



# **Solitary Confinement**

**at**

# **St. Elizabeths Hospital**

January 28, 2019

## **Disability Rights DC at University Legal Services**

Since 1996, Disability Rights DC at University Legal Services (DRDC), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for people with disabilities in the District of Columbia. DRDC has the authority to investigate allegations of abuse and neglect of people with disabilities throughout the District in accordance with the congressional mandate under the P&A laws, 42 U.S.C. §§ 10801 *et seq.*; 42 U.S.C. §§ 15043; 29 U.S.C. §§ 794e *et seq.*; 42 U.S.C. § 300d-53. Pursuant to the P&A laws, DRDC also has access to facilities in the District providing psychiatric care and treatment and can monitor these facilities for compliance related to consumer rights and safety. 42 C.F.R. § 51.42. In addition, DRDC provides legal advocacy to protect the civil rights of District residents with disabilities.

DRDC staff directly serve hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education and group advocacy efforts. DRDC staff address client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, inclusion and special education, and the improper use of seclusion, restraint and medication.

## I. Introduction

On July 23, 2018, Disability Rights DC (“DRDC”) opened an investigation based on an allegation that a patient at St. Elizabeths Hospital (“SEH”) housed on ward 1D had been secluded in a solitary confinement cell. On August 13, 2018, DRDC conducted a monitoring visit on ward 1D in the presence of the 1D charge nurse and the Department of Behavioral Health Assistant General Counsel (“AGC”). DRDC observed a locked door at the end of a hallway on the unit. Behind the locked door were three rooms – two solitary confinement seclusion rooms called “safety suites” and a room containing a bed with leather restraints attached. The AGC and the charge nurse reported that patients with significant behavioral issues were locked in the “safety suites” as a “last resort” and that their use was not considered seclusion pursuant to hospital policy. DRDC inquired as to why the hospital did not consider use of the “safety suites” to be a form of seclusion, given that patients were locked in the room and not allowed to leave. The AGC replied that under hospital policy, the room was a “general security measure” as referenced in D.C. regulations; therefore, its use was not considered by the hospital to be seclusion. The charge nurse stated that if the hospital considered placing patients in these rooms to be seclusion, the patients would have to be released “when they calmed down.” The AGC provided DRDC with a copy of St. Elizabeths “General Protective Security Measures” Policy Number 103.03 (“The 2018 Policy”) -- a relatively recent policy that did not come into effect until May 29, 2018.<sup>1</sup>

Alarming, this new 2018 Policy allows for the unlawful seclusion and restraint of patients, and describes the measures outlined as “general security measures” -- a vague and undefined term referenced in D.C. regulations. The 2018 Policy allows for patients to be *(1) locked in solitary confinement seclusion rooms for indefinite periods of time, (2) placed in “flex cuff” handcuffs for transportation within the hospital, and (3) secluded and confined to a small area of their unit for an indefinite amount of time. The hospital inexplicably and wrongly considers that these measures are not seclusion or restraint, even though these measures fit squarely under the definition of seclusion and restraint contained in D.C. law and Center for Medicare and Medicaid Services (“CMS”) regulations.*

At least four patients (and possibly many others) have been subjected to these measures since the 2018 Policy has been enacted. The hospital must immediately cease implementing these measures and discontinue this illegal and harmful policy.

## II. District Law and Federal Regulations Clearly Define Restraint and Seclusion

CMS regulations, D.C. law, and D.C. regulations all place specific and clear limits on the use of restraint and seclusion with mental health consumers. As the hospital’s own seclusion and restraint policy aptly notes:

**Because of the trauma inducing aspects of seclusion and restraint, as well as the potential for physical and psychological harm and loss of dignity, seclusion or restraint shall only be used in emergency situations that pose an**

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<sup>1</sup> SEH Policy 103.03.

immediate risk of an individual physically harming him/herself, staff or others, when less restrictive interventions are not viable or have been ineffective and when the individual's behavior **at the time** poses a greater risk to himself or others than the risk of using seclusion or restraint.<sup>2</sup>

Seclusion is both defined by federal regulation and D.C. law. CMS regulations define seclusion as “the involuntary **confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.**”<sup>3</sup> CMS guidelines note that “**if a patient is restricted to a room alone** and staff are physically intervening to prevent the patient from leaving the room . . . the room is considered locked [...] the patient is being secluded.”<sup>4</sup> D.C. law provides a very similar definition for seclusion – “any involuntary confinement of a consumer **alone in a room or an area from which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.**”<sup>5</sup>

Further, CMS regulations define restraint as “any manual method, physical or mechanical device, material, or equipment that **immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.**...”<sup>6</sup> A device, material, or piece of equipment is not “easily removable” and thus, constitutes a restraint, if it cannot be “removed intentionally by the patient in the same manner as it was applied by the staff.”<sup>7</sup> D.C. regulations limit the type of mechanical restraint the hospital can use and do not allow for the use of handcuffs.<sup>8</sup> Moreover, the regulations specifically prevent the use of ambulatory restraints, such as wristlets or anklets.<sup>9</sup>

Federal regulations and D.C. law impose multiple restrictions and protections when staff employ seclusion and restraint, including that seclusion and restraint: (1) can only be used in an emergency when necessary to prevent serious injury to the consumer or others;<sup>10</sup> (2) can only be used when less restrictive alternatives have been considered and determined ineffective;<sup>11</sup> (3)

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<sup>2</sup> St. Elizabeths Policy, *Restraint and Seclusion for Behavioral Reasons*, Policy Number 103 III.A. (Revised May 28, 2015) (emphasis added).

<sup>3</sup> 42 C.F.R. § 482.13 (e)(1)(ii) (emphasis added).

<sup>4</sup> CMS Interpretive Guidelines for 42 C.F.R. §482.13 (e)(1)(ii), at p. 104 (emphasis added).

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf>

<sup>5</sup> D.C. Code §7-1231.02 (24) (emphasis added). *See also* D.C. Mun. Regs. tit. 22A § 500.5.

<sup>6</sup> 42 C.F.R. § 482.13 (e)(1)(i)(A) (emphasis added).

<sup>7</sup> CMS Interpretive Guidelines for 42 C.F.R. § 482.13(e)(1)(i)(A), at p. 96. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf>

<sup>8</sup> D.C. Mun. Regs. tit. 22A § 501.7(c). Methods of restraint that may be prescribed include only four-point restraints, five-point restraints, physical holds, legally mandated restraints, medical restraints and drugs used as a restraint. D.C. Mun. Regs. tit. 22A §503.2.

<sup>9</sup> D.C. Mun. Reg. 22-A § 505.1(b) prohibits the use of ambulatory restraints, defined as “restraints which allow the consumer to walk around while restrained, such as wristlets or anklets.”

<sup>10</sup> D.C. Code §7-1231.09(c).

<sup>11</sup> D.C. law mandates that “seclusion and restraint can only be used in an emergency when: [...] less restrictive interventions have been considered and determined to be ineffective to prevent serious injury to the consumer or others.” D.C. Code §7-1231.09(c)(2). *See also* 42 C.F.R. § 482.13(e)(2).

require a doctor's order;<sup>12</sup> and (4) must be ended at the earliest possible time.<sup>13</sup> These restrictions and requirements are essential to protect the safety and dignity of patients. As CMS interpretive guideline notes, the intent of the regulations is to "identify patients' basic rights, ensure patient safety, and **eliminate the inappropriate use of restraint or seclusion.**"<sup>14</sup>

Although there are multiple restrictions and consumer protections for when staff employ seclusion and restraint, the District's regulations do exclude "general protective measures," "time-out," and certain other "protective measures" from the definition of seclusion and restraint.<sup>15</sup> "General protective measures" include locked wards and "special security measures;" however, the regulations do not define those terms. This "general security measure" exception appears to exclude the hospital's large, multi-room locked wards/units from the definition of seclusion.<sup>16</sup> Nevertheless, whatever "general protective measures" are, they certainly cannot be so broad as to include forcibly restricting someone to one locked room-- the very thing prohibited under the federal and D.C. legislation-- thereby allowing the exception to swallow the rule.

### **III. The Hospital's Policy Wrongly Exempts the Use of its Solitary Confinement Seclusion Rooms as a Form of Seclusion in Violation of D.C. Law and Federal Regulations.**

#### **1. The Solitary Confinement Seclusion Room and the 2018 Policy**

The 2018 Policy allows the hospital to seclude patients by restricting them in "safety suites" on unit 1D, which, according to the policy, are "designated to house individuals in care who are unable to function safely around other individuals in care."<sup>17</sup> Under the 2018 Policy, a patient may be secluded in a "safety suite" when: 1) the patient's behavior represents a serious threat to the health and safety of both the patient and other individuals and/or staff on the unit; 2) the patient's behavior consistently requires an undue portion of staff's attention at the expense of other individuals in the milieu; 3) safety care and behavioral approaches have been implemented

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<sup>12</sup> D.C. law mandates that "any consumer to whom seclusion or restraint is applied must be seen by his or her attending or treating physician within one hour after the initiation of the seclusion or restraint" in order to evaluate the continued need for these measures. D.C. Code §7-1231.09 (f). The physician may only renew the original order for four hours for adults and "no use of seclusion or restraint may extend beyond a 24-hour period." D.C. Code §7-1231.09 (f)-(g). CMS regulations state that "Each order for restraint or seclusion used for the management of violent or self-destructive behavior... may only be renewed in accordance with the following limits for up to a total of 24 hours: 4 hours for adults 18 years of age or older..." 42 C.F.R. § 482.13(e)(8)(i)(A).

<sup>13</sup> D.C. Code §7-1231.09(d)(4). *See also* 42 C.F.R. § 482.13(e).

<sup>14</sup> CMS Interpretive Guidelines for 42 C.F.R. § 482.13(e), at p. 90 (emphasis added).

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf>

<sup>15</sup> D.C. Mun. Reg. 22-A § 500.9. Under D.C. Mun. Reg. 22-A § 500.9(a), "restraints and seclusion shall not include general protective security measures including, without limitation, locked wards, or other special security measures adopted in youth residential treatment centers, maximum security hospitals or forensic units in psychiatric hospitals, or specific security measures ordered by a court."

<sup>16</sup> The hospital has eleven wards/units that it calls "houses." The units are each locked, preventing access to the interior halls of the hospital without permission. Nevertheless, these wards/units contain large interior areas in which patients can move from bedrooms to the dining areas or the meeting space or several large lounging areas. Though locked into the unit, consumers have access to multiple rooms and can mingle freely with other patients and staff.

<sup>17</sup> SEH Policy 103.03 (II).

but have been unsuccessful; 4) other attempts at behavior management to sustain safety in a less restrictive environment were unsuccessful;<sup>18</sup> and 5) at least two individuals among the Director of Medical Affairs, Chief Nursing Executive, and Chief Clinical Officer approve the use of the safety suite.<sup>19</sup> A patient may leave the “safety suite” when: 1) the patient meets the requirements of the step-down plan; 2) an assessment describing the risk to the stability of the unit and the safety of the other individuals support the team’s findings that a patient has met the step-down criteria; and 3) at least two individuals among the Director of Medical Affairs, Chief Nursing Executive, and Chief Clinical Officer approve the step-down of the safety suite.<sup>20</sup> The 2018 Policy also has various other requirements including clinical and administrative staff requirements while a patient is in the “safety suite.”<sup>21</sup>

As previously noted, DRDC conducted a monitoring visit of a location staff refer to as the “safety suite” on unit 1D. As shown in the pictures below, both of the “safety suites” consist of two separate solitary confinement seclusion rooms, both locked with heavy metal doors.



*Locked door to the first room*



*Locked door to the internal room*

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<sup>18</sup> These attempts include but are not limited to Clinical Consult Team meetings (CCT), zoning, medication interventions, repeated use of restraint and seclusion, and increased monitoring/intervention by Safety Department staff. SEH Policy 103.03 (IV)(B)(3)(a)(iv).

<sup>19</sup> SEH Policy 103.03 (IV)(B)(3)(a).

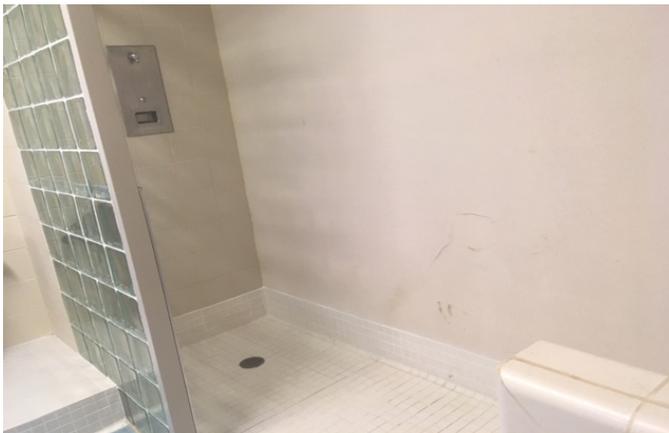
<sup>20</sup> SEH Policy 103.03 (IV)(B)(3)(c).

<sup>21</sup> For example, the 2018 Policy requires: 1) that the individual’s treatment plan be reviewed and revised to reflect the change in treatment; 2) that the patient’s attending psychiatrist notify the patient’s guardian, advocate, family, and lawyer about his move to a higher level of care; 3) there is a behaviorally anchored plan to step-down from the security suite; 4) the home unit’s nursing staff is responsible for the patient’s stay; and 5) the criteria for step-down is reviewed every seven days at a minimum or sooner if the plan criteria is met, or at the individual’s treatment plan review. SEH Policy 103.03 (IV)(B)(3)(b).

The room behind the internal locked door (the “internal room,”) contains a bed, a shower stall, and a toilet. See pictures below.



*Internal room with mattress against the wall*



*Shower in internal room*



*Toilet in internal room*

The room behind the first locked metal door, pictured below, contains a single chair and a television set behind a plexiglass screen. Hospital staff informed DRDC that this is a locked “step down” room. Patients are permitted to leave the locked internal room and access the “step-down” room for specified periods and can sit in the chair and watch television only when they have met certain behavioral criteria.



*Locked “step down” room with chair and television*

There is restricted access to an enclosed outside concrete area accessible behind a locked door off of the “security suite.” It measures approximately 30 feet by 6 feet and is caged-in with a wire mesh on top. See the picture below.



The hospital's use of these solitary confinement seclusion rooms fits squarely within the CMS regulation definition of seclusion, which states that "seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving."<sup>22</sup> It also meets the D.C. law definition of seclusion because patients are confined alone in the room and are not permitted to leave.<sup>23</sup> Inexplicably, the 2018 Policy does not recognize that placing patients in the solitary confinement seclusion room is seclusion, but rather calls such use a "general security measure," attempting to exempt the use of the room from the District law, even though the rooms are clearly used to seclude individuals.

## **2. At Least Four Patients have been Illegally Secluded in the Solitary Confinement Seclusion Rooms.**

Pursuant to our federal authority, DRDC requested, and the hospital provided, redacted clinical documentation and unusual incident reports related to patients that have been locked in the "safety suite" since January 1, 2015. Although the 2018 Policy was not in effect until May 29, 2018, since at least September 2017, the hospital has developed "step down" plans for at least four patients, which allowed staff to lock the patients in the solitary confinement seclusion room for extended periods of time. After a specified number of days of being locked in the solitary confinement seclusion room, the plans allowed for the patients to engage in activities outside of the rooms for relatively brief periods of time if they met certain behavioral criteria; however, the plans allowed for the patients to be locked in the rooms for the majority of their days, evenings and nights. Below is a discussion of each patient's "step down plan."

### Patient I

Patient I's step-down plan required the completion of two **steps** and the completion of six **phases**. Under the plan, Patient I was to be locked in the solitary confinement seclusion room *for a minimum of eleven (11) days*. Step 1 required Patient I to demonstrate safe behaviors for the duration of the step-down plan. Step 2 required the completion of each of the six phases without the presence of any target behaviors. Phase 1 required **one complete calendar day** of safe behaviors before advancing to phase 2. Phase 2 required **two days** of safe behavior while Patient I listened to music and/television programming as scheduled and allowed fifteen minutes of phone use per day.<sup>24</sup> Phase 3 included thirty minutes of "suite" courtyard<sup>25</sup> time for **two days**. Phase 4 added one hour of television on unit 1D while eating lunch and one hour of television on unit 1D while eating dinner for **two days**. Weather permitting, the second day of Phase 4 also called for Patient I to spend thirty minutes in the unit 1D courtyard/milieu. Phase 5 required Patient I to safely attend **two days** of scheduled gym time with the other patients of unit 1D. Phase 6 required Patient I to attend 1D Unit Programming for **two days**.<sup>26</sup> Each of these phases had to be completed successfully before Patient I could advance to the next.

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<sup>22</sup> 42 C.F.R. § 482.13 (e)(1)(ii).

<sup>23</sup> D.C. Code §7-1231.02 (24).

<sup>24</sup> Patient I's revised step-down plan did not indicate how long Patient I must watch television and listen to music in phase 2. The plan only stated that these activities begin/continue "as scheduled." CCT Note, Mar. 29, 2018 p. 9.

<sup>25</sup> The "courtyard" is the concrete area topped with barbed wire shown in the photographs on page 6 of this report.

<sup>26</sup> Patient I's Revised Step-Down Plan. (Attached to CCT Note, Mar. 29, 2018).

## Patient II

Patient II's "step down" plan mandated that Patient II complete five "phases" prior to being released from the solitary confinement seclusion room. Each phase had to be completed successfully before Patient II could advance to the next. To successfully complete all five phases, Patient II was to be confined to the solitary confinement seclusion room for *a minimum of twenty (20) days*. Phase 1 required that Patient II demonstrate safety and rule adherence for **four consecutive days**. Phase 2 required that Patient II demonstrate safe television room behaviors and safe dormitory behavior for **four consecutive days**. Phase 3 included absence of the dangerous behaviors in Phase 1 through Phase 2, and also required that Patient II demonstrate safe courtyard behaviors for **four consecutive days**. Phase 4 included the absence of the dangerous behaviors in Phase 1 through Phase 3 and safe headphone usage for **four days**. Phase 5 required **four successful days** of safe milieu (unit 1D) television time to meet the behavioral step-down criteria.<sup>27</sup>

## Patient III

Patient III's plan mandated that he complete six "phases" prior to being released from the solitary confinement seclusion room. All six phases required that Patient III demonstrated safe "dormitory" behaviors and safe behaviors required in all previous phases. To complete all six phases, Patient III was to be confined to the solitary confinement seclusion room for *a minimum of twenty-five (25) days*. Phase 1 required that Patient III demonstrate safe behaviors for **five consecutive days**. Phase 2 included sixty minutes of watching television in the adjacent room and safe "dormitory" behaviors for **four consecutive days**. Phase 3 included fifteen minutes in the security suite courtyard for **four consecutive days**. Phase 4 included thirty minutes of watching television in the unit 1D milieu with supportive safety precautions for **four consecutive days**. Phase 5 required thirty minutes of watching television in unit 1D milieu without supportive safety precautions for **four consecutive days**. Phase 6 required thirty minutes of unit 1D milieu courtyard time for **four consecutive days**.<sup>28</sup>

## Patient IV

Patient IV's plan mandated that Patient IV complete five "phases." To complete all five phases, Patient IV was to be confined to the solitary confinement seclusion room for *a minimum of twenty (20) days*. Phase 1 required that Patient IV demonstrate safety and rule adherence in the solitary confinement seclusion room for **four consecutive days**. Phase 2 required that Patient IV display continued absence of dangerous behaviors in Phase 1 and safe television room behaviors for **four consecutive days**. Phase 3 included absence of the dangerous behaviors in phases 1 and 2 and safe courtyard access for **four consecutive days**. Phase 4 required that Patient IV use the gym for **four days** to earn television time in the milieu. Phase 5 required Patient IV to complete **four consecutive days** of safe milieu TV time to meet the behavioral

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<sup>27</sup> Patient II's Step-Down Plan from the Security Suite. (Attached to CCT Note, Mar. 30, 2018).

<sup>28</sup> Patient III's Step-Down Plan from the Security Suite. (Attached to Clinical Consultation Meeting, Sept. 15, 2017).

step-down criteria.<sup>29</sup> Phase 5 was particularly disturbing. This phase required that Patient IV demonstrate that he was ready to return to the milieu by maintaining the standards and demonstrating increased ability to follow directives in the previous phases as demonstrated by **four consecutive days, two days in “shackles” and two days out of “shackles.”**<sup>30</sup> D.C. regulations expressly forbid shackling a patient.<sup>31</sup>

These four plans contained punitive requirements and restrictions during each phase, and required the patients to demonstrate consistent “safe behaviors” as determined by the treatment team drafting the step-down plans.<sup>32</sup> Under the plans, the patients were punished if they failed to comply with the required behaviors since they were prevented from moving to the next phase, which could significantly prolong the length of time the patient was locked in the solitary confinement seclusion room.<sup>33</sup> Prolonging seclusion to punish unwanted behavior is strictly prohibited by D.C. law.<sup>34</sup>

### **3. Patients Confined and Secluded Pursuant to the Policy are Denied the Protections of D.C. Law and CMS Regulations.**

When hospital staff locked these patients in the “safety suites,” they were, in fact, locking them in seclusion and placing them in solitary confinement for an extended period. Patients locked and secluded in these rooms pursuant to the 2018 Policy are denied the protections of D.C. law and CMS regulations governing seclusion and restraint. Both D.C. law<sup>35</sup> and CMS regulations<sup>36</sup> allow for seclusion only in an emergency when necessary to prevent serious injury

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<sup>29</sup> Patient IV’s Step-Down Plan from the Security Suite. (Attached to Clinical Consultation Meeting, Feb. 23, 2017).

<sup>30</sup> *Id.*

<sup>31</sup> D.C. Mun. Reg. 22-A § 505.1(b) prohibits the use of ambulatory restraints, defined as “restraints which allow the consumer to walk around while restrained, such as wristlets or anklets.”

<sup>32</sup> For example under Patient II’s Step Down Plan, phase 1 describes safe dormitory behaviors as, “No attempts to engage in physically aggressive behaviors (pushing, punching, kicking, spitting, throwing objects or liquids); No verbally aggressive behavior (threats to harm staff, yelling obscenities at staff); And no attempts to bang, kick tear paper or destroy property, and no attempts to make weapons or hide any objects.” Patient II’s Step-Down Plan from the Security Suite. (Attached to Clinical Consultation Team Meeting, Mar. 30, 2018).

<sup>33</sup> For example, during each phase, Patient IV’s plan required that he 1) not attempt to talk to any other patients during TV time; 2) not go outside of the zoned area; and (3) not engage in “negotiating” behaviors in which he requests to stay longer than the 30 minutes or go somewhere outside of the zoned area. Patient IV’s Step-Down Plan from the Security Suite. (Attached to Clinical Consultation Team Meeting, Feb. 23, 2017).

<sup>34</sup> DC Code § 7-1231.09(a) states that “Consumers have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff.”

<sup>35</sup> DC Code § 7-1231.09(c) states, “Seclusion or restraint can be used in an **emergency** when: 1) the use of seclusion or restraint is, in the written opinion of the attending physician, **necessary to prevent serious injury to the consumer or others**; 2) Less restrictive interventions have been considered and determined to be ineffective to prevent serious injury to the consumer or others; and 3) Pursuant to the written order of the attending physician, which shall never be written as a standing order or on an as-needed basis, and which must be followed by consultation with the consumer’s treating physician as soon as possible if the order was not written by the consumer’s treating physician.” In addition, DC Code § 7-1231.09(d)(4) states that, “any use of seclusion shall be ended at the earliest possible time.”

<sup>36</sup> 42 C.F.R. § 482.13 (e) states, “All patients have the right to be free from physical or mental abuse, and corporal punishment. [...] Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.” In addition, 42 C.F.R. §

to the consumer or others, and only when less restrictive interventions have been considered and determined to be ineffective to prevent serious injury. Critically, both D.C. law<sup>37</sup> and CMS regulations<sup>38</sup> require that seclusion end at the earliest possible time.<sup>39</sup> However, the 2018 Policy and the step-down plans written pursuant to the 2018 Policy allow for seclusion regardless of the patient's current behavior, including periods of time when the patient is calm and not dangerous. Also, D.C. law requires that the hospital collect and analyze seclusion and restraint data to reduce the occurrence of emergency situations that precipitate the use of seclusion and restraint and to ensure its safety when used.<sup>40</sup> Because the hospital does not consider the use of the room to be seclusion, and it does not track its use; the 2018 Policy has no tracking and trending requirement. D.C. law and CMS regulations have numerous other staff requirements that provide critical protections for the patients that the 2018 Policy does not require.<sup>41</sup>

Moreover, the use of solitary confinement is particularly disturbing.<sup>42</sup> Secluding individuals in solitary confinement can be harmful to an individual's mental health and has been

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483.358(e)(1) states "each order for restraint or seclusion must be: limited to no longer than the duration of the emergency safety situation [...]".

<sup>37</sup> D.C. Code § 7-1231.09(d)(4) states that, "any use of seclusion shall be ended at the earliest possible time." *See also* D.C. Code § 7-1231.09(g) ("No use of seclusion or restraint may extend beyond a 24-hour period."). *See* 42 C.F.R. § 483.358(e).

<sup>38</sup> 42 C.F.R. § 483.358(e) states, "Each order for restraint or seclusion must: 1) be limited to no longer than the duration of the emergency safety; and 2) Under no circumstances exceed 4 hours for residents ages 18 to 21 [...]". *See also* 42 C.F.R. § 482.13(e)(9) ("Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.") *See also* CMS Interpretive Guideline. The Interpretive Guidelines for 42 C.F.R. § 482.13(e)(9), at 118. ("Restraint or seclusion may only be employed while the unsafe situation continues. Once the unsafe situation ends, the use of restraint or seclusion must be discontinued.") <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf>

<sup>39</sup> This obligation was understood and acknowledged by St. Elizabeth's staff. As noted in the introduction, during the DRDC inspection of Unit 1D, the charge nurse stated that if the hospital considered placing patients in "safety suites" to be seclusion, the patients would have to be released "when they calmed down."

<sup>40</sup> D.C. Code § 7-1231.09(j)(4).

<sup>41</sup> For example, D.C. law requires that an attending physician write an order for seclusion and the length of the physician's original order cannot exceed twenty-hours. D.C. Code § 7-1231.09(c)(3). *See also* D.C. Code § 7-1231.09(g). CMS regulations also require a physician or other licensed practitioner to write orders for seclusion. 42 C.F.R. § 482.13(e)(5). *See Also* CMS Interpretive Guideline. The Interpretive Guidelines for 42 C.F.R. § 482.13(e)(5), at 109. ("The regulation requires that a physician or other LIP (licensed independent practitioner) responsible for the care of the patient to order restraint or seclusion prior to the application of restraint or seclusion.") <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf>. The Policy does not require a physician's written order, which is required by D.C. law. D.C. Code § 7-1231.09(c)(3). Unlike D.C. law, SEH's policy does not include post-seclusion plan that involves the patient and his family. D.C. Code § 7-1231.09(j)(3). Moreover, the Policy does not require that a physician see the patient within one hour of the seclusion and decide if there is a need for continued seclusion as required by D.C. law. D.C. Code § 7-1231.09(f). *See also* 42 C.F.R. § 482.13(e)(12)(ii)(D). Under the Policy, the determination of when to terminate the seclusion is based on the step-down plan criteria and the management of the patient's stay is the responsibility of the home unit's nursing staff, noting that "the nursing protocol for the management of an individual's stay in Safety Suite is the responsibility of the home unit's nursing staff and is implemented in conjunction with the Safety Department." SEH Policy 103.03(IV)(B)(3)(b)(iv).

<sup>42</sup> According to the National Commission on Correction Health Care, solitary confinement is defined as "the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals...an individual who is deprived of meaningful contact with others is considered to be in solitary confinement." The Commission also notes that "Many national and international organizations have recognized prolonged solitary confinement as cruel, inhumane, and degrading treatment, and harmful to an individual's health." <https://www.ncchc.org/solitary-confinement>.

shown to both exacerbate preexisting mental illnesses and create new mental illness in individuals who had previously not had one.<sup>43</sup> According to an article published in the Journal of American Academy of Psychiatry and the Law, “The adverse effects of solitary confinement are especially significant for persons with serious mental illness, commonly defined as a major mental disorder (e.g., schizophrenia, bipolar disorder, major depressive disorder) that is usually characterized by psychotic symptoms and/or significant functional impairments. The stress, lack of meaningful social contact, and unstructured days can exacerbate symptoms of illness or provoke recurrence.”<sup>44</sup> A collaborative study between Yale and the Association of State Correctional Administrators stated, “a consensus has emerged that individuals identified as having serious mental illness should not be placed into restrictive housing.”<sup>45</sup> Moreover, the American Correctional Association’s Standards state that a correctional facility should not place a person with serious mental illness in “Extended Restrictive Housing.”<sup>46</sup>

In sum, when the Hospital locks patients in the solitary confinement seclusion room, they are not only violating CMS regulations and D.C. law that provide critical protections, they are harming the patients. It is inconceivable that the hospital developed a policy that allows such a practice, and equally disturbing that the hospital ignored D.C. law and CMS regulations and relied on a misinterpretation of a D.C. regulation to lock patients in solitary confinement seclusion rooms. The Hospital must immediately and permanently stop the use of solitary confinement seclusion room.

#### **IV. The Hospital’s Policy Allowing for the use of Zoning for Behavioral Reasons Violates D.C. Law and Federal Regulations.**

The 2018 Policy also allows for hospital staff to seclude patients by restricting them to “a safe section” of the unit, which the policy refers to as “zoning.”<sup>47</sup> “Zoning” is described as a “special level of observation that manages an individual in care within a particular area of the unit.”<sup>48</sup> According to the policy, staff can restrict a patient to a “zoned” area when their behavior

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<sup>43</sup> Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol’y, 325, 333 (2006) (quoting “I have observed that, for many of the inmates so housed, incarceration in solitary caused either severe exacerbation or recurrence of preexisting illness, or the appearance of an acute mental illness in individuals who had previously been free of any such illness”).

<sup>44</sup> Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. Am. Acad. Psychiatry Law, 104-5 (2010). <http://jaapl.org/content/jaapl/38/1/104.full.pdf> (citing Sasha Abramsky & Jamie Fellner, *Ill-Equipped: US Prisons and Offenders with Mental Illness*. Human Rights Watch, p. 145-68 (2003)).

<sup>45</sup> The Association of State Correctional Administrators and the Liman Center for Public Interest Law at Yale Law School. *Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell*. P. 46. (Oct. 2018). <https://www.documentcloud.org/documents/4999225-ASCA-Liman-2018-Restrictive-Housing-Revised-Sept.html>

<sup>46</sup> *Id.* at 47. Extended Restrictive Housing is defined as “housing that separates the offender from contact with the general population while restricting an offender/inmate to his/her cell for at least 22 hours per day and for more than 30 days for the safe and secure operation of the facility (quoting material from, ACA Standard 4-RH-0031, *American Correctional Association Restrictive Housing Performance Based Standards August 2016*. At 35. *See also*, at 3). <http://asca.net/pdfdocs/8.pdf>

<sup>47</sup> SEH Policy 103.03(II).

<sup>48</sup> *Id.*

is deemed a danger to themselves or others and less restrictive behavioral interventions were unsuccessful.<sup>49</sup>

Although the Policy states that “zoning does not restrict movement of the individual as a seclusion or restraint, but merely keeps the individual in a safe section of the unit wherein the individual is free to move around,”<sup>50</sup> the practice of “zoning” fits squarely in the D.C. law definition of seclusion -- “any involuntary confinement of a consumer alone in a room or *an area* from which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.”<sup>51</sup> As is the case with the use of the solitary confinement seclusion rooms, “zoning” of patients is clearly seclusion. Again, the hospital has developed a policy that wrongly exempts “zoning” as a form of seclusion, and thus deprives the patients of the protections afforded to them under D.C law and CMS regulations. For example, as previously discussed, D.C. law requires that seclusion be terminated at the earliest possible time.<sup>52</sup> However, the 2018 Policy indicates that staff can only terminate zoning when the treatment team deems the patient is no longer a risk to the unit or others based on the treatment team’s assessment and findings and has met the step-down criteria in his plan, and not based on whether or not his current behavior poses an emergency.<sup>53</sup>

The Unusual Incident Reports provided to DRDC by the hospital indicate that Patient II was placed in “zoning” in at least four incidents.<sup>54</sup> Significantly, the use of zoning was not reported as seclusion in the UIs so the Hospital does not appear to be collecting data on its use in order to improve safety, as required by law.<sup>55</sup> During each incident, SEH staff placed Patient II in a designated zone area on his unit. (The zoning area was not described in Patient II’s UIs.) In each incident, if Patient II left the zoning area, staff placed him in the unit seclusion room. In one incident, staff placed him in the seclusion room because “he kept jumping back and forth across the line and was not receptive to staff directive.”<sup>56</sup> In another incident, Patient II left the zoning area which led to a verbal altercation with a staff member. According to the incident report, after the verbal altercation, he was “given the opportunity to walk to the seclusion room.”<sup>57</sup> Patient II ignored the staff member’s directive, which led to staff placing Patient II in a physical hold and moving him to the seclusion room.<sup>58</sup> Staff not only illegally secluded Patient II in the “zoning area,” staff used the threat of seclusion, and further seclusion as punishment for not complying with the terms of his “zoning” step-down plan-- both strictly prohibited by D.C.

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<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> D.C. Code §7-1231.02 (24) (emphasis added).

<sup>52</sup> D.C. Code § 7-1231.09(d)(4).

<sup>53</sup> SEH Policy 103.03(IV)(B)(2)(c).

<sup>54</sup> UI DB #23552, dated January 2, 2018; UI DB #23746, dated February 9, 2018; UI DB #23777, dated February 14, 2018; and UI DB #23843, dated February 23, 2018.

<sup>55</sup> D.C. Code § 7-1231.09(j)(4).

<sup>56</sup> UI DB #23746, dated February 9, 2018.

<sup>57</sup> UI DB #23843, dated February 23, 2018.

<sup>58</sup> While he was being moved to the seclusion room, Patient II kicked and resisted while the staff attempted to place Patient II in a physical hold. UI DB #23843, dated February 23, 2018.

law.<sup>59</sup> Moreover, consumers subject to “zoning” do not receive the many other protections required by law.<sup>60</sup>

## V. The Hospital’s 2018 Policy Allowing for the Use of Flex Cuffs Violates D.C. Law and Federal Regulations.

Under the 2018 Policy, SEH allows for the use of “flex cuffs”<sup>61</sup> when moving an individual “posing a serious risk of harm to self or others” to the restraint room, seclusion room, or the safety suite.<sup>62</sup> It further authorizes the use of flex cuffs when moving an individual out of the safety suite prior to meeting the consumer’s plan step-down criteria.<sup>63</sup>

Although the 2018 Policy does not define “flex cuffs,” below is a picture of a common form of plastic flex cuffs. DRDC has recently observed security staff carrying this type of plastic flex cuff.



*Picture of flex cuffs from the Internet.*

The use of flex cuffs falls squarely within the CMS regulations and D.C. Code definition of restraint.<sup>64</sup> Flex cuffs are clearly a device that immobilizes or reduces the ability of a patient to move his or her arms.<sup>65</sup> When staff place a flex cuff around the wrist of a patient, the ability

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<sup>59</sup> D.C. Code § 7-1231.09(a) states “Consumers have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff.”

<sup>60</sup> *Supra* (See footnotes 34 to 38).

<sup>61</sup> The policy does not define flex cuffs. However, the dictionary definition of flex cuffs is “a plastic strip that can be fastened as a **restraint** around a person's wrists or ankle.” <https://www.merriam-webster.com/dictionary/flex-cuff>. DRDC staff has observed plastic handcuffs attached to security personal’s belts.

<sup>62</sup> SEH Policy 103.03(IV)(A)(1).

<sup>63</sup> *Id.*

<sup>64</sup> D.C. Code § 7-1231.02(23). *See also* 42 CFR § 482.13(e)(1)(i).

<sup>65</sup> 42 CFR § 482.13(e)(1)(i)(A). “A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.”

of the patient to use his or her arms is reduced. In addition, a flex cuff is not “easily removable,” as they cannot be removed by a patient.<sup>66</sup>

In its email response to our request for records, the Hospital noted that it had not used flex cuffs.<sup>67</sup> However, the use of flex cuffs is referenced in both the unusual incident reports and step-down plans. For example, Patient I was handcuffed and moved to a seclusion room because a maintenance worker had to fix the security suite’s lock.<sup>68</sup> Alarming, Patient IV’s step-down plan required Patient IV to be shackled for two days and demonstrate an increased ability to follow directives.<sup>69</sup>

D.C. regulations prohibit the use of handcuffs and shackles, stating that, “Restraints or seclusion shall never take *the form of* pepper spray, mace, *handcuffs*, or electronic devices . . . .”<sup>70</sup> Flex cuffs and shackles are a type of handcuff and, therefore, their use is prohibited. D.C. regulations also prohibit the use of restraints “which allow the consumer to walk around while restrained, such as wristlets or anklets.”<sup>71</sup> Furthermore, the use of flex cuffs and shackles do not fall within the allowed methods of restraint that may be prescribed in an emergency.<sup>72</sup> Moreover, D.C. regulations strictly prohibit the use of unofficial restraints or seclusion, thus the Hospital’s use of flex cuffs and shackles is prohibited.<sup>73</sup>

## VI. Conclusion

St. Elizabeths hospital is not a prison. It is a psychiatric facility responsible for providing treatment to the patients entrusted to its care. According to their own website, the mission of the hospital is to provide “a healing environment with dedicated and committed people who provide high quality care that supports recovery and treatment.” Its “staff are committed to making sure

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<sup>66</sup> CMS Interpretive Guidelines for 42 C.F.R. § 482.13(e)(1)(i)(C), at 101. A device is considered a restraint if it is not, “easily removeable” meaning that “the manual method, device, material, or equipment can be removed intentionally by the patient in the same manner as it was applied by the staff.” <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf>

<sup>67</sup> Email from Andrea Procaccino, Staff Attorney at DRDC, to Lauren Hnatowski, Assistant Gen. Counsel to St. Elizabeths Hospital, (Aug. 20, 2018, 5:34pm) (on file with author) (quoting “At this time, the Hospital has not needed to utilize flex cuffs”).

<sup>68</sup> UI DB ##24116, dated April 6, 2018.

<sup>69</sup> Patient IV’s Step-Down Plan from the Security Suite. (Attached to Clinical Consultation Meeting, Feb. 23, 2017). Under Phase 5, Patient IV must demonstrate his return to the milieu by “maintaining the standards of Phases 1-4 and demonstrating increased ability to follow directives by maintain the standards of Phases 1-3 and demonstrating increased ability to follow directives as demonstrated by four consecutive days of (**two days in shackles** and two days out of shackles): not attempting to talk to any IICs during, not going outside of the zoned area, and not engaging in “negotiating” behaviors in which he requests to stay longer than the 30 minutes or go somewhere outside of the zoned area.”

<sup>70</sup> D.C. Mun. Reg. 22-A § 501.7(c) states that, “Restraints or seclusion shall never take the form of pepper spray, mace, *handcuffs*, or electronic devices [...]” (emphasis added).

<sup>71</sup> D.C. Mun. Reg. 22-A § 505.1(b).

<sup>72</sup> D.C. Mun. Reg. 22-A § 503.2 states that, “Methods that may be prescribed in an emergency for consumers receiving services from an MH provider identified in § 500.7 of this chapter include: Four-point restraints; Five-point restraints; Physical Holds; Legally mandated restraints; Medical restraints; and Drugs used as a restraint.”

<sup>73</sup> D.C. Mun. Reg. 22-A § 505.1(i) states that, “In employing restraints and seclusion, the following measures are strictly prohibited: [...] The use of unofficial restraints or seclusion, which includes any restraint or seclusion applied without the written authorization of the attending physician or physician assistant.”

that each person who comes through (its) doors is treated with respect, dignity, [...] and is empowered to be an active partner in recovery.”<sup>74</sup>

The hospital cannot disregard well established CMS regulations and D.C. laws and illegally seclude and restrain patients. Locking patients in a solitary confinement seclusion room is not only illegal, it is traumatic and damaging to a patient’s recovery. Placing patients in flex cuffs and shackles is equally harmful.

Even if the Hospital were to treat these practices as seclusion and restraint, and, thus follow the strict requirement of federal and District law, the hospital should not use the solitary confinement seclusion room under any circumstances. All the wards at the hospital have seclusion rooms. It should never be necessary to expose any patient to a prison-like solitary confinement room. Furthermore, flex cuffs, a form of handcuffs, and shackles are strictly prohibited by D.C regulations and should also never be used. Finally, if “zoning” is to be used, the hospital must consider it a form of seclusion and follow all the legal requirements for seclusion.

## **VII. Recommendations**

- 1) St. Elizabeths hospital immediately rescind the 2018 Policy. The hospital should stop the use of the “safety suite” and flex cuffs described in the 2018 Policy and stop the use of shackles.
- 2) The Department of Behavioral Health in conjunction with the Department of Health, should investigate the hospital’s use of the “safety suite,” “zoning” and the use of flex cuffs and shackles.
- 3) If the Hospital continues the use of “zoning,” they must consider it a form of restraint and abide by all federal regulations and D.C. laws and regulations governing seclusion.

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<sup>74</sup> Description of Saint Elizabeths Hospital, <https://dbh.dc.gov/page/saint-elizabeths-hospital> (last visited Dec. 21, 2018).