Questions from Providers	Answer
Will the use of seclusion, restraint, and time out policies and procedure also need to be estavhlished by July 17th?	If you are an existing provider that utilized restraint and/or timeout, previous OHR-approved policies and procedures for restraint and time out should currently be in place. If you are an eligible entity seeking to transition your license type to include CRC or CSU, and the organization seeks to utilize seclusion, policies and procedures that address the use of seclusion along with the "Existing Provider Human Rights Compliance Verification Checklist" (HRCVC) will need to be submitted and approved prior to the use of seclusion. Written policies and procedures specific to the use of seclusion must be established on the date the HRCVC is submitted for approval.
Will DBHDS provide a training on seclusion? How will this be measured?	The DBHDS Office of Human Rights (OHR) currently has training titled "Restriction, Behavioral Treatment Plans (BTPs), & Restraints" that address the use of seclusion. To register for this and all other training offered by the OHR refer to the "Community Provider Training Calendar" located under the "Resources for Licensed Providers" Tab of the OHR webpage. The OHR portion of the Crisis Regulatory Training is also available on the OHR webpage.

Please describe and define what constitutes a "qualified professional" specific to the review of a seclusion or restraint incident. Would a staff that is a certified TOVA trainer be a qualified professional or is this referring to an licensed staff.	"qualified professional" is not a defined term in the Human Rights Regulations but the "qualifications" of staff involved in the use of seclusion should be rooted in standard best-practice and evident in a provider's policies as well as the assigned role/staff 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. Specific to the "qualified professional" referenced in section 12VAC35-115-110, providers must ensure that only staff that have been trained in the proper and safe use of seclusion perform, monitor, or end the use of seclusion; and that that staff is involved in the care of the individual.

For the policies that require OL and OHR review and approval. What is the method of submission to get those policies approved by OL and OHR. I am assuming OL will be an Info mod or portal message in CONNECT. But not sure about OHR.	Please note that this process is facilitated outside of CONNECT and directly with the Office of Human Rights via OHRpolicy@dbhds.virginia.gov Providers currently licensed for CRC under 07-006 who are applying to transition to 02-040 or 02-041, or providers currently licensed for a mental health residential crisis stabilization service under 01-019 and 01-020 that WILL implement seclusion must: EMAIL to OHRPolicy@dbhds.virginia.gov: 1) a completed Existing Provider Compliance Verification Checklist that includes a response to questions about the use of seclusion, restraint and/or timeout AND 2) a (Behavior Management) Policy that addresses the organizations use of seclsusion and addresses all elements outlined in 12VAC35-115-110 The Existing Provider Human Rights Compliance Verification Checklist is available on the OHR webpage and is referenced in the Office of Human Rights section of the Office of Licensing "DBHDS Seclusion Attestation Form".
If there is a fire emergency onsite, would a delay in helping those with physical disabilities evacuate the building count as seclusion?	Providers must have written procedures in place to address all known potential delays in helping individuals who are receiving services to evacuate from the services setting in any type of emergency (see 12VAC35-115-50 and 12VAC35-115-60). Per 12VAC35-115-30 "Seclusion" means 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 it.

This is a question for office of human rights. Being that I am a provider who diagnose and prescribe. If we can stabilize someone with medications, why is this considered a restraint during crisis situations. Inpatient facilities can medicate to stabilize but we can't? That kind of makes it hard because who wants to keep filling out CHRIS reports in order to treat clients appropriately. This is a part of stabilizing in the community.	By definition (see 12VAC35-115-30), a restraint is the use of a mechanical device, medication, and/or physical intervention to prevent an individual from moving his body to engage in a behavior that places him or others at imminent risk. When an individual is involuntarily administered a medication that is not in a behavioral emergency this is referred to as a pharmacological restraint. CHRIS reports to the Office of Human Rights (OHR) are required in instances of improper use of restraint; or when the provider receives a complaint about the use of restraint. Unless there is a known improper use or complaint, every instance of pharmacological restraint is not reportable to OHR in CHRIS. Inpatient facilities licensed and operated by DBHDS are also subject to compliance with the Human Rights Regulations. There is also the requirement for an annual report of instances of seclusion and restraint per 230(C)(2).
Why would I need to add seclusion to my license? What are the pros and cons of it.	The decision to utilize seclusion rests with the licensed provider and should be based on the provider's ability to comply with all corresponding state and feral laws and regulations, and constructed around the provider philosophy and staff knowledge, skills and expertise. Per 12VAC35-115-110 only providers of residential facilities for children licensed under 12VAC35-46, an inpatient hospital, and after July 17th, CRCs or CSUs can make this decision.

Do the updates regulations for Restraint/Time-out/Seclusion that were presented for Crisis Service providers, also apply to other types of DBHDS licensed providers who have policies for restraint/time-out/seclusion (such as DD waiver providers)? Or do the updates ONLY apply for Crisis Services?	As of 7/17/2024 regulation 12VAC35-115-110(C)(3) has been updated as follows (*please see underlined text as to the newly added amendment to the regulation): Seclusion may be used only in an emergency and only in facilities operated by the department: residential facilities for children that are licensed under Regulations for Children's Residential Facilities (12VAC35-46); inpatient hospitals; and crisis receiving center or crisis stabilization units that are licensed under Part VIII (12VAC35-105-1830 et seq.) of 12VAC35-105. Therefore, the "updates" now also apply to providers seeking to transition (or begin services) as a Crisis Receiving Centers (CRC) or Crisis Stabilization Unit (CSU).
Will a new provider require to submit a seclusion policy if their not practicing it?	No but entirely new providers, who do not currently have a DBHDS-license to provide any service must complete the “Human Rights Compliance Verification Checklist” (HRCVC) as well as submit their Complaint Resolution Policy describing compliance with 12VAC35-115-175 to OHRPolicy@dbhds.virginia.gov. There is a space on the HRCVC for new providers that do not intend to use seclusion as an emergent response to indicate that they will NOT use seclusion. Existing providers who decide to offer CSU or CRC services for the first time must complete and submit the “Existing Provider Human Rights Compliance Verification Checklist” and indicate on the Checklist whether they will or will NOT use seclusion as an emergent response. Providers that will use seclusion must also submit a Policy.

Regarding 115-110 (C)(17) - There are adverse behavioral events that would suggest the need for seclusion, which could include aggression. Is it the intent of this regulation that Face to Face monitoring means a staff member is in the room with someone who might be agitated and aggressive?	The intent of 12VAC35-115-110.C.13 and C.17 are to ensure that video or audio monitoring or surveillance is not substituted to replace face to face observation and assessment of the individual. Additionally 12VAC35-115-110.C.8.c. requires assurance of health and wellness during seclusion, and that an individual is released from seclusion immediately when criteria is met.
Regarding 105-1930 - if you have previously received email notification that your use of cameras is approved by OHR, will that suffice for changing to the 02-040 license? Or is there a specific form or process that needs to be completed?	If an existing provider has already received approval of their policy for the use of audio/video monitoring, another approval is not required. If there are changes to the Policy, the revised policy must be reviewed, consult your assigned or Regional Advocate for more information.
To confirm, a qualified professional can give "approval" for use of seclusion in an emergency in the approved setting, correct? The "order" or "approval" does not need to come from a licensed professional like an RN, physician or LPN?	The HRR do not specify credentialing of staff outside of “qualified professional” but whomever the provider identifies to write these orders should have knowledge, skills, abilities, and experience determining the need for seclusion and restraint. Whomever the qualified professional is that is writing the order should be involved in providing services to the individual and this task along with the specific role should be documented in the provider policies/job descriptions. As a reminder: providers must ultimately comply with all state and federal laws - with the higher standard taking precedence. If for example, there is a CMS requirement that says an RN must write the order, that is who we would expect the provider to delegate this responsibility to.

For clarification, regarding OHR training overview- page 85, last bullet point- Are the new providers- specifically CSUs and CRC's required to have a written order for an individual to be placed in seclusion? If so, who can write the orders?	Yes. The HRR do not specify credentialing of staff that write orders, but it should be commensurate with knowledge, skills, experience of that staff and well documented in provider policies/job descriptions. Also note that the HRR prohibit the use of standing orders for seclusion (or restraint).
Can electronic surveillance be used in a seclusion room along with direct observation?	Yes. Providers should have approved policies describing how they will inform individuals and staff about the use of surveillance in their program. The policy should also describe how they will review and store any recordings and who will have access to them - including DBHDS for reviews and complaint investigations. More OHR Guidance about this is forthcoming, in the meantime remember to submit these policies to OHR for review prior to implementation and to contact your local Regional Advocate with questions.