SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Children and Families Committee

BILL:	SB 2662
INTRODUCER:	Senator Campbell
SUBJECT:	Persons with Developmental Disabilities or Mental Illness
DATE:	March 29, 2006
REVISED:	4/03/06

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Goltry	Whiddon	CF	**Fav/3 amendments**
2.			HC	
3.			JU	
4.			HA	
5.				
6.				

Please see last section for Summary of Amendments

- [ ] Technical amendments were recommended
- [x] Amendments were recommended
- [ ] Significant amendments were recommended

I. Summary:

Senate Bill 2662 amends sections of chapters 393, 394, 400, and 916, F.S., to add legislative intent, definitions, and regulatory authority relating to the use of restraint and seclusion with persons with mental illnesses or developmental disabilities. The bill requires the Agency for Persons with Disabilities (APD), the Department of Children and Family Services (DCF), and the Agency for Health Care Administration (AHCA) to adopt rules which assure that the use of restraint and seclusion is consistent with recognized best practices and professional judgment and provide for reporting, data-collection, and information dissemination.

This bill substantially amends the following sections of the Florida Statutes: 393.063, 393.067, 393.13, 394.453, 394.455, 394.457, 394.879, 400.960, 400.967, 408.036, 744.704, 916.105, 916.106, 916.107, 916.1093, 943.0585, 943.059

II. Present Situation:

For many years, decisions about policies and services for persons with disabilities were made without the involvement of those individuals and their families. Because of this, many of these policies failed to meet the needs of the people they were intended to serve. Increasingly, advocacy groups consisting of consumers and “survivors” have begun to get deeply involved in policy development and service planning and have been quite vocal about practices that they

have experienced as counterproductive at least and abusive at worst. In spite of substantial progress in the disability field and the advent of effective interventions for challenging behaviors that may present in persons with mental illness or developmental disabilities, the use of restraint and seclusion continues. During the last twenty years there has been increasing recognition of the danger that use of these procedures presents to clients subjected to them and the staff who must apply them. More recently, there has been a focus on the re-traumatizing effect of using these procedures on persons who may have a history of abuse or other significant trauma as well as the trauma-inducing effects of the procedures themselves. The National Institute of Mental Health (NIMH) reports, "Even those who do get treatment cannot be assured of a straightforward road to health. Evidence from other NIMH studies suggest that many people suffering from severe mental illness have had traumatic or harmful experiences while being treated in various psychiatric settings and have been victimized while living in community settings."[1]

The use of restraint and seclusion as a means of controlling the behavior of persons with disabilities was at one time a fairly common practice. "Concern about these practices has been longstanding, and rules limiting their use were announced in 1973 in the first major case aimed at reforming a public mental health system (Wyatt vs. Stickney, 1973) and in 1982 in the seminal United States Supreme Court decision on the constitutional right to liberty of individuals with disabilities. (Youngberg vs. Romeo, 1982) As often occurs, however, court pronouncements alone are unable to change institutional cultures and entrenched practices. Beginning in the 1990s, a variety of significant initiatives were undertaken to reduce and, in some instances, ultimately eliminate the use of restraint and seclusion."[2]

Currently, federal regulations governing hospitals provide guidelines for the use of restraint and seclusion and for reporting on the utilization of these procedures. The Centers for Medicare and Medicaid (CMS) conditions for participation for hospitals provide that a "patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The term ''restraint'' includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving."[3] The regulations also provide that restraint or seclusion "can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective."[4] The regulations provide specific guidance regarding the circumstances of use, physicians' orders, documentation, monitoring of the individual during the restraint or seclusion, and the training of staff. This regulation also requires that a hospital must report to CMS any death of an individual that occurs

[1] Frueh BC, Knapp RG, Cusack KJ, Grubaugh AL, Sauvageot JA, Cousins VC, Yim E, Robins CS, Monnier J, Hiers TJ. Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting. Psychiatr Serv 56: 1123-1133, 2005 cited by National Institute of Mental Health, Fiscal Year 2007 Budget.
[2] U.S. Department Of Health And Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services *Ending Harm From Restraint and Seclusion: The Evolving Effort*s, November 23, 2005.
[3] 42 CFR 482.13(f)
[4] Ibid.

while a person is restrained or in seclusion or "where it is reasonable to assume that a patient's death is a result of restraint or seclusion."[5]

There are also provisions in the conditions of participation for intermediate care facilities for the mentally retarded (ICF-MR but ICF-DD in Florida) which govern the use of restraints and seclusion in these facilities. The ICFs must comply with provisions in the guidelines for management of inappropriate client behavior relating to use of restraints, seclusion, and time out. These standards provide that the facility must "(i) Insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective."[6] A facility may employ physical restraint only "as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied; (ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or (iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists."[7]

Psychiatric Residential Treatment Facilities (RTFs) provide inpatient services for children under 21 years of age. Because these facilities receive Medicaid reimbursement they are also subject to CMS regulations regarding the use of restraint and seclusion. The regulations for RTFs are detailed and specific as they relate to definitions of restraint and seclusion and the circumstances required for the use of these interventions. These provisions include the requirement that "Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation" and "Restraint or seclusion must not result in harm or injury to the resident and must be used only—(i) To ensure the safety of the resident or others during an emergency safety situation; and (ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired."[8]

Accreditation organizations such as the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the Commission on Accreditation Facilities (CARF) have standards relating to the use of restraint and seclusion with which facilities seeking accreditation must comply. These standards are substantially similar to the CMS standards.

Both APD and DCF have some statutory provisions in place regarding the use of restraint and seclusion. The rights of persons with developmental disabilities articulated in s. 393.13(g), F.S., state that "(p)ersons who are developmentally disabled shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect." Section 393.13(4)(i), F.S., states, "Clients shall have the right to be free from unnecessary physical, chemical, or mechanical restraint. Restraints shall be employed only in emergencies or to protect the client from imminent injury to himself or herself or others. Restraints shall not be employed as punishment, for the convenience of staff, or as a

[5] Op cit.
[6] 42 CFR 483.450(b)
[7] 42 CFR 483.450(d)
[8] 42 CFR

substitute for a habilitative plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the client and shall be designed to allow the greatest possible comfort."

The use of restraint must be reported daily to facility administrators and a summary of the report is to be sent monthly to the area administrator for APD and the local advocacy council. The reports must include all instances of restraints, the reason for the restraint, the type of restraint used, and how long it was used. Each area submits these reports to the APD headquarters quarterly. A copy of the rules relating to use of restraint must be posted in living areas of residential facilities and given to all staff members of licensed facilities. Staff training must include a section on rules relating to use of restraint.[9]

Similarly, s. 394.459(4)(b), F.S., provides that "Clients shall have the right to be free from unnecessary physical, chemical, or mechanical restraint. Restraints shall be employed only in emergencies or to protect the client from imminent injury to himself or herself or others. Restraints shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitative plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the client and shall be designed to allow the greatest possible comfort."

All of Florida's state mental health treatment facilities have received training from the National Association of State Mental Health Program Directors (NASMHPD) on achieving reductions in the use of seclusion and restraint and have developed plans to reduce their use.[10] These plans will be monitored by the DCF Mental Health Program Office. The department has also developed operating procedures for the use of seclusion and restraint by state facilities.

Data on the use of seclusion and restraint is reported to the Mental Health Program Office on a monthly basis by state mental health facilities and these facilities are reviewed every year as part of a quality review process. The department was scheduled to begin piloting a new Critical Incident Reporting System for mental health and substance abuse facilities on March 15, 2006. This system, scheduled for statewide implementation in FY 2006-07, will collect information regarding incidents of seclusion and restraint.

Rule 65E-5, F.A.C., contains language regarding the use of seclusion and restraint for community receiving facilities and civil state treatment facilities. Comparable language regarding use of seclusion and restraint in forensic state treatment facilities is not in rule. According to DCF, there is no statutory authority in ch. 916, F.S., for the department to adopt these requirements in Rule 65E-20, F.A.C., relating to forensic facilities.

Pursuant to federal law, CMS must report Florida restraint or seclusion related deaths to the Advocacy Center for Persons with Disabilities (Advocacy Center) which is the state's federally

[9] s. 393.13 (i), F.S.

[10] There is a national initiative, led by the National Association of State Mental Health Program Directors (NASMHPD) to reduce the use of seclusion and restraints in all programs that treat persons with mental illness and increase sensitivity to and awareness of trauma histories.

mandated and funded protection and advocacy (P&A) for persons with disabilities.[11] [12]The Advocacy Center has authority to access records from facilities that treat people with disabilities as well as agencies that investigate alleged incidents of abuse or neglect. Where a complaint indicating circumstances for which abuse or neglect may be suspected has come to the attention of a state's P&A or where a P&A has found probable cause to suspect abuse or neglect in connection with the death of a person with developmental disabilities or mental illness, the P&A may request and receive access to records of the deceased individual and to all investigatory documents, records, and witness statements.[13]

Hospitals receiving federal funds must report to CMS any death that occurs while an individual is restrained or in seclusion, or where it is reasonable to assume that an individual's death is a result of restraint and seclusion.[14] Although CMS has directed its regional offices to share selected death report information to state P&As, this system of reporting - hospital to CMS and CMS to the Advocacy Center –does not work according to the Advocacy Center. Florida hospitals are often late sending reports to CMS and sometimes never send them; CMS often fails to notify the Advocacy Center in a timely manner, and often sends incomplete information. Several other P&As across the country encounter this problem with the CMS reporting system. P&As in at least 10 states now receive direct reporting of serious injuries or deaths due to restraint or seclusion by some or all facilities utilizing restraint and seclusion via state statute, regulation, or agreement.[15]

According to the Advocacy Center, based on data they have received from the federal CMS, Florida has the highest per-capita restraint/seclusion related death rate of any state during 2004 and 2005. Of these deaths, 14 of the 16 suspicious deaths that came to the attention of the

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[11] Pursuant to 42 C.F.R. 51.41(a), P&As are entitled to the "prompt" disclosure of records and records may not be withheld pending completion of related criminal investigations. See *Wisconsin Coalition For Advocacy, Inc. v. Busby*, No. 02-C-871 (E.D. Wi) September 24, 2003(unpublished); *Robbins v. Budke*, 739 F. Supp. 1479 (D. N.M 1990). The Advocacy Center also operates under Part C of Title I of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (the DD Act), 42 U.S.C. 15041-15045. The DD Act requires "immediate access, not later than 24 hours" to records requested by a P&A investigating the death of an individual with a developmental disability. See 42 U.S.C. 15043(a)(2)(J)(ii). Courts are applying this more specific period to the PAIMI Act. See *Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center*, 894 F. Supp. 424 (M.D. Ala. 1995), aff'd, 97 F.3d 492 (11th Cir. 1996; *Iowa Protection and Advocacy Services, Inc. v. Gerard treatment Programs* (N.D. Iowa, June 14, 2002, unpublished).

[12] CMS sent a letter to its regional offices on March 23, 2000 stating: "[e]ffective immediately, upon receipt of information about a patient restraint death, the RO will provide the following information to the appropriate state Protection and Advocacy Group (P&A): hospital's name, hospital's address, patient's name and date of death."

[13] See 42 U.S.C. Secs 6041-6043, 42 U.S.C. Sec 732, 42 U.S.C. § 10805 and 10806.

[14] 42 CFR Sec 482.13(f)(7) (directing hospitals to report to CMS); 42 CFR 483.374 (directing PRTFs for persons under 21 to report directly to the P&A by the end of the next business day).

[15] Arizona-Codified in state regulations for the Office of Behavioral Health Licensing (OBHL) at A.A.C. R9-202 A as well as in the Dept. of Behavioral Health Services Provider Manual. The AZ P&A also receives mortality reports and addendums from DBHS on a quarterly basis pursuant to ACDL v. Allen 197 F.R.D. 689 (D. Ariz. 2000) and as codified in GA 3.7 of the DBHS Provider Manual.
California-Health and Safety Code Section 1180-1180.6
Connecticut-Conn. Gen. Stat. § 46a-152 (2004)
Illinois-405 ILCS 5/2-201, 208 (2005)
Maine-Chapter 511 §19509
Maryland-MD Code, Health-general, §7-207,1003,1005, and § 10-714
Michigan-MCLS § 722.122e (2005)
Pennsylvania, Kentucky, and Massachusetts P&As also receive direct reporting but not pursuant to state statute or regulation.

Advocacy Center involved the use of restraint and/or seclusion. The Advocacy Center learned of these deaths from a variety of sources, including the CMS, AHCA, APD, DCF, and newspaper articles, as well as from families and friends of the deceased. However, the unreliability and uncertainty of the reporting procedures in Florida make it difficult to know with complete certainty the extent of use of restraint and seclusion.

Of the 14 deaths related to restraint and/or seclusion known to the Advocacy Center, 12 occurred in settings that are the subject of SB 2662. Six occurred in private receiving facilities (local psychiatric facilities where individuals are held for involuntary examination or short term treatment under ch. 394, F.S.), four in state mental health treatment facilities, two in group homes for individuals with developmental disabilities, one in the parking lot of a public receiving facility while the individual was in police custody, and one in a jail.

Analysis by the Advocacy Center of the 12 restraint and/or seclusion related deaths (that occurred in settings covered by SB 2662) has shown the following:

- Problems exist with the reporting and investigation systems of each entity (CMS, AHCA, APD, and DCF).
- Interventions that are nationally recognized as high risk contributed to several of the deaths. When staff and/or security personnel use specific practices in combination, it is particularly dangerous. In a physical restraint episode (commonly known as a "take down"), the high risk interventions are wrist restraints behind the back, prone position, weight on the back of the torso and airway obstruction (such as a towel, pillow or blanket over the face).
    - Two individuals were handcuffed behind their backs while held face down, a position that a number of training manuals warn against because of the possibility of fatality from asphyxiation.
    - Six individuals were face down (prone) as they struggled.
    - Three individuals had towels, clothing, or blankets over their faces.
    - Five individuals had weight or pressure on torso.
    - At least six of the incidents involved three-nine staff and security.
    - At least eight individuals had conditions known to increase the danger of using restraint.
    - At least seven individuals were obese or overweight.
    - At least one had a seizure disorder.
    - At least three had cardiovascular conditions.
- In 11 deaths, the Medical Examiners have completed their investigations. Identified causes of death included traumatic or positional asphyxiation, acute psychotic reaction, and injuries sustained during restraint efforts and asphyxia due to aspiration of stomach contents secondary to being physically restrained.
    - In three deaths, the Medical Examiner found asphyxia (positional or traumatic).
    - In two deaths, the Medical Examiner found traumatic injuries.
    - Two were ruled accidental, one was ruled a homicide; two were ruled natural causes and in the four remaining deaths, the Medical Examiner made no ruling.
    - To date, no criminal charges have been filed in any of these cases.
- A disproportionate percentage of the 12 individuals were members of racial or ethnic minorities:
    - Three of the individuals were white.

- Five of the individuals were African America.
- Two of the individuals were Haitian.
- Two of the individuals were Hispanic.

As reported by the Advocacy Center, several of the restraint episodes arose over disputes between staff and individuals about behavior. Often that behavior was part of a recurrent, predictable behavioral pattern that in and of itself was not highly dangerous. In at least one situation, the escalation that resulted in injury and death began when a staff member asked an individual to surrender an item in his or her possession.

In November 2005, the Substance Abuse and Mental Health Administration (SAMHSA) released a report "Ending Harm from Restraint and Seclusion: The Evolving Efforts." Major findings of the report were that "(r)egulatory efforts to date have emphasized ending physical harm and death from the use of restraint and seclusion. These efforts have accomplished a great deal; the severity of the problem has received widespread public attention and the major stakeholders now agree that these practices are dangerous, are not clinical treatments, and should only he used briefly and as a last resort to prevent serious harm. However, little is known publicly about the prevalence of these practices at many mental health facilities and at other facilities at which people with mental illness reside and/or receive treatment (such. as emergency rooms, schools, jails and prisons). Addressing the serious harms resulting from restraint and seclusion can only be accomplished by avoiding the use of these interventions. To do so requires going beyond current rules and approaches. The lessons to be learned from organizations with successful initiatives to reduce restraint, and seclusion include: (1) the need for a consumer focused, recovery oriented, program; (2) ongoing management commitment; (3) the establishment of reduction targets; (4) compilation and use of data to measure progress and reach those targets; and (5) staff training focused on prevention and de-escalation."[16] The report also indicated "(m)any states and providers have adopted policies that mirror the minimum standards provided in the federal regulations. While some states have adopted somewhat more stringent standards in some key areas, our review of selected state statutes, agency regulations, and agency and facility policies regarding the use of restraint and seclusion revealed few significant differences with the federal mandates. It is noteworthy that most state statutes and regulations appear to focus at least as much on the safe use of restraint and seclusion as they do on reducing their use. The consensus in state regulations and facility policies regarding the risks inherent in the use of restraint and seclusion is a significant new development in psychiatry and public mental health."[17]

III. Effect of Proposed Changes:

Senate Bill 2662 amends legislative intent sections in chapters 393, 394, 400, and 916, F.S., to add provisions relating to the use of restraint and seclusion on persons with mental illness and developmental disabilities who are receiving services from state operated, funded, or regulated facilities and programs. It adds language stating that it is the policy of the state that the use of seclusion and restraint is justified only as an emergency safety measure, and it is the

[16] *Ending Harm From Restraint and Seclusion — The Evolving Efforts*, DHHS Pub. (draft) Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.
[17] Ibid

Legislature's intent to achieve an ongoing reduction in the use of seclusion and restraint for persons with developmental disabilities or mental illnesses.

The bill adds definitions of "restraint" and "seclusion" to chapters 393, 394, 400, and 916, F.S, and requires DCF, APD, and AHCA to develop rules regarding seclusion and restraint use in mental health facilities and programs, developmental disability facilities and programs, and ICF-DDs. The rules adopted must:

- Include provisions governing the use of restraint and seclusion consistent with recognized best practices and professional judgment.
- Prohibit inherently dangerous restraint or seclusion procedures.
- Establish limitations on the use and duration of restraint and seclusion.
- Establish measures to ensure the safety of clients and staff during an incident of restraint or seclusion.
- Establish procedures for staff to follow before, during, and after incidents of restraint or seclusion.
- Establish professional qualifications of and training for staff engaged in the use of restraint or seclusion.
- Establish mandatory reporting, data-collection, and data-dissemination procedures and requirements.
- Require that each instance of the use of restraint or seclusion be documented in the facility's record of the client.

The bill takes effect on July 1, 2006.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Agency for Persons with Disabilities
No information on fiscal impact was provided.

Agency for Health Care Administration
No information on fiscal impact was provided.

Department of Children and Family Services:
"According to the definition of "seclusion" in the proposed bill, state mental health forensic treatment facilities would not be able to lock client bedroom doors during the normal hours of sleep. This situation presents a safety concern that carries a fiscal impact. Clients would have access to common areas of the facility throughout the night, which would result in a need for increased staff supervision to ensure safety. Additionally, the bedroom doors at Florida State Hospital Forensic (FSH) and Geo Care, Inc./South Florida Evaluation and Treatment Center (SFETC) automatically lock when they are closed. This would need to be changed if the proposed bill was implemented because according to the definition of seclusion, approximately 616 clients would be considered in seclusion every night. Therefore, 200 doors at FSH and 200 locks at SFETC would need to be replaced so they can be opened by the client from the inside. These two facilities have different types of doors, which accounts for the reason that only the locks need to be replaced in one facility and the entire door needs to be replaced in another."

To replace a door at FSH is $999 a door X 200 doors = **$199,800**
To replace the locks at SFETC is $225 a door X 208 doors = $46,800 X 7% tax = **$50,076***
(*This amount would need to be added to the contract for Geo Care, Inc. for fiscal year 2006-2007 as a one time non-recurring payment.)

The number of increased FTEs that would be necessary to ensure safety of persons served at FSH and NFETC during the night shifts are:
FSH would require 16 Human Service Workers X $31,283 = **$500,528 annually**
NFETC would require 20 Unit Treatment and Rehabilitation Specialist Positions X $32,375 = **$647, 500 annually**

TOTAL Year 1 = $1,944,528*
* Includes standard non-recurring expense and OCO for new positions and the cost of replacing doors and locks

TOTAL Year 2 = $1,517,064

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not address whether the department and the agencies are to work together on the development of rules so that the state has consistent standards. This collaborative effort would be particularly important in the area of data collection and dissemination to provide consistency and comparability across agencies.

The Department of Children and Family Services comments, "the definition of seclusion in the bill does not provide an exemption for the temporary seclusion of clients during an emergency situation such as a riot or hostage situation. It also does not provide an exemption for clients being locked in their rooms during sleeping hours to protect themselves from other people possibly entering their room during the night. If implemented as proposed, forensic state treatment facilities would be required to change the locking mechanisms on their bedroom doors as these doors lock automatically, providing safety to clients during sleeping hours. Additionally, forensic facilities would need to increase the number of staff on the night shift to ensure a safe environment if clients are allowed access to areas outside their bedrooms during this time."[18]

[18] Department of Children and Family Services, Bill Analysis Senate Bill 2662, March 8, 2006.

VIII. Summary of Amendments:

Barcode 475732 by Children and Families
Amends the definition of "restraint" in ch. 394, F.S., to clarify that a medication that is part of an individual's ongoing treatment for a diagnosed mental illness is not considered a chemical restraint.

Barcode 172420 by Children and Families
Amends the definition of "restraint" in ch. 916, F.S., to clarify that for forensic clients of the Department of Children and Families, a medication that is part of an individual's ongoing treatment for a diagnosed mental illness is not considered a chemical restraint.

Barcode 170226 by Children and Families
Amends the definition of "seclusion" in ch. 916, F.S., to clarify that confining clients in forensic facilities to their rooms during an emergency situation does not constitute "seclusion" as defined. This amendment eliminates the fiscal impact of this provision.