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Policy Research Institute

# *Seclusion and Restraints*



The Nation's Voice on Mental Illness

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TASK FORCE REPORT



The Nation's Voice on Mental Illness

## Seclusion and Restraints – Task Force Participants

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## NAMI Policy Research Institute

The NAMI Policy Research Institute (NPRI) is one of the nation's foremost consumer- and family-oriented policy groups dedicated to addressing mental illness issues across the life span. The Institute's mission is to drive national, state, and local debates on reforms and investments in the nation's mental illness delivery and financing system. As part of its mission, the Institute provides technical assistance to NAMI state organizations and local affiliates on pivotal issues such as Medicaid financing, access to medications, and children's delivery issues. The Institute brings together policy-makers, advocates and scientists through various forums, including special task forces, to develop solutions and expand support for science-based, recession-proof treatment and recovery systems.

## Executive Summary

It is clear that there is an emerging consensus within the field concerning the goal of reducing and ultimately eliminating the use of seclusion and restraints in treatment settings. Several alternatives are in place for responding to individuals experiencing crises. Training of clinicians on seclusion and restraints and best practices in reducing the use of these aversive techniques should be conducted throughout the country.

The State of Pennsylvania has for the last three years undertaken a systematic effort to reduce the use of seclusion and restraints in its public psychiatric hospitals. Some hospitals have nearly eliminated the use of these interventions, with no apparent negative impacts on the safety or well-being of patients or staff.

## Background

At the recommendation of the NAMI Board of Directors, the NAMI Policy Research Institute (NPRI) convened a task force to address the one-hour rule and related issues relevant to the use of seclusion and restraints in psychiatric treatment facilities. These issues include necessary and appropriate clinical competencies for those authorized to institute and monitor restraint use, indications for when the use of seclusion and restraints are appropriate, and alternatives to the use of restraints.

## Introduction

In 1999, following revelations in the Hartford Courant and other publications of a disturbing pattern of deaths and serious injuries suffered by individuals subject to physical and mechanical restraints in psychiatric treatment settings, the Federal Health Care Financing Administration (HCFA, now CMS) issued an interim final rule setting forth standards governing the use of these aversive measures in Medicare and Medicaid funded programs. Included within these standards was the so-called "one-hour rule", specifying that physicians, or licensed independent practitioners (LIPs), must conduct face to face assessments of all individuals placed in seclusion or restraints within one hour of the time these measures are instituted.

Even as the broad mental health community has moved towards consensus on many issues pertaining to seclusion and restraints, the one-hour rule has remained a source of division.

Most advocacy organizations support the rule, contending that it is necessary because situations involving the use of seclusion and restraints constitute psychiatric emergencies and physicians bear ultimate responsibility for responding to people experiencing medical emergencies.

Some organizations representing providers or treatment facilities oppose the rule. Those who oppose the rule believe that it imposes unnecessary burdens on hospitals, particularly hospitals in rural regions where there may not always be a qualified physician or LIP available to conduct a face-to-face

adolescent is separated from his/her peers in the presence of his/her peers. (Added June 2000)

(7.8.9.3) Exclusionary time-out is an involuntary procedure where a child or adolescent is separated in a designated area away from his/her peers but is not physically prevented from leaving. (Added June 2000)

(7.8.10) If children and adolescents are to be secluded, the order must be by a physician or a licensed independent mental health practitioner competent in these procedures and recognized by state law. (Added June 2000)

(7.8.11) While in seclusion and/or restraint, the child or adolescent should be constantly, visually monitored by staff. Video monitoring, if used by itself, is not sufficient. (Added June 2000)

(7.8.12) When treating children and adolescents with mental illnesses, mechanical restraint, brief physical holding, and "therapeutic holding" should be differentiated. (Added June 2000)

(7.8.13) Mechanical restraint should be generally avoided and used only in rare circumstances to protect the child or adolescent from self-harm and harm to others in emergency situations. (Added June 2000)

(7.8.14) Brief physical holding is a form of temporary physical restraint and is different than "therapeutic holding." "Therapeutic holding" is not supported by adequate scientific evidence or detailed practice guidelines, and, therefore, is not supported by NAMI as an accepted form of treatment. (Added June 2000)

(7.8.15) Brief physical holding should only be carried out by professionally recognized and trained mental health professionals licensed by a governmental body. (Added June 2000)

(7.8.16) Escorting and immediate physical separation of children and adolescents in conflict are not considered restraint. (Added June 2000)

serious injury. Any death or serious physical injury associated with the use of restraint shall be reported to a designated legal entity within the state for investigation. (Revised February, 2000)

(7.8.5) The family, client, and involved staff should undergo a debriefing after each restraint or seclusion incident, within 24 hours. The circumstances leading to the restraint or seclusion and a discussion of why alternatives to restraint or seclusion failed should be documented in the clinical record. Future suggested interventions should be discussed at these debriefings. Following each use of restraint and seclusion, the patient should receive counseling specific to the incident. (Revised February, 2000)

(7.8.6) Treating professionals must adhere to the patient's advance directive, if there is one. (Revised February, 1999)

(7.8.7) Medication is typically important for the treatment of the symptoms of mental illness. However, medication should never be used for the purposes of discipline, staff convenience, immobilization, or reducing the ability to ambulate.

(7.8.8) Any institution using seclusion, restraint, time-out, or brief physical holds must provide appropriate initial and recurrent training of staff, not only in the safe application of these interventions, but also in techniques of de-escalation which reduce the need for these interventions. No staff member should be involved in seclusion or restraint before completing the required training. (Added April, 2000)

(7.8.9) When treating children and adolescents with mental illnesses, facilities and governing policies should differentiate between seclusion, inclusionary time-outs, and exclusionary time-outs. (Added June 2000)

(7.8.9.1) Seclusion is the involuntary placement of a child or adolescent, for any period of time, in a locked room where the child or adolescent is alone and is physically prevented from leaving. (Added June 2000)

(7.8.9.2) Inclusionary time-out is an involuntary procedure where a child or

assessment within one hour. Some have also suggested that the rule has had a chilling effect on the willingness of hospitals to admit individuals with more severe psychiatric symptoms, therefore shifting the burden of responding to psychiatric crises to law enforcement and corrections.

In October 2002, the Centers for Medicare and Medicaid Services (CMS) convened a "town hall" meeting on the one-hour rule. In introducing this meeting, Thomas Barker, outreach and policy advisor to CMS Administrator Tom Scully, indicated that CMS is considering but has not yet decided whether to change the current requirement that a physician or LIP conduct the face-to-face evaluation. The purpose of the meeting, he explained, was to obtain input from the broad mental health community about the rule and its impact within psychiatric treatment facilities.

In 1999, when the Hartford Courant published its series, "Deadly Restraint: A Nationwide Pattern of Death", the mental health community was sharply divided over issues such as:

- (a) whether seclusion and restraints were being used excessively and inappropriately,
- (b) whether there was a need to regulate the use of seclusion and restraints, and even
- (c) whether the use of seclusion and restraints were therapeutic under certain circumstances.

Today, divisions within the mental health community over seclusion and restraints have significantly diminished. In 2003, there is broad agreement that seclusion and restraints are justified only as a last resort to emergency responses. There is also broad agreement that a well-trained professional staff in adequate numbers can usually avert seclusion and restraints through the use of alternate crisis de-escalation techniques.

Additionally, organizations such as the National Association of State Mental Health Program Directors (NASMHPD), the American Psychiatric Nursing Association (APNA), the American Psychiatric Association (APA) and the National Association of Psychiatric Health Systems (NAPHS) have exerted leadership in reducing seclusion and restraints by publishing manuals and

developing cutting-edge training programs.

To provide guidance to the NAMI Board of Directors, the Task Force on Seclusion and Restraints met on March 27, 2003 to obtain information on efforts to reduce seclusion and restraint and to hear perspectives on the one-hour rule from different mental health stakeholders.

### **Reducing the Need for Seclusion and Restraints**

Task Force participants were enlightened and informed about the emerging consensus within the field concerning the goal of reducing and eliminating the use of seclusion and restraints in psychiatric treatment settings. Particularly informative were presentations about alternative strategies for responding to individuals experiencing crises, training of clinicians on seclusion and restraints and alternatives, and emerging best practices in specific states and treatment settings around the country.

The Task Force also heard presentations that highlight the challenge of finding a balance that maximizes safety while maintaining a patient's dignity and avoids inappropriate use of seclusion and restraint. Task Force participants said that one of the greatest lessons learned is the need to devote resources to improving a facility's overall culture, environment and approach to philosophy of care and patient safety. For example, task force members indicated that teaching staff de-escalation techniques to prevent the use of seclusion and restraint is really teaching hospital staff a new way of improving care and communications throughout the treatment program.

Several representatives discussed the importance of creating new approaches to dealing with escalating behaviors in order to reduce the use and need for seclusion and restraints. Within the therapeutic environment, crisis prevention and early intervention are critical tools.

Some of the techniques highlighted include:

**Treatment Malls:** In an effort to more actively engage patients in their recovery process and decrease aggression, a structured, supportive, centralized

## **Appendix**

### **NAMI's Policy on Restraints and Seclusion**

#### 7.8 Use of Restraints and Seclusion

(7.8.1) The use of involuntary mechanical or human restraints or involuntary seclusion is only justified as an emergency safety measure in response to imminent danger to one's self or others. These extreme measures can be justified only so long as, and to the extent that, the individual cannot commit to the safety of themselves and others. (Revised February, 1999)

(7.8.2) Restraint and seclusion have no therapeutic value. They should never be used to "educate patients about socially acceptable behavior;" for purposes of punishment, discipline, retaliation, coercion, and convenience; or to prevent the disruption of the therapeutic milieu. (Revised February, 1999)

(7.8.3) Restraints shall be used only on the order of a physician with competency in psychiatry or a licensed independent practitioner recognized by state law. These professionals must be competent in providing alternatives to restraint, eliminating circumstances which give rise to the possible need for restraint, and applying restraints in safe and appropriate use. Restraints shall only be used for emergency safety use. Within an hour of initiating restraint, the physician or licensed independent practitioner shall complete a face-to-face evaluation of the patient. While in restraint the patient shall be continually and directly observed, person-to-person, by an appropriately trained professional. Specific behavioral criteria written by the physician, including the patient's verbal assurance of safety, shall specify when the restraints will be discontinued, to ensure minimum usage. (Revised April, 2000)

(7.8.4) Every restraint shall generate an incident analysis. An incident analysis is a process of identifying the basic or causal factors that underlie variation in performance, including occurrence or possible occurrence of a reportable event. The incident analysis shall be available to the designated legal entity within the state which will investigate reportable deaths and

facilities to provide effective and humane treatment to individuals with severe mental illnesses, and the impact on the use of seclusion and restraints on the safety of consumers and staff in these settings.

Based on the meeting and information presented, the NAMI Board of Directors concluded that the current policy on the one-hour rule should not be changed at this time. It will be important to carefully review all proposed changes recommended by the CMS and to communicate information, utilizing members of the Seclusion and Restraints Task Force as advisors, to ensure that these changes do not jeopardize the considerable progress that has been made in reducing seclusion and restraints and deaths and injuries from these interventions.

## Conclusion

It is clear that there is an emerging consensus within the field concerning the goal of reducing and ultimately eliminating the use of seclusion and restraints in treatment settings. Several alternatives are in place for responding to individuals experiencing crises. Training of clinicians on seclusion and restraints and best practices in reducing the use of these aversive techniques should be conducted throughout the country.

The State of Pennsylvania has for the last three years undertaken a systematic effort to reduce the use of seclusion and restraints in its public psychiatric hospitals. Some hospitals have nearly eliminated the use of these interventions, with no apparent negative impacts on the safety or well-being of patients or staff.

Based on the discussion at the task force meeting, NAMI's policy on the one-hour rule and on seclusion and restraints should remain unchanged at this time and any proposed changes by CMS should not interfere with progress made in reducing the use of seclusion and restraints.

We hope that this report will encourage the mental health field to continue working toward the goal of eliminating seclusion and restraints in mental health treatment systems and facilities.

rehabilitation and training model has been developed in the form of treatment malls. The model's milieu is based on the principles of psychosocial rehabilitation which provides for individual self-determination in an almost "community college" type atmosphere which offers engagement for all hospitalized individuals. Patients move about freely with greatly increased access to numerous campus locations, and their "home" unit is used for evening activities and sleeping.

**Low stimulus areas:** For individuals who struggle with persistent symptoms and have short attention spans, frustration and aggressiveness can be easily triggered. In an effort to actively engage these individuals and control for sensory overload, special low-stimulus areas have been developed. This environment includes restful sounds, fountains, soothing lights, mobiles, and a number of small rooms for self time where reading, listening to music, visiting with a peer and a host of other activities occur. Group participation is kept to low numbers and only lasts for 30 minutes at the most, with considerable flexibility based on individualized need.

**Art activities and Art Therapy:** With individuals who are particularly symptomatic, somewhat non-communicative, and potentially violent, many programs find that art therapy can be a useful intervention. In the absence of an art therapist, some clinicians have found that simple art work with crayons can be a practical means to help such individuals communicate their feelings.

**Comfort Rooms:** Comfort rooms are a preventative tool that may help to reduce the need for seclusion and restraint. Comfort items are stuffed animals, soft blankets, headphones, audiotapes, reading materials, etc., for persons wishing to use the room. The room is set up to be physically comfortable and pleasing to the eye including a recliner chair, walls with soft colors, murals, and colorful curtains.

**De-Escalation Preference Forms:** This tool is used to assess histories of trauma and abuse and to reduce the use of seclusion and restraint. The form asks individuals in advance about what might work to help calm them should a crisis occur. This enables staff and the individual to enter into a partnership of safety and assist in the development of a treatment plan.

Calming strategies on the form that the individual can choose from include listening to music, getting a hug with consent, calling a friend, writing a letter and exercise. The form also helps to identify things that may upset the individual, trauma history, physical contact preferences and helpful medications.

These alternatives represent a new way of reducing the need and use of seclusion and restraints, which involves a holistic, humane approach for caring. Treatment in the psychiatric environment involves caring for patients both individually and in the context of a therapeutic environment. Task Force members said that such treatment focuses on using the range of interpersonal situations found in a shared living/group experience for treatment purposes.

## **The Pennsylvania Seclusion and Restraints Reduction Initiative**

The Task Force also heard testimony on the Pennsylvania Seclusion and Restraints Reduction Initiative, which is considered by many experts to be a national model of excellence. In 1997, the Pennsylvania Department of Public Welfare instituted an aggressive program to reduce and ultimately eliminate seclusion and restraints in its nine state hospitals. The philosophy behind this initiative was that most individuals in these institutions are already victims of trauma and intrusive interventions such as seclusion or restraints only serve to re-traumatize these individuals and are therefore contrary to their best therapeutic interests.

Three years later, Pennsylvania has reduced incidents of seclusion and restraints in its nine state hospitals by 74 percent, and reduced the number of hours individuals spent in seclusion and restraints in these hospitals by 96 percent! This statewide program, which has been instituted both in civil and forensic hospitals, has the highest standards for seclusion and restraints in the nation. Pennsylvania's hospitals have experienced no increase in staff injuries since this program has been implemented. In addition, these changes were implemented without any additional funds, using only existing

2. State and local mental health systems and agencies must ensure appropriate, high quality care for all individuals, including efforts to reduce and eliminate the use of seclusion and restraint.

3. Changing standards of national accrediting and certifying organization (e.g., JCAHO, CMS) may influence mental health programs to reduce and eliminate seclusion and restraint. System-wide change is most likely to occur when states and mental health programs decide to improve their own treatment cultures by: establishing high standards for respectful, therapeutic interactions; increasing the amount and types of "active treatment" given each day; evaluating the number and type of staff, their qualifications and the role each has in the potential seclusion and restraint events; deemphasizing "control" and "compliance" in favor of therapeutic relationships that offer individuals choices for interventions and routines; and, explicitly adopting the concept that treatment can only occur in the context of continuous quality improvement.

4. Necessary and appropriate clinical competencies are needed for individuals authorized to institute and monitor the use of mechanical and physical restraints, including training in crisis de-escalation techniques and alternatives to seclusion and restraints.

5. Indicators and guidelines are needed for determining when, if ever, seclusion and restraints should be used.

6. Emerging models and best practices for staff training on crisis assessment, intervention and de-escalation techniques should be replicated and adapted as soon as possible throughout the mental illness delivery system. Comfort rooms and low-stimulus areas are specific strategies that should be adopted and adapted on a widespread basis.

7. New strategies and mechanisms should be implemented for monitoring and evaluating seclusion and restraint-related deaths and serious injuries in psychiatric facilities.

8. A thorough evaluation of the one-hour rule should be conducted to determine the impact of the current rule on the ability of psychiatric treatment

alternative, less intrusive techniques for de-escalating psychiatric crises.

A critically important issue that several members of the Task Force highlighted concerned the qualifications, training and skills necessary for conducting face-to-face evaluations. Many members said that psychiatrists are receiving no training in their residency programs and that teaching curriculums should stress training of clinicians on seclusion and restraints and alternatives.

Task Force members said that one critical attribute is the ability to expertly assess both the psychiatric and medical status of the individual. Many of the documented restraint related deaths are due to acute medical causes secondary to the imposition of restraints.

A second, and equally important issue that was highlighted by Task Force members was that the professional responsible for conducting the face-to-face evaluation, must be proficient and experienced in crisis de-escalation techniques, alternatives to restraints, in the safe use of restraints, and the ability to teach and oversee humane interventions that avoid the use of seclusion and restraint instead of following a response trajectory that inevitably leads to seclusion and restraint use.

A third issue is that efforts must be undertaken to develop, refine and implement specific training protocols, requirements and qualifications for all professionals responsible for performing the critical responsibilities of those authorized to conduct face to face evaluations.

## Recommendations

Based on the presentations and discussion at the meeting, the Task Force identified the following goals and potential strategies:

1. The long-term goal of all mental health treatment facilities and systems should be the elimination of seclusion and restraints.

staff and resources.

By July 2000, Pennsylvania reported that one state psychiatric hospital had not used seclusion for over 20 months. Another hospital had used neither seclusion nor restraints for eight of the last 12 months, and others were approaching zero use.

Pennsylvania began its reform project by carefully tracking the use of seclusion and restraints, and then used that 1997 data as its baseline to measure improvements. A workgroup of practicing, hospital clinicians set about developing new policies and procedures, goals, strategies, and monitoring systems to design and implement the new approach. Key among these goals was developing a new philosophy of care – one that identified seclusion and restraint as a treatment failure and restricted it to emergency use only.

Mental health officials have cited a number of innovations as critical to the success of the program. Among them are:

- Computerized data collection and analysis;
- Strategies for organizational change;
- Staff training in crisis prevention and intervention;
- Risk assessment and treatment-planning tools;
- Patient debriefing methods;
- Recovery-based treatment models; and
- Adequate numbers of staff.

Also critical was changing the culture of state hospitals. Pennsylvania did this by requiring open public access to seclusion and restraints data, by creating competition among hospitals to reduce seclusion and restraints, and by giving awards and acknowledgements for improvement.

The key elements of Pennsylvania's reduction policy include:

- Seclusion and restraints must be the intervention of last resort.
- Seclusion and restraints are exceptional and extreme practices and should not be used as a substitute for treatment, nor as punishment or for the convenience of the hospital staff.



- Seclusion and restraints are safety measures, not therapeutic techniques, which should be implemented in a careful manner.
- Staff should include patient strengths and cultural competencies to prevent incidents of seclusion and restraints.
- Staff should work with consumers to end seclusion and restraints as quickly as possible.
- A physician must bear ultimate responsibility at all times for ordering seclusion and restraints.
- Orders are limited to one-hour and require direct physician contact with the client within 30 minutes.
- The consumer and the family are considered part of the treatment team.
- Consumer advocates should be viewed as spokespeople for consumers and involved in care and treatment.
- Patients and staff must be debriefed after every incident and treatment plans must be revised.
- Staff must be trained in de-escalation techniques.
- Patient status must be reviewed prior to utilizing seclusion and restraints.
- Leaders of the hospital, clinical department heads and ward leaders are accountable at all times for all usage of seclusion and restraints.
- Accountability is demonstrated as a component of the hospital's "performance improvement" index and in staff competency evaluations.
- Data regarding the use of seclusion and restraints are made available to consumer and family organizations and government officials.

*For more information about the Pennsylvania Initiative, visit [www.dpw.state.pa.us/omhsas/omhleadingway.asp](http://www.dpw.state.pa.us/omhsas/omhleadingway.asp).*

## **The NTAC/CMHS Initiative**

The National Technical Assistance Center (NTAC) for State Mental Health Planning, in conjunction with the Federal Center for Mental Health Services (CMHS), is coordinating four regional National Executive Training Institutes for the reduction of the use of seclusion and restraints. In researching promising practices and through the development of its curriculum, the Institute faculty has found that training on seclusion and restraint reduction is greatly

On the issue of physicians responding to a psychiatric crisis, several Task Force members pointed out that it is hard to imagine that the proposition that physicians are the most appropriate individuals to respond to medical emergencies would be disputed in any other medical field. The best person to respond to a cardiac emergency is a cardiologist. The best person to respond to someone experiencing insulin shock is an endocrinologist. It follows, then, that the best person to respond to a psychiatric emergency is a psychiatrist.

Conversely, several Task Force members remarked that standard medical school and residency training for psychiatrists does not include training on crisis response or crisis de-escalation techniques and therefore psychiatric nurses may actually be better trained and have more experience in responding to these situations.

NAMI's policy that a physician or LIP should be responsible for conducting a face to face evaluation and assessing the medical status and continuing need within one hour after the initiation of this intervention reflects recognition that these situations truly constitute medical emergencies, necessitating interventions by physicians.

After receiving input from the Task Force, the NAMI Board concluded that its current policy on the one-hour rule should not be changed at this time. However, the Board recognizes that empirical evidence is needed about:

- (1) The impact of the current rule on the ability of psychiatric treatment facilities to provide effective and humane treatment to individuals with severe mental illnesses;
- (2) The impact of the rule on the ability of psychiatric treatment facilities to protect the safety of staff and other patients;
- (3) The impact of the rule on preventing deaths and serious injuries resulting from the use of restraints; and
- (4) The impact of the rule on reducing the use of restraints in psychiatric treatment settings and enhancing the ability and willingness of staff to use

This change would allow psychiatric treatment facilities to seek waivers exempting them from complying with the requirement that the face-to-face evaluation be conducted by a physician or LIP. Facilities granted waivers would be permitted to conduct face-to-face evaluations with Registered Nurses (RN's). These facilities would be required to establish outside committees to scrutinize each individual use of seclusion and restraints and if violations occur, revert to current one-hour requirements.

- RN Performs the One-hour Evaluation

This option would delete the current one-hour requirement with physician and allow an appropriately trained RN or other LIP to perform the one-hour evaluation.

- Delete the One-hour Rule

This option would eliminate the one-hour requirement and add continuous monitoring of individuals in seclusion or restraints as a requirement.

## **NAMI's Policy on Seclusion and Restraints**

In 2000, the NAMI Board of Directors drafted a comprehensive policy on the use of seclusion and restraints. This policy, which includes the requirement that one-hour face to face evaluations be conducted by physicians or LIPs, was written in the wake of the Hartford Courant expose in October, 1998 that hundreds of children and adults in psychiatric and mental retardation facilities had died after being restrained during the preceding 10 years. The series revealed that the use of restraints in many facilities throughout the country was virtually unregulated, with restraints being applied by psychiatric aides and others with little or no training in the use of these potentially deadly interventions or in preventative or alternative techniques.

NAMI's policy on restraints (see attached) emphasizes that the use of restraints is never appropriate as a therapeutic intervention but is only justified as an emergency safety measure in response to imminent danger to self or others.

needed by all mental health personnel involved in all aspects of treatment. This training should include:

- Reducing use of seclusion and restraints, starting with the essential components of trauma informed mental health systems of care; • Understanding of the neurobiological and psychological aspects of trauma and its effect on the human organism; and
- The use of a public health prevention model to guide assessment, treatment planning and interventions.

Administrators, physicians, nurses, psychologists, social workers, and mental health technicians must all be educated and direct care staff require supervision and role modeling of new practices over time. The NTAC/CMHS Institute's focus is on the roles and responsibilities of an organization's leadership in facilitating the cultural and operational changes that reduce the use of seclusion and restraint.

*For more information about the NTAC/CMHS Institute, visit [www.nasmhpd.org/ntac/topics/seclusionrestraint.html](http://www.nasmhpd.org/ntac/topics/seclusionrestraint.html).*

## **Perspectives on the "One-Hour Rule"**

There are growing concerns in the advocacy community that the Federal Center for Medicaid and Medicare Services (CMS) is planning to propose changes to the one-hour rule this year. In October, 2002, at its "Town Hall Meeting on the One Hour Rule", Tom Barker, the outreach and policy advisor to CMS Administrator Thomas Scully, announced that CMS was contemplating four options. These options include:

- Maintaining the Current Rule

The current rule requires a physician or LIP to conduct a face-to-face evaluation within one-hour of initiating seclusion and restraint.

- Maintain the Current Rule, With Modifications for Certain Facilities.