

**ADVOCATE COALITION FOR APPROPRIATE USE OF RESTRAINTS**

c/o NAMI, 200 North Glebe Road, Suite 1015, Arlington, VA 22203-3754

May 17, 1999

Honorable Donna E. Shalala  
Secretary  
Department of Health and Human Services  
615 F Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Shalala:

We are a coalition of advocates alarmed by the deaths and serious injuries caused by the use of restraints in HCFA funded facilities for the purpose of the treatment of persons with psychiatric illnesses, mental retardation, and other disabilities.

For many months we have worked with U.S. Congressional offices, federal administrative agencies, professional societies, and provider associations. We are alarmed that given at least six deaths related to the use of restraints since the October 1998 *Hartford Courant* series which documented the deaths of 142 persons because of the use of restraint, the Department's first public response apparently will be a Medicare hospital condition of participation announcement which emphasizes that restraints may be used for the treatment of medical symptoms. Given the gravity of this national crisis, if this is the extent of the response, this is completely inadequate.

We have shared many detailed comments with many federal officials over the past months, particularly with the Health Care Financing Administration (HCFA). These comments and papers are available to you upon request. Our comments consistently made four points:

1.           The use of restraints in the treatment of psychiatric illness and for persons with mental retardation or other disabilities, is only appropriate for responding to emergency safety situations. The use of restraints in treatment facilities for persons with psychiatric illness and mental retardation is a reflection of a treatment failure. HCFA and Department arguments that restraints are appropriate for the treatment of medical symptoms have no scientific basis. No professional peer reviewed publication describes the therapeutic value of the use of restraints. The Department must acknowledge this lack of science base and restrict the use of restraint to emergency situations involving safety.

2. A Medicare hospital COP announcement is an inadequate response to this national crises of death and serious injuries. Five of the reported deaths since October 1998 have been children and adolescents and three of these deaths have been in Residential Treatment Centers. One involved a nine year old, 53 pound boy, crushed in restraint for reasons of discipline in a RTC specializing in the treatment of psychiatric illness which advertised itself as a medication free facility. How does this happen? Because there are no HCFA RTC rules. Here is a Medicaid benefit, established in 1972, expanded in 1990, with a proposed rule published in November 1994. In November 1998 HCFA published a partial final rule which merely said that Medicaid RTCs must meet whatever accreditation process the state determines.

When HCFA announces its Medicare hospital COP related to restraints, it must, in the same issue of the Federal Register on that same day, announce at minimum a notice of proposed rule making applying a single national restraint policy to all HCFA funded programs.

3. All deaths and serious injuries which potentially may be related to restraints must be reported to a third party, independent state-based authority which has the ability to investigate the circumstances behind such death and injury. To adequately respond to such national crises, HCFA must include this provision.
4. HCFA standards must be based on best practices throughout the nation. We have offered many citations about these practices. They are available to you upon request.

As more vulnerable persons with serious mental illness, mental retardation, and other disabilities die, are physically injured, and are psychologically scarred for life because of restraints applied for inappropriate reasons, the national government must make some affirmative statement in response. Such statement must acknowledge that: a single HCFA-wide standard is necessary, restraints are only appropriate for emergency safety reasons, all deaths and injuries must be reported to an entity which can investigate such deaths, and standards must be based on nationally documented best practice, not on the lowest common denominator of practice.

**Thank you for giving this issue the national attention it requires.**

**Sincerely,**

**E. Clarke Ross, D.P.A., National Alliance for the Mentally Ill, 703-312-7894,  
on behalf of:**

**Kathy McGinley, Ph.D., The ARC**

**Chris Koyanagi, Bazelon Center for Mental Health Law**

**Curt Decker, J.D., National Association of Protection and Advocacy Systems**

**Pope Simmons, National Council for Community Behavioral Health**

**Al Guida, J.D., National Mental Health Association**

# MENTAL HEALTH

News for policy and program decision-makers.

Weekly

ISSN 1058-1103

Vol. 9, No. 21

Monday, May 24, 1999

## Coalition urges HCFA to draft national restraint policy

A group calling itself the Advocate Coalition for Appropriate Use of Restraints last week voiced concern to Health and Human Services (HHS) Secretary Donna Shalala that the Health Care Financing Administration (HCFA) will not go far enough in responding to a call to regulate restraint use in psychiatric facilities.

The topic has received much attention since an investigative series in the Hartford (Conn.) Courant last year documented patient deaths resulting from seclusion and restraint (see *MHW*, Oct. 26, 1998). Since then, bills regulating restraint use have been introduced in both houses of Congress. Also, the CBS news show "60 Minutes II" broadcast hidden-

camera footage of restraint abuses at a Charter Behavioral Health Systems facility (see *MHW*, April 26).

In a May 17 letter to Shalala, the coalition addressed the possibility that HCFA's first public response to the outcry over restraint use will be an inadequate one that is limited to a condition of participation (COP) announcement for hospitals that receive Medicare payment.

Deaths resulting from restraint occur in all kinds of facilities, particularly in residential treatment centers, E. Clarke Ross, deputy executive director for public policy at the National Alliance for the Mentally Ill (NAMI), told *MHW*. "Focusing on Medicare hospitals does not reflect an adequate

response to the national crisis that is occurring," Ross said.

The coalition includes NAMI, the Arc, the Judge David L. Bazelon Center for Mental Health Law, the National Association of Protection and Advocacy Systems, the National Council for Community Behavioral Healthcare and the National Mental Health Association.

Tremendous disagreement exists within HHS and HCFA over how HCFA should respond to the restraint problem, Ross said. The coalition's letter assumes the worst of the possible moves by HCFA, which plans to

(See *Restraint*, page 2)

### Also This Week

Cigna focuses on reducing length of mental health disability ..... Page 3

NMHA evaluates managed care's approval/denial decisions ..... Page 5

Group starts funding campaign for mental health research ..... Page 5

Managed behavioral firms agree to adhere to code of conduct ..... Page 6

Third time's the charm for Oklahoma parity legislation ..... Page 6

## CentraLink seeks financial recovery, sets sights on goals for 2000

Over the last 10 years, CentraLink Inc. rode the wave of managed behavioral health care, providing executive education through a growing number of conferences to an industry that continued to proliferate. In conjunction with its nonprofit partner, the Institute of Behavioral Healthcare (IBH), the for-profit CentraLink provided the flagship forum for the industry, the annual "Behavioral Healthcare Tomorrow" (BHT) conference.

Then came the consolidation years, 1997 and 1998. Dozens of managed behavioral health care companies and provider groups were acquired or went out of business. The number of executives who had flocked to CentraLink's conferences shrank. An organization that prided itself on looking into the crystal ball and divin-

ing the future of behavioral health got blindsided.

To many observers, last year's BHT conference in Chicago signaled the beginning of the end. The meeting lacked the energy, excitement and participation of previous years. It appeared that in the seismic shift that struck the industry, CentraLink had sat on top of the fault line.

The company drastically reduced its staff, from 35 employees to seven. It cut its number of conferences, from 18 in 1998 to seven for this year.

And last September it sold its magazine, also called *Behavioral Healthcare Tomorrow*, to Manisses Communications Group Inc., publisher

(See *CentraLink*, page 4)

(*Restraint, from page 1*)

make an announcement in conjunction with the June 7 White House Conference on Mental Health.

The Clinton administration has expressed its support for congressional bills that would regulate restraint use, Ross said, but a core group of physicians and psychiatrists within the federal government are arguing that restraints have a therapeutic value.

Ross says such arguments are based on custom, not science.

The coalition's position is that restraint use is only appropriate for responding to emergency situations, and that its use indicates treatment failure. All deaths and serious injuries potentially related to restraints should be reported to an independent, state-based authority, the coalition says. And it insists that HCFA standards be based on best practices.

In March, Sens. Joseph I. Lieberman (D.-Conn.) and Christopher J. Dodd (D.-Conn.) both introduced bills regulating the use of restraints. Lieberman's bill would amend Medicare and Medicaid regulations to restrict the use of restraints by extending existing protections for nursing homes to mental health facilities. Dodd's bill would require the Substance Abuse and Mental Health Services Administration (SAMHSA) to restrict the use of restraint and to ensure adequate training and staff levels (see *MHW*, March 29).

The bills could receive strong bipartisan support, and the senators are working behind the scenes to make sure that happens. On the House side, Rep. Diana L. DeGette (D.-Colo.) introduced a bill with colleagues Rosa DeLauro (D.-Conn.) and Fortney "Pete" Stark (D.-Calif.).

The issue stands to receive scrutiny during the appropriations process, and instructions could be attached to the HHS budget regulating restraint use.

Last month, a key subcommittee of the Senate Appropriations Committee heard public testimony on restraint use. Sen. Arlen Specter (R.-Pa.), chairman of the Labor, HHS and Education Subcommittee, questioned whether criminal sanctions could be imposed on clinicians and facilities that were reckless in their care of patients who died while in restraints (see *MHW*, April 19).

While the possibility of imposing criminal sanctions is remote, Ross said, "It elevates the consequences and stakes of this whole thing."

The issue is at the forefront of discussions for a number of organizations, including the American Psychiatric Association (APA), the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of Psychiatric Treatment Centers for Children (NAPTCC).

The APA is slowly coming around on the issue, Ross said. It and the American Academy of Child and

Adolescent Psychiatry both have dropped policy language about the therapeutic value of restraints. But the APA does not endorse current legislation, nor does it support the reporting of deaths and injuries to third-party entities.

One stumbling block is the issue of who should be able to approve restraint use. NAMI supports requiring physician approval in all cases. Organizations such as NASMHPD and NAPTCC say such a requirement is not possible, given the availability of psychiatrists. Currently, no restrictions exist on who can approve restraint use.

### Residential treatment

NAMI began documenting deaths and injuries from restraint use shortly after the Courant series was published. One major area of concern has been the number of incidents involving children and adolescents in residential treatment centers.

Residential treatment centers remain essentially free of federal regulations, despite a Medicaid benefit first created in 1972 and expanded in 1990. States can use any accrediting body they choose for the centers, a situation that a number of mental health advocates want changed.

In March, a 53-pound, nine-year-old boy died after being placed in a "basketball hold" at a facility in Banner Elk, N.C. The center, called Grandfather Home, advertises itself as a medication-free facility, and the boy had been taken off medication upon

## MENTAL HEALTH Weekly

A Manisses Communications Group, Inc. Publication

Mental Health Weekly (ISSN 1058-1103) is an independent newsletter meeting the information needs of mental health professionals. Published every week except for the first Monday in July, the last Monday in August, the last Monday in November and the last Monday in December. Mental Health Weekly costs \$587 a year for institutions and \$499 a year for individuals, accepts no advertising and is supported solely by its readers. Printed in the USA.

Senior Managing Editor: William Kanapaux  
Editorial Assistant: Brandi S. Dougherty

Executive Editor: Gary A. Enos  
Production Editor: Helen Ebrahim  
Copy Editor: Susan Farley

Publisher: Fraser A. Lang  
V.P. Finance: Paul J. Maloney, C.P.A.  
V.P. Marketing: Betty Rawls Lang  
Consulting Editor: Robert B. Whitcomb

©1999 by Manisses Communications Group, Inc., The Newsletter Publishers Association. All rights reserved. Reproduction in any form without the consent of the publisher is strictly forbidden. For reprint permission, contact Barbara Deekle, reprint coordinator, at (800) 333-7771 (9-5 EST).

Business/Editorial Office: P.O. Box 9758, Providence, RI 02940-9758; (401) 831-6020. Reader FAX: (401) 861-6370. E-mail: [genos@manisses.com](mailto:genos@manisses.com)

Customer Service and Subscription Information (800) 333-7771; E-mail: [manisseacs@manisses.com](mailto:manisseacs@manisses.com)

admission, Ross said.

The situation demonstrates the need for minimal abuse-prevention standards, he said.

NAPTCC executive director Joy Midman says none of her member facilities have been involved in the deaths reported by the *Courant* and NAMI. Grandfather Home is not even on NAPTCC's mailing list.

"We want to take a proactive stance on this without castigating an industry," Midman told *MHW*.

Midman believes Specter's hearing went too far, substituting sensationalism for substantive debate. NAPTCC members, who held their annual meeting this month, are working toward a restraint-use policy and are identifying best practices, with an emphasis on staff training and workforce development.

NAPTCC supports mandatory reporting to a state agency, Midman said, but the question is whether it will do any good without appropriate staffing and training.

Four areas of the restraint debate concern NAPTCC members, Midman said:

- Lack of an exact definition for the terms "seclusion" and "restraint."
- The impracticality of requiring a physician-ordered directive for each use of restraint.
- The agency to which facilities would be required to report incidences. Reporting to the federal bureaucracy would do little good, Midman said.
- The lack of standards for staff training. Dodd's office is considering the possibility of a multi-state pilot that would involve a

certification program for child-care workers. Lawmakers would be better-served to see the results of such an initiative before developing regulations, she said.

NAPTCC does not support current legislation because it does not address all facilities equally, she said. While the Lieberman and Dodd bills cover HCFA and SAMHSA, respectively, juvenile justice and welfare dollars are overlooked. To enact legislation before creating a level playing field is ridiculous, she said.

Sixteen states currently have mandatory reporting requirements, she said, and legislation should continue to be pursued at the state level.

NAPTCC also is looking into the use of advance directives as a possible solution to problems with restraint use, Midman said.

## Cigna focuses on reducing length of mental health disability

Cigna Group Insurance, a subsidiary of Cigna Corp., has teamed up with sister subsidiary MCC Behavioral Care Inc. to target mental health disability in the workplace. The insurance company covers 18 million employees at 20,000 businesses.

The health insurer has seen a substantial increase in the number of disability claims involving a diagnosis of a mental or nervous condition in the last five years. Kenneth Millsap, assistant vice president of loss containment at Cigna Group Insurance, told *MHW*.

Another factor spurring Cigna to reduce the length of mental health disability claims is the potential for a successful legal challenge to the 24-month cap many employers place on mental health disability. Some federal district courts have ruled that the cap violates the Americans with Disabilities Act (ADA), but a case has yet to be favorably decided at the appellate level. No such cap exists for physical disability benefits, which are payable

until the policyholder turns 65 (see *MHW*, June 22, 1998).

Cigna also wants to better assist customers and their employees in getting the best and most appropriate treatment at earlier stages of disability in order to reduce the amount of time an employee is out of work, Millsap said.

Cigna conducted a six-month pilot program last year for a couple of major customers and realized a 15 percent reduction in the duration of short-term disabilities. "We felt it was a big enough impact that we wanted to roll it out across the board," Millsap said.

According to Cigna, mental illness is the primary diagnosis in up to 20 percent of disability claims and is the secondary diagnosis in up to 65 percent of claims. Depression is the disorder present for nearly 80 percent of claims in which mental illness is the primary diagnosis.

The increase in mental health-

related disabilities appears to be linked to corporate consolidation and downsizing, Millsap said. Long-term employees whose jobs become at risk face greater levels of stress, as do employees who find their workloads increasing as a result of staff reductions. An overall increase in personal stressors also appears to have played a role in the jump in disability claims, he said.

Early results for clinical intervention were promising. MCC, Cigna Corp.'s managed behavioral health care subsidiary, first focused on 250 claims — ranging from three months to eight years — in which a mental health disorder was the primary diagnosis. Following MCC's involvement

**Professional books  
are available with the  
click of a mouse  
[www.bhrpress.com](http://www.bhrpress.com)**

**FAX**

UNITED STATES SENATOR • CONNECTICUT

**Joseph I. Lieberman**



Fax to: Reverend Date \_\_\_\_\_

Fax# 456-5557 Pages \_\_\_\_\_

From: \_\_\_\_\_

Message: \_\_\_\_\_

# United States Senate

WASHINGTON, DC 20510

April 19, 1999

Dear Colleague:

We are writing to ask you to join us in cosponsoring S. 736, the Freedom from Restraint Act. This legislation is intended to reduce the use of dangerous restraints in mental health facilities funded by Medicare and Medicaid.

The Freedom from Restraint Act would extend existing nursing home standards on the use of restraints to mental health patients and codifies an existing reporting requirement for deaths and serious injuries to institutions funded by the Medicare and Medicaid programs.

The legislation was prompted by a series of articles describing 142 deaths that were caused by restraint and seclusion in mental health facilities published by *The Hartford Courant*. The series is available at <http://www.courant.com/news/special/restraint/reform.stm>

In many ways, reading the articles was a trip back into Medieval times, into an existence that otherwise would have been invisible to most of us.

- deaths were reported in 30 states.
- 33 percent of the victims were suffocated.
- More than 26 percent of those killed were children under 17 - a rate that is nearly twice their proportion in mental health institutions.

The Hartford Courant articles were spurred by the suffocation of an 4 foot 11 inch, 96 pounds 11-year old boy named Andrew McLain in a Connecticut mental health facility. Andrew's last minutes of life began when an aide ordered Andrew to move to another table at breakfast. When he disobeyed, he was taken to a seclusion room. Andrew died of asphyxiation face down, with two health care workers lying on his back and legs.

The other 141 deaths reported by the Hartford Courant are equally chilling.

- Tristan Sovern got up from group session on the day he was to be discharged. Staff restrained Sovern face down on the floor. During the struggle, staffers put a towel over the boy's mouth and held a bed sheet around his head. He died of suffocation.
- In Massachusetts, 12-year-old Robert Rollins was suffocated after a dispute over his missing teddy bear.
- Nineteen-year-old Melissa Neyman suffocated when staffers at a Washington residential facility strapped her to her bed at 10 p.m. and didn't check on her until the next morning, when they found her dead entangled in her own restraints.
- Edith Campos, 15, was crushed face down at an Arizona youth center. Edith was

looking at a family photograph when a male aide instructed her to hand over the "unauthorized" personal item.

— Dustin Phelps, 14, died when the owner of an Ohio home wrapped him in a blanket and a mattress and tied it together with straps. Dustin was left in the mattress for four hours.

We feel a sense of urgency. Since the articles were published, we have received reports of the deaths of an additional 6 patients — five of whom were children. Just last Friday we learned of yet another young boy who died in a mental health facility in Chesterfield, Virginia, after the use of restraints and seclusion.

Federal funding sources including Medicare and Medicaid comprised almost 40% of the \$36 billion that flowed into mental health organizations in 1994. However, the Congressional Research Service when asked to study federal law on the use of restraints in mental health facilities stated "Federal coverage is piecemeal and uncertain."

The Freedom from Restraint Act of 1999 steps into this void by extending an existing procedural safeguard on the use of restraints, codifying current reporting policies in use by the medical community, and applying those requirements to facilities that accept Medicare and Medicaid funding.<sup>1</sup>

First, the bill takes a provision that was passed in 1987 (OBRA '87) for nursing homes and extends its coverage to the mental health population. The provision allows restraints to be used, but requires that their use be approved with a physician's written orders, and only for the safety of the patient (not for discipline or convenience). This decade-old provision on the right to be free of restraints is credited as the basis of the dramatic reduction of the use of restraints in nursing homes of over 1/3 in the last 8 years alone.

Second, the bill codifies the death and injury reporting requirements of the largest accrediting organization (the Joint Commission on Accreditation of Health Care Organizations-JCAHO). The Joint Commission specifically supports "the mandatory reporting and disclosure of deaths related to the use of restraints" as the "sine que non for gaining a true understanding of the underlying causes and developing appropriate preventive measures for the future.

Under the requirements, facilities would be required to report all unexpected deaths and serious injuries, and the steps they will take to prevent their reoccurrence. The reporting requirement is limited to sentinel events — a term of art defined as a serious, unexpected injury unrelated to the natural course of the individual's illness.

A facility would never need to file a report unless a patient unexpectedly dies or receives a serious injury while under their care.

---

<sup>1</sup> We have also introduced companion legislation for which Senator Dodd is the principle sponsor for a different funding stream, the Substance Abuse and Mental Health Services Administration and Senator Specter recently held hearings on restraint use in the Labor, HHS, Education Subcommittee of Appropriations.

In the case of a facility where deaths and repeated serious injuries occur, the name and address of the provider would also be required and that information (along with the injuries and curative steps) would be entered into a publicly available database. Otherwise the name and the address of the facility would be kept confidential.

Privacy protections for the victims is mandated. Furthermore, the facility's internal work product to analyze and prevent sentinel events (the "root cause analysis") is confidential..

Pennsylvania has demonstrated the progress that can be made if we take steps to reduce restraint and seclusion. They have already producing dramatic reductions in the use of restraints and seclusion in its state mental hospitals. We need to extend their success to the nation.

We are encouraged by the response to our legislation, which is supported by advocates, providers, accreditors, and psychiatrists.

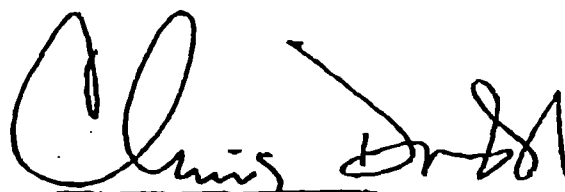
Among endorsers are the National Alliance for the Mentally Ill, the Joint Commission on Accreditation of Healthcare Organizations, the National Council for Community Behavioral Health Care and other providers, the National Mental Health Association, the National Association of Protection and Advocacy Systems, and the Bazelon Center for Mental Health Law. Leading psychiatrists including the Director of the Yale Child Study Center and the Medical Director of InPatient Services of Child Psychiatry at Yale New Haven Hospital wrote that they "support the Freedom From Restraint Act of 1999 and applaud your efforts to improve the quality of care provided to individuals with serious psychiatric disorders."

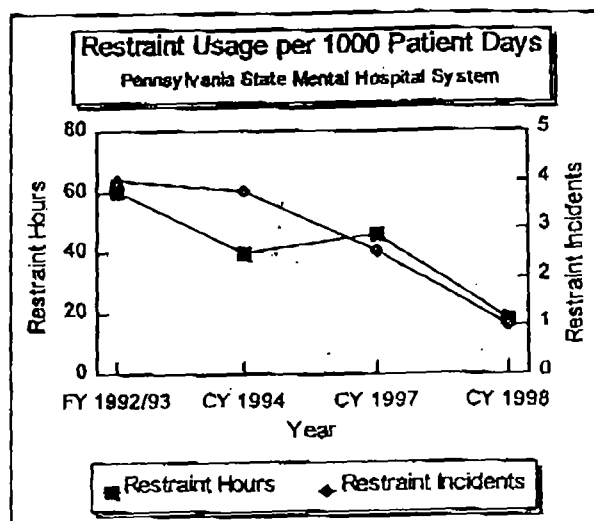
Finally, the HCFA Administrator Nancy-Ann Min DeParle wrote "in strong support of your efforts to provide additional Federal oversight to prevent inappropriate seclusion and restraint practices in mental health settings."

For further information, please call Ned McCulloch in Sen. Lieberman's office at 224-4041 or Jim Fenton in Senator Dodd's office at 224-2823

Sincerely,

  
Joseph I. Lieberman  
U.S. Senator

  
Christopher J. Dodd  
U.S. Senator



## **S. 736-- THE FREEDOM FROM RESTRAINT ACT OF 1999**

The Freedom from Restraint Act extends current restraint protections for nursing home residents to all mental health patients in facilities receiving Medicaid and Medicare funds, and requires that deaths and serious injuries to mental health patients be reported. The legislation builds on successful laws that have reduced the use of restraints in nursing homes by one-third since 1991 and which patients, physicians, and providers have found workable. The protections can be implemented quickly and broadly due to their foundation in existing laws and policies, but bring important new rights to mental health patients.

### **Right To Be Free From Restraints**

Mental health patients will be protected by restrictions on the use of restraints. Under the bill, providers shall "protect and promote the right of each such patient to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience".

The bill does not prohibit the use of restraints, but establishes procedural safeguards to protect patients from their overuse. Under the legislation, a restraint may only be imposed "to ensure the physical safety of the patient or other patients" with a physician's "written order" specifying the "duration and circumstances" under which the restraints are to be used. Under emergency circumstances, specified by the Secretary of Health and Human Services, restraints may be used until a written order can be obtained.

Rather than create a entirely new standard, the bill simply broadens legislation that has successfully protected nursing home residents (passed in 1987 as part of the Omnibus Budget Reconciliation Act) to include the mental health population. In nursing homes, the restraint standard has proven workable and is credited for the dramatic reduction in the use of restraints by nursing homes of over one-third in the last eight years alone, according to the Health Care Finance Administration.

### **Required Reporting of Deaths and Sentinel Injuries**

Unexpected deaths, serious injuries, known as "sentinel events," and the steps taken to prevent their reoccurrence will be reported.

Death of a mental health patient triggers the broadest reporting. Upon a death, the facility is required to file a report with the police, the state licensing agency, the protection and advocacy system, any relevant national accrediting body and the Department of Health and Human Services. Upon receipt of a report, either HHS or the national accrediting body will ensure that the provider investigates the injury, determines its cause, and takes action to correct the problem and reduce the likelihood of its repetition. Finally, the report of the death and corrective steps will be entered into a database available to the public through the Internet including the name and address of the provider in the case of a death related to restraints or seclusion.

Serious, unexpected injuries to a mental health patient that fall short of death will be reported to HHS or to the facility's national accrediting body in the case of an accredited facility. This requirement builds upon existing "sentinel event" reporting practices and definitions of the Joint Committee on Accreditation of Healthcare Organizations to minimize duplication and is intended to bolster those efforts. The reports of the injury and the steps to prevent its reoccurrence will be added to the publicly available database.

Finally, whenever a pattern of poor performance emerges for a facility, the name and address for that facility will be included in the publicly available database along with the records of all injuries or deaths that occurred at the facility.



**Joint Commission**  
on Accreditation of Healthcare Organizations

March 24, 1999

The Honorable Christopher J. Dodd  
444 Russell Senate Office Building  
Delaware and Constitution Avenues, N.E.  
Washington, D.C. 20510-0702

The Honorable Joseph I. Lieberman  
706 Hart Senate Office Building  
Second Street and Constitution Avenue, N.E.  
Washington, D.C. 20510-0703

Dear Senators Lieberman and Dodd:

The Joint Commission commends your leadership in seeking to reduce the number of restraint-related deaths of individuals under treatment for psychiatric or psychological conditions. The occurrence of restraint-related deaths presents a most serious and complex set of issues for all of us in health care and for public policy-makers. Meaningful solutions will clearly require significant efforts by all interested parties. Such efforts must be of the highest priority, for the issues involved go to the very heart of patient rights and patient safety.

The Joint Commission views many of the provisions contained in your bill as critical elements of a framework for addressing both restraint-related deaths and other sentinel events that occur in the delivery of health care. We support the mandatory reporting and disclosure of deaths related to the use of restraints as the essential foundation for determining the magnitude of the problem and for identifying the causal factors that have contributed to the devastating occurrences portrayed in the recent *Hartford Courant* series.

However, as your bill recognizes, reporting is only the first step towards substantive improvements in protecting patient rights and improving patient safety. The critical next step is to elucidate through careful analysis the systems problems that frequently underlie sentinel events. This in-depth root cause analysis which should immediately follow any sentinel event is the vehicle that permits the involved health care organization to fully understand what happened, why it happened and what steps must be taken to reduce the likelihood of any future recurrence. We strongly agree with your premise that the confidentiality of this root cause analysis must be protected in order to foster and assure full exploration and understanding of all potential contributing factors. By establishing a non-punitive environment in which organizations can

Senators Dodd and Lieberman

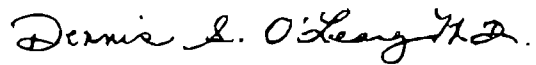
March 24, 1999

Page Two

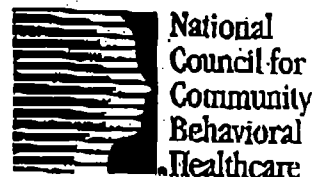
examine their mistakes honestly, this bill will both foster better and safer care in organizations where sentinel events have occurred, and create the opportunity for sharing lifesaving "lessons learned" with like health care organizations.

Again, we the appreciate the opportunity to work with you and others as your legislation moves forward. Congratulations on your leadership on this matter.

Sincerely,



Dennis S. O'Leary, M.D.  
President



National Office  
12300 Twinbrook Parkway  
Suite 320  
Rockville, Maryland 20852  
301/984-6200  
Fax 301/881-7159  
Website: www.nccbh.org

Capitol Hill Office  
900 2nd Street, N.E.  
Suite 216  
Washington, D.C. 20002  
202/442-1240

President and CEO  
Charles G. Ray  
of Directors  
1998-1999

Chair  
B.R. (Pete) Kennerly, MPH  
First Vice Chair  
Peter W. Zvenbergen, Jr.

Second Vice Chair  
Marilyn LaCelle, ACSW  
Secretary-Treasurer  
Frank J. Falanga

Chair, Public Policy  
Hubert Wirtz, MA, MBA

Region I  
Dale Klabaker, MSW, PhD  
Sandra Slevet

Region II  
Leonard S. Altamura, DSW  
Frank J. Falanga

Region III  
Lynette M. Brown  
Matthew J. Havumaki

Region IV  
Howard F. Bracco, PhD  
Elizabeth Rubenyer

Region V  
Susan D. Muchwalter, PhD  
Rev. Randolph Kempainen

Region VI  
Spencer E. McClure

Region VII  
Kenneth R. Winkler  
Peter W. Zvenbergen, Jr.

Region VIII  
E. Brent Frazier, MS  
Frank L. Lane, MS

Region IX  
V. Jerome Doyle  
Walter H. Kasa

Region X  
Michael B. Herzog, PhD  
Marilyn LaCelle, ACSW

State Association  
Representatives  
Judy Dierenfeld  
Elizabeth Funk

April 12, 1999

The Honorable Joseph I. Lieberman  
706 Hart Office Building  
Washington, DC 20510

Dear Senator Lieberman:

The National Council for Community Behavioral Healthcare (NCCBH) and its 800 community mental health and substance abuse provider members holds dear the belief that behavioral health services must be based on the strengths and needs of the consumer—who must be treated with dignity and respect. Accordingly, NCCBH shares the outrage of others in the behavioral health community concerning the recent reports of deaths and other serious incidents due to the inappropriate use of seclusion and/or restraints on people with behavioral health disorders.

Therefore, it is with great pleasure that I report to you that the NCCBH, with its Public Policy Committee and Board of Directors, supports your current legislation, S. 736, which reforms seclusion and restraints of persons in psychiatric facilities, as part of our larger commitment to appropriate and consumer-centric levels of care.

As the legislative process moves forward, we hope we will have the pleasure of additional dialogue that could take into account some of the unique situations potentially faced by community providers, who may possess crisis beds, in rural medically underserved areas.

We thank you for your leadership on this important historic issue. The NCCBH is committed to seeing that this important legislation become law.

Very truly yours,

*Pope M. Simmons*

Pope M. Simmons  
Vice President of Government Relations



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

MAR 24 1999

The Honorable Joseph I. Lieberman  
United States Senate  
Washington, D.C. 20510

Dear Senator Lieberman:

I am writing in strong support of your efforts to provide additional Federal oversight to prevent inappropriate seclusion and restraint practices in mental health settings. The President, Secretary Shalala, and I share your concern over the recent reports of children who died after being inappropriately restrained, and we applaud your efforts to protect all hospital patients from harm associated with the use of seclusion and restraints. We look forward to working with you on the specifics of the legislation as it moves forward.

I would also like to take this opportunity to update you on the Administration's recent efforts to protect children and other hospital patients from harm associated with the inappropriate use of restraints. As you may know, in the Notice of Proposed Rulemaking (NPRM) for the new Medicare hospital Conditions of Participation (CoP), HCFA proposed a CoP to address patients' rights. Within this CoP, HCFA proposed standards restricting for the first time, the use of restraints in hospital settings. The Medicare hospital CoPs apply to all patients in hospitals who participate in the Medicare program, therefore, these rights extend beyond the Medicare population in these facilities. In addition, the hospital CoPs apply to Medicaid hospitals as well.

Because of the importance of this issue to the health and safety of patients, we plan to carve out the "Patients Rights" section (which addresses the seclusion/restraint issue) of the CoP from the larger hospital conditions of participation regulation so that we can publish the standard in final by late summer. By carving out this section, HCFA will be able to move more quickly to hold all hospitals that participate in Medicare and Medicaid accountable for the inappropriate use of seclusion and restraints. The proposed Patient Rights CoP will apply to all participating hospitals, including acute, psychiatric, rehabilitation, long-term, children's, and alcohol-drug hospitals.

In addition to our efforts with hospitals, HCFA already has regulations restricting the use of restraints in settings including intermediate care facilities for the mentally retarded (ICFs-MR) and nursing facilities. In addition, the Clinton Administration has made improving the quality of nursing home care and oversight a top priority. Last July, the President announced a broad initiative to strengthen the enforcement of our nursing home regulations, which we published in 1995.

The Honorable Joseph I. Lieberman

In addition to HCFA's efforts, a number of other federal agencies are increasing attention to inappropriate seclusion and restraint practices. Most notably, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services (SAMHSA) Administration within the U.S. Department of Health and Human Services provides funds to state protection and advocacy systems. These systems, present in each state, have a strong record of addressing and resolving consumer complaints related to the misuse of seclusion and restraint. Moreover, HCFA staff are actively participating with CMHS in the development and implementation of an action plan that will continue to address problems with the misuse of seclusion and restraints in our nation's health care facilities.

Your legislation will add to these efforts by expanding the scope of this policy to patients in settings that HCFA does not have the authority to regulate such as residential treatment centers for children and congregate care services under a waiver authorized under section 1915(c). Your bill also emphasizes the need for more accurate and timely reporting through the establishment or designation of sentinel events restraint database. We look forward to working with you and with your staff on this approach.

The President, Secretary Shalala, and I strongly support your interest and efforts and those of your colleagues to prevent the inappropriate and dangerous use of restraints in mental health settings, and I am confident that we can work together to protect the children and other vulnerable patients who are currently at risk.

Sincerely,



Nancy-Ann Min DeParle  
Administrator

YALE UNIVERSITY



Donald I. Cohen, M.D.  
Director, Child Study Center  
Irving B. Harris Professor of  
Child Psychiatry, Pediatrics  
and Psychology  
Yale University School of Medicine



Chief, Child Psychiatry  
Children's Hospital at  
Yale-New Haven

March 23, 1999

The Honorable Joseph Lieberman  
United States Senate  
Washington, D.C.

Dear Senator Lieberman,

We are writing to provide support for the Freedom From Restraint Act of 1999 and to applaud your efforts to improve the quality of care provided to individuals with serious psychiatric disorders.

The scope and burden of serious psychiatric disorders in children and adolescents is enormous. In the United States and worldwide, up to 8% of all children have serious emotional, development and behavioral disorders. Only a small proportion of these children requires treatment in specialized, inpatient hospital settings. Those who require inpatient care generally suffer from the most severe and broad-based disturbances that affect their social, emotional, intellectual and behavioral development and functioning. These complicated patients require thorough diagnostic assessment and multi-modal therapy. Some of these children present difficulties which are a threat to their own physical safety or to the physical safety of other patients and clinicians. This type of clinical situation requires thorough, specialized assessment to define an appropriate treatment plan to help the child regain control and to prevent any harm to himself/herself or others. Such a plan may include careful observation, more intensive or one-on-one staffing, the utilization of behavioral techniques that allow the child to calm down and reorganize, the judicious use of medication, analysis of the precipitants and management of outbursts, and the use of time-out and quiet rooms.

On occasion, in the context of a comprehensive treatment/intervention program, it may at times also be necessary to use physical restraints to protect the child or others from imminent harm. When they are used, the methods for applying the restraint, including the use of any mechanical devices, must be employed only by individuals who are specially trained. At times, restraints must be used to deal with an urgent situation. When restraints are used with children or adolescents, it is essential that certain conditions are met: that the danger of harm is real and imminent, the restraints must be prescribed by a physician, the restraint methods must be fully documented and approved, the clinicians using the methods must be well trained in a documented training program, the restraint use must be carefully monitored, the restraints are discontinued as soon as the danger for harm is no longer imminent, and the entire process must be accurately reported. When possible, it is important to obtain informed consent from the guardians of the child/adolescent before any restraint method is used. In cases of emergency, to protect a child or others, the parents/guardians should be notified as soon as possible and provided with a detailed description and, if feasible, observation of the method of restraint. Following each use of restraints, it should be clinically evaluated by the full clinical team to determine if other approaches might have been used or should be used in the future.

We believe that the Freedom From Restraint Act of 1999 is a movement in the right direction. It will increase awareness of the importance of providing optimal care to individuals with the most serious psychiatric disorders who are hospitalized for evaluation and treatment. The Act clearly defines that the purpose of restraints is for the safety of the individual or other individuals and the Act helps assure that restraints will be used only with suitable medical oversight. We also appreciate the importance of detailed assessment of sentinel events. We believe that the Act will help in the process of improving clinical care of children and adolescents, as well as adults with psychiatric disorders.

There are rapid advances in knowledge about the causes and treatment of psychiatric disorders of children, adolescents, and adults. We can look forward to further improvements in the prevention of disorders and their effective amelioration. Hopefully, this knowledge will reduce the burden of suffering for individuals and their families, and will help reduce the need for hospitalization and restraints. However, at the same time, it is critically important to improve the current care that individuals in hospital are receiving. To do this will require varied types of efforts for training of clinicians and staff, funding for services, and improvement in settings of care. The Freedom From Restraint Act highlights one, specific issue involved in providing high quality, compassionate care. As child and adolescent psychiatrists, we are very pleased by your concern and by the leadership that you have taken to help assure that individuals with psychiatric disturbances will receive the best treatment possible.

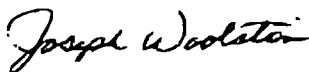
Sincerely,



Donald J. Cohen, M.D.  
Irving B. Harris Professor of  
Child Psychiatry, Pediatrics and Psychology  
Director, Yale Child Study Center



John Schowalter  
A.J. Solnit Professor of  
Child Psychiatry & Pediatrics  
Clinical Director, Yale Child Study Center



Joseph Woolston, M.D.  
Associate Professor of Child Psychiatry  
Medical Director of InPatient Services of  
Child Psychiatry at Yale New Haven Hospital



March 24, 1999

370 Linwood Street  
New Britain, CT 06052  
(860) 224-9113  
FAX: (860) 826-1739  
www.klingberg.com

U.S. Senator Joseph Lieberman  
706 Senate Hart Building  
Washington, D.C. 20510

Dear Sen. Lieberman:

As a provider of mental health services to Connecticut's children and families, Klingberg Family Centers applauds your efforts to ensure the safety and wellbeing of individuals being cared for in institutional settings. We trust that The Freedom From Restraint Act of 1999 will result in agencies adopting policies that protect both their patients and those that are caring for them.

Through our years of work with children and families, we recognize the value of regularly taking a critical look at how best to serve others. The people we are striving to help are facing complex problems which can be responded to with a wide range of therapeutic interventions. Physical interventions conducted in a spirit of concern for the client and others can successfully calm an individual who needs help in gaining control of their behavior. In addition to establishing regulations and clearly defining the boundaries in the use of physical restraint, it is critically important to thoroughly train staff members in order to equip them to provide the best treatment to those in their care.

We certainly agree that the appropriate and therapeutic use of physical restraint deserves thoughtful consideration and we would hope that one day we might eliminate the need for this level of intervention altogether. In our commitment to developing and adhering to best practices, Klingberg Family Centers would welcome the opportunity to assist you in exploring this issue further. We would be happy to consult with both the National Association of Psychiatric Treatment Centers for Children and the Child Welfare League of America to find other examples of how facilities across our nation are addressing this issue with competency and caring. Please feel free to contact me at (860) 224-9113 if we can be of any help.

Sincerely,

Rosemarie A. Burton  
President



**National  
Mental  
Health  
Association**

1021 Prince Street, Alexandria, VA 22314-2971 • Phone (703) 684-7722 • Fax (703) 684-8988 • TTY (800) 433-5959 • [www.nmha.org](http://www.nmha.org)

Monty Moeller, Chair of the Board • Michael M. Faenza, President and CEO

March 23, 1999

The Honorable Joseph I. Lieberman  
706 Hart Senate Office Building  
Washington, D.C. 20510

Dear Senator Lieberman:

On behalf of the National Mental Health Association (NMHA) – which represents 340 affiliates in 41 states – I am writing to express our support for your legislation, which reforms seclusion and restraint practices in all psychiatric facilities in the United States. We believe that your measure will both curb abusive restraint practices and, more importantly, save lives. By introducing this proposal, you are displaying outstanding leadership and addressing an ongoing crisis which threatens the health and safety of consumers around the nation.

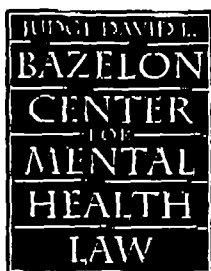
In particular, NMHA was very pleased that the measure limits the use of restraints only to those situations where the safety of consumers is in jeopardy. These provisions should virtually eliminate the abusive use of vests, nets, manacles and other devices solely to administer punishment or for staff convenience. Moreover, the legislation reforms shoddy record keeping practices, and clearly requires that psychiatric facilities must report all deaths to appropriate accreditation agencies, state authorities and legal advocacy organizations. Our members also strongly agree with provisions in your bill that impose stiff monetary sanctions, and threaten the loss of federal funds for those hospitals and residential treatment centers for children that fail to comply with the new reporting requirements.

As the legislative process moves forward, we hope engage in a dialogue regarding further improvements. Specifically, NMHA strongly believes that consumer/family/volunteer monitoring groups should be installed at every psychiatric facility in America. These groups could play a vital ombudsman role and avoid tragedy. Additionally, NMHA hopes that you will seriously reconsider language in your legislation that maintains the confidentiality of death reports.

Sen. Lieberman, your bill is a historic step forward. We look forward working closely with you to ensure that this important measure becomes law.

Sincerely,

Michael M. Faenza  
President & CEO



Civil Rights and Human Dignity

BOARD OF TRUSTEES

Robert A. Burt, Chair  
Yale Law School

Eileen A. Bazelon, MD  
Department of Psychiatry,  
Medical College of Pennsylvania

Barbara Cutler  
Mediate, Inc., New York NY

Mary Jane England, MD  
Washington Business Group  
on Health

Kenneth R. Felberg  
Attorney, Washington, DC

Elliot F. Gerson  
ETC, Inc., Washington, DC

Howard H. Goldman, MD  
Department of Psychiatry,  
University of Maryland  
School of Medicine

Nikki Heldepriem  
Foreman, Heldepriem & Mager, Inc.  
Washington, DC

Emily Hoffman  
New York NY

C. Lyonel Jones  
Legal Aid Society of Cleveland

Miriam Kravitz  
Executive Director, INCube, Inc.  
New York NY

Martha L. Milrow  
Harvard Law School

Stephen J. Morse  
University of Pennsylvania  
Law School

Carlos Perez  
AHEAD-Adolescent Mental Health  
Self-Help Network in  
South Texas

Louise E. Sagalyn  
Sagalyn Associates,  
Washington, DC

H. Rutherford Turnbull, III  
Beach Center for Families and  
Disability, University of Kansas

Ronald H. Welch  
Zuckerman, Spender, Goldstein,  
Taylor & Koller, L.L.P.  
Washington, DC

HONORARY TRUSTEE

Miriam Bazelon Knox  
Washington, DC

EXECUTIVE DIRECTOR

Robert Bernstein, Ph.D.

March 24, 1999

The Honorable Joseph Lieberman  
The Honorable Christopher Dodd  
United States Senate  
Washington, DC 20510

Dear Senators Lieberman and Dodd:

On behalf of the Judge David L. Bazelon Center for Mental Health Law - a national nonprofit advocacy organization that uses litigation and federal policy reform to define and uphold the legal rights of children, adults and elders with mental disabilities - I am pleased to express our endorsement of the Patient Freedom from Restraint Act of 1999.

With the *Hartford Courant* newspaper articles revealing the appalling instances of institutional abuse of seclusion and restraints, the Bazelon Center strongly believes the time has come to stop this disturbing national problem. Furthermore, we believe that children and adults who receive mental health care in institutions or residential treatment settings have a right to protection from harmful and even life-threatening care. This right should not be threatened by the current lack of national standards governing the use of seclusion and restraints.

The Lieberman/Dodd Patient Freedom from Restraint Act has taken the critical step forward in the Senate in exploring ways to reduce and document these tragedies. Without national standards, instances of abuse and senseless deaths of children and adults in these settings will continue to be a crisis in our country.

Your leadership on this important issue is greatly appreciated. We commend you for your initiative and interest in enacting into law seclusion and restraint projections. We look forward to consulting with you further on this issue of great importance.

Sincerely,

Robert Bernstein, Ph.D.  
Executive Director

# NAMI Statement

---

## INTRODUCTION OF LEGISLATION FOR NATIONAL STANDARDS TO PREVENT ABUSE OF RESTRAINTS AND SECLUSION

Statement of  
Laurie Flynn, Executive Director  
National Alliance for the Mentally Ill (NAMI)

Congressional News Conference  
March 25, 1999

NAMI is pleased with the leadership that members of Congress are providing today with the introduction of three bills to address the need for national standards to prevent abuse of restraints and seclusion in psychiatric facilities. Each bill represents an important step forward from the status quo and a serious, thoughtful response to a national crisis.

Last year, *The Hartford Courant* published a special investigative series that put a spotlight on the crisis, documenting 142 deaths around the country that occurred over a decade during or shortly after restraints or seclusion were imposed on individuals being treated for psychiatric conditions. An estimate by the Harvard Center for Risk Analysis, commissioned by the *Courant*, further indicated that between 50 and 150 such deaths occur every year.

NAMI is especially proud that the presidents of two Connecticut NAMI affiliates played a critical role in helping to focus the series: Karen Hutchin of Granby and Jeanne Landry-Harpin of Woodbridge.

Since the *Courant* published the series in October 1998, NAMI has pressed for federal and state action to end such abuses. We also have received a steady stream of reports of new abuses and new deaths, as well as ones experienced by consumers in the past.

Every report received represents a cry of anguish. People are dying, including children. Today, NAMI is releasing a summary of reports compiled since *The Hartford Courant* series appeared. Five deaths have occurred over the past five months. Four of them have been of youths under the age of 18. These are only the ones we know about.

On behalf of NAMI's more than 208,000 members nationwide, I call on Congress to adopt national standards that restrict the use of seclusion and restraints to emergency situations in which physical safety is at risk. Mandatory reporting of deaths and injuries to legal authorities must be required.

This is an urgent problem. It will not go away. Deaths and human trauma will continue unless Congress acts.

National Alliance for the Mentally Ill  
200 North Glebe Road, Suite 1015 • Arlington, VA 22203-3754  
703-524-7600 • Fax 703-524-9094

SENATOR LIBERMAN-DC

05/11/99 THE 12:16 FAX 2280341

### DeGette-Stark-DeLauro Bill

NAMI strongly endorses the bill being introduced today by Representatives Diana DeGette (D-CO), Rosa DeLauro (D-CT), and Pete Stark (D-CA).

"The Patient Freedom From Restraint Act" represents the strongest and most protective approach being proposed. The legislation:

- recognizes that restraints never should be considered part of therapeutic treatment, but rather used only in emergency responses, which can only be justified if physical safety is at risk;
- requires consistency in the regulation of restraints for all Medicare and Medicaid facilities that provide treatment to persons with psychiatric illnesses;
- requires mandatory reporting of deaths and serious injuries to a legal authority in each state;
- enacts "best practice" standards; and
- includes strong sanctions.

### Lieberman Bill

Senator Joseph Lieberman (D-CT) will introduce legislation co-sponsored by Senator Christopher Dodd (D-CT) that also establishes a nationally consistent standard for Medicare and Medicaid facilities, based on recognition that restraints and seclusion are appropriate only in emergency situations that involve physical safety.

This legislation also mandates reporting of deaths and serious injuries to federal and state agencies, and if the facility is accredited, to the industry's Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

NAMI regards Senator Lieberman's leadership as making a significant, positive contribution to the issue; however, we are disappointed by some provisions in the bill. Its approach allows a facility to determine for itself whether a death or injury constitutes an "unexpected occurrence" that requires that it be reported. Only reports of deaths and injuries that are part of an undefined "pattern of poor performance" will become public information. Facility analyses of deaths also will remain "confidential," denying consumers and families access to important information. We hope that these provisions will be modified after further deliberations.

### Dodd Bill

Senator Christopher Dodd is also introducing legislation today, co-sponsored by Senator Lieberman, that would amend the "Protection & Advocacy for Mentally Ill Individuals Act" (PAMII) to require the reporting of restraints- and seclusion-related deaths within seven days.

As a member of the Senate Committee on Health, Education, Labor and Pensions, which has jurisdiction over PAMII, Senator Dodd's leadership will be important in the legislative process. His focus on PAMII has the potential to broaden dimensions of the congressional debate.

The Lieberman and Dodd bills will complement each other and together provide a foundation for action in the Senate.

# NAPAS

National Association of Protection & Advocacy Systems

## Executive Committee

President  
Lois Simpson  
Louisiana  
(504) 522-2337

Vice President  
Catherine Blakemore  
California  
(916) 488-9955

Secretary  
Rick Tessandore  
Alaska  
(907) 344-1002

Treasurer  
Carolyn Knight  
Ohio  
(614) 466-7264

## Regional Officers

Region I  
Catherine Blakemore (CA)  
Jackson (NM)  
Nelson (UT)

Region II  
Marshall (AL)  
Joyce Ringer (GA)  
Lois Simpson (LA)

Region III  
Marcel Chaine (NY)  
Kim Moody (ME)  
Christine Griffin (MA)

Region IV  
John Basham (KY)  
Carolyn Knight (OH)  
Victoria Rasmussen (NE)

Region V  
Lyon (ND)  
Linda Potter (MI)  
Rick Tessandore (AK)

## At-Large

Hilamah Gardiner (PA)  
Bob Kafka (TX)

Executive Director

Curtis L. Decker, J.D.

March 25, 1999

The Honorable Joseph I. Lieberman  
The Honorable Christopher J. Dodd  
United States Senate  
Washington, DC 20510

Dear Senators Lieberman and Dodd:

I wish to express the support of the membership association for the nation's federally mandated disability rights system -- the Protection and Advocacy (P&A) System -- for the Freedom from Restraint Act of 1999.

This legislation represents an important step in the development of a national strategy to minimize the misuse of restraints and seclusion at facilities serving persons with mental illness and developmental disabilities. The misuse of restraints such as the use of brute force, manacles and drugs -- for reasons of staff convenience, discipline and punishment, rather than as an emergency safety measure -- results in 100 or more needless patient deaths each year, and perhaps thousands more serious injuries. This amounts to a national crisis in our system of care for these vulnerable individuals, especially children, who suffer the brunt of these abuses.

These deaths and injuries have been allowed to occur because there are currently no national, enforceable standards governing the use of restraint and seclusion, and no federal requirement that restraint-related deaths and injuries be reported to outside independent agencies for investigation and corrective action.

We strongly support the minimum standards contained in the bill on the use of restraints and seclusion applicable to both mental health and developmental disabilities facilities. And, we generally support as well the requirement that a broad range of deaths of persons with mental illness be reported to P&As and other oversight agencies so that appropriate investigations and corrective action may occur. However, in the area of reporting we believe the bill does not go far enough.

First, the bill should be expanded to require the reporting of deaths of persons with developmental disabilities, as well as those with mental illness. There is no reason

to believe that persons with developmental disabilities, including mental retardation, are subject to any lower levels of abusive restraint and seclusion practices than are mental health consumers. Reporting of deaths in this very vulnerable population is critically needed as well.

Second, the reporting requirement must be extended to all deaths in these facilities, not only those which the facility determines are "unrelated to the natural course of the individual's illness or underlying condition," as provided for in the bill. This limitation leaves open the possibility that many deaths which were actually precipitated by the misuse of restraint and seclusion will go unreported. Oversight agencies must have access to reports of all deaths so that they can make a valid, independent determination as to which deaths may have been restraint-related, and thus require follow up.

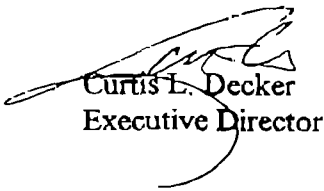
We appreciate the prominent role for the P&A System carved out this Act. We believe this to be an appropriate role given the System's existing unique federal mandate to investigate and remedy abuse and neglect of persons with disabilities, including the misuse of restraint and seclusion. In fiscal year 1998 alone P&As responded to about 34,450 reports of abuse and neglect. Our system has been quite successful in uncovering and remedying these practices -- but could do much more with the federal reporting requirement contained in the bill.

Under current federal law, P&As can only investigate under narrow circumstances such as when family members suspect foul play and contact the P&A. Because facilities serving persons with mental retardation or mental illness are not required to report deaths that may be related to the misuse of restraints, a large number of these deaths simply do not come to the attention of the P&A System, and may not be investigated. These facilities too often dismiss restraint-related deaths as unfortunate isolated incidents and not as the manifestation of systemic failures; further, they may rationalize them as a result of the patient's underlying condition.

Once the P&A receives these reports required under this bill, their trained investigators and legal staff can determine which deaths may be due to the misuse of restraint, and can take appropriate corrective actions to ensure that these abuses do not occur in the future. For example, through negotiation or litigation, if necessary, corrective actions could be imposed to reform facility practices or statewide policies, appropriate compensation for family members of the deceased can be obtained, and staff involved in the death can be subjected to termination and/or criminal prosecution.

Again, I would like to express our general support for this critically needed legislation. However, we strongly recommend that the concerns noted above be addressed.

Sincerely,

  
Curtis L. Decker  
Executive Director

106TH CONGRESS  
1ST SESSION

# S. 736

To amend titles XVIII and XIX of the Social Security Act to ensure that individuals enjoy the right to be free from restraint, and for other purposes.

---

## IN THE SENATE OF THE UNITED STATES

MARCH 25, 1999

Mr. LIEBERMAN (for himself and Mr. DODD) introduced the following bill;  
which was read twice and referred to the Committee on Finance

---

## A BILL

To amend titles XVIII and XIX of the Social Security Act to ensure that individuals enjoy the right to be free from restraint, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the "Freedom From Re-  
5       straint Act of 1999".

1 SEC. 2. INDIVIDUALS' RIGHT TO FREEDOM FROM RE-  
 2 STRAINT AND REPORTING OF SENTINEL  
 3 EVENTS UNDER MEDICARE.

4 (a) IN GENERAL.—Part D of title XVIII of the Social  
 5 Security Act (42 U.S.C. 1395x et seq.) is amended by add-  
 6 ing at the end the following:

7 "INDIVIDUALS' FREEDOM FROM RESTRAINT AND  
 8 REPORTING OF SENTINEL EVENTS

9 "SEC. 1897. (a) DEFINITIONS.—In this section:

10 "(1) PROVIDER OF SERVICES.—The term 'pro-  
 11 vider of services' has the meaning given that term  
 12 in section 1861(u), except that for purposes of this  
 13 section the term includes a psychiatric hospital but  
 14 does not include a home health agency.

15 "(2) SENTINEL EVENT.—The term 'sentinel  
 16 event' means an unexpected occurrence involving an  
 17 individual in the care of a provider of services for  
 18 treatment for a psychiatric or psychological illness  
 19 that results in death or serious physical or psycho-  
 20 logical injury that is unrelated to the natural course  
 21 of the individual's illness or underlying condition.

22 "(b) PROTECTION OF RIGHT TO BE FREE FROM RE-  
 23 STRAINTS.—A provider of services eligible to be paid  
 24 under this title for providing services to an individual enti-  
 25 tled to benefits under part A or enrolled under part B  
 26 (including an individual provided with a Medicare+Choice

1 plan offered by a Medicare+Choice organization under  
2 part C) shall—

3 “(1) protect and promote the right of each such  
4 individual to be free from physical or mental abuse,  
5 corporal punishment, involuntary seclusion, and any  
6 physical or chemical restraints imposed for purposes  
7 of discipline or convenience;

8 “(2) impose restraints—

9 “(A) only to ensure the physical safety of  
10 the individual or other individuals in the care or  
11 custody of the provider; and

12 “(B) only upon the written order of a phy-  
13 sician that specifies the duration and cir-  
14 cumstances under which the restraints are to be  
15 used (except in emergency circumstances speci-  
16 fied by the Secretary until such an order could  
17 reasonably be obtained); and

18 “(2) submit the reports required under sub-  
19 section (c).

20 “(c) REPORTS.—

21 “(1) REPORTS TO AGENCIES OR ENTITIES WITH  
22 OVERSIGHT AUTHORITY.—

23 “(A) IN GENERAL.—A provider of services  
24 shall report each sentinel event that occurs to

1 an individual while the individual is in the care  
 2 or custody of the provider to—

3 “(i) in the case of a provider of serv-  
 4 ices participating in the program estab-  
 5 lished under this title or the medicaid pro-  
 6 gram under title XIX as a result of accred-  
 7 itation by a national accrediting body, the  
 8 national accrediting body for that provider;  
 9 and

10 “(ii) in the case of all other providers  
 11 of services, the Secretary or, upon agree-  
 12 ment between the Secretary and the rel-  
 13 evant State, the State agency designated  
 14 by the Secretary.

15 “(B) INVESTIGATION AND FURTHER RE-  
 16 PORTING OF SENTINEL EVENTS.—Upon receipt  
 17 of a report made pursuant to subparagraph  
 18 (A), the agency or entity with oversight author-  
 19 ity shall—

20 “(i) ensure that the provider—

21 “(I) conducts an investigation of  
 22 the sentinel event reported;

23 “(II) determines the root cause  
 24 or causes of the sentinel event; and

1           “(III) establishes a time-limited  
2           plan or strategy, that allows the agen-  
3           cy or entity with oversight authority  
4           to review and approve the analyses  
5           and any corrective actions proposed or  
6           made by the provider of services, to  
7           correct the problem or problems that  
8           resulted in the sentinel event, and to  
9           lead to risk reduction; and

10          “(ii) prepare and submit the reports  
11          required under paragraph (2).

12          “(2) REPORTS TO THE SECRETARY.—

13          “(A) IN GENERAL.—Subject to subpara-  
14          graph (D), the agency or entity with oversight  
15          authority shall submit a report containing the  
16          information described in subparagraph (B) to  
17          the Secretary in such form and manner, and by  
18          such date, as the Secretary prescribes.

19          “(B) INFORMATION TO BE REPORTED.—

20          “(i) IN GENERAL.—The report sub-  
21          mitted under subparagraph (A) shall be  
22          submitted to the Secretary at regular in-  
23          tervals, but not less frequently than annu-  
24          ally, and shall include—

1           “(I) a description of the sentinel  
2           events occurring during the period  
3           covered by the report;

4           “(II) a description of any correc-  
5           tive action taken by the providers of  
6           services with respect to the sentinel  
7           events or any other measures nec-  
8           essary to prevent similar sentinel  
9           events from occurring in the future;

10          “(III) proposed systems changes  
11          identified as a result of analysis of  
12          events from multiple providers; and

13          “(IV) such additional information  
14          as the Secretary determines to be es-  
15          sential to ensure compliance with the  
16          requirements of this section.

17          “(ii) INFORMATION EXCLUDED.—The  
18          report submitted under subparagraph (A)  
19          shall not identify any individual provider of  
20          services, practitioner, or individual.

21          “(C) ADDITIONAL REPORTING REQUIRE-  
22          MENTS WHEN A PROVIDER HAS BEEN IDENTI-  
23          FIED AS HAVING A PATTERN OF POOR PER-  
24          FORMANCE.—

1           “(i) IN GENERAL.—In addition to the  
 2           report required under subparagraph (A),  
 3           the agency or entity with oversight author-  
 4           ity shall report to the Secretary the name  
 5           and address of any provider of services  
 6           with a pattern of poor performance.

7           “(ii) DETERMINATION OF PATTERN.—  
 8           The agency or entity with oversight au-  
 9           thority shall determine if a pattern of poor  
 10          performance exists with respect to a pro-  
 11          vider of services in accordance with the  
 12          definition of pattern of poor performance  
 13          developed by the Secretary under clause  
 14          (iii).

15          “(iii) DEVELOPMENT OF DEFINI-  
 16          TION.—The Secretary, in consultation with  
 17          national accrediting organizations and oth-  
 18          ers, shall develop a definition to identify a  
 19          provider of services with a pattern of poor  
 20          performance.

21          “(D) AUTHORITY TO WAIVE REPORTING  
 22          REQUIREMENT.—The Secretary may waive the  
 23          requirement to submit a report required under  
 24          this paragraph (but not a report regarding a  
 25          sentinel event that resulted in death required

1 under paragraph (3)) upon consideration of the  
2 severity of the sentinel event.

3 “(3) ADDITIONAL REPORTING REQUIREMENTS  
4 FOR SENTINEL EVENTS RESULTING IN DEATH.—In  
5 addition to the report required under paragraph (1),  
6 a provider of services shall report any sentinel event  
7 resulting in death to—

8 “(A) the Secretary or the Secretary’s des-  
9 ignee;

10 “(B) the State Attorney General or, upon  
11 agreement with the State Attorney General, to  
12 the appropriate law enforcement agency;

13 “(C) the State agency responsible for li-  
14 censing the provider of services; and

15 “(D) the State protection and advocacy  
16 system established pursuant to part C of title I  
17 of the Developmental Disabilities Assistance  
18 and Bill of Rights Act (42 U.S.C. 6041 et seq.)  
19 for the State in which the event occurred.

20 “(4) RESPONSIBILITIES OF THE AGENCY OR  
21 ENTITY WITH OVERSIGHT AUTHORITY.—Upon re-  
22 ceipt of a report of a sentinel event that resulted in  
23 death, the agency or entity with oversight authority  
24 shall, in addition to the requirements of paragraph  
25 (2)—

1           “(A) determine whether the death was re-  
2           lated to the use of restraints or seclusion; and

3           “(B) notify the Secretary of the determina-  
4           tion.

5           “(5) SANCTIONS FOR FAILURE TO REPORT.—

6           “(A) IN GENERAL.—The Secretary shall  
7           establish sanctions, including intermediate sanc-  
8           tions, as appropriate, for failure of a provider  
9           of services or an agency or entity with oversight  
10          authority to submit the reports and information  
11          required under this subsection.

12          “(B) REMOVAL OF AGENCY OR ENTITY  
13          WITH OVERSIGHT AUTHORITY.—The Secretary,  
14          after notice to an agency or entity with over-  
15          sight authority of a provider of services, as de-  
16          termined in paragraph (1), and opportunity to  
17          comply, may remove the agency or entity of  
18          such authority if the agency or entity refuses to  
19          submit the reports and information required  
20          under this subsection.

21          “(6) LIABILITY FOR REPORTING.—An indi-  
22          vidual, provider of services, agency, or entity shall be  
23          liable with respect to any information contained in  
24          a report required under this subsection if the indi-  
25          vidual, provider of services, agency, or entity had

1 knowledge of the falsity of the information contained  
 2 in the report at the time the report was submitted  
 3 under this subsection. Nothing in the preceding sen-  
 4 tence shall be construed as limiting the liability of  
 5 an individual, provider of services, agency, or entity  
 6 for damages relating to the occurrence of a sentinel  
 7 event, including a sentinel event that results in  
 8 death.

9 “(7) NONDISCLOSURE OF ANALYSIS.—Notwith-  
 10 standing any other provision of law or regulation,  
 11 the root cause analysis developed under this sub-  
 12 section shall be kept confidential and shall not be  
 13 subject to disclosure or discovery in a civil action.

14 “(d) ESTABLISHMENT OR DESIGNATION OF SEN-  
 15 TINEL EVENTS DATABASE.—

16 “(1) IN GENERAL.—Not later than 1 year after  
 17 the date of enactment of this section, the Secretary  
 18 shall establish or designate a database of informa-  
 19 tion using the reports submitted under paragraphs  
 20 (2) and (3) of subsection (c) (in this subsection re-  
 21 ferred to as the ‘Sentinel Events Database’).

22 “(2) CONTENTS.—

23 “(A) IN GENERAL.—Subject to subpara-  
 24 graph (B), the Sentinel Events Database shall  
 25 include the following:

1           “(i) The name and address of any  
 2           provider of services that is the subject of  
 3           a report submitted under subsection (c)(3),  
 4           if the agency or entity with oversight au-  
 5           thority has determined that the death was  
 6           related to the use of restraints or seclu-  
 7           sion.

8           “(ii) The information reported by the  
 9           agency or entity under subparagraphs (B)  
 10          and (C) of subsection (c)(2).

11          “(B) CONFIDENTIALITY.—The Secretary  
 12          shall establish procedures to ensure that the  
 13          privacy of individuals whose treatment is the  
 14          subject of a report submitted under paragraph  
 15          (2) or (3) of subsection (c) is protected.

16          “(3) PROCEDURES FOR ENTRY OF INFORMA-  
 17          TION.—

18          “(A) IN GENERAL.—The Secretary shall—

19               “(i) prior to entry of information in  
 20               the Sentinel Events Database, disclose the  
 21               information to the provider of services that  
 22               is the subject of the information; and

23               “(ii) establish procedures to—

24                       “(I) resolve disputes regarding  
 25                       the accuracy of the information; and

1                   “(II) ensure the accuracy of the  
2                   information.

3                   “(B) NO DELAY OF SANCTIONS.—Any  
4                   sanction to be imposed by the Secretary against  
5                   a provider of services or an agency or entity  
6                   with oversight authority in relation to a sentinel  
7                   event shall not be delayed as a result of a dis-  
8                   pute regarding the accuracy of information to  
9                   be entered into the database.

10                  “(4) ACCESS TO THE DATABASE.—

11                  “(A) AVAILABILITY.—The Secretary shall  
12                  establish procedures for making the information  
13                  maintained in the Sentinel Events Database re-  
14                  lated to a sentinel event resulting in death, and  
15                  any reports of sentinel injuries arising from  
16                  those providers of services with a pattern of  
17                  poor performance identified in accordance with  
18                  subsection (c)(2)(C), available to Federal and  
19                  State agencies, national accrediting bodies,  
20                  health care researchers, and the public.

21                  “(B) INTERNET ACCESS.—In addition to  
22                  any other procedures that the Secretary devel-  
23                  ops under subparagraph (A), the information in  
24                  the Sentinel Events Database shall be accessible  
25                  through the Internet.

1           cumstances specified by the Secretary until  
2           such an order could reasonably be ob-  
3           tained); and

4           “(C) submit the reports required under  
5           subsection (c) of section 1897 (relating to sen-  
6           tinel events) in the same manner as a provider  
7           of services under that section is required to  
8           submit such reports.”.

9       (b) DEFINITION OF CONGREGATE CARE PRO-  
10   VIDER.—Section 1905 of the Social Security Act (42  
11   U.S.C. 1396d) is amended by adding at the end the fol-  
12   lowing:

13       “(v) The term ‘congregate care provider’ means an  
14   entity that provides hospital services, nursing facility serv-  
15   ices, services of intermediate care facilities for the men-  
16   tally retarded, hospice care, residential treatment centers  
17   for children, services in an institution for mental diseases,  
18   inpatient psychiatric hospital services for individuals  
19   under age 21, or congregate care services under a waiver  
20   authorized under section 1915(c).”.

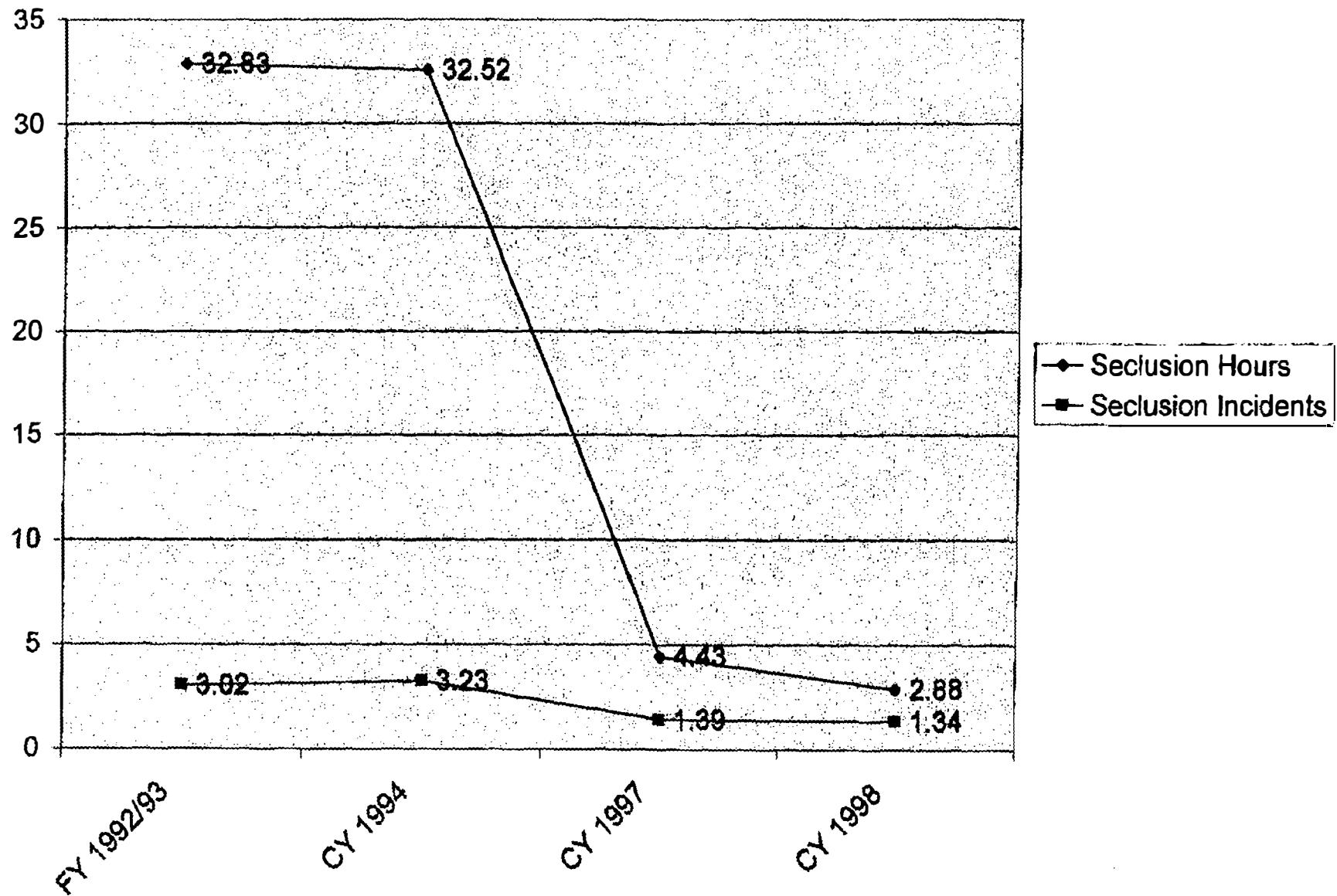
21       (c) EFFECTIVE DATE.—

22           (1) IN GENERAL.—Subject to paragraph (2),  
23       the amendments made by this section take effect on  
24       the date of enactment of this Act.

1           (2) REPORTING REQUIREMENTS.—The report-  
2   ing requirements under section 1902(a)(66)(C) of  
3   the Social Security Act (42 U.S.C.  
4   1396a(a)(66)(C)), as added by subsection (a), shall  
5   apply to sentinel events occurring on and after the  
6   date of enactment of this Act.

○

Pennsylvania State Mental Hospital System  
Seclusion Usage per 1000 Pt. Days



SEYMOUR LIEDELMAN - DC



# **OMHSAS POLICY**

## **RESTRICTED USE**

- Seclusion/restraint use permitted only as a safety measure when all else has failed and the patient presents imminent danger of physical harm to self or others.

TF00077 VUJ 07.77 707 0077,00

- DEVALUK LIEBEKMAN-DC

## **MONITORING**

- All use and duration is monitored at the team, hospital and state levels
- Statewide performance indicators monitor and compare use within and among all hospitals over time
- Seclusion and restraint incidence and hours are reported to JCAHO quarterly, as part of the SMHs approved ORYX system.
- Injury or death in seclusion and restraint are reported to state police, Coroners Office, etc., and treated as sentinel events.

## **RESULTS:**

- Dramatic decline in use and duration.
- Goal of elimination announced by Deputy Secretary Curie.

## **CONDITIONS NEEDED TO SIGNIFICANTLY ALTER SECLUSION AND RESTRAINT USE**

- Strong leadership commitment: State and local.
- Adequate staff/pt. ratio (2 to 1).
- Staff training in verbal crisis de-escalation techniques and safe physical management.
- Involvement and commitment by all levels of staff.
- Abundance of active, meaningful treatment options, which foster choice and consumer involvement.
- Systematic consumer risk assessment and risk-based treatment planning, which address the precipitants of violence.

- Aggressive use of 2<sup>nd</sup> generation antipsychotic medications.
- An environment of care that fosters patient dignity and choice and eliminates rules made for staff convenience.
- Open communication about goal of elimination and hospital progress toward that goal.

2.

# SECLUSION AND RESTRAINT USE

PENNSYLVANIA'S STATE MENTAL HOSPITAL SYSTEM COMPLIES WITH OR EXCEEDS ALL JCAHO STANDARDS FOR THE USE OF SECLUSION AND RESTRAINT. THE FOLLOWING CHART COMPARES OMHSAS POLICIES WITH THE JCAHO STANDARDS WHICH THEY EXCEED.

## JCAHO STANDARDS

SECLUSION AND RESTRAINT ORDERS MAY BE WRITTEN FOR UP TO FOUR HOURS.

PATIENTS MAY BE RETURNED TO SECLUSION OR RESTRAINTS WITHOUT A NEW ORDER, IF RELEASED BEFORE THE ORIGINAL ORDER EXPIRES.

AFTER THE ORIGINAL 4 HOUR ORDER EXPIRES, ANY LICENSED, QUALIFIED PERSON (SUCH AS A REGISTERED NURSE) MAY ASSESS THE PATIENT AND CONTINUE THE ORDER FOR AN ADDITIONAL FOUR (4) HOURS. THE ORDER MAY BE CONTINUED FOR UP TO 24 HOURS WITHOUT A NEW ORDER BEING WRITTEN.

NO PATIENT DEBRIEFING REQUIRED

## PENNSYLVANIA OMHSAS POLICY

SECLUSION AND RESTRAINT ORDERS MAY NOT EXCEED ONE HOUR.

A NEW PHYSICIAN'S ORDER IS REQUIRED BEFORE THE PATIENT MAY BE RETURNED TO SECLUSION OR RESTRAINT AFTER AN EARLY RELEASE.

A NEW ORDER MUST BE WRITTEN BY A PHYSICIAN AFTER THE ORIGINAL ONE HOUR ORDER EXPIRES. THE PHYSICIAN MUST REASSESS THE PATIENT IN PERSON EACH TIME AN ORDER IS WRITTEN.

PATIENT DEBRIEFING IS REQUIRED AFTER RELEASE FROM SECLUSION OR RESTRAINT, AND THE TREATMENT PLAN MUST BE UPDATED AFTER EACH SECLUSION/RESTRAINT INCIDENT.

## **JCAHO STANDARDS**

**PATIENTS IN RESTRAINTS MUST BE MONITORED EVERY 15 MINUTES.**

**ANY LICENCED, INDEPENDENT PRACTITIONER MAY ORDER RESTRAINT OR SECLUSION WITH LEGAL AND ORGANIZATIONAL AUTHORIZATION.**

**ANY AUTHORIZED PERSON MAY INITIATE SECLUSION AND RESTRAINT FOR UP TO ONE HOUR IN AN EMERGENCY. A LICENSED, AUTHORIZED PRACTITIONER MUST BE CALLED TO PROVIDE AUTHORIZATION FOR CONTINUED USE WITHIN ONE HOUR OF ITS INITIATION.**

## **OMHSAS POLICY**

**PATIENTS IN RESTRAINT ARE KEPT UNDER CONSTANT OBSERVATION WITH STATUS DOCUMENTED EVERY 15 MINUTES.**

**ONLY A PHYSICIAN MAY ORDER SECLUSION OR RESTRAINT.**

**REGISTERED NURSES MAY SECLUDE OR RESTRAIN A PATIENT IN AN EMERGENCY, BUT A VERBAL PHYSICIAN'S ORDER MUST BE IMMEDIATELY OBTAINED, AND THE PHYSICIAN MUST PERSONALLY ASSESS THE PATIENT WITHIN 30 MINUTES.**



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

*Identical letter sent to Lieberman*The Administrator  
Washington, D.C. 20201

MAR 24 1999

The Honorable Christopher J. Dodd  
United States Senate  
Washington, D.C. 20510

Dear Senator Dodd:

I am writing in strong support of your efforts to provide additional Federal oversight to prevent inappropriate seclusion and restraint practices in mental health settings. The President, Secretary Shalala, and I share your concern over the recent reports of children who died after being inappropriately restrained, and we applaud your efforts to protect all hospital patients from harm associated with the use of seclusion and restraints. We look forward to working with you on the specifics of the legislation as it moves forward.

I would also like to take this opportunity to update you on the Administration's recent efforts to protect children and other hospital patients from harm associated with the inappropriate use of restraints. As you may know, in the Notice of Proposed Rulemaking (NPRM) for the new Medicare hospital Conditions of Participation (CoP), HCFA proposed a CoP to address patients' rights. Within this CoP, HCFA proposed standards restricting for the first time, the use of restraints in hospital settings. The Medicare hospital CoPs apply to all patients in hospitals who participate in the Medicare program, therefore, these rights extend beyond the Medicare population in these facilities. In addition, the hospital CoPs apply to Medicaid hospitals as well.

Because of the importance of this issue to the health and safety of patients, we plan to carve out the "Patients Rights" section (which addresses the seclusion/restraint issue) of the CoP from the larger hospital conditions of participation regulation so that we can publish the standard in final by late summer. By carving out this section, HCFA will be able to move more quickly to hold all hospitals that participate in Medicare and Medicaid accountable for the inappropriate use of seclusion and restraints. The proposed Patient Rights CoP will apply to all participating hospitals, including acute, psychiatric, rehabilitation, long-term, children's, and alcohol-drug hospitals.

In addition to our efforts with hospitals, HCFA already has regulations restricting the use of restraints in settings including intermediate care facilities for the mentally retarded (ICFs-MR) and nursing facilities. In addition, the Clinton Administration has made improving the quality of nursing home care and oversight a top priority. Last July, the President announced a broad initiative to strengthen the enforcement of our nursing home regulations, which we published in 1995.

The Honorable Christopher J. Dodd

In addition to HCFA's efforts, a number of other federal agencies are increasing attention to inappropriate seclusion and restraint practices. Most notably, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services (SAMHSA) Administration within the U.S. Department of Health and Human Services provides funds to state protection and advocacy systems. These systems, present in each state, have a strong record of addressing and resolving consumer complaints related to the misuse of seclusion and restraint. Moreover, HCFA staff are actively participating with CMHS in the development and implementation of an action plan that will continue to address problems with the misuse of seclusion and restraints in our nation's health care facilities.

Your legislation will add to these efforts by expanding the scope of this policy to patients in settings that HCFA does not have the authority to regulate such as residential treatment centers for children and congregate care services under a waiver authorized under section 1915(c). Your bill also emphasizes the need for more accurate and timely reporting through the establishment or designation of sentinel events restraint database. We look forward to working with you and with your staff on this approach.

The President, Secretary Shalala, and I strongly support your interest and efforts and those of your colleagues to prevent the inappropriate and dangerous use of restraints in mental health settings, and I am confident that we can work together to protect the children and other vulnerable patients who are currently at risk.

Sincerely,



Nancy-Ann Min DeParle  
Administrator

## **THE FREEDOM FROM RESTRAINT ACT OF 1999**

### **SUMMARY OF THE NEW LEGISLATION**

This legislation would essentially expand the requirements governing the use of restraints and seclusion in nursing homes to include hospitals participating in the Medicare and Medicaid program and intermediate care facilities for the mentally retarded, hospices, residential treatment centers for children and institutions of mental disease participating in the Medicaid program. This new legislation would allow these facilities to impose physical restraints only upon the written order of a physician and only when necessary to ensure the physical safety of the patient or of other patients. Providers would be required to report all instances of serious patient injury or death related to the use of restraints to a central database to be established by the Secretary. HHS would be required to ensure that the provider investigated the cause of the patient injury and death and established a strategy to prevent similar injuries.

### **SUMMARY OF THE HARTFORD CASES**

The Freedom From Restraint Act of 1999 was inspired by a series of cases in Connecticut during October of 1998 in which several mentally ill children residing in psychiatric institutions died after being restrained by facility staff. The Harvard Center for Risk Analysis estimates that between 50 and 150 such deaths occur annually across the country. Reports indicated that many of the restraints being used routinely in the Connecticut facilities are not supposed to be used as part of patient care. A number of the patients died in the same type of a restraint hold, in which a patient is restrained face down on the floor, with their arms crossed beneath them and a staff member exerting pressure on their backs. In addition, there were indications that the restraining holds were not used as a last resort, but rather as a routine method of discipline. For instance, one of the children who died was restrained because he became upset after he was unable to find his favorite teddy bear.

### **HCFA PROPOSAL**

HCFA has been aware of patient advocate concerns about the inappropriate use of restraints for over a year. In response, HHS published an NPRM in December of 1997 that proposed to modify the Medicare Conditions of Participation for hospitals to prohibit the use of seclusion or restraints except when in accordance with a patient's plan of care and should be used only as a last resort. Providers would be required to use restraints in the least restrictive manner possible and must be removed at the earliest possible time.

At this point, despite the fact that comments were submitted to the agency in April of 1998, HCFA has not taken steps to codify these conditions of participation into a final rule. However, because of the importance of this issue to the health and safety of patients, HCFA will carve out the Patients Rights section of the new Conditions of Participation. This section, which addresses the use of restraints, will be published in final form by late summer.

On a staff level, HCFA has objected to Senator Lieberman's proposal to create a centralized database to track patient deaths and injuries caused by the inappropriate use of restraints because of privacy concerns.

### **THE NEW LEGISLATION BUILDS ON HCFA'S CURRENT AUTHORITY**

Currently, HCFA only has authority to require Medicare and Medicaid hospitals to comply with the standards for the use of restraints proposed in the NPRM. Senator Lieberman's proposed legislation would provide HCFA with the authority to require intermediate care facilities for the mentally retarded, hospices, residential treatment centers for children, and institutions of mental disease that are participating in the Medicaid program to comply with stricter standards around the use of patient restraints.

## LEVEL 1 - 3 OF 70 STORIES

Copyright 1999 The National Journal Group, Inc.  
Health Line

February 1, 1999

SECTION: POLITICS & POLICY

LENGTH: 354 words

HEADLINE: RESTRAINTS: FED. LEGISLATION AIMS TO FILL REGULATORY VOID

BODY:

Federal legislation regulating the use of physical restraints on mental health patients is on the verge of introduction, largely in response to a Hartford Courant series that exposed many abuses. The Courant reports that bill sponsor Sen. Joseph Lieberman (D-CT) said, "The evidence compiled is so overwhelming and the issues are of life-and-death (importance). Unless someone can come up with an argument that I haven't heard of, I expect bipartisan support." Rep. Diana DeGette (D-CO), co-author of the House bill with Rep. Pete Stark (D-CA), said, "What really pains me is that a disproportionate number of those who died from **restraints are children.**" The DeGette-Starks bill would "create specific and detailed federal guidelines on restraint and seclusion use in **mental** health facilities," as well as "track the use of restraint and seclusion nationwide and require all deaths to be reported to independent, federally funded agencies in each state." Stark said, "As for-profit **hospitals** care more and more about the bottom line and less and less about patient care, the incidents of unsafe care are increasing."

REAX

Although the use of restraints is regulated in nursing homes under a landmark 1987 reform bill, mental health facilities are not required to report deaths from restraints. Curtis Decker, executive director of a coalition of advocacy groups in favor of the bill, said, "We don't want to give facilities the wiggle room to pick and choose what deaths to report." The industry largely opposes the legislation, preferring instead to study the problem and produce voluntary guidelines. American Psychiatric Association Medical Director Dr. Steve Mirin said, "We think legislation should grow out of the understanding of the problem, instead of preceding it with a whole host of regulatory changes." Stark responded, "Regulation is considered a bad word mostly by people who are providing poor quality care or harming people" (Weiss/Altimari, 1/31). [Click here for recent coverage.](#)

LANGUAGE: ENGLISH

LOAD-DATE: February 1, 1999



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group

LEVEL 1 - 38 OF 70 STORIES

Copyright 1998 Boston Herald Inc.  
The Boston Herald

May 5, 1998 Tuesday FIRST EDITION

SECTION: NEWS; Pg. 007

LENGTH: 458 words

HEADLINE: Tragedy spurs review; State analyzes policy after teenager's death

BYLINE: By BEVERLY FORD

BODY:

Mourners bid a tearful farewell yesterday to a 16-year-old boy who died while being restrained at a Marlboro group home, as officials from the state Department of Health and Human Services met to discuss the use of restraints in state-run **institutions**.

"We want to make sure the state's policy with regard to restraints is uniform from agency to agency," department spokesman David Ball said of yesterday's session, which was scheduled after the death last week of Mark Soares at the Wayside Carriage House, a home for troubled teens.

Soares, who died Wednesday night after being restrained by two councilors at the Marlboro facility, was buried at Fairview Cemetery yesterday following a funeral Mass attended by more than 100 friends, family members and social workers at the Cathedral of the Holy Cross.

"This should never have happened," said Junito Rosado, 17, of the South End, clutching a flower at the boy's gravesite. "I know Mark and he wouldn't have wanted to leave like this."

An autopsy on Soares was performed Friday but the cause of his death has not been released.

Ball said the death of the Hyde Park boy prompted Health and Human Services Secretary William O'Leary to call a meeting with department heads from social services, youth services, **mental** health, **mental** retardation and the Office for Child Care Services to discuss **restraint** techniques used at the state's group homes and **institutions**.

Officials from those agencies were instructed to evaluate their restraint policies within the next few days to insure they comply with state standards, Ball said.

"We do prohibit any restraint that causes pain or is excessive force, such as headlocks," said Ball, "but we may have to strengthen those regulations."



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

The Boston Herald, May 5, 1998 Tuesday

Eric Masi, president of the Wayside Youth and Family Support Network, which operates the home where Soares died, denied that headlocks are used at the facility despite a published report that said the teen died when he was placed in a headlock by one of the councilors.

Both councilors were questioned by investigators and have since been placed on paid administrative leave.

Masi said Soares was restrained when he became disruptive after a schoolwide meeting was held to discuss rumors that a resident had marijuana.

He was one of five youths who were told after that meeting to remain in their rooms until a search could be conducted by school officials, Masi said.

Photo Caption: FINAL TRIBUTE: The family and friends of Mark Soares, a troubled 16-year-old youth who died Wednesday while being restrained at a Marlboro group home, place flowers on his casket at Fairview Cemetery in Hyde Park after his funeral yesterday. Staff photo by Jim MahoneyPhoto Caption: MARK SOARES; Buried yesterday

LOAD-DATE: May 05, 1998



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group

LEVEL 1 - 40 OF 70 STORIES

Copyright 1997 Telegram & Gazette  
TELEGRAM & GAZETTE (WORCESTER, MA.)

July 10, 1997 Thursday, ALL EDITIONS

SECTION: NEWS; Pg. A1

LENGTH: 671 words

HEADLINE: State cites improper restraint in boy's death;  
Investigation of Devereux Center fatality

BYLINE: Nancy Sheehan; Telegram & Gazette Staff

DATELINE: RUTLAND

BODY:

A 12-year-old Devereux Center student was improperly restrained during an incident that ended in his death, a state investigation has determined.

The state Office for Children, in conjunction with the state Department of Social Services, investigated the April 21 death of Robert T. Rollins, who was enrolled at the residential school for emotionally and behaviorally disturbed students.

Investigators determined that a female staff member used an unapproved technique while trying to restrain the child during an episode of violent behavior.

The child was choking and gagging, authorities said. The staffer was the only one restraining him. Rollins was pronounced dead at University of Massachusetts Hospital in Worcester, where he was taken by helicopter after EMTs summoned to the school could not revive him.

#### DONE ANOTHER WAY

"We're not saying that this particular method of restraint caused this child's death. We're saying that the restraint should have been done one way when in fact it was done another way," said Douglas P. Pizzi, spokesman for the state Office for Children.

The woman, not named in a report on the investigation, no longer works at Devereux, and the rest of the staff has been trained in proper ways to restrain violent students, Pizzi said. The report has been forwarded to Worcester District Attorney John J. Conte's office, which is doing its own investigation.

Meanwhile, DSS, which stopped placing children at the school after Rollins' death, has lifted that restriction.

"We went in and made sure they had the most current practices and policies in place," Lorraine Carli, DSS spokeswoman, said. "We made



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group



LEXIS·NEXIS®

Ⓜ A member of the Reed Elsevier plc group

sure that all the staff were trained on issues of restraint and that their policies were up to speed.

#### REFERRALS TO PROGRAM

"We worked with them and, after the conclusion of our investigation, we began opening up referrals to the program," she said.

Rollins, of New Haven, Conn., was placed at Devereux by DSS's Connecticut counterpart, the Department of Children and Families. There were 36 Massachusetts students at the school at the time of Rollins' death. Those students remained at Devereux while the DSS and OFC conducted their investigation.

OFC, which grants licenses to residential facilities for children, has sent the matter to its legal department, which will determine whether further action is necessary.

"The matter is far from closed," Pizzi said. "We want to make sure that this doesn't happen again. It's fine that they've gone and retrained their staff, but we want to make sure that in the future people who come on board are correctly trained and that they follow all the proper procedures. "

Devereux officials did not respond to telephone messages left over the past two days.

Pizzi said several methods can be used to restrain people in danger of hurting themselves or others. At Devereux, a widely accepted system called SOLVE, or Strategy of Limiting Violent Episodes, was in place.

#### AT SHOULDER LEVEL

According to Pizzi, when a single staffer is trying to restrain someone, SOLVE guidelines call for placing the person face down on the floor with wrists crossed in front at shoulder level. That wrist position keeps the person's head from banging on the ground and keeps stress off the diaphragm, which controls lung action. Placing the crossed wrists in a lower position can interfere with breathing, he said.

"From interviewing witnesses to this event at the school - including the woman who was conducting the **restraint** - we've determined that the **child was restrained** with his wrists crossed under his torso," Pizzi said.

In its brochures Devereux describes itself as the nation's largest nonprofit provider of **mental** health and developmental disability programs. Devereux's programs in 12 states and the District of Columbia include **hospital**, campus-style, community and outpatient facilities.

The Rutland campus has a capacity for 112 students.

LANGUAGE: ENGLISH



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group

LOAD-DATE: July 11, 1997



**LEXIS·NEXIS®**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS®**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS®**  
A member of the Reed Elsevier plc group

LEVEL 1 - 39 OF 70 STORIES

Copyright 1998 Sun-Sentinel Company  
Sun-Sentinel (Fort Lauderdale, FL)

April 8, 1998, Wednesday, Palm Beach EDITION

SECTION: LOCAL, Pg. 1B

LENGTH: 593 words

HEADLINE: STATE MUST PAY \$ 18 MILLION FOR MISTREATMENT

BYLINE: HENRY FITZGERALD JR. ; Staff Writer

BODY:

Aaron Wynn was awarded \$ 18 million last week when a jury ruled doctors and employees at two state-run mental hospitals violated his civil rights by tying him down and giving him improper medication.

Wynn's attorney, Dianne J. Weaver, said doctors strapped him to a bed for 2 1/2 years of his three-year stay at the South Florida Evaluation and Treatment Center in Miami-Dade County. She also said psychiatrists at the facilities treated Wynn for a mental illness, but he actually suffered from a brain injury that occurred in a motorcycle accident.

That wouldn't happen today, said officials with the Florida Department of Children & Families. Policies regarding restraints have changed since Wynn was hospitalized. But the system that improperly placed him in a state mental institution has not.

Mental-health advocates say the problems that led to Wynn's suit need to be fixed by the Legislature. The state has no treatment system for brain-injured people. They are often lumped into the same facilities with the mentally ill, but treatment for the two are vastly different.

"We need to know where these brain-injured people should go and which department is responsible for treating them," said John Bryant, assistant department secretary for mental health. "We were never charged with the specific responsibility for treating brain-injured patients, but in the absence of other programs, we picked them up."

Wynn, 30, was at the South Florida Center for treatment to enable him to stand trial for a 1988 battery charge on a law-enforcement officer. While he was there, his family said his condition worsened, but he was released anyway in 1991.

Two years later, he was charged with manslaughter after he became confused in a Fort Lauderdale Publix, bolted from the store and knocked over Pauline Jackson, 85. She hit her head on the pavement and died the next day.

Wynn was then sent to the North Florida Evaluation and Treatment Center in Gainesville for treatment to enable him to stand trial on those charges. His family said while there, he was placed in a drab, windowless room.



LEXIS·NEXIS™

A member of the Reed Elsevier plc group



LEXIS·NEXIS™

A member of the Reed Elsevier plc group



LEXIS·NEXIS™

A member of the Reed Elsevier plc group

Sun-Sentinel (Fort Lauderdale), April 8, 1998

'The Wynn case is a classic example of what can happen,' Bryant said. 'The state Legislature still has not effectively addressed this issue.'

Officials hope a bill now before lawmakers will deal with the problem.

Wynn's family sued the Department of Children & Families and 22 employees of the South Florida Center and its counterpart in North Florida.

Stephen LeClair, an assistant attorney general who argued the state's case, said Wynn was not mistreated, but restrained because he was frequently combative.

Weaver said she's not against restraints if they are used properly.

'Using restraints is a good, recognized procedure if someone is a danger to himself or others,' she said. 'But you don't just strap people down and walk away from them. There are standards you must adhere to, and that didn't happen in in this case.'

The department reviews its guidelines annually and has updated them several times since Wynn was a patient.

The current policy says that restraint is an option only after verbal intervention, time out, separation or seclusion fails. In an effort to prevent misuse, the department has increased monitoring, narrowed the number of people who can order their use and increased therapeutic techniques.

'I'm more confident now than before I got here that a situation like Aaron Wynn's won't happen again,' Bryant said. 'The system has learned a hell of a lot from the Wynn case.'

LOAD-DATE: April 9, 1998



LEXIS·NEXIS  
A member of the Reed Elsevier plc group



LEXIS·NEXIS  
A member of the Reed Elsevier plc group



LEXIS·NEXIS  
A member of the Reed Elsevier plc group

LEVEL 1 - 43 OF 70 STORIES

Copyright 1996 Information Access Company,  
a Thomson Corporation Company;  
ASAP

Copyright 1996 Nursecom, Inc.  
Journal of Child and Adolescent Psychiatric Nursing

October 21, 1996

SECTION: No. 4, Vol. 9; Pg. 7; ISSN: 1073-6077

IAC-ACC-NO: 19105430

LENGTH: 5599 words

HEADLINE: Staff members' beliefs about seclusion and restraint in child  
psychiatric **hospitals**.

BYLINE: Goren, Suzanne; Curtis, W. John

BODY:

BACKGROUND. Staff members beliefs about seclusion and restraint are influential in determining how and when these interventions are employed. Yet there are few studies of staff beliefs in individual **hospitals** and no comparative studies across **hospitals**.

OBJECTIVE. To measure staff members' beliefs about the rationale for and efficacy of the use of seclusion and restraint with children and adolescents.

METHODS. A survey of staffmembers (N = 320) from 13 public and private child psychiatric **hospitals** RESULTS. Results indicate a low to moderate level of confidence among all staffgroups regarding the efficacy of seclusion and restraint. Staff members from private **hospitals** were significantly more positive in their assessment of these interventions than were staff members from the public sector.

CONCLUSION. We hypothesize that the persistent use of coercive interventions in which staff have a low level of confidence reflect both the influence of tradition in the management aggressive behavior and unacknowledged avoidant/coercive staff responses to patents labeled as deviant. Differences between the public and private sectors and between **hospitals** within each sector imply that the practice of seclusion and restraint may be idiosyncratic to each **institution**, and suggest the need for a generally accepted standard for their use.

Key words: Child psychiatric nursing, organizational climate, psychiatric **hospital**, seclusion & restraint, staff members' beliefs attitudes

Concern about patients rights and the mandate to deliver the least restrictive psychiatric service possible have led to a recent (1985-1995) increase in articles dealing with the use of seclusion and restraint. For the most part, the literature reflects the use of these interventions in adult psychiatric **hospitals**, reporting on the rationale for their use, their



LEXIS-NEXIS<sup>TM</sup>  
A member of the Reed Elsevier plc group



LEXIS-NEXIS<sup>TM</sup>  
A member of the Reed Elsevier plc group



LEXIS-NEXIS<sup>TM</sup>  
A member of the Reed Elsevier plc group

effectiveness, the circumstances under which they are employed, and their impact on patients and staff (Brown & Tooke, 1992; Fisher, 1994). In contrast, none of the 55 articles surveyed by Brown & Tooke and only 12 of the 96 reviewed by

Fisher reported on the use of seclusion and restraint of children and adolescents. Nevertheless, these interventions are widely used in child psychiatric settings (Gair, Bullard, & Corwin, 1965; Garrison, 1984; Joshi, Capozzoli, & Coyle, 1988; Wherry, 1986), and their use with children continues to stimulate controversy and debate (Gast & Nelson, 1977; Goren, Singh, & Best, 1993; Harrell & Orem, 1980; Miller, 1986).

Three studies included in Fisher's review (1994) deal with children's responses to being secluded. Each reports both positive emotional responses, e.g., a feeling of safety and that adult caring is being demonstrated (Cotton, 1989), a calming effect (Josh et al., 1988), and negative responses, e.g., agitation (Millstein & Cotton, 1990), and anger and sadness (Josh et al., 1981). Another study (Gair, et al., 1965), not included in Fisher's review, suggests that seclusion provides a locus for staff and children to work out their relationships. None of these studies surveys children's own responses to the seclusion experience, relying instead on staff members' inferences regarding children's reactions. Since the adult psychiatric literature consistently indicates that staff members and adult patients differ markedly in their reactions to seclusion (Brown & Tooke, 1992; Richardson, 1987; Way & Banks, 1990) and that in general, staff members' intentions and patients' perceptions of treatment also differ (Sullivan & Yudelowitz, 1991), staff members' assumptions regarding children's reactions cannot be assumed to be valid without confirmation from the children themselves.

At present, research into children's firsthand experience of seclusion is extremely limited. However, one completed study (Miller, 1986) and one pilot study (Faison & Goren, 1993), both of which involved asking previously secluded children to draw the seclusion room and talk about it, suggest that children's predominate experience of seclusion is that it is punishing and frightening, and that their reactions of fear, anger, and hostility are quite similar to those reported by secluded adults (Plutchik, Karasu, Conte, Siegel, & Jerrett, 1978; Wadson & Carpenter, 1976). In a study involving asking children in a psychiatric hospital and their parents to rate the desirability of several treatments for behavioral problems (aggression and hyperactivity), seclusion was the only alternative rated as least acceptable by both groups (Kazdin, (1984). Given the scarcity of data on children's responses, it is not possible to make definitive statements about similarities between their responses and those of adults, nor to claim that the few children interviewed are necessarily representative of secluded children. It is fair to say, however, that despite the common use of seclusion and restraint in child psychiatric hospitals and in many residential programs, and the routine monitoring of these interventions as a hospital indicator of quality assurance, these interventions are used without research-based understanding of their impact on children.

There are no studies in the literature comparing beliefs and practices related to seclusion and restraint among child psychiatric hospitals. Of the few multiinstitutional studies surveyed, three collected data only on adults (Okin, 1985; Thompson, 1986; Way & Banks, 1990). One small study (28 subjects in 4 hospitals) combined data from child and adult facilities (Steele, 1993), one collected child psychiatric data but omitted them from analysis (Carpenter, Hannon, McCleery, & Wenderling, 1988), and two dealt with legislation regarding



**LEXIS·NEXIS™**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS™**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS™**  
A member of the Reed Elsevier plc group

seclusion of children and adolescents (Fassler & Cotton, 1992; Swett, Michaels, & Cole, 1989). This represents a significant gap in our understanding of aggression management in child psychiatric facilities, as compared with a considerable body of literature related to adult patients. The latter demonstrates that institutional variables-including generally held attributions about psychiatric symptomatology, values, standards of practice, rules, social norms, and performance expectations of staff and patients-exert significant influence on the management of aggression (Goffman, 1961; Milne, 1985; Stanton & Schwartz, 1954; Stotland & Kobler, 1965).

Given the impact of staff members' perceptions of patients' deviance on staff/patient interactions, investigation of staff members' beliefs regarding coercive intervention with children should shed some light on what at present is a common but poorly understood practice (Walsh & Randell, 1995). Yet, as of this writing, this is totally uncharted territory. The purpose of this pilot study was to take a first step in addressing this issue by investigating staff beliefs about these interventions in a sample of public and private child/adolescent psychiatric hospitals.

#### Methods

##### Sample

Letters requesting participation in the study were sent to a convenience sample of Directors of Nursing of 20 private and public child/adolescent psychiatric hospitals. Those agreeing to participate were then sent a copy of the survey, with a cover letter requesting that all staff providing direct service complete and return the survey. The response rate was requested of all institutions, but was provided by only a few.

Thirteen institutions participated, and a total of 320 subjects completed surveys (216 from private institutions and 111 from public institutions) were returned. Positions held by survey respondents were therapist, nurse, paraprofessional, teacher, allied professional (occupational, music, art therapists), and administrator. Eighteen respondents reported positions that were not readily classifiable by profession (e.g., program manager) and 21 respondents did not report their position. Those who did not report their position and those whose positions were not classifiable were not included in any subsequent statistical tests using respondent position as an independent variable.

Other respondent characteristics included: 41% reported providing service to both children and adolescents, while 38% reported working only with adolescents and 22% reported working only with children. Most (78%) reported working at their current institution for at least one year, and 38% had worked at the same institution for more than five years. Interestingly, while 74% of those completing the survey reported that the aggression management training provided them was adequate, 90% of the respondents indicated an interest in additional training in this area.

##### Instruments

In addition to demographic questions about the respondents, the survey consisted of two scales, one testing respondents' beliefs about patients'



LEXIS·NEXIS<sup>™</sup>  
A member of the Reed Elsevier plc group



LEXIS·NEXIS<sup>™</sup>  
A member of the Reed Elsevier plc group



LEXIS·NEXIS<sup>™</sup>  
A member of the Reed Elsevier plc group

reactions to seclusion and restraint and the other testing beliefs about appropriate use of these interventions.

**Patient Reaction Scale.** The 9 items comprising the Patient Reaction Scale (PR, Table 1) were drawn from the literature. The items reflecting beneficial or therapeutic effects of seclusion and/or restraint on children and adolescents were drawn from those commonly identified in the professional child psychiatric literature discussed above, which is generally quite positive about the use of these interventions (Cotton, 1989; Joshi et al., 1988). Items reflecting negative effects on youngsters were drawn from the literature that suggests non-efficacy or identifying non-beneficial effects (Angola, 1989; Natta, Holmbeck, Kupsi, Pines, & Schulman, 1990; Goren, 1991; Goren, et al., 1993; Miller, 1986). In the absence of published self-reports by children and adolescents, additional items were taken from the studies of adult responses to these interventions, which are generally negative (Binder & McCoy, 1983; Brown & Tooke, 1992; Hammill, 1987; Wadeson & Carpenter, 1976). Each item on the PR scale was rated on a five-point Likert-type scale. This scale measured how often the respondent believed that a particular effect (represented by each item) resulted from the seclusion and/or restraint of a patient. The anchors for the scale were "never" (1), "seldom" (2), "occasionally" (3), "usually" (4), and "always" (5). Responses were coded so that a higher score reflected a belief that the effects of seclusion and/or restraint were more beneficial than negative. Coefficient alpha for the sub-scale was 0.71, indicating adequate internal reliability.

Table 1. Staff Members' Beliefs Regarding Patients' Responses to Seclusion and/or Restraint (PR Scale)

| Item                                                  | Mean | SD   |
|-------------------------------------------------------|------|------|
| * Patient feels embarrassed or humiliated             | 2.90 | 1.01 |
| * Patient feels that the environment is safer         | 3.31 | 0.93 |
| * Patient feels a greater sense of control            | 3.06 | 0.99 |
| * Patient has a greater understanding of own behavior | 3.17 | 0.92 |
| * Patient becomes increasingly                        | 2.93 | 0.81 |



agitated

|                                  |      |      |
|----------------------------------|------|------|
| * The need for further seclusion | 3.37 | 0.78 |
|----------------------------------|------|------|

is decreased

|                                  |      |      |
|----------------------------------|------|------|
| * Patient's negative behavior is | 3.40 | 0.78 |
|----------------------------------|------|------|

decreased

|                                 |      |      |
|---------------------------------|------|------|
| * Patient feels violated by the | 3.09 | 0.91 |
|---------------------------------|------|------|

physical contact

|                               |      |      |
|-------------------------------|------|------|
| * Patient is reminded of past | 2.95 | 0.98 |
|-------------------------------|------|------|

physical or sexual abuse

N = 314

Appropriate use of seclusion and/or restraint scale. The patient behaviors listed on the Use of Seclusion and/or Restraint Scale (USR), Table 2, include those most commonly identified in the literature on the use of seclusion and restraint with children and adolescents as initiating coercive interventions by staff (e.g., physical aggression toward staff, physical aggression toward peers, self-injury), others that also appear, though less often (e.g., non-compliance, threats of violence) (Garrison, 1984; Goren et al., 1993), and two psychiatric symptoms-hyperactivity (Erickson & Realmuto, 1983; Rosen & Di Giacomo, 1978) and hallucinations.

Table 2. Staff Members' Beliefs About the Appropriate Use of Seclusion and/or Restraint (USR Scale)

| Behavior                              | Appropriate |
|---------------------------------------|-------------|
| * Physical aggression toward staff    | 71.4        |
| * Physical aggression toward peers    | 69.0        |
| * Self-injury                         | 54.7        |
| * Threats of violence                 | 31.0        |
| * Noncompliance with staff directives | 9.4         |
| * Hallucinations                      | 6.0         |
| * Hyperactivity                       | 3.7         |



N = 320

Respondents rated how often seclusion and/or restraint was an appropriate staff response to these patient behaviors on a five-point Likert-type scale, with anchors as on the PR scale, from "never" (1) to "always" (5).

## Results

### Patient Response

An analysis of variance was performed to examine differences in perception of positive and negative effects of seclusion and/or restraint among respondents holding different positions. As these mean scores show, respondents across all positions generally rated seclusion and/or restraint as seldom or occasionally having a positive effect on a patient. The overall mean for all positions was 3.2, indicating that the average respondent rated seclusion and/or restraint as slightly more often than occasionally having a positive effect on a patient. Table 3 shows the means and standard deviations of the PR subscale for each group.

Table 3. Scores on PR Subscale by Position Categories

| Position              | Mean | SD   |
|-----------------------|------|------|
| * Therapist           | 3.28 | 0.40 |
| * Nurse               | 3.26 | 0.46 |
| * Paraprofessional    | 3.24 | 0.47 |
| * Teacher             | 3.01 | 0.69 |
| * Allied Professional | 2.99 | 0.61 |
| * Administrator       | 2.42 | 0.79 |

N = 278 Note. Scores were divided by 9 to obtain mean scaled scores with a range from 1 to 5. Responses to items reflecting a negative reaction to seclusion and/or restraint were reverse coded prior to ANOVA.

The overall F for the comparison between positions was significant ( $F(5, 272) = 5.4$ ,  $p$  [is greater than] 0.01). A Duncan multiple range test, employed to test for differences between pairs of groups on the PR scale, indicated that only administrators differed significantly from other respondents. Administrators' scores were significantly lower (expressing the belief that seclusion and/or restraint has a less beneficial effect on the patient) than respondents in all other position categories.

A second set of analyses was undertaken to examine differences on the PR scale between and within staff of public and private institutions. An ANOVA was



LEXIS·NEXIS™

A member of the Reed Elsevier plc group



LEXIS·NEXIS™

A member of the Reed Elsevier plc group



LEXIS·NEXIS™

A member of the Reed Elsevier plc group

performed to determine if there was an overall difference on scores from the PR scale between all **institutions** (public and private). The F for all **institutions** was statistically significant ( $F(12,300) = 3.97$ ,  $p$  [is greater than] 0.001). Additional analyses of variance performed to determine whether there were statistically significant differences on the PR scale score within each group (public and private **institution**) showed no statistically significant difference on PR scale scores within the public **institutions** group, while there was a statistically significant difference on PR scale scores within the private **institutions** group ( $F(8, 197) = 2.78$ ,  $p$  [is greater than] 0.01).

A t-test showed a statistically significant difference between respondents from public **institutions** and private **institutions** on the PR scale. Respondents from private **institutions** scored higher (belief in more positive patient response than respondents from public **institutions**) ( $t(2,318) = -3.64$ ,  $p$  [is greater than] 0.001).

#### Appropriate Use of Seclusion and Restraint

There were both consistency and scatter in the responses to this scale, with 70% agreement that seclusion and/or restraint is an appropriate response to physical aggression, and more than 90% agreement that these interventions are inappropriate responses to noncompliance with staff direction, hallucinations, and hyperactivity. However, self injury and threats of violence, both of which are commonly identified as precursors to seclusion and/or restraint (Goren et al., 1993; Walsh & Randell, 1995) are more controversial, with approximately 50% of the respondents approving the use of these interventions for self-injury, and 30% for threats of violence (see Table 2).

Since the items on this sub-scale did not form a continuous scale, each item was treated separately for statistical analysis. A chi-square test was done to determine whether or not beliefs about the appropriateness of the use of seclusion and/or restraint as an intervention in response to these patient behaviors was dependent on the position held by respondents. The results were significant only for self-injury, the behavior about which respondents were most evenly divided, with nurses responding more positively ([chi-square]  $2 = 11.5$ ,  $p$  [is greater than] .05) than other groups.

A chi-square test also was performed to determine whether or not responses to items on the USR scale were dependent upon the type of **institution** (public or private) at which the respondent was employed. These analyses showed that reported staff beliefs were dependent on type of **institution** for all of the items on the USR scale, with the magnitudes of the [chi square]s ranging from 12.7 to 30.6 with all  $p$ 's statistically significant. The pattern of results generally showed that a greater proportion of respondents from private **institutions** than public **institutions** responded more positively about the use of seclusion and/or restraint as a treatment for these behaviors.

#### Discussion

Patient response. Staff members' low to moderate level of confidence in patients' positive responses to seclusion and/or restraint, as indicated by all respondent groups, raises some perplexing issues about the persistence of the use of these interventions in child psychiatric facilities. Why would staff repeatedly engage in dangerous, upsetting interventions that they themselves



LEXIS·NEXIS  
A member of the Reed Elsevier plc group



LEXIS·NEXIS  
A member of the Reed Elsevier plc group



LEXIS·NEXIS  
A member of the Reed Elsevier plc group

believe are unlikely to produce desired change? One might hypothesize that these interventions are habits of practice, based on attitudes and beliefs with little empirical evidence to support them. Nursing tradition includes seclusion and restraint of patients as essential interventions; they are taught in psychiatric nursing curricula, presented in current texts (Hogarth, 1991; Stuart & Sundeen, 1995) without reference to the lack of evidence documenting their effectiveness with either adults (Brown & Tooke, 1992) or children and adolescents (Angola, 1993; Garrison, 1994; Goren et al., 1993; Patterson, 1976), and included in new staff orientation programs in most **hospitals**. In addition, very little has appeared in the child psychiatric nursing literature to challenge the necessity of their use and offer practical alternatives (Goren, Abraham, & Doyle, 1996). The paradox of the nursing role, e.g., the need to meet order-oriented professional expectations by maintaining a regimented milieu while simultaneously developing therapeutic alliances with children most likely to disrupt it, may in part explain nurses being more willing than other groups to advocate the use of coercive interventions for self-injurious behavior. Nursing performance often is judged on the basis of the unit being quiet and under control, without consideration of what type of interventions are required to produce the subdued milieu. In contrast, administrative roles, which are most distant from the daily life on the unit, and hence from the aggressive and counteraggressive components of child/staff interaction, allow those who hold them to be more comfortable acknowledging the negative aspects of these interchanges.

The reason that staff members in private **hospitals** reported more positive beliefs about patient responses to seclusion and restraint than those in public **hospitals** is unclear. Since there were no significant differences in the demographic variables of the staff in either type of **institution**, one looks to the nature of the **institutions** themselves for hypotheses. The results reported here may have been skewed by the staff of one public **institution** already being engaged in an effort to reduce the use of these interventions. Alternately, one might speculate that these results are related to the patient advocacy system, which is integral to most public **institutions** and absent in most private ones. Whatever the cause for the disparity, the differences between the public and private sectors and among **hospitals** within each sector suggest that beliefs about the use of seclusion and restraint are related to the culture of each organization rather than to a generally accepted external standard.

Appropriate use of seclusion and restraint. The outcomes of this study confirm what is reported in the literature, i.e., that physical violence is the most frequent antecedent behavior to the seclusion and/or restraint of both children, adolescents, and adults (Brown & Tooke, 1992; Fisher, 1994). What is worthy of note here is that noncompliance with staff direction, which is commonly associated with seclusion of youngsters (Goren et al., 1993; Walsh & Randell, 1995), was rated by 90% of the respondents in this study as a behavior for which seclusion is not appropriate. This may reflect the fact that youngsters' initial refusal to comply rarely results in seclusion or restraint. Rather, an escalating pattern of increased staff demand and increased patient noncompliance, initially described in Patterson's (1976) seminal work on coercive parenting, leads to the verbal threats and/or physical aggression which are then given as the rationale for coercive intervention.

The related literature dealing with adult and nonpsychiatric patients characterized by staff members as "difficult" also may shed some light on our



**LEXIS·NEXIS**

A member of the Reed Elsevier plc group



**LEXIS·NEXIS**

A member of the Reed Elsevier plc group



**LEXIS·NEXIS**

A member of the Reed Elsevier plc group

findings. As argued by Kelly and May (1982), the literature on these patients is theoretically and methodologically flawed by investigators' assumption that labels of behavior as symptomatic, noncompliant, and disruptive reflect objective realities, rather than definitions placed on patient behavior by staff members themselves. (Perhaps the most sobering example of this is Rosenhans' 1973 classic study in which **hospital** staff defined normal behavior of research assistants pretending to be psychiatric inpatients as pathological and, when subsequently informed that more pseudo-patients were to be admitted, categorized authentic psychiatric patients as researchers.) Patient behaviors most likely to be defined as deviant include hostility, uncooperativeness, aggressiveness, challenging staff, and making staff feel angry or ineffectual (Carveth, 1995; Kelly & May, 1982; Podrasky & Sexton, 1988), all of which lead to avoidant responses (ignoring the patient, treating the patient as an object, sacrificing humanistic care in favor of institutional routines and rules) or attempts to modify patient behavior through persuasion or coercion (Carveth).

There is an urgent need in child psychiatric **institutions** for research that is explicit in its focus on the organization and the staff, and which deals with the possibility that the routines and rules ostensibly designed to promote order may in fact encourage uproar. If, as Carveth (1983) suggests, institutional order in the general **hospital** serves as a shield against the terror of death, the emphasis on order in the psychiatric **hospital** may be understood as staff's unacknowledged shield against the terrors of mental illness, loss of control, and violence. Institutional limits set on youngsters' right to question, argue, complain, challenge and refuse are usually far more stringent than those of the community, and generally offer few alternatives beyond compliance, withdrawal, or rebellion. Goffman (1972) describes the scenario: "If you rob people of all customary means of expression of anger and alienation and put them in a place where they have never had better reason for these feelings, then the natural course will be to seize upon what remains" (p. 147).

Several limitations of this pilot study affect the generalizability of the findings. As with all attitudinal studies, no conclusions can be drawn about the actual behavior of respondents. Improvement in the tools is also needed: The survey instrument should be redesigned to allow staff members to differentiate their beliefs regarding seclusion and mechanical and chemical restraint. With the exception of one **institution**, the sample represents only the Southeast United States. It is quite possible that there are significant regional differences in staff members' beliefs that are not reflected here; future studies would be strengthened by items that allow comparisons across regions. The results of this small, preliminary study however, do identify many needs for research in this area. **Hospital**-based and multiinstitutional investigations of practice norms, staff beliefs, patient perceptions, organizational values and policies, and the impact of patient advocacy within and external to the **institution** are needed to develop humane, rational, effective approaches to the management of children's and adolescents' aggressive behavior.

### Conclusions

We hypothesize that the widespread use of coercive interventions in which staff members have a low level of confidence reflects both the persistence of unexamined, traditional practices in psychiatric **hospitals** in the United States similar to those Chapman (1993) noted in the U.K., as well as unacknowledged avoidant/coercive staff responses to patients labeled as deviant. Differences



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group

between the public and private sectors and between **hospitals** within each sector imply that the practice of seclusion and restraint may be idiosyncratic to each **institution**. These differences suggest the need for a research-based, generally accepted standard for their use.

### References

Angold, A. (1989). Seclusion: A review. *British Journal of Psychiatry*, 154, 437-444.

Binder, R., & McCoy, S. (1983). A study of patients' attitudes toward placement in seclusion. *Hospital and Community Psychiatry*, 34, 1052-1054.

Brown, J., & Tooke, S. (1992). On the seclusion of psychiatric patients. *Social Science and Medicine*, 35, 711-721.

Carpenter, M., Hannon, V., McCleery, G., & Wenderling, J. (1988). Variations in seclusion and restraint practice by **hospital** location. *Hospital and Community Psychiatry*, 39, 418-423.

Carveth, J. (1995) Perceived patient deviance and avoidance by nurses. *Nursing Research*, 44, 173-178.

Chapman, G. (1983) Ritual and rational action in **hospitals**. *Journal of Advanced Nursing*, 8, 13-20.

Cotton, N. (1989). The developmental-clinical rationale for the use of seclusion in the psychiatric treatment of children. *American Journal of Orthopsychiatry*, 59, 442-450.

Erickson, W., & Realmuto, G. (1983). Frequency of seclusion in an adolescent psychiatric unit. *Journal of Clinical Psychiatry*, 44, 238-241.

Faison, C., & Goren, S., (1993). Children's perception of seclusion. Unpublished manuscript.

Fassler, D., & Cotton, N. (1992). A national survey on the use of seclusion in the psychiatric hospitalization of children. *Hospital and Community Psychiatry*, 43, 370-374.

Fisher, W. (1994). Restraint and seclusion: A review of the literature. *American Journal of Psychiatry*, 151, 1584-1591.

Gair, D., Bullard, D., & Corwin, J. (1965). Seclusion of children as a therapeutic ward practice (abstract). *American Journal of Orthopsychiatry*, 35, 251-252.

Garrison, W. (1984) Aggressive behavior, seclusion, and physical restraint in an inpatient child population. *Journal of the American Academy of Child and Adolescent Psychiatry*, 23, 448-452.

Gast, D., & Nelson, G. (1977). Legal and ethical considerations for the use of time out in special education settings. *Journal of Special Education*, 11, 457-469.



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group

Goffman, I. (1961). *Asylums*. Chicago: Aldine.

Goffman, I. (1972). *Interaction rituals*. Hammondswoth, England: Penguin.

Goren, S. (1991). What are the considerations for the use of seclusion and **restraint with children** and adolescents (Clinical Forum)? *Journal of Psychosocial Nursing and Mental Health Services*, 29(2), 32-33.

Goren, S., Singh, N., & Best, A. (1993). The aggression-coercion cycle in inpatient child psychiatry. *Journal of Child and Family Studies*, 2(1), 61-73.

Goren, S., Abraham, I., & Doyle, N. (1996). Reduction of violence in a child psychiatric **hospital** through planned organizational change. *Journal of Child and Adolescent Psychiatric Nursing*.

Hammill, K. (1987). Seclusion: Inside looking out. *Nursing Times*, 83, 38-39.

Harrell, S., & Orem, R. (1980). Preventing child abuse and neglect: A guide for staff in residential **institutions**. DHHS Publication No. OHDS 8030255, Washington, DC: U. S. Government Printing Office.

Hogarth, C. (1991). *Adolescent psychiatric nursing*. St. Louis: Mosby

Joshi, P., Capozzoli, J., & Coyle, J. (1983). Use of a quiet room on an inpatient unit. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 642-644.

Kazdin, (1984). Acceptability of aversive procedures and medication as treatment alternatives for deviant child behavior. *Journal of Abnormal Child Psychology*, 12, 289-302.

Kelly, M., & May, D. (1982). Good and bad patients: A review of the literature and a theoretical critique. *Journal of Advanced Nursing*, 7, 147-156.

Miller, D. (1986). The management of misbehavior by seclusion. *Residential Treatment for Children and Youth*, 4(1), 63-73.

Millstein, K., & Cotton, N. (1990). Predictors of the use of seclusion on an inpatient child psychiatric unit. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 256-264.

Milne, D. (1985). The more things change the more they stay the same: Factors affecting the implementation of the nursing process. *Journal of Advanced Nursing*, 10, 39-45.

Natta, M., Holmbeck, G., Kupst, M., Pines, R., & Schulman J. (1990). Sequences of staff-child interactions on a psychiatric inpatient unit. *Journal of Abnormal Child Psychology*, 18, 1-14.

Okin, R. (1985). Variation among state **hospitals** in the use of seclusion and restraint. *Hospital and Community Psychiatry*, 36, 643-652.

Patterson, G. (1976). The aggressive child: Victim and architect of a



**LEXIS·NEXIS™**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS™**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS™**  
A member of the Reed Elsevier plc group

coercive system. In E. Mash, L. Hamerlynck, & L. Handy (Eds.), *Behavior Modification and Families, 1. Theory and Research*, (pp. 131-158). New York: Brunner/Mazel.

Plutchik, R., Karasu, T., Conte, H., Siegel, B., & Jerrett, I. (1978). Toward a rationale for the seclusion process. *Journal of Nervous and Mental Disease*, 166, 571-579.

Podrasky, D., & Sexton, D. (1988). Nurses' reactions to difficult patients. *Image*, 20(1), 16-21.

Richardson, B. (1987). Psychiatric inpatients experience of the seclusion room experience. *Nursing Research*, 36, 234-238.

Rosen, H., & Di Giacomo, J. (1978). The role of physical restraint in the treatment of psychiatric illness. *Journal of Clinical Psychiatry*, 39, 228-332.

Rosenhans, D. (1973). On being sane in insane places. *Science*, 179, 250-258.

Stanton, S., & Schwartz, M. (1954). *The mental hospital: A study in institutional participation in psychiatric illness and treatment*. New York: Basic Books.

Steele, R. (1993). Staff attitudes toward seclusion and restraint: Anything new? *Perspectives in Psychiatric Care*, 29(3), 23-28.

Stuart, G., & Sundeen, G. (1991). *Principles and practice of psychiatric nursing* (4th ed.). St. Louis: Mosby

Sullivan, C., & Yudelowitz, I. (1991). Staff and patients: Divergent views of treatment. *Perspectives in Psychiatric Care*, 27(3), 26-30.

Swett, C., Michaels, A., & Cole, J. (1989). Effects of a state law on rates of restraint on a child and adolescent unit. *Bulletin of the American Academy of Psychiatry and Law*, 17, 165-169.

Thompson, P. (1986) The use of seclusion in private psychiatric hospitals in the Newcastle area. *British Journal of Psychiatry*, 149, 471-474.

Wadson, H., & Carpenter, W. (1976). Impact of the seclusion room experience. *Journal of Nervous and Mental Disease*, 163, 318-328.

Walsh, E., & Randell, B. (1995). Seclusion and restraint: What we need to know. *Journal of Child and Adolescent Psychiatric Nursing*, 8(1), 28-38.

Way, B., & Banks, S. (1990). Use of seclusion and restraint in public psychiatric hospitals: Patient characteristics and facility effects. *Hospital and Community Psychiatry*, 41, 75-81.

Wherry, J. (1986). The therapeutic use of seclusion with children and adolescents. *Residential Treatment with Children and Youth*, 4(1), 51-61.

Suzanne Goren, PhD, RN, is a Post-Doctoral Fellow, University of Washington, Seattle. W. John Curtis, MA, is a Research Assistant, Commonwealth Institute of



LEXIS·NEXIS®

A member of the Reed Elsevier plc group



LEXIS·NEXIS®

A member of the Reed Elsevier plc group



LEXIS·NEXIS®

A member of the Reed Elsevier plc group

Child Family Studies, Medical College of Virginia/Virginia Commonwealth University, Richmond, VA.

GRAPHIC: Illustration; Table

LANGUAGE: ENGLISH

IAC-CREATE-DATE: March 7, 1997

LOAD-DATE: March 08, 1997



**LEXIS·NEXIS®**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS®**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS®**  
A member of the Reed Elsevier plc group

LEVEL 1 - 53 OF 70 STORIES

Copyright 1992 The New York Times Company  
The New York Times

February 13, 1992, Thursday, Late Edition - Final

SECTION: Section B; Page 9; Column 1; Metropolitan Desk

LENGTH: 584 words

HEADLINE: Wide Use of Force on Disturbed Children Is Found

BYLINE: By CELIA W. DUGGER

BODY:

Poorly trained workers in **institutions** for emotionally disturbed children in New York State all too often handle disruptive behavior by putting youths in locked rooms, straitjackets or padded wrist cuffs, or controlling them through other kinds of physical force, a state report released yesterday concluded.

The New York State Commission on Quality of Care for the Mentally Disabled found that workers with little more than a high school education were left with disturbing frequency to monitor children at night and on weekends when professional staff members went home.

"If the staff are not trained to defuse a situation and calm a child, they often resort to physical restraints," said Clarence J. Sundram, chairman of the commission. Such restraints include straitjackets, padded wrist cuffs and sheets that immobilize a child in bed from the neck down, he said.

The report by the commission, which is appointed by Gov. Mario M. Cuomo, is based on reports of abuse and neglect involving 823 children in state-supported public and private **institutions** between October 1986 and September 1989.

No Blame, No Case

Only a quarter of the reports were confirmed, but that proportion underestimates the magnitude of the problem, the commission cautioned. In many cases, investigators found that a child had been neglected or abused, but could not determine which worker was to blame. Under state law, those reports are not counted as confirmed cases of institutional child maltreatment.

Almost one-fourth of the reports involved improper use of seclusion or **restraining** devices to subdue unruly **children**, the study found.

Officials at the state Office of **Mental** Health acknowledged the problem and said the agency was upgrading staff training and bolstering administrative supervision of workers during evenings and weekends.

"We need to work with staff to develop alternative ways of dealing with **children** so the use of physical **restraint** is unnecessary or decreased," said Gloria Newton-Logsdon, associate commissioner for children and families.



LEXIS-NEXIS<sup>TM</sup>  
A member of the Reed Elsevier plc group



LEXIS-NEXIS<sup>TM</sup>  
A member of the Reed Elsevier plc group



LEXIS-NEXIS<sup>TM</sup>  
A member of the Reed Elsevier plc group

The New York Times, February 13, 1992

Dr. Newton-Logsdon said the agency was trying to make sure that there are more nurses and therapists working evenings and weekends, when children have more free time and more often get into trouble.

About 11,000 children a year are served in **hospitals** and other group treatment centers in New York State. The Commission has not completed its analysis of reports filed in 1990 and 1991, but the patterns appear to be the same, Mr. Sundram said.

#### Many 'Repeat' Victims

Almost half the reports filed involved a "repeat" child who was the subject of at least one other report of abuse or neglect. Thirty-two children surfaced in four or more reports.

More broadly, the Commission raised questions about the general conditions for children who live for a few months or even years in group treatment centers.

"Children living in these settings are deprived of many of the normal activities of childhood -- like being a part of a neighborhood, attending a regular school, having a bicycle, being a Scout, playing an intramural or interscholastic sport," the report said.

Instead of being in a family, they are in **institutions** where the staffs change in shifts, turnover is high, treatment is limited and punishment is too often the means of reining in a child's behavior, the report said.

The state is training families to care for these often very troubled youngsters, but many more such homes are needed, the report said.

LANGUAGE: ENGLISH

LOAD-DATE: February 13, 1992



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group



LEXIS·NEXIS®  
A member of the Reed Elsevier plc group

LEVEL 1 - 55 OF 70 STORIES

Copyright 1991 The Times Mirror Company  
Los Angeles Times

May 10, 1991, Friday, Ventura County Edition

SECTION: Metro; Part B; Page 1; Column 2

LENGTH: 706 words

HEADLINE: STATE AUDIT CRITICIZES CAMARILLO HOSPITAL;  
MENTAL HEALTH: THE SURVEY QUESTIONS THE USE OF RESTRAINTS ON SOME RETARDED  
CHILDREN. A PATIENTS' ADVOCATE DEFENDS THE STATE FACILITY.

BYLINE: By TINA DAUNT, TIMES STAFF WRITER

BODY:

Camarillo State **Hospital** uses physical restraints on mentally retarded children more than any other California **institution**, according to an investigation by the state auditor general's office.

Of 44 children in the **hospital's** Developmental Center last year, 27 were restrained with straps, mittens, helmets or drugs to modify behavior problems, said acting Auditor General Kurt Sjoberg.

A random sampling of six children revealed that three of the youngsters had been restrained without the approval of their parents or a **hospital** behavior-modification board, in violation of their civil rights, Sjoberg said.

Top officials at Camarillo State **Hospital** could not be reached for comment Thursday. But a patient rights advocate employed there said he is unaware of the problems listed in the state audit.

"I think we are doing a reasonably good job," Bob Hentley said.

According to state law, **hospitals** are allowed to use restraints on some patients, especially when they are in danger of harming themselves or others.

But Sjoberg said state investigators were alarmed to find that Camarillo and five other state **hospitals** for the mentally disabled have failed to obtain proper approval before using the restraints. And, in some cases, the children are believed to have been confined longer than necessary because procedures were not followed, Sjoberg said.

For example, Camarillo staff members placed a child in mittens and a helmet five times between August, 1989, and April, 1990, without recording either how long the client was kept in restraints or assessing the child's condition at least every 30 minutes, as required by law, according to the audit.

The audit was requested more than a year ago by the state Legislature following reports, which first surfaced at Sonoma State **Hospital**, that mentally retarded children in the state's **hospitals** were being abused. Several investigators spent about a month interviewing staff and patients and combing



LEXIS-NEXIS<sup>®</sup>  
A member of the Reed Elsevier plc group



LEXIS-NEXIS<sup>®</sup>  
A member of the Reed Elsevier plc group



LEXIS-NEXIS<sup>®</sup>  
A member of the Reed Elsevier plc group

1991 Los Angeles Times, May 10, 1991

through documents at Camarillo State **Hospital**.

Sjoberg said the auditor general's office is recommending that the **hospitals** follow guidelines more closely before using restraints on the children.

"Overmedicating or tying a child to a chair can have devastating effects on a young life," Sjoberg said. "One would certainly hope they would be working toward making that life as positive as possible."

Responding to the state report, Camarillo's Hentley said mentally retarded children housed at the **hospital** tend to be more mobile and aggressive than youngsters at other state facilities. Therefore, restraints are needed to curb the youngsters' behavior problems, officials said.

While the Camarillo staff failed to obtain permission to use restraints on three of the six children surveyed by investigators, two other state facilities were found to be worse in failing to secure consent for restraints, Sjoberg said.

At Stockton Developmental Center in Stockton, **hospital** staff did not obtain permission to restrain 83% of the children surveyed there last year. And at Lanterman Developmental Center in Pomona, permission was not obtained in 70% of the restraint incidents checked by the state.

Carole Hood, deputy director of the state Department of Developmental Services, acknowledged the problems at the **hospitals**.

"In some cases the procedures were not followed," Hood said. "Oftentimes the behavior of the clients is aggressive and there is a very real threat of them injuring themselves or the staff. . . . While the staff was trying to make reasonable decisions to protect the health of the patients, unfortunately that meant that they did not follow the policies."

"We now need to make some changes."

Hood said **hospital** officials have been made aware of the problems and have agreed to make sure that patients' rights are protected.

Peggy Collins, consultant to the state Senate Special Committee on Developmental Disabilities and Mental Health, said she believes that the use of restraints should be abandoned at the state facilities.

"It is just inappropriate," Collins said. "It is ghastly, shocking and of grave concern to us."

Collins, an aide to state Sen. Dan McCorquodale (D-San Jose), said she plans to take the issue up with lawmakers.

LANGUAGE: ENGLISH



LEXIS·NEXIS<sup>®</sup>  
A member of the Reed Elsevier plc group



LEXIS·NEXIS<sup>®</sup>  
A member of the Reed Elsevier plc group



LEXIS·NEXIS<sup>®</sup>  
A member of the Reed Elsevier plc group

LEVEL 1 - 56 OF 70 STORIES

Copyright 1990 Sentinel Communications Co.  
Orlando Sentinel Tribune

March 20, 1990 Tuesday, 3 STAR

SECTION: LOCAL & STATE; Pg. B6

LENGTH: 464 words

HEADLINE: RESTRAINT LED TO CHILD'S BREAKDOWN, MOTHER SAYS IN SUIT

BYLINE: By Mary Meehan Of The Sentinel Staff

BODY:

A teacher's forceful **restraint** of a handicapped child resulted in the youngster's **mental** breakdown and destroyed the benefits of four years of intensive therapy, says a \$5 million lawsuit the child's mother has filed against the Orange County School Board.

In the suit, which also names the state Department of Health and Rehabilitative Services, Beth Smith says her 15-year-old daughter isn't getting the education she is guaranteed under federal law.

School board attorney Drew Thomas would not comment on whether the child was wrongly restrained, but has asked in court documents that the suit be dismissed.

Thomas said Smith can file an administrative appeal if she feels her daughter is not receiving an adequate education. The mother has not completed that process, he said.

Thomas also said that under federal law a school board can't be liable for the actions of an employee unless that employee is acting in response to a specific board policy.

According to the lawsuit filed last month in U.S. District Court in Orlando, a teacher at Robert E. Lee Middle School and two other school employees forcibly held Smith's daughter, Natalie, in a chair for more than 45 minutes on Sept. 26. One employee held her arms, another her feet and a third kept the girl's head between her knees, the suit said.

Smith said she found her daughter in that position, screaming, when she arrived at school.

The school employees are not defendants in the lawsuit.

After the restraint, Natalie became paranoid of people, allowing only her mother near her, the suit said. Since October, she has been in an isolation unit at Florida **Hospital** Orlando and is under HRS care because her mother cannot afford private treatment.

Natalie, who was born without sections of her brain's temporal lobes, has no short-term memory. She underwent residential treatment at Shands Teaching



LEXIS-NEXIS

A member of the Reed Elsevier plc group



LEXIS-NEXIS

A member of the Reed Elsevier plc group



LEXIS-NEXIS

A member of the Reed Elsevier plc group

Orlando Sentinel Tribune, March 20, 1990

**Hospital** in Gainesville from 1984-88. Since 1988 she has lived with her mother, a secretary, and attended Orlando's Lee Middle School.

Natalie's condition makes her easily upset and confused. Because she does not respond to normal methods of discipline, experts from Shands gave Natalie's teacher two months of instruction on how to handle the girl.

According to the suit, Natalie and the teacher got into a shouting match and later Natalie scratched another child. The suit says that the teacher and other employees then restrained Natalie in the chair.

Smith wants HRS and the school district to place her daughter in a private **hospital**. Smith's attorney Larry Brown said that could cost \$750 a day and treatment might take four or five years.

Thomas said the law requires a "free and appropriate public education" but does not require the school district to pay for private, more specialized care.

LANGUAGE: ENGLISH

LOAD-DATE: May 27, 1993



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group



**LEXIS·NEXIS**  
A member of the Reed Elsevier plc group

**Chris Jennings' Schedule**  
**Tuesday March 23, 1999**

9:30 - Mtg w/ DPC Team Leaders  
(Bruce's ofc)

1:00 - Health Policy Conf. Call  
Call 456-6755/6766 Code 8251

2:00 - Medicare Deputies Mtg - Rm 100

3:45 - LV for 4:00 mtg (Car Reserved)

4:00 - Mtg on "Home Health Care"  
w/McGovern, Coburn, Weygand  
416 Cannon House Ofc. Bldg.

5:00 - RTN to WH - (Car Reserved)  
\*\*\*\*\*

Revised: 10:00am - 3/23.

# DRAFT

DOJ Task Force

## National Health Care Fraud Task Force Mission Statement (Revised 3/05/1999)

### Background

Fraud schemes in the U.S. health care system cost taxpayers billions of dollars every year -- draining precious resources away from Medicare, Medicaid and other federal and state programs that provide vital care to the nation's elderly, poor, and disabled. As the U.S. health care system moves increasingly toward managed care, the related payment system will create new incentives for fraud that involve the intentional denial of medically necessary services, posing a threat to the health and safety of individual patients.

Numerous agencies at the federal, state and local level are responsible for fighting health care fraud and abuse. The increased commitment to anti-fraud efforts at all levels of government creates a corresponding need for more effective mechanisms to coordinate such efforts. The policy decisions made by one level of government will have an impact on the others, which highlights the need for early consultation and communication on policy development and implementation. At this time, however, there is no single, high-level mechanism to foster communication and coordination of federal, state and local health care fraud and abuse efforts.

### Establishment and Purpose

A National Health Care Fraud and Abuse Task Force ("National Task Force") should be established as a high-level mechanism to more effectively coordinate the efforts of federal, state and local agencies responsible for anti-fraud efforts. The National Task Force will facilitate coordination and communication among federal, state and local agencies and provide an opportunity for consultation on policy development and implementation. The National Task Force will consider a full range of issues relating to health care fraud, including:

- Strategies to bolster the investigation and prosecution of criminal and civil health care fraud.
- Policies and procedures for the coordination of enforcement efforts that impact multiple jurisdictions and/or enforcement agencies, including at the national, regional, and local level through task forces, working groups, and other similar mechanisms.
- Training programs for prosecutors, investigators and other law enforcement officials, with an emphasis on the development of "best practices" and the use of inter-agency efforts to combat health care fraud.

# DRAFT

# DRAFT

- Policies and procedures to ensure that appropriate alternative remedies at the federal and state level are considered in the course of enforcement efforts, including (but not limited to) programmatic exclusion, civil recovery, antitrust, consumer fraud, and drug enforcement.
- Use of information technologies to combat health care fraud and abuse, both to detect and punish such problems and to foster improved communications among federal, state and local law enforcement.
- Mechanisms to ensure that federal, state and local enforcement agencies stay informed of emerging health care fraud and abuse issues, such as changes in payment and reimbursement systems that create new opportunities for fraudulent and abusive practices and require corresponding changes in enforcement and regulatory practices.

The National Task Force should consider the full range of health care fraud and abuse issues, including abuse and neglect of individual patients in health care settings. The National Task Force will coordinate its efforts with existing entities to focus on issues such as consumer fraud and elder abuse in non-health care settings.

## Membership

The National Task Force will be composed of officials from the U.S. Department of Justice, Federal Bureau of Investigation, U.S. Department of Health and Human Services, Office of Inspector General, National Association of Attorneys General, National Association of Medicaid Fraud Control Units, and the National District Attorneys Association.

## Administration and Procedures

The National Task Force (composed of not more than two principals from each member entity) shall meet at least once annually, with additional meetings as necessary. Senior staff from member entities shall meet on a quarterly basis to discuss issues, ensure proper follow-up and implementation pursuant to directives from the National Task Force, and prepare agendas, briefing materials, and other matters. The National Task Force shall be chaired by the Deputy Attorney General or his designee. The Executive Director of the Task Force shall be the Special Counsel for Health Care Fraud, U.S. Department of Justice, or such other person as directed by the Chair.

## Coordination with Existing Entities

The Executive Director of the National Task Force shall ensure appropriate coordination with existing entities, including the Executive Level Working Group for Prosecutorial Relations, the Health Care Fraud Working Group (chaired by the Criminal Division, Department of Justice), and other relevant entities.

# DRAFT

LEVEL 1 - 11 OF 14 STORIES

Copyright 1998 The Hartford Courant Company  
THE HARTFORD COURANT THIS SERIES DEADLY RESTRAINT IS  
AVAILABLE ON THE COURANT'S WEB SITE, INCLUDING A NATIONAL  
DATABASE OF RESTRAINT-RELATED DEATHS, A DISCUSSION FORUM AND  
MORE. WWW.COURANT.COM

October 14, 1998 Wednesday, STATEWIDE

SECTION: MAIN; Pg. A7

LENGTH: 374 words

HEADLINE: RHODE ISLAND SHATTERING 'WALL OF SILENCE' ON INSTITUTIONAL ABUSE;

SERIES: Deadly Restraint  
Part Four of Five  
No Justice

BYLINE: DAVE ALTIMARI; Courant Staff Writer

DATELINE: PROVIDENCE, R.I. --

BODY:

Brian O'Rourke is about to go on trial for breaking someone's arm.

His case, scheduled to start this fall, wouldn't seem different from thousands of other assault cases across the country -- except for one thing.

The former employee at the state's only mental hospital is accused of injuring a patient during a restraint. He faces a maximum of 20 years in prison if convicted.

The O'Rourke case highlights the aggressive approach Rhode Island Attorney General Jeffrey Pine takes in prosecuting institutional abuse.

"People who work in institutions in Rhode Island know if they even slap someone in the face our office will be watching and coming after them," Pine said.

Pine's tactics are the exception. Across the country, few employees are tried and even fewer punished for restraints that end in death or injury to a patient.

In Rhode Island, though, officials arrested 27 people on charges of abuse in state or private facilities in 1997.

Many of those arrested received plea bargains with no jail time, but the typical deal yields an important condition: The worker gives up his right to work again at any facility, state-owned or private.

While Pine acknowledges abuse cases can be difficult to prosecute, he said they are not impossible and the message sent by ignoring them is much louder than losing a case.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

|                                 |              |
|---------------------------------|--------------|
| # of pages - 22                 |              |
| To                              | From         |
| Deborah Adkins                  | Alwyn Cassil |
| Dept/Agency                     | Phone        |
|                                 | 202-260-4448 |
| Fax #                           | Fax #        |
| 456-5557                        |              |
| NSN 7540-01-317-7368            |              |
| GENERAL SERVICES ADMINISTRATION |              |

THE HARTFORD COURANT THIS SERIES DEADLY RESTRAINT IS AVAILABLE ON THE CO

"I remember when drunk driving cases were supposed to be untriable," Pine said. "You're never going to change people's attitudes if you don't prosecute cases and show people there is a consequence for their actions."

Rhode Island is doing more than aggressively prosecuting cases.

Using mostly federal grants, Pine turned his Medicaid fraud unit into a training unit. The group travels to nursing homes, children's facilities and private psychiatric hospitals to train workers on what is patient abuse and how to spot it.

In the three years since the program started, the unit has trained more than 9,000 workers, Pine said. The visits have opened the door to institutions that are normally insular and protect their own.

"If you train people to recognize abuse," he said, "they will be more likely to turn someone in and not keep the wall of silence that exists in most places if something goes wrong."

LANGUAGE: ENGLISH

LOAD-DATE: October 15, 1998

## LEVEL 1 - 12 OF 14 STORIES

Copyright 1998 The Hartford Courant Company  
THE HARTFORD COURANT

October 11, 1998 Sunday, STATEWIDE

SECTION: MAIN; Pg. A10

LENGTH: 1370 words

HEADLINE: GLOSSARY: TECHNICAL DEFINITIONS

SERIES: Deadly Restraint  
A five-part series

BODY:

\* Commonly used terms and their definitions.

**PHYSICAL RESTRAINT:** A broad category of restraints in which a patient's movements are restricted by the use of physical force. This action is usually taken to prevent an upset or agitated person from hurting himself or others.

**MECHANICAL RESTRAINT:** A broad category of restraints in which a patient is immobilized through external devices such as straps, belts, wrist or ankle cuffs, or restrictive clothing such as straitjackets.

**SECLUSION:** When a patient is separated from the general population of a facility and not permitted to return at will. Typically, the person is placed in a designated room, which is often padded. The room is often locked but typically has observation windows or cameras so staff may watch.

**TWO-POINT RESTRAINTS:** A standard mechanical restraint method. A device wraps around the waist and has straps or cuffs that go around the wrists to immobilize the arms.

**FOUR-POINT RESTRAINTS:** Another standard mechanical restraint method. The patient is placed on his back, typically on a bed. The wrists and ankles are strapped to the bed to immobilize the patient.

**FIVE-POINT RESTRAINT:** Same as above, with the addition of a strap or cloth device to restrict the patient's midsection.

**TAKEDOWN:** A broad term referring to a worker forcing the patient to the ground.

**BASKET HOLD:** A commonly used, but often misused, term. Leading experts describe a basket hold as a physical restraint in which a worker holds a patient from behind. The worker grasps the patient's wrists, and crosses the patient's arms across his or her chest. The worker then brings the patient to a seated position by stepping back and riding the patient down along the worker's thigh.

**BODY NET:** A vinyl net that is used to wrap a patient securely. The net has openings through which the arms are pulled and then strapped to the patient's

THE HARTFORD COURANT, October 11, 1998

side.

**BODY BAG:** A large piece of reinforced cloth or canvas that is wrapped around the body and secured with zippers or straps.

**STRAITJACKET:** A coat-like device that is worn by a patient and used to bind his arms tightly against his body. Also known as a camisole.

**FLOOR HOLD:** A broad term encompassing a number of physical restraints during which a patient is forced to lie on the floor.

**FACE-DOWN RESTRAINT:** A broad term referring to a physical restraint during which the patient is facing the ground and staff members are either atop or beside the patient.

**VEST POSY:** A vest that some facilities use during a bed or chair restraint.

**PELVIC POSY:** A cloth device that some facilities use during a bed restraint. The vest goes across the pelvis and keeps a person from wriggling out of arm and leg restraints.

**CARDIAC CHAIR:** A padded recliner into which a patient is strapped. Often used in nursing homes. Also known as geri-chair or restraint chair.

**THORAZINE:** a tranquilizer used in psychiatric hospitals to calm unruly patients. In some cases found by The Courant, Thorazine was administered during a restraint.

**LANGUAGE:** ENGLISH

**LOAD-DATE:** October 15, 1998

## LEVEL 1 - 10 OF 14 STORIES

Copyright 1998 The Hartford Courant Company  
THE HARTFORD COURANT

October 15, 1998 Thursday, STATEWIDE

SECTION: MAIN; Pg. A1

LENGTH: 1936 words

HEADLINE: FROM 'ENFORCER' TO COUNSELOR;  
WITH STRONG LEADERSHIP, THE CYCLE CAN BE BROKEN

SERIES: Deadly Restraint  
Part Five of Five  
Solutions

BYLINE: ERIC M. WEISS; Courant Staff Writer

BODY:

Will Overton used to be called "The Enforcer."

With 280 pounds of solid Tennessee muscle wrapped around a 6-foot-3 frame, the aide at the Harold W. Jordan Center was called in to help "shuffle" patients -- slamming them to the ground face-down if they acted up or disobeyed. And the 30 mentally retarded and mentally ill patients -- people accused of murder, rape and other crimes -- often disobeyed.

"I used to be a bad boy," said Robert Hall, a short, wiry patient with the energy of a wound rubber band. "I was shuffled about every day."

Not anymore. Behind the Nashville center's locked gates and razor wire a radical turnaround has occurred in the last year. Shuffling is now forbidden, and staff has been increased and given intensive training.

Tennessee's example shows that, with strong leadership, the physical restraint of patients can be minimized -- indeed, nearly eliminated -- safely and without exorbitant cost.

"If we could do it here," said Frances Washburn, deputy superintendent of Clover Bottom Development Center, which includes the Jordan unit, "it can be done anywhere."

But the routine and frequently dangerous use of restraints persists elsewhere, even though the solutions are often simple and straightforward: better training, stronger oversight, uniform standards and the collection and sharing of information.

Federal officials and health groups say they are working on it.

The U.S. Center for Mental Health Services has begun a five-state pilot program to collect restraint and seclusion data. The U.S. Department of Veterans Affairs is tracking deaths more closely.

THE HARTFORD COURANT, October 15, 1998

The Joint Commission, the nation's leading hospital accreditation organization, has strengthened its guidelines on restraint and seclusion. And the American Medical Association has begun studying the use of restraints on children.

"Those steps sound pretty inadequate to me," said Dr. Joseph Woolston, medical director for children's psychiatric services at Yale-New Haven Hospital. "This sort of half-hearted patchwork approach will probably do more harm than good by giving an illusion that something is happening when it is not."

So for now, it is left to individual hospitals to find their own way. Those committed to the task illustrate what can be done.

Riverview Hospital for Children and Youth, a state-run psychiatric hospital in Middletown, Conn., uses an intensive training program that emphasizes nonphysical intervention when a patient loses control.

"These situations are often chaotic and unpredictable, and without proper training, staffers are just winging it," says Linda Steiger, executive director of Wisconsin-based Crisis Prevention Institute.

CPI, a leading private training company, provides instruction to Riverview workers. The cost is minimal: \$895 per person for a four-day program to teach a small number of designated staffers, who then instruct their peers.

Tighter procedures also emphasize that every restraint is a major step -- literally, a matter of life and death.

At Riverview, a staffer is required to constantly monitor anyone in mechanical restraints. That ensures a patient's vital signs remain strong, and provides an incentive to end the intervention as soon as the patient regains control.

At Tennessee's Jordan Center, patient treatment plans that include the use of restraint are, for the most part, rejected. And every use of emergency restraint is investigated and must be defended.

"When forced to go through the self-analysis and justifications, they solve it at a lower level the next time and without restraints," said Thomas J. Sullivan, who heads Tennessee's Division of Mental Retardation Services. "Of course, this requires staff to give up total control."

Emergency restraints are so infrequent now that Sullivan gets an e-mail message every time they are used. He's gotten an average of just two to three e-mails per month since January.

Accountability means staffers share more information and learn from the mistakes of others. Techniques found to be dangerous, such as face-down floor holds and mouth coverings, have been outlawed in certain places as a result.

But tough lessons learned by individual hospitals typically aren't shared with facilities on the other side of town or 10 states away. Each hospital is left to reinvent procedures or learn the hard way -- through the death of a

THE HARTFORD COURANT, October 15, 1998

patient.

It doesn't have to be that way.

New York state has reduced restraint use and the number of related deaths by requiring the reporting of usage rates and by investigating all deaths.

After New York required all mental health facilities to say how often they use restraints -- and published the numbers -- the top three users revamped their policies and brought their numbers down.

When it came to deaths, the state used to allow each hospital to decide which ones were questionable enough to report. It was notified of 150 cases over three years. Once mandatory reporting of every death was instituted 20 years ago, the number of deaths requiring further investigation rose to 400 a year.

"When people have a choice in classifying deaths -- with one choice resulting in tremendous scrutiny, the other resulting in none, what do you think they're going to do?" said Clarence Sundram, the former chairman of the independent New York agency that tracks and investigates deaths.

Accountability has produced results. Restraint-related deaths in the past five years have been cut nearly in half as compared with the preceding five years, New York state records show.

Nationwide accountability could accomplish the same.

"There needs to be some kind of state-by-state evaluation to gather comparative statistics and give an annual report to Congress," said Dr. E. Fuller Torrey, a prominent psychiatrist and author.

"Until you embarrass the individual states," Torrey said, "nothing will be done."

The federal government has shown a willingness to intercede on this very issue -- in response to charges that the elderly were being abused.

When the U.S. Food and Drug Administration estimated in 1992 that more than 100 people annually were killed through the use of mechanical restraints in nursing homes, the agency tightened rules on their use.

"We also thought these cases were flukes," said the FDA's Carol Herman, "until we started digging."

The FDA now considers lap and wheelchair belts, fabric body holders and restraint vests to be prescription devices. Manufacturers are subject to FDA inspections to ensure quality control.

Such steps, advocates say, have both reduced and improved the use of restraints. In the mental health field, strong and independent government oversight can weed out bad practices and bad facilities as well, they say.

"We can't do it alone," said Curtis L. Decker of the National Association of Protection and Advocacy Systems. "The only way to truly protect patients is through a large, comprehensive monitoring program."

THE HARTFORD COURANT, October 15, 1998

That means a system where government regulators, not the industry, are charged with oversight, he said. An internal patient grievance system would be bolstered by a well-funded network of independent advocates trained in death investigations.

More than money, though, many analysts say a culture in which restraints are used too soon, too frequently and for the wrong reasons must be changed.

"The single biggest prevention method is the avoidance of restraints to begin with," Sundram said. "It is often the training and opinions of staff that dictate restraints, rather than patient behavior."

In Tennessee, "the changes were top-down, bottom-up and a hard sell everywhere," Sullivan said. Before taking the top Tennessee job, Sullivan spent 27 years as an official in Connecticut's Department of Mental Retardation.

Reducing restraint use was just one of many changes forced on Tennessee by two lawsuits filed by the U.S. Department of Justice and by patient advocates. "It was a system that was disintegrating," said Ruthie Beckwith of People First of Tennessee, a patient advocacy organization that sued the state.

The state responded with new leadership, more money and staff and an intensive training regimen emphasizing calming words instead of brute force.

The total cost for the Jordan Center: \$12,665 for training in restraint use and alternative methods; \$255,372 annually in additional staffing to address not only restraint issues but massive deficiencies in overall patient care.

The changes in technique weren't easy on staff. About a half-dozen aides quit. Others grouched. But most stayed and changed.

"It was a rough couple of months," said Robert Zavala, an aide at Jordan. "At first, they just told us we couldn't put our hands on them. Everyone was like, 'Oh, so all I can do now is run away?' "

Bernard Simons, the Clover Bottom superintendent who oversaw the transition, remembers a defining moment. He received a frantic call from staffers at Jordan saying a patient was smashing furniture and asking whether they could restrain him.

"I said, 'Let him break it,' " Simons said. "So you're going to risk hurting yourself or the patient for a \$100 coffee table? The state will buy a new one."

The changes are both profound and surprising to staff and patients who remember the old ways.

"Before, we weren't earning their respect, it was just fear," said Overton, the burly aide who still wears a belt that says "Boss."

"Now, I'm more of a counselor or big brother than an enforcer," Overton said. Like a Cold War relic, he now uses skills other than just his brawn, such as his woodworking knowledge, which he passes on to patients in a new class he teaches.

THE HARTFORD COURANT, October 15, 1998

"I used to get shuffled a whole lot of times when I would go off and hit someone," said David Holland, 24, who has been at the Jordan Center for 2 1/2 years. "Now, they give us a lot more time to chill out, calm down. It's getting better each day."

\*\*\*\*\*

#### WAYS TO IMPROVE THE SYSTEM

Based on interviews with health care experts, workers, advocates, patients, hospital administrators and government officials, The Courant's investigation has highlighted ways to make restraint use less dangerous. They include:

Better and more frequent training.

Staff should be trained regularly in nonphysical methods to calm patients, and in safe techniques to restrain patients.

Universal CPR training.

All hands-on staff should be trained in the use of CPR, which not only enables workers to save lives but to recognize the patient's signs of distress.

Uniform national standards.

National standards should be set on how and when to use restraints. Minimum staff training should be required in their use.

Monitoring patients in restraint.

Patients in physical restraints should be monitored by a staffer not involved in the restraint. Patients in mechanical restraints should be monitored constantly or at frequent, regular intervals.

Elimination of bad techniques.

Restraints that are found to be dangerous, such as face-down floor holds and mouth coverings, should be banned nationwide.

Universal reporting of restraint deaths.

Restraint-related deaths and injuries should be reported to a national clearinghouse so lessons can be shared and potentially deadly errors averted.

Research.

Professional research needs to be done in this largely unexplored area. In particular, the issue of children being restrained warrants concerted study.

Thorough investigation.

All sudden, unexpected deaths such as those following a restraint should be thoroughly investigated by medical examiners and police.

GRAPHIC: PHOTOS: (2 color), Rich Messina / The Hartford Courant; PHOTO 1: MIKE

THE HARTFORD COURANT, October 15, 1998

PIGNONE, an aide at the Harold W. Jordan Center, talks with a patient on the grounds of the Nashville facility. Recent changes at the center are the result of Tennessee's efforts to minimize the need to physically restrain patients. "If we could do it here, it can be done anywhere," said a Jordan Center administrator.; PHOTO 2: HE STILL WEARS A BELT THAT SAYS "BOSS," but these days Will Overton sees himself more as a big brother to patients at the Jordan Center. The center is an example of how mental health facilities can, through sufficient staffing and intensive training of aides, reduce the inclination to physically restrain patients.

LANGUAGE: ENGLISH

LOAD-DATE: October 15, 1998

LEVEL 1 - 8 OF 14 STORIES

Copyright 1998 The Hartford Courant Company  
THE HARTFORD COURANT

October 17, 1998 Saturday, STATEWIDE

SECTION: MAIN; Pg. A1

LENGTH: 1175 words

HEADLINE: REFORM URGED IN USE OF RESTRAINTS;  
U.S. LAWMAKERS RESPOND TO REPORT ON DEATHSSERIES: Deadly Restraint  
Taking ActionBYLINE: DAVE ALTIMARI and  
ERIC M. WEISS; Courant Staff Writers

BODY:

Members of Connecticut's congressional delegation and a leading advocacy group called for investigation and reform Friday in the wake of a Courant report on the misuse of restraints in psychiatric and mental retardation facilities nationwide.

"I was stunned by the number of deaths," said U.S. Sen. Christopher J. Dodd, D-Conn. "Like most people, I never realized the lack of standards, training and policing of psychiatric institutions. We have to adopt some national standards to stop this from happening."

U.S. Sen. Joseph I. Lieberman, D-Conn., said he will call for congressional hearings in January based on the newspaper's report, which he called "heartbreaking and infuriating."

"All the deaths are tragic, but it's the children who are in a weaker position that we feel for the most," Lieberman said. "These deaths happened in dark spaces that we don't ever see but now must explore."

Lieberman and Dodd said they have assigned staff to draft proposed legislation.

The Courant reported this week that 142 people died during or shortly after restraint or seclusion nationwide in psychiatric facilities, mental retardation centers and group homes over the past 10 years.

But because many of these cases go unreported, the actual number of deaths during or after restraint is believed to be much higher.

Between 50 and 150 such deaths occur every year across the country, according to a statistical estimate commissioned by The Courant and done by a research specialist at the Harvard Center for Risk Analysis.

The National Alliance for the Mentally Ill called for the U.S. Department of

THE HARTFORD COURANT, October 17, 1998

Justice and the U.S. Department of Health and Human Services to launch a "thorough national investigation to determine the magnitude of abusive and harmful seclusion and restraint practices in psychiatric treatment facilities."

"Many of the restraints used routinely in these facilities aren't supposed to be used," the alliance's executive director, Bill Emmitt, said Friday. "This is a group of people whose rights are being egregiously violated."

The alliance, the nation's leading advocacy group for the mentally ill, also called for:

- \* Independent investigations into all deaths in psychiatric institutions.
- \* A shift in hospital oversight from the existing system, which relies heavily on an industry-funded accreditation group, to a system using independent inspectors.
- \* National standards on the appropriate use of restraints, and funding to train mental health workers.

Justice Department officials said Friday they could not comment until they have reviewed the alliance's request.

But an official with the nation's hospital association called the alliance's demands an "overreaction."

"To cast a shadow over every psychiatric hospital and say they're guilty until proven innocent is wrong," said Rick Wade, senior vice president of the American Hospital Association.

A top official with the U.S. Center for Mental Health Services -- the federal government's mental health agency -- said he is open to a discussion of the alliance' proposals.

"We're willing to take a hard look at whatever is being discussed, and we'd be glad to sit down and look at NAMI's ideas," Dr. Thomas Bornemann said. "Under our current legislation we're unable to track deaths."

That would change if members of Connecticut's congressional delegation have their way. Lieberman, Dodd and U.S. Rep. Rosa L. DeLauro, D-3rd District, said Friday a national clearinghouse should be established to track restraint-related deaths.

"I'm appalled at the number of deaths," DeLauro said. "It's staggering and outrageous, and this is something I will get involved in."

Lieberman said he plans to ask the General Accounting Office to document and investigate the number of restraint-related deaths across the country and report to Congress.

In its report, The Courant documented 23 deaths nationwide during an 11-month period in 1997 and 1998. The period began with the death of one Connecticut boy, Robert Rollins, and ended with the death of another, Andrew McClain.

THE HARTFORD COURANT, October 17, 1998

The report found many similarities in the cases, including poor training and inadequate emergency response.

For example, Robert and Andrew died in virtually the same restraint hold. The boys were each restrained face down on the floor, with their arms crossed beneath them and a staff member exerting pressure on their backs.

This week, Robert's family contacted DeLauro and Lieberman, asking for a ban on the hold that killed the 12-year-old New Haven boy.

Robert died in April 1997 at the Devereaux School in Rutland, Mass., after he became upset that he couldn't find his favorite teddy bear.

Robert, who weighed less than 90 pounds, was restrained face down on the floor by a social worker even as Robert made "barking noises" in a futile struggle to breathe.

His lifeless body was left on the floor while the social worker went to attend to another student. His death was ruled an accident, and no one was arrested.

"Something has to be done to stop these kids from getting killed," said Sheila Ford, Robert's aunt.

Lieberman said he hopes to expand nursing home legislation, approved in 1987, that restricted the use of restraints. "For some reason that's not clear to me, psychiatric facilities were excluded from that legislation," Lieberman said.

Dodd said solutions also could include national licensing for all mental health aides. Only three states -- California, Colorado and Kansas -- actively license aides.

He said other potential moves -- such as reviewing the effectiveness of the nation's protection and advocacy system, and of its hospital oversight system -- will be studied.

"I want to research to what extent we are involved with funding and provide some federal law so we can stop these deaths," Dodd said.

Several candidates for congressional office also pledged their support for reform measures. They included Gary Franks, Dodd's Republican opponent; Kevin O'Connor and John Larson, candidates in the 1st Congressional District; and Martin Reust, the Republican candidate in the 3rd District.

"We need to find out the magnitude of [the problem] and, if it is happening, we need to address it immediately," Franks said. "Getting an independent third party to look into these facilities with unannounced visits seems to be a good move as well."

#### Calls for action

\* Congressional hearings sought. U.S. Sen. Joseph Lieberman said he will call for congressional hearings on the misuse of restraints.

THE HARTFORD COURANT, October 17, 1998

\* Legislation being drafted. Lieberman and U.S. Sen. Christopher Dodd said they are researching reform legislation such as nationwide licensing of mental health aides.

\* A call for a federal investigation. The country's leading advocacy group for the mentally ill has asked the U.S. Justice Department and the Department of Health and Human Services to investigate restraint abuses nationwide.

\* Proposals to document deaths. Members of the state's congressional delegation called for a national effort to track all restraint-related deaths.

LANGUAGE: ENGLISH

LOAD-DATE: October 19, 1998

LEVEL 1 - 6 OF 14 STORIES

Copyright 1998 The Hartford Courant Company  
THE HARTFORD COURANT

December 16, 1998 Wednesday, STATEWIDE

SECTION: MAIN; Pg. A7

LENGTH: 547 words

HEADLINE: USE OF IMPROPER RESTRAINTS WIDESPREAD, GROUPS SAY

BYLINE: MICHAEL REMEZ; Courant Staff Writer

DATELINE: WASHINGTON --

BODY:

Advocates for people with mental illnesses told Sen. Joseph I. Lieberman Tuesday that the use of improper and deadly restraints in mental health facilities is a critical and widespread problem.

The Connecticut Democrat gathered the advocates in his office to discuss strategy for passing legislation to address the problem in 1999. He heard blunt talk that the number of deaths and serious injuries caused by improper restraints is much higher than reported because so many remain undetected.

"It is a catastrophe," said E. Clarke Ross, deputy director of the National Alliance for the Mentally Ill.

In October, The Courant documented that 142 people died while or shortly after being restrained or secluded in psychiatric hospitals, mental retardation facilities or group homes over the past 10 years.

"We think that's by far the tip of the iceberg," said Curtis L. Decker, executive director of the National Association of Protection and Advocacy Systems Inc.

A statistical analysis done for The Courant by a researcher for Harvard Center for Risk Analysis bears that out. That analysis estimated that between 50 and 150 such deaths occur every year across the country.

Lieberman presented the advocates with draft legislation that essentially would extend rules limiting the use of restraints in nursing homes to other facilities. That legislation was initially adopted in 1987.

Joined by Sen. Christopher J. Dodd, D-Conn., and other lawmakers, Lieberman also is asking the investigative arm of Congress, the General Accounting Office, to conduct its own review, compiling independent numbers and looking at uniform policies or protocols that could be put in place.

Lieberman, who will be the top-ranking Democrat on the Senate Government Affairs Committee next year, also plans to ask Sen. Fred Thompson, R-Tenn., the committee chairman, to hold hearings on deadly restraints in the coming months.

THE HARTFORD COURANT, December 16, 1998

The legislation being drafted would add new requirements concerning the use of restraints and seclusion to the Medicare and Medicaid programs that help pay for the private mental health and mental retardation facilities.

Part of Tuesday's discussion amounted to which legislative approach would create the most benefit while engendering the least opposition -- a delicate balancing of policy and politics.

Chris Koyanagi, a lobbyist for the Bazelon Center for Mental Health Law, said nursing home operators objected to the restrictions on restraints when they were first enacted, but have learned to live with them today.

The advocates said Lieberman's proposal is a good starting point, though they seemed eager to make it more expansive. They stressed that some use of restraints is appropriate, but that they must be accompanied by proper training and used only when absolutely necessary, in consultation with medical professionals.

Ross said he hoped any hearings would include people representing facilities that do not use restraints as well as family members of residents of facilities that have been plagued by problems.

Decker said the groups want to work with Lieberman, Dodd and others to propose realistic legislation.

"We want to see results," Decker said. "We'll work certainly to make sure we put together something that will pass."

LANGUAGE: ENGLISH

LOAD-DATE: December 18, 1998

## LEVEL 1 - 4 OF 14 STORIES

Copyright 1999 Denver Publishing Company  
The Rocky Mountain News(Denver, Co.)

January 5, 1999, Tuesday,

SECTION: LOCAL; Ed. F; Pg. 8A

LENGTH: 346 words

HEADLINE: HOSPITALS OPPOSE BILL TO RESTRICT USE OF RESTRAINTS;  
LAWMAKER SAYS STATE AGENCIES BACK PROPOSAL TO CURB PRACTICE

BYLINE: Ann Imse; News Staff Writer

BODY:

Colorado hospitals are resisting any restrictions on their ability to tie down patients, isolate them or have staff physically restrain them.

The Colorado Health and Hospital Association is the only organization opposing state Rep. Moe Keller's third attempt to limit the use of restraints and solitary confinement. Mental hospitals, Youth Corrections and all other state agencies have accepted her bill, Keller said.

It would bar hospitals, schools, group homes, youth jails and others from restraining people unless there is imminent threat of bodily harm. It would prevent them from using restraints to prevent property damage, as a punishment, or for the convenience of staff.

The bill does not apply to law enforcement, so it would not limit the El Paso County jail's use of restraint boards to control inmates. One inmate died on the board last year, and the jail suspended use of it pending a review.

An investigation by the Hartford Courant last year found that 50 to 150 people a year die in restraints. Many victims are disabled. And

'It takes away the ability of people

on site to make the best decision'

nearly 60 percent of the deaths occurred in hospitals.

In Denver, an Alzheimer's patient last year strangled on the restraints tying her to a bed at Columbia North Suburban hospital. Hospital staff had promised she would be checked every 15 minutes. Instead, she was left alone for an hour.

After the death, the hospital stopped using that type of restraint.

Keller gave hospitals a loophole by allowing them to restrain patients if that is part of their medical care. But the hospitals want a complete exemption.

"It takes away the ability of the people on site to make the best decision," said Peg O'Keefe, a spokeswoman for the Colorado Health and Hospitals Association.

Youth Corrections, which was criticized by Human Rights Watch in 1997 for its use of solitary confinement and restraints, has signed off on Keller's bill.

The bill does not apply to nursing homes that comply with more stringent federal rules.

GRAPHIC: Photo;

Moe Keller.

LANGUAGE: ENGLISH

LOAD-DATE: January 8, 1999

## LEVEL 1 - 2 OF 14 STORIES

Copyright 1999 The Hartford Courant Company  
THE HARTFORD COURANT

January 31, 1999 Sunday, 7 HARTFORD NORTH FINAL

SECTION: MAIN; Pg. A1

LENGTH: 1802 words

HEADLINE: LEGISLATORS TAKE AIM AT RESTRAINT

BYLINE: ERIC M. WEISS And DAVE ALTIMARI; Courant Staff Writers

BODY:

Seeking to reform practices that have killed hundreds of the nation's most vulnerable, lawmakers are preparing federal legislation that would for the first time regulate the use of restraints in mental health facilities.

At least two major bills to make the use of restraints less frequent and less dangerous will be introduced in Congress next month.

For the families of those who died pinned face down on the floor or tied up and ignored for hours, their stories will finally be heard. The Senate's powerful Appropriations Committee plans to hold a hearing on deadly restraints within weeks.

The actions come in response to a five-part series published last October by The Courant, which found 142 people died during or shortly after restraint or seclusion in the past decade.

Because many of the deaths go unreported, though, the actual number of restraint-related deaths in mental health and mental retardation facilities is much higher. Between 50 and 150 such deaths occur every year across the country, according to a statistical estimate commissioned by The Courant.

Federal agencies are now studying the number of restraint deaths and questioning industry-controlled oversight of the mental health system.

And the industry itself, while still questioning the need for new regulation, is paying more attention to the types of deaths once dismissed as flukes.

With President Clinton on trial in the Senate and Washington entering its second year fixed on the sex- and-lying scandal, some advocates fear restraint reform could get lost in the partisan shuffle.

But legislators and other advocates say the issue is both compelling and straightforward -- and they are preparing for a big push to get legislation passed this year.

"The evidence compiled is so overwhelming and the issues are of life-and-death," said Sen. Joseph I. Lieberman, D-Conn., who is sponsoring legislation in the Senate. "Unless someone can come up with an argument that I haven't heard of, I expect bipartisan support."

'My poor baby'

As policymakers consider their options, bad techniques, poor training, insufficient staffing and inadequate investigation persist.

THE HARTFORD COURANT, January 31, 1999

And youngsters, such as Laura Hanson, continue to die in restraints.

The 17-year-old Florida girl died last November in the same face-down restraint hold that killed 11-year-old Andrew McClain in a Connecticut psychiatric hospital just eight months earlier.

After Hanson got into a fight with her roommate on the night of Nov. 19, two aides at a West Palm Beach mental health center entered her room and placed her in a hold. Within 10 minutes, she was limp and unconscious. That evening, she was dead.

"She would tell me sometimes that she had been in a hold but I didn't know what that meant," said her dad, Leroy Hanson. "If I did, I would have yanked her out of there."

Leroy Hanson hasn't heard anything from hospital officials since that night -- except for a plant they sent to the funeral. The plant sits dying in Hanson's trailer. He hasn't watered it once.

"That plant is going to sit there and die just like they did to my daughter -- my poor baby," Hanson said.

In Washington, lawmakers say legislation is needed to stop the killing.

"What really pains me is that a disproportionate number of those who died from restraints are children -- those who are least able to defend themselves," said U.S. Rep. Diana DeGette, D-Colo., the main author of the House bill.

She is working on the bill with Rep. Fortney "Pete" Stark, D-Calif., the ranking Democrat on the Ways and Means Subcommittee on Health.

#### House, Senate proposals

The DeGette-Stark bill would, for the first time, create specific and detailed federal guidelines on restraint and seclusion use in mental health facilities. While restraint standards exist for nursing homes, restraints in mental health facilities are virtually unregulated.

The bill also would track the use of restraint and seclusion nationwide and require all deaths to be reported to independent, federally funded agencies in each state. Currently, there are no national statistics and many restraint deaths go unreported -- to police, regulators and even families. "We don't want to give facilities the wiggle room to pick and choose what deaths to report," said Curtis L. Decker, executive director of the group representing advocacy organizations nationwide. "We must deal with all deaths to get to the restraint deaths."

The bill would also require facilities to provide annual training of mental health aides. Many of the deaths uncovered by The Courant could have been prevented by staff who were better trained in the safe use of restraints and emergency procedures.

Lieberman's Senate bill looks to build on landmark nursing home reform legislation passed in 1987, which included tough rules on the use of restraint and seclusion. His bill would expand those same rules to cover mental health facilities, as well as require deaths and serious injuries to be reported.

"It seems odd to me that mental health facilities weren't covered," Lieberman said. "After all, the problems with restraints are even more likely to occur in mental health facilities than in nursing homes, simply because of the nature of the populations."

The reforms are credited with making nursing homes safer.

Restraint and seclusion use in nursing homes has dropped by nearly a third nationwide since 1996, according to the federal Health Care Financing Administration. In Pennsylvania, which has moved aggressively to curb

THE HARTFORD COURANT, January 31, 1999

restraint use, rates have dropped by more than half.

Mental health advocates would prefer the legislation to be as specific as possible, instead of leaving the details to the bureaucracy to develop. The reason: "When it comes time to write the rules, consumers are often outmaneuvered by the health care industry's dozens of lawyers and lobbyists," said E. Clarke Ross, the public policy director for the National Alliance for the Mentally Ill.

#### Industry: More study needed

Organizations that represent mental health providers question whether nursing home language is adaptable to the mental health field. Others question whether new regulation is needed at all.

They call, instead, for more study, more discussion and more time. "We think legislation should grow out of the understanding of the problem, instead of preceding it with a whole host of regulatory changes," said Dr. Steve Mirin, medical director for the American Psychiatric Association. Stark said he has a clear understanding of the problem. "As for-profit hospitals care more and more about the bottom line and less and less about patient care, the incidents of unsafe care are increasing," the California congressman said. "Regulation is considered a bad word mostly by people who are providing poor quality care or harming people."

Industry groups representing hospitals and private psychiatric facilities are working to compile a list of voluntary policy "guidelines" and compiling a list of experts and facilities that do things right.

In the health field, consensus on what are the best practices often leads to generally accepted standards, said Dr. Bernard Arons, the top mental health official with the Department of Health and Human Services.

But advocacy groups say the problems are greater than figuring out the best restraint hold or praising a conscientious practitioner. There must be major changes in the way the nation's hospitals and mental health facilities are regulated and inspected.

The Courant investigation found mental health oversight to be ineffective and rife with conflicts of interest. It's a system where the industry is trusted to police itself, where poor facilities are often given high grades, where few are ever punished or closed.

"There have to be regulations and standards, there has to be better data collected, and there has to be independent investigations," said Decker, advocacy group leader. "There has to be a complete plan."

There are signs, now, that the system is being studied seriously.

A bipartisan group of 10 Congressional members, citing The Courant series, has asked the General Accounting Office, the investigative arm of Congress, to research restraint deaths nationwide.

The Health Care Financing Administration, which runs the giant Medicare and Medicaid programs, has established a task force to explore restraint use and oversight issues raised by The Courant.

And the inspector general of the U.S. Department of Health and Human Services is re-examining the large role that the Joint Commission plays in certifying the safety of the nation's hospitals. The federal government relies on the Joint Commission, an industry-controlled accreditation agency, to certify that a psychiatric hospital meets the standards of Medicare and Medicaid. But Joint Commission inspectors almost never revoke or deny accreditation and have given clean bills of health to facilities later found to be dangerous and incompetent.

Several weeks after The Courant's series ran in October, the Joint

THE HARTFORD COURANT, January 31, 1999

Commission issued an action alert to its 18,000 member organizations -- only the eighth alert of its kind -- warning them of the dangers of restraints. Joint Commission officials also are considering beefing up their restraint standards, and have scheduled public hearings in March in Washington, Atlanta and San Francisco.

#### Shifting attention

More than proposals and studies, it will take continued attention focused on the issue when Congress shifts its focus from impeachment. When that happens, members say, Congress will be in a legislating mood.

"I can't tell you how eager we are to get back to legislation," said a weary U.S. Rep. Christopher Shays, R-Conn., who said he is inclined to support the House bill. "We've basically had a year's hiatus."

Eager, too, are the families of those who have died.

"Nothing can bring back Tristan or any of the other children," said Jean Allen, the mother of Tristan Govern, a 16-year-old North Carolina boy who died after aides wrapped a towel and bed sheet around his head.

"It is sad that it took major headlines for people to be made aware that this is a big issue," she said. "But if anything good can come out of these tragedies, it is the laws and guidelines to protect other children and vulnerable adults. "And that," she said, "would be a step in the right direction."

LANGUAGE: ENGLISH

LOAD-DATE: February 1, 1999