

DEFERENCE ≠ ABDICATION: APPLICATION OF *YOUNGBERG* TO PROLONGED SECLUSION AND RESTRAINT OF THE MENTALLY ILL

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It is the sad reality that our prisons have become the new “institutions” for housing the severely mentally ill in the aftermath of the deinstitutionalization movement. Instead of compassionate medical treatment, these individuals are often isolated for long periods of time (seclusion) or tied down against their will (restraint) when they “fail to comply” with an order or “act out” in the corrections setting. Frequently, the very behavior triggering placement of mentally ill “prisoners” into prolonged and illegal seclusion and restraint is a manifestation of their illness(es), which is only exacerbated by the harsh conditions of confinement and a “corrections” environment, as opposed to a treatment- and rehabilitation-centered milieu. Indeed, they are often left without any medical supervision whatsoever, much less the minimally adequate treatment that the law requires.

This Article explores emerging thought and the legal underpinnings for challenging the status quo of the failure to protect the basic civil rights of confined mentally ill individuals. When challenged or otherwise subject to scrutiny, deference given under the law to clinical decisions in the corrections setting regarding the care and treatment of confined mentally ill individuals should not amount to the complete abdication of jurisprudential responsibility for ensuring equal protection of the law to those who need the protections of our

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Constitution the most. When it comes to unjustified and prolonged seclusion and restraint of severely mentally ill individuals, the authors of this Article believe that the medical and clinical professionals currently enlisted to provide their services to such mentally ill prisoners should not be given any deference to order prolonged seclusion and restraint as part of their so-called "clinical" decision-making.

INTRODUCTION

It is no secret that the prisons have become the new "institutions" for the severely mentally ill in the aftermath of deinstitutionalization. The confinement of the mentally ill to prison (which, as explained below, can occur in Massachusetts even if the individual has not been convicted of a crime) is nothing short of a moral disgrace. Moreover, even if a person with mental illness is able to find treatment, or is involuntarily committed, the Supreme Court only recently recognized that there was a corresponding obligation to provide care. In fact, it was not until 1982 that the Supreme Court, in *Youngberg v. Romeo*,¹ first acknowledged a mentally ill person's substantive civil rights under the Fourteenth Amendment to the Constitution.² Specifically, *Youngberg* held that civilly committed mental patients had the right to "reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by these interests."³

While the issues relating to the substantive civil rights due individuals suffering from mental illness are many, this Article focuses first on cases discussing the deference some courts have given to medical and clinical professionals in exercising their so-called "judgment" when it comes to the treatment of mentally ill patients and in particular their use (and overuse) of seclusion and restraint as a manner of "treatment" and, all too often, punishment. Thereafter, this Article will provide a brief analysis of the evolution of the emerging professional consensus that the use of prolonged seclusion and restraint on individuals with serious mental illness can never be justified as "treatment" and results in significant and sometimes permanent harm to a patient's mental health. Next, this Article will discuss how this emerging consensus of thought with respect to the use of prolonged seclusion and restraint should provide the catalyst through which the basic precepts of *Youngberg* can be reinvigorated for utilization to protect the most vulnerable of our society. Finally, this Article will discuss a pending action in the Superior Court of Massachusetts, where a judge has issued an injunction to prevent prolonged seclusion in line with the rationale supporting the *Youngberg* decision. Ultimately, the authors of this Article believe that the medical and

1. 457 U.S. 307 (1982).

2. *Id.* at 314-15.

3. *Id.* at 307.

clinical professionals enlisted to provide their services to the mentally ill should not be given any deference in their so-called “clinical” decisions when it comes to unjustified prolonged seclusion and restraint. Simply put, deference given to clinical decisions should not amount to complete abdication of jurisprudential responsibility for ensuring equal protection of the laws to those who need the protections of our Constitution the most.

In *Youngberg*, the Supreme Court acknowledged that those suffering from mental illness, and who have been involuntarily institutionalized, not only are entitled to confinement in safe conditions, but also that they are entitled to freedom from undue bodily restraint and to a right to “minimally adequate habilitation.”⁴ The Court further opined that if mentally stable criminals were entitled to such liberties under the Constitution, those (through no fault of their own) suffering from mental illness should be entitled to those same liberties and freedoms.⁵ In fact, the Court further noted that “[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.”⁶ Ironically, most of the recent case law centers on the use of solitary confinement in prisoners’ rights cases, as opposed to the rights of those subject to excessive undue restraint as civilly committed patients in state mental hospitals.⁷

The discussion and ultimate holdings rendered in *Youngberg* provide a relatively heightened level of substantive civil rights to involuntarily institutionalized individuals and are, no doubt, an important stride in equalizing the rights afforded to the mentally ill. However, after declaring the mentally ill individual’s right to freedom from undue bodily restraint and minimally adequate medical treatment, the *Youngberg* Court adopted the Third Circuit’s holding that “the Constitution only requires that the courts make certain that professional judgment in fact was exercised.”⁸ The *Youngberg* Court further limited its holding by stating that “the decision, if made by a professional, is presumptively valid . . . [unless the decision] is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”⁹ While it has been acknowledged by at least one court that this

4. *Id.* at 316, 319 (citing Brief for Respondent at 8, 23, 45, 457 U.S. 307 (1982) (No. 80-1429)) (“[W]e agree with his view and conclude that respondent’s liberty interests require the State to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint. In view of the kinds of treatment sought by respondent and the evidence of record, we need go no further in this case.”).

5. *Id.* at 316.

6. *Id.* at 321-22 (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)).

7. *Coleman v. Brown*, 922 F. Supp. 2d 1004, 1009 (E.D. Cal. 2013).

8. *Youngberg*, 457 U.S. at 321 (quoting *Romeo v. Youngberg*, 644 F.2d 147, 178 (3d Cir. 1980)).

9. *Id.* at 323.

standard could be considered ambiguous,¹⁰ it appears from cases that immediately followed that only the most egregious of situations (i.e., death) triggered the courts to determine that a professional had departed from a recognized standard to such a degree that he or she could be held liable for the damage done.¹¹

Sadly, the mentally ill patients being adversely affected by this holding are often completely unaware that the treatment they are being subjected to on a daily basis is abhorrent, unacceptable, and is such that no “normally” functioning individual would be subjected to it. Since the *Youngberg* decision, some courts have been missing the mark as to what circumstances require court intervention to hold these medical and clinical professionals liable for their actions (and often, inaction).¹² At what point do we say “enough is enough” when giving clinical and medical professionals such great deference? When does such deference amount to a complete abdication by the trier of fact with respect to making a case-specific factual inquiry as to the reasonableness of the clinical judgment being challenged?

It would be contrary to public policy not to accord some level of deference to a qualified professional in making decisions regarding the treatment of mentally ill patients.¹³ It would be unreasonable to expect the courts to be tasked with the responsibility of holding a hearing every time a doctor was required to make a judgment call to ensure that the patient’s rights were being protected. There are situations in which it is arguably more acceptable and understandable that certain freedoms would be denied to the mentally ill (such as when an emergency exists and when there is a real risk the patient will harm herself or others). For example, the Second Circuit rationally found that there was no breach of constitutional rights despite a patient being administered psychotherapeutic drugs against his will (which would normally violate a person’s rights) where he had first been examined by five separate doctors over the course of his hospitalization, and all of those doctors came to the same conclusion: that the administration of such drugs was medically necessary where the patient “made threatening statements to his family, patients, and staff, and exhibited delusions and paranoid ideation.”¹⁴

In theory, providing clinical and medical professionals who are on the ground and interfacing with patients with the leeway to do their job in the best way they know how, consistent with their experience and training, provides an

10. *Hopper v. Callahan*, 562 N.E.2d 822, 826 (Mass. 1990).

11. *See, e.g.*, *Dolihite v. Maughon*, 74 F.3d 1027, 1046 (11th Cir. 1996); *Houghton v. South*, 965 F.2d 1532, 1536 (9th Cir. 1992); *Doe v. Gaughan*, 808 F.2d 871, 884 (1st Cir. 1986).

12. *Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993) (“Professional judgment . . . creates only a ‘presumption’ of correctness; welcome or not, the final responsibility belongs to the courts.”).

13. *See, e.g.*, *Rogers v. Okin*, 738 F.2d 1, 8 (1st Cir. 1984).

14. *Kulak v. City of New York*, 88 F.3d 63, 75 (2d Cir. 1996).

increased benefit to all within their care. With respect to severely mentally ill individuals, it is not a far stretch to reason that because these individuals are incapable of caring for their own basic needs, they are equally incapable of making reasonable decisions related to their own medical care. Of course, the corollary is that those charged with stepping in to provide that care should do so responsibly.

This analysis assumes that clinical decisions are made in well-staffed mental health facilities, which is often not the case. For example, in Massachusetts, the maximum security mental health hospital at the notorious Bridgewater State Hospital (Bridgewater), which is administered by the Commonwealth's Department of Corrections, is a facility where the vast majority of patients are not serving criminal sentences. These patients are often sent there for "evaluations" (which inevitably conclude that the patient is either incompetent or lacked criminal responsibility, but the patient still can be committed indefinitely to Bridgewater) from the Commonwealth's Department of Mental Health, frequently after being charged with "crimes" that are manifestations of their disabilities. A patient throwing a chair is not uncommon in mental health facilities, but in Massachusetts, it also is a technical felony—assault with a deadly weapon. Charging patients who, by definition, cannot possibly have the necessary mens rea required for culpability has been a convenient method to "dump" more challenging patients into Bridgewater. Unfortunately, Bridgewater has one-third of the clinical staffing that other comparable civil mental health facilities have. Once at Bridgewater, patients are subjected to the use of prolonged seclusion and restraint where decisions are based, in large part, on the lack of resources at the facility. More often than not, it is untrained correctional officers at Bridgewater that initiate the seclusion or restraint—not clinical staff. With a patient population of approximately 300, Bridgewater patients received an aggregate 148,000 hours in seclusion in 2013, whereas the entirety of the Commonwealth's Department of Mental Health secluded 625 patients for less than 3000 hours over the same period of time.

The problem is that patients suffer brutal injuries and even death from harsh conditions of confinement because clinical judgments are often affected by extraneous factors—inadequate resources, deference to direct care staff with limited training, and administrative convenience. Stated simply, it is often more convenient to lock a patient in a seclusion room than address his or her underlying behaviors. Regrettably, some federal decisions post *Youngberg* have shied away from making the necessary fact-specific inquiry to support reasonable challenges to such irresponsible behavior, instead summarily declaring that with due deference given to the medical and clinical professionals under *Youngberg*, the challenged behavior must go unchecked.¹⁵

15. *But see* Lombard v. Eunice Kennedy Shriver Center for Mental Retardation, Inc., 556 F. Supp. 677, 679 (D. Mass. 1983) (holding, seven years before *Hopper*, that "the

In an extremely disturbing decision rendered by the Eleventh Circuit, it was held that professionals of the Eufaula Adolescent Center¹⁶ (a mental health facility where the plaintiffs' son had been involuntarily committed) did not act outside the purview of acceptable professional judgment simply because plaintiffs' expert affidavit "suffer[ed] from several flaws," which failed to establish the degree to which the professionals allegedly departed from acceptable professional practices.¹⁷ In this case, a patient was left with an unaltered treatment plan despite numerous episodes of self-mutilation, erratic behavior, and verbal threats of suicide, all of which were documented and noted by those working with him.¹⁸ The same patient was thereafter "found hanging in his . . . closet by a shoestring" and ultimately rendered severely brain damaged.¹⁹ In addition to the court's seeming disregard for plaintiffs' expert affidavit establishing a clear departure from acceptable professional standards, the court ultimately determined that the defendants could not be held liable because the facts of the case were not as egregious as in others decided by the same court.²⁰ One example the court gave was that of a case in which a psychiatrist instructed staff to discontinue a patient's antidepressant medication without having the patient monitored thereafter for adverse effects.²¹ The patient died in a segregation cell nine days before her scheduled release. In another comparison, the court reviewed a case in which a patient was not given the proper medication for his manic depression.²² The patient thereafter "slashed his forearm . . . gouged his left eye out . . . cut his scrotum, losing both testicles, and so severely damaged his right eye that he lost his sight in it."²³

There are a multiple flaws in this decision and with the degree of deference it grants to the state. First, it appears that, to show a substantial departure from reasonable professional judgment, the ultimate price must be paid by the mentally ill patient. Apparently, the mentally ill patient rendered severely brain-damaged as a result of the substantial departure from reasonable professional judgment is less egregious than the mentally ill patient who died in her segregation cell after her antipsychotic medications were abruptly discontinued.²⁴ Second, if not death, it is entirely absurd that it takes a patient blinding and sterilizing himself, in addition to other self-inflicted injuries as a result of being improperly medicated, for a court to step in and recognize that

Fourteenth Amendment imposes an affirmative obligation on the state to provide adequate medical care for involuntarily committed residents of state mental institutions").

16. Located in Alabama.

17. *Dolihite v. Maughon*, 74 F.3d 1027, 1046-47 (11th Cir. 1996).

18. *Id.* at 1036-39, 1045.

19. *Id.* at 1039.

20. *Id.* at 1048-49.

21. *Id.* at 1048 (citing *Greason v. Kemp*, 891 F.2d 829 (11th Cir. 1990)).

22. *Id.* at 1049 (citing *Waldrop v. Evans*, 871 F.2d 1030 (11th Cir. 1989)).

23. *Id.* (quoting *Waldrop*, 871 F.2d at 1032).

24. *Id.* at 1048.

there has been a departure from proper professional judgment to hold those charged with the patient's care accountable.

While the Ninth Circuit conforms to the holdings of *Youngberg*, the court still fell woefully short in addressing conduct that a reasonable person would never tolerate with respect to his own treatment. In a 1992 decision, the court held that when determining the liability of a mental health professional, "courts must restrict their inquiry to two questions: (1) whether the decisionmaker is a qualified professional entitled to deference, and (2) whether the decision reflects a conscious indifference amounting to gross negligence, so as to demonstrate that the decision was not based upon professional judgment."²⁵ Despite this attempt at standardization, it unfortunately took a non-violent patient being murdered as a result of a hospital's failure to adequately monitor penal patients with "demonstrated homicidal propensities"²⁶ for the court to step in and take a hard look at the facts of the case to determine whether there might indeed be something wrong with the professional judgment, or lack thereof, being exercised by an institution.²⁷

On the other end of the spectrum, in 1996, the Massachusetts Supreme Judicial Court considered the circumstances under which a patient died while in seclusion at the Solomon Carter Fuller Mental Health Center (Fuller).²⁸ The plaintiffs, claiming the denial of substantive due process rights, asserted violations of 42 U.S.C. § 1983 and also asserted state law claims for wrongful death, medical malpractice, and negligence. Each defendant moved for summary judgment on the federal civil rights claims. A judge of the Massachusetts Superior Court allowed the motion, without objection, as to the claims against defendants Callahan²⁹ and Gibson³⁰ in their official capacities. He rejected, however, the assertion of each defendant that he was entitled to qualified immunity from the remaining § 1983 claims, concluding that Hopper had constitutional rights that were clearly established at the time of the alleged violations and that these rights may have been violated. Then, applying the standard for determining personal liability under § 1983 stated in *Youngberg*, the judge concluded as to each defendant that there was a genuine dispute of material fact as to whether that standard was violated and that, therefore, summary judgment was not warranted on the § 1983 claims. The defendants then sought interlocutory appellate relief from the denial of their summary judgment motions.

25. *Houghton v. South*, 965 F.2d 1532, 1536 (9th Cir. 1992).

26. *Estate of Connors v. O'Connor*, 846 F.2d 1205, 1206-07 (9th Cir. 1988).

27. *Id.* at 1208-09.

28. *Hopper v. Callahan*, 562 N.E.2d 822 (Mass. 1990).

29. Commissioner of the Massachusetts Department of Health at the time.

30. Superintendent and Area Director of the Solomon Carter Fuller Mental Health Center at the time.

The facts surrounding the plaintiff's death in *Hopper* are fairly straight forward: she was admitted to Fuller involuntarily due to exacerbated symptoms of schizophrenia.³¹ Thereafter, she complained of severe abdominal and genital pain, and refused to wear clothes.³² In response to this, the plaintiff was placed into seclusion where she was only seen once briefly, hours after the initial seclusion order was signed, in violation of Department of Mental Health policies.³³ After being in seclusion for almost twenty-four hours, the plaintiff was discovered dead in the seclusion cell.³⁴ On appeal, the Commonwealth's highest court first acknowledged that seclusion of the plaintiff would "be justified only if there was an emergency or medical necessity requiring that seclusion."³⁵ The court also took care to mention that approximately three months prior, another patient had died in the same seclusion cell, and "[a]n investigation of the earlier death found deficiencies in medical and nursing supervision and training at Fuller."³⁶ The court ultimately affirmed the trial court's denial of the physicians', psychiatrists', and supervisors' motions for summary judgment. As to the § 1983 claim, the court held that the plaintiff had a clearly established federal right to receive adequate medical care and not to be unduly restrained. Moreover, the court held that the physicians were not entitled to summary judgment because disputed issues of fact existed regarding the propriety of their seclusion orders and the adequacy of their treatment of the plaintiff. Further, while the *Hopper* court ultimately decided that the record was inadequate to determine whether the psychiatrist departed from the standard of care, it did hold that the two attending doctors "could be found to have applied no medical judgment at all" when they completely forwent their responsibility to the plaintiff to provide minimally adequate medical care, as is the plaintiff's right under *Youngberg*.³⁷ Thus, the *Hopper* court reestablished the basic tenets found in *Youngberg*; namely, that an involuntarily committed psychiatric patient has a clearly established federal due process right (a) to essential medical care and (b) not to be unduly physically restrained.

More recently, the First Circuit addressed the issue of deference given to clinical judgment in the prisoner rights case of *Kosilek v. Spencer*.³⁸ In *Kosilek*, the First Circuit affirmed that transgender inmates have a constitutional right to access transition-related care, including gender-confirming surgeries, while incarcerated. On appeal, the Massachusetts Department of Correction (DOC) attacked the district court's decision, claiming that the court erred in finding

31. *Hopper*, 562 N.E.2d at 827.

32. *Id.*

33. *Id.*

34. *Id.* at 828.

35. *Id.* at 826.

36. *Id.* at 828.

37. *Id.*

38. 740 F.3d 733 (1st Cir. 2014).

that the DOC's decision not to provide Kosilek sex reassignment surgery constituted inadequate medical care in violation of the Eighth Amendment and the precepts found in *Youngberg*. In disposing the DOC's appeal, the *Kosilek* court stated that it is mindful of the "difficult tasks faced by prison officials every day. But as the Supreme Court has cautioned, while sensitivity and deference to these tasks is warranted, '[c]ourts nevertheless must not shrink from their obligation to enforce the constitutional rights of all persons, including prisoners.'"³⁹ Indeed, the *Kosilek* court correctly noted that because "the trial judge had the opportunity to preside over two lawsuits involving the same players and similar allegations, to hear evidence in this case over the course of a twenty-eight-day trial, to question witnesses, to assess credibility, to review a large volume of exhibits . . . [he] was well-placed to make the factual findings he made, and there is certainly evidentiary support for [his] findings."⁴⁰ Those "findings" ultimately trumped the defendants' argument that they should be given great deference in their clinical decision to ignore Kosilek's civil right to minimally adequate medical care, even in the context of a prison."⁴¹ Indeed, utilizing a fact-specific inquiry approach to claims that clinical deference should be paramount ensures, at a minimum, some modicum of judicial supervision over questionable clinical and medical care. Inapposite to the Eleventh and Ninth Circuit cases discussed in this Article, the First Circuit has been making this fact-specific inquiry with respect to the clinical deference defense for some time. "Indeed, when it comes to constitutional rights, none of the professionals ha[ve] the last word. Professional judgment, as the Supreme Court has explained, creates only a 'presumption' of correctness; welcome or not, the final responsibility belongs to the courts."⁴²

Since *Youngberg* and *Hopper*, courts have begun to recognize the dangers posed by the confinement of mentally ill prisoners to prolonged seclusion. It cannot be disputed that the emerging consensus is that there is no professional basis in subjecting prisoners to prolonged isolation.⁴³ With respect to prisoners, courts have recognized that placing them into prolonged isolation puts them at a particularly high risk for suffering severe injury to their mental health and, as one court put it, can be "the mental equivalent of putting an asthmatic in a place with little air to breathe."⁴⁴ In fact, the Eastern District of California recently opined that it has been well-established that the court actually has a duty to step in and intervene where punishment is found to be cruel and unusual and that it

39. *Id.* at 772 (quoting *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011) (internal quotation marks omitted)).

40. *Id.* at 773.

41. *Id.*

42. *Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993) (quoting *Youngberg v. Romero*, 457 U.S. 307, 323 (1976)).

43. See, e.g., Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325 (2006).

44. *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

“may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration.”⁴⁵ To the extent that prisons (places that house those who have committed crimes and arguably deserve to be punished) are being held to such a standard, so too should this standard be applied to institutions that house the involuntarily committed where these incapacitated patients are no less human than a “normally functioning” prisoner. Moreover, this same standard should be applied to involuntarily committed patients since courts have held that those similarly situated in confinement not designed to punish are entitled to better conditions than those who are incarcerated for having committed crimes.⁴⁶

In addition, professional associations have, in recent years, become more vocal about recognizing the dangers of prolonged seclusion. The American Bar Association (ABA) has stated that prisoners diagnosed with serious mental illness should not be placed in isolation for longer than three to four weeks because of its damaging effects.⁴⁷ Further, the American Psychiatric Association’s Position Statement on Segregation of Prisoners with Mental Illness states that “[p]rolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential [for] harm to such inmates.”⁴⁸

Even the Federal Register acknowledges that restraint or seclusion of a mentally ill patient is only appropriate to the extent that there is no better way to protect the patient and those around him or her from harm.⁴⁹ In Massachusetts, use of seclusion and restraint is only acceptable to the extent that there is an emergency situation in which the patient has harmed or presents a serious threat of harm to himself or others.⁵⁰ The *Hopper* case discussed above provides an excellent example of how the court can and should step in when automatic deference given to medical professionals would result in extreme danger for the civilly committed, mentally ill. As noted above, the patient in *Hopper* presented exacerbated psychosis.⁵¹ However, there was no indication that the patient was in a position to cause harm to herself or to others. In fact, quite the contrary was the case. She was in excruciating pain

45. *Coleman v. Brown*, No. CIV. S-90-520 LKK/DA (PC), 2014 WL 14009964, at *5, (E.D. Cal. Apr. 10, 2014) (quoting *Brown v. Plata*, 131 S. Ct. 1910, 1928-29 (2011)).

46. *Youngberg*, 457 U.S. at 321-22 (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)).

47. AM. BAR ASS’N, STANDARDS FOR CRIMINAL JUSTICE: TREATMENT OF PRISONERS, §§ 23-1.0(o), 23-2.8(a) (2011).

48. AM. PSYCHIATRIC ASS’N, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (2012).

49. 42 C.F.R. § 482.13(e)(2) (2012).

50. MASS GEN. LAWS ANN. ch. 123, § 21 (West, Westlaw through 2014 Sess.); see also *Hopper v. Callahan*, 562 N.E.2d 822, 826 (Mass. 1990); *O’Sullivan v. Sec’y of Human Services*, 521 N.E.2d 997, 1000 (Mass. 1988).

51. *Hopper*, 562 N.E.2d at 827.

due to complications from an ectopic pregnancy, and she was placed in seclusion because she refused to wear clothes and to get up off of the floor.⁵² The court specifically acknowledged that this was not an emergency situation that would reasonably constitute the use of seclusion.⁵³ Moreover, the defendants in *Hopper* allowed the patient to remain in seclusion, without the presence of an emergency situation, for more than five hours after the original seclusion order had expired without authorization.⁵⁴ In reversing summary judgment for the defendants at the trial level, the *Hopper* court correctly held the defendants open to accountability for the patient's death, even going so far as to note that the defendants were not able to hide behind their allegation that they were unaware that their acts or omissions had violated the patient's civil rights to freedom from undue restraint and minimally adequate medical care.⁵⁵

Massachusetts is well-equipped to turn the tide on these sorts of cases. As noted by the Commonwealth's highest court in 1985, the Massachusetts civil rights law,⁵⁶ like other civil-rights statutes, is remedial.⁵⁷ Thus, the court found "it is entitled to liberal construction of its terms."⁵⁸ As noted by the *Batchelder* court, the legislature enacted the state equivalent to 42 U.S.C. § 1983 to provide a remedy for deprivations of civil rights that extends "beyond the limits of its Federal counterpart."⁵⁹ The point is that states can and should go further to protect mentally ill patients under their own civil-rights statutes and state constitutions from the use and overuse of prolonged seclusion and restraint. Where a state's own constitution and laws provide for greater civil liberty protections to its citizens than do the federal counterparts, there is no reason to be bound on a state level by federal jurisprudence limiting vindication of a mentally ill patient's civil rights.

With respect to applying the precepts of *Youngberg* in a more progressive fashion, Massachusetts courts are currently being presented with the opportunity to set yet another example for other states to follow as they have done on so many other issues considered to be of great social importance.⁶⁰ A case currently⁶¹ being prosecuted in Norfolk County Superior Court involves

52. *Id.* at 822, 827.

53. *Id.* at 828.

54. *Id.*

55. *Id.* at 825.

56. MASS. GEN. LAWS ANN. ch. 12, §§ 11H-I (West, Westlaw through 2014 Sess.).

57. *Batchelder v. Allied Stores Corp.*, 473 N.E.2d 1128, 1130-31 (Mass. 1985).

58. *Id.* at 1130.

59. *Id.*

60. *See, e.g., Goodridge v. Dep't of Pub. Health*, 798 N.E.2d 941 (Mass. 2003) (striking down a law purporting to limit marriage to heterosexual couples); *Fountas v. Comm'r of the Dep't of Revenue*, 922 N.E.2d 862 (Mass. App. Ct. 2010) (unpublished table decision) (affirming trial court's dismissal of challenge to the Commonwealth's Health Care Reform Act, a predecessor to the federal Affordable Care Act).

61. As of the date of submission of this Article, the case is live.

the legal obligation that the defendants (both the Commonwealth of Massachusetts and institutional defendants) have to not only three named plaintiffs, but also to approximately 175 other similarly situated “civilly committed” patients at Bridgewater State Hospital (Bridgewater). All of these plaintiffs are similar: they were not confined to Bridgewater as a result of actually having been convicted of a crime; rather, they are involuntarily “civilly committed” and subject to harsh conditions of confinement and inadequate medical care. They all present mental disabilities ranging from severe intellectual deficits to autism and schizophrenia, disabilities that both require and would benefit from adequate medical care. Finally, all of these plaintiffs are entitled to protection from unlawful government action and the full protections of the Massachusetts Seclusion and Restraint law,⁶² the regulations that Bridgewater itself has promulgated,⁶³ and the protections secured by actions brought under 42 U.S.C. § 1983 (and state equivalents) as established in *Youngberg*.⁶⁴

In its recent decision regarding one plaintiff’s (John Doe) motion for preliminary injunction, the court found that there was a likelihood of success on the merits with respect to several of the plaintiff’s claims, including that the plaintiff was being illegally secluded and/or restrained in non-compliance with applicable statutes, including his right to be free from undue bodily restraint as provided for in *Youngberg*.⁶⁵ However, the defendants have already started to argue that professional and clinical judgment with respect to the adequacy of Mr. Doe’s medical care while at Bridgewater should be given great deference. This is a man who has, notwithstanding serious mental illness—with diagnoses that include autism, intellectual disability, and schizophrenia—thanks to the professional and clinical judgment of Bridgewater staff spent over 1300 hours in seclusion over a course of less than six months. He also has been placed in isolated locked corridors while other “patients” enjoy access to the television room. Incredibly, not only has Mr. Doe suffered extended use of seclusion, but also he is kept in seclusion although the supposed emergency that placed him in seclusion has ended. Bridgewater records for Mr. Doe’s “treatment” show his continued seclusion for drooling, yelling, or being unresponsive to interview questions. Upon deposing one of Mr. Doe’s “treating” clinicians, it became readily apparent that Bridgewater’s default position is to allow patients to remain in seclusion despite there being no emergency situation that would warrant such treatment. In fact, in cases where the secluded patient refuses to communicate with the clinician while in seclusion, the clinician kept the patient

62. Mass Gen. Laws Ann. ch. 123, § 21 (West, Westlaw through 2014 Sess).

63. Use of Seclusion and Restraints for Bridgewater State Hospital, 103 BSH 651 (Mass. Dep’t of Corr. 2012) (on file with author).

64. See *Minich v. Spencer*, No. NOCV201400448, 2014 WL 3816980 (Mass. Sup. Ct. 2014).

65. *Id.* at *1-2.

in continued seclusion even though it was obvious that the emergency that originally led to the seclusion had passed. Moreover, the deposed clinician admitted that due to severe understaffing at Bridgewater, it was necessarily true that seclusion and restraint hours increased; with less staff available to actually treat patients, the overworked and undermanned staff simply resort to increasing use of seclusion and restraint to address any behavior Bridgewater staff deem inappropriate.

In light of an emerging consensus on the devastating effects of solitary confinement on individuals,⁶⁶ coupled with oftentimes more comprehensive state versions of § 1983 statutes, perhaps the only real solution to the problem at hand is to create favorable precedent within state courts for the argument that the *Youngberg* deferential standard has no applicability when it comes to treatment of the mentally ill and, specifically, the (over) use of seclusion and restraint to “treat” these individuals. Where seclusion and restraint practices are being utilized illegally and repeatedly, a court could make a determination that the clinical or medical professional judgment being made with respect to the undue bodily restraint is *not* entitled to deference.⁶⁷ Certainly such a determination could be rationally supported by reference to more expansive state versions of 42 U.S.C. § 1983 (as was done in *Batchelder v. Allied Stores Corp.*), broader protections provided under state constitutions, or even state agency regulations concerning the use of seclusion and restraint of the mentally ill.⁶⁸ Where a confined mentally ill individual’s civil liberty rights are being infringed, does it make sense to give those infringing such rights the benefit of the doubt under the deference to clinical judgment referred to by the *Youngberg* Court? Where it is now undisputed that prolonged seclusion and restraint is wholly indefensible, whether termed “treatment” or otherwise, the authors of this Article believe the answer is an unequivocal “no.”

66. See, e.g., Grassian, *supra* note 43.

67. See, e.g., Cameron v. Tomes, 990 F.2d 14, 20 (1st Cir. 1993) (“Indeed, when it comes to constitutional rights, none of the professionals ha[ve] the last word. Professional judgment, as the Supreme Court has explained, creates only a ‘presumption’ of correctness; welcome or not, the final responsibility belongs to the courts.” (quoting *Youngberg v. Romero*, 457 U.S. 307, 323 (1982))).

68. For example, in addition to the state’s seclusion and restraint law, Bridgewater has implemented its own regulations, including 103 BSH § 651 (2012), that cover, among other topics, the “appropriate” use of and, importantly, the circumstances requiring the discontinuation of the use of seclusion and restraint on individuals committed to the facility.

