CHAPTER 234–S.F.No. 3049

An act relating to children's mental health; requiring children's mental health providers to develop a plan for and comply with requirements on the use of restrictive procedures; modifying chemical use assessments; establishing a mental health needs work group; requiring data to determine substance abuse treatment effectiveness; amending Minnesota Statutes 2006, section 256B.0943, subdivision 5; Minnesota Statutes 2007 Supplement, section 254A.19, subdivision 3, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 245.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[245.8261] RESTRICTIVE PROCEDURES PLANNING AND REPORTING.**

Subdivision 1. **Scope.** (a) This section applies to providers of the following mental health services for children:

(1) emergency services as defined in sections 245.4871, subdivision 14, and 245.4879;

(2) family community support services as defined in section 245.4871, subdivision 17;

(3) day treatment services as defined in section 245.4871, subdivision 10;

(4) therapeutic support of foster care as defined in section 245.4871, subdivision 34;

(5) professional home-based family treatment as defined in sections 245.4871, subdivision 31, and 245.4884, subdivision 3; and

(6) mental health crisis services as defined in sections 245.4871, subdivision 24a, and 245.488, subdivision 3.

(b) Providers of mental health services for children under paragraph (a) must meet the requirements of this section before using a restrictive procedure with a child.

Subd. 2. **Restrictive procedures plan.** (a) A services provider under subdivision 1, paragraph (a), shall have on file and available for viewing a restrictive procedures plan for children in its program that must include at least the following:

(1) the list of restrictive procedures the provider intends to use;

(2) how the provider will monitor and control the use of restrictive procedures;

(3) a description of the training that staff who use restrictive procedures must complete prior to staff implementation of restrictive procedures;

(4) how the provider will document information needed to prepare the annual report required in subdivision 15; and

(5) how the provider will ensure that the child receives treatment for any injury caused by the use of a restrictive procedure.

(b) For purposes of this section, allowable restrictive procedures include those procedures allowed under subdivision 4, paragraph (a).

Subd. 3. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Commissioner" means the commissioner of human services.

(c) "Child" means a person under 18 years of age.

(d) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21, as required for children's mental health services providers in section 245.4876, subdivision 3. The individual treatment plan must be based on a diagnostic assessment, which includes assessments and review of medical conditions and risks of psychological trauma that might be incurred by use of seclusion or restraint.

(e) "Mechanical restraints" means the use of devices to limit a child's movement or hold a child immobile. The term does not mean mechanical restraints used to:

(1) treat a child's medical needs;

(2) protect a child known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness; or

(3) position a child with physical disabilities in a manner specified in the child's plan of care.

(f) "Physical escort" means physical intervention or contact used as a behavior management technique to guide or carry a child to safety or away from an unsafe or potentially harmful and escalating situation.

(g) "Physical holding" means physical intervention intended to hold a child immobile or limit a child's movement by using body contact as the only source of physical restraint. The term does not mean physical contact:

(1) used to facilitate a child's response or completion of a task when the child does not resist or the child's resistance is minimal in intensity and duration; and

(2) necessary to conduct a medical examination or treatment.

(h) "Restrictive procedures" means application of an action, force, or condition that controls, constraints, or suppresses the action, behavior, intention, bodily placement, or bodily location of a child in a manner that is involuntary, unintended by that child, depriving, or aversive to that child.

(i) "Time out" means removing a child from an activity to a location where the child cannot participate or observe the activity and includes moving or ordering a child to an unlocked room.

(j) "Seclusion" involves the confining of a child alone in a room from which egress is beyond the child's control or prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the child from leaving the room. The room used for seclusion must be well-lighted, well-ventilated, clean, have an observation window that allows staff to directly monitor the child in seclusion, fixtures that are tamperproof, electrical switches located immediately outside the door, and

doors that open out and are unlocked or locked with keyless locks that have immediate release mechanisms.

Subd. 4. **Allowable procedures.** (a) A provider may use one or more of the following restrictive procedures:

(1) physical escort;

(2) physical holding;

(3) seclusion; and

(4) the limited use of mechanical restraints only in emergency situations.

(b) A provider shall permit use of restrictive procedures only by a mental health professional under section 245.4871, subdivision 27, or by a mental health practitioner under section 245.4871, subdivision 26, who is acting under the clinical supervision of a mental health professional.

Subd. 5. **Parental consent and notification.** Parental consent for use of seclusion and restraint procedures must be obtained when a child begins receiving services; the agreement must be reviewed at least quarterly. A provider shall notify the child's parent or guardian of the use of a restrictive procedure on the same day the procedure is used, unless the parent or guardian notifies the provider that the parent or guardian does not want to receive notification or the parent or guardian requests a different notification schedule.

Subd. 6. **Physical escort requirements.** The physical escort of a child may be used to control a child who is being guided to a place where the child will be safe and to help de-escalate interactions between the child and others. A provider who uses physical escorting with a child shall meet the following requirements:

(1) staff shall be trained according to subdivision 12;

(2) staff shall document the use of physical escort and note the technique used, the time of day, and the names of the staff and child involved; and

(3) the use of physical escort shall be consistent with the child's treatment plan.

Subd. 7. **Physical holding or seclusion.** Physical holding or seclusion may be used in emergency situations as a response to imminent serious risk of physical harm to the child or others and when less restrictive interventions are ineffective. A provider who uses physical holding or seclusion shall meet the following requirements:

(1) an immediate intervention must be necessary to protect the child or others from physical harm;

(2) the physical holding or seclusion used must be the least intrusive intervention that will effectively react to an emergency;

(3) the use of physical holding or seclusion must end when the threat of harm ends;

(4) the child must be constantly and directly observed by staff during the use of physical holding or seclusion;

(5) the use of physical holding or seclusion must be used under the supervision of a mental health professional;

(6) staff shall contact the mental health professional to inform the mental health professional about the use of physical holding or seclusion and to ask for permission to

use physical holding or seclusion as soon as it may safely be done, but no later than 30 minutes after initiating the use of physical holding or seclusion;

(7) before staff uses physical holding or seclusion with a child, staff shall complete the training required in subdivision 12 regarding the use of physical holding or seclusion at the program;

(8) when the need for the use of physical holding or seclusion ends, the child must be assessed to determine if the child can safely be returned to the ongoing activities at the program;

(9) staff shall treat the child respectfully throughout the procedure;

(10) the staff person who implemented the use of physical holding or seclusion shall document its use immediately after the incident concludes and the documentation must include at least the following information:

(i) a detailed description of the incident which led to the use of physical holding or seclusion;

(ii) an explanation of why the procedure chosen needed to be used;

(iii) why less restrictive measures failed or were found to be inappropriate;

(iv) the time the physical hold or seclusion began and the time the child was released;

(v) documentation of the child's behavioral change and change in physical status for each 15-minute interval the procedure is used; and

(vi) the names of all staff involved in the use of the procedure and the names of all witnesses to the use of the procedure; and

(11) if seclusion is used, the room used for the seclusion must:

(i) be well-lit, well-ventilated, and clean;

(ii) have an observation window which allows staff to directly monitor a child in seclusion;

(iii) have fixtures that are tamperproof, with electrical switches located immediately outside the door;

(iv) have doors that open out and are unlocked or are locked with keyless locks that have immediate release mechanisms; and

(v) have objects that may be used by a child to injure the child's self or others removed from the child and the seclusion room before the child is placed in seclusion.

Subd. 8. **Exempt techniques and procedures.** (a) Use of the instructional techniques and intervention procedures listed in this subdivision is not subject to the restrictions established by this section. The child's individual treatment plan, as defined in section 245.4871, subdivision 21, and as required in section 245.4876, subdivision 3, must address the use of these exempt techniques and procedures. Exempt techniques and procedures include:

(1) corrective feedback or prompt to assist a child in performing a task or exhibiting a response;

(2) physical contact to facilitate a child's completion of a task or response that is directed at increasing adaptive behavior when the child does not resist or the child's resistance is minimal in intensity and duration;

(3) physical contact or a physical prompt to redirect a child's behavior when:

(i) the behavior does not pose a serious threat to the child or others;

(ii) the behavior is effectively redirected with less than 60 seconds of physical contact by staff; or

(iii) the physical contact is used to conduct a necessary medical examination or treatment; and

(4) manual or mechanical restraint to treat a child's medical needs or to protect a child known to be at risk of injury from an ongoing medical or psychological condition.

(b) The exemptions under this subdivision must not be used to circumvent the requirements for controlling the use of manual restraint. The exemptions under this subdivision are intended to allow providers the opportunity to deal effectively and naturally with instruction and treatment interventions.

Subd. 9. **Conditions on use of restrictive procedures.** Restrictive procedures must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under section 626.556, the reporting of maltreatment of minors;

(2) restrict a child's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, or necessary clothing or to any protection required by state licensing standards and federal regulations governing the program;

(3) be used as punishment or for the convenience of staff; or

(4) deny the child visitation or contact with legal counsel and next of kin.

Subd. 10. **Prohibitions.** (a) The following actions or procedures are prohibited:

(1) using corporal punishment such as hitting, pinching, slapping, or pushing;

(2) speaking to a child in a manner that ridicules, demeans, threatens, or is abusive;

(3) requiring a child to assume and maintain a specified physical position or posture, for example, requiring a child to stand with the hands over the child's head for long periods of time or to remain in a fixed position;

(4) use of restrictive procedures as a disciplinary consequence;

(5) totally or partially restricting a child's senses, except at a level of intrusiveness that does not exceed:

(i) placing a hand in front of a child's eyes as a visual screen; or

(ii) playing music through earphones worn by the child at a level of sound that does not cause discomfort;

(6) presenting an intense sound, light, noxious smell, taste, substance, or spray, including water mist;

(7) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except as provided under paragraph (b).

(b) When the temporary removal of the equipment or device is necessary to prevent injury to the child or others or serious damage to the equipment or device, the equipment or device shall be returned to the child as soon as possible.

Subd. 11. **Training for staff.** (a) Staff who use restrictive procedures shall successfully complete training in the following skills and knowledge areas before using restrictive procedures with a child:

(1) the needs and behaviors of children;

(2) relationship-building;

(3) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may trigger behavioral escalation;

(4) de-escalation methods;

(5) avoiding power struggles;

(6) documentation standards for the use of restrictive procedures;

(7) how to obtain emergency medical assistance;

(8) time limits for restrictive procedures;

(9) obtaining approval for use of restrictive procedures;

(10) the proper use of the restrictive procedures approved for the program, including simulated experiences of administering and receiving physical restraint;

(11) thresholds for employing and ceasing restrictive procedures;

(12) the physiological and psychological impact of physical holding and seclusion;

(13) how to monitor and respond to the child's physical signs of distress; and

(14) recognizing symptoms of and interventions with potential to cause positional asphyxia.

(b) Training under this subdivision must be repeated every two years.

Subd. 12. **Administrative review.** The provider shall complete an administrative review of the use of each restrictive procedure within three working days after the use of the restrictive procedure. The administrative review shall be conducted by someone other than the person who decided to impose the restrictive procedure, or that person's immediate supervisor. The child or the child's representative shall have an opportunity to present evidence and argument to the reviewer about why the procedure was unwarranted. The record of the administrative review of the use of a restrictive procedure must state whether:

(1) the required documentation was recorded;

(2) the restrictive procedure was used in accordance with the treatment plan;

(3) the standards governing the use of restrictive procedures were met; and

(4) the staff who implemented the restrictive procedures were properly trained.

Subd. 13. **Review of patterns of use of restrictive procedures.** At least quarterly, the treatment provider shall review the provider's patterns of the use of restrictive procedures. The review must be completed by the treatment provider or the program's advisory committee. The review shall consider:

(1) any patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a procedure, individuals involved, or other factors associated with the use of restrictive procedures;

(2) any injuries resulting from the use of restrictive procedures;

(3) actions needed to correct deficiencies in the program's implementation of restrictive procedures;

(4) an assessment of opportunities missed to avoid the use of restrictive procedures; and

(5) proposed actions to be taken to minimize the use of physical holding or seclusion.

Subd. 14. **Annual report.** A provider using restrictive procedures shall annually submit a report to the commissioner stating the number and types of restrictive procedures performed. The report shall be submitted in a form and manner prescribed by the commissioner. Agencies with high use of restrictive procedures will be reviewed by the commissioner to determine needed changes in policies and procedures, including staff training.

Sec. 2. Minnesota Statutes 2007 Supplement, section 254A.19, is amended by adding a subdivision to read:

Subd. 1a. **Emergency room patients.** A county may enter into a contract with a hospital to provide chemical use assessments under Minnesota Rules, parts 9530.6600 to 9530.6655, for patients admitted to an emergency room or inpatient hospital when:

(1) an assessor is not available; and

(2) detoxification services in the county are at full capacity.

Sec. 3. Minnesota Statutes 2007 Supplement, section 254A.19, subdivision 3, is amended to read:

Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) or (c), an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral relationship resulting in shared financial gain with a treatment provider.

(b) A county may contract with an assessor having a conflict described in paragraph (a) if the county documents that:

(1) the assessor is employed by a culturally specific service provider or a service provider with a program designed to treat individuals of a specific age, sex, or sexual preference;

(2) the county does not employ a sufficient number of qualified assessors and the only qualified assessors available in the county have a direct or shared financial interest or a referral relationship resulting in shared financial gain with a treatment provider; or

(3) the county social service agency has an existing relationship with an assessor or service provider and elects to enter into a contract with that assessor to provide both assessment and treatment under circumstances specified in the county's contract, provided the county retains responsibility for making placement decisions.

(c) The county may contract with a hospital to conduct chemical assessments if the requirements in subdivision 1a are met.

An assessor under this paragraph may not place clients in treatment. The assessor shall gather required information and provide it to the county along with any required documentation. The county shall make all placement decisions for clients assessed by assessors under this paragraph.

Sec. 4. Minnesota Statutes 2006, section 256B.0943, subdivision 5, is amended to read:

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and performance measurement. The provider must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and upon each subsequent update.

(b) The administrative infrastructure written policies and procedures must include:

(1) personnel procedures, including a process for: (i) recruiting, hiring, training, and retention of culturally and linguistically competent providers; (ii) conducting a criminal background check on all direct service providers and volunteers; (iii) investigating, reporting, and acting on violations of ethical conduct standards; (iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws; (v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers; and (vi) documenting that each mental health professional, mental health practitioner, or mental health behavioral aide meets the applicable provider qualification criteria, training criteria under subdivision 8, and clinical supervision or direction of a mental health behavioral aide requirements under subdivision 6;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) if a client is receiving services from a case manager or other provider entity, a service coordination process that ensures services are provided in the most appropriate manner to achieve maximum benefit to the client. The provider entity must ensure coordination and nonduplication of services consistent with county board coordination procedures established under section 245.4881, subdivision 5;

(4) a performance measurement system, including monitoring to determine cultural appropriateness of services identified in the individual treatment plan, as determined by the client's culture, beliefs, values, and language, and family-driven services; and

(5) a process to establish and maintain individual client records. The client's records must include:

(i) the client's personal information;

(ii) forms applicable to data privacy;

(iii) the client's diagnostic assessment, updates, results of tests, individual treatment plan, and individual behavior plan, if necessary;

(iv) documentation of service delivery as specified under subdivision 6;

(v) telephone contacts;

(vi) discharge plan; and

(vii) if applicable, insurance information.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Sec. 5. **MENTAL HEALTH NEEDS; WORK GROUP.**

(a) The commissioner of human services shall convene a work group of stakeholders from the child, adolescent, and adult mental health system and members of the health economics program at the Minnesota Department of Health to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. The work group shall develop recommendations on how to meet the acute mental health needs of children, adolescents, and adults.

(b) The plan shall include an analysis of the current capacity and utilization of:

(1) inpatient hospital psychiatric beds;

(2) partial hospitalization programs;

(3) children's and adults' residential treatment facilities;

(4) mobile crisis services and adult crisis homes;

(5) intensive outpatient services; and

(6) supportive housing arrangements.

The plan shall also include an analysis of the number of practicing psychiatrists and other mental health professionals and the present staffing needs of both inpatient and community programs. The commissioner shall use available reports and data, and may collect new data where necessary.

(c) The commissioner shall report the findings of the work group to the chairs of the standing committees in the house and senate with jurisdiction over mental health by January 16, 2009. The report shall include recommendations for:

(1) any expansion in capacity for facilities listed in paragraph (b), including location, type, specialization, optimum size, and geographic accessibility;

(2) identifying obstacles in rules, licensing, or payment rates that limit recommended expansion;

(3) strategies to maximize federal matching dollars; and

(4) strategies to improve the efficient transition from inpatient to community settings.

Sec. 6. **[254B.051] SUBSTANCE ABUSE TREATMENT EFFECTIVENESS.**

In addition to the substance abuse treatment program performance outcome measures that the commissioner of human services collects annually from treatment providers, the

commissioner shall request additional data from programs that receive appropriations from the consolidated chemical dependency treatment fund. This data shall include number of client readmissions six months after release from inpatient treatment, and the cost of treatment per person for each program receiving consolidated chemical dependency treatment funds. The commissioner may post this data on the department Web site.

EFFECTIVE DATE. This section is effective January 1, 2009.

Presented to the governor April 23, 2008

Signed by the governor April 25, 2008, 3:56 p.m.