strategic-planning-reports/nimhstrategic-plan-2008.pdf>.

151. *Id.*

152. *E.g.*, Bond et al., *supra* note 92, at 448–58.

153. *Id.*

154. *Id.*

assessment of the transformative process as it relates to ethnic minorities.

*B. Actions to Reduce Disparities in the Use of S&R Amongst Ethnic Minorities*

Immediate steps can be taken that may alleviate the stressful conditions inherent in inpatient care. First, ethnically diverse and culturally competent clinicians can help alleviate potential distrust between the clinicians and patients. When there is a clear disparity in power and authority in such settings, ethnic minority patients are at greater risk of being secluded or restrained.<sup>155</sup> Given the level of physical and psychological trauma associated with S&R, it may behoove healthcare providers to make efforts to hire personnel that reflect the ethnic backgrounds of the patients for whom they care and serve.<sup>156</sup> Secondly, organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the Center for Medicare and Medicaid Services can do a better job of outlining procedures to ensure that patients are not treated differentially across ethnic groups. Additionally, these organizations are in the position to shine light on an issue that has not received the level of attention it merits by recording the ethnic backgrounds of the patient *and the clinicians*, to include their immigration status.

Advocate organizations such as the National Alliance on Mental Illness (NAMI), the National Associational Association of State Mental Health Program Directors (NASMHPD), and other organizations have championed the reduction and ultimate elimination of S&R.<sup>157</sup> NASMHPD specifically calls for the prevention, reduction, and ultimate elimination of S&R for

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155. *Id.*; Price et al., *supra* note 138; Duncan, *supra* note 92; Sagar & Schofield, *supra* note 92.

156. Bond et al., *supra* note 94; Price et al., *supra* note 138; Sagar & Schofield, *supra* note 94.

157. Robert W. Glover, *Reducing the Use of Seclusion and Restraint: A NASMHPD Priority*, 56 PSYCHIATRIC SERVICES, 1141, 1141–42 (2005); NAT'L ALLIANCE ON MENTAL ILLNESS, POL'Y RES. INST., TOPICS: SECLUSION AND MECHANICAL RESTRAINTS: TASK FORCE REPORT (2003) [http://www.nami.org/Template.cfm?Section=Issue\\_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=42920](http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=42920) [hereinafter NAT'L ALLIANCE].

individuals diagnosed with mental illnesses,<sup>158</sup> and NAMI consistently champions efforts to reduce the use of S&R practice that would otherwise not serve as an emergency safety measure.<sup>159</sup> As this area of ethnic healthcare disparities receives greater attention, advocate organizations will likely take notice and help to push this important area into the public spotlight.

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158. NAT'L ALLIANCE, *supra* note 157.

159. Knight, *supra* note 86.