Factors to consider in evaluating the appropriateness of restraints during forensic evaluations

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Forensic examiners frequently conduct evaluations with individuals who may be regarded as dangerous. To manage this situation, forensic examiners may prefer examinees to wear restraints. Available literature indicates that the use of restraints may be both physically and psychologically detrimental and thus possibly both reduces the yield and limits the utility of psychological test data. Although there is a lack of research addressing this concern, one must use the available information to inform the decision on utilization of restraints during forensic evaluations. In addition, professional ethics, test standards and norms, the reported adverse effects of restraints on both psychiatric patients and inmates, and the concept of forced medication are reviewed to help assess the appropriateness of restraints during forensic evaluations. This analysis provides forensic examiners with insight and recommendations to determine if the use of restraints is best practice during forensic evaluations, particularly within the United States.

Key words: ethics; forensic evaluation; medication; prison; psychiatric hospital; restraints.

You enter a small room and sit down at a table in preparation for a forensic evaluation. The forensic examinee, seated across from you, is a large individual, charged with a violent crime. You have the option of having the handcuffs removed from the examinee during the forensic evaluation. Should s/he remain in restraints?

In the United States, forensic examiners are typically psychologists or psychiatrists who conduct evaluations to resolve issues critical to the legal system. The current focus is on criminal forensic evaluations including questions about competence to stand trial, mental state at time of offense, and risk of violence. Thus, forensic examiners often are called upon to evaluate inmates and

psychiatric patients who might be considered dangerous. Indeed, a survey by Leavitt, Presskreischer, Maykuth, and Grisso (2006) revealed that forensic psychologists and psychiatrists in Massachusetts reported experiencing various types of aggression when working with an adult criminal forensic sample. More specifically, 31% stated they had been threatened, 51% reported they had been harassed/intimidated, and 15% indicated they had been the target of an act of physical aggression within the context of adult criminal forensic evaluations (Leavitt et al., 2006). One possible solution to offset the physical risk associated with such evaluations is for the examinee to wear restraints. However, there is a scarcity of research on this topic, so

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it is unclear whether it is ethical or clinically appropriate to do this type of evaluation while the examinee is in restraints. In order to shed light on these questions, this paper examines professional ethics, assessment standards, the harmful effects of restraints on people, and the concept of involuntary medication. In addition, implications, recommendations, and alternatives to restraints during forensic evaluations of psychiatric patients and inmates are presented. While most of the research discussed was conducted in the United States, findings from Brazil (Filho & Garrafa, 2002), the Netherlands (Veltkamp et al., 2008), and Australia (Kinner et al., 2017) are included. Additionally, much of the research may generalize to forensic evaluations in other countries, although there are likely differences in attitudes toward and tolerance of restraints around the world.

Adverse effects of restraints on psychiatric patients

It is important to first consider the adverse effects of restraints on psychiatric patients and inmates in general prior to discussing the appropriateness of restraints during forensic evaluations. Restraints are used to protect psychiatric patients from harming themselves, other patients, and staff members (Mohr, Petti, & Mohr, 2003). During forensic evaluations, examinees who are restrained would normally have their wrists and/or ankles restrained; however, in a psychiatric hospital, patients are often restrained onto a bed at both wrists and ankles. According to Fisher, more than 20% of psychiatric patients are physically restrained at some point while hospitalized (1994). More recently, researchers examined the rates of restraint use on two inpatient psychiatric units of an independent hospital in New York over a six-year period (Jacob et al., 2016). The findings indicated that the number of individual patients who required restraints ranged between 58 and 93 annually with the yearly rate of 3.94 restraint

episodes per patient (Jacob et al., 2016). Fortunately, there is increasing agreement between both patients and mental health providers that restraints pose significant problems. For example, Kinner et al. (2017) found that mental health consumers and providers in Australia agreed that restraints are harmful, breach human rights, erode the trust between patients and providers, and either cause or trigger past trauma.

Moreover, the examinees who have endured past trauma could re-experience it if forced to wear restraints. The use of restraints in prisons often leads women to recall the earlier experience of being sexually violated (Mohr et al., 2003). Between 34% and 53% of individuals with serious mental illness report childhood sexual or physical abuse (e.g., Greenfield, Strakowski, Tohen, Batson, & Kolbrener, 1994). Gallop, McKay, Guha, and Khan (1999) conducted a qualitative study of the experience of restraints and seclusion in psychiatric hospitals by women with a history of childhood sexual abuse. The women reported feeling degraded and terrified, particularly when male staff members were involved in the restraint process. Some women also felt as though the restraints were a form of punishment and likened the experience of being restrained to their previous sexual abuse. Furthermore, none of the women felt as though the restraints made her feel safe (Gallop et al., 1999). Although the Gallop et al. (1999) article indicated that most of the women experienced full-body restraints, one could imagine that even handcuffs, waist restraints, and/or ankle shackles could also elicit negative feelings.

Children and adolescents who were restrained in psychiatric facilities recounted marked startle responses, nightmares, intrusive thoughts and avoidance responses. Children and adolescents also reported distressing memories and trepidation at hearing and seeing other patients being restrained. They further reported a lack of trust in mental health professionals after being restrained. Finally,

some of the children conveyed that the actual restraint experience had caused direct trauma (Mohr, Mahon, & Noone, 1998).

Donat (2005) discussed how many psychiatric facilities heavily rely on restraints, seclusion and PRN (i.e., as needed) medication to manage patients' negative behaviors, instead of implementing behavioral treatment plans to change behavior. Donat (1998) described how behavioral plans were implemented for patients who had been administered three PRNs in one week. After the execution of the behavioral plan, there was a 60% reduction in the use of restraints and seclusion with those patients (Donat, 1998). Thus, there are effective alternatives to using restraints that offer possible long-term decreases in aggressive behaviors. If restraint, seclusion, and PRN use continues, patients may not learn coping skills that they need outside of a hospital setting, possibly resulting in multiple admissions to psychiatric hospitals.

Adverse effects of restraints on inmates

Prisons within the United States utilize several types of restraints, including handcuffs, shackles, leg irons and chains (Cohen, 2006; Rhodes, 2004). Rhodes (2004) also described a stun belt, which can inflict a 50,000-volt shock to prisoners. The sheer threat of the shock is used to coerce appropriate behavior among prisoners (Rhodes, 2004). It is difficult to determine the frequency or even the number of prisoners who are restrained (Martin, 2006; Rhodes, 2004), because handcuffs and other restraining devices are so frequently used (Cohen, 2006; Martin, 2006). According to the American Correctional Association (2008), restraints are only to be used to prevent harm to self or others; they cannot be utilized to punish an inmate. However, it is unlikely that all correctional staff consistently adhere to these guidelines. Furthermore, inmates have experienced physical injuries from restraints, including bruises,

lesions, broken bones, and asphyxia (Martin, 2006).

African Americans are over-represented in correction populations in the United States (Harrison & Beck, 2006; Sabol & Couture, 2008). African American prisoners are also restrained more frequently than their white counterparts (Bersot & Arrigo, 2011). Perhaps due to subconscious discrimination against African Americans by correctional staff (Mushlin & Galtz, 2009), they receive more disciplinary reports (Ramirez, 1983) and are placed in restraints (Bersot & Arrigo, 2011) and solitary confinement (Arrigo & Bullock, 2008) more than Caucasian inmates.

Incarcerated women experience a unique set of problems. According to Blackburn, Mullings, and Marquart (2008), 68% of their sample of female inmates reported sexual victimization within their lifetimes, and 17% reported being sexually victimized within prison. The use of restraints in prisons leads women to recall the earlier experience of being sexually violated (Mohr et al., 2003). Thus, restraints can be exceptionally distressing for women with histories of sexual abuse. Moreover, many states permit restraints to be used on women who are pregnant or even in the process of giving birth which places the mother and baby at risk (Amnesty International, 2008).

The prevalence rate of serious mental illness for inmates is 14.5% for men and 31% for women. However, when posttraumatic stress disorder (PTSD) is classified as a serious mental illness, the rates increase to 17.1% for men and 34.3% for women (Steadman, Osher, Robbins, Case, & Samuels, 2009). Thus, PTSD accounts for a significant percentage of mental illness within correctional facilities, and examinees may re-experience adverse emotional effects from previous trauma if they are forced to wear restraints during forensic evaluations.

It seems clear that restraints contribute to both physical and psychological injuries in

correctional settings. Forensic examiners should be especially knowledgeable about the additional hardships the mentally ill, African Americans, women and other minority populations may endure while restrained in prison.

Assessment standards

In high-risk assessment settings, such as prisons and forensic psychiatric hospitals, it is critical to balance safety and clinical needs. Often the examinee is restrained, security personnel are present, or both. The two most commonly used psychological tests by forensic psychologists (Archer, Buffington-Vollum, Stredny, & Handel, 2006) are the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher et al., 2001) and the Wechsler Adult Intelligence Scale-IV (WAIS-IV; Wechsler, 2014). Thus, it is critical to determine whether examinees in restraints can physically complete these tests with valid results. Though it may be physically possible for individuals wearing restraints to complete the MMPI-2 (Butcher, 2001) or the MMPI-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) in a satisfactory manner, it would be very difficult or nearly impossible for them to maximally complete several subtests on the WAIS-IV. Depending on the type of restraints, individuals limited in their hand movements would likely struggle with Block Design, Coding, and Symbol Search, thus affecting the validity of scores.

There are several obstacles present in prisons in the United States that could violate assessment standards and procedures. Most psychological tests have been standardized and normed in a controlled test setting, and actual assessment situations aim to replicate these environments (Vanderhoff, Jeglic, & Donovick, 2011). However, this is almost impossible to do in a prison setting where safety takes precedence. Many prisons cannot provide adequate assessment facilities, and due to safety reasons, testing may occur in common areas where staff and other prisoners

may observe the evaluation, thus limiting confidentiality. This type of setting can be distracting to the examinee, particularly when there is a lot of noise and other people around the assessment area (Vanderhoff et al., 2011).

Vanderhoff et al. (2011) also discussed the effects of third-party observation on psychological testing, including how, due to safety concerns, most assessment sessions in prisons are supervised by security personnel via video camera, through a window, or having an officer sit in the testing room with the inmate. There is a growing body of research on the effects of third-party observers on examinee performance, including lower scores on tests that measure processing speed, attention (Keher, Sanchez, Habif, Rosenbaum, & Townes 2000), verbal fluency (Horwitz & McCaffrey, 2008) and memory (Lynch, 2005). These effects have been noticed when the third party is physically present or when the evaluation is recorded via audio recorder or video camera (Constantinou, Ashendorf, & McCaffrey, 2002, 2005). Thus, assessment results may be distorted if instead of using restraints, a guard or officer is present, or if the session is recorded.

The use of restraints during psychological assessment in prisons can only exacerbate these challenges. Attempting to complete a test that measures one's intelligence, memory and attention, among other domains, is a complex task in its own right. When inmates have the added complications of having to complete these tests without adequate space or privacy, restraints would likely further impede their performance in an already non-standardized assessment environment. Many examinees use their hands to help them think, communicate or relieve anxiety, but individuals who are restrained are challenged to do so. The use of restraints limits the ability to assess for certain domains of neurocognitive functioning, such as visual-motor skills, fine motor skills, and nonverbal intelligence (Vanderhoff et al., 2011). Specific tests that may be impossible to administer with restraints include finger tapping, grooved

pegboard, and grip strength. Moreover, third-party observers already negatively affect individuals' test results, and their scores are likely further impaired due to wearing restraints while being watched or recorded, perhaps due to embarrassment, shame, decreased motivation, or intimidation.

Professional ethics

Forensic examiners must adhere, to professional ethics when assessing prisoners or forensic psychiatric patients. For example, The Principles of Medical Ethics, governed by the American Psychiatric Association, dictates that psychiatrists should provide medical care 'with compassion and respect for human dignity and rights' (American Psychiatric Association, 2013). Some forensic examiners may feel that requiring examinees to wear wrist and/or ankle restraints is inconsistent with their duty to treat individuals with compassion and dignity.

With regard to ethics for psychologists, Standard 9.06 of the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017) requires psychologists to consider the purpose of the assessment, various test factors and test-taking abilities that might reduce the accuracy of their interpretations. For example, many forensic hospitals, prisons and jails fail to provide adequate conditions for taking psychological tests (Vanderhoff et al., 2011). Similarly, wearing handcuffs hinders test-taking ability for various tasks (e.g., Block Design on the WAIS-IV). The presence of a third party may also have unknown effects on test results. It is unknown whether psychologists routinely are considering Standard 9.06's intent when interpreting tests administered to forensic populations.

Furthermore, Standard 9.11 requires psychologists to maintain security of test materials to protect the integrity of tests (American Psychological Association, 2017). At times, it may be necessary to choose between using restraints and having a third party present for

safety purposes during the assessment. Third-party presence not only affects examinees' performances, but also gives the third party casual information about the observed tests, which may lead to further public leak of test items (Vanderhoff et al., 2011).

Another relevant standard is 1.02 (American Psychological Association, 2017), which requires psychologists to resolve conflicts that surface between the Ethical Principles of Psychologists and Code of Conduct and laws/regulations. For example, a psychologist may believe an examinee needs to have his/her handcuffs removed in order to complete a psychological test, but a corrections officer may refuse this action due to security reasons. It may be difficult or impossible for psychologists to convince law enforcement officers to allow the handcuffs to be removed in order for the examinee to adequately complete testing.

Finally, Principle E, Respect for People's Rights and Dignity (American Psychological Association, 2017), is especially relevant with this population. Prisoners and involuntarily committed patients have already lost many of their rights, and individuals in restraints experience further loss of autonomy and dignity. In accordance with this ethical principle, forensic examiners may need to consider alternatives (e.g., escort presence outside of evaluation room) to restraints in order to maintain prisoners' self-respect during forensic evaluations.

Involuntary medication as a form of restraint

Forcing psychiatric patients or prisoners to take sedating medications to control socially disruptive behavior, rather than to manage psychiatric symptoms such as psychosis, is often referred to as *chemical restraint* (Jarett, Bowers, & Simpson, 2008). Many people refuse to take prescribed medication because they feel the adverse side effects outweigh the benefits. Moreover, some people with psychiatric illness do not believe they

are mentally ill or are concerned about becoming addicted to the medication (Jarrett et al., 2008). Kinderman and Tai (2008) discussed arguments against involuntary medication. They purported that it is inherently wrong to force people to do something against their will, and that coercion pushes people away from the mental health field in addition to causing distrust of it. One patient recounted his unpleasant experience with neuroleptic medications: "The more I tried to think, the harder it was to think. The more I tried to move my body, the harder it was to move my body . . . it was incredibly intrusive" (Lavelle & Tusaie, 2011, p. 275). Holloway and Szmukler (2003) stated that physicians must believe that a patient poses a danger to self or others in order to force medication onto that person.

Greenburg, Moore-Duncan, and Herron (1996) investigated psychiatric patients' retrospective views of involuntary medication. Although the study only included 30 patients, the results are still telling. Sixty-percent of the patients were retrospectively in favor of having been coerced to take medication. On the other hand, 57% feared side effects, 30% believed nothing was wrong with them, 17% did not want to be told what to do, and 20% feared being weakened by the medication. Moreover, 43% of the sample did not believe physicians should be allowed to force medication. The surveyed patients described feeling fear, helplessness, anger and/or embarrassment at the time they were involuntarily medicated (Greenburg et al., 1996). Veltkamp et al. (2008) determined that allowing psychiatric patients in the Netherlands to select the type of treatment provided to them decreased the amount of negative emotional reactions, and also did not adversely affect patients' trust in the mental health field.

There are several notable legal cases in the United States related to whether or not the court can force involuntary medication upon an individual. For example, in *Washington v. Harper*, a prison inmate (Harper) who was

physically aggressive when not on psychiatric medication, was forced to take such medications against his will. When Harper sued alleging that the due process clause of the 14th Amendment was violated, the U.S. Supreme Court decided that he had to take the medication because he posed a danger to himself and others in the prison, and they found that the medication was in his best interest (*Washington v. Harper*, 1990). Another landmark case is *Riggins v. Nevada* (1992), in which the U.S. Supreme Court determined that a mentally ill individual cannot be forced to take medication for the sole purpose of establishing competence during court proceedings. A final significant case is that of *Sell v. United States*, regarding Dr. Sell, a dentist charged with Medicaid fraud. He was found incompetent to stand trial due to a delusional disorder, but he was not considered violent. Dr. Sell refused to take medication that could possibly restore him to competency. Though the U.S. Supreme Court ruled that he had a right to refuse medication, he was confined on a forensic psychiatric unit for seven years, which was longer than what he would have served in prison if found guilty (*Sell v. United States*, 2003). These cases suggest how medication might be viewed as a form of restraint, in that psychotropic medication is sometimes administered against a patient's will. However, refusal to take it may result in a longer confinement, as in the case of *Sell v. United States* (2003).

Psychologists need to consider whether they should examine individuals who have been chemically restrained/medicated, as sedating effects of the medication may decrease their performance on some tasks. Furthermore, the person's emotional reaction to the restraint may affect performance in unknown ways, including cooperation and effort level.

Forensic examiners and restraints

Only one publication specifically addressed the issue of forensic examiners conducting evaluations with inmates in restraints, and it

was from outside of the United States. Filho and Garrafa (2002) surveyed 49 forensic psychiatrists in Brazil to determine whether they kept their examinees in handcuffs during the evaluation. It is noteworthy that the escorting police officers usually recommended that the handcuffs not be removed, contending that the examinee was very dangerous. Furthermore, the police officers told the forensic examiners that if the handcuffs were removed, the examiners were responsible for any resulting escapes or assaults. Although it is unlikely in most jurisdictions within the United States that police officers would tell forensic examiners that they would be responsible for resulting escapes or assaults if handcuffs were removed, forensic examiners may feel obligated to comply with the recommendations of police officers/escorts, who lack knowledge about forensic evaluations. Of the surveyed forensic psychiatrists, 86% of them believed that there was at least one evaluation in which it was appropriate to keep the examinee handcuffed throughout the evaluation, and 77% had done so. They cited fear of escape or assault, the inflexibility of the police officers, and the poor security measures at the institution as reasons they had kept examinees handcuffed. Along a similar note, 53% felt pressured by the police officers and other staff to keep the examinees handcuffed. On the other hand, 22% of the forensic psychiatrists never evaluated the examinees while restrained, because they believed handcuffs limited the behavior of the examinees, as well as made them feel embarrassed and intimidated. Filho and Garrafa (2002) noted that almost half (43%) of the forensic psychiatrists indicated that the examinees rarely requested that their handcuffs be removed, and 35% reported that examinees had never asked them to be removed.

Other than this one study from Brazil, it is unclear how often forensic examiners experience fear during such evaluations. Certainly, history and personal factors of examiners lead some to be more fearful than others (and

maybe with certain types of patients). Of course, self-awareness is critical for mental health professionals who work with forensic examinees. These are questions that need further study, as do the feelings of the patients undergoing forensic evaluation while restrained.

Although there is very little published information directly related to assessing the appropriateness of restraints during forensic evaluations, the preceding literature may help forensic examiners decide best practices. By combining this literature with what is known about examinees in general, there are several possible implications of using restraints during forensic evaluations.

First, restrained individuals may not be able to satisfactorily complete some of the most important tests (e.g. WAIS-IV), which would diminish the validity and utility of the evaluation. There is a lack of norms and standardized assessment procedures for restrained individuals during forensic evaluations (Vanderhoff et al., 2011).

Furthermore, the use of restraints within a prison or psychiatric hospital may engender a feeling of additional degradation, which might be particularly concerning for individuals who have been historically discriminated against. Similarly, Herivel and Wright (2003) suggested that restraints within the criminal justice system may reinforce a 'sense of social and economic immobility among the disadvantaged, particularly African Americans and women' (p. 240). Thus, some individuals may feel that restraints are both a reminder of their abstract immobility within society and a form of double enslavement when they are already within a locked environment.

Another implication of using restraints during forensic evaluations is increased distrust of the forensic examiner who is perceived as already not on 'their side'. The literature suggests that this distrust could be exacerbated if the examinee is unable to exercise choice during the evaluation (Veltkamp et al., 2008). It may also be important for

forensic examiners to demonstrate that they trust examinees by allowing choice regarding restraints, if possible. If examinees feel trusted, they may be more willing to cooperate with the evaluation, which could increase effort and openness, and decrease exaggeration or malingering.

One should also consider the effect that restraints might have on social psychology factors, such as obedience, persuasion and social desirability. It is difficult to know whether these factors would result in examinees being more or less guarded, open and honest, but they are nevertheless important issues to contemplate when deciding whether or not to conduct forensic evaluations while an individual is restrained.

Practical considerations

Several important questions to consider when determining whether or not to conduct a forensic evaluation while the examinee is restrained include the following: Is the examinee considered dangerous? Does s/he have a recent history of violence toward others? Is there adequate staff to remain in close proximity to the evaluation area and adequately intervene if needed? Would a third-party presence negatively affect the test results? Will tests that require physical mobility be utilized? Are medications an appropriate alternative to physical restraints? Do circumstances allow the examinee to exercise his/her voice with regard to which restraints to use? Can the examinee choose medication instead of restraints? Is the examinee pregnant? Does the examinee have a history of sexual assault? Is the examinee a member of a historically disadvantaged group? Answers to each of these questions may affect decisions about conducting the evaluation and how one interprets the results.

In consideration of these questions, complacency regarding the evaluation of examinees in restraints needs to be questioned. This is the professional and ethical responsibility of the examiner. The above questions need to

be addressed, and alternatives to restraints must be considered. Allowing patients/inmates to voice their thoughts and feelings regarding restraints and their consideration of alternatives is one possible step in the right direction.

A primary goal of this paper is to offer recommendations based on the reviewed literature, with a particular focus on the United States. If safety does not preclude, it may be best to free the examinee of the restraints, but have an adequately trained staff member remain nearby, but outside of the assessment area. In this way, the examinee is physically both capable of completing any testing in accordance with current assessment standards/norms and less likely to experience psychological harm from wearing restraints during the evaluation. Furthermore, the forensic examiner can feel safer with the staff nearby. Indeed, Filho and Garrafa's (2002) survey indicated that the most frequently used approach by forensic examiners to 'protect themselves' was having a police officer either inside their office or directly outside of their office during forensic evaluations; this safeguard was employed by 77% of the respondents (p. 34). Finally, the forensic examiner can arrange to sit closer to the exit door to increase his/her ability to leave the room if necessary.

If restraints must be utilized for safety during the evaluation, the forensic examiner probably needs to have some discussion with the examinee regarding those issues that preclude removal of the restraints. This may help some with the development of rapport and trust during the evaluation.

If restraints are required only as result of facility policy or procedure that cannot be appealed, the examiner needs to decide whether to participate in that process. Institutional culture must be challenged at times for positive change to occur. The mental health professional is in a position to start the dialogue that could lead to systemic changes in the use of restraints during forensic evaluations.

Ethical standards

Declaration of conflicts of interest

Rachel C. Rock has declared no conflicts of interest

Clayton Shealy has declared no conflicts of interest

Martin Sellbom has declared no conflicts of interest

Ethical approval

This article does not contain any studies with human participants or animals performed by any of the authors.

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