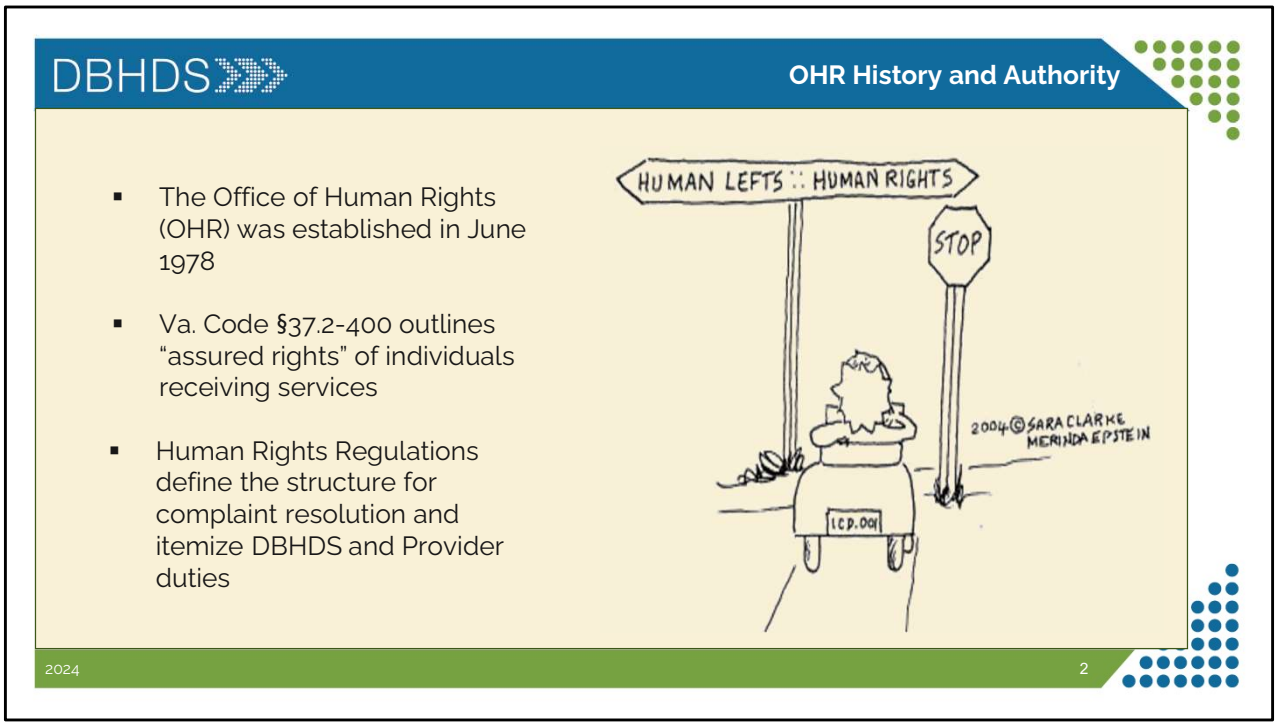
Today we are going to be reviewing: some brief history regarding the Human Rights Regulations, applicable regulations (and amendments to the regulations) pertaining to the use of seclusion, and compliance in provider use of seclusion, time-out, and restraints.

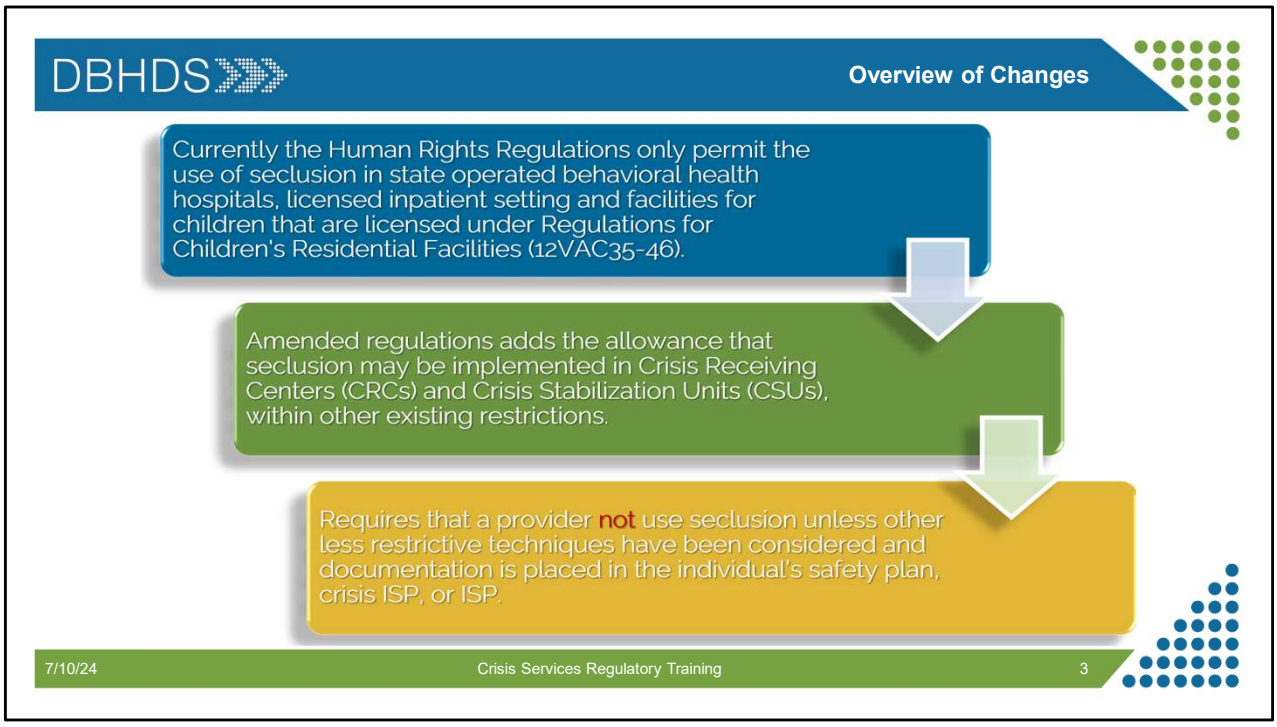


The Department of Behavioral Health and Developmental Services (DBHDS) Office of Human Rights (OHR) was established in June of 1978 with the implementation of a human rights structure within state operated facilities. Today Virginia Code §37.2-400 authorizes the Human Rights Regulations (HRR) to further define and protect specific *"assured"* rights for individuals receiving services not just in state operated facilities, but also from programs that are licensed or funded by the Department (DBHDS) in the community; in addition to identifying provider and the departments responsibilities in maintaining an individual's human rights.

The statutory purpose for the OHR is to perform oversight and enforcement of these HRR in both State Operated Facilities and Community Providers that are licensed or funded by DBHDS. In addition to defining an individuals assured rights, the HRR also outlines the departments human rights complaint resolution process designed to ensure investigation and mitigation of complaints that allege a human rights violation – which is anything ranging from Abuse, Neglect, and Exploitation; to complaints about confidentiality or the lack of participation in treatment and decision making; all the way to complaints about what's on the menu or what a person may or may not have access to in a particular services

setting.

For the sake and purpose of today's training, we will be discussing the amended regulations impact on the ability to perform seclusion, and compliances to do so per the HRR. *As a note: When reviewing regulations and attempting to verify what regulation belongs to the Office of Licensing (OL) or OHR; Chapter **105** is related to OL, and Chapter **115** is related to OHR. Hopefully this call out helps with determining which office you are needing to consult when needed.*



The use of seclusion is not new to the HRR, however, currently they indicate that seclusion can only be used in certain service settings such as: State Operated Behavioral Health facilities, licensed inpatient settings, and children's residential facilities that are licensed under 12VAC35-46. The amended regulations allow for expansion on the services settings that can perform seclusion.

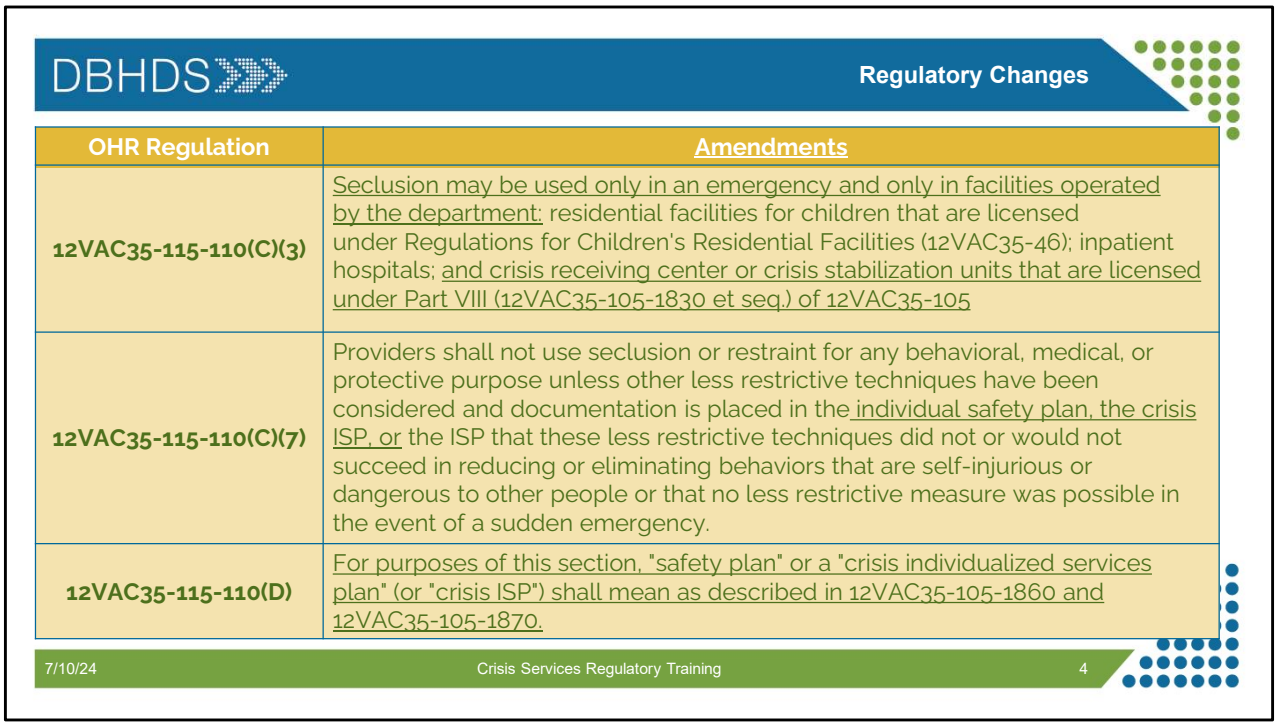
As of 7/17/24: Seclusion **may also be used only in an emergency** and only in ***crisis receiving centers or crisis stabilization units that are licensed under Part VIII (12VAC35-105-1830 et seq.)***

The use of seclusion in CRCs and CSUs will be governed by existing requirements in the HRR that apply to the use of seclusion *and restraint*, and at a minimum expect that:

- Least restrictive techniques have been considered or attempted prior to use
- Staff performing seclusion are trained in use of seclusion, per the providers behavior management plan
- Documentation exists indicating that the organization will use seclusion at the providers location
- The use of seclusion and/or restraint is documented in the individuals safety

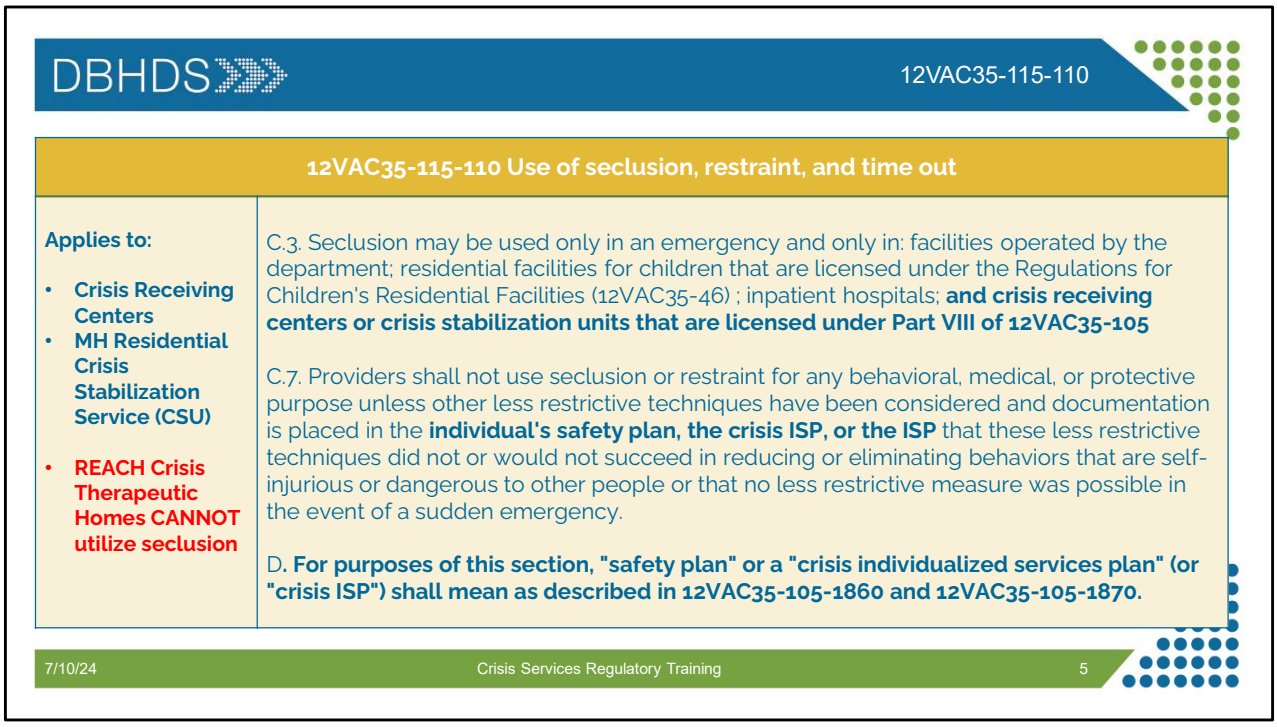
plan, crisis ISP, or ISP as applicable
- Providers shall not use seclusion in a Behavioral Treatment Plan per 12VAC35-115-105(H)
- Standing orders for seclusion and restraint are not permitted

We'll discuss these more in-depth as we move through today's training.



There are 3 main subsections of the HRR in section -110 that received the aforementioned amendments, which includes specifically subsections: C.3., C.7., and D. These additions are underlined in the slide for your awareness. In brief review they are as follows:

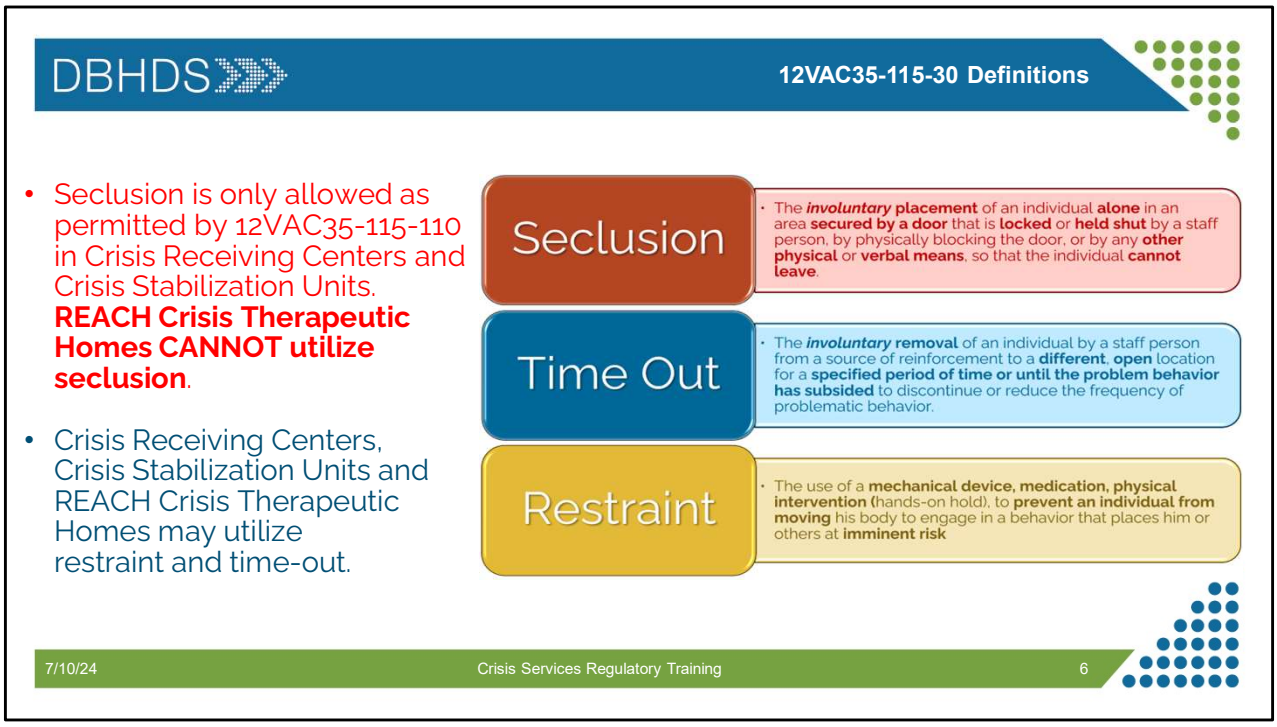
- In regulation C.3. please note that Crisis Receiving Centers (CRCs) and Crisis Stabilization Units (CSUs) have been added to the regulation, noting the appropriate license type
- In regulation C.7. please note that the updated regulation will reflect that the use of seclusion will be documented in the individuals safety plan, the crisis ISP (or the ISP)
- Regulation D is newly added to the HRRs. It identifies the terminology used and the associated "definition" via the Office of Licensing, as to what qualifies as such. So it is an alignment that points to both the Office of Licensing and the Office of Human Rights joint expectation of what is considered a safety plan or Crisis ISP; and what that shall include.



Chapter 115 (which again pertains to the HRRs) Section –110 of the Virginia Code is all about the **use of seclusion, restraint, and time out** – so with that, the following slides and regulations will be specifications from this section.

This slide is simply an additional visualization of the previously reported information regarding the addendums all in one place. On the left of the slide, you will note to whom these regulations apply.

We'll review these ammendments in detail following this same formatting but first I want to level set with a few important defnitions.



Let's briefly review the definitions – and the differences – of Seclusion, Time out, and Restraint as understanding these practices are foundational in use.

Seclusion is an involuntary process. This simply means that the individual *did not have a choice* in whether they were secluded. Furthermore, an individual is secluded when they are placed alone in an area that is secured by a locked door or a door that is held shut, or by a staff person physically blocking the door, or by another physical or verbal means, causing the individual not to be able to leave. **What is important to note regarding use of seclusion are the following components of the definition**: The **involuntary** placement of an individual *alone* in an area secured by a door that is *locked or held shut by a staff person*, by *physically blocking the door*, or by any other *physical* or *verbal* means, so that the individual *cannot leave.*

Time out unlike seclusion is the *involuntary* **removal** of an individual by a staff person from a source of reinforcement to a **different**, **open** location for a **specified period of time or until the problem behavior has subsided** to discontinuance or to reduce the frequency of problematic behavior.

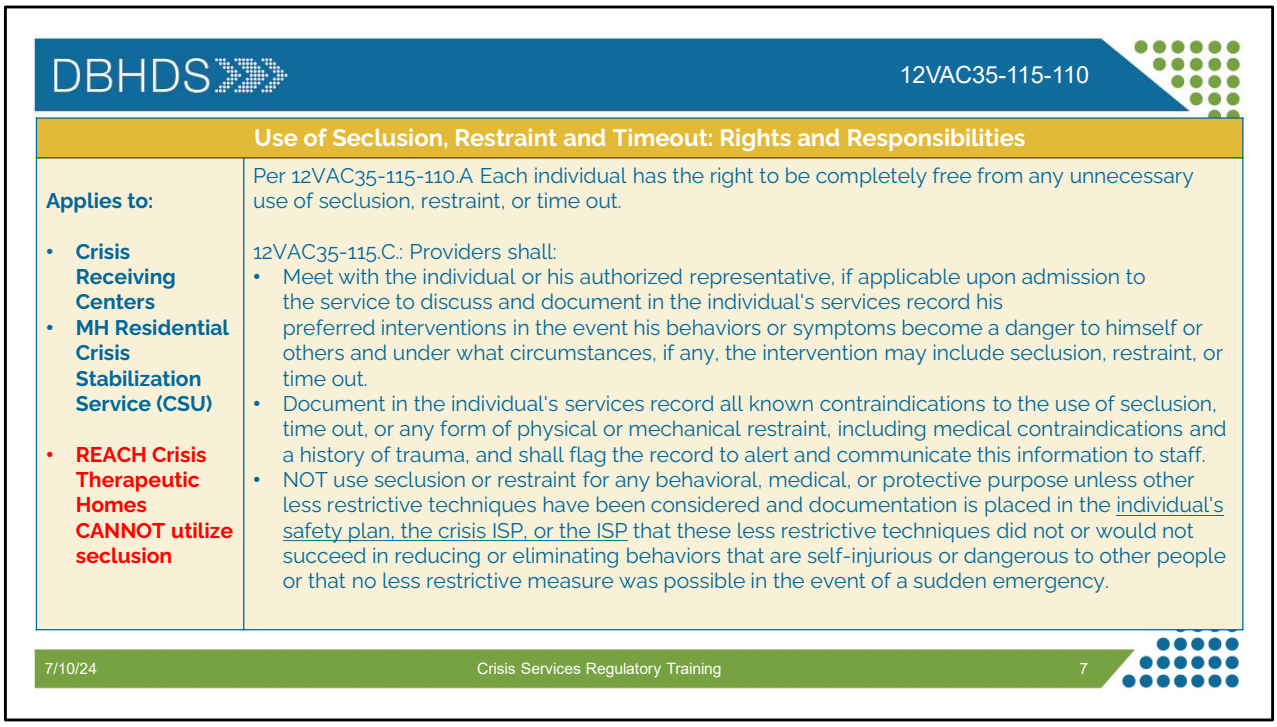
While both seclusion and time out are involuntary, note **the difference with seclusion is in the act of putting an individual in a closed environment** vs removing or relocating an individual from one environment to an alternate open environment/location.

Restraint is the use of a **mechanical device, medication, and/or physical intervention** (hands-on hold), to **prevent an individual from moving** his body to engage in a behavior that places him or others at **imminent risk.**

All three of these (Seclusion, Time out, and Restraint for behavioral purposes) are restrictions and do have the commonality of being involuntary and all should end based on predetermined criteria or when the problematic behaviors (Time out) or those that demonstrate imminent risk (Seclusion and Restraint) were to end.

CRCs, CSUs, and Reach Crisis Therapeutic Homes may utilize time out, and restraint per the providers approved Behavior Management Plan. While CRCs and CSUs will be included as licensed service settings that may use seclusion as of 7/18/24, it is pertinent to note that **REACH Crisis Therapeutic Homes are not permitted to utilize seclusion**.

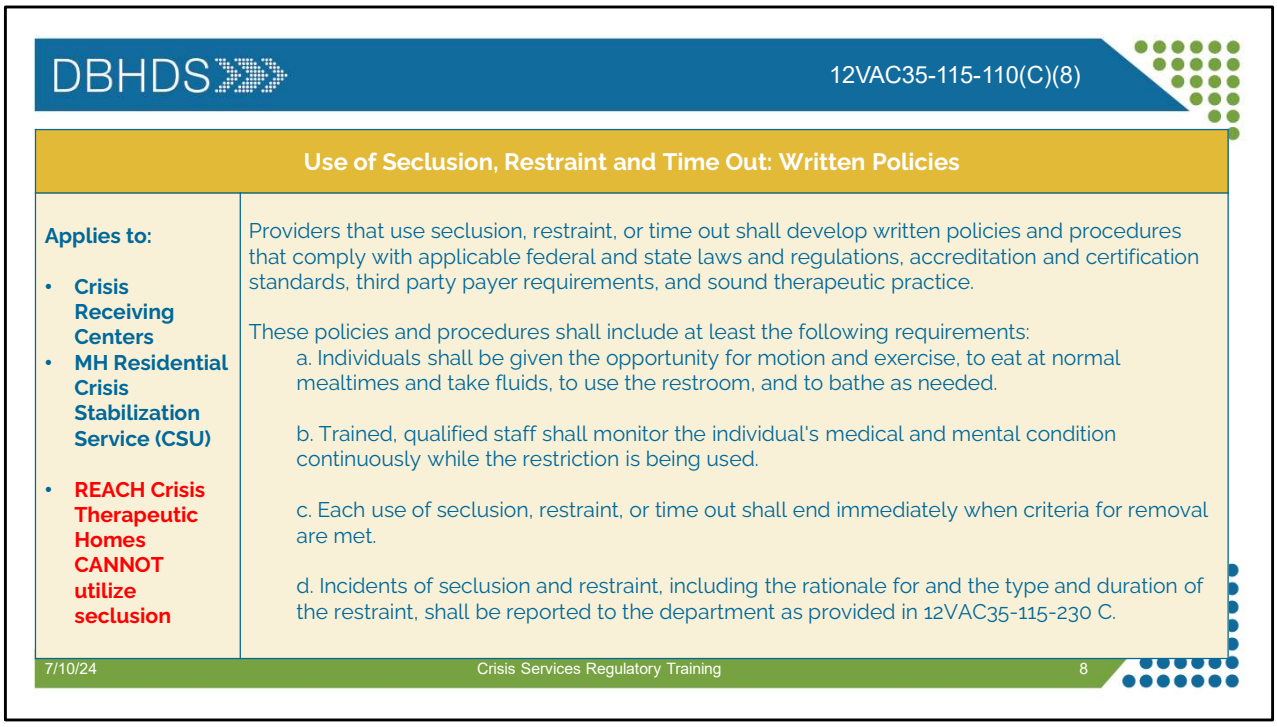
We'll take a look at all of the existing and applicable regulations specific to seclusion and continue to point out to whom they apply in the following slides.



Per 12VAC35-115-110.A Each individual has the right to be completely free from any ***unnecessary*** use of seclusion, restraint, or time out. So how do we determine when seclusion, restraint, or time out is unnecessary?

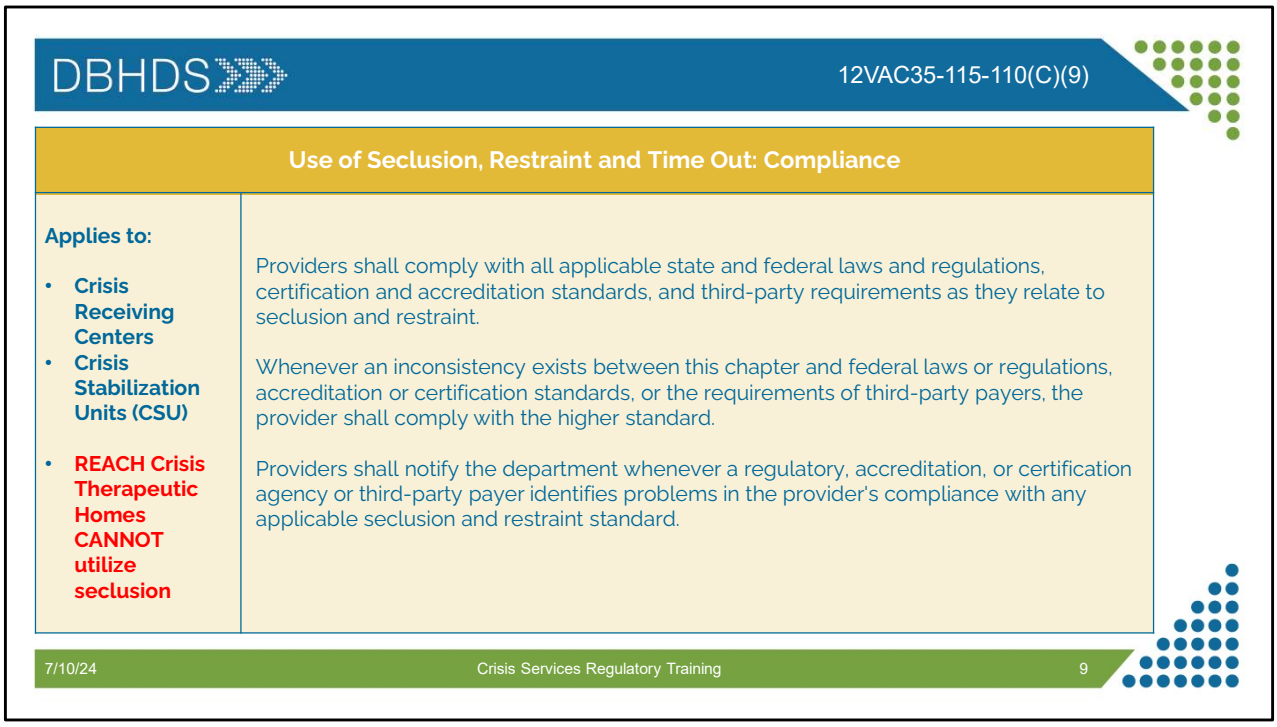
Subsection C answers this question - The provider has the responsibility to speak with the individual (and authorized representative where applicable) pertaining to preferred interventions during times of behavioral escalation or emergencies; noting use of seclusion, restraint, or time-out and criteria that ends use; identifying and documenting medical conditions, or physical or mental health concerns (such as trauma) that would need to be known in performing seclusion, restraint, or time out, so this can be communicated where needed.

Overall: seclusion, time-out, or restraints for behavioral purpose are for emergent use. Prior to implementing these restrictions, less restrictive interventions will need to be attempted and documented in the safety plan, crisis ISP, or ISP that they were not effective or have been previously identified as ineffective.



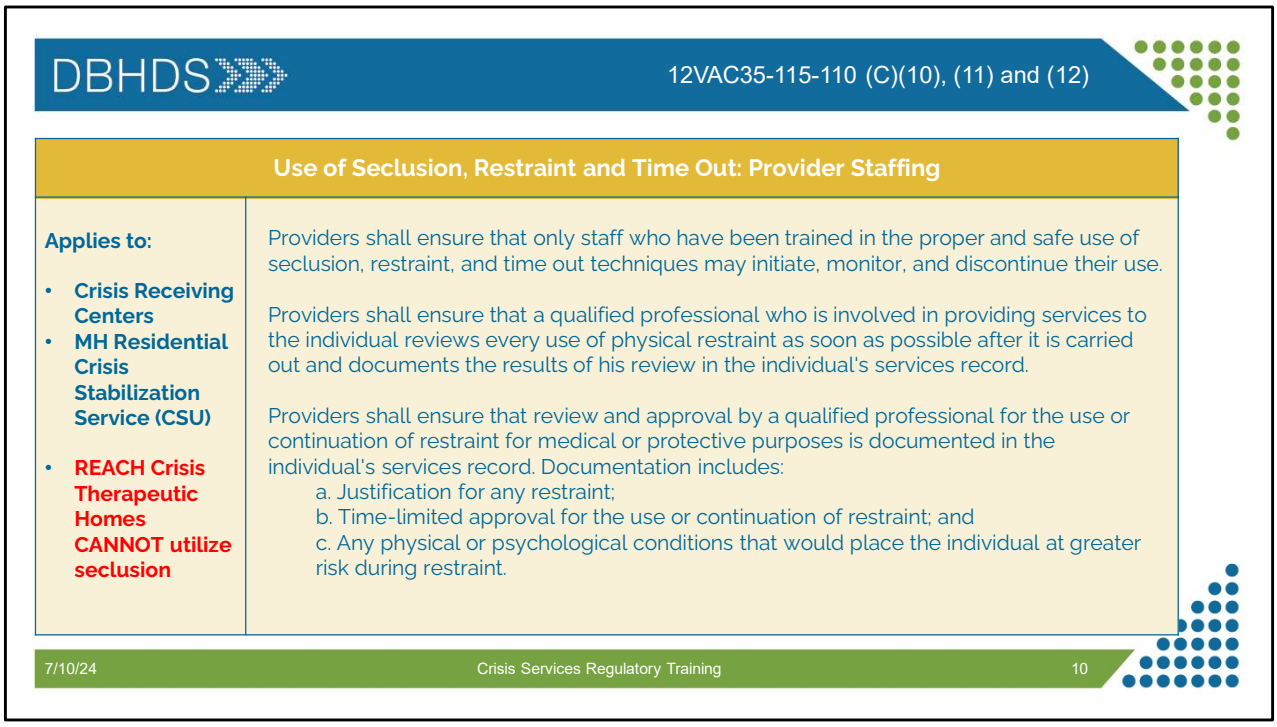
Per 12VAC35-115-110.C.8., providers who utilize seclusion, restraint, or time out will need to have developed written policies and procedures that comply with the Human Rights Regulations. These policies and procedures require submitting to the Office of Human Rights to ensure they do not conflict with the Human Rights Regulations. Any updates or changes made to these policies and procedures will need to be resubmitted to the OHR for review as well. The process for submitting policies will be presented a little later on in today's presentation.

At minimum providers will want to ensure that the policies allow the individual the opportunity for motion; drink and meals; access to use the restroom; and bathing while in seclusion. Additionally, the policies and procedures need to address staff training and specifically what that includes, as well as having *qualified staff* monitor health and wellness during the use of seclusion, restraints, or time-out.



12VAC35-115-110.C.9 notes that providers must comply with state and federal law, certification and accreditation standards, and third-party entities such as DMAS or CMS pertaining to service provision and the use of seclusion and restraints. If and when issues pertaining to provider compliance with the standards of use of seclusion or restraints are identified by any party – be it an individual, a provider employee, an outside accrediating body, DMAS, CMS or any other party - the provider must make OHR aware via CHRIS, as this could identify improper use or need for further investigation.

In addition, should a provider encounter what could be viewed as inconsistency between the state/federal laws, certification and accreditation, or third-party entities, they should reach out to their Human Rights advocate or Advocate Manager via direct email or phone. The provider will be compelled to comply with the higher standard of the parties involved.



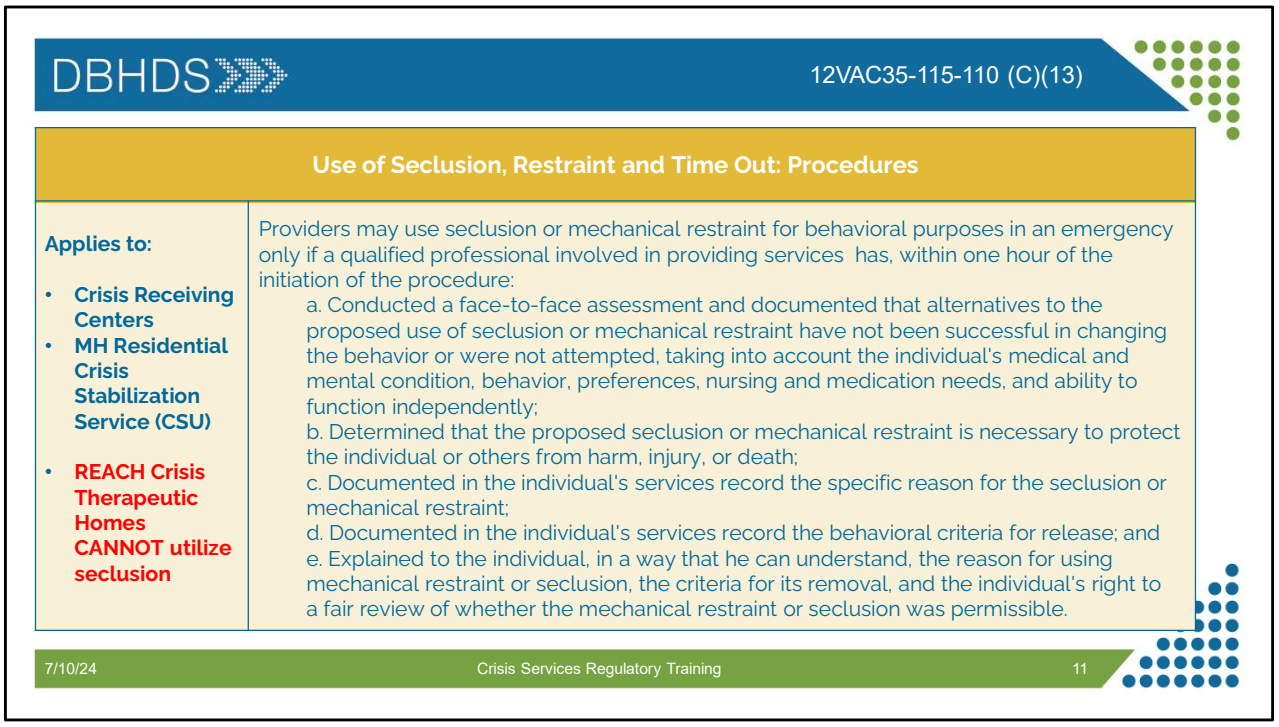
12 VAC 35-115-110.C.10, 11 and 12 dive a little deeper into what has been previously referenced regarding trained staff. Providers must ensure that only staff that have been trained in the proper and safe use of seclusion, restraint, and time out perform, monitor, or end the use of seclusion, restraint, and time out; and that that staff is a qualified professional, involved in the care of the individual.

Specifically pertaining to physical restraints, a qualified professional must review every use as soon as possible following the instance and making note of the results of this review in the individuals service record.

Restraint for medical or protective purposes must also have documented justification for restraint and it must include at a minimum the time limit approval, and any noted physcial or psychological conditions that would place the individual at greater risk during restraints.

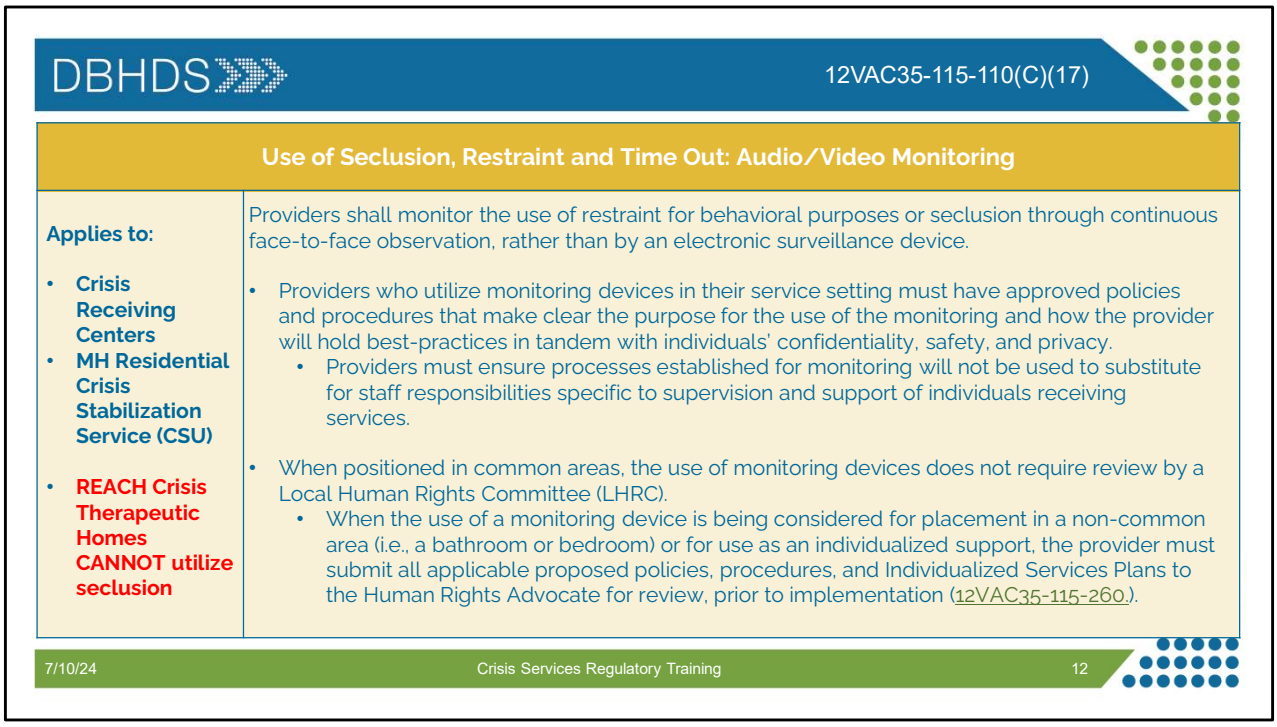
Before we move on, I'll note here that "qualified professional" is not a defined term in the HRR but these "qualifications" should be rooted in standard best-practice and evident in a provider's policies and more specifically in the job

description. It should be clear that the staff who are entrusted with actions assigned by regulation to a "qualified professional" have appropriate experience, knowledge and training consistent with the task they are performing.



Regulation 12VAC35-115-110.C.13 can be viewed as the "Appropriate use" of Seclusion. When seclusion (or mechanical restraint for behavioral purposes) is warranted or required, this regulation summarizes very important procedural components on what is necessary to perform seclusion, which include:

- Having conducted a face to face assessment, documenting alternatives have been unsuccessful and noting contraindications or preferences in times of use of seclusion and restraint
- Identified and discussed with the individual when there is imminent risk (and what that means), that seclusion and restraint for behavioral purpose will be utilized; the reason; and the criteria for release; and right to a fair review pertaining to questions if the use was appropriate.



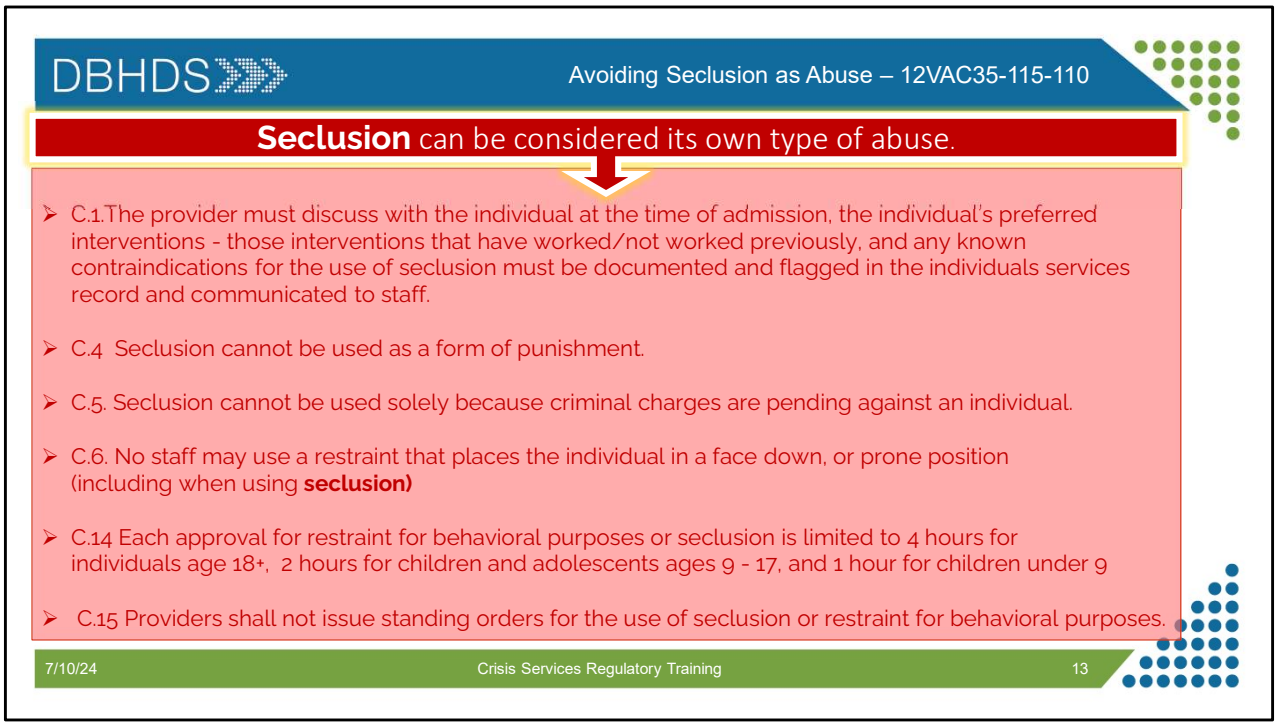
Per 12VAC35-115-110(C)(17) Providers shall monitor the use of restraint for behavioral purposes or seclusion through continuous face-to-face observation, rather than by an electronic surveillance device.

This is not saying that the use of surveillance or audio/video monitoring equipment is not allowed. What is it saying is that at no time does use of audio or video surveillance constitute or replace "face to face monitoring," for the sake and purpose of restraints or seclusion. During the use of seclusion or restraints for behavioral purposes, providers are to have continuous face to face monitoring for health and safety; as well as to verify when the seclusion or restraint release criteria has been met.

Individuals have the right to reasonable privacy and confidentiality per sections 12VAC35-115-50(C)(3)(a) and 12VAC35-115-80 of the HRR. As such, providers who intend to utilize monitoring devices in their service setting must have approved policies and procedures that make clear the purpose for the use of the monitoring and how the provider will hold best-practices in tandem with individuals' confidentiality, safety, and privacy. These policies must be submitted for approval directly through the Office of Human Rights Regional Manager or

otherwise assigned Human Rights Advocate prior to implementation or use. General policies applied to all do not require review by the Local Human Rights Committee.

When seeking to use surveillance and monitoring equipment in areas that would be considered private locations such as the bedroom or restroom, the associated policies and procedures *and the ISP for the specific individual for whom this has been determined to be necessary* must also be supplied to the assigned Regional Manager or Human Rights Advocate prior to implementation and may require additional review by the Local Human Rights Committee. If this is the case, you will be directed regarding the specific type of LHRC Review Form necessary.



A few slides previous we discussed appropriate use of seclusion. Let's look at some additional regulations that a provider must be mindful of while performing seclusion. Given that abuse is broadly defined as staff, knowingly, recklessly, or intentionally causing physical/emotional/psychological harm, injury, or death. This means that if performed *improperly* - meaning when there is no imminent risk, there is no evidence of need documented in the ISP, the staff performing the restraint or seclusion are not qualified by training and experience, or when the restraint or instance of seclusion is not otherwise performed per regulations - *that instance of restraint or seclusion can be considered abuse.*

<u>Examples include</u>:

- Recklessly/Intentionally - Locking an individual in a room/area alone (when there is no emergency or imminent risk or not in the individuals crisis ISP or ISP)
- Intentionally - Barricading an individuals in an area with furniture or other objects denying ability to leave
- Knowingly/Intentionally - Verbally threating consequences or forbidding an individual to leave an enclosed area
- KRI - Intimidating behavior denying exit from an enclosed area

Listed on the slide there are examples of regulations that can result in a complaint alleging abuse or if discovered could be grounds for an substantiated abuse finding specific to the improper utilization of seclusion.

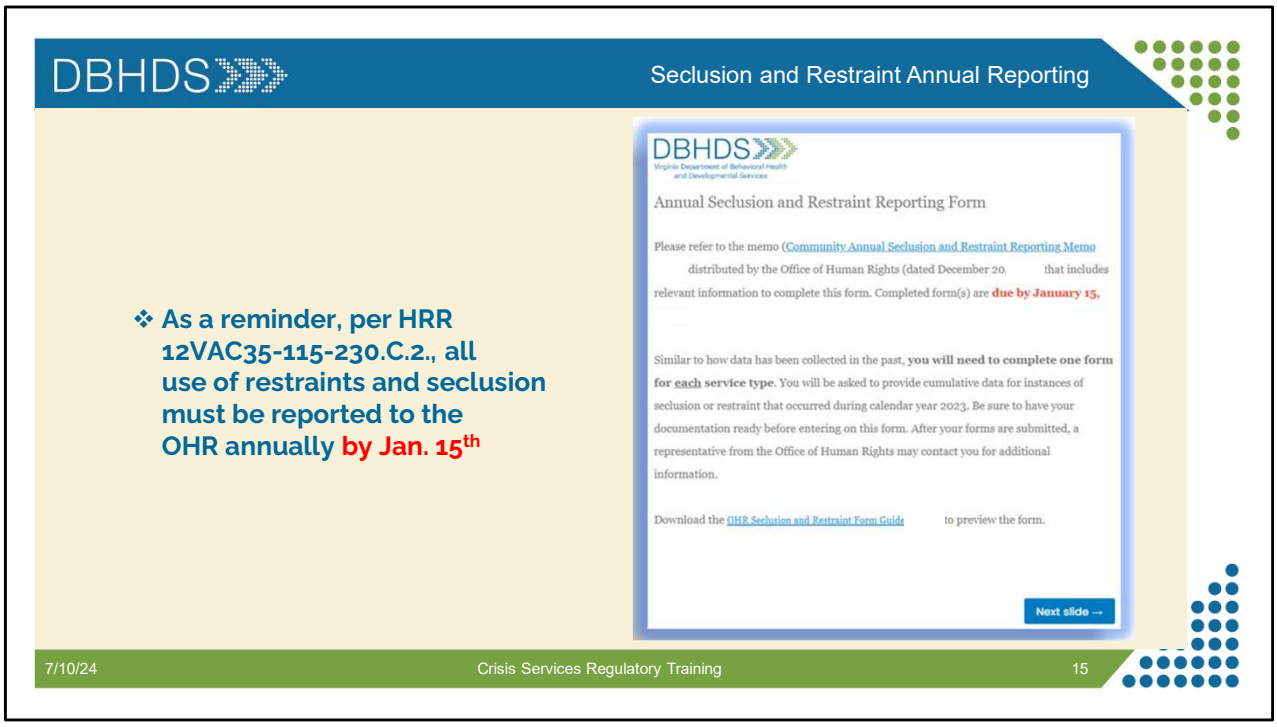
Being mindful of and following the regulations as indicated will aid in supporting an individual maintain their rights during uses of seclusion. As we've discussed, this provider duty is outlined in –110(C)(1) as the provider assesses and documents the individual's preferences regarding the use of seclusion. Additional previous examples during the presentation include **C.8.a-c**:

a. Individuals shall be given the opportunity for motion and exercise, to eat at normal mealtimes and take fluids, to use the restroom, and to bathe as needed.
b. Trained, qualified staff shall monitor the individual's medical and mental condition continuously while the restriction is being used.
c. Each use of seclusion, restraint, or time out shall end immediately when criteria for removal are met.

As indentified on the previous slide, should their be a complaint made or improper use discovered involving the use of restraint, time-out and/or seclusion - a CHRIS report will be warranted within 24 hours of discovery; (and **authorized representatives, as applicable must be notified within the same 24 hours).**

CHRIS reports are to be completed regarding complaints with or without ANE or injury, about/during seclusion (in specific reference to this training), or overall pertaining to services or how they are provided

Complete the ”Abuse Report” tab for complaints that specifically allege Abuse, Neglect, or Exploitation (ANE); and as a reminder when a provider receives a complaint that does not allege ANE it is entered as a "Complaint Report ". Note that there may be occasions where you are completing both an Abuse or Complaint report for the OHR and a Serious Injury Report for the Office of Licensing. More information about this can be found in the Office of Human Rights and Office of Licensing trainings that specifically address reporting requirements and the use of CHRIS.

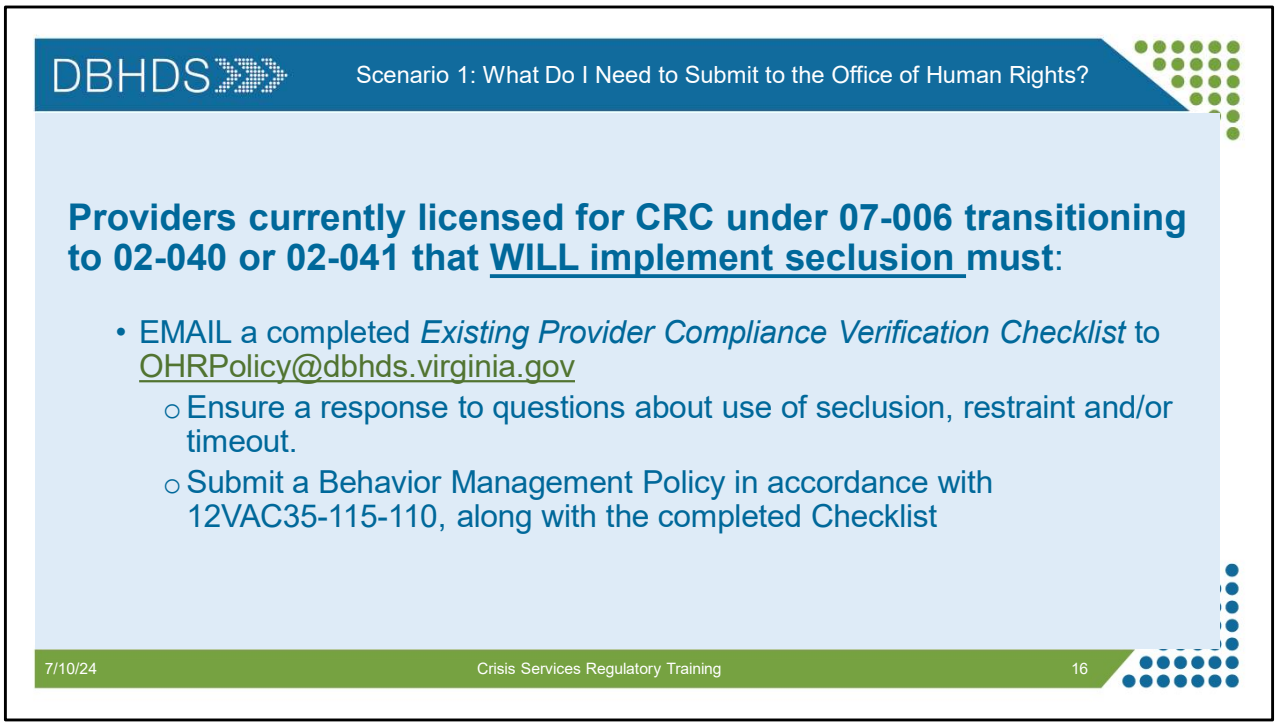


As a friendly reminder - all Physical, Mechanical, and Pharmacological Restraint(s) and all instances of Seclusion are to be reported to the Office of Human Rights annually for ***any*** instance of use which occurred within the year previous. This includes those reported previously in CHRIS. Per regulation 12VAC35-115-230.C.3. Providers should be keeping internal record of instances compiled monthly; then reporting those out annually to the Office of Human Rights via the Seclusion and Restraint annual survey.

As we introduce the use of seclusion in these newer community-based crisis settings, the OHR is looking at ways to collect and review provider data – primarily in an effort to ensure safe, necessary and appropriate use for individuals but also as a means for expanding systemic understanding about the different uses for seclusion across service settings and specifically with individuals in crisis. Please be patient as we develop and streamline processes for categorizing and collecting this data.

This concludes the Office of Human Rights portion of the training today. Thank you for your time - and please don't hesitate to reach out to the Office of Human Rights (again regarding Regulations **in chapter 115**) for technical assistance or

guidance! There are no "consequences" for outreach to the office. We encourage contact to best support a provider in maintaining an individuals Human Rights!



Providers currently licensed for CRC under 07-006 and are applying to transition to 02-040 or 02-041 that WILL implement seclusion must:

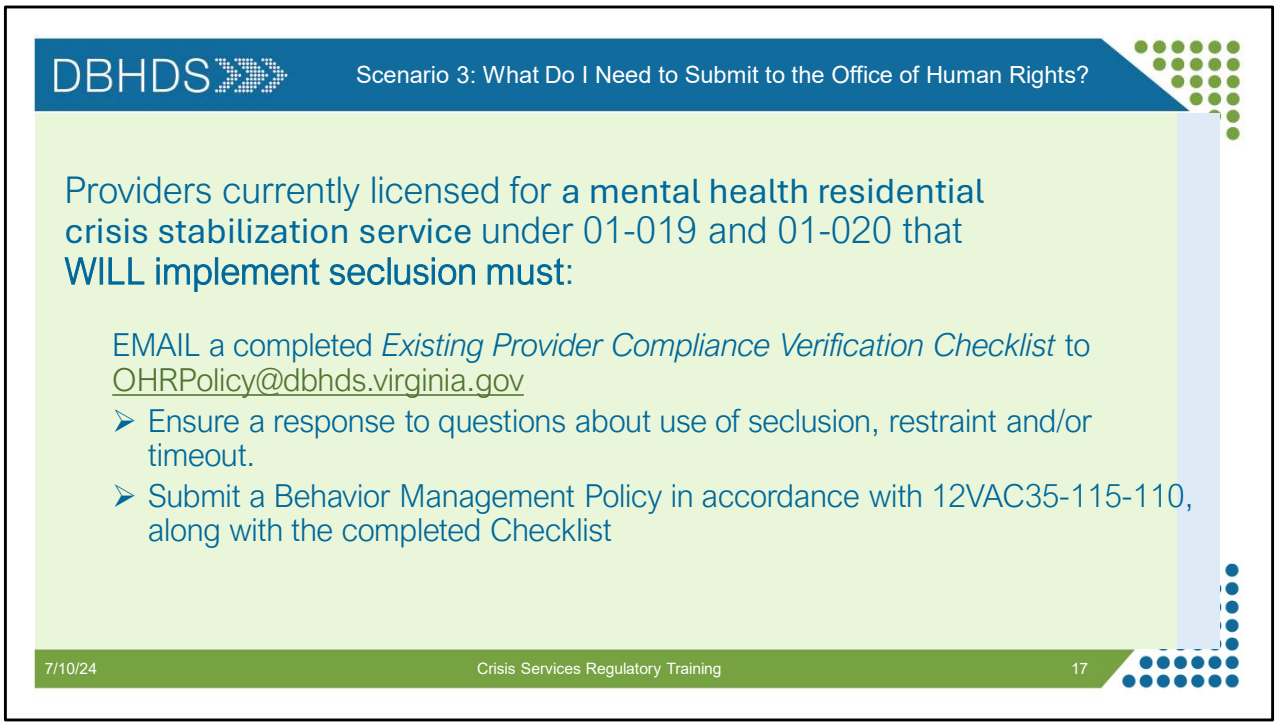
1) Submit a Behavior Management Policy in accordance with 12VAC35-115-110, along with the completed Existing Provider Compliance Checklist via Email: OHRPolicy@dbhds.virginia.gov
2) Submit a response to questions about the use of seclusion, restraint and/or timeout.

Providers cannot utilize seclusion until the provider's Policy for the use of seclusion has been reviewed and approved by the Office of Human Rights.

Please note that this process is facilitated outside of CONNECT and with the Office of Human Rights

The Existing Provider Human Rights Compliance Verification form will be available on the OHR webpage and is referenced in the Office of Human Rights section of the DBHDS Seclusion Attestation Form. A screenshot of what that Existing Provider Human Rights Compliance Verification form will be shown later

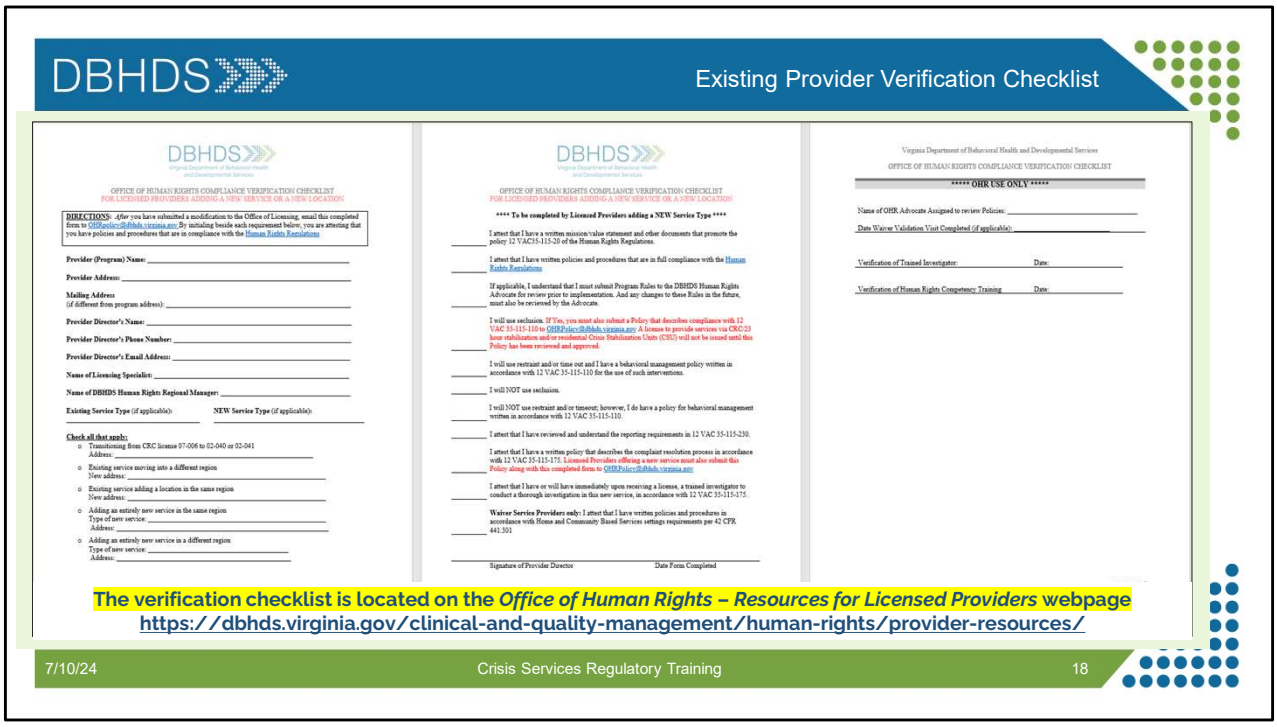
in the presentation.



Providers currently licensed for a mental health residential crisis stabilization service under 01-019 and 01-020 that WILL implement seclusion must:

1) Submit a Behavior Management Policy in accordance with 12VAC35-115-110, along with the completed Existing Provider Compliance Checklist via Email: OHRPolicy@dbhds.virginia.gov
2) Submit a response to questions about the use of seclusion, restraint and/or timeout.

A screenshot of the Existing Provider Compliance Verification Checklist, which should be used for transitions related to both the CRC/23 hour stabilization service and existing Residential Crisis (CSU) licenses, is located on the next slide.



Here we have the E*xisting provider human rights verification checklist* form. This document has been updated to reflect policy requests specific to whether an existing provider of crisis services intends to use seclusion or not. It will be found on the *Office of Human Rights – Resources for Providers* web page under Licensing procedures – Existing Provider Information beginning 7/18/24. The highlighted portion of the slide is a link to the webpage that can be accessed when viewing the PowerPoint electronically. The actual web address is: https://dbhds.virginia.gov/clinical-and-quality-management/human-rights/provider-resources/

Following completing organizational demographic information, and information regarding your service, you will be expected to initial beside each requirement indicating that you are in compliance with the requirement noted. The completed form signed by the provider Director as *attestation of compliance,* will then be returned to the Office of Human Rights.

What is important to note regarding the form is:

- This form verifies that you as the provider will or will not be utilizing seclusion, and if so that you have submitted policies pertaining to the use of

seclusion and in direct compliance with 12VAC35-115-110 along with the form;
- Providers transitioning a service to the new license or existing providers beginning a new service for CRCs / Residential CSUs, who intend to use seclusion must have and submit their policy and this checklist to OHR
- **Providers cannot utilize seclusion until the policies and checklist have been reviewed and approved**

Again, this process for the OHR is outside of CONNECT and initiated via email through OHRpolicy@dbhds.virginia.gov