REPORT OF THE VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Seclusion and Restraint Practices (Chapter 795, 2024)

TO THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 4

COMMONWEALTH OF VIRGINIA
RICHMOND
2026

COMMONWEALTH of VIRGINIA

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January 16, 2026

To: The Honorable Glenn A. Youngkin, Governor of Virginia
The Honorable Winsome Earle-Sears, Lieutenant Governor of Virginia
The Honorable L. Louise Lucas, President pro tempore, Virginia Senate
The Honorable Don Scott, Speaker, Virginia House of Delegates

From: Nelson Smith, Commissioner, Department of Behavioral Health and Developmental Services

RE: Senate Bill 569, 2024

Chapter 795 of the 2024 Virginia Acts of Assembly directs the Department of Behavioral Health and Developmental Services to convene a work group to propose additional regulations to allow for the use of evidence-based and recovery-oriented seclusion and restraint practices and alternative behavior management practices that may limit or replace the use of seclusion and restraint in hospitals, residential programs, and licensed facilities. The language states:

> *§ 2. The Department shall convene a work group to propose additional regulations to allow for the use of (i) evidence-based and recovery-oriented seclusion and restraint practices and (ii) alternative behavior management practices that may limit or replace the use of seclusion and restraint in hospitals, residential programs, and licensed facilities. In developing such regulations, the work group shall (a) solicit input from experts in the field of behavioral health, persons with relevant lived experience with the Commonwealth's behavioral health system, and staff from both public and private providers; (b) review any data and other information made available by the Department regarding seclusion and restraint, serious incidents, and complaints and investigations regarding the misuse of seclusion and restraint; (c) review current regulations and training policies; (d) examine practices used in other states, best practice recommendations from the Substance Abuse and Mental Health Services Administration, and evidence-based and trauma-informed practices recommended by other national experts; (e) identify practices and approaches that safely de-escalate persons in crisis and reduce or replace the use of seclusion and restraint; and (f) identify staffing, training, and monitoring practices related to seclusion and restraint and that limit and ensure the appropriate use of seclusion and restraint. The work group shall include the Secretary of Health and Human Resources or his designee; the Commissioner of Behavioral Health and Developmental Services or his designee; staff*

from public and private facilities, including frontline workers with treatment experience; at least three mental health consumers; representatives of the disAbility Law Center of Virginia; representatives of the Institute of Law, Psychiatry, and Public Policy at the University of Virginia; staff representatives of community services boards; at least one member of the House of Delegates, to be appointed by the Speaker of the House of Delegates; and at least one member of the Senate, to be appointed by the Senate Committee on Rules. The Department may seek assistance from faculty and students of institutions of higher education in the Commonwealth and, subject to the availability of funding, may contract with a third-party expert to lead and advise the work group. The Department shall submit a report of its findings, recommendations, and proposed regulations to the General Assembly by November 1, 2025.

In accordance with this item, please find enclosed the report for 2024 Senate Bill 569. Staff are available should you wish to discuss this request.

CC: Janet V. Kelly, Secretary of Health and Human Resources

SB569 Seclusion and Restraint Practices Workgroup Report

(Chapter 795, 2024 Virginia Acts of Assembly)

December 1, 2025

DBHDS Vision: A Life of Possibilities for All Virginians

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SB569 Workgroup Report

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Executive Summary

Senate Bill 569 (2024) directed the Department of Behavioral Health and Developmental Services (DBHDS) to convene a workgroup to propose additional regulations allowing for (i) evidence-based and recovery-oriented seclusion and restraint practices and (ii) alternative behavior management practices that may limit or replace the use of seclusion and restraint in hospitals, residential programs, and licensed facilities. This report provides the General Assembly with DBHDS and workgroup recommendations and consultant research findings.

Virginia has an opportunity to lead the nation in reducing seclusion and restraint use in behavioral health and developmental disability services. Research demonstrates that comprehensive, coordinated efforts can successfully limit seclusion and restraint to true emergency situations. The Commonwealth can implement these proven strategies through the recommendations outlined in this report. This work occurs within a uniquely challenging operational environment shaped by Virginia's robust human-rights protections and statutory requirements such as "Bed of Last Resort," both of which influence how frequently restrictive interventions must be reported and where individuals with the highest acuity are served.

Importantly, Virginia's long-standing human rights regulations and broad reporting requirements set a higher standard for transparency than many states, shaping how data in this report should be interpreted.

The Evidence Base for Transformation

Centers for Medicare and Medicaid Services (CMS) data released April 2025, which reflects calendar year 2023, demonstrates that Virginia's inpatient psychiatric hospitals (public and private) rank 5th highest in utilization among all 50 states, D.C., and Puerto Rico for physical restraint use at 0.90 per 1,000 hours – three times the national average of 0.30 per 1,000 hours. Virginia ranks 14th highest for seclusion use at 0.45 per 1,000 hours – 1.3 times the national average of 0.36 per 1,000 hours. It is important to note that Virginia's human-rights and regulatory framework is widely understood to require broader reporting of restrictive interventions than many other states, which can make utilization rates appear higher even when practice patterns are similar.

While these disparities demand action regardless of measurement considerations, direct state comparisons may be misleading because state regulatory frameworks create conflicts that influence provider interpretation and reporting practices even within federally regulated settings. Analysis reveals significant definitional variations across states that can affect reported rates. Virginia's definitional framework captures a broader scope of restrictive interventions as reportable incidents, while other states use various exclusions that may reduce their reported rates. Another factor to consider is that states may divert patients to criminal justice systems rather than treating them in psychiatric facilities. These practices and definitional differences make direct state comparisons potentially misleading, as "better performing" states may simply be avoiding reporting restraint use rather than avoiding restraint use itself or using a narrower scope of restrictive interventions as reportable incidents.

The legal framework of "Bed of Last Resort"[1] is also unique to Virginia and should be considered when making cross state comparisons of use of seclusion and restraint in state operated facilities. Under Bed of Last Resort, state hospitals are required to admit individuals under a temporary detention order (TDO) for whom no private bed could be located during the emergency custody order (ECO) period. Within five years of passage in FY 2014, Civil TDO admissions to state hospitals had risen by almost 400 percent. This increased demand for services has created hospital census pressures that have had significant impacts on the state hospital system's ability to maintain a safe therapeutic environment and adequate staffing levels.

When viewed together, Virginia's broader definitions, stronger human-rights safeguards, and statutory admissions mandate create structural conditions that elevate reported rates even as they strengthen individual protections and transparency. Acknowledging these differences, the evidence base remains a tool to understand the overarching landscape in which public and private facilities in Virginia implement restrictive interventions.

NOTE: For community-based settings, incident data for individuals receiving behavioral health, mental health, intellectual disability, and developmental disability (BH/MH/IDD) services is nationally systematically unavailable to the public for benchmarking, unlike hospital settings which have federal reporting requirements.

The Solution Framework

Through intensive stakeholder engagement, the Senate Bill 569 Workgroup achieved consensus on recommending implementation of[2] the Six Core Strategies for Reducing Seclusion and Restraint Use (6CS), a nationally recognized, evidence-based framework developed by the National Association of State Mental Health Program Directors (NASMHPD). Through the 6CS framework, Virginia can establish clear 'No Force First' messaging that positions the use of seclusion and restraint, except in true emergencies, as system failure requiring prevention strategies. The framework accomplishes this transformation through six core strategies:

1. Leadership Toward Organizational Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of Restraint/Seclusion Prevention Tools
5. Involving People Who Are Receiving Services
6. Debriefing Techniques

Implementation Roadmap and Resource Requirements

Immediate actions requiring minimal financial resources can create a system-wide foundation for transformation and include establishing a unified philosophy of care system-wide, reaching consensus on key definitions and embedding 6CS principles, leveraging existing infrastructure to create communities of practice and peer learning opportunities. Additionally, there is a need to increase the community provider reporting rate, currently at 70 percent, for seclusion and

[1] 2014 Virginia Acts of Assembly Chapter 691

[2] Several workgroup members noted the importance of DBHDS gathering additional input on how 6CS will be implemented.

restraint incidents that represents a fundamental system reliability problem requiring implementation of enforcement mechanisms.

Longer-term actions with significant fiscal impact include workforce development, data system improvements, and training standardization.

Virginia's approach should strive to prioritize resourced implementation providing training and technical assistance, infrastructure support, and phased implementation with adequate provider support and engagement of diverse stakeholders to ensure successful adoption across settings.

The Bottom Line
Virginia has the evidence, stakeholder consensus, and agency commitment necessary for transformational change. Other leading states have proven that reducing and eliminating seclusion and restraint enhances rather than compromises safety while reducing costs and improving therapeutic outcomes. Embedding evidence-based, trauma-informed practices in permanent regulatory frameworks, would position the Commonwealth as a national leader in behavioral health transformation. With clearer definitions, strengthened data systems, and reforms that reflect Virginia’s unique statutory and human-rights context, the Commonwealth can make meaningful progress toward reducing reliance on restrictive interventions across all settings.

This report provides an overview of Virginia's seclusion and restraint performance compared to national benchmarks, presents the Senate Bill 569 Workgroup's consensus recommendations organized within the Six Core Strategies framework, and outlines implementation priorities for transforming Virginia's behavioral health and developmental disabilities system to prioritize prevention over restrictive interventions.

Introduction

Virginia is at a defining crossroads in its approach to behavioral health and developmental disabilities services. While the Commonwealth has an established commitment to recovery-oriented and trauma-informed principles, there remains a demonstrated need to strengthen implementation of these approaches in reducing seclusion and restraint. States across the nation are achieving measurable reductions in these interventions while improving safety and outcomes. Virginia can enhance existing trauma-informed frameworks by systematically implementing and enforcing evidence-based strategies that operationalize the Commonwealth's values of prevention, dignity, and recovery.

Background and Context
Senate Bill 569 (2024) directed the Department of Behavioral Health and Developmental Services (DBHDS) to convene a workgroup to propose additional regulations allowing for (i) evidence-based and recovery-oriented seclusion and restraint practices and (ii) alternative behavior management practices that may limit or replace the use of seclusion and restraint in

hospitals, residential programs, and licensed facilities. Pursuant to SB569, DBHDS issued a Request for Proposals (RFP) in the fall of 2024 to contract with a consultant to:

- Survey all Virginia licensed providers on restraint/seclusion regulations, policies, and training effectiveness; analyze results
- Review Virginia Restraint/Seclusion data against peer states and national averages; collaborate with National Research Institute (NRI) for inpatient analysis; evaluate data validity and reporting gaps
- Conduct national review of 8+ states' Restraint/Seclusion regulations and policies (including a Pennsylvania case study); compare with Virginia's current and draft regulations against Substance Abuse and Mental Health Services Administration (SAMHSA) best practices
- Analyze Virginia's current de-escalation training models; conduct literature review and peer state interviews; provide recommendations for alignment with national best practices
- Facilitate stakeholder workgroup meetings; provide administrative support and present research findings
- Submit comprehensive final report summarizing workgroup consensus recommendations and all analysis findings

In April 2025, Blue Octopus Consulting (BOC) was awarded this contract and collaborated with DBHDS staff to compile this final report for the General Assembly.

The Joint Legislative Audit and Review Commission's (JLARC) 2023 report documented concerning patterns across Virginia's state psychiatric hospitals. These findings are well-documented and are not restated in this report with the exception of JLARC Recommendation 26 directing DBHDS to evaluate whether alternatives to the Therapeutic Options program for patient behavior management would improve staff's ability to safely and effectively prevent and de-escalate patient aggression and minimize the use of seclusion and restraint, with instructions to replace current training if better behavior management programs are identified. This important recommendation is addressed in subsequent sections.

In July 2025, the Commonwealth Center for Children and Adolescents (CCCA) presented on their progress on addressing issues identified in the JLARC report to the Behavioral Health Commission. Actions included implementation of the UKERU® crisis intervention program offering alternatives to seclusion and restraints through trauma-informed care and prevention techniques, removal of Emergency Restraint Chairs from operational use, transition of two seclusion rooms to sensory rooms, and enhanced seclusion and restraint committee processes.

Legislative Response:
Responding to several factors impacting crisis and on-going behavioral health and developmental disabilities services in Virginia, the General Assembly passed Senate Bill 569 in 2024, establishing a dual-track approach: the legislation addressed immediate crisis service needs by permitting seclusion for crisis service providers in emergencies while simultaneously establishing a stakeholder workgroup process to examine seclusion and restraint practices across the entire continuum of care.

Track 1: Emergency Crisis Service Regulations - SB569 first directed the State Board of Behavioral Health and Developmental Services to "amend its regulations to ensure that its licensing and human rights regulations support high-quality crisis services, including by authorizing the appropriate and safe use of seclusion in crisis receiving centers and crisis stabilization units" In response, the State Board promulgated final amended regulations effective July 17, 2024.

Track 2: Comprehensive System Examination - The second component of SB569 established the broader mandate relevant to this report: directing DBHDS to convene a workgroup to "propose additional regulations to allow for the use of (i) evidence-based and recovery-oriented seclusion and restraint practices and (ii) alternative behavior management practices that may limit or replace the use of seclusion and restraint in hospitals, residential programs, and licensed facilities."

Workgroup members represented stakeholders across provider leadership, advocates, legislators, frontline staff, people with lived experience, and state agency employees (see appendix for workgroup membership list). Four workgroup sessions were conducted with opportunities for public comment at each.

Critical Scope Considerations:
SB569's comprehensive mandate encompasses diverse provider types across behavioral health and intellectual/developmental disability services, each operating under different regulatory frameworks and reporting requirements including but not limited to:

Hospitals: State psychiatric hospitals and private psychiatric facilities where both seclusion and restraint may be permitted under specific circumstances

Residential Programs: Group homes, residential treatment facilities, and settings with varying levels of restrictive practice authorization

I/DD Service Providers: Many intellectual and developmental disability providers operate under existing prohibitions against seclusion use, focusing primarily on restraint reduction and positive behavior support approaches

Crisis Services: The newly regulated crisis receiving centers and crisis stabilization units where emergency interventions may be necessary

State hospitals already operate under extensive oversight with robust data reporting, training requirements, and quality standards through Joint Commission accreditation and Centers for Medicare and Medicaid (CMS) compliance frameworks. These facilities have comprehensive systems for incident reporting, staff training documentation, and outcome monitoring that exceed baseline regulatory requirements for licensed community providers.

The slate of recommendations and considerations acknowledge this tiered implementation reality: state facilities can leverage their existing robust oversight infrastructure to advance culture change initiatives, while community providers may require enhanced regulations,

particularly around training frequency and data reporting standards, to achieve comparable prevention-focused outcomes.

Purpose of Report

This report provides the General Assembly with DBHDS and workgroup recommendations and Blue Octopus Consulting's (BOC) research findings. The central focus is evidence-based strategies to achieve systematic culture change that prioritizes safety for both staff and people receiving services while consistently reducing reliance on seclusion and restraint. The primary goal is to transform organizational cultures so that prevention becomes the default approach and any use of restraint or seclusion beyond emergency and imminently dangerous situations is recognized as treatment failure.

Recognizing that Virginia's behavioral health system faces significant resource constraints, this report identifies both low-cost, high-impact interventions and strategic investments that enhance safety through better training, transparent data sharing, and collaborative oversight. The analysis demonstrates that sustainable change requires an intentional shift from punitive compliance to learning-focused partnerships between DBHDS and providers.

Through eight-state comparative analysis, a provider survey, stakeholder interviews, and workgroup facilitation, this report delivers consensus recommendations and expert guidance for embedding evidence-based practices that build staff confidence, enhance safety, and create accountable yet supportive systems that operationalize Virginia's trauma-informed values.

Methodology

Research Approach

Blue Octopus Consulting (BOC) employed multiple research methods to examine Virginia's seclusion and restraint practices and identify evidence-based improvement strategies. The study included systematic comparative analysis across eight benchmark states, comprehensive stakeholder engagement within Virginia, quantitative data analysis, extensive literature review, and four workgroup sessions[3] to develop consensus recommendations.

Data Collection

Virginia Provider Survey: In 2024, Virginia operated 5,021 licensed services delivered by 2,187 providers. A 31-question anonymous survey administered to all licensed providers and state facilities in May 2025. Of 1,042 respondents who initiated the survey, 611 qualified respondents from organizations that permit seclusion and restraint completed the survey. The survey utilized role-based question routing providing targeted questions for Directors/Owners (37 percent), Supervisors/Managers (29 percent), and Direct Support Professionals (34 percent) across all service settings.

[3] One workgroup session was facilitated by DBHDS staff in 2024.

Eight-State Comparative Analysis: States were selected based on DBHDS specifications and demonstration of exemplary practices: Pennsylvania (deep-dive case study), New York, Colorado, Arizona, Missouri, Ohio, Maine, and Massachusetts. Analysis included regulations, policies, publicly available data, and structured stakeholder interviews using a standardized 12-question protocol.

Stakeholder Engagement: Confidential interviews were conducted with Virginia stakeholders including state hospital staff, community providers, crisis services, and individuals with lived experience. Four workgroup sessions were facilitated as platforms for information sharing and consensus development among diverse stakeholders.

National Benchmark Data: Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facility Quality Measure Data (pulled April 2025 representing CY2023 data – lagged release, most recent available in April 2025) – federal reporting; state-level comparisons; inpatient only; National Research Institute (NRI) Data (Q2 2023–Q2 2025) – inpatient only; demographic and facility-level metrics. NRI includes data from inpatient psychiatric facilities that contract directly with NRI. Participating facilities include a mix of state-operated hospitals, state facilities managed by private companies, and a small number of privately operated inpatient psychiatric hospitals that elect to contribute data directly or via CMS and Joint Commission reporting. Per the NRI, for the specific restraint and seclusion measures used in this report, the NRI comparison group is overwhelmingly composed of state-operated facilities (approximately 95–97 percent). Limitations: Scope Gap – No systematic community provider incident data for BH/MH/IDD; no federal reporting requirements for community settings → no consistent benchmarking with inpatient. Transparency Issues – Only Ohio and Pennsylvania provided meaningful community data; all other states denied requests, request is pending, or the cost was significant. Access Restrictions – NRI unable to release some benchmark state datasets due to privacy rules and data agreements. Comparability Challenges – Definitions of "seclusion" and "restraint" vary by source and state; not aligned with VA regulations. True 'apples-to-apples' comparisons are limited. Incomplete Dataset Coverage – Facility mix in NRI data complicates interpretation (state, private).

Analysis Methods

Quantitative data analysis employed descriptive statistics to compare Virginia's performance against national and peer state benchmarks.

Comprehensive Data Analysis: National and Virginia data analysis incorporated CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) data, National Research Institute (NRI) comparative analysis, DBHDS licensing and incident reporting data, and Office of Human Rights investigations and trends.

BOC developed a structured Comparative Analysis Workbook using a standardized data extraction tool to enable side-by-side comparison of Virginia's performance against eight peer states selected for geographic diversity, data availability, and relevance to Virginia's system. The workbook consolidated multiple state data sources (NRI, CMS, state agency portals, published research) into standardized format organized by measure type (core seclusion/restraint metrics,

demographics, facility characteristics, system context) with annotations documenting sources, definitions, and caveats for transparency and reproducibility. Key data components included restraint and seclusion hours and rates, demographic variance analysis (age, gender, race/ethnicity), and facility/system capacity metrics (hospital size, workforce shortages). A separate Demographics Data worksheet captured NRI Behavioral Healthcare Performance Measurement System (BHPMS) data comparing Virginia's rates to national aggregate participating organizations. Eight-state comparative analysis examined legislative and regulatory approaches across Pennsylvania, Massachusetts, Ohio, New York, Colorado, Arizona, Maine, and Missouri, with in-depth Pennsylvania case study analyzing alignment with SAMHSA best practices.

Data Source Notes:

- CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program: Calendar Year 2023 data, publicly released April 2025 (lagged release-most recent data available from CMS in April 2025). Includes state-level restraint and seclusion rates for all reporting psychiatric facilities. National benchmarks are volume-weighted averages calculated by CMS by summing all facility numerators and dividing by the sum of all facility denominators, expressed per 1,000 inpatient hours. Weighted national restraint rate (HBIPS-2): 0.30 hours per 1,000 inpatient hours. Weighted national seclusion rate (HBIPS-3): 0.36 hours per 1,000 inpatient hours. State rankings were determined by ordering all 52 reporting jurisdictions by their rates.

- NRI Benchmarking Data: Quarterly restraint and seclusion data from Q2 2023 through Q2 2025. The NRI dataset includes inpatient psychiatric facilities that contract directly with NRI. Participating facilities include a mix of state-operated hospitals, state facilities managed by private companies, and a small number of privately operated inpatient psychiatric hospitals that elect to contribute data directly or via CMS and Joint Commission reporting. Per the NRI, for the specific restraint and seclusion measures used in this report, the NRI comparison group is overwhelmingly composed of state-operated facilities (approximately 95–97 percent). The Virginia NRI data reflect only state-operated facilities reported through DBHDS. Data were stratified by patient demographics including age, race/ethnicity, gender, length of stay, admission legal status, and facility size.
    - *Quarterly vs. Averaged Data Approach:* NRI data can be analyzed either as multi-quarter averages or as single-quarter snapshots. Averaging across multiple quarters smooths quarterly variation and provides a long-term trend perspective. Using the most recent quarter (as done in this report) provides a current-state view of performance and highlights recent conditions in Virginia’s facilities. Both approaches are valid and complementary; the averaged view captures general patterns, while the single-quarter analysis shows the most up-to-date status.

- Virginia's performance was compared to national weighted averages (CMS) and peer facility benchmarks (NRI). Disparity analysis examined differences in restrictive practice use across demographic groups to identify equity concerns.

- Because Pennsylvania was selected as a high-performance benchmark state, the analysis also reviewed the *Pennsylvania State Hospital Risk Management Summary and Indicator Report (January 2025)* to examine state hospital performance separately from the CMS statewide aggregate, which includes both private and general hospital psychiatric units. For the full reporting year (February 2024–January 2025), Pennsylvania's state hospitals reported 22.57 hours of restraint use across 545,004 patient days, equivalent to 0.04 hours of restraint per 1,000 patient days. The report also documented zero instances of seclusion since July 2013, indicating sustained elimination of this practice across all state hospitals.[6]

- Provider survey data was analyzed using frequency distributions and cross-tabulations by respondent role (Directors/Owners, Supervisors/Managers, Direct Support Professionals) to identify implementation barriers and training gaps. Qualitative survey responses were coded thematically to identify recurring patterns across ten major themes presented in findings.

- Qualitative data from stakeholder interviews underwent thematic analysis to identify implementation barriers, cultural challenges, and recommendation priorities. Interview findings were triangulated with survey data and comparative state analysis to validate themes and inform recommendations.

Key Limitations

Insufficient Input from People Receiving Services: Despite comprehensive efforts to engage individuals through multiple channels, qualitative data collected through interviews overrepresents providers and state agency employees relative to people with direct experience receiving these interventions and with lived experience of seclusion and restraint

Data Transparency Barriers: Most comparison states declined data sharing requests for community settings. Only Ohio and Pennsylvania provided meaningful community data, limiting comprehensive cross-state analysis. National Research Institute contractual agreements prevented access to some benchmark state datasets. The absence of federal data standardization across both inpatient facilities and community providers, lack of transparency requirements that would enable states to learn from each other's successes and failures, and fragmented reporting systems that prevent comprehensive analysis of what interventions actually work to reduce restrictive practices is a significant issue. These barriers leave states operating without the benefit of collective knowledge about effective transformation approaches. This data collection experience underscores the need for standardized definitions and transparent reporting frameworks across the country, reinforcing Virginia's opportunity for leadership in systematic data sharing and accountability.

Definitional and Reporting Inconsistencies: Differing state definitions of seclusion and restraint, potential incident diversion to criminal justice systems, and extreme state variations could suggest reporting inconsistencies rather than practice differences in some instances. States vary dramatically in seclusion and restraint definitions and reporting practices. Virginia's 70 percent provider reporting rate may indicate more complete reporting compared to states with greater

underreporting. The extreme variations observed between states (up to 90x differences) suggest definitional inconsistencies rather than purely practice differences.

Special Populations: This analysis does not address how seclusion and restraint practices specifically affect specialized populations with unique communication, sensory, or cognitive needs. Key populations not examined include individuals who are Deaf or Hard of Hearing, those with traumatic brain injury, autism spectrum disorders, limited English proficiency, or complex medical conditions that may affect mobility or cognitive processing. These populations may experience disproportionate impacts from restrictive interventions due to communication barriers, sensory sensitivities, or specialized care requirements that standard de-escalation approaches may not address effectively. Future analysis should include targeted data collection and policy development for these vulnerable groups to ensure equitable and appropriate care across all populations served.

Workgroup Representation: Including legislatively mandated stakeholders and encouraging community participation while holding the workgroup to a functional size created an ongoing challenge for ensuring diverse perspectives were consistently represented throughout the process. Stakeholder workgroups overrepresented provider perspectives relative to people receiving services, family members, and advocacy organizations, influencing recommendation priorities.

Findings

Research findings of Blue Octopus Consulting (BOC) demonstrate Virginia's seclusion and restraint challenges across multiple data sources and stakeholder perspectives. The following section examines provider experiences, performance data, research, and peer state comparisons to establish both the scope of current problems and the foundation for evidence-based solutions.

Literature Review

Blue Octopus Consulting (BOC) conducted a systematic literature review of 50 sources (2005-2024) examining evidence-based practices for seclusion and restraint reduction across healthcare, behavioral health, and developmental disability settings. The review analyzed federal research, peer-reviewed studies, state implementation evaluations, and organizational case studies to identify critical success factors. Key findings consistently demonstrate trauma-informed care frameworks and Six Core Strategies implementation achieve significant reductions when supported by comprehensive organizational culture change, leadership commitment, and real-time data systems rather than isolated training interventions.

Key Highlights from Literature Review

SAMHSA Federal Validation: The most comprehensive validation of systematic approaches comes from SAMHSA's federal evaluation of the Six Core Strategies across 43 facilities in 8 states. Results demonstrated that 95 percent of facilities succeeded in implementing evidence-based strategies, with 65 percent achieving stable implementation. Among facilities with stable implementation, 71 percent reduced seclusion hours by an average of 19 percent and 54 percent reduced restraint hours by an average of 55 percent, regardless of facility characteristics including mission, specialties, security level, ownership, and size.

Training Effectiveness with Critical Limitations: Federal comparative effectiveness research reveals significant evidence gaps for common seclusion and restraint reduction training models and intervention strategies. An Agency for Healthcare Research Quality review (2016) found "extremely limited" evidence for most approaches used in acute psychiatric settings - not because interventions are ineffective, but because trauma-informed staff training, structured de-escalation curricula, risk assessment tools, and environmental modifications lack randomized controlled study designs. This creates a disconnect between formal research evidence and demonstrated practical success. Many training models and intervention strategies already implemented across Virginia - including trauma-informed culture change, team-based de-escalation training, and data-driven reduction initiatives - may not appear in literature reviews despite producing measurable outcomes. However, systematic analysis reveals that training alone produces limited sustained impact without broader organizational change. As noted in McDonnell et al. (2023), "training is often treated as a first-line response despite limited evaluation" and requires embedding within prevention strategies and leadership accountability frameworks to achieve meaningful outcomes. The evidence indicates that success depends on comprehensive, systematic implementation rather than adopting individual practices in isolation. Organizational transformation efforts consistently failed when implemented as isolated training interventions without addressing underlying structural and policy barriers - a finding that reinforces the need for Virginia's comprehensive approach rather than training-focused solutions alone.

Additionally, BOC's literature review revealed significant evidence gaps for Virginia's primary crisis intervention training program. Despite Therapeutic Options' widespread use across Virginia's behavioral health system (utilized by approximately 65 percent of survey respondents plus state psychiatric hospitals), systematic searches across multiple academic databases, government sources, and training evaluation repositories yielded minimal peer-reviewed evidence supporting its effectiveness in reducing seclusion and restraint.

On its website, Therapeutic Options describes itself as "research based" and states that it draws "extensively on the research literature from psychology, behavioral neuroscience, psychiatry, behavior analysis, education, traumatology, rehabilitation, kinesiology, and advocacy." While these references suggest a broad theoretical foundation, it was difficult to identify independent, peer-reviewed studies that directly evaluate Therapeutic Options. This lack of publicly available evidence is consistent with JLARC's Recommendation 26, for DBHDS to assess whether alternative approaches might better support staff in safely preventing and de-escalating patient aggression while minimizing seclusion and restraint. However, as previously noted, the lack of evidence basis for approaches used in acute care settings is a systemic issue. The evidence indicates that success depends on comprehensive, systematic approach rather than adopting individual practices in isolation.

Workforce Prerequisites: Research confirms the connection between workforce instability and increased restraint use. Friedman's analysis of 251 individuals with I/DD found that those experiencing direct support professional turnover had significantly more emergency room visits, abuse incidents, and injuries regardless of support needs. The Massachusetts Disability Law Center documented that "workforce staffing issues are responsible for a greater frequency of incidents of abuse and neglect and human rights violations."

Implementation Insight: Atdjian and Huckshorn's (2024) cautionary analysis demonstrates that even dramatic, sustained success over multiple years can be rapidly lost without external regulatory mandates. A Department of Justice (DOJ)-monitored facility achieved 98 percent restraint reduction by year 4, but "rose again at a devastatingly high rate and reached even higher levels than at the start" when monitoring ended and Six Core Strategies practices were discontinued, emphasizing the need for permanent regulatory embedding rather than voluntary adoption.

Lesson for Virginia: Even sustained success over multiple years can be rapidly lost without permanent regulatory frameworks and external accountability. Embedding prevention-focused approaches in regulatory requirements is important particularly as Virginia's DOJ oversight transitions to Permanent Injunction status.

Virginia Provider Survey
May 2025 Survey of DBHDS Facilities and Licensed Providers
Refer to Appendix A for detailed analysis of the provider survey

Survey Response Profile: 611 qualified respondents representing organizations that permit seclusion and restraint use, with responses from Directors/Owners (37 percent), Supervisors/Managers (29 percent), and Direct Support Professionals (34 percent) across all service
settings.

Major Themes Identified:

1. Fear-Based Organizational Culture - Impacts all roles with providers reporting staff "feeling unsafe to respond for fear of losing their jobs." This fear is reinforced by "overly punitive abuse and neglect 201 investigations leading to terminations and staff feeling unsafe to respond for fear of losing their jobs," creating a culture where some staff are paralyzed by fear of consequences rather than empowered to provide effective care. This punitive approach can undermine honest incident reporting and learning-focused improvement efforts.
2. Chronic Staffing Shortages - Creating cascading effects on training quality and safety.
3. Training Inadequacies - Insufficient training frequency identified as critical barrier.
4. Documentation Burden - Complex reporting without meaningful prevention insights.
5. Regulatory Clarity Gaps - Confusion about compliance requirements and implementation. Provider feedback revealed that "there appears to be a lot of 'interpretation' of regulation and guidance that varies between advocates from region to region and at times, within the same region. This creates confusion amongst providers." This inconsistent regulatory interpretation undermines provider confidence and creates implementation uncertainty across the system.
6. DBHDS Oversight Gaps - Systemic deficiencies in state-level guidance and support. Provider assessment identified that "there appears to be a gap in prevention strategies, emergency preparedness, and clearly defined, consistently applied expectations for all staff involved in behavioral interventions," indicating fundamental oversight failures that leave providers without adequate direction during crisis situations.

7. Prevention Culture Development - Providers recognize the potential for prevention-focused cultures to be effective but emphasize this requires genuine organizational commitment.
8. Enhanced Data Collection Needs - Focus on prevention and meaningful analysis.
9. Population Mixing Concerns - Provider feedback identified service delivery concerns about combining different populations inappropriately. It is important to remember that people may have co-occurring developmental disabilities and behavioral health challenges. However, provider responses indicated problems with service design that may allow for individuals with intellectual/developmental disabilities to be placed in behavioral health settings when not clinically appropriate or without adequate supports putting staff and people receiving services at risk.
10. Provider Implementation Support Needs - When asked what else DBHDS could do, providers consistently emphasized practical support over additional regulations: "more training, resources, and guidance/templates." This indicates providers want implementation tools, technical assistance, and practical guidance rather than more regulatory requirements.
    Specific implementation barriers were detailed by another provider: "Information needs to be clear, simple, easy to train staff about. If DBHDS is going to require 'qualified professionals' review information (which does make sense), can DBHDS provide a pool of resources for providers where staff with those credentials are available and do so without making this an unfunded mandate? Clarify overtly what types of restraints do/do not need to be included in annual report (e.g., those implemented based on a medical order)." This demonstrates the need for clear communication, resource support to meet requirements, and specific definitional clarity.

Concerning Survey Findings Requiring Immediate Attention: Provider survey responses revealed fundamental misunderstandings about appropriate seclusion and restraint use that demonstrate urgent need for comprehensive training and culture change initiatives. When asked "When is it appropriate to use seclusion?" 11.24 percent of respondents (39 individuals) indicated seclusion is appropriate "as a consequence for aggressive behavior" - representing use of seclusion as punishment rather than emergency safety intervention.

Restraint survey responses showed parallel concerning patterns: 11.13 percent of respondents (60 individuals) indicated restraint is appropriate "as a consequence for aggressive behavior," again representing punishment use that violates human rights principles. While positive findings included 95.73 percent correctly identifying "immediate risk of serious harm" and 76.81 percent recognizing "less restrictive alternatives attempted and failed" as appropriate criteria, these misconceptions about punishment use reveal a concerning gap in staff understanding of trauma-informed care principles and human rights protections that require immediate comprehensive training intervention.

The Definitional Challenge

Definitional clarity directly impacts data validity, provider compliance, training effectiveness, and ultimately the safety of both staff and individuals receiving services. Without clear, consistent definitions that distinguish between medical/safety interventions and behavioral

restraints, providers cannot effectively implement trauma-informed practices or accurately report on reduction efforts.

Cross-State Definitional Variations

BOC's eight-state analysis revealed significant definitional inconsistencies across states that create barriers to meaningful comparison and learning. Some states define restraint broadly to encompass any limitation of movement, while others create specific carve-outs for medical devices, safety equipment, and therapeutic interventions. These variations may explain the extreme disparities observed in reported restraint rates (up to 90x differences between states), suggesting definitional inconsistencies rather than purely practice differences.

Virginia's Specific Definitional Conflicts

Virginia's current definitions are also not fully aligned with CMS:

1. Threshold Language Discrepancies:
    - Virginia: "imminent risk" vs CMS: "immediate physical safety"
    - This creates ambiguity about when interventions are justified, with different urgency standards potentially leading to inconsistent application
2. Differences:
    - Virginia includes medical/protective restraints as restraint types
    - CMS excludes medical/protective measures from restraint definition
    - Other states create similar carve-outs: Pennsylvania and other benchmark states exclude medical devices, safety equipment, and protective measures from restraint definitions
    - This fundamental scope difference means Virginia providers over-report when compared to CMS and certain peer state expectations, inflating apparent restraint rates and creating misleading performance comparisons

These specific conflicts exemplify how definitional inconsistencies create practical compliance burdens for providers operating under multiple regulatory frameworks.

The National Definitional Crisis

Recent systematic review and content analysis research by Muluneh et al. (2025)[4] reveals a fundamental crisis in definitional consistency that undermines effective seclusion and restraint reduction efforts nationally. The study analyzed 95 research papers across six databases, finding that even among studies specifically focused on restrictive practices, there was no universally accepted definition for any form of restraint or seclusion. The study's comprehensive analysis found "inconsistencies in the terminologies and conceptual boundaries used to describe the constructs of different forms of restrictive care practices underscore the need to move forward in endorsing consensus definitions that reflect the diverse perspectives, ensuring clarity and consistency in practice and research."

Four Critical Dimensions of Definitional Failure across the Nation

[4] Muluneh ZB, Chavulak J, Lee DA, Petrakis M, Haines TP. Variations in definitions used for describing restrictive care practices (seclusion and restraint) in adult mental health inpatient units: a systematic review and content analysis. Soc Psychiatry Psychiatr Epidemiol. 2025 Jan;60(1):1-24.

1. Definitions Are Inconsistent Across Every Dimension

The systematic review found that variation extends beyond simple wording differences to fundamental building blocks of definitions:

- Scope of restriction: What counts as restraint (full immobilization versus partial restriction)
- Intent and outcome considerations: Whether safety versus behavior control purpose is embedded in the definition itself
- Temporal factors: Whether timing and duration are definitional elements or separate practice standards
- Patient autonomy recognition: Whether individual choice and consent are explicitly acknowledged in definitional frameworks

This multi-dimensional perspective should guide Virginia's analysis of which core elements belong in the definition itself versus which elements to regulate through separate practice standards and implementation guidance.

2. National Inconsistency Creates Invalid Data and Undermines Oversight

The research demonstrates that without uniform definitions, states and facilities cannot:

- Compare rates of seclusion and restraint across hospitals and systems accurately
- Track reduction strategies effectively or measure intervention success
- Avoid measurement bias and systematic errors that compromise quality improvement efforts

This finding validates Virginia's data collection challenges and provides compelling rationale for definitional reform: data quality and oversight effectiveness will only be as robust as the underlying definitional framework.

3. Provider Confusion and Compliance Barriers

Definitional ambiguity creates practical implementation challenges where providers face conflicting expectations across different regulatory and accreditation bodies. Staff cannot effectively implement consistent practices when fundamental terms lack clear, standardized meaning across systems.

4. Training and Culture Change Impediments

Without definitional clarity, trauma-informed training becomes ineffective as staff cannot distinguish between appropriate safety interventions and harmful behavioral restraints. Culture change initiatives fail when the behaviors being transformed are not clearly defined and consistently understood across all stakeholders.

Virginia Definitions: Gaps

Temporal Elements Missing: The Muluneh study found researchers and jurisdictions disagree about whether and how to include timing factors in the definitions of seclusion and restraint. Virginia's definitions lack:

- Minimum duration thresholds (when does a brief hold become restraint?)
- Maximum duration limits embedded in the definition

- Frequency considerations for repeated brief interventions (some states do not require instances to be reported separately if they occur within several minutes of each other, treating brief connected episodes as a single incident rather than multiple restraint events)

Terminology Variations: The general restraint definition uses "imminent risk" while "restraints for behavioral purposes" uses "emergency" and "safety issues require immediate response" - creating potential implementation confusion.

Chemical Restraint Implementation Challenges: While Virginia attempts to distinguish pharmacological restraint from standard treatment ("not a standard treatment for the individual's medical or psychiatric condition"), the research shows this remains practically difficult to implement consistently.

Internal Definitional Inconsistency: Virginia has different seclusion definitions across regulations - general licensing excludes "verbal means" while children's residential and human rights regulations include it. This exemplifies the jurisdictional variation the Muluneh study identifies as problematic.

Implications for Virginia's Transformation
Virginia's comprehensive approach must prioritize definitional standardization as a foundational element that enables all other improvement efforts. The state's current provider confusion, data quality challenges, and compliance difficulties stem partially from definitional inconsistencies that undermine systematic transformation efforts.

Virginia Performance Data Analysis
As discussed in the previous section, there are significant limitations to cross state comparisons of rates of utilization of seclusion and restraint due to significant variation in definitions and reporting requirements. This analysis synthesizes findings from available national benchmarking, demographic equity analysis, system capacity assessment, and data quality evaluation and should be reviewed with those limitations in mind.

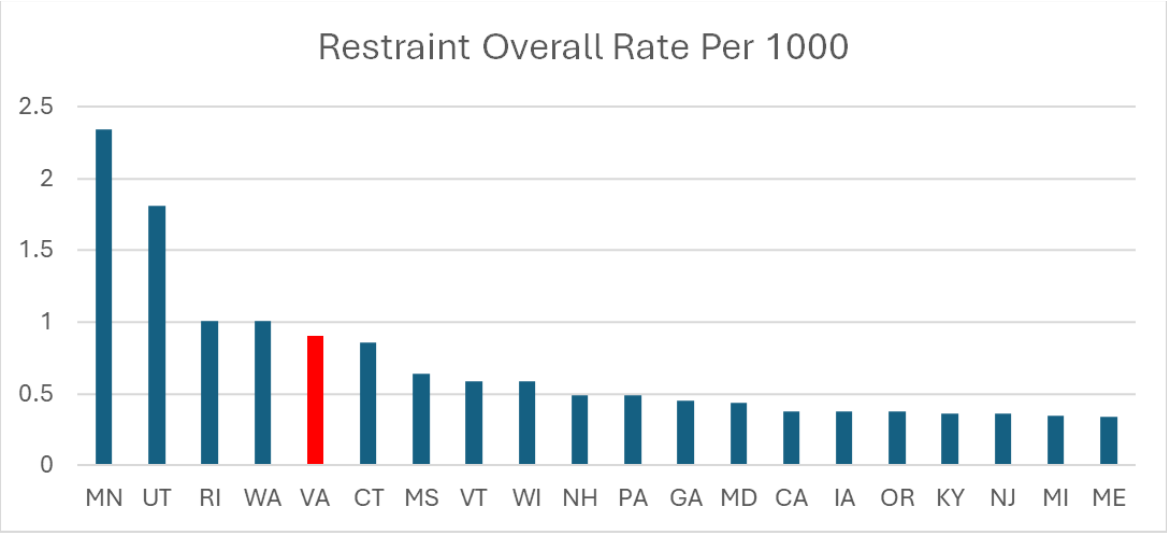
National Performance[5]
Multiple independent data sources indicate Virginia underperforms national and peer benchmarks for utilization of seclusion and restraint. However, cross-state comparisons are challenging as it is not possible to quantify the extent to which variation in reported rates of utilization can be attributed to differences in definitions and reporting requirements across states as discussed in the previous section. Additionally, the unique impact of “Bed of Last Resort” should also be considered when comparing Virginia state hospitals to other states. Under Bed of Last resort, state hospitals are required to admit individuals under a temporary detention order (TDO) for whom no private bed could be located during the emergency custody order (ECO) period. Civil TDO admissions to state hospitals rose dramatically after the legislation was implemented in FY 2014. By FY 2019, civil TDO admissions to state hospitals had risen by

[5] Contextual considerations: Virginia may provide more intensive psychiatric care rather than diverting patients to criminal justice systems; Virginia's reporting practices may capture interventions that other states classify differently; Virginia's patient population characteristics may differ from national averages

almost 400 percent. This increased demand for services and high hospital census has had significant impacts on the state hospital system's ability to maintain a safe therapeutic environment and adequate staffing levels.

Centers for Medicare & Medicaid Services Inpatient Psychiatric Facility Quality Measure Data by State[6] indicate that Virginia's public and private inpatient psychiatric hospitals rank 5th highest among all fifty states and two jurisdictions for physical restraint use at 0.90 per 1,000 hours – three times the national average of 0.30 per 1,000 hours. Virginia's seclusion performance, while elevated, is less extreme at 13th highest nationally (0.45 per 1,000 hours vs. 0.36 national average).

Inpatient Psychiatric Hospitals Restraint CMS IPFQR Data (Calendar Year 2023)

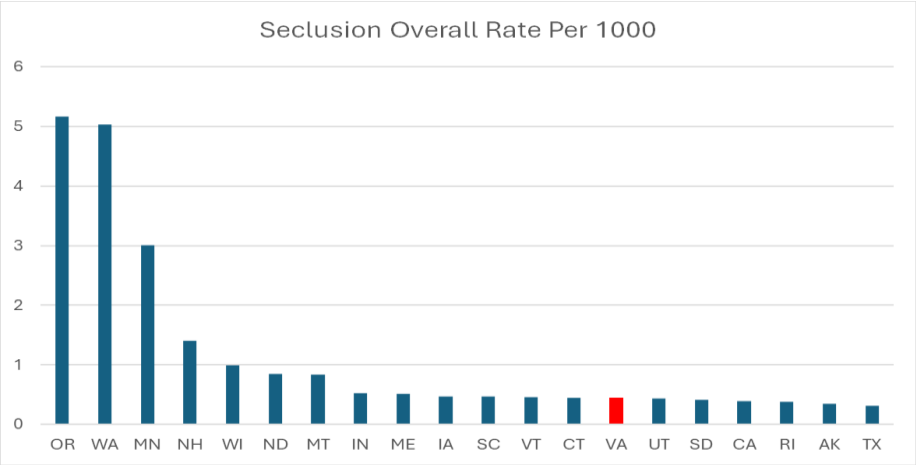


Physical Restraint Performance • National Rank: #5 highest utilization out of 52 jurisdictions • Rate: 0.90 per 1,000 patient-hours vs. 0.30 national average • Performance Gap: 3.0x higher than national rate • Benchmark Comparison: Ranks #1 highest utilization among 9-state benchmark group 4.1x higher than benchmark average 12.9x higher than best benchmark state (Missouri)

Centers for Medicare & Medicaid Services Inpatient Psychiatric Facility Quality Measure Data by State (Released April 2025). Please note this data set only reflects data from calendar year 2023.

[6] CMS IPFQR: The IPFQR dataset applies to Medicare-participating inpatient psychiatric facilities (IPFs): psychiatric hospitals and psychiatric units within acute-care or critical access hospitals eligible for payment under the IPF Prospective Payment System (IPF PPS). Inclusion is based on Medicare certification and participation (IPF PPS), not on ownership. The IPFQR measure files themselves do not include a state/private ownership label, but I was able to get ownership by linking facility IDs to external hospital general information CMS datasets. The IPFQR data includes both state-operated and private facilities that participate in Medicare.

Inpatient Psychiatric Hospitals Seclusion CMS IPFQR Data (Calendar Year 2023)



Virginia's Seclusion Performance • National Rank: #13 (tied w/ Connecticut) out of 52 jurisdictions (Top 27%) • Rate: 0.45 per 1,000 patient-hours vs. 0.36 national average • Performance Gap: 1.3x higher than national rate • Benchmark Comparison: Higher rate of seclusion than 7 of 8 benchmark states

Centers for Medicare & Medicaid Services Inpatient Psychiatric Facility Quality Measure Data by State (Released April 2025). Please note this data set only reflects data from calendar year 2023.

Virginia has the highest rate of restraint and one of the highest rates of seclusion among benchmark states. Virginia's restraint rate (0.90 hours per 1,000 patient hours) is about three times higher than the group average (0.30) and roughly 13 times higher than Missouri's 0.07. Virginia's seclusion rate (0.45 hours per 1,000 patient hours) is roughly twice the group average (0.22).

Benchmark State Comparison of Restraint and Seclusion Usage[3]

State	Restraint hrs/1,000	Rank (1=best)	Seclusion hrs/1,000	Rank (1=best)
Missouri	0.07	1	0.11	2
Arizona	0.10	2	0.11	2
Ohio	0.11	3	0.21	7
Colorado	0.16	4	0.18	5
New York	0.23	5	0.17	4
Massachusetts	0.27	6	0.09	1
Maine	0.34	7	0.51	9
Pennsylvania	0.49	8	0.18	5
Virginia	**0.90**	**9**	**0.45**	**8**

The Centers for Medicare & Medicaid Services data on use of seclusion and restraint in public and private facilities referenced above does not allow for analysis by subpopulation. National Research Institute Data does allow for analysis by subpopulation. However, this data set focuses on state operated facilities[7]. While rates of seclusion and restraint were generally elevated in Virginia compared to national averages, the differences were particularly significant for children as noted in the tables below. Virginia currently operates one state facility for children: The Commonwealth Center for Children and Adolescents (CCCA).

NRI Rates of Restraint and Seclusion of Children in State Facilities by Age (Average: Q2 2023 to Q2 2025)

	1–12 VA	1–12 National	13–17 VA	13–17 National
Hours of Restraint (per 1,000)	10.48	0.85	10.28	0.76
% of Patients Restrained	50%	28%	51%	19%
Hours of Seclusion (per 1,000)	5.53	1.15	3.55	0.38
% of Patients Secluded	50.24%	18.51%	20.34%	6.58%

NRI Rates of Restraint and Seclusion of Children in State Facilities by Age (Q2 2025)

	1–12 VA	1–12 National	13–17 VA	13–17 National
Hours of Restraint (per 1,000)	12.94	0.81	8.67	0.76
% of Patients Restrained	57.10%	22.80%	55.30%	19.90%
Hours of Seclusion (per 1,000)	4.33	0.89	9.13	0.32
% of Patients Secluded	50.00%	13.50%	31.60%	6.40%

Recent actions taken by CCCA to address seclusion and restraint use include implementation of the UKERU® crisis intervention program offering alternatives to seclusion and restraints through trauma-informed care and prevention techniques, removal of Emergency Restraint Chairs from operational use, transition of two seclusion rooms to sensory rooms, and enhanced seclusion and restraint committee processes.

Annual Seclusion and restraint DBHDS Reporting Summary (CY2024)
Provider Response and System Coverage: In 2024, Virginia operated 5,021 licensed services delivered by 2,187 providers. Of these, 3,525 services submitted required annual seclusion/restraint reports (70 percent response rate), while 1,496 services (30 percent) failed to report. While this reflects data visibility gaps across Virginia's behavioral health system, it is also possible that providers that failed to report did not have any instance of seclusion or restraint to report. As a comparison, of the providers responding to a survey conducted for this workgroup

[7] National Research Institute: Includes national data from inpatient psychiatric facilities that contract directly with NRI. Participating facilities include a mix of state-operated hospitals, state facilities managed by private companies, and a small number of privately operated inpatient psychiatric hospitals that elect to contribute data directly or via CMS and Joint Commission reporting. Per the NRI, for the specific restraint and seclusion measures used in this report, the NRI comparison group is overwhelmingly composed of state-operated facilities (approximately 95–97%). The Virginia data reflect only state-operated facilities reported through DBHDS.

only 41 percent reported having policies that allowed the use of seclusion and 63 percent reported having policies that allowed the use of restraint.

Incident Patterns and Distribution: Among responding providers, 333 licensed services (9 percent of all respondents) reported at least one seclusion or restraint incident. The 2024 incident breakdown revealed:

- 32 percent physical restraints
- 59 percent mechanical restraints (highest number of instances AND minutes)
- 6 percent seclusion
- 3 percent pharmacological restraints

Notably, while mechanical restraints accounted for the highest number of instances and total minutes reported, physical restraints affected the greatest number of individuals - suggesting different usage patterns across intervention types.

Community Provider Data

- Unlike inpatient settings with federal reporting requirements, community provider data remains systematically unavailable to the public for benchmarking nationally.
- For benchmarks, the only community-provider data available came from Ohio and Pennsylvania. Ohio reports on restrictive measures (manual, mechanical, chemical, and time-out) but does not separately report seclusion. Pennsylvania bans seclusion outright in its HCBS/DD system and only permits physical restraint. This makes Virginia unique among the three states and therefore difficult to compare.
- Virginia's requirement for providers to report annually on all instances of seclusion or restraint and to only report through CHRIS those that are tied to abuse or neglect collectively captures less incident detail than peer states like Pennsylvania (EIM system) and Ohio (OhioITMS).
- Critical data elements missing: antecedent documentation, debriefing.

While comparative national data was not available across all settings, this review did identify significantly higher rates of seclusion and restraint in Virginia’s public and private inpatient hospitals when compared with inpatient hospitals in other states. Solutions to address this issue will need to be multi-faceted, addressing provider accountability, practice transformation, and equity concerns. Comparative data was not available for community settings, but a review of data collected in other states suggests that improvements in the community data reporting system are warranted.

Multi-State Comparative Analysis

Blue Octopus Consulting conducted an in-depth multi-state comparative analysis to identify successful approaches to seclusion and restraint elimination and reduction. Through extensive interviews, policy review, and data analysis, clear patterns emerge around implementation of evidence-based frameworks, particularly the Six Core Strategies.

Several states provided extensive stakeholder interviews and detailed implementation insights, while others contributed primarily through policy documentation and publicly available data. The depth of analysis varies accordingly, with more comprehensive findings available for states

that participated in extended consultation processes. Key findings from each state are summarized in the appendices of this report.

Virginia Six Core Strategies Highlights

- Leadership (6CS1)
    - Comprehensive leadership frameworks exist but aren't clearly presented as a unified philosophy of care across settings. DBHDS expects providers to operate under core philosophical tenets – namely, that services should be recovery-oriented, person-centered, trauma-informed, community- integrated, and respectful of individuals' rights and choices.
    - Departmental Instruction 214 is applicable to state-operated facilities and outlines a clear and comprehensive philosophy of care and a position on restraint/seclusion use. However, this is not formally applicable to community-based providers.
- Data (6CS2)
    - Significant improvement is required in this area and work has been underway in the Department to revamp data systems and collection requirements.
- Workforce Development (6CS3)
    - Virginia does not participate in The National Core Indicators ® Intellectual and Developmental Disabilities (NCI IDD) State of the Workforce Survey and cannot compare state data with other similarly situated states. The NCI data reveals year-to-year changes in demographics, turnover, vacancy rates, wages, tenure, and benefits. States who participate in NCI can compare their data to other similarly situated states, identify areas where targeted interventions are needed, and cultivate innovative strategies on a statewide level.
    - The Virginia Health Workforce Development Authority conducted a study[8] of challenges faced by Virginia's health care workforce including behavioral health and primary care providers. The authors of the 2023 study provided a comprehensive list of tiered recommendations to address the articulated challenges.
    - Virginia maintains strong reporting and training requirements, but providers must define key policy elements like retraining frequency.
- Prevention Tools (6CS4)
    - Therapeutic Options used widely in DBHDS operated facilities as well as de-escalation techniques such as Defuse, Mental Health First Aid and CIT; Ukeru has also been piloted; providers across settings report a variety of other tools/training programs including Ukeru, Mandt, and Crisis Prevention Institute.
- Involvement of People Receiving Services (6CS5)
    - People with lived experience, peers, and advocates are included in various ways including peer-support specialists on staff, Human Rights Committees, stakeholder workgroups, etc.
    - DBHDS offers a Peer Recovery Specialist Certification and works with Virginia Commonwealth University to offer the Recovery Leadership Academy to provide organizational leadership skills and experiences to Certified Peer Recovery

[8] Virginia Healthcare Workforce Development Authority Study on the Virginia Primary Care, Nursing, and Behavioral Health Workforce Phase 1 Report Overview Presentation, February 9, 2023.

Specialists and Family Support Partners. The ALLY Alliance supported by The Arc of Virginia launched in 2019 as a statewide network of self-advocates to develop leadership skills, make connections, and develop advocacy tools for creating change locally and across Virginia.

- Debriefing (6CS6)
    - While required in regulation, providers reporting in CHRIS do not have to report if they conducted a debriefing and if they did not, why not. Virginia providers subject to CMS standards are required to conduct post- intervention debriefings within 24 hours of the restraint or seclusion.[9]

Cross-State Validation of Virginia's Challenges
Workforce and Training Gaps: Multiple states confirmed workforce instability as a primary concern related to reducing seclusion and restraint. Massachusetts Department of Mental Health (DMH) noted that "staffing shortages across the field tend to be most indicative of elevated use of seclusion and restraint," while New York providers documented direct correlation between vacancy rates and incident patterns.

Fear-Based Organizational Cultures: Several states described similar organizational culture challenges requiring systematic leadership intervention. Ohio's culture change initiatives that address staff trauma, Colorado's nurturing approach to provider support, and Massachusetts's focus on highlighting success stories rather than punishment all validate Virginia's provider survey findings about fear-based cultures undermining effective care.

Data Collection and Transparency: States consistently emphasized the importance of non-punitive data collection approaches that support learning rather than compliance burden. Ohio's experience with providers "making up data" when they perceive punitive intent may connect to Virginia's 70 percent reporting rate and validates the need for transparency and supportive accountability frameworks.

Training Fragmentation and Standardization Needs: Multiple states addressed training fragmentation like Virginia's 15+ different crisis intervention training programs. Ohio's Crisis Intervention Program Assessment Tool, Colorado's comprehensive training academy, and Missouri's certification process all demonstrate approaches to creating consistency while maintaining provider flexibility.

Recommendations

The workgroup achieved consensus on 17 recommendations. The workgroup recommendations are presented with additional considerations offered by the Department and are organized within the Six Core Strategies (6CS) framework. The 6CS framework functions as an integrated system where each strategy reinforces and amplifies the others.

[9] 42 CFR 483.370

Leadership establishes the philosophical foundation that enables all other strategies. Without clear executive commitment prioritizing prevention over intervention, workforce development efforts lack focus, data systems default to compliance rather than learning, and prevention tools remain underutilized.

Recommendations:

- Workgroup Recommendation #1: Create unified philosophy of care system-wide: "DBHDS is committed to creating an environment free of violence and coercion based on prevention strategies; assuring a safe environment for individuals receiving services and staff; focusing on the elimination of seclusion and restraint consistent with the principles of recovery and person-centeredness; and building a trauma-informed system of care."

- The Department recommends establishing a Six Core Strategies Framework with Prevention First Philosophy across all service settings.

- Workgroup Recommendation #2: Ensure alignment between Virginia definitions and CMS requirements to eliminate regulatory conflicts for impacted providers.

- Workgroup Recommendation #3: Adopt a carve-out to exclude from the definition of restraint any protective or medical devices, supports, or physical interventions used for therapeutic, orthopedic, or safety purposes, when prescribed by or used under the direction of a licensed medical professional and not intended to control behavior.

  **DBHDS recommends creating a distinction within the definition of restraint and reporting requirements rather than adopting a carve out to exclude*

- Workgroup Recommendation #4: Develop setting-specific implementation guidance documents as companions to regulations (addressing confusion about how regulations apply across different settings).

- The Department recommends analyzing definitions and related stakeholder input against four critical dimensions of definitional failure (Muluneh et al.) ensuring that clear delineation for appropriate use of seclusion and restraint is articulated across state regulations.

Why This Matters:

- DBHDS currently lacks a formal, unified philosophical foundation, leading to fragmented approaches to seclusion and restraint reduction across providers and systems. 6CS provides a federally validated framework and is anchored by the principle that seclusion and restraint represent system failures requiring organizational response rather than acceptable interventions. While these interventions may be necessary in genuine emergencies to ensure safety, they should represent exceptions rather than routine responses to behavioral challenges. Reduction efforts must focus on genuine prevention rather than system displacement – diverting individuals to criminal justice or other systems where they face potentially greater risks and restrictions undermines the entire transformation goal.

- Virginia's current "imminent risk" language creates a lower threshold for restraint/seclusion use compared to federal CMS "immediate physical safety" standard. This terminology difference affects when staff are permitted to intervene and creates compliance conflicts for providers who must follow both state and federal standards. Aligning with the more restrictive CMS standard strengthens patient protections while ensuring consistent risk assessment criteria.

- Centers for Medicare and Medicaid Services (CMS) and some peer states exclude the use of certain medically supportive or protective devices when prescribed by a licensed medical professional that are currently included in Virginia's definition of restraint. Amending Virginia's definition of restraint and associated reporting requirements to clearly distinguish between these different types of interventions will increase alignment with national standards while maintaining Virginia's commitment to regulating and monitoring a wider scope of interventions.

- Currently, guidance documents are limited in scope. The lack of clarity addressed by service providers in the survey and in workgroup sessions regarding use of seclusion and restraint can be addressed through various means. Departmental guidance documents can aid providers with regulatory compliance.

Data provides feedback loops that inform all other strategies. Workforce development programs need outcome data to demonstrate effectiveness; prevention tools require tracking to identify successful interventions; debriefing processes depend on quality data to drive learning.

Recommendations:

- Workgroup Recommendation #5: Increase community provider reporting frequency from annual to semi-annual or quarterly.

- Workgroup Recommendation #6: Establish routine sharing of aggregated seclusion and restraint data back to providers.

- Workgroup Recommendation #7: Create centralized, plain-language online resource hub with Six Core Strategies prominently featured.

- The Department recommends requiring enhanced community provider reporting with simple debriefing verification and developing a standardized debriefing framework.

- The Department recommends establishing a data transparency framework to support public access.

Why This Matters: Increased reporting frequency across all settings will provide more opportunities for monitoring emerging trends and identifying patterns in real time as opposed to annual reviews. Community providers expressed significant concerns about administrative reporting burden related to increased frequency. Providers also acknowledged the importance of transparency. Public accountability drives improvement while helping families make informed

choices about services. Current seclusion/restraint data is not easily accessible to people accessing services, advocates, or the public, limiting external accountability pressure that can motivate provider improvement and system-wide change.

Providers need centralized access to resources, training materials, policy guidance, and best practices. Current information is scattered across multiple DBHDS systems and difficult to locate, creating barriers for providers seeking to improve their practices. A comprehensive resource hub can accelerate improvement by making evidence-based resources easily accessible to all providers.

Workforce Development creates human capacity to implement prevention tools and operationalize leadership philosophy during crisis situations. Staff lacking de-escalation training or working in fear-based cultures cannot effectively utilize prevention approaches.

- Workgroup Recommendation #8: Require all providers authorized to use seclusion and restraint to incorporate the Six Core Strategies framework into their training programs as evidence-based practice focused on prevention and trauma-informed care without being overly prescriptive.

- Workgroup Recommendation #9: Establish specific training frequency standards (currently regulations only require providers to complete initial training with staff).

- Workgroup Recommendation #10: Mandate standardized core training elements that include meeting cultural competency expectations across all provider types while allowing setting-specific adaptations.

- Workgroup Recommendation #11: Support development of social support networks among staff who work in difficult environments with trauma exposure.

- Workgroup Recommendation #12: Address workforce retention issues and staff wellbeing as essential components of seclusion and restraint reduction.

- Workgroup Recommendation #13: Develop clear and accessible processes for professional development, especially for Direct Support Professionals and Frontline Supervisors.

- Workgroup Recommendation #14: Establish accessible and regularly occurring opportunities for provider networking across systems to reduce isolation and build connections.

- Workgroup Recommendation #15: Establish formal communities of practice by provider type for ongoing learning, support, problem-solving, and innovation.

- Workgroup Recommendation #16: Create annual DBHDS conference bringing together stakeholders from behavioral health, developmental services, crisis providers, advocacy organizations, and people with lived experience.

Why This Matters: The provider survey revealed systemic gaps in knowledge and attitudes across the spectrum from leadership to frontline staff and across institutional and community service providers. The SB569 Workgroup yielded many workforce development recommendations as the ongoing workforce shortage and high turnover rates create opportunities for increased use of seclusion and restraint when unnecessary. The Workgroups clearly supports more opportunities for cross-system capacity building including communities of practice, professional development, conferences, social networking and more.

Regarding training specifically: current regulations allow too much variation in training frequency, contributing to competency gaps that compromise safety. Additionally, documented racial disparities require cultural competency training as a patient safety issue, not optional diversity training.

Finally, adopting the Six Core Strategies framework throughout the training programs across the Commonwealth will support the integrated shift in philosophical approach to reducing and eliminating the use of seclusion and restraint by focusing on prevention first methods and relying on restrictive interventions in an absolute emergency use only model.

Prevention Tools give trained staff concrete alternatives to restrictive practices. Environmental modifications, individualized planning, and de-escalation techniques translate philosophical commitment into daily practice.

- The Department recommends the General Assembly to consider leveraging CARES Act Section 3715 Providing Home and Community Based Services in Acute Care Hospitals as a prevention tool.

- The Department will consider the Six Core Strategies Framework as a promising option for standardizing a statewide approach to prevention and limiting seclusion and restraint use to truly emergent situations.

Why This Matters: Virginia already guarantees the right to have direct support persons present in hospitals. However, support persons are not eligible for Medicaid reimbursement in Virginia. This creates a funding barrier that can prevent familiar caregivers from staying with the people they support. A person is at greater risk of being restrained when they are not able to access support from staff or caregivers who know them and can support communication of their preferences. . The CARES Act allows states to reimburse direct support professional staff time during short-term hospital stays under 1915 (c) waiver programs.

Therapeutic options is frequently utilized across the state (65 percent of providers reported using in the survey and it is frequently used in state-operated facilities). There is limited independent evaluation of Therapeutic Options' effectiveness. As DBHDS reported to the Behavioral Health Commission in July 2025, the Commonwealth Center for Children and Adolescents has implemented the Ukeru intervention program with elimination of emergency restraint chairs,

conversion of two seclusion rooms to sensory rooms, reduced physical restraints.[10] DBHDS will evaluate outcome data to determine if utilization of Ukeru should be expanded. Although not enterprise wide, state facilities have also incorporated other practices such as the Defuse program. The department is continually looking for opportunities to enhance and expand training.

Involvement of People Receiving Services ensures prevention approaches are informed by lived experience and responsive to individual preferences. This input provides essential feedback on which prevention approaches are most effective.

- Workgroup Recommendation #17: Encourage meaningful involvement of people with lived experience in training design, delivery, or evaluation of training content.

- The Department recommends conducting dedicated stakeholder engagement to expand input on seclusion and restraint practices from individuals and families receiving services and with lived experience of restraint and/or seclusion.

Why This Matters: Despite comprehensive efforts to engage individuals through multiple channels there were barriers to receiving adequate input from people with lived experience during the SB569 workgroup and research process. Including legislatively mandated stakeholders and encouraging community participation while holding the workgroup to a functional size created an ongoing challenge for ensuring diverse perspectives were consistently represented throughout the process. There was also a very limited response to direct outreach efforts likely reflecting barriers including the sensitive nature of the topic and unfamiliarity with the project and the contractor despite explanatory materials. The voices of people receiving services are essential for understanding the lived experience of restraint/seclusion and identifying effective alternatives that work from the individual's perspective. Without this input, policies risk being developed without understanding their real-world impact on the people most affected. Training content can be vastly improved to support staff in meeting the varied needs of people receiving services if they participate in the design, delivery, and/or evaluation of training materials.

Debriefing creates learning loops that continuously improve all other strategies. Learning-focused incident analysis identifies training gaps, environmental barriers, and opportunities for prevention enhancement.

- The Department recommends developing a standardized debriefing framework and requiring enhanced community provider reporting with debriefing validation.

Why This Matters: Provider feedback revealed inconsistent debriefing practices, with many lacking structured approaches to learning from incidents. Effective debriefing is critical for transforming negative experiences into learning opportunities that prevent recurrence and improve practices. Without standardized debriefing, opportunities to identify system improvements and individual treatment modifications are missed. Community providers

[10] https://bhc.virginia.gov/documents/July%202025%20CCCA%20slides.pdf

expressed significant concerns about administrative reporting burdens while acknowledging the importance of debriefing for learning and improvement. Capturing this data is an essential component of the Six Core Strategies framework.

Conclusion

Seclusion and restraint reduction is a deeply complex issue affecting Virginia's most vulnerable populations. The impact of restrictive practices on individuals and communities underscores the need for proactive transformation. With the leadership of the SB569 Workgroup, provider organizations, advocacy groups, and people with lived experience, conversations around trauma-informed care and prevention-first approaches are expanding in scope and depth. Providers and stakeholders throughout the Commonwealth are positioned to become part of the transformation movement by implementing the Six Core Strategies and evidence-based practices. This capacity building enables communities to come together, share resources, and create opportunities for systematic culture change.

The recommendations offered in this report have the potential to translate this alignment into a practical plan for measurable change. By continuing to invest in workforce development, data transparency, prevention tools, and culture change initiatives, Virginia can collectively work towards a future where seclusion and restraint are not only reduced but limited to situations where truly necessary for safety.

Virginia’s strong human-rights framework and statutory requirements such as Bed of Last Resort create conditions that heighten transparency and accountability, even as they place additional operational pressures on providers. Clarifying definitions, strengthening reporting consistency, and aligning regulatory expectations will help ensure that data reflect practice rather than structural artifacts. Particular attention will be needed in settings serving children and adolescents, where national research and Virginia’s own data indicate both elevated risk and significant opportunities for improvement through specialized, developmentally appropriate models of care.

DBHDS will continue to nurture the connections necessary for lasting transformation while building trauma-informed systems that prioritize prevention and reduce reliance on restrictive practices. With clearer expectations, shared accountability, and sustained commitment across public and private systems, the Commonwealth can create environments where restrictive interventions become rare exceptions and where safety, dignity, and recovery remain at the center of care.

Appendices

Appendix A

Workgroup Membership List

First Name	Last Name	Organization
Del. Rodney	Willett	Delegate, Virginia House of Delegates
Sen. Creigh	Deeds	Senator, Virginia Senate
Leah	Mills	Deputy Secretary of Health and Human Resources
Hallie	Pence	Executive Director, Right Help Right Now
Martin	Mash	Executive Director, VOCAL Virginia
Heather	Orrock	Executive Director, Mental Health Virginia
Will	Childers	Chair, State Human Rights Committee
Jennifer	Spangler	Self-Advocate with Lived Experience
Kristine	Konen	Self-Advocate with Lived Experience
John	Cimino	disAbility Law Center of Virginia
Daniel	Murrie	Director, Institute of Law, Psychiatry, & Public Policy (ILPPP)
Kandace	Miller	Crisis Services Department Director, Highlands Community Services Board
Victoria	Hannigan	DSP Crisis Staff Member, Highlands Community Services Board
Jim	Lundy	Chief Nurse Executive, South West Virginia Mental Health Institute
George	Newsome	Facility Director, Commonwealth Center for Children and Adolescents
Michael	Triggs	Chief Executive Officer, Poplar Springs Hospital
Tonya	Milling	Executive Director, Arc of Virginia
Teri	Morgan	Executive Director, Virginia Board for People with Disabilities
Jennifer	Faison	Executive Director, Virginia Association of Community Services Boards
Mindy	Carlin	Executive Director, Virgina Association of Community Based Providers
Jennifer	Fidura	Executive Director, Virginia Hospital and Health Care Association
Christine	Schein	Director of Behavioral Health Initiatives, Virginia Hospital and Health Care Association
Bill	Elwood	Executive Director, Virginia Coalition of Private Provider Associations
John	Weatherspoon	Chief Executive Officer, Wall Residences
Kim	Sanders	Chief Operating Officer, Grafton & President, Ukeru Systems
Alexis	Mapes	VP Clinical Operations, Connections Health Solutions (CRC and CSU Service Provider)
Melissa	Garcia	VP Clinical Operations, Dominion Hospital (HCA)
Dev	Nair	Assistant Commissioner, DBHDS Division of Provider Management
Suzanne	Mayo	Assistant Commissioner, Division of Facilities Services
Curt	Gleeson	Assistant Commissioner, DBHDS Division of Crisis Services
Nicole	Gore	Assistant Commissioner, DBHDS Community Behavioral Health
Eric	Williams	Assistant Commissioner, DBHDS Division of Developmental Services
Taneika	Goldman	Director, DBHDS Office of Human Rights
Jae	Benz	Director, DBHDS Office of Licensing
Mary	Broz-Vaughan	Director, Office of Regulatory Affairs
Crystal	Lipford	Director of Quality and Risk Management, Division of Facilities Services

Workgroup Facilitators

First Name	Last Name	Organization
Laura	Bennett	Co-founder & CEO, Blue Octopus Consulting
Quillin	Musgrave	Sr. Project Manager, Blue Octopus Consulting
Carter	Barker	Programs and Partnerships Manager, Blue Octopus Consulting

Appendix B

Key Concepts and Definitions by Blue Octopus Consulting

Six Core Strategies for Reducing Seclusion and Restraint Use Framework (6CS)[11]: The organizing principle for this report and workgroup/BOC recommendations, developed by the National Association of State Mental Health Program Directors (NASMHPD). This framework, included in the SAMHSA National Registry of Evidence-Based Programs and Practices, synthesizes evidence-based strategies for reducing restraint and seclusion use across six interconnected domains:

1. *Leadership Towards Organizational Change:* This first strategy is considered core to reducing the use of restraint and seclusion through the consistent and continuous involvement of senior facility leadership. Senior leadership must articulate values that expect restraint and seclusion reduction, develop facility-specific improvement plans, and maintain 24/7 oversight of every incident. The strategy requires daily executive investigation of causality, policy review, and direct engagement with frontline staff.
2. *Use of Data to Inform Practice:* This requires systematic collection and analysis of data at individual unit levels to drive continuous improvement. Facilities must establish baseline usage rates and continuously track multiple variables including unit, shift, and daily patterns; staff involvement; consumer demographics; concurrent medication use; and injury rates for both consumers and staff. The strategy emphasizes setting measurable improvement goals and monitoring changes over time through comparative analysis. Data collection enables facilities to identify patterns, trends, and contributing factors that inform targeted interventions and policy modifications to reduce restrictive practice use.
3. *Workforce Development:* This strategy creates trauma-informed, recovery-oriented treatment environments that prevent coercive interactions and reduce conflicts through comprehensive staff preparation. This primary prevention strategy encompasses intensive ongoing training, mentoring, and supervision to build staff knowledge about trauma prevalence, recovery principles, and person-centered approaches. Implementation includes evidence-based seclusion/restraint training vendor selection, individualized treatment planning with consumer participation, and adequate therapeutic activities that teach self-management skills. The strategy integrates trauma-informed principles throughout all human resources processes including hiring interviews, job descriptions, performance evaluations, and orientation programs. Staff receive specialized education on trauma's developmental impacts, recovery concepts, and violence prevalence in mental health populations to create therapeutic environments that minimize triggers and promote healing rather than control.
4. *Use of Restraint/Seclusion Prevention Tools:* This strategy reduces the use restraint and seclusion through a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment and includes the use of assessment tools to identify risk for violence and restraint/seclusion history; the use of an universal trauma assessment; tools to identify persons with high risk factors for death and injury;

[11] A Snapshot of Six Core Strategies for the Reduction of S/R, National Association of State Mental Health Program Directors (Revised 11/20/06 by Kevin Ann Huckshorn).

the use of de-escalation surveys or safety plans; the use of person-first, non-discriminatory language in speech and written documents; environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self-management skills.

5. *Consumer Roles:* This strategy establishes formal inclusion of consumers, families, and advocates in organizational decision-making and oversight activities to reduce restraint and seclusion use. This strategy incorporates lived experience perspectives into event oversight, monitoring, debriefing interviews, peer support services, and key facility committees with meaningful roles and authority. Implementation requires executive-level supervision and support for consumer staff and volunteers, recognizing the inherent challenges of these positions and providing protection, mediation, and advocacy for their integration. The strategy emphasizes ADA compliance in job descriptions, work expectations, and hours while ensuring staff understand the legitimacy and importance of consumer roles. Consumer involvement spans all organizational levels from direct service delivery to policy development, creating accountability structures that center the perspectives of those most directly affected by seclusion and restraint practices.
6. *Debriefing Techniques:* This strategy requires thorough analysis of every restraint and seclusion event to generate knowledge that informs policy improvements and prevents future incidents. This strategy employs rigorous examination using root cause analysis methods to understand contributing factors and system failures. Implementation includes immediate post-event acute analysis and formal problem analysis with treatment teams. A secondary goal involves mitigating potential trauma effects for involved staff, consumers, and witnesses through structured processing of events. The strategy recognizes that facilities treating children with frequent holds may need modified approaches, focusing debriefing efforts on patterns such as multiple holds on the same children, repeated staff involvement indicating training needs, or unusually prolonged restraint episodes. Debriefing can transform incidents into organizational learning opportunities that drive systematic improvements in policies, procedures, and practices.

Trauma: While there is no universal definition of trauma, SAHMSA's definition is commonly referenced: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[12]

Trauma-Informed Care: Shifts the focus from "What's wrong with you?" to "What happened to you?" A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — to provide effective health care services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness. It can also help reduce avoidable care and excess costs for both the health care and social service sectors.[13]

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[12] SAMHSA (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach SAMHSA's Trauma and Justice Strategic Initiative.

[13] Trauma-Informed Care Implementation Resource Center, Center for Health Care Strategies

Restraint and Seclusion:
Children's Residential Facilities (12VAC35-46)
General Licensing Regulations (12VAC35-105)
Human Rights Regulations (12VAC33-115)

"Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means so that the individual cannot leave the area.

"Restraint" means the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk. There are three kinds of restraints:

1. Mechanical restraint means the use of a mechanical device that cannot be removed by the individual to restrict the individual's freedom of movement or functioning of a limb or portion of an individual's body when that behavior places him or others at imminent risk.
2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that individual's behavior places him or others at imminent risk and the administered medication is not a standard treatment for the individual's medical or psychiatric condition.
3. Physical restraint, also referred to as manual hold, means the use of physical intervention or hands-on hold to prevent an individual from moving his body when that individual's behavior places him or others at imminent risk.

"Restraints for behavioral purposes" means using a physical hold, medication, or a mechanical device to control behavior or involuntarily restrict the freedom of movement of an individual in an instance when all of the following conditions are met: (i) there is an emergency; (ii) nonphysical interventions are not viable; and (iii) safety issues require an immediate response.

"Restraints for medical purposes" means using a physical hold, medication, or mechanical device to limit the mobility of an individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not the accepted clinical practice for treating the individual's condition.

"Restraints for protective purposes" means using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual or it may create a passive barrier, such as a helmet to protect the individual.

"Restriction" means anything that limits or prevents an individual from freely exercising his rights and privileges.

The definitions above are identical across all three regulatory chapters with the following

exceptions:

- The general licensing regulations (Chapter 105) do not include verbal means as seclusion
  > "Seclusion" means the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it.
- The children's residential regulations (Chapter 46) do not include a definition of restriction.

Appendix C

Multi-State Comparative Analysis by Blue Octopus Consulting

This analysis examines eight benchmark states to identify successful approaches to restraint and seclusion elimination and reduction. (Pennsylvania as the leading model is spotlighted separately). Through extensive interviews, policy review, and data analysis, clear patterns emerge around implementation of evidence-based frameworks, particularly the Six Core Strategies (6CS).

Several states provided extensive stakeholder interviews and detailed implementation insights, while others contributed primarily through policy documentation and publicly available data. The depth of analysis varies accordingly, with more comprehensive findings available for states that participated in extended consultation processes.

Key findings from each state are summarized below:

Arizona
6CS Highlights

- Leadership (6CS1)
    - Arizona's crisis system reflects two decades of sustained leadership, with Arizona Health Care Cost Containment System (AHCCCS) and state policymakers aligning Medicaid policy, legislation, and law enforcement partnerships to guarantee rapid access (e.g., 10-minute police drop-offs) and universal acceptance at crisis centers. This consistent leadership positioned Arizona as a leading crisis services model, emulated by states across the country.[14]
- Data (6CS2)
    - AHCCCS Policy 962 requires all behavioral health inpatient facilities (BHIFs) and mental health agencies to submit reports of any seclusion/restraint event involving AHCCCS members within 5 business days. If there's injury/complication, then within 24 hours.
- Workforce Development (6CS3)
    - Workforce Development Coalition organized by Arizona Health Care Cost Containment System provides training resources, conducts annual workforce surveys, and collaborates on statewide initiatives through "5 C's" framework (Commitment, Culture, Connectivity, Capability, Capacity).
    - Article 9 training required within 90 days for DD staff, with 3-year renewal.
- Debriefing (6CS6)
    - The Arizona Healthcare Cost Containment System requires member and staff debriefing within 24 hours of the use of seclusion or restraint. The debriefing is documented in their reporting system.

Colorado
6CS Highlights

[14] https://crisisnow.com/wp-content/uploads/2020/02/CrisisNow-LeadToSystemSuccessInAZ.pdf

- Leadership (6CS1)
    - "Philosophy of care" emphasizing dignity, respect, and trauma-informed approaches across both BH/MH and IDD systems.
    - Colorado created a Performance Management and Outcomes team focused on quality improvement rather than compliance enforcement. Their approach asks leadership, "What do you want to work on? What's important to your agency?" The team emphasizes: "We're not there in a regulatory fashion, trying to see how we can support you. Just telling them what's wrong doesn't create long-term systemic change."
    - Colorado developed a systematic five-phase process for trauma-informed care implementation: Phase 1 (baseline assessment), Phase 2 (physical management and crisis reduction planning), Phase 3 (treatment plan co- development involving families), Phase 4 (medical services and cultural responsiveness), and Phase 5 (aftercare planning). This structured approach provides clear benchmarks for organizational transformation.
- Workforce Development (6CS3)
- Established Behavioral Health Administration (2022) as cabinet-level entity; workforce development report focuses on peer support standardization, K-12 Hummingbird Initiative, and community college micro-credentialing.
- Annual competency demonstration required. 3-year evaluation of evidence-based practices.
- Adrienne Palazzolo, Performance Management Outcomes & Training Administrator with Colorado's Division of Child Welfare, developed a comprehensive Training Academy for residential providers that was adopted into law in 2024. The academy addresses workforce retention and provides consistent messaging across all staff levels with three training tracks: direct care (40 hours), supervisors (additional 6 hours), and clinical/leadership.
- The 30-module curriculum (one hour each) covers comprehensive topics including milieu management, regulations, reporting, healthy sexuality, boundaries, attachment, neuroscience, epigenetics, disability, aftercare, and LGBTQ+-specific content. Critically, Palazzolo developed this comprehensive program with NO BUDGET, leveraging community partners including domestic violence agencies, suicide prevention organizations, and public health groups to create modules.

Maine

6CS Highlights

- Leadership (6CS1)
    - Maine's Riverview Psychiatric Center has become a model for other psychiatric hospitals through its "hands-on only when absolutely necessary" philosophy, training staff to prioritize verbal de-escalation with adequate time investment. The facility combines sensory rooms on every unit with a comprehensive Treatment Mall offering 70+ evidence-based therapeutic groups designed to address early agitation and promote community reintegration skills.[15]

[15] https://www.maine.gov/dhhs/riverview/patient-information/treatment-services

    - MaineCare does not reimburse providers for time periods when restraint is used in outpatient behavioral health settings, creating financial disincentives for restraint use (2023).
    - In June 2025, Maine enacted LD 769, which bans the planned use of restraints in adult developmental disability services, allowing restraint only in true emergencies and strengthening oversight through a new Support and Safety Committee.[16]
    - The Co-Occurring Collaborative Serving Maine (CCSME) has been at the forefront of system change since 1992, developing new service models such as the state's first co-occurring ACT team, a jail diversion FACT team, and a co-occurring court, while supporting the spread of evidence-based practices like DBT and motivational interviewing, and managing federal initiatives to expand integrated behavioral health infrastructure statewide. Most recently, CCSME partnered with DHHS on Maine's Certified Community Behavioral Health Center (CCBHC) State Planning Grant (2023–2024), providing training, technical assistance, and resources on CCBHC evidence-based programs, governance, and workforce development.[17]
- Workforce Development (6CS3)
    - The Maine Behavioral Health Workforce Development Collaborative (MBHWDC), delivered through the public platform Partnership for ME, expands statewide capacity by connecting practitioners with training, certifications, and career resources. It supports workforce development across prevention, intervention, treatment, and recovery, strengthening staff skills in trauma-informed and evidence-based practices that reduce reliance on restraint and seclusion.[18]
- Consumer Involvement (6CS5)
    - Established Consumer Council System by law (2008) with exclusively lived-experience staff/leadership providing statewide and regional policy input, annual conferences, and regular podcasts on mental health care.
    - CCSME incorporates consumer voices directly on its board and in its projects, ensuring people with lived experience guide the development of innovative service models and participate in statewide training, technical assistance, and policy initiatives.

Massachusetts

6CS Highlights

- Leadership (6CS1)
    - "Restraint represents treatment failure" - clear elimination philosophy.
    - DMH facilities must develop strategic plans to eliminate restraint/seclusion with annual updates.

[16] https://www.mainepublic.org/politics/2025-06-13/mills-signs-bill-eliminating-planned-use-of-restraints-for-adults-with-developmental-disabilities

[17] https://ccsme.org/category/initiatives/

[18] https://partnershipforme.org/

    - Achieved 80 percent+ reductions in restraint/seclusion episodes across child and adolescent facilities (2000-2005).
    - Featured prominently as model in SAMHSA's business case for reducing restraint/seclusion.
- Workforce Development (6CS3)
    - Health Policy Commission operates Behavioral Health Workforce Center for research and policy recommendations; $18M Behavioral Health Supervising Clinicians Incentive Program (SCIP) funds clinical supervisors for new trainees.
    - DDS DMH mandates crisis management certification with annual recertification.
- Debriefing (6CS6)
    - State regulation 115CMR§5.11 explicitly mandates debriefing requirements for Department of Developmental Services after restraint incidents.

Missouri

6CS Highlights

- Leadership (6CS1)
    - Missouri's Department of Mental Health implemented Regional Behavior Support Committee meetings around 2020, bringing together state behavioral analysts and providers to review Behavioral Support Plans containing questionable elements including seclusion/restraint. The committees worked collaboratively with providers on alternative strategies, estimating a 60 percent reduction in restraint and seclusion use following implementation of this process.
    - In interviews with committee members/providers, they emphasized significant reductions resulted from DMH policy changes driven by providers and community members, rather than legislative victories or mandates. Around 2023, DMH implemented a total ban on seclusion in all intellectual/developmental disability services.
- Workforce Development (6CS3)
    - MO TaP apprenticeship program enrolled 533 direct care professionals (2022-2024); released 2024 workforce study report; coordinates quarterly cross-system networking events for knowledge sharing.
    - Missouri received a Targeted Technical Assistance (TTA) grant to develop the Behavioral Health and Intellectual Disabilities (BHID) Program, bringing behavioral health and developmental disabilities together to serve individuals with both intellectual disabilities and severe behavioral health issues. This collaboration led to the Missouri Alliance for Dual Diagnosis, which defined best practices, brought providers together across disciplines, and provided statewide clinical training.
- Prevention Tools (6CS4)
    - Missouri uses a Positive Behavior Support model with tiered levels of intervention and value-based payment to providers for staff training, including a training and certification process specific to Missouri's PBS model. The state frames efforts not as "reducing seclusion and restraint" but as "shifting to Positive Behavior Supports as a framework," demonstrating how messaging and philosophical framing influence implementation success.
- Consumer Involvement (6CS5)

- Operates annual Real Voices-Real Choices Consumer Conference and Partners in Policymaking program training adults with disabilities and parents to engage elected officials and local decision-makers.

New York

6CS Highlights

- Leadership (6CS1)
  - "Restraint/seclusion represents treatment failure" with strong elimination commitment clearly displayed on their website with resources and 6CS framework.
  - In interviews, New York providers emphasized that New York has a "CLEAR approach to the use of restrictive interventions." Providers reported being "very clear on what was allowed and not allowed" with definitions that were unambiguous for their facilities.
  - New York's Office for People With Developmental Disabilities (OPWDD) uses Administrative Memoranda (ADM) that carry the same weight as regulatory statutes, providing detailed guidance that eliminates implementation confusion. The state maintains robust audit functions to review records, allegations, and various situations, ensuring consistent oversight across providers.
- Workforce Development (6CS3)
  - Regional Centers for Workforce Transformation coordinate multi-agency recruitment/retention platform for DD sector; Office of Mental Health supports loan repayment, expanded credentialing with SUNY/CUNY, and provider wage increases.
  - Justice Center provides debriefing toolkit but Office for People with Developmental Disabilities does not require debriefing after restraint incidents; Office of Mental Health does require debriefing for behavioral health services.
  - In interviews, New York providers identified a direct correlation between restraint/seclusion incidents and staffing patterns, noting that vacancy rates over 5-7 percent should trigger major concern, though most agencies operate at 15-17 percent vacancy regularly. To address workforce shortages, providers bring in international workers through special visa programs.
  - The New York Alliance for Inclusion and Innovation developed workforce support tools including a Realistic Job Preview video and guide for hiring processes, along with public service announcements and other resources.
- Prevention Tools (6CS4)
  - New York ARC of Delaware County: Never-Use Model
    - In an interview, the Executive Director of ARC of Delaware County, described an organization that has never used physical or restrictive interventions since inception in 1967 by Board of Directors directive. Operating in very rural New York and serving individuals with complex cases, their approach centers on person-driven relationships across all levels: staff-to-staff, staff-to-client, and peer-to-peer.
    - Their model includes supervisors working with maximum five staff with weekly meetings for preventative problem-solving, culture of positive reinforcement combined with environmental barriers and supports, and staff working across system roles with children and adults in day

habilitation and residential settings. When individuals arrive with restraint in their Behavior Support Plan, ARC maintains their non-restraint approach regardless.

Ohio

6CS Highlights

- Leadership (CS1)
    - Ohio's transformation under former Department of Developmental Disabilities Director (DODD) John Martin demonstrates the critical importance of this strategy. Martin, who led DODD for 12 years and was instrumental in reducing unnecessary restraint/seclusion usage through Ohio's Positive Culture Initiative, emphasized in an interview with the BOC team and DBHDS leadership that sustainable change requires fundamental shifts in organizational philosophy:
        - "Culture doesn't shift with rules. Hopefully, rules support culture change. Rules don't change behavior, they just support behavior." Martin stressed that good providers try to follow regulations, but bad providers don't, making vision and training essential components alongside regulatory frameworks.
        - Martin's approach centered on "prophetic imagination," drawing from Robert K. Greenleaf's servant leadership principles to create vision and excite people to follow it. "Prophets need examples to show the work is possible," he explained, noting the importance of talking to providers with established track records of not using restraint/seclusion to speak across the state about transformation possibilities.
        - Ohio's systematic approach included identifying agencies willing to explore restraint reduction and providing seed money to help them implement positive behavior supports. Martin assembled teams of "early adopters" who met regularly with problem-solving groups to identify effective strategies. A crucial insight emerged: "We can't expect staff to treat the people they serve any better than how supervisors treat the staff," highlighting the need for organizational culture transformation at all levels.
- Data (6CS2)
    - Ohio's approach to data collection emphasizes learning rather than punishment. Martin stressed: "If people think it's punitive, they make up their data - it teaches people not to report." To communicate non-punitive intent, Ohio connects data with philosophy, telling providers, "you won't know what they need without data" and ensuring that oversight visits position staff as helpers rather than "prison guards."
    - Ohio's incident reporting system uses Salesforce technology in the public domain, requiring providers to submit monthly trends reports and counties to report quarterly on trends and patterns. The state's responsibility includes analyzing trends and patterns statewide to determine necessary interventions. When providers fail to report restraint/seclusion use immediately, Ohio uses this as opportunity to require follow-up analysis and plans of correction addressing how organizations will prevent recurrence, creating a culture of problem-solving rather than compliance burden.

- Workforce Development (6CS3)
    - Department of Mental Health and Addiction Services launched Wellness Workforce initiative; Great Minds Fellowship provides up to $10,000 for recent behavioral health graduates.
    - Annual competency demonstration. 20 specific content areas for restraint training.
- Prevention Tools (6CS4)
    - Ohio developed the Crisis Intervention Program Assessment Tool (CIPAT) enabling providers to self-assess crisis intervention training programs against Ohio's Positive Culture Initiative core concepts and develop customized curricula. This provider-led assessment approach emerged when Ohio's legal department declined to endorse specific training programs due to liability concerns, shifting from state mandates to provider accountability.
    - Environmental modifications emphasized technological solutions over staffing-intensive responses, recognizing that deploying multiple staff often escalates situations through power struggles. Ohio incorporated "extreme blocking" techniques (adapted from Grafton's model) into training curricula and promoted technological alternatives like cameras and remote supports as safer de-escalation tools.

Virginia Highlights

6CS Highlights

- Leadership (6CS1)
    - Comprehensive leadership frameworks exist but aren't clearly presented as a unified philosophy of care across settings. DBHDS expects providers to operate under core philosophical tenets – namely, that services should be recovery-oriented, person-centered, trauma-informed, community- integrated, and respectful of individuals' rights and choices.
    - Departmental Instruction 214 applicable to state-operated facilities outlines a clear and comprehensive philosophy of care and a position on restraint/seclusion use. However, this is not formally applicable to community-based providers.
- Data (6CS2)
    - Significant improvement is required in this area and work has been underway in the Department to revamp data systems and collection requirements.
- Workforce Development (6CS3)
    - Virginia does not participate in The National Core Indicators ® Intellectual
    - and Developmental Disabilities (NCI IDD) State of the Workforce Survey and cannot compare state data with other similarly situated states. The NCI data reveals year-to-year changes in demographics, turnover, vacancy rates, wages, tenure, and benefits. States who participate in NCI can compare their data to other similarly situated states, identify areas where targeted interventions are needed, and cultivate innovative strategies on a statewide level.
    - The Virginia Health Workforce Development Authority conducted a study of challenges faced by Virginia's health care workforce including behavioral health and primary care providers. The authors of the 2023 study provided a

comprehensive list of tiered recommendations to address the articulated challenges.[19]
    - Virginia maintains strong reporting and training requirements, but providers must define key policy elements like retraining frequency.
- Prevention Tools (6CS4)
    - Therapeutic Options used widely in DBHDS operated facilities; providers report a variety of other tools/training programs including Ukeru, Mandt, and CPI.
- Consumer Involvement (6CS5)
    - People with lived experience, peers, and advocates are included in various ways including peer-support specialists on staff, Human Rights Committees, stakeholder workgroups, etc.
    - DBHDS offers a Peer Recovery Specialist Certification and works with Virginia Commonwealth University to offer the Recovery Leadership Academy to provider organizational leadership skills and experiences to Certified Peer Recovery Specialists and Family Support Partners. The ALLY Alliance supported by The Arc of Virginia launched in 2019 as a statewide network of self-advocates to develop leadership skills, make connections, and develop advocacy tools for creating change locally and across Virginia.
- Debriefing (6CS6)
    - While required in regulation, providers reporting in CHRIS do not have to report if they conducted a debriefing and if they did not, why not. Virginia providers subject to CMS standards are required to conduct post-intervention debriefings within 24 hours of the restraint or seclusion.[20]

[19] Virginia Healthcare Workforce Development Authority Study on the Virginia Primary Care, Nursing, and Behavioral Health Workforce Phase 1 Report Overview Presentation, February 9, 2023.
[20] 42 CFR 483.370

Appendix D

Virginia Network of Private Providers, Inc.

Building Meaningful Lives for Extraordinary People

https://vnppinc.org

Re SB569

8 December, 2025

To Whom it May Concern:

The 120+ members of the Virginia Network of Private Providers want to thank the Department of Behavioral Health and Developmental Services and their consultants for facilitating participation of the SB569 Workgroup on Seclusion and Restraint. We support the recommendations as presented, but wish to highlight the following:

Recommendation #3 – We strongly support carving out (or drawing a distinction) which substantially reduces the burdensome reporting of the protective or supportive devices when ordered by a medical professional. Not only is it an added unnecessary burden, but it results in extraordinarily misleading data.

Prevention Tools – VNPP is requesting not only a "Section 1" bill, but also budget amendments in both House and Senate to allow, under limited circumstances, the implementation and funding of the provisions allowed by Section 3715 of the Cares Act. We will appreciate any support in this endeavor that DBHDS is permitted to offer!

Thank you for your work on this important topic.

Jennifer G Fidura
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December 17, 2025

Re: SB569 Seclusion and Restraint Practices Workgroup

Dear Ms. Lent,

We first want to thank the Department of Behavioral Health and Developmental Disability Services (DBHDS) for the opportunity to participate on the SB569 Seclusion and Restraint Practices Workgroup and wish to submit brief comments on the recommendations made:

Leadership – We support the four recommendations and offer whatever support and information we may have available from the array of Crisis Services in Virginia and in other states to assist with the implementation. While seclusion and restraint are tools that support the ability of a provider to operate under the Crisis Now model and accept all individuals, we strongly support Recommendation #1.

Data – We support the recommendations and would be happy to assist in the development of the DBHDS recommended development of a standardized debriefing framework supported by data from our internal systems.

Workforce Development – While we support the concepts presented in Recommendations 8 through16, we expect that, upon review, many of the training and workforce support and retention strategies currently in place in our agency will be comparable to those suggested.

Prevention Tools – We can actively support DBHDS on these two suggestions. Involvement of People Receiving Services – We support this recommendation and routinely engage the peer recovery specialists in training at all levels.

Again, thank you for the opportunity to be part of this discussion.

Sincerely,

Alexis Mapes, LPC

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Connections Health Solutions
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Pronouns: she, her, hers