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Federal Standards for Use of Restraint and Seclusion

Nearly two years after *The Hartford Courant* highlighted an appalling number of deaths among children and adults with a mental illness from the use of restraints and seclusion across the country, Congress has set a protective floor of national standards that must be met by a variety of psychiatric treatment facilities. The new standards will not, however, preempt federal and state laws and regulations that are more protective of patients' rights, such as the rules promulgated last year by the Health Care Financing Administration (HCFA) for hospitals participating in the Medicaid or Medicare program.

The new protections establish two sets of standards, depending on the type of facility. One applies to "non-medical community-based facilities for children and youth." The facilities will be defined in regulations and will include group homes and the like. The other set applies to any health care facility that receives federal appropriated funds, such as a public or private general hospital, an intermediate-care facility or other health care facility. All must comply with the general principle of protecting and promoting the right to be free from restraints and seclusion for purposes of discipline or convenience.

The statute requires that seclusion and restraint be used only:

- to ensure the physical safety of the individual or others; and
- subject to a written order by a physician or other licensed practitioner permitted by the facility and state law. In most cases, the written order will be obtained soon after the restraint or seclusion is initiated by staff.

Medications and drugs that are used to control behavior and are not a standard treatment for the individual's condition are considered a form of restraint. Accordingly, they are subject to the same requirements.

Deaths Must Be Reported Promptly

Facilities must also report, to agencies designated by the Secretary of the Department of Health and Human Services each death that occurs while a resident is restrained or in seclusion and each death that occurs within 24 hours after the person has been released from the restraints and seclusion or where it is reasonable to assume the death was the result of the restraints and seclusion. The designated agencies are likely to include protection and advocacy systems, which have unique federal authority to investigate and legally pursue instances of abuse and neglect in facilities. The notification must be provided within 7 days of the death of the resident.

In addition, the Secretary, within one year of enactment, must issue rules on appropriate training in the use of restraints and seclusion, in alternatives to their use and in adequate facility staffing.

Special Restrictions in Facilities for Children

Use of restraints and seclusion in "non-medical, community-based facilities for children and youth" is:

- limited to emergency situations to protect the immediate physical safety of the person or others; and
- imposed only by individuals trained and certified by a state-recognized body in a list of competencies, including the physiological and psychological impact of restraint and seclusion, in monitoring physical signs of distress and in the prevention of restraint and seclusion use. However, an interim requirement was included to provide protections until a state develops a certification process for the competency areas. During this period, a supervisory or senior staff person, trained in restraint and seclusion and competent to make a face-to-face evaluation, will make a patient assessment within one hour of the initiation of restraint or seclusion and continue to monitor the use for its duration.

In these facilities, time-out and physical escorts are not defined as seclusion or restraint. Accordingly, the new requirements do not apply to these procedures. However, for this limited group of youth-serving facilities, mechanical restraints and drugs are prohibited as a form of restraint and seclusion can only be used when a staff member is continuously monitoring face-to-face.

Reporting of deaths that occur must be made by each facility to the appropriate state licensing or regulatory agency, determined by the Secretary of the Department of Health and Human Services. The notification must be made within 24 hours of the death.

Furthermore, within six months of enactment, the Secretary must release regulations regarding national training standards and within a year states that license these facilities are required to develop a set of monitoring requirements on behavior management.

Reference

Public Law 106-310, Children's Health Act of 2000 (Sections 3207 and 3208)

These restraint and seclusion requirements amend Title V of the Public Health Service Act (42 USC 290aa et seq.) by adding Section 591 and 595. You may access the law online.