TASC Training & Advocacy Support Center

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Q&A:

Medication Restraint

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Q.: Facilities and programs in our state do not have a uniform approach to using medication as a restraint – that is, using chemical restraint. Is there a national consensus on when and under what circumstances it is legal and appropriate to restrain using medication?

A.: States take different approaches to medication restraint. The federal government has its own rules for programs that receive federal funds. Accrediting authorities have standards that usually follow the federal rules. Federal and state courts that have examined medication restraint have come to different conclusions about what the constitution and law require. However, despite this variety of approaches, there are some common rules and themes on which P&As can draw in their advocacy.

I. What is medication restraint?[1]

Restraint, whether by physical, mechanical or chemical means, is appropriately used only as a response to an immediate risk of physical harm. The Centers for Medicare and Medicaid (CMS), in its conditions of participation for hospitals receiving federal funds for example, requires that restraint "may only be imposed to ensure the

[1] The terms "medication restraint" and "chemical restraint" are used interchangeably in this Q&A. As there are several Fact Sheets and Q&As about restraint and seclusion available on the TASC website, an in depth discussion of restraint is unnecessary here. *See, e.g.*, Susan Stefan, Constitutional Rights Issues in the Use of Restraint and Seclusion in Schools (Jan. 2009) (hereafter "Stefan Restraint in Schools") available at: http://www.tascnow.com/tasc/images/Documents/Publications/TASC_PUBLICATIONS/FACTSHEETS/TASC_Const_Rights_Issues_209.pdf; Robert Fleischner, A Model Restraint Statute, (Apr. 2006) available at: http://www.tascnow.com/tasc/images/Documents/Publications/TASC_PUBLICATIONS/FACTSHEETS/TASC_an_mod_res_pol_406.pdf; and Robert Fleischner, Cases Addressing the Legal Limits on the Use of Restraint in Jails, Prisons and Juvenile Facilities (June 2004) available at: http://www.tascnow.com/tasc/images/Documents/Publications/Q_A/TASC_0406_cj_an.pdf.

immediate physical safety of the patient, a staff member, or others."[2] Restraint may not be used, according to CMS, "unless less restrictive interventions have been determined to be ineffective."[3]

CMS defines medication restraint as the use of "a drug or medication … as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage [of the drug] for the patient's condition."[4] Therefore, under the CMS framing, a person who poses an immediate risk of physical harm to self or to others may be restrained (including by the use of medication) if less restrictive interventions are determined not to be effective.

The CMS rules provide a starting place for considering the use of chemical restraint. However, it is important to keep in mind that the CMS rules focus on ensuring safe restraint practices rather than emphasizing its reduction or elimination.[5] Some local rules are more proscriptive procedurally and, arguably, more protective of residents' rights.[6] Standards and definitions vary from state to state and even from setting to setting within a state.[7] It is critical, therefore, that P&A staff advocating for reform of chemical restraint policies be familiar with whatever state statutes, regulations and policies exist.

II. Constitutional challenges to restraint with medication.

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[2] 42 C.F.R. § 482.13(e) (2006).

[3] 42 C.F.R. § 482.13(e)(2).

[4] 42 C.F.R. § 482.13(e)(1)(i)(B). Compare that definition applicable to hospitals receiving CMS funds to 42 C.F.R. § 483.352 defining "drug used as a restraint" in Medicaid funded Psychiatric Residential Treatment Centers ("PRTF") for youth under 21. ("Drug used as a restraint means any drug that (1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others; (2) Has the temporary effect of restricting the resident's freedom of movement; and (3) Is not a standard treatment for the resident's medical or psychiatric condition.") (emphasis in original deleted).

[5] The CMS rules were promulgated in 2007 pursuant to the agency's authority and responsibilities under the 2000 Children's Health Act, P.L. 106-310, Part H, § 591, 42 U.S.C. § 290ii. That statute created national restraint standards for federally funded facilities. CMS first promulgated an Interim Final Rule which in some ways was more protective of facility residents than the Final Rule. *See*, Janice LeBel, "Regulatory Change: A Pathway to Eliminating Seclusion and Restraint or 'Regulatory Scotoma'?" 59 Psychiatric Services 194 (2008) (suggesting that CMS yielded to influential stakeholder critics of the interim rules, including professional and hospital associations) available at: http://ps.psychiatryonline.org/doi/full/10.1176/ps.2008.59.2.194.

[6] Compare generally, e.g., the Massachusetts Department of Mental Health rules which are focused on prevention and actually seek to eliminate the use of all forms of restraint. 104 Code Mass. Regs. 27.00.

[7] For example, Massachusetts has seven different sets of rules that apply to children depending on which agency regulates the setting. For a slightly outdated but still instructive analysis see Robert D. Fleischner, Kathryn Rucker and Susan Stefan, "Restraint and Seclusion of Children and Adolescents in Massachusetts" (2007) available at: http://www.masslegalservices.org/system/files/library/Restraint_Seclusion_Adolescents_in_MA_t.pdf.

Restraint (and occasional efforts to reform and eliminate it) has been a part of the mental health and developmental disability systems for hundreds of years. Recent reform initiatives are not unlike efforts by early 1800s reformers to reduce or eliminate its use.[8] Occasional court challenges during the past centuries were mostly limited to damages cases alleging excessive use of force. However, in *Youngberg v. Romeo*, the Supreme Court held that residents of a facility for people with developmental disabilities have a constitutionally protected due process interest in safe conditions and in freedom from bodily restraint, except to the extent that restraint must be used to assure safety.[9]

Consequently, subsequent challenges to the use of medication restraint have usually been rooted at least in part in the 14th Amendment.[10] For example, although the plaintiffs prevailed on their right to refuse treatment claims, an early systemic challenge to Massachusetts' chemical restraint practices was largely unsuccessful. The First Circuit held that the then existent state regulations were more than sufficient to provide constitutional procedural due process.[11]

Most other courts have analyzed chemical restraint through a substantive due process lens. For example, in a case involving a restraint death after prone physical and chemical restraints, the Sixth Circuit held that an injection of a medication by a non-supervisory nurse did not violate the person' substantive due process interest in being free from undue bodily restraint. The court described the analysis this way:

> [T]the appropriate source for [the plaintiff's] excessive force claim is the Fourteenth Amendment, which provides him, as a patient of a state care institution, with the constitutional right recognized in *Youngberg* to freedom from undue bodily restraint in the course of his treatment. Basing this right in substantive due process … allows for balancing the individual's liberty interest against the State's asserted reasons for restraining the individual's liberty while in its care. It also gives proper deference to the decisions of institutional

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[8] Janet Colaizzi, "Seclusion & Restraint: A Historical Perspective," 43 J. Psychosocial Nursing and Mental Health Services (2005) abstract and partial article available at: http://www.healio.com/psychiatry/journals/jpn/2005-2-43-2/%7B3d4d98a6-3dff-4ba1-9142-d4655470b14a%7D/seclusion--restraint-a-historical-perspective.

[9] 457 U.S. 307, 315-16 (1982).

[10] Some cases have made claims under the Fourth and Eighth Amendments and the Equal Protection Clause. For an analysis of some of those cases in the school context *see* Stefan, Restraint in Schools, n. 1 *supra*.

[11] *Rogers v. Okin*, 738 F.2d 1, 7 (1st Cir. 1984) (rules requiring that, *inter alia*, chemical restraint may not be used without written authorization and reviewed at least every eight hours by a physician who shall authorize in writing its continuation or cessation and shall make a written record of the reasons, are more than required by the constitution). The current Massachusetts regulations provide more stringent procedures. *See*, n. 6, *supra*.

professionals concerning medical treatment.[12]

Also applying *Youngberg*, a U.S. district court in Pennsylvania found that an institution's use of chemical restraint did not substantially depart from acceptable professional practice where the use of the medication came after trying alternatives and where the restraint was used for safety and habilitative purposes.[13]

Other courts have struggled to reconcile the Supreme Court's opinion in *Cnty. of Sacramento v. Lewis*,[14] which applied a deliberate indifference-shocks the conscious analyses to a substantive due process claim, with the *Youngberg* professional judgment analysis. For example, by applying a *Youngberg* analysis to its consideration of whether there was deliberate indifference, a federal court in the District of Columbia held that a psychiatric institution's use of restraint, including involuntary medication, on juveniles was not such a substantial departure from accepted professional judgment as to shock the conscience and violate the constitution.[15] Other courts considering chemical restraint have applied *Youngberg* either without any mention of *Lewis* or by distinguishing it.[16]

These cases, and others, point to the difficulty of prevailing in constitutional challenges to chemical restraint practices. However, as the professional consensus on what constitutes acceptable restraint practices becomes even more firmly established, it may be that a *Youngberg* challenge will more likely be successful.

III. Restraint challenges under the ADA

Some plaintiffs have used the Americans with Disabilities Act ("ADA") as a vehicle to

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[12] *Id.* at 686-87. The court rejected a claim that restraints violated the 4th Amendment. A 4th Amendment analysis would have been advantageous to the plaintiff as it would have been under a less stringent reasonableness standard. The court allowed the plaintiff's 14th Amendment excessive force complaints arising from the prone restraint to proceed.

[13] *U.S. v. Pennsylvania*, 902 F. Supp. 565, 640 (W.D. Penn. 1995). The court's apparent approval of chemical restraint for "habilitative purposes" is contrary to most currently accepted standards and justifications for the use of restraint. *See, e.g.*, this statement by the Bazelon Center: "Seclusion and restraint are safety measures, not treatment, and they should never be part of standard treatment for someone's condition. Their use—particularly when it is recurrent or protracted-- represents a treatment failure and should be addressed as such." Bazelon Center, "Where We Stand: Restraint and Seclusion" available at: http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Restraint-and-Seclusion.aspx.

[14] 523 U.S. 833 (1998).

[15] *Jordan v. District of Columbia*, 161 F. Supp. 3d 45 (D.D.C. 2016).

[16] *Lanman v. Hinson*, 529 F.3d 673, 681-82 (6th Cir. 2008)(no mention of *Lewis*); *Williams v. Wasserman*, 164 F. Supp. 2d 591, 615 n. 21, 620-22 (D. Md. 2001) (distinguishing *Lewis*, analyzing use of chemical restraint under substantive due process standards but finding that PRN orders for involuntary medication do not violate the constitution). As noted in the text *ante*, most current professional and state standards prohibit the use of PRN (that is, "as needed") restraint orders.

challenge restraint practices. In *Jansen v. Minnesota Dep't of Human Svcs.*, the plaintiffs challenged parts of the state's *Olmstead* plan that had been drafted pursuant to a settlement in the case. The court rejected the plaintiffs' objections that the plan's restraint provisions violated provisions of the settlement agreement, finding:

> The *Olmstead* Plan contains sufficient and reasonable measurable goals intended to eliminate the use of restraint and seclusion in compliance with the parties' Settlement Agreement. These goals include specific numeric goals for reducing the use of restrictive procedures by disability service providers,… completely prohibiting the use of mechanical restraint by disability service providers with limited exceptions to prevent serious injury, and reducing the emergency use of restrictive procedures in schools with a strategy directed at the eventual elimination of all seclusion in schools.[17]

Some ADA challenges to physical and mechanical restraint have been brought against schools.[18] These cases are complicated if a student's Individual Education Program ("IEP") allow for restraint.[19] Chemical restraint is probably rare in schools and, according to a 2013 survey of state laws and regulations, is expressly forbidden in 13 states.[20] The U.S. Department of Education recommends that chemical restraints not be used in schools except with a doctor's order.[21]

III. Commonly accepted medication restraint standards.

Even if the constitution and the ADA do not mandate particular methods of medication restraint, a review of professional[22] and accreditation standards,[23] state and federal[24]

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[17] *Jensen v. Minnesota Department of Human Services*, 138 F. Supp. 3d 1068, 1073–74 (D. Minn. 2015)(internal citations and footnotes omitted).

[18] *See, e.g.*, *Ebonie S. v. Pueblo School Dist. 60*, 819 F. Supp. 2d 1179 (D. Colo. 2011) (genuine issue of material fact as to whether school's use of secure wrap-around table that included restraint bar to restrain student is an ADA violation), aff'd 695 F.3d 1051 (10th Cir. 2012)(affirming other findings expressly without comment on ADA claim); cert. denied 133 S. Ct. 1583 (2013). For a more complete analysis of school restraint cases, see Stefan, Restraint in Schools, n. 1 *supra*. For a listing of state laws and regulations regarding schools, see U.S. Dep't of Education, "Summary of Seclusion and Restraint Statutes, Regulations, Policies and Guidance by State and Territory" (2010) available at: www.pbis.org/common/cms/files/pbisresources/SeclusionRestraint_summary_ByState.pdf.

[19] *See, e.g., Hernandez v. Board of Educ. of Albuquerque Public Schools*, 124 F. Supp. 3d 1181 (D.N.M. 2015)(IEP included restraint; no ADA violation). For an analysis the interaction of IEPs and restraints see Stefan Restraint in Schools, n. 1 *supra*.

[20] Autism National Committee, My State's Seclusion and Restraint Laws (2103) available at: http://www.autcom.org/pdf/MyStateRestraintSeclusionLaws.pdf.

[21] U.S. Dep't of Education, "Restraint and Seclusion Resource Document" (2012) available at: https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf.

[22] See, e.g., Am. Psychiatric Nurses Assoc., APRN Position on Use of Seclusion and Restraint (2014) available at: http://www.apna.org/i4a/pages/index.cfm?pageid=3730;

[23] The most important of which are probably those of the Joint Commission, which are only available for purchase. For a summary of the standards, see CPI, "Joint Commission Standards

statutes and policies and guidance, and the accompanying literature[25] suggest that the procedures listed below are widely accepted. These measures are in addition to the rules that apply to all restraints or seclusion. If chemical restraint is used in programs or facilities that house children and adolescents, stricter standards, including shorter time frames, for instance, should apply.[26]

(1) Chemical restraint may only be used in an emergency situation, where there is an imminent risk of physical harm and less restrictive interventions have either been tried and failed or have been determined to be ineffective.[27]

(2) Chemical restraints may only be ordered by a physician and may not be administered except upon the order of a physician. All orders shall be in writing, stating the reasons for the medication restraint and why less restrictive measures were or would not have been successful.

(3) PRN ("*pro re nata*") medicine restraint orders (e.g., "as needed for agitation") are not allowed.

(4) A telephone order may be accepted for medication intended for use as a chemical restraint when a physician is not available. In such cases, a physician shall examine the patient/resident within one hour of the telephone order. Until a physician arrives, appropriate staff shall monitor the resident's physical well-being.

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on restraint and Seclusion/Nonviolent Crisis Intervention Training Program" (2009) available at: http://www.crisisprevention.com/CPI/media/Media/Resources/alignments/Joint-Commission-Restraint-Seclusion-Alignment-2011.pdf. *See also*, Nat'l Commission on Correctional Health Care, "Restraint and Seclusion Standards" (2008), summary available at: http://www.ncchc.org/restraint-and-seclusion, described and interpreted at Am. Psychiatric Ass'n, "Use of Restraint and Seclusion in Correctional Mental Health Care" (2006) available at: https://www.psychiatry.org/File%20Library/Psychiatrists/.../rd2006_Seclusion.pdf.

[24] *See, e.g.*, the CMS rules *supra* at nn. 2-5 and accompanying text.

[25] There is a significant body of literature about restraint; including many which examine the regulations and policies. *See, e.g.*, Stephan Haimowitz, Jenifer Urff & Kevin Ann Huckshorn, "Restraint and Seclusion – A Risk Management Guide" (2006) (summarizing various standards and describing restraint reduction successes in a variety of setting) available at: https://www.power2u.org/downloads/R-S%20Risk%20Manag%20Guide%20Oct%2006.pdf;

[26] Compare, for example, the provision in the CMS restraint rules that apply to adults with those for children.

[27] Whether chemical restraint is less or more restrictive than, for example, mechanical restraint is a matter of debate and ultimately perhaps the individual's personal preference. Some programs mandate that newly admitted residents complete a crisis intervention plan which sets out measures the person prefers be used to respond to a crisis and avoid the use of restraint. The plan may include a preference for one form of restraint over another if restraint is necessary. Crisis intervention plans are required in Massachusetts psychiatric hospitals. Each individual plan, written with full participation of the resident, must include an identification of the triggers that signal or lead to agitation or distress, the most effective and preferred approaches to reducing distress, and preference if restraint is used. 104 Code Mass. Regs. § 27.12(3).

(5) When a physician is available, the physician shall personally examine the person prior to ordering medication as a chemical restraint with attention to the current situation, the person's prior mental and physical status and his or her history before drugs are administered.

(6) After the medication administration, the person's mental, physical and motor responses and vital signs shall be monitored by a nurse at appropriate intervals, at least once every 30 minutes.

(7) If the individual who is chemically restrained is also placed in mechanical restraints or in seclusion, he or she should be evaluated for release from restraint or seclusion in accordance with the applicable standards.

(7) Proper documentation relating to the effect of the medication shall be recorded in the medical record by appropriate trained personnel.

(8) Staff and resident debriefing after the restraint shall include a consideration of the appropriateness of the medical restraint and the resident's response to the medication.[28]

Conclusion

P&As advocating for reform of the use of medication restraints are likely to find stronger support in the emerging professional consensus and existing rules and policies than in the case law. Advocates can draw on a growing body of regulatory standards, professional literature and well documented actual experience in many states and facilities.

[28] For a useful description of appropriate debriefing techniques, *see* NASMHPD, "Six Core Strategies for Reducing Seclusion and Restraint Use©" (2006) available at: https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf.