

October 29, 2002

**STATEMENT OF
THE NATIONAL ASSOCIATION OF
STATE MENTAL HEALTH PROGRAM DIRECTORS**

Andrew D. Hyman, Director of Government Affairs and Legislative Counsel

My name is Andrew Hyman. I am here today representing the National Association of State Mental Health Program Directors (NASMHPD) and on behalf of Dr. Robert Glover, NASMHPD's Executive Director.

NASMHPD represents the \$23 billion public mental health systems that serve 6.1 million people in 50 states, four territories, and the District of Columbia. Our members are the directors of the state mental health systems. In that capacity, our members, among other responsibilities, administer 230 state psychiatric hospitals serving approximately 50,000 patients on any given day. In general, these patients are among the most severely ill and difficult to treat of all people with mental illnesses. Most are poor and uninsured.

In the mid-1990s, NASMHPD identified the reduction of seclusion and restraint as a major policy goal. Then in July 1999, in the wake of significant attention being brought to the issue by advocates throughout the country, NASMHPD adopted a position statement declaring that seclusion and restraint "are safety interventions of last resort and are not treatment interventions." Moreover, in the statement NASMHPD articulated its commitment to the goal of "preventing, reducing, and ultimately eliminating" the use of these interventions. Consequently, state mental health agencies have initiated a range of activities that has resulted in the dramatic reduction in the use of restraints and seclusion in psychiatric facilities. These efforts should be enhanced and expanded, for there is so much more to be accomplished.

We understand that the focus of this town hall meeting is on a single provision contained in the Interim Final Rule on Conditions of Participation for hospitals, namely, the requirement that a face-to-face evaluation be conducted by a physician or licensed independent practitioner within one hour of the initiation of the intervention. In general, state psychiatric hospitals are able to meet this requirement. Because restraints and seclusion always carry significant risk of injury – both physical and psychological – we support this provision and emphasize that such interventions, on the rare occasions they are used, must be terminated as soon as possible.

We hope that CMS' efforts to review its seclusion and restraint policies, however, will not be limited to a discussion of the one-hour rule. While regulatory requirements are a necessary component of ensuring safety and promoting patients' rights, our experience and research clearly demonstrate that reducing the use of these interventions requires a fundamental change in the coercive culture that has dominated many institutions for decades. The federal government may play a vital role in facilitating this culture change. Indeed, the identification of seclusion and restraint reduction as a priority issue for the

Substance Abuse and Mental Health Services Administration suggests that it is prepared to do so.

But what exactly does this mean?

First, virtually every success story of facilities dramatically reducing the use of restraints and seclusion – and there are many – begins with leadership at the highest levels sending the unambiguous message that these measures are treatment failures that can and must be prevented. CMS can exercise this leadership by collaborating with SAMHSA to develop and implement a comprehensive strategy to reduce restraint and seclusion use in all settings. Although this strategy should include federal rules protecting patients' rights, it must also include high-profile statements identifying the reduction of restraints and seclusion as an Administration priority; oversight to ensure compliance with the law; and technical assistance to assist mental health systems and facilities achieve the goal.

Second, the Administration should support research and data collection efforts designed to identify and evaluate best practices in reducing and eliminating the use of restraints and seclusion. Experts in this area agree on a broad range of effective practices, including the following: (1) comprehensive assessments when an individual is admitted to a hospital to identify histories of trauma, effective calming techniques, and de-escalation strategies; (2) oversight at the highest levels of management to hold staff accountable whenever restraints or seclusion are used; and (3) debriefings involving staff and patients as soon as possible after the use of these interventions. However, there remains a lack of data about the effectiveness of numerous other potentially promising techniques and related policies that might contribute to seclusion and restraint reduction. Additional research also would inform our ability to eliminate the use of seclusion and restraint among populations with special needs or presenting unique safety issues, such as forensic patients, individuals with co-occurring mental illnesses and mental retardation or developmental disabilities, and adolescents.

Having issued interim final rules addressing seclusion and restraints in hospitals and residential treatment facilities and facing the task of engaging in additional rulemaking pursuant to the Children's Health Act of 2000, the Department of Health and Human Services is in a unique position to undertake a comprehensive strategy that could achieve the goal of reducing and ultimately eliminating the use of these coercive and damaging interventions. NASMHPD and the state mental health agencies are eager to work in partnership with you if you assume this challenge. Thank you for the opportunity to provide this brief statement.