INTRODUCTION

The following model restraint statute is offered as a comprehensive attempt to incorporate current progressive professional and legal standards regarding the use of restraint and seclusion into a legislative or regulatory format. We have tried to address all the aspects of restraint that we believe a state should regulate. To accomplish this, we have drawn extensively on professional standards, existing and proposed laws and regulations (including, particularly, statutes in California and Texas, and regulations in Pennsylvania and Massachusetts), as well as findings by national professional groups such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Association of State Mental Health Program Directors (NASMHPD), and standards promoted by the Department of Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA). Throughout the model we indicate the source of the language or concept. We have also drawn on our own experience in reviewing records of hundreds of restraint episodes, interviewing and advocating for individuals who have been restrained, and discussing restraint policies and practices with clinicians, administrators and policy makers.
An expressed purpose of the model statute is to substantially reduce and even eliminate the use of restraint. The model is also designed to ensure that in the rare occasions when restraint may be used, it is used in a manner that, to the fullest extent possible, ensures the safety and health of the individual being restrained and the staff implementing the restraint, and that genuine and thorough debriefing realistically reduces the chance that it will be used on the individual in the future. Finally, the model seeks to ensure a fully transparent system that is open to meaningful oversight by administrators, consumers, family members, and advocates. Protection and Advocacy systems may find this model helpful in fashioning new legislation or reforming existing laws. If legislative action is not possible, the model may be useful in drafting regulations.

WHAT TO EXPECT

Although there is a potent and compelling movement nationally for the reform of restraint practices, advocates should be prepared to experience strong and powerful opposition to their efforts to mandate reform through statutory or regulatory change. Some will object to encoding new practices in the law, others will object that implementation (particularly data collection) will be too expensive, employee unions may express fears that reducing the use of restraint would reduce their revenue, and other stakeholders may oppose the imposition of new requirements.

2 Other helpful materials on restraint and seclusion can be found in the members only section of the NDRN website. Advocates may find a chart comparing the several relevant federal statutes prepared by Beth Mitchell of Advocacy, Inc., the Texas, to be particularly useful. Also, CPR has prepared a checklist to evaluate restraint records that references the federal and JCAHO standards through out. Both documents should be available at www.NDRN.org.

3 Inasmuch as professional and legal standards regarding the use of restraint are the subject of considerable debate and discussion, it is likely that changing ideas will warrant modification of this model statute. Comments and suggestions may be addressed to the author.

4 The path of this reform is well known. It began with the extraordinary series on restraint deaths in the Hartford Courant. That series led to Congressional action and changes in rules at the Center for Medicare and Medicaid (CMS). JCAHO followed suit with changes in its rules. Perhaps the most powerful impetuses have been the successful efforts to nearly eliminate restraint use in Pennsylvania and the national leadership of NASMHPD, particularly through its excellent training materials and events. For its part, SAMHSA has provided strong federal financial and technical support to several states to implement restraint reduction initiatives.

5 For example, at a recent public hearing on proposed regulations in Massachusetts, several witnesses that testified that although their facilities fully supported efforts to reduce the use of restraint, they thought it ill advised to mandate changes through regulation or statutes.

6 Proposed legislation in Florida, for example, may be carried with a fiscal note that claims that data collection and analysis will cost hundreds of thousands of dollars.
restraint will put staff at risk, hospitals will complain about provisions that require a doctor to examine anyone in restraints within an hour, and so on. There are reasonable responses to all these concerns and advocates should be well prepared to offer them. Thankfully, the supportive literature is quickly expanding as social scientists study the pioneering work in Pennsylvania and elsewhere.

Unfortunately, sometimes the catalyst for reform comes from a horrible restraint incident, usually a death. Even in the face of tragedy, substantially reducing or eliminating restraint requires a cultural shift away from ingrained practices. Change cannot be accomplished without strong committed leadership from the very top of the impacted agencies and facilities. Therefore, it will be important to try to enlist agency leaders, consumers, family members and professionals to support any reform efforts.

14 IMPORTANT ELEMENTS TO INCLUDE IN RESTRAINT RULES

The proposed statute attempts to address 14 elements that we believe are important to reform. It would be the rare jurisdiction, indeed, that enacted a law or promulgated regulations that adequately addressed all of the elements. There inevitably will be compromises and “trade-offs” that advocates will have to make to secure reform. However, we offer a comprehensive draft because we believe that it can provide a model against which to measure success. Therefore the rules should include:

1. A strong purpose statement

A statement of legislative or regulatory intent or purpose that restraint is an extraordinary and dangerous intervention and that the state’s goal is to substantially reduce or eliminate its use.

2. Definitions and conditions for use of restraint

Definitions are crucial as they will determine what kind of interventions are classified as restraints. For example, chemical restraint and seclusion should be included in the definitions. The definitions should ensure that restraint is an intervention to be used only in emergencies. Emergencies warranting restraint should be defined as narrowly as possible. The several kinds of

7 Evidence in Pennsylvania and Massachusetts is to the contrary. The number of overall staff injuries are reportedly down since the majority of injuries occur during restraint.

8 Even private corporations that have long provided training on how to restrain people are now increasing their emphasis on alternatives to restraint and are advocating that restraint use can be substantially reduced.
restraint (e.g., mechanical, physical, chemical, seclusion) should be identified and carefully defined.

3. Limits on kinds of restraints

Certain inherently dangerous, inhumane, or unnecessary kinds of restraint should be specifically banned. Prone restraint is perhaps the most obvious. Handcuffs are another. Restraint chairs and “walking restraints” (belts, cuffs, and shackles) may also be considered for restrictions or outright banning. Likewise, any technique that will obstructs the individual’s airways should be banned. PRN or “as needed” restraint orders of all kinds should be forbidden.

4. Admission screening and other requirements

There should be requirements that relevant screening, evaluation, and planning take place upon or shortly after admission. Perhaps the most important is to determine whether the individual has been a victim of physical, sexual, or emotional abuse. There should also be a discussion with the individual to determine what interventions or activities other than restraint may be successful to help calm the person.

5. Who may order restraint and what the order must state

There should be a strong preference that restraint may only be ordered by a physician and that a doctor’s order should always be required for any kind of chemical restraint. If the doctor is not present when the restraint is ordered and if some other authorized person ordered it, there should be a requirement that the person be examined by a doctor within one hour of the restraint. The order itself should state the reasons for the restraint in conduct-specific, not conclusory, terms. It should describe (in more than a mere check-the-box format), the alternatives which were tried and failed. The duration of the restraint order (which may be for a shorter time than the maximum allowed by the statute) should be set forth in the order as should the criteria for release from the restraint.

6. Monitoring, assessment, and comfort

There should be requirements for ongoing, constant monitoring and engagement with the person in restraint. There should be regular periodic assessment for medical problems and for release and standards to ensure the individual comfort (e.g., bathroom breaks).

9 Several P&As have used the Protection and Advocacy, Inc.’s excellent “The Lethal Hazard of Prone Restraint: Positional Asphyxiation,” (2002) to convince authorities in their states of the dangers of prone restraint. The report is available on the California P&A’s web site at www.pai-ca.org/pubs/701801.pdf. Although experience and the literature seems to strongly support elimination of the prone restraint, this remains a controversial subject in many jurisdictions.
7. Duration of order

The statute or rules should mandate that an order may be valid for no more than one to three hours and should limit the number of cumulative consecutive hours a person may be restrained. There should be shorter permissible durations for youth and adolescents than for adults.

8. Renewal

The rules should require that the emergency situation which warranted the restraint must continue to exist for an order to be renewed. Subsequent orders should state the justification for the renewal and the criteria for release. If the restraint order is renewed more than once, someone in authority (e.g., facility head, medical director, Commissioner) should be notified.

9. Debriefing

There should be a debriefing after every restraint which includes the individual and the involved staff together. The purpose is to consider both why the restraint happened and how it can be prevented in future. Every restraint incident should result in a review of the person’s treatment plan.

10. Staff Training

Provisions for staff training in alternatives to restraint and in the need to reduce and eliminate its use should be included in the statute.

11. Transparency

Meaningful and relevant data collection and dissemination of information about restraint usage by facility and program are essential to promote and sustain reform.

12. Leadership notification

Facility and agency leadership should be notified about restraint use to ensure meaningful oversight.

13. P&A and family notification

With the permission of the individual, his or her family should be promptly notified of any use of restraint. All injuries and deaths in restraint should be reported to the P&A.
14. Licensing requirements

Licensing regulations should require all facilities to have a restraint reduction plan that involves leadership commitment and reinforcement. The facility should be required to demonstrate progress to reduce and eliminate the use of restraint.

**MODEL RESTRAINT STATUTE OR REGULATIONS**

A model statute follows. Annotations to statutes, regulations, rules or literature from which the provision is drawn appear in *italics* after the relevant section.

(1) **Legislative findings.** The Legislature finds and declares all of the following:

(a) The use of seclusion and restraint in behavioral health care poses inherent risks both physically and psychologically to individuals subject to restraint and seclusion and staff who utilize these interventions. Physical risks include serious injury or even death, and psychological injuries include retraumatization for individuals with histories of abuse.

(b) Both state operated and private facilities in [Our State] have reduced the use of restraint and seclusion to virtual elimination, while other facilities serving similar individuals continue to experience hundreds of episodes of restraint and seclusion each year. Research has demonstrated that the key variable in achieving meaningful reduction of restraint and seclusion is a firm commitment by facility, agency and state leadership to the goal of reduction of restraint and seclusion.

(c) It is therefore the policy of the [Our State] to achieve an ongoing reduction in the use of restraint and seclusion on [Our State citizens] in facilities operated, certified, licensed or monitored by the [several agencies of Our State] with the goal of reducing restraint and seclusion to the status of rare events, and to reduce the behavioral emergencies that have prompted their use, and wherever possible to eliminate the use of restraint entirely.

(2) **Scope.** Unless otherwise provided herein, this chapter shall apply to all facilities operated, licensed, monitored, or certified by [the several agencies of Our State] that utilize seclusion or behavioral restraints.10

(3) **Definitions.** For purposes of this chapter, the following definitions shall apply:

   (a) **Authorized Physician.** An authorized physician is any physician who has been authorized by the facility director to order medication restraint, mechanical restraint, physical restraint or seclusion, to examine persons in such restraint or seclusion, and to assess for readiness for release and order release from restraint or seclusion.


   (b) **Authorized Staff Person.** An authorized staff person is any physician, physician’s assistant, or psychiatric registered nurse who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion pursuant, and to assess for readiness for release and order release from restraint or seclusion.

   **Source:** 104 Code Mass. Regs. 27.12 (5).

   (c) **Behavioral Restraint.** Any mechanical, physical or medication restraint or containment as defined in this section.

   **Source:** Calif. H&S Code, § 1180.1(a).

   (d) **Containment.** A brief physical restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others.

   **Source:** Calif. H&S Code, § 1180.1(a).

   (e) **Emergency.** The occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. A substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such

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10 Although most reform efforts have been directed to the benefit of people with mental illness, the rules proposed here can also be applied (perhaps with some revisions) to programs that serve people with mental retardation and other disabilities. With other changes, the rules could also apply to behavioral restraints in prisons, jails, and juvenile justice facilities. Certainly, the goal of eliminating the use of restraint should apply whatever the setting.
harm. A threat to property is not an emergency.

**Source:** Mass. Gen. Laws c. 123 § 1; Tx. Statutes c. 42 Human Res. Code, § 42.0422; JCAHO standards PC 12.60 (restraint or seclusion limited to emergencies when there is an imminent risk of a patient physically harming himself or herself, staff, or others and non-physical interventions would not be effective); CMS regulations at 42 CFR 482.13(f) (emergency is defined as a situation where the patient’s behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff or others).

(f) **Facility.** Any program, hospital, unit, ward of any entity operated, licensed, monitored or certified by [the several agencies of Our State].

**Source:** See more extensive definition of facility in Tx. Statutes c. 322 § (1)

(g) **Individual.** An individual receiving services in a state mental health treatment facility or community receiving facility. The term is synonymous with “client,” “customer,” “consumer,” “resident,” “patient,” or “person served.”

(h) **Restraint.** Restraint includes mechanical restraint, physical restraint, and medication used to control behavior in an emergency or any involuntary PRN medication. Restraint means bodily physical restriction, mechanical devices, or any device that unreasonably limits freedom of movement. Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, and supportive body bands, or other physical holding when necessary for routine physical examinations and tests or for orthopedic, surgical and other similar medical treatment purposes or when used to provide support for the achievement of functional body position or proper balance or to protect a person from falling out of bed.

(i) **Medication Restraint.** Medication restraint occurs when a person is given medication involuntarily for the purpose of immediate control of the individual’s behavior.

**Source:** Calif. Stat. 1180.4(k)(client has right to be free from the use of a drug used to control behavior or restrict freedom of movement, if that drug is not a standard treatment for the person’s medical or psychiatric condition); 104 Code Mass. Regs. 27.12 (5)(a)(3)(a); JCAHO defines chemical restraint as the “inappropriate use of a sedating...drug.” PC 12.60.3-4.

(ii) **Mechanical Restraint.** Mechanical restraint occurs when a physical device or devices
are used to restrict the movement of a person or the movement or normal function of a portion of his or her body.

(iii) Physical Restraint. Physical restraint occurs when a manual method is used to restrict a person’s freedom of movement or normal access to his or her body.

(iv) Seclusion. Seclusion occurs when a person is involuntarily confined in a room and is prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to, the following:

(A) manually, mechanically, or electrically locked doors, or “one-way doors,” that, when closed and unlocked, cannot be opened from the inside;

(B) physical intervention of staff;

(C) coercive measures, such as the threat of restraint, sanctions, or the loss of privileges that the person would otherwise have, used for the purpose of keeping the person from leaving the room.

Source: Calif. St. § 1180.1(c), (d), (e); Tex. Stat. § 322.001(3) (seclusion); Mass. Gen. Laws, c. 123 § 1; 104 Code Mass. Regs. 27.12 (5)(3)-(4); JCAHO Glossary (defining seclusion, restraint, and chemical restraint); CMS Regulations at 42 C.F.R. 482.13(f)(restraint) and 42 C.F.R. 482.13(f)(1) (seclusion)(involuntary confinement of a person in a room or area where the person is physically prevented from leaving); 42 C.F.R. 482.13(e)(1)(chemical restraint)(“medication used to control behavior or to restrict the patient’s freedom of movement and that is not a standard treatment for the patient’s medical or psychiatric condition”).

(3) Data Collection. This section shall apply to all facilities operated, licensed, or certified by [the several agencies of Our State] that utilize seclusion or behavioral restraints as defined in this chapter.

(a) [The several agencies of Our State] shall jointly establish a system of mandatory, consistent, timely, and publicly accessible data collection reflecting the use of seclusion and behavioral restraints in facilities. Such data shall be compiled in a manner that allows for standard statistical comparison.

(b) [The several agencies of Our State] shall develop a mechanism for making this information publicly accessible on the Internet. Information will be posted on a monthly basis on each agency’s website beginning six months after the effective date of this section.

(c) Data collected pursuant to this section shall include all of the following relating to
each facility:

(i) The number of deaths that occur as a result of takedown or any form of behavioral control by any facility staff, or while persons are in seclusion or behavioral restraints, or within 48 hours of release from seclusion or restraints, or where it is reasonable to assume that serious injury or death was proximately related to the use of seclusion or behavioral restraints.

(ii) The number of serious injuries sustained by persons as a result of takedowns or any form of behavioral control by any facility staff, or while individuals are in seclusion or behavioral restraints or where it is reasonable to assume that serious injury or death was proximately related to the use of seclusion or behavioral restraints.

(iii) The number of serious injuries sustained by staff that occur during the use of takedowns, behavioral control, seclusion or behavioral restraints.

(iv) The number of incidents of seclusion.

(v) The number of incidents of use of restraints, and the kinds of restraints used.

(vi) The duration of time spent per incident in seclusion.

(vii) The duration of time spent per incident in behavioral restraints.

(viii) The number of times an involuntary emergency medication is used to control behavior, and whether or not in each case medication was used in combination with behavioral restraint or seclusion.

(ix) The number of individuals subject to restraint and/or seclusion more than ten times in a single month.

(x) The number of individuals subject to renewal of restraint or seclusion orders each month.

(d) Each facility shall report each death or serious injury of a person occurring during, or related to, the use of seclusion or behavioral restraints. In addition to any other statutory and regulatory requirements, this report shall be made to [a single responsible agency of Our State] and to the [Our State’s Protection and Advocacy System] no later than the close of the business day following the death or injury. The report shall include the encrypted identifier of the person involved, and the name, street address, and telephone number of the facility.
(4) Initial assessment and reassessment. A facility shall conduct an initial assessment of each person upon admission to the facility, or as soon thereafter as possible. This assessment shall include input from the person and from someone whom he or she desires to be present, such as a family member, significant other, or authorized representative designated by the person, if the desired third party can be present at the time of admission. This assessment shall also include, based on the information available at the time of initial assessment, all of the following:

(a) A person's preferences regarding de-escalation or the use of seclusion or behavioral restraints, including any advance directive or crisis plan that the person may present.

(b) The use of a De-escalation Preference Form or Personal Safety Plan to be developed by [Our State Agency] which allows an individual to identify early warning signs, triggers and precipitants of distress, stress or aggression, and that cause a person to escalate, as well as techniques, methods or tools that help the person to control his or her own behavior, and including preferences relating to the gender of staff assigned to monitor a person in restraint, shall be mandatory in all facilities. The said Form and Plan shall be completed for every individual admitted and the individual’s record shall include documentation of their use in treatment planning and in de-escalation efforts, if any.

(c) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion. These conditions include but are not limited to obesity, cardiac conditions, pregnancy, asthma or other respiratory conditions, impaired gag reflex, back conditions, seizure disorders, deafness, blindness, and hemophilia.

(d) Any trauma history, including any history of sexual or physical abuse that the individual feels is relevant.

(e) A reassessment including (a)-(d) above shall be completed whenever there is a significant change in an individual’s physical or psychological condition, and in conjunction with reassessments required by federal or state law.
(5) Requirements for the Use of Restraint and Seclusion. The following requirements shall apply to the use of restraint and seclusion.

(a) Emergency Basis for Behavioral Restraint or Seclusion. A facility may use behavioral restraint or seclusion for emergencies only, and only for the duration of the emergency.

(b) Limitations on Behavioral Restraint and Seclusion. The following limitations apply to the use of restraint and seclusion:

(I) A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity, including techniques in which a staff member places pressure on a person's back or places his or her body weight against the person's torso or back. Use of such restraint will result in immediate disciplinary suspension and investigation of staff who utilized these methods of restraints.

(ii) A pillow, blanket, or other item covering the person's face as part of a physical or mechanical restraint or containment process. Use of such restraint will result in immediate disciplinary suspension and investigation of staff who utilized these methods of restraint.

(iii) Physical or mechanical restraint or containment on a person who has a known medical or physical condition where there is reason to believe that the use would endanger the person's life or significantly exacerbate the person's medical condition.

(iv) Restraint in a prone position [Optional addition: without a detailed physician’s order specifically requiring the use of this position and explaining the medical justification for the order].

(v) An individual shall not be subject to prone containment unless a designated

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11 The optional language appears in the Massachusetts regulations. Some advocates fear that physicians’ orders will become routine and boilerplate, notwithstanding the requirement of a written explanation.
staff member, not involved in the restraint, observes the person throughout and in no event shall prone containment last longer than ten seconds as clocked and recorded by the designated staff person.

(vi) Restraint or containment with any restraint devices that restrain an individual’s hands behind his or her back.

**Source:** Tex. Stat. § 322.051 (a); Calif. Stat. 1180.4 (c), 104 Code Mass. Regs. 27.12(5)(3)(includes the bracketed optional language); JCAHO PC 12.40, Elements of performance M4 (assess preexisting medical conditions and physical disability that could impact on decisions to restrain; M5 assess history of physical and sexual abuse that could impact on decision to restrain; JCAHO Sentinel Event Alert (attributing twenty deaths in restraints to airway obstruction, prone restraint and take down, and advising providers to avoid those practices).

(vii) No "PRN" or "as required" authorization of behavioral restraint or seclusion may be written.

**Source:** This is a universal limitation contained in every standard and statute of which we are aware. See, e.g., 42 CFR 482.13(f)(3)(ii)(A); JCAHO PC 12.100.3.

(viii) No person shall simultaneously be subject to mechanical restraints and seclusion.\(^{12}\)

(c) **Conditions of Behavioral Restraint or Seclusion.** The following procedures shall apply to the use of restraint and seclusion:

(i) **Personal needs and comfort.** Provision shall be made for appropriate attention to the personal needs of the person, including access to food and drink, toileting facilities, and medical and hygiene needs, by staff escort or otherwise, and for the person’s physical and mental comfort.

(ii) **Physical environment.** The physical environment shall be as conducive as possible to facilitating early release, with attention to calming the person with sensory interventions. Any space used for restraint or seclusion shall include a clock within visual observation of the person.

(iii) **Privacy.** Every effort will be made to protect the individual’s privacy. An individual shall not be placed in four-point restraints in public view, nor may more than one person be restrained in a room.

\(^{12}\) We have seen and heard this is often sited by restraint reviewers as a necessary prohibition. We agree, but can find no like prohibition in the several sources we reviewed.
(d) **Initiation of Behavioral Restraint or Seclusion by an Authorized Physician.** The order that a person be placed in behavioral restraint or seclusion shall be made by an authorized physician who is present when an emergency occurs. The physician’s order and the reasons for its issuance, with specific identification of the actual behaviors involved and not characterizations of the behavior, shall be recorded in writing and signed at the time of its issuance by such physician. Such order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than two hours. The order shall include criteria for early release that are made known to the individual and that permit staff to make objective appraisals as to when an individual can be safely released.

(e) **Initiation of Behavioral Restraint or Seclusion in the Absence of an Authorized Physician.** If an authorized physician is not present when an emergency justifying the use of mechanical restraint, physical restraint or seclusion occurs, a person may be placed in mechanical restraint, physical restraint or seclusion at the initiation of physician’s assistant, registered nurse, or nurse practitioner subject to the following conditions and limitations:

(i) The order and the reasons for its issuance, with specific identification of the actual behaviors involved and not characterizations of the behavior shall be recorded in writing and signed at the time of the incident by such authorized staff person.

(ii) The order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than two hours and shall terminate whenever a release decision is made. The order shall include criteria for early release that are made known to the individual and that permit staff to make objective appraisals as to when an individual can be safely released.

(iii) An authorized physician shall examine the person within one hour of such initiation of mechanical restraint, physical restraint, or seclusion.

Source: 42 CFR 482.13(f)(3)(ii) (requiring order be written by physician or independent practitioner and requiring physician to be consulted as soon as possible if physician did not order); JCAHO PC 12.70 (regarding orders); JCAHO PC 12.170.3 (regarding behavioral criteria for discontinuation); 104 Code Mass. Regs. 27.12 (5)(e).

(e) **Medication Restraint.** A person may be given medication restraint only on the order of an authorized physician who has determined, either while present at the time of the
emergency justifying the use of the restraint or after telephone consultation with an
authorized staff person who is present at the time and site of the emergency and who has
personally examined the person, that such medication restraint is the least restrictive,
most appropriate alternative available. Such order, along with a description of the specific
behaviors which make it the least restrictive and most appropriate alternative available as
well as the expected results of the medication, shall be recorded in the patient’s record at
the time of its issuance. If the physician is not present to write the order, the physician
must dictate this language by telephone at the time of the issuance of the order to the
authorized staff person. Such order shall be signed at the time of its issuance by such
authorized physician if present at the time of the emergency or within one hour of the
order. An authorized physician shall conduct a face-to-face evaluation of the person
within one hour of the initiation of the restraint if the restraint was authorized by
telephone, and record the results of this evaluation in the individual’s records, as well as
recording whether the expected results of the medication have been achieved. Staff shall
monitor the individual carefully and record the effects of the medication restraint at least
once every half hour in the individual’s record.

(f) Continuation of Behavioral Restraint or Seclusion for Additional One-Hour Periods.
Subsequent renewals of mechanical restraint or seclusion may be made for up to a one-
hour period only if an authorized physician has examined the person and ordered such
renewal prior to the expiration of the preceding order, subject to the following conditions
and limitations:

(i) Such a renewal order may only be issued if the person is an adult or minor over
age nine and such physician determines that such restraint or seclusion is necessary to
prevent the continuation or renewal of an emergency condition or conditions.

(ii) Each such order shall be recorded in writing and signed by such physician, but
only after a face-to-face examination of the person in restraint or seclusion by such
physician.

(iii) Each such order shall authorize continued use of restraint or seclusion for no
more than one hour from the time of expiration of the preceding order, shall terminate
whenever a release decision is made.

(iv) No such order for continuation of mechanical restraint or seclusion beyond the
initial order may be issued if the person is a minor under age nine and only one such
order for continuation may be issued if the person is a minor age nine through
seventeen.

Source: 104 Code Mass. Regs. 27.12 (5)(f); JACHO PC 12.110 (requiring
(g) Limitations on Use and Duration of Restraint or Seclusion for Minors.

(i) **Minors under Age Nine.** No minor under age nine may be placed in behavioral restraints. No minor under age nine may be placed in seclusion for more than one hour in any 24-hour period.

(ii) **Minors Age Nine through 17.** No minor age nine through 17 may be in behavioral restraint or seclusion for more than two hours in any 24-hour period.

*Source: 104 Code Mass. Regs. 27.12 (5)(g); CMS regulations, 42 CFR 482.13(f)(3)(ii)(D) (limiting length of restraint orders).*

(h) **Mechanical Restraint or Seclusion Exceeding Three Hours.** If an episode of mechanical restraint or seclusion has exceeded three hours and it is expected that a new order will be issued to extend the episode beyond three hours, prior to the third order extending the use of restraint or seclusion, the facility director and facility medical director shall be notified. The facility medical director shall inquire about the circumstances of the episode of restraint or seclusion, the efforts made to facilitate release, and the impediments to such release, and help to identify additional measures or resources that might be beneficial in facilitating release.

(i) **Mechanical Restraint or Seclusion Exceeding Six Hours or Total Episodes Exceeding Ten Hours in a 48-Hour Period.** If an episode of mechanical restraint or seclusion has exceeded six hours and it is expected that a sixth order will be issued to extend the episode beyond six hours or if episodes of restraint and/or seclusion for a person have exceeded ten hours in the aggregate in any 48-hour period, the following shall occur:

   (i) The person shall receive a physical examination by an authorized physician.

   (ii) The facility director and facility medical director shall be notified.

   (iii) The episode(s) shall be reported to the [Commissioner of Our State’s Department of Mental Health] or designee by the next business day.

*Source: CMS regulations, 42 CFR 482.13(f)(4)(I); 104 Code Mass. Regs. 27.12 (5)(g)3-4.*

(j) **Release Prior to Expiration of Order.** If a person is released from restraint or seclusion prior to the expiration of an order and an emergency occurs prior to such order’s expiration, but no later than fifteen minutes after release, the person may be returned by an authorized staff person to restraint or seclusion without a new order until the time listed in the original order expires. Such return to restraint or seclusion shall be documented in the record.
(k) Monitoring of Persons in Mechanical Restraint, Physical Restraint or Seclusion. The following procedures and requirements shall apply to the monitoring of persons in restraint and seclusion:

(i) There shall be an authorized staff person with oversight responsibility during each episode of mechanical or physical restraint or seclusion.

(ii) Whenever a person is in physical or mechanical restraint or seclusion, a staff person shall be specifically assigned to monitor such person one-on-one. The facility should make every effort to ensure that the gender of the staff person matches the preference stated by the individual in the De-escalation Preference Form or Personal Safety Plan. If this is not possible at the moment the individual is restrained or secluded, staff shall specifically document why it was not possible, and continue to make active efforts to meet the individual’s preference until the individual is released or a staff person of the appropriate gender can be found.

(iii) The staff person conducting such monitoring may be immediately outside a space in which a person is being secluded without mechanical restraint provided that the following conditions are met:

(A) The staff person must be in full view of the person and

(B) The staff person must be able at all times to observe the person and to have immediate physical access to the person in order to be able to respond to any emergency situation.

(iv) The staff person shall monitor a person in mechanical or physical restraint by being situated so that the staff person is able to hear and be heard by the person and visually observe the person at all times. It is not necessary for a staff person monitoring a person in mechanical or physical restraint to be in full view of the person, although if such visibility has been expressed as a preference by the person, consideration shall be given to honoring such preference.

(v) Staff who monitor a person in physical or mechanical restraint or seclusion shall continually assist and support the person, including monitoring physical and psychological status and comfort, body alignment, and circulation, taking vital signs when indicated, and monitoring for readiness for release. Such monitoring activities shall be documented every 15 minutes.
(vi) Staff who monitor a person in restraint or seclusion shall continue appropriate interventions designed to calm the person throughout the episode of restraint or seclusion and shall maintain a log of the individual’s specific behavior with respect to the early release criteria established in the physician’s order.

Source: CA H&S Code § 11804(i) (constant face-to-face observation of persons in both restraint and seclusion); CMS regulations, 42 CFR 482.13(f)(4)(i) (face-to-face or video monitoring); JCAHO PC 12.130 and 12.140 (ongoing assessment and assistance); 104 Code Mass. Regs. 27.12 (5)(h).


(i) Staff conducting monitoring shall continually consider whether a person in mechanical restraint, physical restraint or seclusion appears ready to be released. If the staff person believes that the person is ready to be released from such restraint or seclusion, he or she shall immediately notify an authorized physician or authorized staff person, who shall promptly assess the person for readiness to be released. If the individual believes that he or she had met the release criteria, the individual can request an assessment by an authorized staff person.

(ii) If a person falls asleep while in mechanical restraint, staff conducting monitoring shall notify an authorized physician or authorized staff person, who shall release the person from the restraint or seclusion.

(iii) If, at any time during mechanical restraint, physical restraint, or seclusion, a person is briefly released from such restraint or seclusion to attend to personal needs, hygiene, eating, or other purpose, staff conducting monitoring shall consider the person’s readiness to be permanently released, rather than returned to the restraint or seclusion, and notify an authorized staff person if the person appears ready to be released.

Source: JCAHO PC 12.130 and 12.140 (ongoing assessment and assistance); 104 Code Mass. Regs. 27.12 (5)(h).

(m) Assessment. An authorized staff person or authorized physician shall assess a person in mechanical or physical restraint or seclusion for physical and psychological comfort, including vital signs, and readiness to be released at least every 15 minutes and at any other time that it appears that the person is ready to be released. Such assessments shall be documented in the record, including specific descriptions of the individual’s behavior and the reasons for not releasing the individual from restraint.

(n) Release. A person shall be released from mechanical restraint, physical restraint or seclusion as soon as an authorized physician or authorized staff person determines after examination of the person or consultation with staff that such mechanical restraint, physical
restraint, or seclusion is no longer needed to prevent the continuation or renewal of an emergency and, in no event, no later than the achievement of the early release criteria or the expiration of an initial or renewed order for such mechanical restraint or seclusion, unless such order is renewed.

(6) **Debriefing activities.** A facility shall develop procedures to ensure that debriefing activities occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have prevented or curtailed it, and how to prevent future incidents.

(a) **Staff Debriefing.** As soon as possible following each episode of restraint or seclusion, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing shall, at a minimum, include the following:

(i) identification of what led to the incident;

(ii) assessment of alternative interventions that may have avoided the use of restraint or seclusion;

(iii) determination of whether the person’s physical and psychological needs and right to privacy were appropriately addressed;

(iv) consideration of counseling or treatment for the involved person and staff for any emotional or physical trauma that may have resulted from the incident;

(v) consideration of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;

(vi) consideration of whether other persons and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;

(vii) identification of any environmental precipitants of the restraint or seclusion episode

(viii) identification of needed refinements in the individual’s plan of care or the need for additional assessments to better understand the factors underlying the behavioral problem related to the incident.

(ix) consideration of whether additional supervision or training should be provided to staff involved in the incident;

(x) consideration of whether the incident should be referred for senior administrative or clinical staff review.
(b) **Debriefing of the Person.** Within 24 hours after a person’s release from restraint or seclusion, the person shall be asked to debrief and provide comment on the episode, including the circumstances leading to the episode, staff or person actions that may have helped to prevent it, the type of restraint or seclusion used, and any physical or psychological effects he or she may be experiencing from the restraint or seclusion. Whenever possible and appropriate, the staff person providing the person with the opportunity to comment shall not have been involved in the episode of restraint or seclusion. As part of the debriefing, the person shall be offered the opportunity to provide comment in writing and to participate in care planning meetings aimed at reducing the likelihood of future incidents. All debriefing activities shall be documented and included in the person record and shall be used in treatment planning, revision of the individual crisis prevention plan, and ongoing restraint and seclusion prevention efforts.

*Source: Calif. H&S § 1180.5(b); JCAHO PC 12.160; 104 Code Mass. Regs 27.12(4)(a)- (b).*

(7) **Senior Administrative Review.** The facility director shall ensure that senior administrative and clinical staff and other appropriate staff conduct a review if any of the following apply:

(a) A person or staff member experienced significant emotional or physical injury as a result of the episode.

(b) The episode of restraint or seclusion exceeded four hours or episodes of restraint and/or seclusion for a person exceeded eight hours in the aggregate in any 48-hour period.

(c) An exception to the restrictions on mechanical restraint of minors has occurred.

(d) The episode appears to be part of a pattern warranting review.

(e) The episode is marked by unusual circumstances.

(f) The individual or staff involved in the episode requested such a review.

Senior administrative review shall be conducted by the next business day following the identification of the episode and shall include, but not be limited to, assessment of the need for expert consultation, training, performance improvement activities, or change in policy.

*Source: 104 Code Mass. Regs. 27.12 (4)(c); JACHO PC 12.120 (clinical leaders are told when clients experience extended episodes of restraint or seclusion).*

(8) **Facility licensing and certification requirements.** In addition to complying with all applicable standards in this title, a facility to be licensed by [an agency of Our State] shall include the
following in its application for a license or renewal of a license:

(a) the facility’s plan to reduce and, wherever possible, eliminate restraint and seclusion;

(b) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint and seclusion, including a listing of all types of mechanical restraints used by the facility, a statistical analysis of the facility's actual use of such restraint and seclusion, and a certification by the facility of its ability and intent to comply with all applicable statutes and regulations regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraint and seclusion.

Robert D. Fleischner
Center for Public Representation
Northampton, MA 01060
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