overed 42 incidents of death over the past decade caused by restraint and seclusion in facilities that serve individuals with mental illness and mental retardation (Altimari and Weiss 99). As a result of this report Senators Joe Lieberman (D-Conn) and Chris Dodd (D-Conn) asked the General Accounting Office (GAO) to look into the matter.

In July 1999, before the GAO report was released and legislation progressed, the Health Care Financing Administration (HCFA - the federal agency that adm

that restraint and seclusion use should:

- not be used for coercion, discipline, convenience or staff retaliation ;
- be limited to emergency safety situations and only after less restrictive interventions have failed;
- be authorized by a physician or independent licensed practitioner who evaluates the patient in person within one hour of the intervention;
- never be written as a standing order;
- and be time limited (4 hours for adults, 2 hours for children and adolescents ages 9 to 17 and one hour for those under 9) with the individual's condition continually monitored, assessed and reevaluated and include education and training in the proper use and the use of alternatives.

GAO Report, September 1999

In September 1999 the GAO issued a report that confirmed numerous deaths were occurring as a result of improper use of restraint and seclusion in mental hospitals. The report documented anecdotal and statistical information about patient deaths resulting from seclusion and restraint. Perhaps contributing to the problem was a lack of reporting mechanisms when deaths occurred. Of the 50 states and the District of Columbia, “only 15 states have any systematic reporting to alert [Protection and Advocacy Agencies] to any deaths that occur among individuals in residential treatment settings” (GAO/HEHS-99-176, pg. 5). The report highlighted the responsibility of the federal government to protect children and adults with mental illness or mental retardation from injury and abuse. The GAO recognized the HCFA standards released in July to be a positive step but insufficien

The GAO report acknowledged the success of states like Pennsylvania and Delaware whose standards exceed HCFA imposed regulations and as a result have reduced the total number of deaths caused by restraint and seclusion, 90% and 81%, respectively. In regards to their findings, the report says, "Typically, successful strategies to reduce the use of restraint and seclusion have similar components: defined principles and policies that clearly outline when and how restraint or seclusion may be used; strong management commitment and leadership; . . . and oversight and monitoring" (GAO/HEHS-99-176, 1999, pg. 3-4).

Patient Freedom from Restraint Act of 1999

Lieberman and Dodd responded to the Hartford *Courant* and GAO reports by sponsoring the Patient Freedom from Restraint Act of 1999 (106th Congress, S. 736, H.R. 1313). The purpose of this bill was to provide national standards and restrict the use of restraint and seclusion in mental health facilities that receive federal funds. This legislation confirmed the standards issued in the HCFA's interim guidelines, as well as following the recommendations from the GAO report requiring state-funded facilities to:

> report use of restraints and isolation to the appropriate state Protection and Advocacy agencies
> provide annual training for all staff "with direct resident or patient care responsibility on the proper use of restraints and seclusion, their alternatives, and techniques and methods to identify and defuse potential emergency situations"

Inspector General's Report, August 2000

The Inspector General released a report in August 2000 (Brown, OEI-04-99-00150) evaluating the initial implementation of the HCFA Patients' Rights Condition of Participation standards (which became effective August 1999 – see appendix for full text of the executive summary). The Inspector General's report said that the HCFA requirements still exceeded the standards in most states. It also said that private psychiatric hospitals more frequently fell short of HCFA standards than public hospitals did. The report specifically focused on four areas of the Condition of Participation Standards.

Initiating Restraints and Seclusion: Approximately 3/4s of the states had regulations governing both private and public psychiatric hospitals that met tInitiating Restraint 10.(0 8iTw 10.98 0 0 10.ewt)Tj 10.98 0 0 1

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psychiatric hospitals required monitoring every 15 minutes or less, only 48% of the States required such monitoring in private psychiatric hospitals. A few States had higher standards for patient monitoring requiring continuous (constant) monitoring.

Extending Standards

The HCFA extended their regulations in the January 2001 when they released a new Interim Final Rule. These new regulations, which became effective March 2001, extended standards for the use of restraint and seclusion to psychiatric residential treatment facilities as well as the previously10.98 0 0 10.98 87.361 0 10.98 305.4018 7(

Altimari, D. and Weiss, E. 1998. “Reform Urged In Use of Restraints.” Hartford *Courant*. October 17.

Appendix

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL
JUNE GIBBS BROWN
Inspector General
AUGUST 2000
State Policies for Psychiatric Hospitals

Restraints and Seclusion: Policies for Psychiatric Hospitals OEI-04-99-00150 1

PURPOSE

To describe State policies for restraints and seclusion in psychiatric hospitals.

BACKGROUND

Over five million people experience severe mental illnesses each year. In 1998, Medicare and Medicaid paid almost $6 billion to provide mental health care to over 500,000 beneficiaries in psychiatric hospitals. Mental health care may be provided in publicly (State) or privately owned hospitals. During hospitalization, persons with mental illness may be placed in restraints or seclusion.

The use of restraints and seclusion may be appropriate in some circumstances, but in others it may be inappropriate and abusive. In recent years, various reports have linked numerous deaths to inappropriate use of restraints and seclusion. Mental health advocates have expressed concern that hospitals are too quick to restrain or seclude patients, do not properly monitor them, and keep them restrained or secluded too long.

Such reports raised concern in the Congress, Department of Health and Human Services, and States on policies, standards and oversight for using restraints and seclusion. In response, the Health Care Financing Administration issued new Patients' Rights Condition of Participation

hospital staff said that in an emergency it is often necessary for the closest employee to restrain a patient until other trained staff arrive.

Physician Orders

The Health Care Financing Administration's new Patients' Rights Condition of Participation requires that a physician or other licensed independent practitioner "see and evaluate" the need for restraint and seclusion within 1 hour after the initiation of this intervention.

Policies for 78 percent of States require a physician order within 1 hour of initiating a restraint or seclusion in public psychiatric hospitals. Likewise, 60 percent did so for private psychiatric hospitals. However, most State policies did not specify a "see and evaluate" requirement. To illustrate, only 2 States required their public hospitals to meet the "see and evaluate" requirement. None did so for private hospitals. The other States allowed physician orders for restraint and seclusion to be given over the telephone. In their response to the Health Care Financing Administration's new Patients' Rights Condition of Participation interim final rule, private associations for physicians and hospitals voiced opposition to the new 1 hour "see and evaluate" requirement. They said it will be costly and difficult to implement. They also believe the requirement inappropriately dictates medical practice.

Time Limits

The Health Care Financing Administration's new Patients' Rights Condition of Participation limits duration of physician and licensed independent practitioner orders for restraints and seclusion to 4 hours for adults. However, only 43 percent of States had a limit of 4 hours for public psychiatric hospitals. Only 9 percent of the States set such a limit for private psychiatric hospitals.

Further, only 20 percent of the State policies for physician orders in public psychiatric hospitals met the Health Care Financing Administration's new Patients' Rights Condition of Participation standard of a 2 hour time limit for adolescents, and a 1 hour limit for children. None of the States had similar standards for adolescents and children in private psychiatric hospitals.

Patient Monitoring

The Health Care Financing Administration's new Patients' Rights Condition of Participation requires continual (close, recurring) monitoring of patients that are either restrained or secluded. Many States met this standard. Eighty five percent of State policies for public psychiatric hospitals required monitoringluded. Manyild292.4

For example, HCFA initiated efforts to educate key players such as State agencies, providers, accrediting organizations, and protection and advocacy groups on expected changes in treatment policies and procedures. Further, HCFA has initiated a training program for State and HCFA regional surveyors on the new Patients' Rights Condition of Participation.

The Substance Abuse and Mental Health Services Administration noted that our study is beneficial in that it provides baseline data on compliance with the new Patients' Rights Condition of Participation, and suggested several issues for further study. HCFA staff made similar comments to us in earlier discussion. We agree with the suggestion by SAMHSA and HCFA that more study is needed on the care and services provided to persons with mental illnesses. Our present study was one in a continuing series of studies, audits, and reviews on services to persons with mental illnesses. As we continue to analyze this subject in the future, we would expect to include coverage of some or all of the issues raised by SAMHSA and HCFA.

Both HCFA and SAMHSA also suggested several technical changes to the report for clarification. We made the changes where the scope of our study and facts obtained would support them.

We provide the full text of comments by both HCFA and SAMHSA in the Appendix.