Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 231 (as enrolled) **PUBLIC ACT 527 of 2004**
Senate Bill 1344 (as enrolled) **PUBLIC ACT 531 of 2004**
Sponsor: Senator Bev Hammerstrom
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 1-18-05

RATIONALE

The Mental Health Code allows hospitals and other facilities to place patients and residents in seclusion under certain circumstances and according to specific procedures; for example, seclusion authorized by a physician may continue only for one hour or until a physician can examine the person, whichever is less. In 1997, an amendment to the Code included child caring institutions among the facilities that may use seclusion, since these institutions occasionally need to place a child in seclusion for the safety of the child and others. Child caring institutions, however, do not have full-time physicians on staff, which can make it difficult for them to comply with the requirement that a physician examine a child each time seclusion is used.

In 2001, the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services issued a final rule regarding the safe use of restraint and seclusion in psychiatric residential facilities that provide treatment to people younger than 21. (The HCFA now is called the Center for Medicare and Medicaid Services, or CMS.) In order to receive Medicaid funding, a child caring institution must adhere to the requirements under the final rule.

It was suggested that provisions of the Federal rule should be incorporated into the Code to allow the use of Medicaid funding to treat residents of child caring institutions; reduce reliance on restraint and seclusion in child caring institutions; and improve resident and staff safety and quality of care. (For more information on the Federal rule, and the use of restraint and seclusion, please see **BACKGROUND**, below.)

CONTENT

Senate Bill 231 amended the Mental Health Code to prohibit a minor placed in a child caring institution from being placed or kept in seclusion, except as provided in the child care licensing Act or rules promulgated under the Act.

Senate Bill 1334 amended the child care licensing Act to do the following with regard to child caring institutions that contract with or receive payment from a community mental health services program (CMHSP) or prepaid inpatient health plan:

-- Prohibit the use of mechanical and chemical restraint.
-- Allow the use of personal restraint and seclusion to ensure the safety of a minor or others in an emergency situation.
-- Require staff to undergo continuing education and training in the use of personal restraint and seclusion, and the identification of alternate methods for preventing and defusing an emergency safety situation.
-- Establish procedures for the use of personal restraint and seclusion, including debriefings of all situations in which personal restraint or seclusion is employed.
-- Require an evaluation of a minor by institution staff after the

-- implementation of personal restraint or seclusion.
-- Require a face-to-face assessment of a minor by a licensed practitioner if the use of personal restraint or seclusion exceeds specified time limits.
-- Establish documentation and record-keeping requirements.
-- Require the reporting of instances of death, serious injury, or attempted suicide to the Family Independence Agency (FIA) and the State-designated protection and advocacy system.

The provisions of Senate Bill 1344 apply only to a child caring institution that contracts with or receives payment from a CMHSP or prepaid inpatient health plan for the care, treatment, maintenance, and supervision of a minor in that child caring institution.

Senate Bill 1344 was tie-barred to Senate Bill 231. The bills took effect January 3, 2005. They are described below in further detail.

Senate Bill 231

Under the Mental Health Code, seclusion may be used only in a hospital, center, or licensed child caring institution. ("Center" means a facility operated by the Department of Community Health (DCH) to admit individuals with developmental disabilities and provide habilitation and treatment services.) Under the bill, a minor placed in a child caring institution may not be placed or kept in seclusion except as provided in the child care licensing Act or rules promulgated under it.

(Under the child care licensing Act, "child caring institution" means a child care facility that is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operates throughout the year. An educational program may be provided, but may not be the facility's primary purpose. The term includes a maternity home for the care of unmarried mothers who are minors and an agency group home, which is described as a small child caring institution owned, leased, or rented by a licensed agency providing care for between four and 13 children. The term also includes institutions for mentally retarded or emotionally disturbed minor children. It does not include a hospital, nursing home, home for the aged, boarding school, hospital or facility operated by the State and licensed under the Mental Health Code, or an adult foster care family home or an adult foster care small group home in which a child has been placed.)

Senate Bill 1344

Permitted & Prohibited Restraint

Under the bill, if a child caring institution contracts with and receives payment from a CMHSP or prepaid inpatient health plan for the care, treatment, maintenance, and supervision of a minor child in a child caring institution, the institution may place a minor child in personal restraint or seclusion only as provided by the bill. The institution may not use mechanical or chemical restraint.

The bill defines "personal restraint" as the application of physical force without the use of a device, for the purpose of restraining the free movement of a minor child's body. The term does not include the following:

-- The use of a protective or adaptive device.
-- Briefly holding a minor child without undue force in order to calm or comfort him or her.
-- Holding a minor child's hand, wrist, shoulder, or arm to escort him or her safely from one area to another.
-- Using a protective or adaptive device or a device primarily intended to provide anatomical support.

The bill defines "seclusion" as the involuntary placement of a minor child in a room alone, where the minor is prevented from exiting by any means, including the physical presence of a staff person if the sole purpose of that person's presence is to prevent the minor from exiting the room. The term does not include the use of a sleeping room during regular sleeping hours to ensure security precautions appropriate to the condition and circumstances of a minor child placed in the child caring institution as a result of an order of the family division of circuit court (family court) under Section 2(a) of the juvenile code (described below), if the minor's individual case treatment plan indicates that the security precautions would be in the minor child's best interest.

The bill defines "mechanical restraint" as a device attached or adjacent to a minor child's body that he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body. The term does not include the use of a protective or adaptive device or a device primarily intended to provide anatomical support. The term also excludes the use of a mechanical device to ensure security precautions appropriate to the condition and circumstances of a minor placed in the child caring institution as a result of an order of the family court under Section 2(a) of the juvenile code.

The bill defines "protective device" as an individually fabricated mechanical device or physical barrier, whose use is incorporated in the individualized written plan of service and is intended to prevent the minor child from causing serious self-injury associated with documented, frequent, and unavoidable hazardous events. "Adaptive device" means a mechanical device incorporated in the individual plan of services that is intended to provide anatomical support or to assist the minor child with adaptive skills.

The bill defines "chemical restraint" as a drug that is administered to manage a minor's behavior in a way that reduces the safety risk to the minor or others, has the temporary effect of restricting the minor's freedom of movement, and is not a standard treatment for the minor's medical or psychiatric condition.

(Under Section 2(a) of the juvenile code, the family court has exclusive original jurisdiction in proceedings concerning a juvenile under age 17 if any of the following apply:

-- The juvenile has violated any municipal ordinance or State or Federal law.
-- The juvenile has deserted his or her home without sufficient cause, and the court finds that the juvenile has been placed or refused alternative placement, or the juvenile and his or her parent, guardian, or custodian have exhausted or refused family counseling.
-- The juvenile is repeatedly disobedient to the reasonable and lawful commands of his or her parents, guardian, or custodian, and the court finds that court-accessed services are necessary.
-- The juvenile is repeatedly truant from, or repeatedly violates rules and regulations of, school or another learning program, and the court finds that the juvenile, his or her parent, guardian, or custodian, and school officials or learning program personnel have met on the juvenile's educational problems and educational counseling and alternative agency help have been sought.)

Required Education & Training

Within 180 days after the bill's effective date, a child caring institution must require its staff to have ongoing education, training, and demonstrated knowledge of all of the following:

-- Techniques to identify minors' behaviors, events, and environmental factors that might trigger emergency safety situations.
-- The safe use of personal restraint or seclusion, including the ability to recognize and respond to signs of physical distress in minors who are in or are being placed in personal restraint or seclusion.
-- The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations.

(The bill defines "emergency safety situation" as the onset of an unanticipated, severely aggressive, or destructive behavior that places the minor child or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention, i.e., the use of personal restraint or seclusion as an immediate response to an emergency safety situation.)

A child caring institution's staff must be trained in the use of personal restraint or seclusion, be knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and demonstrate competency regarding personal restraint or seclusion before participating in implementation. Staff must demonstrate their competencies in these areas on a semiannual basis. The FIA must review and determine the acceptability of the child caring institution's staff education, training, knowledge, and competency requirements and the training and knowledge required of

a licensed practitioner in the use of personal restraint and seclusion.

(The bill defines "licensed practitioner" as an individual who has been trained in the use of personal restraint and seclusion, who is knowledgeable of the inherent risks in implementation, and who is a licensed physician, a certified nurse practitioner, a licensed physician's assistant, a registered nurse, a limited licensed psychologist, or a limited licensed counselor. Until July 1, 2005, the term includes a certified social worker registered under the Public Health Code. After that date, the term will include a licensed master's social worker licensed under the Code.)

Limits on Restraint & Seclusion

The bill prohibits the staff of a child caring institution from imposing personal restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. An order for personal restraint or seclusion may not be written as a standing order or on an as-needed basis.

Personal restraint or seclusion must not result in harm or injury to the minor child and may be used only to ensure the child's safety or the safety of others during an emergency safety situation. Personal restraint or seclusion may be used only until the emergency safety situation has ceased and the safety of the minor and of others can be ensured, even if the order for personal restraint or seclusion has not expired. Personal restraint and seclusion of a minor may not be used simultaneously.

Personal restraint or seclusion must be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of physical or sexual abuse.

Notification of Restraint & Seclusion Policy

Under the bill, at the time a minor child is admitted to a child caring institution, it must do all of the following:

-- Inform the minor and his or her parents or legal guardian of the provider's policy regarding the use of personal restraint or seclusion during an emergency safety situation that may occur while the minor is under the care of the child caring institution.
-- Communicate the provider's personal restraint and seclusion policy in language that the minor or his or her parent or legal guardian can understand, including American Sign Language, if appropriate; and procure an interpreter or translator, if necessary.
-- Obtain a written acknowledgment from the minor's parent or legal guardian that he or she had been informed of the provider's policy, and file it in the minor's records.
-- Give a copy of the policy to the parent or legal guardian.

The child caring institution is not required to inform, communicate, and obtain the written acknowledgement from a minor's parent or legal guardian if the minor is within the care and supervision of the child caring institution as a result of an order of commitment of the family court to a State institution, State agency, or otherwise, and has been adjudicated to be a dependent, neglected, or delinquent under the juvenile code, if the minor's individual case treatment plan indicates that such notice would not be in the minor's best interest.

Order & Procedures

The bill provides that an order for personal restraint or seclusion may be written only by a licensed practitioner. A licensed practitioner must order the least restrictive emergency safety intervention measure that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. Consideration of less restrictive emergency intervention safety measures must be documented in the minor's record.

If the order for personal restraint or seclusion is verbal, it must be received by a child caring institution staff member who is a licensed practitioner, a social services supervisor described in R 400.4118 of the Michigan Administrative Code, a supervisor of direct care workers as described in R 400.4120 of the Michigan Administrative Code, or a licensed practical nurse. (The administrative rules set forth requirements for the education and experience of these supervisors.)

A verbal order must be received while child caring institution staff are initiating personal restraint or seclusion or immediately after the emergency safety situation begins. The licensed practitioner must be available to staff for consultation, at least by telephone, throughout the personal restraint or seclusion period. He or she must verify the verbal order in signed, written form in the minor's record.

An order for personal restraint or seclusion must be limited to the duration of the emergency safety situation. It may not exceed four hours for a minor who is 18 or older, two hours for a minor nine to 17 years old, or one hour for a minor under age nine.

If more than two orders for personal restraint or seclusion are ordered for a minor within a 24-hour period, the director of the child caring institution or his or her designated management staff must be notified to determine whether additional measures should be taken to facilitate discontinuation of personal restraint or seclusion.

If personal restraint continues for less than 15 minutes or seclusion continues for less than 30 minutes from the onset of the emergency safety intervention, the child caring institution staff qualified to receive a verbal order, in consultation with the licensed practitioner, must evaluate the minor's psychological well-being immediately after the minor is removed from seclusion or personal restraint. Staff also must evaluate the minor's physical well-being or determine if an evaluation is needed by a licensed practitioner authorized to conduct a face-to-face assessment, as described below.

A face-to-face assessment must be conducted if the personal restraint continues for at least 15 minutes or if seclusion continues for at least 30 minutes from the onset of the emergency safety intervention. The assessment must be conducted by an individual who has been trained in the use of personal restraint and seclusion, and who is licensed as a physician, a certified nurse practitioner, a physician's assistant, or a registered nurse. The assessment must be conducted within one hour of the onset of the intervention and immediately after the minor is removed from personal restraint or seclusion. The assessment must include, at a minimum, the minor's physical and psychological status and behavior, the appropriateness of the intervention measures, and any complications resulting from the intervention.

A minor must be released from personal restraint or seclusion whenever the circumstances that justified its use no longer exist. Each instance of personal restraint or seclusion requires full justification for its use, and the results of the evaluation immediately following the use of personal restraint or seclusion must be placed in the minor's record.

Each order for personal restraint or seclusion must include the name of the licensed practitioner ordering the restraint or seclusion; the date and time the order was obtained; and the personal restraint or seclusion ordered, including the length of time for which the practitioner ordered its use.

The child caring institution staff must document the use of the personal restraint or seclusion in the minor's record. The documentation must be completed by the end of the shift in which the restraint or seclusion occurred. If the restraint or seclusion does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

-- Each order for personal restraint or seclusion.
-- The time the personal restraint or seclusion actually began and ended.
-- The time and results of the one-hour assessment.
-- The emergency safety situation that required the resident to be restrained or secluded.
-- The name of the staff involved.

The child caring institution staff trained in the use of personal restraint continually must assess and monitor the minor's physical and psychological well-being and the safe use of personal restraint throughout its implementation. The institution staff trained in the use of seclusion physically must be present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the minor's physical and psychological well-being. Video monitoring may not be exclusively used to

meet this requirement. The staff must ensure that documentation of staff monitoring and observation is entered into the minor's record.

If the emergency safety intervention continues beyond the time limit of the order, staff authorized to receive verbal orders for personal restraint or seclusion immediately must contact the licensed practitioner to receive further instructions.

As soon as possible after the initiation of personal restraint or seclusion, the staff must notify the minor's parent or legal guardian, and the appropriate State or local government agency that has responsibility for the minor if he or she is under the supervision of the child caring institution as a result of an order of commitment by the family court to a State institution or otherwise. The notification, including the date and time of the notification, the name of the staff person providing it, and the name of the person to whom the notification was reported, must be documented in the minor's record.

The child caring institution does not have to notify the parent or legal guardian if the minor is within the care and supervision of the institution as a result of an order of commitment of the family court to a State institution, State agency, or otherwise, and has been adjudged to be dependent, neglected, or delinquent under the juvenile code, if the minor's individual case treatment plan indicates that such notice would not be in the minor's best interest.

Debriefing

Within 24 hours after the use of personal restraint or seclusion, staff involved in the emergency safety intervention and the minor must have a face-to-face debriefing session that includes all staff involved in the personal restraint or seclusion, unless the presence of a particular staff member may jeopardize the minor's well-being. Other staff members and the minor's parent or legal guardian may participate in the debriefing if the child caring institution considers it appropriate.

The institution must conduct a debriefing in a language the minor understands. The debriefing must give both the minor and the staff the opportunity to discuss the circumstances resulting in the use of personal restraint or seclusion and strategies the staff, the minor, or others could use to prevent the future use of personal restraint or seclusion.

Within 24 hours after the use of personal restraint or seclusion, all child caring institution staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, all of the following:

-- Discussion of the emergency safety situation that required personal restraint or seclusion, including a discussion of precipitating factors that led up to the situation.
-- Alternative techniques that might have prevented the use of personal restraint or seclusion.
-- The procedures, if any, for staff to implement to prevent a recurrence of the use of personal restraint or seclusion.
-- The outcome of the emergency safety intervention, including any injury that might have resulted from the use of personal restraint or seclusion.

The staff must document in the minor's record that both debriefing sessions took place, and include the names of staff who were present and staff who were excused, and changes to the minor's treatment plan that result from the debriefings.

Reporting Serious Occurrences

Each child caring institution subject to the bill must report each serious occurrence to the FIA, which must make the reports available, upon request, to the designated State protection and advocacy system (described below). Serious occurrences to be reported include a minor's death, serious injury, or suicide attempt. Staff must report any serious occurrence involving a minor by the close of the next business day after the occurrence. The report must include the name of the minor, a description of the occurrence, and the child caring institution's name, street address, and telephone number. (The bill defines "serious injury" as any significant impairment of the minor child's physical condition as determined by qualified medical personnel that results from an emergency safety intervention, including burns, lacerations, bone fractures, substantial hematoma, and injuries to

internal organs, whether self-inflicted or inflicted by someone else.)

As soon as possible and not later than 24 hours after the occurrence, the institution also must notify the minor's parent or legal guardian, and, if the minor is under the institution's supervision as a result of a family court order of commitment, the appropriate State or local government agency that has responsibility for the minor.

Staff must document on the minor's record that the serious occurrence was reported to both the FIA and the State-designated protection and advocacy system. The name of the person to whom notification of the incident was reported also must be documented. A copy of the report must be maintained in the minor's record, as well as the child caring institution's incident and accident report logs.

(Under the Mental Health Code, the Governor is required to designate an agency to implement a program for the protection and advocacy of the rights of persons with developmental disabilities and mental illness. The designated agency has the authority to pursue legal, administrative, and other appropriate remedies to protect the rights of the developmentally disabled and the mentally ill and to investigate allegations of abuse and neglect. The designated agency is independent of any State agency that provides treatment or services other than advocacy services to persons with developmental disabilities and the mentally ill. Michigan Protection and Advocacy Services is the State-designated agency.)

Record-Keeping; Reporting

Each child caring institution subject to the bill must maintain a record of the incidences in which personal restraint or seclusion was used for all minors. The record must include all of the following information:

-- Whether personal restraint or seclusion was used.
-- The setting, unit, or location in which personal restraint or seclusion was used.
-- Staff who initiated the process.
-- The duration of each use of personal restraint or seclusion.
-- The date, time, and day of the week restraint or seclusion was initiated.
-- Whether the minor or staff sustained injuries.
-- The minor's age and gender.

Each child caring institution annually must submit to the FIA a report containing the aggregate data from the record of incidences for each 12-month period as directed by the FIA. The FIA must prepare the reporting forms, aggregate the data collected from each child caring institution, and report the data annually to each child caring institution and the State-designated protection and advocacy system.

MCL 330.1742 (S.B. 231)
722.102b-722.102e (S.B. 1344)

BACKGROUND

Use of Restraint & Seclusion

In 1999, the U.S. General Accounting Office (GAO) issued a report entitled *Improper Restraint or Seclusion Use Places People at Risk.* The GAO identified components of successful strategies states had used to reduce the use of restraint and seclusion, including clearly defined policies and principles outlining when and how restraint may be used; a strong commitment by management to the philosophy that restraint should be an emergency technique and last resort, rather than a treatment; staff training in the safe use of restraint and seclusion, and alternative intervention techniques; and oversight and monitoring.

The GAO found that the use of restraint often involved physical struggling and pressure on the chest, which can cause interruptions in breathing. Among deaths in which restraint or seclusion was identified as a factor, the causes of death were asphyxiation, strangulation, cardiac arrest or other cardiac complications, fire, smoke inhalation, drug overdoses or interactions, blunt trauma, choking, and aspiration. The GAO also found numerous examples of physical injuries, such as bruising and broken bones, and severe trauma to patients, especially among those who had been sexually abused in the past.

The use of restraint and seclusion can be harmful to facility staff, as well, according to the report. It cited several studies documenting that most assaults on staff members by patients are committed during the application of restraint or seclusion, and

that most staff injuries are sustained in trying to control violent patients.

The report noted that children were subjected to the procedures at higher rates than adults, and also were at greater risk for physical injury because employees accustomed to restraining adults did not adjust the force they used accordingly.

CMS Final Rule

The final rule (42 CFR 483) imposes procedural, reporting, and training requirements regarding the use of restraint and seclusion in nonhospital psychiatric facilities serving people younger than 21. It provides that each resident has the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; prohibits the simultaneous use of restraint and seclusion; and prohibits an order for restraint or seclusion from being written as a standing order or on an as-needed basis.

The rule prohibits the restraint or seclusion from resulting in harm to the patient and continuing beyond the end of the emergency safety situation. Upon admittance, incoming residents and their parents must be notified of the facility's policy regarding the use of restraint and seclusion.

Under the rule, restraint and seclusion may be ordered only by a physician or other authorized licensed practitioner trained in the use of emergency safety interventions. The physician or licensed practitioner must order the least restrictive emergency safety intervention possible under the circumstances. Within one hour of the initiation of an intervention, the physician or other practitioner must conduct a face-to-face assessment of the resident.

The rule also sets time limits for the duration of restraint or seclusion, and requires every serious occurrence (i.e., a resident's death, serious injury, or suicide attempt) to be reported to the state Medicaid agency (the FIA in Michigan), and, unless prohibited by state law, the state-designated protection and advocacy system.

The rule requires facility staff to have ongoing education and training, and demonstrate knowledge, in identification of factors that may trigger emergency safety situations, the use of nonphysical intervention skills, and the safe use of restraint and seclusion. Additionally, staff must be certified in the use of cardiopulmonary resuscitation.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills will improve safety for residents and staff, as well as the quality of care children receive in child caring institutions that contract with a CMHSP or prepaid inpatient health plan. Although the use of seclusion and all forms of restraint once were considered acceptable methods to control disobedient children, there is a growing consensus that these procedures sometimes do more harm than good, and should be implemented only by trained personnel and only when a clear threat is posed to residents and staff.

Due to a statewide trend toward the deinstitutionalization of mental health patients, child caring centers are treating greater numbers of children with more severe emotional disorders or disabilities than in the past. Some people believe that the use of seclusion or restraint sends a conflicting message to the troubled children who have been placed in what is supposed to be a safe, therapeutic environment. Often, a child who previously experienced neglect or abuse feels threatened by the implementation of seclusion or restraint and only becomes more aggressive. If facility staff have more training in de-escalating a potential emergency safety situation before restraint or seclusion becomes necessary, presumably residents will be more trusting of staff and more open to treatment. This, in turn, will help child caring institutions avoid the need for a licensed practitioner to conduct a face-to-face exam, a requirement that child caring institutions have difficulty meeting.

Undoubtedly, residents of child caring institutions sometimes behave in ways that endanger themselves, other children, and workers. Implementation of seclusion or restraint, however, can be dangerous, or even deadly, for residents and staff. A person can suffocate when restrained in certain positions. In some cases, restricting

movement might interfere with the way a person's body metabolizes medication he or she is taking, endangering his or her life. When it becomes necessary to restrain a person physically, or place him or her in a room alone, it is imperative that the treatment be done by trained staff who know which techniques should be avoided due to the potential for injury or death, and can recognize signs that a person is in physical distress.

In situations in which a child's behavior endangers his or her own safety or that of others, the bills will ensure that the child is restrained or secluded safely and appropriately. Senate Bill 1344 incorporates many of the key provisions of the Federal rule, including the prohibition against employing restraint or seclusion except as an emergency safety intervention, the requirement that the procedures be ordered only by a health professional trained in their use and inherent risks, parental notification requirements, time limits, debriefings, and reporting requirements. Furthermore, the bill prohibits the use of mechanical and chemical restraint, and allows only the use of personal restraint and seclusion.

The reporting and record-keeping requirements under the bill also will help improve resident and staff safety. According to the GAO report described above, the lack of a comprehensive reporting system for deaths and injuries in which restraint or seclusion was a factor prevented the true scope of the problem from being known. Under the bill, in addition to reporting serious occurrences to the FIA and Michigan Protection and Advocacy, a child caring institution must keep a record of all uses of personal restraint and seclusion, and submit an annual report to the FIA. This will help child caring institutions to discover patterns in their use of personal restraint and seclusion, and the circumstances that lead to emergency safety situations; as well as identify aspects of their policies and procedures that need to be improved.

As updated by the bills, Michigan's policy regarding the use of restraint and seclusion on minors will reflect an increasingly accepted philosophy that health care workers should not employ either of those procedures as a treatment, but only as a last resort in a potentially dangerous situation. The bills should lead to a reduction in the need for restraint and seclusion, and ensure that this population of vulnerable children receives appropriate treatment in an environment that protects their safety and dignity.

Response: The provisions of Senate Bill 1344 do not apply to a child caring institution that does not contract with or receive payment from a CMHSP or prepaid inpatient health plan. The bill's protections, however, should be afforded to all children in all child caring institutions. Regardless of how they enter the system, many of the children being treated in child caring institutions previously would have been served in psychiatric hospitals or specialized child caring institutions due to their serious mental health needs. The use of restraint and seclusion can be dangerous whether or not the child caring institution contracts with a CMHSP or prepaid inpatient health plan, and should be regulated.

Legislative Analyst: Julie Koval

FISCAL IMPACT

Senate Bill 231

The bill will have no fiscal impact on State or local government.

Senate Bill 1344

The bill will have an indeterminate impact on the Family Independence Agency. The State licenses approximately 300 child caring institutions, of which 10% are institutions serving children receiving community mental health services that will be affected by the bill. The requirements for reporting, developing and preparing report forms, collecting data, and preparing reports will result in some administrative costs; the amount cannot be determined at this time.

Fiscal Analyst: Steve Angelotti
Constance Cole

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