

Moving Away From Hardware: The JDAI Standards on Fixed Restraint

**Prepared for the Annie E. Casey Foundation
Juvenile Detention Alternative Initiative**

(February 2009)

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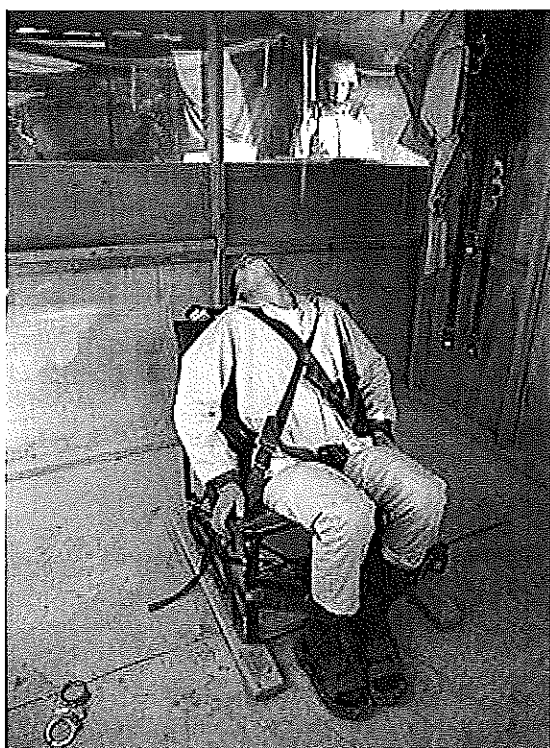
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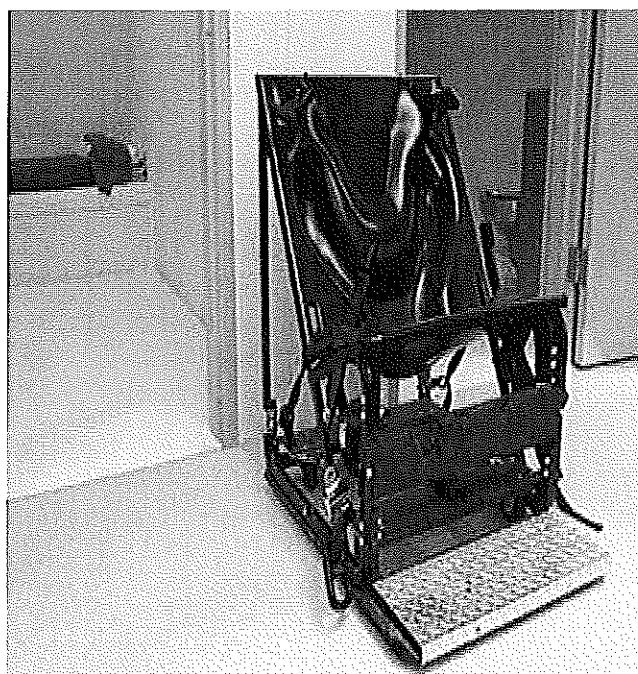
Author's Preface

As the world gave a collective cry of "torture" upon seeing a 2005 *Newsweek* cover photo of an Abu Ghraib Iraqi prison detainee in a restraint chair, some of us had a more personal response. All I could think of was that the restraint chair in the photo was almost exactly like the one we had recently seen in a juvenile detention facility in the United States.

-- Sue Burrell (February 2009)



Newsweek Photo of Inmate in Abu Ghraib
Prison Restraint Chair



Restraint Chair in Juvenile Detention Center
in the United States of America

About the JDAI Facility Conditions Work

This is the first in a series of papers on conditions of confinement issues for the Juvenile Detention Alternatives Initiative (JDAI), to be written by the Youth Law Center and Center for Children's Law and Policy. Both organizations provide technical assistance to JDAI sites on assessing and improving conditions in their local detention centers. The goal of this series is to educate JDAI facility self-assessment teams, and to assist in shaping professional practice for facility staff and administrators, officials with the responsibility for developing state standards, and colleagues in organizations that promulgate juvenile institutional standards.

The core values of JDAI hold that no child should be unnecessarily held in detention, and that those who are detained must be held in safe, humane conditions. In the early years of JDAI, consultants for the Annie E. Casey Foundation conducted annual inspections of detention centers in Initiative sites and tracked changes in conditions. As JDAI grew, it was no longer feasible to dispatch consultants to each individual site, but assuring proper facility conditions has remained a central concern. It is a concern that has grown stronger in the face of evidence that existing standards and systems of oversight have failed to protect children from serious abuse, injury and death in jurisdictions across the country. Accordingly, the Annie E. Casey Foundation asked the Youth Law Center and the Center for Children's Law and Policy to develop a process for assessing and monitoring facility conditions in the JDAI sites. The Foundation launched the JDAI Detention Facility Self-Assessment process and assessment standards in 2004. (Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative, *Detention Facility Self-Assessment (A Practice Guide to Juvenile Detention Reform)* (2006).)

The Detention Facility Self-Assessment uses assessment teams of volunteers from juvenile justice agencies, human service organizations, families involved with the system, and community organizations. The teams are trained in standards for safe and humane detention facilities, how to prepare for and conduct a "self-assessment," how to prepare a report on their findings, and how to monitor implementation of corrective action plans. This work has numerous benefits for the JDAI sites. It provides a means for facilities to receive objective feedback based on a comprehensive set of standards, and offers a baseline from which progress can be measured. It provides an opportunity for the facility to recognize and address problems *before* something bad happens or litigation commences. It provides administrators with information they can use to leverage additional resources. And finally, the process honors JDAI's commitment to providing the means for ongoing self-improvement in the sites.

The standards developed for use in the Detention Facility Self-Assessment process were developed by attorneys with a long history of involvement in institutional litigation, development of state and federal legal standards, and training on institutional conditions. The standards also incorporate input from national experts, and from JDAI site personnel. Our goal in developing the standards was to embody constitutionally required protections, state and federal statutory law, professional standards, and best practices. We addressed issues that, in our experience, have resulted in litigation or harm to youth or staff. And because we knew that there would be people involved in the assessment process who have limited background in facility operations, we also decided to provide specific guidance in areas that are often problematic.

This paper discusses one such area. The use of fixed restraints violates constitutional due process standards, accepted standards of professional practice, and core JDAI values. The use of such restraints may result in harm to youth and/or staff and is likely to result in litigation and negative public attention. In a field that is generally working to reduce the unnecessary use force and mechanical restraint devices, fixed restraints represent an extreme that must be moved out of the continuum.

Moving Away From Hardware: The JDAI Standards on Fixed Restraint

Introduction

“Fixed restraint,” as used in this paper, refers to the attaching of a child’s hands, feet or other body parts to a fixed object such as a bed, chair or bolt in the floor or wall. The central feature of such restraint is that facility staff attach the person to the fixture. While our experience is that not many JDAI sites employ fixed restraints, a few do. Also, sites that do not currently use fixed restraints may be curious about them, given a growing vendor-driven campaign to sell hardware such as restraint chairs, enthusiastically promoted as “safe” and “humane.” The JDAI facility assessment standards prohibit the use of such devices in juvenile detention, and this paper explains why. It provides background on prevalence of use, pertinent legal standards, observations on actual use and rationales for use, and finally, a section on how to move away from using fixed restraints.

Prevalence of Fixed Restraint Use

The most comprehensive national study of practices in juvenile facilities to date is the 1994 *Conditions of Confinement: Juvenile Detention and Corrections Facilities (Research Report)*, published by the federal Office of Juvenile Justice and Delinquency Prevention.¹ That study found that use of fixed restraints is rare. In the 30 days preceding the survey, 32 percent of facilities polled used some form of mechanical restraints (including handcuffs, shackles, security belts, or padded tie-downs), but only 15 percent of those facilities employed fixed restraints.² Thus, over all, fewer than 5 percent of the juvenile facilities in the survey reported using fixed restraints. For that matter, the study found that 40 percent of all juvenile facilities reported no use of mechanical restraints at all in the preceding year.³

Unfortunately, the *Conditions of Confinement Study* has not been repeated, so information on prevalence for the past decade is largely anecdotal. One fascinating piece of work analyzed data from jurisdictions using Council of Juvenile Correctional Administrators performance-based standards. This study links the use of physical and mechanical restraints with adverse conditions in juvenile facilities. Facilities with high numbers of restraint incidents were found to have high rates of injuries to staff and youth, suicidal behaviors with and without injuries, injury through restraint application, assaults on youth and staff, and fear among youth and staff.⁴ The analysis provided separate findings on “chair restraints,” a form of fixed restraint. Researchers found that crowded facilities have higher rates of chair restraint. Also, facilities with a larger proportion of staff who are racial or ethnic minorities were found to have a lower incidence of chair restraints.⁵ The researchers concluded that by reducing the use of restraints in response to youth behavior, facilities may be able to reduce the frequency of injuries to youth and staff, and reduce fear among youth and staff.⁶

Harm Associated With Used of Fixed Restraint

While comprehensive data are not kept on death or injuries resulting from the use of fixed restraints, media reports of deaths and wrongful death lawsuits regularly appear. A compelling series published in the

Hartford Courant in 1998 detailed 142 deaths over a ten year period resulting from seclusion and restraint in institutions. The results included 44 mechanical restraint deaths, with many involving four or five-point restraints, restraint chairs, and other forms of fixed restraint.⁷ There is little specific research in the criminal or juvenile justice systems, but a 2000 article described 11 correctional inmate restraint chair deaths (adult and juvenile), and a series of other cases involving injuries occurring between 1994 and 1999. This is especially remarkable because restraint chairs have only come into use in corrections in the past 15 years or so.⁸ Alarming evidence of restraint chair use on children has prompted Amnesty International to call for federal authorities to investigate the use of restraint chairs in juvenile facilities. To reduce the need for use of force, the group has also recommended that state and local governments provide adequate resources to prevent overcrowding, employ sufficient staff; and provide training for child care staff, especially those working with children with mental health problems.⁹

There is also substantial narrative evidence on the physical and psychological harm from institutional restraint. In 2000, the General Accounting Office published a report on treatment facilities describing restraint-related asphyxiation, strangulation, cardiac arrest, choking, and aspiration, often in connection with fixed restraint.¹⁰ It found that children are at higher risk of injuries or death when seclusion or restraint are used.¹¹

A Protection and Advocacy, Inc. review of the research on dangers of seclusion and restraint has catalogued an even wider set of physical dangers in connection with manual and mechanical restraint: asphyxiation, choking, strangulation, cerebral and cerebellar oxygen deprivation (hypoxia and anoxia), broken bones, lacerations, abrasions, injury to joints and muscles, contusions or bruising, overheating, dehydration, exhaustion, blunt trauma to the head, broken neck, wrist and leg compression, dislocation of shoulder and other joints, hyperextension or hyperflexion of the arms, exacerbation of existing respiratory problems, decreased respiratory efficiency, decrease in circulation to extremities, deep vein thrombosis, pulmonary embolism, cardiac and/or respiratory arrest, and death.¹²

These risks exist even when the restraint is applied correctly. The risks are exacerbated when the youth restrained has preexisting medical or physical risk factors, such as obesity, respiratory and cardiac conditions, and drug or alcohol use.¹³ The Protection and Advocacy report also details the adverse psychological effects associated with seclusion and restraint:

The risk of trauma is greater with individuals with a history of abuse. Individuals who have been restrained and secluded describe these events as punitive and aversive, leaving lingering psychological scars. Children and adolescents restrained during a psychiatric hospitalization report recurrent nightmares, intrusive thoughts, avoidance behaviors, enhanced startle response, and mistrust of mental health professionals resulting from the incidents, even years after the event. Restraint and seclusion may evoke feelings of guilt, humiliation, embarrassment, hopelessness, powerlessness, fear, and panic. Restraint and seclusion compromise an individual's ability to trust and engage with others, and create a violent and coercive environment that undermines forming trusting relationships and, by extension to the education setting, learning. [Internal citations omitted.]¹⁴

Although the report does not break out the form of mechanical restraint, it is easy to see that fixed restraint exerts the most physical restriction and greatest loss of personal autonomy, and thus is especially likely to result in injury or psychological harm. This is especially so, given the evidence that children struggle against being restrained, especially when the situation or method of restraint is extremely unpleasant or aversive.¹⁵

Legal Standards

Freedom from bodily restraint is at the core of liberty protected by the Fourteenth Amendment Due Process Clause of the United States Constitution.¹⁶ While any form of restraint may be subject to constitutional scrutiny, the use of mechanical devices that literally pin a child to a bed, a chair or a wall have received particular attention. Legal challenges involving the use of fixed restraints have repeatedly surfaced as an issue in juvenile institutional litigation.

In 1976, the federal court for the Southern District of New York considered the case of *Pena v. New York State Division for Youth*, involving the treatment of boys in a state training school.¹⁷ Among the challenges in the case was the institution's failure to comply with its own regulations governing use of restraints. The regulations provided:

"Physical restraints may only be used in cases where a child is uncontrollable and constitutes a serious and evident danger to himself or others. They shall be removed as soon as the child is controllable. The use of physical restraints shall be prohibited beyond one half hour. If restraints are placed on a child's hands and feet, hands and foot restraints are not to be joined, as for example, in hog tying. When in restraints, the child may not be attached to any furniture or fixture in the room."¹⁸

The court found that violation of those regulations also violated the Constitution. In granting an injunction, the court found these practices to be anti-therapeutic and specifically ordered that "in no cases should a boy be restrained to a piece of furniture."¹⁹

A decade later, the plaintiffs in *Hollingsworth v. Orange County*, challenged the practice of using long cotton strips to affix children to a bed in a California juvenile detention center.²⁰ The court found that this violated the Fourteenth Amendment. The court stopped short of completely abolishing fixed restraints, but its finding that, except in a clear emergency, only a psychiatrist was qualified to authorize fixed restraints, was tantamount to a prohibition.²¹ As in most facilities, since on-site psychiatric services were limited, this holding strictly circumscribed the practice.²²

In the years since *Pena* and *Hollingsworth*, at least six juvenile facility cases have abolished the use of fixed restraints as part of a settlement or consent decree.²³ In sum, the cases involving use of fixed restraints have either completely prohibited their use or have imposed strict preconditions for their use that few juvenile detention centers could meet.

Professional Standards

Despite the frequency with which fixed restraints have surfaced in litigation, professional standards have not always reflected court findings or settlements. Thus, the American Correctional Association *Standards for Juvenile Detention Facilities* permit the use of four or five-point restraint (arms, head, legs secured) with the approval of the warden/superintendent or designee.²⁴ A second standard requires facilities to have written policies on the types of restraints that may be used for medical and psychiatric purposes, but does not limit those devices.²⁵

The National Commission on Correctional Health Care (NCCHC) has clearly struggled to come up with a coherent standard, and has wound up with one set of policies to be used when restraint is ordered by

child care staff for "security reasons," and another to be used for clinically ordered restraint for behavior dangerous to self or others as a result of medical or mental illness.²⁶ Clinically ordered restraint must be authorized by a physician (or other qualified health professional where permitted by law).²⁷ The standard permits four-point restraints and restraint chairs, but expresses grave concerns. The commentary to the standard observes:

Serious injuries and deaths, though rare have occurred as a result of the process of applying restraints. Injuries usually occur during the restraint process, but also can be the result of nerve or artery constriction (e.g., aspiration of vomitus, gagging, or covering the mouth and/or nose of the restrained person). When restraint practices are misused and result in litigation, judges either have forbidden their use or placed their use solely under the supervision of medical staff.²⁸

The commentary also notes that "Many programs choose not to use fixed restraint."²⁹ The impression left by the NCCHC standards is that the drafters wanted to limit fixed restraint, but were unwilling to promulgate standards that would render "out of compliance" facilities that still use them and facilities that permit fixed restraint to be authorized by child care staff.

The American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform has noted the confusion with respect to use of mechanical restraints and has called for national policies that address the types of restraint that may be used, and who may authorize them.³⁰ The recommendations call for standards at least as stringent as in hospital settings.³¹

Other professional standards have taken a stronger position. Standard 4.61 of the *Standards for the Administration of Juvenile Justice*, developed by the National Advisory Committee for Juvenile Justice and Delinquency Prevention, adopted the court's position in *Pena* (above), limiting any use of restraints to one half hour and specifying that, "When in restraints, a juvenile should not be attached to any furniture or fixture." The commentary to that standard explains that: "To attach anyone to a piece of furniture unnecessarily is to degrade them and to damage their human dignity. The standard grants no exceptions to this prohibition. The standards as a whole reflect an attempt to make the juvenile system more humane. Strictly limiting the use of mechanical restraints is one step in this direction."³²

The Institute of Judicial Administration/American Bar Association *Standards Relating to Corrections Administration* are even more strict. Standard 7.8 permits the use of mechanical restraints only during transportation.³³ The American Bar Association reasoned that, "...there has been a consistent history of abuse of these methods in juvenile corrections settings," and that if children are held in small secure or non-secure programs, "...it should not be necessary to use mechanical restraints within the facility,"³⁴

More recently, the Council of Juvenile Correctional Administrators Performance Based Standards provide that facilities shall "Minimize the use of restrictive and coercive means of responding to disorder." Expected practices include the following: "Youths are not cuffed to walls, beds, fixtures, or fences."³⁵

So, as in the legal cases, professional standards (with the exception of American Correctional Association) either prohibit the use of fixed restraints, or drastically limit their use to match mental health system practice. This is significant because, when courts decide whether a particular practice violates the Fourteenth Amendment Due Process Clause, they look at whether it represents a substantial departure from accepted professional judgment, practice, or standards.³⁶ The use of fixed restraints in juvenile detention centers is surely a "substantial departure."

On the Ground Observations

Facilities using fixed restraint generally believe their practices are necessary to deal with youth who are "out of control." While facility staff often justify their use of fixed restraint as needed to deal with mental health crises, in our experience, fixed restraints are used in many situations that do not fit this description. Moreover, facilities often use fixed restraints when some lesser intervention would resolve the situation. The following examples demonstrate these points:

- In one facility, staff regularly resorted to use of a restraint chair when youth refused to obey verbal orders. Instead of staff managing the incident verbally or escorting the youth to his or her room, the whole living unit would become enmeshed in an elaborate process of summoning backup, cuffing the youth, and placing him or her in the restraint chair. This was often preceded by the administration of pepper spray (oleoresin capsicum), so the youth was restrained while in extreme distress because of the use of chemical restraints.
- In another facility, two young men bored with the lack of activity during many months of confinement had a competition to see who could be tied down to the bed more often and for longer. The "winner" told us he was tied down for 14 hours. This unsettling contest consumed enormous amounts of staff time and energy.
- Yet another facility had special rooms for youth who were "out of control." They were equipped with bolts on the floor, to which youth could be attached with metal handcuffs and thereby not damage the expensive safety surfacing of the walls in the room.
- In still another facility, there were bolts on the desk to which youth were shackled while staff prepared paperwork. In another, there were bolts on the wall to restrain and separate youth from one another while they awaited movement to another location.
- In another facility, young women were restrained spread eagled on their back to bolts in cement labs for "offenses" such as refusing to come out of their cell when they were suspected of being at risk for suicide. Sometimes they were restrained in this position all night. If they refused to disrobe, their clothing was cut off with scissors, sometimes by male staff.

None of these situations involved truly "out of control" youth. Fixed restraints were clearly used for administrative convenience or as a punitive measure when youth disobeyed or aggravated staff. Each of the situations could have been prevented or safely addressed without the use of fixed restraints.

Even in situations involving "out of control" youth, facilities often resort to fixed restraints when lesser measures would safely address the situation. Thus, in one facility, we observed a young woman with mental illness who would provoke situations and demand to be restrained. She would swallow batteries, paper clips or whatever she could find and then scream that she wanted to be in the restraint chair. The facility obliged. Acceding to the bizarre demands of this mentally disturbed youth did not give her the kind of therapeutic attention she really needed.

Rationales for Use

The following are arguments often advanced for the use of fixed restraints, and the reasons JDAI's team of national experts and technical assistance providers rejected these rationales in drafting the JDAI detention facility standards.

Perception That These Devices Are Necessary Equipment

The full page ads for the "Emergency Restraint Chair" (E.R.C., Denison Iowa) tout it as the latest breakthrough in safety: "It's like a padded cell on wheels." Among the asserted virtues of the contraption are that it reduces the need for additional personnel, reduces liability, and protects staff as well as the person being restrained.³⁷ A competitor, the Humane Restraint Company, can supply a full range of products – emergency restraint chairs, restraint beds, restraint boards, and restraints for individual parts of the body (torso, limbs, etc.). Its restraint chair is designed "to help control, combative, self-destructive or potentially violent detainees."³⁸ Corrections publications and vendor halls at conferences are filled with ads and infomercials suggesting that these are a necessary part of modern professional practice.

These products may have legitimate uses in emergency rescue or some law enforcement situations, but in the context of the JDAI standards, they have no place in safe and humane juvenile facilities. They are marketed as helpful conveniences, but are not necessary and are antithetical to the way we want children to be treated. Facilities that employ proper classification; have adequate, well-trained staff; and provide proper mental health support have no need for these "products." The fact that the vast majority of juvenile detention centers in the country manage crisis behavior without resort to such devices serves as the best evidence that fixed restraint is not necessary to maintain a safe, effective facility.

To Prevent Injury to Staff or Youth

One of the justifications sometimes offered for use of fixed restraint is that it reduces injuries to staff and children. Our experience has been quite the opposite. In fact, we have visited a number of facilities where the application of fixed restraints itself results in injuries to staff and children. In lawsuits the Youth Law Center has been involved in children were left bruised, and some suffered from restricted blood flow from the use of fixed restraints. The experts in our cases have spoken of the psychological danger fixed restraint poses for children who have experienced sexual or physical abuse. They have also pointed out the anti-therapeutic impact of dealing with mentally disturbed youth by imposing external controls at a time when we should be teaching them how to develop their own internal controls.

Existing research correlates high numbers of restraint incidents with high rates of injuries to youth, injuries to staff, injuries of youth by staff, and injuries in restraint incidents, among other negative factors.³⁹ The real safety issue is whether staff are well-trained to prevent and de-escalate crisis situations and to safely intervene if they must place their hands on youth.

Mental Health Rationale

The use of fixed restraints is often justified as a necessary form of clinical restraint for people acting out or out of control because of mental health disorders. While much of the case law and professional standards point to an absolute prohibition on use of fixed restraints, a few cases and the NCCHC standards carve out a limited exception for authorization by a physician or a psychiatrist. In developing the JDAI standards, we rejected this "carve out" for four reasons.

First, despite the therapeutic justification, fixed restraints are hardly ever actually applied by mental health professionals in juvenile detention centers. Few detention centers have substantial on site physician or psychiatrist time, so restraints are inevitably be applied by someone else, thus undermining the authorization requirements.

Second, the mental health world itself is moving away from use of mechanical restraints, including fixed restraints. A Mental Health America Position Statement concludes that "seclusion and restraints have no therapeutic value, contribute to human suffering, and have frequently resulted in severe emotional and physical harm, and even death."⁴⁰ The Position Statement finds that use and abuse of seclusion and restraints are symptoms of poor quality of care in facilities, poor state oversight, and misdirected public policy.⁴¹ Mental Health America (formerly the National Mental Health Association) joins the National Association of Mental Health Program Directors and the Commonwealth of Pennsylvania in adopting the goal of eliminating the use of seclusion and restraints.⁴²

The National Association of State Mental Health Program Directors (NASMHPD) "Position Paper on Seclusion and Restraint" clarifies that its goal of eliminating the use of seclusion and restraint can best be achieved by:

(1) early identification and assessment of individuals who may be at risk of receiving these interventions; (2) high quality, active treatment programs (including, for example, peer-delivered services) operated by trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations; (3) policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures; and (4) effective quality assurance programs to ensure this goal is met and to provide methodology for continuous quality improvement. These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.⁴³

The Centers for Medicare and Medicaid Services (CMS) have strictly limited the use of restraints in hospitals receiving federal funding. The regulations recognize a legitimate role for restraint *in this setting* to manage violent or self-destructive behavior that threatens the immediate physical safety of the patient, staff, or others, but even in hospitals, its use is strictly limited.⁴⁴ In response to comments on the proposed regulations complaining that use of mechanical restraints is a time honored tradition, CMS stated:

To that argument, we reply that standards of care continually evolve. For example, at one time patient shackles were considered a standard intervention. Habit does not justify the continued use of an intervention when alternative methods that are safer and more effective are available. The numerous training programs that emphasize alternative techniques for handling violent or self-destructive behavior and symptoms demonstrate that clinicians recognize the risks inherent in the use of restraint and seclusion. Practitioners in the field of medicine are constantly searching for better ways to manage symptoms and conditions that have traditionally been treated through the use of restraint or seclusion or both. We support those efforts."⁴⁵

Third, in the interim until fixed restraint is eliminated from the mental health and juvenile detention center worlds, to the extent that its use is perceived as necessary for medical or mental health reasons, the youth can be more effectively managed in a hospital that employs the staffing and protections required by the CMS guidelines. Detention facilities are not equipped with the medical and mental health personnel required to safely supervise these restraints. Detention facilities can and should establish relationships and agreements with outside hospitals that can manage the rare youth who needs restraint for his or her own safety.

Finally, the use of fixed restraints is self-defeating and harmful. Clinical research has found that use of interventions such as strapping youth to beds may actually worsen the effects of trauma experienced by so many incarcerated youth. Children who have experienced trauma may suffer from depression or anxiety, as well as externalized conditions such as aggression, conduct problems, and oppositional or defiant behavior.⁴⁶ Subjecting youth to restraint, especially fixed restraint, may result in "retraumatization" as youth revisit abusive experiences, and this in turn may lead to more trauma related behavior. As one mental health professional put it, "There was a tacit belief that containing children, setting harsh limits, and imposing a physical restraint or seclusion was somehow therapeutic. How we got the idea that meeting a child's history with violence was somehow going to be palliative and restorative, we don't know."⁴⁷ The mental health rationale for using fixed restraints is out of date and out of touch with its impact on children with mental health needs.

For Punishment

While we do not often hear the use of fixed restraints consciously justified as a form of punishment, their use as a sanction for disobeying staff or breaking rules in non-emergency situations sometimes acts as de facto punishment. To the extent that facilities condone this use of fixed restraints, they violate constitutional protections against corporal punishment of children.⁴⁸ Any use of force at a juvenile institution must be reasonably related to the system's purpose of treatment and rehabilitation, and use of fixed restraints as a sanction for minor transgressions does not meet that test.

How to Move Away From Using Fixed Restraints

People who work in facilities that use fixed restraints often have a difficult time imagining how they could do without them. What do you do with a kid who is banging his or her head? How do you handle a child who is truly out of control? What if you don't have good professional mental health support? And for staff in facilities where fixed restraint is an option, the prospect of suddenly not having that option in these situations poses legitimate concerns.

As a starting point, it is important to remember that most juvenile facilities do *not* use fixed restraint (see Prevalence discussion above) – so we know children can be safely cared for without it. Also, removing this option from the continuum does not leave the facility without effective interventions. The JDAI Detention Facility Self-Assessment standards recognize that there may be times when it is necessary to place hands on youth to move or contain them, or even to briefly use some form of mechanical restraint. The standards address that need, and provide guidance on acceptable forms of physical intervention.⁴⁹

Second, we know that the use of control measures, including restraint, is often linked with understaffing and overcrowding.⁵⁰ Having adequate staffing and maintaining institutional (and individual living unit) populations at or below capacity is an essential part of eliminating fixed restraint.

Third, the system needs to shift from a perception that restraint reflects a failure of the child, and toward an understanding that it represents a failure of the system to anticipate the need for treatment and support or to provide appropriate alternative interventions. As in the mental health system, this means embracing the concept of elimination of fixed restraint and deliberately moving toward that goal. This cultural shift must be an integral assumption in hiring, policy development, and training.

Fourth, the system must provide qualified mental health professionals to assist in the transition. Even in facilities that use fixed restraints infrequently, it is common to find that a few youth are repeatedly restrained. For some, being physically restrained is how they have interacted with abusive adults. In others, the demand for restraint has been consciously cultivated in concert with professionals who urged it as an alternative to self-harm destructive behavior. Changing these patterns requires committed professional mental health involvement. Their guiding hand is needed to assist in identifying youth who are especially at risk of mental health crises; to intervene before the actual need for restraint arises; to support staff in developing alternative approaches to dealing with disturbed children; and to work with youth, families and staff to understand and learn from what happened after a behavioral incident occurs.

Fifth, the system must develop a transition plan that gives staff the tools needed to change their practice with respect to fixed restraint. Staff should receive training on the impact of family disruption, mental illness, trauma, adolescence, and other factors that affect behavior of detained youth. Staff must learn to recognize individual "triggers" for acting out behavior; and how to head off behavioral crises by verbal or physical de-escalation techniques, moving the child to a less stressful location, bringing in staff or mental health professionals that are especially skilled at calming youth, and involving families in behavior management.

As part of the transition plan, institutional policies must be revised to address training on de-escalation, crisis intervention and hands on use of force or restraint, the expected hierarchy of intervention (from least to most intrusive), a requirement that the least restrictive appropriate intervention be used, the permissible and prohibited forms of force and mechanical restraints, requirements for medical and mental health staff involvement, time limits on restraint and monitoring requirements, provisions for moving the child to a mental health facility if he/she child remains out of control for a long period, documentation of any use of force and/or mechanical restraints, procedures for debriefing with staff, the child, and the child's family, and administrative oversight for use of force or restraints. The JDAI Detention Facility Self-Assessment standards may be a helpful tool in the revision process, since each of these issues is included.⁵¹

There is no set way to eliminate fixed restraint, but there are a couple of well worn paths. The first is to provide in-house professional expertise to work with staff in the transition. Thus, one facility (that knew it was in danger of being sued) hired a psychiatrist to come in on a regular basis to provide training to staff and to review restraint incidents with staff. The training helped staff to feel more confident about their de-escalation skills. The review process gave staff and supervisors a practical way to explore what might have been handled differently in specific situations. And, as mentioned earlier, transition "training" should not be limited to staff. Youth who have been or are likely to be involved in restraint incidents and their families must also be included in developing preventive strategies and working through restraint incidents to understand how alternative interventions could have been employed.

As part of the transition, many jurisdictions have found it useful to hire good quality consultants to train staff about how to prevent the need for restraints, and how to gain physical control of the situation without resorting to fixed restraints. A number of consulting firms specialize in this kind of training and facilities should find one that provides a good fit for them. While they are often brought in after a death or a lawsuit, these consultants are increasingly employed by agencies wanting to do the right thing before they are forced to do it.

JKM Training, Inc., in Pennsylvania, for example, has a program called Safe Crisis Management -- with a full range of training that can be tailored to the needs of the site.⁵² They provided an excellent training for JDAI sites in California as part of the Detention Facility Self-Assessment training. Their training focuses almost entirely on prevention and de-escalation to reduce the need to place hands on children, and on safe

physical interventions that do not include the use of fixed restraints. They also have had good success in helping jurisdictions to develop transitions plans. In one facility housing a highly mentally disturbed population, they focused on reducing the length of time children are held in restraints to two minutes, and in another facility, they focused on briefly using handcuffs (instead of something more intrusive) to quickly quell disturbances.⁵³ Working with experts is a good way to provide the kind of support and ongoing feedback staff need to develop confidence in their new skills. Facilities considering this approach should talk with sister jurisdictions that have used this kind of training to understand what is involved and how it works.⁵⁴

There is also a great deal of information available from local and state agencies that have undergone transitions with respect to use of restraint. For example, the Commonwealth of Pennsylvania has drafted an excellent policy bulletin, "Strategies and Practices to Eliminate the Use of Unnecessary Restraints."⁵⁵ Pennsylvania has long prohibited the use of fixed restraints,⁵⁶ and the bulletin appears to have been developed in the context of concerns over prone restraint (placing the child face down), but the principles are very much the same as those needed for transitioning away from use of fixed restraints.

The Pennsylvania bulletin sets forth the following six best practice strategies for transitioning away from the use of restraint:

1. Leadership must support organizational change and adhere to best practice standards.
2. Data should be used to inform practice change.
3. Hiring decisions and training must reflect the agency's values about restraint and provide staff with the tools they need to implement them.
4. Intake screening and assessment should be used to recognize and prevent restraint incidents; families and the youth themselves should be engaged in prevention and debriefing if restraint is used.
5. Families and youth should be involved in organizational change for quality improvement.
6. Debriefing of the staff involved and child should become a routine part of understanding any restraint incident; mental health and administrative/training staff should be involved, and alternative ways to handle incidents should be explored in each instance.⁵⁷

This list is strikingly similar to the approach used in other parts of JDAI – working from core values, using data, training staff to empower them, engaging families, using past experience to improve practice in the future. And again, the key elements of good practice are embodied in the JDAI Detention Facility Self-Assessment standards. Adopting this thoughtful approach to eliminating fixed restraints should fit with approaches already in practice in JDAI sites.

Because the mental health world has been engaged in a similar evolution in moving away from use of restraint, it too has excellent resources that may be adapted to juvenile justice use. For example, there is a federal Substance Abuse and Mental Health Services Administration program, "Roadmap to Seclusion and Restraint Free Mental Health Services," with a complete training course available on line. While the materials are designed for use in mental health facilities, juvenile system practitioners will find a great deal of useful material for application in detention facilities.⁵⁸

Also in the mental health world, there are also a number of jurisdictions with specific experience in reducing the use of restraints in children's residential treatment programs. The directors of those programs describe the culture shift in moving to a belief that restraint is a treatment failure, and the positive impact the shift has had in recruiting staff who don't want to wrestle children to the floor. They also speak of the benefits to

children of helping them to assert control over their behavior and make choices instead of using coercion. These systems, too, have a great deal to offer jurisdictions making the transition away from restraints.⁵⁹

Conclusion

In drafting the JDAI Detention Facility Self-Assessment standards prohibiting the use of fixed restraints, we took all of these things into account. The facts that they are not used in most facilities; that courts have condemned them or drastically reduced their use; that the rationales used to support their use do not stand up to scrutiny; and that there are good training programs and support systems to help with the transition away from fixed restraint, all played a part in our decisions about standards.

Beyond all this, we drafted the standards with an eye to core JDAI values. In our training for JDAI facility self-assessment teams, we always speak of treating children in detention the way we would want our own children to be treated. It is difficult to imagine a situation in which a parent would want his or her child subjected to the contraptions that appear in the preface to this paper, and even more difficult to conceive of a "therapeutic" use for them. We hope this paper will be useful to practitioners, and that it will inspire change toward safer, more humane treatment of out of disturbed children in juvenile detention facilities.

Acknowledgments

This paper benefited greatly from the thoughts and suggestions of Mark Soler, Dana Shoenberg, Paul De Muro, and Joe Mullen. Its views on fixed restraints have been honed through many years of work with wise practitioners including Paul De Muro, John Rhoads, David Roush, Earl Dunlap, and Youth Law Center colleagues Carole Shauffer, Mamie Yee, Alice Bussiere, Corene Kendrick, Maria Ramiu and Jennifer Rodriguez (and former colleagues Mark Soler, Marc Schindler, James Bell, Shannan Wilber, and Neelum Arya). The fact that this paper has been written at all is a result of the ongoing commitment to and support of the JDAI facility conditions work by Bart Lubow and the Annie E. Casey Foundation.

¹ U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, *Conditions of Confinement: Juvenile Detention and Corrections Facilities (Research Report)*, prepared by Dale G. Parent, et al., Abt Associates, Inc. (1994). The study covered 984 public and private juvenile detention centers, reception centers, trainings schools, ranches, camps and farms in the United States. The survey had a 76-percent response rate, and findings were corroborated by site visits to more than 90 facilities. (*Id.*, at "Executive Summary," pgs. 1-2.)

² *Id.*, at p. 184, and note 24. The number of detention centers using fixed restraint was actually slightly lower, at 13 percent. *Id.*, at p. 185, Table 7B-11.

³ *Id.*, at p. 184. Among facilities that used mechanical restraints, detention centers were more likely to use them than ranches, training schools or reception centers, but even so, 28 percent of detention centers used no mechanical restraints at all in the preceding year. *Id.*, at p. 184.

⁴ New Amsterdam Consulting, Inc., *Performance-based Standards for Youth Correction and Detention Facilities (2007 Research Report)*, Scottsdale, Arizona (July 2007), p. 12, on line at <http://pbstandards.org/aboutpbs.aspx>.

⁵ *Id.*, at pgs. 12-13.

⁶ *Id.*, at p. 20.

⁷ E.M. Weiss, et al., "Deadly Restraint: a Hartford Courant Investigative Report," *Hartford Courant* (October 11-15, 1998), on line at <http://www.charlydmiller.com/LIB05/1998hartforddata.html>.

⁸ Anne Marie Cusac, "The Devil's Chair – misuse of restraint chairs," *The Progressive* (April 2000), on line at http://www.progressive.org/mag_cusacchair.

⁹ Amnesty International, *Betraying the Young: Children in the US Justice System*, on line at <http://www.amnestyusa.org/document.php?id=D94FCE82406321E18025690000692DCA&lang=e>.

¹⁰ United States General Accounting Office (GAO), "Mental Health - Improper Restraint or Seclusion Use Places People at Risk." Report to Congressional Requesters (GAO/HEHS-99-176, September 1999), at pgs. 6-7.

¹¹ *Id.*, at p. 7.

¹² Protection and Advocacy, Inc., *Restraint & Seclusion in California Schools: A Failing Grade* (June 2007), pgs. 22-23, and studies cited therein.

¹³ *Id.*, at p. 23, and studies cited therein.

¹⁴ *Id.*, at p. 24, and studies cited therein.

¹⁵ *Id.*, at pgs. 23-24, and studies cited therein.

¹⁶ *Youngberg v. Romeo*, 457 U.S. 307, 318 (1982).

¹⁷ *Pena v. New York State Division for Youth*, 419 F.Supp. 203, 210 (S.D.N.Y.1976).

¹⁸ *Id.*, at p. 209, note 2, quoting from 9 N.Y.C.R.R. § 168.3, subd. (a). The language prohibiting fixed restraint is still in the regulation more than 30 years after *Pena*.

¹⁹ *Id.*, at p. 211.

²⁰ *Hollingsworth v. Orange County*, Case No 51-08-65 (Super. Ct. Orange Co., Calif. 1990).

²¹ *Id.*, Statement of Judgment and Decision, filed July 27, 1990, pgs. 39-40.

²² The *Hollingsworth* litigation and legal issues are described in Sue Burrell, "Due Process Limitations on the Use of Four-Point Restraints in Juvenile Detention Facilities," 12 *Children's Rights Legal Journal* (Summer 1991), pgs 12-15.

¹⁷ "The practices of restraining feet, attaching hands and feet, as in hog-tying, and attachment to objects or fixtures are specifically prohibited." *Terry D. v. Rader*, No. CIV-78-0004-T (W.D. Okla. 1982), stipulated agreement, January 11, 1982, p. 12(B); "The defendants will not permit Juvenile Hall staff to use leg-shackles, strait-jackets, four-point restraints, or any other type of mechanical or chemical restraints (including mace) on detained youth at the Juvenile Hall for any purpose." *Shaw v. San Francisco*, No. 915763 (Super. Ct. 1993), settlement agreement, October 4, 1993, pp. 7-8; "The State Defendants shall not permit employees to restrain youths to fixed objects." *E.R. v. McDonnell*, Civ. No. 94-N-2816 (D. Colo. 1995), settlement agreement, May 26, 1995, p. 10; *Horton v. Williams*, No. C94-5428 RJB (W.D. Wash. 1995), stipulation & judgment resolving certain claims and continuing trial on the remaining ones, July 26, 1995, p. 7, ¶34; "Youth at the MRYDC will never be restrained to a fixed object or have their hands and feet bound together." *Doe v. Napper*, No. 1-93-CV-642-JEC (N.D.Ga. 1998), stipulation for consent decree, Jan. 26, 1998, p. 9; "No other forms of mechanical restraints may be used (including 4 or 5 point restraints). This, however, does not apply to medical or mental health restraints ordered by a medical or mental health professional." *U.S. v. Louisiana*, Civ. No. 98-947-B-1 (M.D. La. 2000), United States' Jena agreement, April 13, 2000, p. 8, ¶25. One additional case did not completely abolish the use of fixed restraint, but the settlement limited their use to situations approved by a mental health professional; the facility involved in the litigation was subsequently closed. *Christina A. ex rel. Jennifer A. v. Bloomberg*, 167 F.Supp.2d 1094, 1097 (D.S.D. 2000).

²⁴ American Correctional Association, *Standards for Juvenile Detention Facilities*, 3rd edition, Standard 3-JDF 3A-16-1, revised January 1995, *2008 Standards Supplement* (2008), p. 203.

²⁵ American Correctional Association, *Standards for Juvenile Detention Facilities*, 3rd edition, Standard 3-JDF 4C-33-1, added August 1991, *2008 Standards Supplement* (2008), p. 210.

²⁶ The NCCHC standards do not explain the distinction between restraints use for security reasons and those used for clinical reasons.

²⁷ National Commission on Correctional Health Care, *Standards for Health Services in Detention and Confinement Facilities*, Standard Y-I-01: Use of Mechanical Restraint (2004), p. 131.

²⁸ *Id.*, at p. 132.

²⁹ *Id.*

³⁰ Louis J. Kraus, M.D. and William Arroyo, M.D., "Recommendations for Juvenile Justice Reform" (Second Edition) American Academy of Child and Adolescent Psychiatry Committee on Juvenile Justice Reform (October 2005), p. 71.

³¹ *Id.*

³² United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention, *Standards for the Administration of Juvenile Justice: Report of the National Advisory Committee for Juvenile Justice and Delinquency Prevention* (1980), Standard 4.61 (Mechanical Restraints), pgs. 504-505.

³³ Institute of Judicial Administration/American Bar Association, *Standards Relating to Corrections Administration*, Standard 7.8 (1980), pgs. 28-29.

³⁴ *Id.*, at pgs. 29, 145.

³⁵ Council of Juvenile Correctional Administrators, *PbS Goals, Standards, Performance Measures, Expected Practices and Processes*, Order Standard, OEP 10 (2008), p. 8.

³⁶ *Youngberg v. Romeo*, *supra*, note 16, 457 U.S. at p. 323.

³⁷ E.R.C., Inc. (Denison, Iowa), on line at <http://www.restraintchair.com/>.

³⁸ Humane Restraint Company (Waunakee, Wisconsin), on line at <http://www.humanerestraint.com/>.

³⁹ New Amsterdam Consulting, Inc., *Performance-based Standards for Youth Correction and Detention Facilities (2007 Research Report)*, *supra*, note 4, at p. 12.

⁴⁰ Mental Health America, "Position Statement 24: The Use of Restraining Techniques and Seclusion," on line at <http://www.mentalhealthamerica.net/go/position-statements/24>.

⁴¹ *Id.*

⁴² *Id.*

⁴³ National Association of State Mental Health Program Directors, "Position Paper on Seclusion and Restraint," adopted by the membership July 15, 2007, on line at http://www.nasmhpd.org/general_files/position_statement/posses1.htm.

⁴⁴ Federal Register, vol. 71, no. 236, pgs. 71378 - 71428 (December 8, 2006), 42 CFR Part 482 (Dec. 8, 2006) Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare and Medicaid Programs; Hospital Conditions of Participation; Patients' Rights; Final Rule (effective January 8, 2007).

⁴⁵ *Id.*, at p. 71384.

⁴⁶ Julian D. Ford, et al, "Trauma Among Youth in the Juvenile Justice System: Critical issues and New Directions," National Center for Mental health and Juvenile Justice, Research and Program Brief (June 2007), pgs. 1, 3, on line at http://www.ncmhjj.com/pdfs/trauma_and_youth.pdf.

⁴⁷ Quoting Janice LeBel, Massachusetts Department of Mental Health, in Scott Kirkwood, "Practicing Restraint," *Children's Voice* (September/October 2003), on line at <http://caica.org/NEWS%20Children's%20voice%20article%202003.htm>.

⁴⁸ See, for example, *In re S.D.*, 832 So.2d 415, 434 (La.App.4th Cir. 2002) (physical abuse); *Nelson v. Heyne*, 355 F.Supp. 451 (N.D.Ind. 1972) (beatings with a paddle), *aff'd*, 491 F.2d 352 (7th Cir.1974), *cert den.*, 417 U.S. 976 (1974); *Morales v. Turman*, 383 F.Supp. 53 (E.D.Tex.1974) (physical beatings and use of tear gas), *rev'd on other grounds*, 562 F.2d 993 (5th Cir.1977); *Santana v. Collazo*, 533 F.Supp. 966 (D.P.R.1982) (beatings of children who escaped from institution and were recaptured), *aff'd in part and vacated and remanded in part*, 714 F.2d 1172 (1st Cir.1983), *cert. denied*, 466 U.S. 974 (1984); *Milonas v. Williams*, 691 F.2d 931 (10th Cir.1982) (grabbing children by the hair, pulling them backwards, and flinging them against walls), *cert. denied*, 460 U.S. 1069 (1983).

⁴⁹ Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative, *Detention Facility Self-Assessment (A Practice Guide to Juvenile Detention Reform)*, section VI, Restraints, Isolation, Due Process, and Grievances, pgs. 89-91, on line at <http://www.jdaihelpdesk.org/Pages/PracticeGuides.aspx>.

⁵⁰ Sue Burrell, Paul DeMuro, Earl Dunlap, Carl Sanniti, and Loren Warboys, *Crowding in Juvenile Detention Centers: A Problem-Solving Manual*, National Juvenile Detention Association and Youth Law Center, for the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (December 1998), pgs. 6-8 and studies cited therein.

⁵¹ Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative, *Detention Facility Self-Assessment (A Practice Guide to Juvenile Detention Reform)*, *supra*, note 49, section VI, Restraints, Isolation, Due Process, and Grievances, pages 89-91, on line at <http://www.jdaihelpdesk.org/Pages/PracticeGuides.aspx>.

⁵² JKM Training, Inc., on line at on line at <http://www.jkmtraining.com>.

⁵³ Electronic communication from Joe Mullen to Sue Burrell (December 23, 2008).

⁵⁴ JKM Training, Inc. has worked in the following jurisdictions (though in many of these, the work was part of a broader reform effort to reduce the use of force and not focused on fixed restraints specifically): Los Angeles County, Santa Cruz County, and Alameda County California; California Department of Corrections and Rehabilitation, Division of Juvenile Justice; State of Louisiana Department of Juvenile Justice; State of Tennessee Corrections Academy; Connecticut Juvenile Training School (CJTS); Madison County Detention, Ill.; Calhoun County Juvenile Home, Michigan; Bruce Normile Juvenile Center, Missouri; State of New Mexico Division of Juvenile Justice; Youth Study Center, Philadelphia, Pennsylvania; most juvenile detention centers in Pennsylvania; and the Pennsylvania State Youth Development Center system. (Electronic communication from Joe Mullen to Sue Burrell (February 4, 2009).

⁵⁵ Commonwealth of Pennsylvania, Department of Public Welfare, "Strategies and Practices to Eliminate the Use of Unnecessary Restraints" (Draft January 30, 2006).

⁵⁶ Juvenile Detention Centers Association of Pennsylvania, *Juvenile Detention Program Standards*, (1993), "Mechanical Restraint," Standards 9, 9.5, pgs. 18-19.

⁵⁷ *Id.*, at pgs. 5-8.

⁵⁸ United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, "Roadmap to Seclusion and Restraint Free Mental Health Services," on line at <http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4055/>.

⁵⁹ One excellent article on the cultural shift and positive impacts for staff is Scott Kirkwood, "Practical Restraint," *supra*, note 47, *Children's Voice* (September/October 2003), on line at <http://caica.org/NEWS%20Children's%20voice%20article%202003.htm>.