The section of the MS DMH Minimum Standards for Community Mental Health/Mental Retardation Services which addresses the use of restraints (or prohibition thereof). The entire document can be accessed via our website www.dmh.state.ms.us. See the public documents tab at the top of the page.

_Taken from the Mississippi Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services...

_The entire set of Standards can be accessed through our website: dmh.state.ms.us under public documents._

Section C - Rights of Individuals Receiving Services

90.0*  There must be written policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal guardian(s) is informed of their rights while served by the program, at intake and at least annually thereafter if he/she continues to receive services. The individual receiving services and/or parent/legal guardian must also be given a written copy of these rights, which at a minimum, must include:

- a. The options within the program and of other services available;
- b. Program rules and regulations;
- c. Program's responsibility for the referral of those persons whom the program is unequipped to serve;
- d. The right to refuse treatment;
- e. The right not to be subjected to corporal punishment or unethical treatment including but not limited to the following:
  - (1) The right to be free from all forms of abuse or harassment;
  - (2) The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- f. The right to voice opinions, recommendations, and to file a written grievance which will result in program review and response without retribution. (See also Part II, Organization and Management, Section G - Grievance and Complaint Resolution);
- g. The right to personal privacy, including privacy with respect to facility visitors in day programs and residential programs as much as physically possible;
h. The program's nondiscrimination policies related to HIV infection and AIDS;

i. The right to considerate, respectful treatment from all employees of the provider program;

j. The right to have reasonable access to the clergy and advocates and access to legal counsel at all times;

k. The right of the individual being served to review his/her records, except as restricted by law;

l. The right to participate in and receive a copy of the comprehensive treatment/habilitation/service plan including but not limited to the following:

   (1) The right to make informed decisions regarding his/her care, including being informed of his/her health status, being involved in care planning and treatment and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

   (2) The right to access information contained in his/her clinical records within a reasonable time frame. (A reasonable time frame is within five (5) days; if it takes longer, the reason for the delay must be communicated). The provider must not frustrate the legitimate efforts of individuals being served to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits. State statute 41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated; and,

   (3) The right to be informed of any hazardous side effects of medication prescribed by staff medical personnel.

m. The ability to retain all Constitutional rights, except as restricted by due process and resulting court order;

n. The right to have a family member or representative of his/her choice notified promptly of his/her admission to a hospital; and,

o. The right to receive care in a safe setting.
Providers must establish and implement written policies and procedures specifying that:

a. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support.

b. Providers are prohibited from the use of seclusion except for certified Intensive Residential Treatment Services (See Part VIII, Section M.).

c. Providers are prohibited from the use of chemical restraints.

The definition of seclusion, mechanical restraint and chemical restraint are as follows:

1. **Seclusion** means a behavior control technique involving locked isolation. Such term does not include a time out.

2. **A mechanical restraint** is the use of a mechanical device, material, or equipment attached or adjacent to the individual’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body;

3. **A chemical restraint** is a drug or medication that is used as a restraint to manage behavior or restrict the individual’s freedom of movement that is not a standard treatment for the individual’s medical or psychiatric condition;

Providers must ensure that all staff who may utilize physical restraint(s)/escort successfully complete training and hold a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

Providers utilizing physical restraint(s)/escort must establish and implement written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum;

a. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use;

1. **A physical restraint** is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort;
A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location;

b. Requirements that in emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the individual from injuring himself/herself or others. A Emergency is defined as a situation where the individual’s behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, staff, or others (see 90.4b for need of Behavior Support Plan);

c. Requirements that physical restraints/escorts are used as specified in the Behavior Support Plan only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm. The utilization of other less restrictive alternatives must be documented in the individual’s case record;

d. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior Support Plan by order of a physician or other licensed independent practitioner as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider and documented in the case record.

Providers must establish and implement written policies and procedures regarding the use of physical restraint(s)/escort with implementation (as applicable) documented in the Behavior Support Plan and in each individual case record:

a. Orders for the use of physical restraint(s)/escort must never be written as a standing order or on an as needed basis (that is, PRN);

b. A Behavior Support Plan must be developed by the individual’s treatment team when these techniques are implemented more than three (3) times within a thirty day period with the same individual. The Behavior Support Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior Support Plan must be developed with the signature of the program’s clinical director.
c. In physical restraint situations, the treating physician must be consulted within twenty-four hours and this consultation must be documented in the individual's case record.

d. A supervisory or senior staff person with training and demonstrated competency in physical restraint(s) who is competent to conduct a face-to-face assessment will conduct such an assessment of the individual's mental and physical well-being as soon as possible but not later than within one hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained as per Standard 90.2 monitors the situation for the duration of the intervention;

e. Requirements that staff record an account of the use of a physical restraint(s)/escort in a behavior management log that is maintained in the individual's case record by the end of the working day. The log must include:

1. Name of the individual for whom the physical restraint(s)/escort intervention is implemented;

2. Time that physical restraint(s)/escort intervention began;

3. Behavior warranting utilization of physical restraint(s)/escort intervention;

4. Type of physical restraint(s)/escort that was utilized during intervention.

5. Documentation of less restrictive alternative methods of managing behavior which have been determined to be ineffective in the management of the individual's behavior.

6. Documentation of visual observation by staff of individual while he/she is in physical restraint(s)/escort, including description of behavior at that time;

7. Time that the physical restraint(s)/escort intervention ended;

8. Signature of staff implementing physical restraint(s)/escort procedure and staff observing individual for whom physical restraint(s)/escort intervention was implemented.

9. Documentation of supervisory or senior staff person's assessment of the restrained/escorted individual's mental and physical well-being during and after physical restraint(s)/escort utilization, including the time the assessment was conducted.
(10) Documentation of the use of physical restraint(s)/escort in emergency situations must clearly describe the precipitating events that necessitated their use.

90.5 γ Providers must establish and implement policies and procedures that physical restraint is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of physical restraint. Additionally, individuals must not be restrained for more than sixty (60) minutes at any one time. They must be released after those sixty minutes. A face-to-face assessment must take place at least every twenty (20) minutes while the individual is being restrained.

90.6 γ Providers must establish and implement policies and procedures specifying that physical restraint(s)/escort must be in accordance with a written modification to the comprehensive treatment/service/habilitation plan of the individual being served as well as all of the following:

a. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;

b. Requirement(s) that physical restraint(s)/escort must be in accordance with safe, appropriate restraining techniques; and;

c. Requirement(s) that physical restraint(s)/escort must be ended at the earliest possible time (i.e., when the individual's behavior has de-escalated and that individual in no longer in danger of harming him/herself or others;)

d. Requirement(s) that physical restraint(s)/escort must not be used as a form of punishment, coercion or staff convenience;

e. Requirement(s) that supine and prone restraints are prohibited as part of an individual's Behavioral Support Program; and

f. Requirement(s) that all physical restraint(s)/escort can only be implemented by someone holding certification as per Standard 90.2.

90.7 γ Programs utilizing time-out must have written policies and procedures that govern the use of time-out and documentation of implementation of such procedures in case records of individuals receiving services. The policy/ procedures must include, at a minimum, the following provisions:

a. Clear definition(s) of time-out and the appropriate conditions and documentation associated with its use:
(1) A time out is a behavior management technique which removes an individual from social reinforcement into a non-locked room, for the purpose of calming. The time out procedure must be part of an approved treatment program. Time out is not seclusion.

(2) Quiet time is a behavior management technique that is part of an approved treatment program and may involve the separation of the individual from the group, for the purpose of calming. Quiet time is not time out.

b. Requirement(s) ensuring that the use of time-out procedures is justified as documented and approved in a comprehensive treatment/service/habilitation plan;

c. Requirement(s) ensuring that time-out be used only after less restrictive procedures have been implemented and determined to be ineffective. The utilization of other less restrictive alternatives must be documented in the individual case record; and

d. Requirement(s) that a locked door must not be component of timeout.

90.8 γ Programs utilizing time-out must have written and implemented policies and procedures that time-out is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of time-out. Placement of an individual in a time out room can not exceed one hour.

90.9 γ There must be written and implemented policies and procedures requiring that a Behavior Support Plan be developed by the individual’s treatment team, including participation of the individual as appropriate, to address the behavior(s) warranting the utilization of the time-out procedure and adhere to the following:

a. The Behavior Support Plan must be developed in accordance with the individual’s comprehensive treatment/habilitation plan and have signature approval by the program’s clinical director.

b. The Behavior Support Plan must not include the use of time out as a form of punishment, coercion or for staff convenience.

91.0 The utilization of time-out must be documented in a behavior log completed/maintained in the individual’s case record which, at a minimum, must include:

a. Name of the individual for whom the time-out intervention is implemented;
b. Time that time-out intervention began;

c. Behavior(s) requiring time-out intervention;

d. Documentation of visual observation by staff while individual is in time-out, including description of behavior at that time;

e. Time that the intervention ended; and

f. Signature of staff implementing procedure and observing individual for whom time-out intervention was implemented.

91.1 In the case of residential placement, the program must have written and implemented policies and procedures that:

a. Provide the individual receiving services with means of communicating with persons outside the program;

b. Provide for visitation by close relatives and/or significant others during reasonable hours;

c. Provide for safe storage, accessibility and accountability of funds of individuals receiving services;

d. Provide for individuals to send/receive mail without hindrance;

e. Provide for individuals to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in the individual case record. (Any individual restriction on private telephone use must be reviewed at a minimum every seven days).

91.2 An individual receiving services cannot be required to do work which would otherwise require payment to other program staff or contractual staff. For work done, wages must be in accordance with local, state, and federal requirements or the program must have a policy that the individuals do not work for the program.

91.3 A record of any individuals for whom the provider is a conservator or a representative payee must be on file with supporting documentation.

91.4 For programs serving as conservator or representative payee, the following action must be taken for each individual:

a. A record of sums of money received for/from each individual and all expenditures of such money must be kept up to date and available for inspection;
b. The individual and/or his/her lawful agent must be furnished a receipt, signed by the lawful agent(s) of the program, for all sums of money received and expended at least quarterly.
91.5 All programs that provide services for children under the age of eighteen (18) must have on file an assurance signed by the Executive Officer of the provider stating compliance with provisions of Public Law 103-227 (Pro-Children Act of 1994). Note: This standard includes a current Certification Regarding Environmental Tobacco Smoke required of providers funded by the Department of Mental Health.