Because restraint is inherently dangerous, especially when used on children and adolescents, it is strictly limited and heavily regulated by federal and state law and regulations and by national licensing and accreditation standards. With a few exceptions, the limitations on the use of restraints with children and adolescents are considerably more exacting than those for adults. There are, for example, greater restrictions on the use and duration of restraint, and more stringent reporting requirements. Some types of community residential programs may not use mechanical restraint at all. Other programs are forbidden from using certain other forms of restraint and seclusion.

These are important matters. Not only does restraint have critical physical and clinical implications, but injuries or death from restraint or seclusion may result in legal liability. A number of cases arising from injuries and death during restraint and seclusion have been filed in Massachusetts, including a case in which a jury awarded $100,000 in compensatory damages and 1.5 million dollars in punitive damages (the punitive damage award was reduced by the judge to just over a million dollars) to a man who was punched in the head and whose neck was twisted while he was being restrained. In addition to the civil action, the aide who punched the man in the head was arrested and faced criminal charges.
Although staff actually performing the restraint and seclusion have been sued, Massachusetts case law also creates liability for supervisory staff who abdicate their responsibilities to ensure that restraint and seclusion are only used when absolutely necessary, and to prevent abuse during restraint and seclusion procedures. Finally, even in the absence of death or injury, liability can arise from use of seclusion and restraint for inappropriate purposes, or restraint and seclusion that, even though initially appropriate, is extended long after the individual has regained control and is calm.

Because several different state agencies may serve a single child or adolescent, and since those agencies may each have their own rules and be regulated by different federal entities, the regulatory scheme is sometimes confusing. This chapter describes the various legal, licensing and accreditation requirements that apply to child and adolescent programs and facilities and attempts to explain what the rules mean, how they should be implemented, and how courts have interpreted them.

1. OVERVIEW OF FEDERAL AND STATE REGULATORY LIMITATIONS ON THE USE OF RESTRAINT AND SECLUSION IN PROGRAMS SERVING CHILDREN AND ADULTS.

Since different kinds of children’s facilities and programs are subject to different requirements, it is important to know which rules apply. In fact, some programs may be subject to more than one set of rules (or to both rules and accreditation requirements) and the requirements of each may differ.

*Federal regulatory requirements are new and continually being updated. Some Massachusetts rules have been updated to conform with federal requirements and professional judgment about the use of restraint.*

Until recently, the regulation of restraint and seclusion was mostly a matter of state law and, to a limited extent, accreditation standards. Most federal requirements are new since 1999, when the Centers for Medicare and Medicaid Services (CMS) issued its rules. Professional and accreditation standards followed suit. For example, the Joint Commission on Accreditation of Health Care Organizations’s (JCAHO) accreditation requirements were revised to substantially
increase oversight of restraint and seclusion. These new standards took effect in 2001. Massachusetts’s Department of Mental Health (DMH) has revised its restraint and seclusion regulations for inpatient facilities, bringing them into conformity with the federal rules, JCAHO standards, and the consensus of professional judgment concerning the use of restraint and seclusion. DMH’s regulations took effect on April 6, 2006.

More regulations are expected from both the federal government and JCAHO. The United States Department of Health and Human Services (HHS) is in the process of developing the regulations relating to restraint and seclusion that are required by the Children’s Health Act of 2000, P.L. 106-310 (2000), codified at 42 U.S.C. §§ 290ii and jj. In early 2006, JCAHO added measurement of hours in restraint and seclusion as “core indicators” for psychiatric inpatient facilities. This means that by the time these measures are implemented in 2008, all JCAHO accredited inpatient psychiatric facilities will have to provide JCAHO with quarterly data on the number of hours patients spend in restraint and seclusion, and the public will be able to compare hospitals’ performance on this core quality indicator.

Therefore, while the information in this chapter is up to date as of April 2006, the reader should be aware of which regulations apply to his or her facility or program and keep up to date on any new regulations. Agencies which provide legal assistance to individuals with psychiatric disabilities are listed at the end of this chapter, and may be able to provide up-to-date information on restraint and seclusion regulations. In addition, web sites with this information are listed.

Seclusion and restraint are among the highest priorities of licensing and certification agencies, who are also in the process of changing their requirements

JCAHO’s accreditation standards are important because it accredits many inpatient facilities and some community programs. JCAHO accredited facilities and programs are considered by CMS to meet its certification requirements, as long as JCAHO ensures the facility meets CMS restraint and seclusion certification requirements where they are more stringent than those of the JCAHO. The Massachusetts DMH also “deems” JCAHO accredited facilities and programs to meet most of the DMH licensing requirements.
JCAHO’s revised restraint standards took effect in 2001. For the most part, they conformed to new CMS conditions of participation involving patient rights (including restraint and seclusion) and rules relating to psychiatric residential treatment centers for individuals under the age of twenty-one.

While JCAHO receives many complaints about patient care and cannot respond to all of them, it has emphasized on its website that complaints regarding restraint and seclusion will receive the highest investigative priority. This is also true at CMS, the federal Medicaid agency, which has suspended certification at a number of facilities due to violations of conditions of participation relating to restraint and seclusion.

*Massachusetts programs and facilities that serve youth may be subject to one or more of several state agency restraint rules.*

Children and adolescents in Massachusetts may receive services from a variety of programs funded or regulated by any one of several state agencies. Although this chapter will consider the federal requirements and the DMH regulations applicable to inpatient facilities, with only occasional reference for comparison purposes to Department of Early Education and Care (EEC), Department of Youth Services (DYS), and Department of Education (DOE) standards, it is obviously important for service providers, consumers, family members, and advocates to know just which rules apply.

The following agencies that may be involved in a young person’s life have significant impact on the use of restraint:

**DMH:** A child or adolescent may receive mental health services from a program or facility operated, under contract with, or funded by the Department of Mental Health. DMH has very specific regulations on the use of restraint and seclusion. However, these regulations apply only to programs or facilities operated, licensed, or contracted for by DMH, except for those children’s programs that although contracted for by DMH, are licensed by EEC.

- DMH operates (sometimes under contract with private or public providers) inpatient facilities for children and adolescents, such as
those at Westborough, Worcester, and Taunton State Hospitals. The DMH regulations apply to those units, which are considered part of the state psychiatric hospitals, which in turn are certified by JCAHO.

- DMH licenses Behaviorally Intensive Residential Treatment programs or (BIRT) units. These BIRT Units tend to serve younger children who are referred for behavioral health services by the Department of Social Services. BIRTs are secure treatment settings, often located on the campuses of state DMH facilities, such as those programs at Tewksbury and Westborough State Hospitals.

- DMH licenses all inpatient mental health units, including child and adolescent mental health units, in private and public (for example, city or county) hospitals. Although the Department of Public Health (DPH) may also license the hospital as a whole, the DMH regulations apply to the mental health units (but not, for example to the emergency room, where restraint may also be used). However, DPH and DMH are increasingly working cooperatively when a DMH client is restrained in the emergency department.

- DMH licenses Intensive Residential Treatment Programs (IRTPs), which vendors operate under contracts with the Department, that provide residential diagnosis and treatment to adolescents. IRTPs can admit youth on an involuntary basis. 104 CMR 27.04(1). The DMH restraint regulations apply in the IRTPs, and IRTPs (such as the one on the grounds of Westborough State Hospital) may be separately accredited by JCAHO.

- Even though it “contracts” with some community programs for children and adolescents, DMH does not license those programs. 104 CMR 28.01(2). Therefore, the restraint standards in the DMH community licensing regulations do not apply. Since most of these programs are licensed by the Department of Early Education and Care (EEC), the EEC restraint regulations apply. (DMH does license adult mental health community residential programs and does not allow the use of chemical or mechanical restraint or seclusion in those adult community programs. Physical restraint is allowed. 104 CMR 28.05.
This is one area in which the rules applying to adults in community mental health programs are more stringent than those applying to children.

**Department of Early Education and Care:** In 2005, the new Department of Early Education and Care (EEC) assumed the licensing responsibilities of the former Office of Child Care Services (OCCS). In addition to its many other functions, EEC licenses most non-hospital based programs for adolescents and children, including residential programs and Department of Youth Services facilities. EEC has regulations and policies on the use of restraint, 102 CMR 3.07(7)(j), and a detailed policy statement. EEC Policy Statement, Chemical and Mechanical Restraint, P-EEC-R&P-02.

**Department of Youth Services:** DYS’s programs, both community and facility based, regardless of the degree of security, are licensed by EEC. Although EEC has some regulations concerning use of restraint in locked secure detention or treatment programs, the DYS regulations on restraint and seclusion are the main source of rules for DYS operated or contracted programs. 109 CMR 5.05, 6.01-6.04.

**Department of Social Services:** DSS provides a variety of residential services for youth. Although DSS licenses foster homes and pre-adoptive placements, the licensing of group care settings is the responsibility of EEC. If a child is in DSS custody, DSS makes most treatment decisions for him or her. However, DSS seeks court approval for the administration of antipsychotic medications. DSS and DMII jointly operate some hospital based and community programs. The restraint regulations that will apply to a child in a program will depend on which agency (e.g., DMH, EEC) is the licensing authority. Most programs have their licenses posted in a conspicuous place.

**Department of Education:** DOE certifies special education schools, but EEC, in effect, licenses residential portion of schools. DOE has restraint rules that apply to public schools, including charter schools and educational cooperatives. These are found at 603 CMR 46.01.

**Department of Mental Retardation:** Although DMR has extensive restraint regulations, very few children and adolescents with mental retardation are
served in DMR licensed programs. Children with developmental disabilities are likely to be in educational programs, either in their neighborhood schools or in day or residential schools.

**Department of Public Health:** DPH regulates and licenses hospitals. Except for psychiatric units, which are also licensed by DMH and to which the DMH regulations apply, DPH rules apply elsewhere in the hospitals, including emergency rooms. (As described below, if the hospital receives Medicaid funds, as almost all do, the hospital is bound by the CMS “Conditions of Participation,” which include rules on restraint.)

**Different kinds of facilities are also subject to different federal regulations:**

Different federal regulations and statutes apply to different kinds of facilities that serve children.

**Inpatient Facilities**

- *Hospital.* If the facility is a hospital, and it receives payments from Medicare or Medicaid, it is subject to Conditions of Participation relating to patients’ rights, which include limitations on the use of restraint and seclusion. 42 C.F.R. 482.13(f). Any hospital, nursing facility, intermediate care facility, or other health care facility is also subject to the requirements of the Children’s Health Act of 2000, 42 U.S.C. § 290ii., if it receives federal funding, whether directly or indirectly.

- *Psychiatric Residential Treatment Center.* If a facility meets the definition of a “psychiatric residential treatment center” (PRTC) under federal law, it must comply with certain specific regulations promulgated by the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services. A PRTC is “a facility other than a hospital, that provides psychiatric services to individuals under the age of 21 in an inpatient setting.” 42 C.F.R. 483.352. Many states are confused about just which, if any, programs in their states are PRTCs. In Massachusetts, IRTPs may meet the definition. The forthcoming HHS regulations may help define the
programs and set the limitations on the use of restraint and seclusion at PRTCs.

Community Facilities

- **Non-medical, community-based facility for children and youth.** If a facility is a “non-medical, community-based facility for children and youth” it is subject to a part of the Children’s Health Act which prohibits the use of mechanical restraints, 42 U.S.C. § 290jj (b)(3)(B), and permits seclusion and physical restraint only in “emergency circumstances and only to ensure the immediate physical safety of the resident, a staff member or others, and only when less restrictive interventions have been determined to be ineffective.” 42 U.S.C. § 290jj(b)(1)(A). Most such facilities in Massachusetts, presumably, would be licensed by EEC and, if so, its regulations should be consistent with the federal law.

II. RESTRAINT

In this section we describe, in a question and answer format, what the Massachusetts Department of Mental Health and federal rules require in relation to restraint. For the sake of comparison, we occasionally refer to the rules of other Massachusetts state agencies.

*What is the definition of restraint under federal and state law and regulations?*

Federal and state law and regulations all define restraint to include physical restraint, chemical or medication restraint, and mechanical restraint.

The Massachusetts mental health code, which applies to DMH operated and/or licensed inpatient hospitals and to Bridgewater State Hospital (which is operated by the Department of Corrections), defines restraint as “bodily physical force, mechanical devices, chemicals, confinement in a place of seclusion other than placement of an inpatient or resident in his room for the night, or any other means which unreasonably limit the freedom of movement.” M.G.L. c. 123 § 1.

The DMH regulations define restraint as “bodily physical restriction,
mechanical devices, or medication that unreasonably limit freedom of movement.” 104 CMR 27.12(5)(a)(3). EEC policy defines restraint as “the use of any physical, mechanical or chemical means to temporarily control behavior.” EEC Policy Statement, Chemical and Mechanical Restraint, P-EEC-R&P-02, p. 1 (hereafter “EEC Policy”). While DYS allows physical restraint and isolation it defines only mechanical restraint, and that as “[t]he limiting of voluntary physical movement through the use of the following devices: handcuffs, ankle cuffs, security belts, fleece-lined restraints, or any other similar device.” 109 CMR 6.03.

The federal Conditions of Participation for all hospitals receiving Medicare or Medicaid define restraint as “a physical restraint or a drug that is being used as a restraint.” A physical restraint is “any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the patient’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body.” 42 C.F.R. 482.13(f)(1). A drug that is used as a restraint is defined as “a medication used to control behavior or to restrict the patient’s freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition.” 42 C.F.R. 482.13(f)(1).

Under the Children’s Health Act, restraint in non-medical community based facilities for children and youth is divided into mechanical (which is prohibited, see below), defined as “the use of devices as a means of restricting a resident’s freedom of movement,” 42 U.S.C. § 290jj(d)(1), and “physical,” defined as “a personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely” 42 U.S.C. § 290jj(d)(3), and specifically excludes a “physical escort,” (see below). Although this specific section of the law does not contain a definition of chemical restraint, it does prohibit the “use of a drug or medication that is used as a restraint to control behavior or restrict the resident’s freedom of movement that is not a standard treatment for the resident’s medical or psychiatric condition,” 42 U.S.C. §290jj(b)(3)(A), which is identical to the definition of chemical restraint under the portion of the Children’s Health Act which applies to all hospitals and other health facilities receiving federal funds. That portion of the statute contains a substantially similar definition of restraint: “a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs or head freely.”
Are there any exceptions to these definitions of restraint?

A. Medical Support Devices

Massachusetts DMH regulations exclude from the definition of restraint any restraint in association with acute medical or surgical care, adaptive support in response to the patient’s assessed physical needs, or standard practices including limitation of mobility related to medical, dental, diagnostic, or surgical procedures and related post-procedure care. 104 CMR 27.12(5)(a)(3). EEC policy excludes protective devices, such as helmets, when ordered by a physician and voluntary use by a child of protective hand mitts or arm splints to prevent self-injury also when ordered by a physician. EEC Policy, p.1.

Federal conditions of participation for hospitals distinguish between “behavioral” restraints and “restraint for acute medical and surgical care” 42 C.F.R. 482.13(e). If the patient can easily remove the device, it is not a restraint at all, id. If it is not easily removable, it must be “medically necessary,” “needed to improve the patient’s well-being,” and “other less restrictive measures have been determined to be ineffective.” 42 C.F.R. 482.13(e)(1) and (2). It must, of course, be in accordance with the order of a doctor or other licensed independent practitioner and never be written as a “PRN” or “as needed” order. 42 C.F.R. 482.13(e)(3)(ii)(A).

B. Physical Escorts

The Children’s Health Act specifically excludes “physical escort” from the definition of “physical restraint,” for all facilities, including non-medical community-based facilities for children and other facilities. See 42 U.S.C. § 290jj(c)(3), and 42 U.S.C. § 290ii(d)(1)(A). A “physical escort” is defined as “the temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting out to walk to a safe location,” 42 U.S.C. § 290jj(c)(2), 42 U.S.C. § 290ii(d)(3).

Are there any kinds of restraints that cannot be used?

A. Restraints in the Face-Down Position
Under the new Massachusetts DMH regulations, a *face-down position* cannot be used unless there is either “a specified patient preference and no psychological or medical counterindication to its use or there is an overriding psychological or medical justification for its use, which shall be documented.” 104 CMR 27.12(5)(c)(1). Prone restraints are also prohibited in a number of other jurisdictions, including in the Texas mental health system, the Iowa mental health system, the Maryland developmental disability system, and in numerous programs and facilities.

**B. PRN Orders for Restraints**

Both federal and Massachusetts DMH regulations forbid the use of *PRN* (or “as needed”) orders be used for medication restraint, physical restraint, mechanical restraint, or seclusion, 104 CMR 27.12(5)(b)(3). The Massachusetts statute regulating DMH also forbids the use or PRN restraint. M.G.L. c. 123 § 21. Although EEC policy allows PRN medication orders, PRN orders may only apply in non-emergency situations. EEC Policy, p. 1.

**C. Restraint Devices Requiring Keys**

No restraint devices requiring a key for their release can be used in programs regulated by DMH. 104 CMR 27.12(5).

**D. Mechanical Restraint While Sleeping**

The Massachusetts DMH regulations require that if a person falls asleep in restraints, staff must notify an authorized physician or staff person, who will release the individual unless such efforts are reasonably expected to re-agitate him or her. 104 C.M.R.27.12(5)(h)(6)(b).

**E. Chemical Restraints in Certain Contexts**

EEC allows only physical restraint and forbids the use of chemical restraint except with a child specific waiver. EEC Policy, pp. 1-4. There is, however, no provision for a waiver of the prohibition of chemical restraint in the portions of the Children’s Health Act applicable to “non-medical, community based facilit[ies] for children and youth.” 42 U.S.C. 290jj. DOE appears to ban chemical restraints as
well, permitting only the use of physical restraint. 603 CMR 46.01. The Department of Social Services does not permit the administration of psychotropic medication for its wards or children in its custody without a court order (see "Chemical Restraints," below).

F. Mechanical Restraints in Certain Contexts

EEC allows only physical restraint and forbids the use of mechanical restraint except with a child specific waiver. EEC Policy, pp. 1-4. There is, however, no provision for a waiver of the prohibition of mechanical restraint in the portions of the Children’s Health Act applicable to “non-medical, community based facilit[ies] for children and youth.” 42 U.S.C. 290jj. DYS and EEC forbid the use of mechanical restraints that are attached to a fixed object, such as a bed or pole. 109 CMR 6.04(4), EEC Policy, at p. 1.

G. Handcuffs

The Center for Medicare and Medicaid Services issued a policy guidance in May 2005 which warned against the use of handcuffs and other devices commonly carried by security guards or police in restraining individuals for behavioral purposes. Interpretive Guidance to 42 C.F.R. 482.13(f), available online at www.cms.hhs.gov/manuals/107_som107ap_a_hospitals.pdf.

A. PHYSICAL RERAINT

What is physical restraint?

DMH defines physical restraint as occurring when a “manual method is used to restraint a person by restricting a [person’s] freedom of movement or normal access to his or her body.” It does not include “non-forcible” guiding or escorting or things like blocking a blow, breaking up a fight or preventing a fall. Similarly, DOE regulations do not preclude the use of “reasonable force to protect students, other persons or [school employees] from assault or imminent, serious, physical harm.” 603 CMR 46.01(4).

Does holding a child who is out of control count as restraint?
While brief holds do not count as restraints under the federal regulations for the PRTF programs, brief holds are restraints under the new DMH regulations, unless they involve “taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger.” 104 CMR 27.12(5)(a)(3)(c). Therefore, at least in DMH licensed programs for children and youth, all involuntary holds count as restraints if they are used with an intent to control movement, and the federal exception does not matter. This does not mean that staff cannot hold a child who is out of control, but the hold must proceed as and be treated as a restraint, documented as a restraint, and included in statistics relating to restraints.

EEC excludes “physical escorts,” defined as “[t]ouching or holding the hand, wrist, arm, shoulder, or back for the purpose of inducing an acting out resident to walk to a safe location,” from the definition of restraint. 102 CMR 3.02(2).

**May I hug a child to comfort or console him or her?**

Neither federal nor state regulations contemplate that briefly holding a resident without undue force for the purpose of comforting him or her, or holding a resident’s hand or arm to safely escort him or her from one area to another, will be considered a restraint. If a hold is not intended to control the physical movement of a child, it is not likely to be considered a restraint. However, the child or adolescent’s history of sexual abuse should, of course, be taken into account when determining what sources of comfort to provide when the child is in distress.

**B. MEDICATION RESTRAINT**

*When are medications considered “chemical restraints?”*

In Massachusetts DMH regulated programs, chemical restraints are now called “medication restraints” and are defined as “when a patient is given medication involuntarily for the purpose of restraining the patient.” 104 CMR 27.12(5)(a)(3)(a).
Massachusetts law allows the administration of drugs that constitute mental health treatment to an individual without consent only in an "emergency." When there is no emergency, if a person refuses to consent, the program or facility may not administer the medication. The program, DMH, a family member, or a friend, however, may petition a court for the authority to administer the medication. If the court finds (1) that the person is incompetent – that is, not capable of consenting – and (2) that if he or she was capable, would consent, the court may authorize the medication, pursuant to an approved treatment plan. Rogers v. Commissioner of Department of Mental Health, 390 Mass. 489 (1983).

The Rogers case defines two kinds of emergencies in which medication may be given without consent and without a court order. The first is in a situation in which there is an immediate likelihood of serious harm to the person or others – the very standard for the use of restraint in Massachusetts law, M.G.L. c. 123 § 21, and DMH regulations. In other words, medication may be given without consent for the purpose of restraint only when the situation is so dangerous that mechanical restraints would also be justified.

The second kind of emergency is when a doctor determines that medication must be given without even the shortest delay to prevent “immediate, substantial and irreversible deterioration of serious mental illness.” In such a case, which the SJC described as occurring only “in rare circumstances,” Rogers, 390 Mass. at 511, a Rogers petition must be filed in court without delay.

The DMH regulations reflect the court’s holding in the Rogers case. First, they allow the use of medication restraint in emergency situations. Second, while the regulations at 104 CMR 27.12(5)(a)(3)(a)(i) allow for the use of medication without consent for very short term treatment purposes to prevent an irreversible deterioration of a serious mental illness, they also require that the provider seek a Rogers order, by referring back to 104 CMR 27.10(1)(a).

That reference may create some confusion when the individual being medicated is a child or adolescent. Except for a few adolescents who might be considered to be emancipated and able to make their own decisions, DMH considers individuals under 18 to be inherently incapable of giving informed consent to treatment with psychiatric medications. (Sixteen and seventeen year olds are able to make their own decisions about some other mental health
treatment matters, including admission to a mental hospital. 104 CMR 27.05(5)(b). Accordingly, there must be someone authorized to give consent on their behalf.

The general rule in Massachusetts is that parents with custody have the authority to consent to treatment for their children, including treatment with antipsychotic medication. Since parents do not need a court order to consent to treatment, it is likely that they will have already authorized treatment with antipsychotics. Therefore, the program may already have sufficient authorization to treat. EEC’s policy statement reflects this practice and requirement. EEC Policy, at p. 4.

If, on the other hand, the child is in the custody of or is a ward of the Department of Social Services or is the ward of a guardian, a Rogers order is necessary to authorize treatment with antipsychotic medications, and to continue treatment after an emergency use to prevent irreversible deterioration. A guardian or DDS if it is guardian would usually seek authority in a probate court; if the child is in DSS “custody,” DSS usually would petition the juvenile court that placed the young person in its custody. DSS regulations list the medications which it cannot consent to and for which it will seek court authority. 110 CMR 11.14.

DYS also cannot consent to some forms of treatment for children committed to it. DYS regulations set forth a more extensive list than DSS, including mood altering drugs and psychostimulants as well as antipsychotics. Its regulations require that it seek permission of the parent, guardian, or a court. 109 CMR 11.14 (antipsychotics), 11.15 (mood stabilizers); 11.16 (psychostimulants).

Federal regulations define drugs used as restraints as “a drug or medication that is used as a restraint to control behavior or restrict the resident’s freedom of movement that is not a standard treatment for the resident’s medical or psychiatric condition.” 42 U.S.C. § 290jj(b)(3)(A). There is a virtually identical definition at 42 C.F.R. 482.12(f)(1), the Conditions of Participation for hospitals receiving Medicare or Medicaid. Use of drugs in this way is forbidden in non-medical community-based facilities for children and youth. Id.

What is the meaning of “not a standard treatment for the resident’s medical or psychiatric condition” as used in the federal definition?
The answer to this question has not been satisfactorily determined. It could mean any drug that is not part of the client’s current treatment plan. Or, it could mean that the drug is not usually used to treat the client’s diagnosed condition (e.g. Haldol or another antipsychotic administered to an individual who is diagnosed with depression). A coalition of national organizations recommends the following interpretation:

The use of a chemical or drug which is generally considered a standard treatment for the resident's medical or psychiatric condition shall be considered a restraint if such chemical or drug is administered in dosages or amounts or at a frequency that is greater than that necessary to treat the individual’s particular condition.


C. SECLUSION

*What is the definition of seclusion under federal and state law and regulations?*

Massachusetts DMH regulations recognize that seclusion may occur when a person is threatened or coerced to keep him or her from leaving a room. “Seclusion” occurs when a patient is involuntarily confined in a room and prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to “doors that cannot be opened from the inside, physical intervention from staff, coercive measures, including the threat of restraint, sanctions or the loss of privileges the patient would otherwise have, used for the purpose of keeping the patient from leaving the room.” 104 CMR 27.12(5)(a)(4).

Federal laws and regulations generally define seclusion as involuntary confinement in a room where the individual is physically prevented from leaving

*Are there any exceptions to the definition of “seclusion”?*

In DMH regulated settings, “Voluntary, collaborative separation from a group or activity for the purpose of calming a patient” is not seclusion. 104 CMR 27.12(5)(a)(4)(b).
What does “voluntary and collaborative” mean?

This is not entirely clear; if the child asks to leave the group or activity without a prior suggestion from an adult, that is probably “voluntary and collaborative;” any coercion or suggestion of consequences if the child does not separate from the group or activity probably constitutes seclusion.

Is “time out” seclusion?

Some federal statutes, such as the Children’s Health Act, include exceptions for time out, 42 U.S.C. 290ii-1 and 2 and 42 U.S.C. 290jj. Federal regulations governing psychiatric inpatient units for children under the age of 21 contain similar exceptions, 42 C.F.R. 483.350. The recently superseded Massachusetts DMH state regulations contained the same exception. Under the new state regulations, there are no exceptions for time out. Time out is seclusion if it meets the definition of seclusion under the state regulations (see above).

EEC regulations require that a time room may not be locked, except in closely prescribed situations in DYS locked detention or treatment programs. 102 CMR 3.07(7)(l) and (n)(1)-(3).

D. DURATION OF RESTRAINT AND SECLUSION

What is the maximum duration of a restraint or seclusion order?

Under both federal and DMH regulations, the maximum duration for which a restraint or seclusion order can be written for anyone between the age of nine and seventeen is two hours and the maximum duration of a restraint or seclusion of a child under the age of nine is one hour. 104 CMR 27.12 s(g).

Can these orders be renewed?

No order for the restraint or seclusion of a minor under age nine may be renewed, nor can another order be written within the same 24 hour period. No minor age nine through 17 shall be in seclusion for more than two hours in any 24-hour period. 104 CMR 27.12(5)(f)(2). The Massachusetts statute applying to DMH operated and/or licensed facilities also limits seclusion of a minor to no

**What is an individual is released from restraint prior to the expiration of the order?**

If a patient is released from restraint or seclusion prior to the expiration of an order and an emergency occurs prior to the order’s expiration, but no later than one half hour after release, the patient will be returned to restraint or seclusion with a new order for the time remaining left in the order. 104 CMR 27.12(5)(g)(8).

**E. PROCEDURES FOR ORDERING RESTRAINT OR SECLUSION**

**Who can order restraint or seclusion?**

In DMH licensed programs serving youth, an authorized staff person, including any member of the licensed clinical staff at the facility who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion, or authorized physician. 104 CMR 27:12(5)(a).

EEC regulations do not specifically designate who may initiate a physical restraint. However, the administrative designee on the premises must be notified immediately, the on-call administrator must be called after the first five minutes of each physical restraint, and the chief administrative person or his or her designee must approve any restraint for a period longer than 20 minutes. 102 CMR 3.07(7)(j)(5),(6), and (8).

**Who can order the release of a child from restraint or seclusion?**

In programs regulated by DMH, an authorized staff person or authorized physician. 104 CMR 27:12(5)(h). In EEC programs, the youth shall be released from physical restraint at the first indication it is safe to do so or at any sign of physical distress. Inasmuch as the regulations require the administrative designee on the premises to have oversight responsibility of every restraint, presumably that person would order the release. 102 CMR 3.07(7)(j)(5),(10) and (11).

**What is “debriefing” and when is it required?**
DMH facility regulations require that within 24 hours of restraint or seclusion, staff involved in the restraint or seclusion, the patient, and supervisory staff must discuss the circumstances that led to the restraint or seclusion and how to avoid restraint or seclusion in the future. 104 CMR 27:12 (4)(a)(b).

EEC regulations require a program to implement its “processing and follow-up procedures” after the release of a resident from restraint. 102 CMR 3.07(7)(j)(12). “Restraint follow up” is defined as “[r]eview by program management of each restraint with involved staff as part of a feedback and quality assurance process.” 102 CMR 3.02(2). “Processing” is a verbal review of the restraint by staff with the resident, “with the goal of minimizing the need for future restraint.” Id.

What if a child asks to be put in restraint or seclusion?

Staff should try to come up with an alternative that meets the child’s needs, such as a heavy blanket. Since a child who is under sufficient control to ask for restraint is unlikely to present the kind of emergency that is the only justification for restraint, placing the child in restraints—even in response to a request— is not good clinical practice. It is important to understand the roots of the request and try to meet the underlying need. A child may always go voluntarily into his or her room. Confinement to a room does not become seclusion unless it is involuntary or coerced.

Can a guardian consent to restraint or seclusion?

Because restraint and seclusion are emergency behavioral control methods, rather than treatment, a guardian probably cannot consent to them. Even if a guardian does consent to restraint or seclusion, all of the regulations above must still be followed.

Can a child’s attorney visit him or her in restraint or seclusion?

In response to a complaint filed by an attorney, the Department of Mental Health has ruled that an adult’s attorney can generally visit him or her while in seclusion or restraint.
The physician or licensed independent professional on duty should assess the child at that time, and if in his or her judgment it is clinically inappropriate for the child to visit with the attorney, the reasons for this decision, including objective descriptions of the child’s conduct, should be placed in the record.

**What types of formal notice and paperwork are needed to accompany an incident of restraint or seclusion in DMR regulated programs?**

In addition to forms and notice procedures specific to your facility or program, the following types of notice and documentation are generally required before and after every restraint or seclusion event in a DMH regulated program:

**Verbal Notice Requirements:**

DMH currently participates in a statewide restraint reduction initiative funded by Substance Abuse and Mental Health Services Administration (SAMHSA) and directed by the National Association of Mental Health Program Directors and its National Training Assistance Center (NTAC), which is scheduled to continue through 2008.

As part of implementing six core strategies for restraint reduction, eleven DMH operated/contracted mental health facilities, including adolescent units at Taunton and Westborough State Hospital, must institute a process of “witnessing” restraint events whenever they occur. This high level of involvement by program and facility leadership is considered necessary to significantly reduce the amount and duration of restraint episodes and to evaluate the need for emergency measures at the time in which they are contemplated. Notice requirements are designed to assist staff in identifying additional resources, assist in the speedy termination of the episode and/or the prevention of future incidents. Your program may also have a specific protocol for notifying unit supervisors, program directors, facility medical directors, and chief operating officers, or their designees, in the event of a restraint.

Finally, the facility director and facility medical director must be notified if an order is issued to extend a restraint or seclusion episode beyond the patient’s two hours.
Parental Notice

Most parents or guardians expect and/or specifically request that they receive notice as soon as possible after their child/ward has required restraint or seclusion. Parents of minor children and other legally authorized representatives may request to participate in the restraint de-briefing process, and may also review copies of any relevant restraint documentation from the child’s medical record.

Restraint of Minors under 13, Exceeding Six Hours or Multiple Episodes:

Additional regulatory notice requirements apply when mechanical restraint is sought for a minor under thirteen. These include notice to, and review by, the facility medical director prior to, or immediately thereafter, initiation of a restraint. The facility director must also be immediately notified and shall report the event in writing to the Commissioner or designee by the next business day. 104 CMR 27.12(g)(5) Similarly, the facility medical director shall be notified if an episode of mechanical restraint has either exceeded five hours and is expected to require renewal for more than six hours, or if there has been more than two episodes of restraint or seclusion for a patient in any twelve hour period. Id. at (g)(6).

Official Forms/Documents:

At the time when restraint or seclusion is initiated, an order must be obtained by an authorized physician who is present when the emergency occurs, or who evaluates the patient as soon as possible, but no later than one hour after initiation of the restraint by authorized staff. 104 CMR 27.12(5)(d),(e). An authorized staff person or physician must observe and make written note of the patient's physical status, including respiratory functioning, skin color and condition, and presence of any undue pressure on the body. 104 CMR 27.12(5)(e)(3)

Only in exceptional circumstances may an order be renewed without the face to face consultation of an authorized physician. The physician is still required to conduct an in-person evaluation within one hour of the renewal, and may order its continuation for no more than two hours from the initiation of the restraint or seclusion by the authorized staff person. 104 CMR 27.12(5)(f)
Documentation Associated with Prone Restraints

New regulatory provisions require that patients be placed in restraint positions that allow airway access and do not compromise respiration. As a result, face down positions shall not be used unless there is evidence that the following are true: a) there is a specific patient preference and no psychological or medical contraindications to use of the prone position, or b) there is an overriding psychological or medical justification for the use of prone restraint positioning. 104 CMR 27.12(5)(c). Documentation required to support this exception should be found in the physician’s restraint order and may also appear in other medical record documents including the MHIS restraint/seclusion physician instruction assessment. Such orders/assessments should also consider whether specialized equipment and other monitoring techniques might mitigate against perceived medical contraindications.

Revised DMH Emergency Restraint and Seclusion Forms

Forms revised for April 2006 now require the collection of additional information by staff participating in and monitoring a restraint or seclusion event. Triggering events, trauma considerations, and medical risk factors must be noted along with alternative interventions and notice to legally authorized representatives. The patient’s physical status must also be recorded in detail, including breathing, complaints of pain or discomfort, physical injuries and medical attention, if needed. Monitoring and assessment of the need for continuing restraint must be documented by a trained staff person every fifteen minutes and reviewed by an authorized RN at least every thirty minutes.

This restraint form is followed by a revised DMH comment/debriefing form which begins by apologizing to the person restrained. Through this form, staff should obtain the patient’s input regarding why the event happened, their experience in restraint, and how such measures might be avoided in the future. This de-briefing form must be offered to the patient within twenty-four hours of the restraint event.

De-briefing forms (DMH and Facility-based)

In addition to the comment form above, program staff are expected to
undertake their own formal assessment of events leading up to the restraint, any
errors which might have occurred, and ways in which similar incidents can be
avoided in the future. Supervisory staff and staff involved in the event shall
convene as soon as possible following every restraint and shall document their
review for use in treatment planning, possible revision of the patient’s individual
crisis plan, assessment of counseling needs of patient or staff, and their
programmatic restraint prevention efforts. 104 CMR 27.12(4)

The patient debriefing and comment form, or other documentation, shall be
attached to the restraint and seclusion form and included in the patient record.
Copies of the forms shall be promptly sent to the treatment teams and the Human
Rights Officer. The patient shall also be notified of the availability of the
Massachusetts DMH complaint procedure at 104 CMR 32.00. 104 CMR
27.12(4)(b).

Senior Administrative Review

Senior administrative and clinical staff shall be empowered to review all
restraint and seclusion events and to make recommendations regarding the need
for expert consultation, training, performance improvement activities or changes
in policies. This body should also have the ability to review specific incidents of
restraint which fall within the following criteria: patient or staff experience a
significant emotional or physical injury, the episode exceeded six hours, an
exception to the limitations on restraint of minors occurs, the episode is part of a
pattern, is marked by unusual circumstances, results in a complaint or critical
incident report pursuant to 104 CMR 32.00, or staff review is requested. 104
CMR 27.12(4)(c).

Reporting of Patient Injuries and Death

If a child is injured during a restraint event, programs and facilities must
utilize their critical incident forms and associated reporting procedures. Given
that virtually all employees in DMH treatment settings are mandatory reporters,
notice of a child’s injury must also be given to DSS in the form of 51A report, if
his or her injury could be due to alleged abuse or neglect by staff.

If a PRTF is found to be out of compliance with the condition of

**Reporting Restraint Data to DMH, Human Rights Review**

At the end of each monthly reporting period, a facility shall submit copies of restraint and seclusion order forms and attachments to the Commissioner, and an aggregate report for each unit, on an approved form. The Commissioner or designee shall review this statistical data and sample forms and maintain such records organized by facility and unit. 104 CMR 27.12(i)(2).

This restraint data must also be submitted to the Human Rights Committee of the facility, if operated by or contracted with DMH, and otherwise to the Human Right’s Officer. Human Rights Committees/Officers shall have authority to review and monitor the use of all restraints at the facility or program in detail, including behaviors necessitating restraint, patient needs, use of crisis plans, and complaints which concern the abridgement of patient rights by the use of restraint and seclusion. 104 CMR 27.12(I)(3)

These new regulatory requirements are in addition to existing reporting requirements for local facilities and the DMH Divisions of Licensing and Child and Adolescent Services. As noted above, this information will soon be required by federal accreditation entities as well.

**What are patients’ legal rights relating to the use of restraint and seclusion?**

Involuntarily committed clients have a federal constitutional right to free from unreasonable bodily restraint, and from the use of excessive force in state facilities. They also have a right to safety, which may be implicated by dangerous restraint procedures, including airway obstruction, basketholds, or prolonged pressure on the torso during takedowns. In addition, involuntarily committed individuals have a right to minimally adequate treatment that will help them be free from unreasonable bodily restraint. The constitutional standard used in
determining whether a particular practice or omission violates the Constitution is whether the practice or omission constitutes a substantial departure from professional judgment or standards, *Youngberg v. Romeo*, 457 U.S. 307, 323-24 (1982). In private facilities, patients have a right to be free from negligent treatment, i.e. treatment that violates the standards of care.

*Have there been any cases in Massachusetts related to restraint or seclusion?*

Restraint is an unpredictably dangerous practice, especially with children. There have been a number of deaths and injuries in Massachusetts related to restraints or seclusion. Some of these have resulted in litigation and court decisions; others have resulted in settlements; still others have resulted in criminal or licensing investigations. A representative sample is described below.

Jeffrey Bogrett, age 9, died on December 1, 1995 at the New England Center for Autism. In those days before attention was paid to deaths in restraint, his death was merely noted as “sudden death in restraint.”

Robert Rollins, age 12, died on April 21, 1997 at the Devereux School, when staff held him face down with his arms crossed under him. His death was ruled “positional asphyxiation during restraint.” Worcester County District Attorney John Conti investigated the death in contemplation of possible criminal charges, but none were ever brought.

Mark A. Soares, age 16, died on April 29, 1998 at Wayside Academy Carriage House. The staff apparently thought he was “faking unconsciousness.” The autopsy revealed “trauma to the neck.” His family sued, and the case was settled for an undisclosed amount.

During this time, several adults also died in restraints at psychiatric facilities. However, death in restraints is not the only trigger for litigation or investigation. In *Rennie v. Davis*, the First Circuit upheld an award of over one million dollars to a man who had been hit by staff after he had been subdued, 264 F.3d 86 (1st Cir. 2001). Although he suffered no serious physical injuries, he was badly traumatized by the event. The First Circuit also upheld liability for the supervising nurse, who was aware of the unnecessary force and should have stopped it. The First Circuit definitely recognizes a cause of action for failure to
intervene on the part of a supervisor or other individual with responsibility on the scene.

In *Hopper v. Callahan*, an earlier case, the Supreme Judicial Court of Massachusetts also emphasized the responsibility of leadership and supervisory staff. Ms. Hopper had arrived at Solomon Carter Fuller, where she was well known, after complaining about physical pain in her stomach area. She had been seen in an emergency room, which sent her to Solomon Carter Fuller, where, at the request of staff, several psychiatrists signed orders for seclusion. She was kept in seclusion after these orders lapsed; the order was renewed without any psychiatrist or physician seeing Ms. Callahan. She was found dead in the seclusion room of ruptured fallopian tube due to an undiagnosed ectopic pregnancy. The Supreme Judicial Court noted that there was nothing in the record demonstrating any emergency or medical necessity requiring Ms. Hopper to be placed in seclusion, and found that the doctors who ordered Ms. Hopper’s seclusion at the request of staff without personally examining her had acted “with no medical judgment at all,” which created potential liability for them individually under both the United States Constitution and state personal injury statutes.

Other courts have also underscored the importance of physicians having personal contact with the patient, and communication with staff on important issues such as restraint, seclusion, suicidality, and privilege levels. *O’Brien v. Kobrin*, 11 Mass.Rptr. 593 (Mass. Super. April 11, 2000); *Marsters v. St. Elizabeths Hospital*, 1998 Mass.SuperLEXIS 423 (Mass Super July 27, 1995).

*What can I do to help prevent the use of restraint and seclusion?*

**A. Help Prevent the Use of Restraint**

Directly consider and address a patient’s traumatic history, including the traumatic effects of separation, hospitalization and restraint and seclusion. Critically examine the treatment environment to limit triggers or other factors, such as excessive noise or confusion, which might aggravate a client’s traumatic reaction.

Become involved in developing and revising your facility/program’s plan to reduce, and where possible eliminate, the use of restraint and seclusion. These
plans should include the development of cohesive mission statements, policies and procedures to guide and support staff in consistently implementing programmatic and individual patient goals.

Work with your unit/program/hospital leadership to develop sensory interventions which provide an alternative means of de-escalating clients by offering spaces and therapies designed to calm and comfort patients, while also assisting in their development of self-soothing and organizing skills.

Ensure plenty of opportunities for exercise and fresh air, including ones that are not related to smoking cigarettes.

Check your unit’s policies and practices to ensure that you are not asking clients to identify methods of coping (e.g. listening to music) and then take them away when the client gets distressed (i.e., taking away Walkman), or to ensure medication compliance.

Ensure that your treatment staff are actively involving patients and families in the development and regular revision of individualized crisis plans. This new regulatory requirement is specifically intended to cooperatively identify triggers or signs of distress experienced by patients prior to restraint events. Crisis plans should also include client suggestions regarding potentially effective staff interventions and de-escalation strategies.

B. When restraint does occur, analyze the causes and work to prevent them

DMH regulations allow any staff member to request a review of a particular restraint or seclusion episode, 104 CMR 27.12(4)(c)(7). Request reviews of problematic restraint incidents or patterns from your facility senior administrative review committee. This body is empowered by the regulations to respond to specific technical support needs and to recommend and direct resources to program/unit settings, including expert consultation, training and performance enhancement activities.

Utilize the de-briefing process to assess restraint events objectively, to consider alternative interventions in collaboration with the client, and to seek
whatever additional support or counseling the parties involved need in order to repair and improve the therapeutic relationship.

**C. Take advantage of available resources, training, education, and tools**

Maximize the use and development of patient safety tools, such as those available on the Department of Mental Health website, [www.mass.gov/dmh](http://www.mass.gov/dmh).

Seek out staff training and resources on trauma informed care, including materials which can be made available by Janice LeBel, PhD, of the DMH Child and Adolescent Divison’s and the National Technical Assistance Center’s (NTAC’s) technical experts panel. Although not directly about children, Maggie Bennington-Davis and Timothy Murphy’s book, *Restraint and Seclusion: The Model for Eliminating its Use in Healthcare*, (HCPro 2005), which is an extremely useful and practical step-by-step approach to eliminating the use of restraint and seclusion on an inpatient unit.

Learn about, visit, and solicit advice from local and national programs which have successfully reduced and eliminated restraint and seclusion, including Boston University’s IRTP at based at Solomon Carter Fuller Hospital? and Kathy Regan, R.N. and the Cambridge Hospital Child and Adolescent Unit. There is a growing body of state and national success stories in this area, and experts who can provide technical assistance. This now includes statewide grand grounds and round table events coordinated by the three year State Initiative Grant to reduce restraint and seclusion.

*Where can I get further information on current regulations regarding restraint and seclusion of children and adolescents?*

The Center for Medicare and Medicaid Services, [www.cms.hhs.gov](http://www.cms.hhs.gov). This website contains information about the Conditions of Participation for hospitals receiving Medicare and Medicaid funds, including question asked by surveyors to determine whether the hospital’s attention to patient’s rights meets the certification standards in the area of restraint and seclusion, [www.cms.hhs.gov/manuals/107_som/som107ap_a_hospitals.pdf](http://www.cms.hhs.gov/manuals/107_som/som107ap_a_hospitals.pdf).
The Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services has declared that reduction of restraint and seclusion is a major national priority, and has funded a number of grants in mental health programs serving both children and adults aimed at reducing the use of restraint and seclusion. Further information can be found at the website: www.samhsa.gov/Matrix/matrix_seclusion.aspx

The National Association of State Mental Health Program Directors has been a leader in developing techniques to reduce restraint and seclusion. The National Technical Assistance Center of the National Association of State Mental Health Program Directors has provided technical assistance to forty-eight states, including programs aimed specifically at reducing restraint and seclusion use in children’s programs. For further information, see www.nasmhpd.org.

Which organizations provide support for parents of children with severe emotional disabilities?

Parent/Professional Advocacy League, (PAL), 59 Temple Street, Suite 664, Boston, MA 02111, (617) 542-7860; www.ppal.net

PAL is the statewide organization of the Federation of Families for Children's Mental Health.
PAL provides support, education, and advocacy around issues related to children's mental health.

Federation for Children with Special Needs, 1135 Tremont Street, Boston, MA 02120, (617) 236-7210, (800) 331-0688 (in Mass.). www.fcsn.org

The Federation is a center for parents and parent organizations to work together on behalf of children with special needs and their families. The Federation operates a Parent Center in Massachusetts which offers a variety of services to parents, parent groups, and others who are concerned with children with special needs.

Massachusetts Association for Mental Health (MAMH), 130 Bowdoin Street, Suite 309, Boston, MA 02108, (617) 742-7452.

The Massachusetts Association for Mental Health, Inc. is a private, nonprofit,
citizens based organization established in 1913 for advocacy and educational purposes. MAMH has directed its activities towards the successful development of community based housing, education, health care, and mental health services for children, adolescents, adults and seniors. It also provides information and referral services.

**National Alliance for the Mentally Ill (NAMI/Massachusetts),** 400 West Cummings Park, Suite 6650, Woburn, MA. (781-938-4048), Information and Referral Line (800) 370-9085. www.namimass.org

NAMI/Massachusetts is a family based advocacy organization for adults and children with mental illness with many local affiliates and programs. It operates information and referral lines from its Boston and Western Massachusetts offices.

*Which agencies provide legal services to children with severe emotional disabilities?*

**Legal services:** For a complete list of free legal services programs in Massachusetts, go to www.masslegalservices.org.

**The Center for Public Representation,** The Center for Public Representation has a Children’s Law Project which assists children and adolescents in obtaining home and community based services and avoiding unnecessary residential placement. CPR has offices in Newton (617-965-0776) and Northampton (413-586-6024).

**The Disability Law Center,** 11 Beacon Street, Suite 925, Boston, MA 02108 (617) 723-8455 or (800) 872-9992. www.dlc-ma.org

DLC is the protection and advocacy agency for the Commonwealth of Massachusetts. If this agency receives a complaint from a child’s parent about abuse, neglect, or violation of the laws or regulations in a children’s facility, it has federal authority to investigate the complaint, including access to the facility, staff, and records (with the parent’s consent in most, but not all, cases).

**The Mental Health Legal Advisor’s Committee,** 399 Washington Street, 4th Floor, Boston, MA 02108 www.mass.gov/mhlac (617) 338-2345.
MHLAC is an arm of the Supreme Judicial Court of Massachusetts which provides advice on legal matters and represents clients who are having difficulties receiving needed mental health services.

Children’s Law Center of Massachusetts, 298 Union St., 2d Floor, PO Box 710, Lynn, MA 01903. (781) 581-1977.

CLC represents children and youth in legal and administrative proceedings, including child abuse and neglect, runaways, custody and adoption disputes, school matters including suspension/expulsion cases, special education cases, SSI matters, access to adequate and appropriate services for children in the custody of DSS or DYS and the cases of severely handicapped children who are denied services due to bureaucratic red tape.

Massachusetts Advocates for Children, 100 Boylston St., Suite 200, Boston, MA 02116, (617) 357-843.

MAC provides legislative, policy, administrative and case advocacy on behalf of children from low-income families in areas of education, special ed, child welfare and health. Bi-lingual intake (Spanish, English) is available.


(HLA) is a public interest law firm affiliated with Health Care for All. HLA provides education, outreach and free legal representation to eligible consumers who live or work in Massachusetts and seek improved access to health care. HLA has a Children’s Mental Health Project.

The Committee on Public Counsel Services, 44 Bromfield Street, Boston, MA (and twelve other regional locations)(617) 285-4666, www.mass.gov/cpcs.

CPCS provides representation to individuals in Section 7&8 (involuntary commitment) and Rogers (involuntary medication) hearings. It coordinates and oversees the work of attorneys who represent children in delinquency, care and protection (abuse and neglect) and CHINS (children in need of services) cases.