DEPARTMENT OF MENTAL HEALTH REPORT TO
MENTAL HEALTH OVERSIGHT COMMITTEE

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Good Morning. Thank you for the opportunity to come before you and discuss Emergency Involuntary Procedures.

An Emergency Involuntary Procedure is the use of restraint or seclusion when necessary to ensure the immediate safety of the patient, a staff member or others.

The nationally accepted definitions, standards and guidelines across all hospitals are those published by the Centers for Medicare and Medicaid Services. All hospitals in Vermont are subject to these conditions of participation have been under these regulations. CMS conditions of participation state that *Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time*. The interpretive guidelines further clarify that *Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others*.

The definitions as well as the interpretive guidelines are available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf

Definitions of restraint and seclusion:

Restraint

- *Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or*

- *A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition*

Seclusion

- *Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.*

These rules were published by CMS after an extensive period of public input and comment in 2006, effective 2007. The 'new' rules emphasized three improvements over the previous rules. These are:

1. Uniform standards across all areas of the hospital. This was an improvement over previous standards that were different in 'behavioral health' settings versus other areas of the hospital. Included among these were notification of the physician and standards for face to face evaluation by a physician, or other LIP, PA or specifically trained RN.
2. Hospitals were required to train the workforce who may be involved in these procedures to help staff learn de-escalation techniques as well as safe use of restraint and seclusion to minimize chance of injury to patient or others.
3. Reporting any deaths occurring as a result of, during or up to 24 hours following a restraint or seclusion

As we discuss what circumstances pose the need for an Emergency Involuntary Procedures, it is important to know the vast majority people getting inpatient care have not been secluded or restrained. Patients admitted to hospitals involuntarily, by definition, are engaging in behaviors that are dangerous to themselves or others. Inpatient units see many different situations in which there is imminent danger to someone. The staff training focuses on what interventions will help the person manage the behavior safely so that use of restrain and seclusion can be avoided. I

give you three examples of circumstances where there is imminent danger but they represent slightly different windows of time during which staff can intervene. If those are not successful however, the decision about restrain or seclusion has to be made very quickly to prevent serious harm from occurring.

1. A person admitted with suicidal thoughts who is tearing up a bed sheet to create a loop to hang him/herself from the top of the door.
2. A patient with severe paranoid delusions who believes that another patient on the unit is controlling their thoughts and putting voices in their head to say awful things. Patient gets very upset at him and wraps his hands around the other patient's neck.
3. A manic patient, admitted involuntarily due to dangerous behavior, who wants to leave the locked unit in the middle of the night. The staff member tells the patient that they cannot open the door. The patient gets upset and starts assaulting the staff member.

All these situations require urgent action. In each of these cases the staff member will assess the best method of stopping the dangerous behavior. As you can tell, each of the above examples would call for different action before restraint or seclusion is used. The trained staff member has to quickly assess the situation and make a determination as to what is the next best step, including options other than seclusion or restraint, but if those are not effective or cannot be done in a timely manner then, which method of seclusion or restraint is most likely to bring about safety for all concerned.

As we look continually reduce coercion in our healthcare system, the emphasis must remain on training staff to engage patient proactively, emphasize de-escalation and create a culture where the hospital's leadership makes reduction of Emergency Involuntary Procedures a high priority for the organization and paying close attention to these events.

To that end, the Department of Mental Health has two initiatives to meet the goal of reducing Emergency Involuntary Procedures in Vermont.

1. EIP Review Committee: A committee of providers (hospital and community), persons with lived experience, family members, advocacy groups as well as the public to review data on EIPs around the state and discuss directly with hospitals what efforts they are making and what is working well and what challenges they face in accomplishing our common goal of reducing coercion in the system of care.
2. Six Core Strategies: SAMHSA developed six strategies that have been studied and adopted as best practice in reducing restraints and seclusion in psychiatric units. The Department of Mental Health via the Vermont Cooperative for Practice Improvement and Innovation (VCPI) has started the training of the workforce to embed these practices across all hospitals in Vermont. All units serving patients under Level I status have met with the experts and discussing their individual strengths and challenges, to create an plan that is specific to that institution. Furthermore, VCPI is hosting two-day training and bringing in the national experts, including Dr. Kevin Huckshorn, to train designated hospital staff on the Six Core Strategies next week.

Thank you. I welcome your questions and thoughts.

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