

Should Psychiatrists Assist in the Restraint of Children and Adolescents in Psychiatric Facilities?

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Psychiatrists in psychiatric hospitals or residential facilities can find themselves involved in patient crises that precipitate a restraint or seclusion. The decision to become directly involved must be made quickly, with little time for administrative or legal consultation. The psychiatrist's decision to participate in physically restraining or secluding a patient, particularly a child or adolescent, may have long-lasting consequences. This Open Forum is offered to promote a discussion on this topic. (*Psychiatric Services* 64: 173–176, 2013; doi: 10.1176/appi.ps.001652012)

Child and adolescent patients are often admitted to psychiatric hospitals and residential treatment facilities because they have problems with emotional regulation, anger management, and conflict resolution. Within treatment settings, these characteristics can result in self-injury or interpersonal conflict with peers and staff that replay bad experiences that have occurred at home or at school. These behaviors

often create acute behavioral crises that endanger the safety of the child and others. To maintain safety, seclusion or restraint may be implemented in the treatment setting (1,2).

As has been repeatedly shown, seclusion and restraint are high-risk interventions that can result in psychological and physical injury (3) or in death (4). These procedures can be challenging to the emotional and developmental growth of children (5). Yet the consensus gleaned from the literature is that, apart from safety concerns, these interventions have very limited, if any, therapeutic value (6–9).

When do seclusion and restraints commonly occur?

Restraint and seclusion usually are prompted by a child's interpersonal conflicts with peers or staff at the facility, by conflicts with family during treatment, or through a patient's attempts at self-injury. In response to a patient's behavioral crisis, a psychiatrist may be summoned to an impending restraint or seclusion. Restraint limits a person's freedom of movement, and seclusion confines the person to a room. Both are felt by patients as coercive or intrusive interventions that routinely result in fear, anxiety, agitation, and physical resistance.

The psychiatrist may successfully avoid becoming involved in physical containment of a patient by using de-escalation interventions (1,10). If these measures fail or cannot be implemented, then the issue of whether to

physically intervene again arises. The considerations described below are central elements in making an informed choice.

Issues raised by direct involvement of the psychiatrist

The Joint Commission (JC) and the Centers for Medicare and Medicaid Services (CMS) require that a seclusion or restraint be ordered by a psychiatrist, but they provide no guidance about physical involvement. We must then consider how writing a seclusion and restraint order differs from being an active participant in the physical containment of a patient. Ordering restraint or seclusion is an accepted societal responsibility of a psychiatrist; physically restraining patients is not. In fact, when notified of a psychiatrist's physically containing a patient, families, regulatory agencies, and the facility leadership team usually want an explanation of why it was necessary. Direct involvement from a psychiatrist is especially troubling, because restraint or seclusion incidents can arise as the result of negative staff morale or staff-to-staff conflict (10) and in hindsight are difficult to justify to the patient, the patient's family, the facility, and regulatory agencies.

Legal concerns

Psychiatrists' responsibilities to patients include autonomy, beneficence (promote well-being of the patient), nonmaleficence (do not harm the patient), and fiduciary responsibility (place the patient's interests first)

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(1,11,12). Therapeutic interactions that include these principles generally assume that communication in these interactions is verbal. Boundary changes occur when a psychiatrist-patient interaction shifts from voluntary verbal exchanges to forced physical containment (13). Physical contact may engender allegations of sexual or physical abuse. Patients who are watching the physician carry out the restraint or seclusion or who learn of the incident may develop similar concerns about their own psychiatrist-patient relationship. However, if patients are in danger of hurting themselves or someone else and the psychiatrist is the only staff member present, then the psychiatrist must choose either to physically intervene or to call for other trained treatment team personnel. Doing nothing, even with justification of preserving autonomy in the psychiatrist-patient relationship, could be viewed as neglect or as dereliction of professional responsibility.

Criminal

If a patient is harmed in a physical restraint, the psychiatrist involved could be charged with physical assault. Usually, however, criminal charges require proof that there was intent to harm the patient. If a psychiatrist is acting in good faith to restrain a person who would otherwise harm him- or herself or others and the psychiatrist's actions are intended to protect the patient or others from imminent harm, there would likely be no criminal action.

Self-defense

Staff who are in danger of physical harm from a patient have the right to protect themselves. The action taken must be commensurate with the severity of the threat. For example, the use of a gun in response to a verbal threat would not be justified. Physical restraint in response to a threat by a patient must be conducted in the context of the patient's crisis management plan and uphold on behalf of him or her the psychiatrist's beneficence, fiduciary responsibility, and non-maleficence. Further, a psychiatrist who just "jumps into the fray," with no knowledge of restraint techniques or skill in applying them, is more vulner-

able legally than the psychiatrist who has more training in this area.

Civil

Civil actions can involve either state or federal claims (14). A patient may perceive harm from the psychiatrist in some manner that does not constitute a crime and may sue for civil damages, even if law enforcement declines to prosecute. Two advantages to patients bringing these civil suits are that the standard of proof of injury is lower than in criminal prosecutions, and thus the patient is more likely to prevail, and that monetary damages may be assessed for the patient from the psychiatrist. Examples of these suits include intentional infliction of emotional harm, battery, or negligence. The patient usually does not have to prove that the psychiatrist intended harm—only that the psychiatrist failed to carry out his or her professional responsibilities (15,16).

On the federal level, there have been lawsuits claiming that the use of restraint has violated the 14th Amendment right to due process (14). To make this claim the patient must first prove that the psychiatrist was acting as an agent of the state. These suits would not be applicable to restraint or seclusions that occur in private hospitals or clinics. In most of the reported civil cases, courts have deferred to the expertise of the clinician and dismissed the suit. That is, unless egregious behavior was demonstrated, such as beating a patient, the courts generally assume that the professional has used expertise and training in carrying out the restraint or seclusion.

Regulatory and licensing issues

Accrediting bodies (CMS and JC) and other state and federal regulatory agencies would likely be informed of a psychiatrist's participation in a restraint or seclusion through a complaint of improper treatment. The professional would have to explain how his or her behavior was not in violation of a patient's rights. This defense would occur in the context of societal perceptions that have endured for more than a decade, that psychiatrists and psychiatric facilities have abused patients through their use of seclusion and restraint. From a regulatory point of

view, the physical restraint of a patient by a psychiatrist suggests that there has been a failure of treatment and would call for an analysis to examine its root causes (17). For example, was there a failure of nursing, staffing, or deescalation efforts? Was there confusion about the professional roles of staff, a lack of adequate unit staff safety training, or a lack of administrative monitoring efforts to prevent seclusion and restraint?

A psychiatrist could be terminated from employment. His or her reputation could be challenged by investigations by state medical licensing boards or professional organizations and by Web-based public assessments of the psychiatrist's practice abilities. A psychiatrist's malpractice insurance also may be affected by a patient complaint.

Therapeutic issues

A psychiatrist's professional role requires a therapeutic alliance with the patient (12). Specific elements essential to this relationship are often delineated as professional duties in facility job descriptions. Examples would include expectations of professionalism through attire, communication, and maintenance of safe physical boundaries. These elements reflect societal and hence the patient's expectations. Participating in physical restraint is not generally seen as part of a psychiatrist's professional role, so involvement in this way may communicate confusing messages both to staff and to patients. For example, a patient who has been restrained may conclude that treatment is defined as "might makes right" and that verbal therapeutic work is neither authentic nor valuable. Many patients with histories of abuse come to therapy with this mind-set already and thus could view their psychiatrist as another abuser.

Staff may conclude that a psychiatrist who participates in physical containment of a patient wants to support the use of restraints or seclusion as a validated treatment for aggression and violence. An unintended consequence may be that personnel then create crisis situations involving emotionally labile, aggressive, or impulsive patients and call the psychiatrist to help manage

them. The psychiatrist would then become the actual “Doctor Strong,” which in some facilities is the code call for a crisis team to carry out a restraint.

Physical or psychological injury

As with any physical intervention, both the clinician and the patient risk being injured. Either or both could develop long-term disability, financial hardship, and increased individual and family stress. The emotional fallout from the injury could disrupt the therapeutic alliance and prevent further treatment.

Nonparticipation options for psychiatrists

Before crises arise

All staff members responsible for seclusion and restraint procedures should be trained to carry out these procedures. The administrative and clinical team should ensure that individual crisis management and safety plans are effective, known by staff and patients, and practiced to ensure efficacy. Psychiatrists should be aware of these patient plans and their contents and should be familiar with other debriefing strategies that the staff uses when the individual plans fail.

During crises

Psychiatrists can assist in the verbal deescalation efforts, encourage the patient to use his or her individual safety plan, and ensure that trained staff use the appropriate crisis management techniques outlined in the plans (18). The psychiatrist may also observe the restraint to make sure that it is carried out in a manner that meets safety, regulatory, and facility standards. On the other hand, if concerned that being present would lengthen or complicate the restraint, the psychiatrist may choose to leave. Unfortunately, the correct choice in each situation is often best made in hindsight, but prior clinical experience of being present when a restraint or seclusion begins may help in making this decision. Whenever a psychiatrist suspects that a patient is in danger of injury or death because of a restraint or seclusion, the psychiatrist must immediately order termination of the procedure, and alternative interventions must be introduced.

After crises

A psychiatrist who has been actively participating in a physical containment either by restraint or seclusion must assess with the patient to what extent this event has disrupted the physician-patient treatment alliance. Particular attention should be given to the patient's willingness to continue in treatment with the psychiatrist. This view is a direct application of the autonomy element of the physician-patient relationship. If, after discussion and reflection, the patient who was physically restrained by the psychiatrist feels that the physician-patient treatment alliance was violated, then that patient may seek to discontinue the relationship. This decision should be honored if possible. The psychiatrist should then present the results of this discussion to the treatment team and administrative supervisors. Facility administrators or the patient's family, if the patient is a minor, may wish the psychiatrist to continue treating the patient despite the patient's disagreement. Whether this is a viable choice would likely be best decided by a joint conference between the patient, the patient's family, and the treatment team.

To prevent a recurrence of the restraint or seclusion, the psychiatrist must communicate complete information about the restraint to the patient's family or guardian, the treatment team, and the administration. In all of these discussions, suggestions should be made about the processes necessary to prevent similar crises and the skills that might help staff and patients achieve this goal. These findings should be incorporated in the patient's individual crisis management plan. The role the psychiatrist would play in future patient behavioral crises and seclusion and restraint events should be clarified. This information should then be communicated to the patient, the staff, and the facility administrators.

Documentation

The psychiatrist should document the circumstances of the behavioral crisis in clear, factual, and concise sentences that can be understood by patients and families. Documentation should include the reason the restraint or seclusion was necessary and describe the psychiatrist's role during the re-

straint or seclusion. Documentation of these incidents can clarify the clinical circumstances that surround a seclusion and restraint incident and help dispel concerns that information is being omitted or incorrectly stated for self-protection. This information would be essential if litigation ensued.

Conclusions

We have discussed the issues surrounding psychiatrist involvement in physical containment of patients. This information may also be applicable to other clinicians who function as primary therapists with patients in an inpatient or residential facility. By primary therapist we mean social workers, psychologists, and other counselors who have a direct responsibility to provide individual therapy and to manage a patient's treatment in the facility. We exclude nurses, recreational staff, residential care staff, and others whose role is to supervise or provide group therapy or activities, because they do not have these individual primary therapist responsibilities. We have focused mainly on the seclusion and restraint of children and adolescents. However, many of these issues also apply to adult psychiatric patients and crisis management expectations of their treating psychiatrists.

In summary, the choice of what involvement a psychiatrist or clinical professional should have in a restraint or seclusion must be determined by the practitioner in conjunction with the facility in which he or she works. Knowing the issues raised in this Open Forum, planning ahead, and working with the staff should help the psychiatrist or primary therapist to make an informed decision.

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