

BEHAVIOR SUPPORT & MANAGEMENT:

COORDINATED STANDARDS FOR CHILDREN'S SYSTEMS OF CARE

Final Report
to the Governor and Legislature

developed by the

Committee on
Restraint and
Crisis Intervention
Techniques

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BEHAVIOR SUPPORT & MANAGEMENT:

*COORDINATED STANDARDS FOR
CHILDREN'S SYSTEMS OF CARE*

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A Message from the Council on Children and Families

On behalf of the *Committee on Restraint and Crisis Intervention Techniques*, I am pleased to share the report, *Behavior Support and Management: Coordinated Standards for Children's Systems of Care*. The report outlines a comprehensive, coordinated set of standards recommended for use in children's service settings licensed by the Office of Children and Family Services, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the State Education Department. These standards incorporate current knowledge drawn from research, practice guidelines and expertise from the multiple fields represented by the Committee.

These standards underscore the importance of a comprehensive approach to behavior support and management, focusing primarily on prevention and early intervention strategies. The standards are intended to protect the physical, psychological and medical well-being of children served and the safety of staff while also emphasizing an individualized, holistic approach to care.

While recommendations for reports such as this can be driven by issues around resources and current policies, the Committee's priority was on the development of recommendations that took into consideration the best possible course of action for the safety and well-being of children and staff. The Committee's recommendations also note the essential role of leadership in achieving the behavior support and management standards presented here. Based on the Council's work with Commissioners of the state agencies responsible for the implementation of these standards, it is evident the Commissioners are committed to providing the leadership necessary to promote settings of care that improve the safety and well-being of children and staff.

Committee members are to be commended for their diligent effort to address this complex issue. The Council will continue to work with Committee members on this issue as it involves other service settings.



Deborah A. Benson
Acting Executive Director of the Council and Committee Chair

EXECUTIVE SUMMARY

Currently, three systems of care authorize the use of restraint¹ in particular programs that serve children and adolescents—the Office of Children and Family Services (OCFS), Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD). Each state agency has a set of restraint-related policies and regulations applicable to programs under its jurisdiction. Additionally, the State Education Department (SED) authorizes emergency use of reasonable physical force in schools, including schools that provide educational services to children in programs licensed by OCFS, OMH and OMRDD.

In Chapter 624 of the Laws of 2006, the New York State Legislature directed the Council on Children and Families to establish the *Committee on Restraint and Crisis Intervention Techniques* (RCIT Committee) to examine crisis intervention² approaches used by the four state agencies noted above and to:

1. identify the most effective, least restrictive and safest techniques for the modification of a child's behavior in response to an actual or perceived threat by the child of harm or bodily injury to the child or others;
2. review models of crisis prevention and intervention, including the use of physical restraints; and
3. establish uniform and coordinated standards giving preference to the least restrictive alternative for the use of such techniques.

Cross System Issues

The standards established by each agency authorized to use restraint have been influenced by a number of factors, including agency-specific missions; unique characteristics and service needs of children within the systems of care; and federal mandates that differ for each state agency. While purposeful variations distinguish one agency from another, state agencies do share similarities with respect to standards around use of restraint. In fact, all agencies recognize restraint is to be used only when other interventions have been unsuccessful; staff who implement restraint must be trained and show competency in crisis intervention techniques; and serious injuries resulting from restraints must be documented properly and reported to state and federal oversight entities.

Two areas where state agency standards vary are with respect to the conditions that warrant the use of restraint and the types of physical restraints sanctioned for use. The variations observed across state agency regulations and policy directives translate to:

- Children with a disproportionate risk of being restrained due to varying standards;
- Licensed programs at disproportionate risk of citations due to varying restraint techniques;
- Staff at disproportionate risk of inadequately or improperly applying restraints due to lack of training; and

¹ *Physical restraint*, as used in this report, is defined as the application of physical force by one or more individuals that immobilizes or reduces the ability of another individual to move his or her arms, legs, body, or head freely, for the purpose of preventing harm to self or others. Physical restraint is used in emergency situations and does not include the use of touch for the purpose of calming or comforting the individual, or assistance or support of an individual for the purpose of permitting him or her to participate in activities of daily living (ADL), such as eating, dressing and educational activities or for the purpose of conditioning behavior.

² *Crisis intervention* refers to assistance provided to individuals who experience an event that produces emotional, mental, physical and/or behavioral distress. Crisis intervention, as used here, consists of supports including prevention, early intervention and restraint.

- Staff at disproportionate risk of abuse allegations due to risk shifts by providers.

If our intention is to minimize restraints so we minimize risk to children and staff, it follows that we use a common standard that specifies under which conditions restraint is allowed.

Committee on Restraint and Crisis Intervention Techniques

As required by Chapter 624 of the Laws of 2006, the RCIT Committee includes designees of the commissioners of children and family services, mental health, mental retardation and developmental disabilities, education and health. Also included as Committee members are representatives of statewide provider organizations; representatives of regional provider organizations that represent providers of educational and residential services to children; mental health professionals that provide direct care on a regular basis to children; and parent- and youth-representatives of children requiring special services.

Guiding Principles

RCIT Committee members unanimously recognize that the use of positive behavior management approaches are fundamental to any effective crisis intervention approach and are at the very core of child and staff safety. For that reason, a set of guiding principles that reflects the Committee's view of crisis intervention was developed. Major emphasis is placed on behavior supports and management practices that reduce the need for physical restraints. The guidelines outline:

- when restraint is warranted;
- necessary roles of state agencies and providers;
- resources necessary for effective crisis intervention; and
- the responsibilities of leadership, at both the state agency and provider level, to promote crisis prevention practices and the use of restraint in the safest and most individualized manner as possible.

These principles reflect a philosophy of behavior support and management that is endorsed by OCFS, OMH, OMRDD and SED.

Approaches Used

Multiple approaches were undertaken by Council staff and RCIT Committee members to examine issues pertinent to crisis intervention and to fulfill the charge of the legislation. These included a review of: research literature; best practice standards endorsed by national organizations; crisis intervention training models; and current state and federal agency laws, regulations, policies, and practices. Council staff gathered additional information from staff in other states regarding use of particular forms of restraint and convened subcommittees to determine the best ways to operationalize the guiding principles developed by the full Committee. Furthermore, the work of the RCIT Committee is closely linked to changes in state regulations and policies, directly impacting 'how we do business' so the Council convened a meeting with the Chair of the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD)—the entity responsible for investigating restraint-related deaths that occur within OMH and OMRDD service settings, and Commissioners of OCFS, OMH and OMRDD to identify the best ways to address and mitigate the special challenges faced by multiple licensed providers with co-located programs who must comply with conflicting state agency regulations and policies concerning use of restraints.

Coordinated Standards for Behavior Management and Support

As part of Chapter 624 of the Laws of 2006, the RCIT Committee is required to establish coordinated standards for the most effective, least restrictive and safest techniques for the modification of behavior. Given the serious implications of crisis intervention and the complexity related to the coordination of four service systems, a comprehensive approach was used to identify these standards. Based on the review of the literature, best practice standards, and in keeping with the intent of the guiding principles established by the Committee, it is recommended the following coordinated standards be integrated into the current practice and regulations of OCFS, OMH, OMRDD and SED. At this time, the coordinated standards apply to programs outlined in the legislation, with the exception of day treatment programs and community residences. The Council will continue to work with agencies and Committee members on this topic to address the unique and complex issues related to these particular service settings. Though not specified in the legislation, it is recommended the coordinated standards apply to special act school districts (see Appendix G) in the same manner as they apply to private residential and private non-residential schools. Furthermore, these standards are developed for children; yet it is believed the standards could be applicable to settings that serve adults as well.

Staff trained in recognized, competency-based program

Staff training is essential for effective crisis intervention. The literature and best practice standards are clear on the need for staff to be trained in the full continuum of crisis prevention and intervention techniques, ranging from sound communication skills, effective de-escalation techniques tailored to the individual child, and use of more restrictive crisis intervention techniques, including physical restraints. In fact, trained staff are more likely to rely on de-escalation techniques and less likely to apply restrictive forms of crisis intervention. Therefore, it is recommended that a common core of skills be a part of all training provided by OCFS, OMH and OMRDD. Furthermore, competency-based training should be made available to staff employed by providers with multiple licenses so all staff, including education staff, will have a consistent set of crisis intervention skills that can be employed with all children in all settings.

Individual behavior management plan available for children at risk of being restrained

The literature notes children are more likely to be restrained when they first enter a program or when they have extended lengths of stay. As such, all children should have the benefit of a preliminary assessment upon admission to a program and on an ongoing basis to determine if they have behavior management problems and, if so, to identify the most effective forms of crisis prevention and early intervention specific to that child. At a minimum, the assessment should include a history of risk factors; identification of antecedents, early warning behavior and coping mechanisms; and a medical assessment by qualified staff. The likelihood a child will be restrained early in a program is not dependent on the types of services received or the number of licenses a provider may have. This means all children, regardless of the service system or program location should have access to an early risk assessment, followed by an individual behavior management plan as determined by the assessment. A behavior management plan is a valuable tool for all individuals who interact with the child; therefore, it is recommended, particularly in instances where a child may receive education services, in addition to services through OCFS, OMH or OMRDD, that the plan be developed with the involvement of all relevant staff (e.g., residential, clinical, educational) and the final document be made available to them. All team members are responsible for implementation of the plan, as written. The degree to which a plan is individualized will depend upon the involvement of those people who know the child best, including parents or guardians and the children themselves. Therefore, as appropriate, children and their parents or guardians should be actively involved in the development of these plans. Furthermore, the strategies outlined in a behavior management plan are intended to support the child when in distress and help the child integrate effective replacement skills. Therefore,

it is particularly helpful if parents are well-versed in the plan content and able to use the techniques described in the plan so they are equipped to support their child in their home.

A uniform standard for use of restraint

Safe techniques for restraint begin with a universal standard of when a restraint *is* and *is not* warranted. Most practice standards recognize restraint should not be used as a means of discipline or punishment, as a substitute for adequate staffing, as a replacement for treatment, or in any circumstance where less restrictive behavior management techniques would be effective. Furthermore, restraint should not be used in circumstances where an individual may be medically compromised. The widely accepted gold standard used to determine when restraint is necessary is in circumstances that jeopardize the physical safety of a child or others.

A single, uniform standard that permits the emergency³ use of restraint in only the most serious conditions where the safety of a child or others is in jeopardy reduces the chance a child will be restrained unnecessarily; provides greater clarity to staff; and informs children and their families of types of behavior that may result in the most restrictive form of crisis intervention. This is particularly true for multiple licensed providers with co-located programs.

Use of an accepted physical restraint technique

Various forms of physical restraint are presented in the training programs endorsed or provided by OCFS, OMH and OMRDD with prone and supine restraint techniques being predominant. It is accepted that all forms of physical restraint come with inherent risk due to the hazardous circumstances in which restraints are applied—in instances where one's behavior is at a point it may jeopardize the physical safety of self or others. This is further complicated by the fact that staff must exercise judgment during these volatile times, not only with respect to whether the restraint is warranted but in the physical application of the restraint. In most service settings, a common standard for when to use restraint coupled with a standard for regularly available competency-based training can address these issues, regardless of the type of restraint used. However, these standards are not sufficient for staff employed by providers with multiple licenses at co-located programs.

In those limited instances where providers have multiple licenses, staff training and specific protocols will not suffice. In such settings, trained staff are at risk of implementing a form of restraint not endorsed by a given agency and are at greater risk of being investigated for abuse for applying a restraint technique inconsistent with the rules of one of the licensing agencies. Therefore, a single common physical restraint technique is needed for staff employed by these specific providers.

It is recommended a supine restraint technique, which is currently used by two of the three state agencies, be adopted by *multiple licensed providers at co-located sites*. This change will maximize cross-system coordination necessary for these unique sites. While this requires changes within one service system, namely OCFS, it is important to note the number of staff impacted by this change at the multiple licensed sites will be considerable.

The change has implications for training and will require residential treatment center staff currently trained in the use of a prone technique to be trained in a supine technique. Furthermore, the current prone technique requires two staff to complete and it is preferable to use three staff to implement the supine technique. Given these circumstances, it is strongly recommended this form of restraint be

³ The definition of physical restraint notes this form of restraint is used only in emergency circumstances. This is done to distinguish these types of restraints from those used in OMRDD settings where a child may have a conditioning form of restraint noted in an individualized behavior management plan.

used only in conjunction with comprehensive restraint reduction practices and that the implementation be phased in so organizational changes can be made in an effective manner.

As noted, there are different forms of supine restraint currently being used and a single form will need to be adopted by all three agencies for use at the multiple licensed sites. The form of supine restraint technique selected will determine which agency is responsible for training of staff employed by providers with multiple licenses at co-located sites. Prior to this change being implemented, licensing agencies will need time to conduct staffing analyses and it is suggested agencies share their staffing models with sister agencies.

Use of standard monitoring practices during restraints

A clear lesson gleaned from the literature is the importance of monitoring during the time of a restraint. Continual monitoring of individuals in restraint is critical given the health risks associated with their agitated state and as such, numerous guidelines note the importance of monitoring with periodic assessments. At a minimum, it is recommended staff applying the restraint monitor the child's skin color, respiration, level of consciousness and agitation and range of motion in extremities every 15 minutes, regardless of the restraint technique used. Currently, this standard is being met through training programs supported by OCFs, OMH and OMRDD. Additionally, these monitoring practices will become a part of restraint procedures implemented by education staff who participate in this training.

Methods that inform quality and practice from the perspective of children and staff

Two methods recommended as standards for effective and safe behavior management are staff/supervisor reviews of restraint and child/ staff restraint reviews of restraint. The purpose of these reviews is to learn what can be done at the program- and child-level to reduce the likelihood of future restraints and increase safety for children and staff.

Monitoring and data reporting to provide a comprehensive view of restraint use and related injuries

Restraint reduction is a critical component of any safe behavior management approach since reduction of the most restrictive and dangerous form of behavior management will increase safety for children and staff. To that end, it is important for organizations to gain an understanding of the rate at which high risk interventions occur. This information, coupled with reviews of restraint incidents, which provides a view of 'why' restraints happen, will increase capacity of programs and state agencies to make improvements to the quality of care available.

It is recommended that monitoring of physical restraint use and related injuries become a practice standard adopted by all agencies that authorize the use of restraint and that this information be reported to state agencies on a regular basis. Furthermore, it is recommended these data be aggregated on a statewide level and reviewed by state agency leadership for variations and patterns in restraint use and injuries.

Currently, all state agencies require providers to log each occurrence of a restraint and to report any cases that result in serious injury to the designated state agency representative. Since children in programs with a residential component are not directly under the care of their parents and since the providers serve in the capacity of parents, it is essential that any information regarding use of restraints in educational settings be provided to the program with the residential component. This allows staff in both programs to provide supports to the child during this vulnerable time. Additionally, it is critical for such programs to have the most comprehensive view of restraint use within their systems due to the individual and institutional risks associated with restraint use. This

means each agency should identify settings where this information is not currently available and identify ways to incorporate it so a full view of restraint and injury data is available.

Summary and Next Steps

The issues of equity raised initially in this report support the need for coordinated standards that could be adopted by each state agency represented in the legislation to enhance behavioral support strategies currently in place. Although each agency has these standards in place to varying degrees (e.g., staff training, monitoring systems, use of behavior management plans), resources that could assist state agencies to implement these standards at the same level across systems would even out conditions regarding when restraints are applied; the quality of training for those applying crisis intervention strategies; provide an enhanced risk management view, given better monitoring; and improve the overall safety and well-being of children and staff in these settings. It is suggested that representatives from each agency develop an agency-specific work plan that outlines what is necessary for the standards to be implemented within its system and share these documents with the Council.

RECOMMENDATIONS FOR COORDINATED STANDARDS AND GUIDING PRINCIPLES

RECOMMENDATIONS RELATED TO DEVELOPMENT OF COORDINATED STANDARDS FOR BEHAVIOR SUPPORT & MANAGEMENT

Revise current state agency regulations, as necessary, to be consistent with the recommended coordinated standards.

Each agency will need to review and make revisions, as necessary, to current regulations so they are consistent with the standards outlined in this report and to its sister agencies. This does not mean identical regulations are necessary but that the objective of the regulations be consistent. Therefore, it is suggested the Council continue to work with state agencies in this process after the report is submitted to the Governor and Legislature.

Implement a coordinated, *cross-system* approach to behavior management and crisis intervention in multiple licensed, co-located service settings.

In an effort to advance cross-system, coordinated practices across the service systems represented at multiple licensed sites, a standard form of physical restraint will be incorporated into staff training and used for children served by each system of care. A supine technique is recommended for use, given the fact that two agencies currently employ this form of restraint. The form of supine restraint technique used will determine which agency is responsible for staff training at the multiple licensed sites.

Revise training curricula sponsored or provided by state agencies, as necessary, to incorporate skills that promote positive behavioral supports and alternatives to restraint.

The training curricula sponsored by each agency may need to be modified to incorporate some of the additional skills recommended. This is applicable for all programs licensed or operated by state agencies. Additionally, training curricula will need to be modified to incorporate the form of supine restraint to be used for training at the multiple licensed sites with co-located programs. This modification will not be necessary for curricula presented at single

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| | licensed sites. |
| Modify state agency staffing models, as necessary, to provide the staffing needed for the successful implementation of coordinated behavior support and management standards. | Staffing modifications may be necessary in some programs. As such, it would be beneficial for state agencies to share staffing models with one another so each agency has a better sense of the best way to proceed for its own agency. |
| Establish state agency monitoring systems to monitor rates of restraint use and related injuries to children and staff. | The monitoring system should provide a <i>comprehensive</i> view of the extent restraint is used within a given system and the rate of injuries that occur to children and staff as a result of those restraints. The monitoring systems should distinguish between those injuries that require first aid attention and those that require medical attention beyond first aid. Additional information of benefit to leadership pertains to where (e.g., school, cafeteria) and when (e.g., time of event) restraints occur. This may require development or expansion of monitoring systems currently in place. |
| State agencies identify and receive the resources necessary to implement coordinated crisis intervention standards. | The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote positive behavior supports within its specific system. These include but are not limited to such best practices standards as the use of individualized behavior management plans, competency-based staff training and monitoring of restraints. However, if the comprehensive, coordinated standards presented here are to be realized, each agency will need varying degrees of resources to successfully implement the proposed uniform standards. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary. It is suggested that each agency develop a work plan for the implementation of the coordinated standards and share those plans with the Council. |
| Establish a mechanism for the review of changes to regulations that would be applied to multiple licensed providers with co-located programs. | Most of the behavior management standards outlined here are relevant for all providers, regardless of the number and type of licenses held. However, some are especially relevant for the subset of providers with multiple licenses. As such, it is necessary to have a means to review changes in regulations that impact these providers given the consequences these changes have on programs licensed by other service systems. While each agency will retain its independent statutory authority and responsibilities, it is recommended the Council work with state agencies to determine the most appropriate mechanism for the review of such regulations. |

RECOMMENDATIONS RELATED TO LEADERSHIP AND WORKFORCE DEVELOPMENT

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| Either through the development of a <i>Restraint Reduction Plan</i> or through individual leadership approaches, leadership identifies and implements strategies to advance positive | Leadership's ability to influence organizational change is a key predictor of successful positive behavior management, including restraint reduction. A primary reason for the link between leadership and organizational culture is leadership's unique position to use various strategies, including ongoing communication and the use of management processes, organizational |
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| <p>behavior management and restraint reduction efforts.</p> | <p>structures, environmental conditions, and reward systems to institutionalize values that support change.</p> <p>A number of tools are available to leadership that might be used to assist in determining an organization's readiness to incorporate positive behavioral supports. Additionally, <i>Restraint Reduction Plans</i>, if developed and implemented properly, can help organizations identify positive behavior management approaches and reduce the use of emergency restraints.</p> <p>Examples of activities that can be undertaken by individuals in a leadership role to foster organizational change are outlined in this report in Section III.</p> |
| <p>Either through the development of a <i>Restraint Reduction Plan</i> or through individual leadership approaches, leadership incorporates strategies in hiring or workforce development practices to advance positive behavior management and restraint reduction efforts.</p> | <p>Leadership is able to emphasize the importance of positive behavior management and restraint reduction in hiring and workforce development practices. Some strategies available to support organizational change and increase staff retention include but are not limited to providing job candidates with a clear understanding of organizational expectations, including expectations related to crisis intervention techniques and use of accountability practices that promote positive behavior management and restraint reduction practices, such as items within staff's annual performance reviews. Examples are provided in this report in Section III.</p> |
| <p>State agencies provide technical assistance to leadership that allows for the development and implementation of positive behavior management and restraint reduction efforts.</p> | <p>There are many methods available to state agencies to provide technical assistance to support leadership's ability to reduce restraints. Possible forms of technical assistance include but are not limited to annual forums, dissemination of written materials, on-site reviews and leadership training seminars. Different forms of technical assistance may be more effective for some programs than others and program specific support may be required. The most effective form of technical assistance for programs will be decided by each state agency.</p> |

RECOMMENDATIONS RELATED TO TRAINING

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| <p>Provide competency-based training that incorporates a common skill set and maintains a focus on crisis prevention and early intervention while also developing the necessary skills for the safest possible restraint and effective, restorative supports following restraint.</p> | <p>Staff training should provide a holistic approach to the treatment of children, embed the continuous prevention of crisis situations and include a thorough understanding of the trauma, triggers, and re-enactments possible not only in the children but also in the adults who care for the children. Such a training curriculum could address:</p> <ul style="list-style-type: none"> ○ Self-assessment ○ Interpersonal skills ○ Communication skills ○ Crisis recognition skills ○ Crisis prevention skills ○ De-escalation skills ○ Physical restraint skills ○ Debriefing skills <p>While it is critical to re-enforce the full range of skills on a continuous basis, any program hoping to reduce the use of physical interventions should regularly focus on the development of non-physical skills and foster an understanding of how these skills can easily be underutilized in an emergency</p> |
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| | <p>situation. When confronted with crisis situations, staff are more likely to use the most familiar, effective method for intervention. By increasing staff familiarity and comfort level with non-physical skills, the likelihood that these skills will be utilized will be decreased.</p> |
| <p>Implement a culture of continuous growth and support for children and staff.</p> | <p>Training should not be looked upon as an isolated event or scheduled recurring event. Rather, in order to effectively develop and maintain the skills necessary to work in a crisis-vulnerable environment one must be continually striving for higher levels of competence. This is achievable only when a culture exists that fosters continuous growth and support for both its clients and its staff. In order to create this culture, the natural and official leaders must be in alignment and work together toward the common goal by role modeling, teaching, and enforcing the positive organizational values and practices in their everyday interactions. One way this can be accomplished is with a multi-tier system of trainers who are working collaboratively to improve the quality of staff performance on a daily basis. At the heart of this system is the idea that anyone who is a leader in the organization is also a trainer. An example of a multi-tier training system is described in this report in Section III.</p> |
| <p>Make equivalent training opportunities available to staff employed by state-operated and state-licensed programs.</p> | <p>Currently, training opportunities to staff at state-operated programs differ from the training opportunities available to staff at licensed programs. The same training opportunities should be made available to all staff, regardless of how programs are operated, so children within each system of care have staff with consistent skills.</p> |
| <p>State agencies identify and receive, as necessary, the resources required to implement coordinated standards related to training.</p> | <p>The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote effective staff training within its specific system. However, each agency will need varying levels of resources to successfully implement the proposed uniform standards related to training. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary.</p> |

RECOMMENDATIONS RELATED TO BEHAVIOR MANAGEMENT PLANS & RISK ASSESSMENT

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| <p>Conduct structured standard assessments at intake and on an ongoing basis to identify children who may have behavior management problems and be at risk of more restrictive forms of crisis intervention.</p> | <p>Research indicates emergency use of restraint is related to the time in which a child receives services. Specifically, children are more likely to experience this type of restraint early in their placement when they are not familiar with the new setting and staff are not familiar with them as well as when children have longer lengths of stay. Therefore, it is necessary for children to have a preliminary assessment conducted upon their arrival to a program to determine the likelihood they may be at increased risk of an emergency restraint. The assessment should be conducted to determine strategies that could reduce the need for the most restrictive form of crisis intervention. Factors to consider in preliminary assessments are described in this report.</p> <p>The assessment should be conducted periodically, during a child's stay in the program to assess whether conditions have changed (e.g., child's risk of restraint may decrease over time).</p> |
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Each child who is identified as having behavior management problems should have an individualized behavior management plan that is examined on a regular basis for efficacy.

To help staff support children with behavior management issues, it is recommended that an individualized behavior management plan be made available within a reasonable amount of time of the child's arrival to the program. Additionally, the efficacy of the plan should be examined following each restraint.

Where not clinically contraindicated, children and their parents, guardians or advocate actively participate in the development of the child's behavior management plan and approve the plan as written prior to implementation.

Given the individualized approach of a behavior management plan and the serious nature of crisis intervention, it is recommended that children and their parents, guardians or advocates actively participate in the development of the behavior management plan and approve the plan prior to implementation.

Use standard protocols to develop individualized behavior management plans.

Each child should have information in his/her behavior management plan that will allow staff to support him/her in managing behavior. The information should be garnered following a structured, standardized assessment conducted by staff that are qualified and trained as necessary. Additionally, consideration must be given to whether there are medical contraindications to the use of restraint.

Where needed, enhance staffing to incorporate qualifications necessary for the development of behavior management plans.

At present, staff with the recommended qualifications may not be available to develop such plans. Therefore, state agencies will need to conduct staffing reviews to determine: (a) areas where additional staff may be needed and (b) whether staff with particular qualifications are needed.

State agencies identify and receive, as necessary, the resources required to implement coordinated standards related to behavior management plans and risk assessment.

The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote individualized behavior management approaches within its specific system. However, each agency will need varying degrees of resources to successfully implement the proposed uniform standards related to individualized behavior management plans. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary.

RECOMMENDATIONS RELATED TO DEVELOPMENT OF QUALITY ASSURANCE MECHANISMS

Develop and incorporate into regulations a common standard that specifies under which circumstances staff may use restraint.

Currently different standards are outlined in state agency regulations regarding when staff may be required to use restraints. Some standards are broader, encompassing more situations when restraint may be used. This means children in those settings have a greater probability of experiencing restraint. This uneven standard is particularly challenging for children receiving services from multiple-licensed providers where the child may receive services from child welfare or mental health services as well as educational services. For example, a child's behavior in the educational setting may warrant a restraint but that same behavior may not meet the standard for restraint in the residential setting. A common standard used by all state agencies would address this.

On a regular basis, conduct a review of restraints to determine the extent staff followed established procedures and to identify modifications that could improve organizational procedures.

On a regular basis, supervisors and staff should conduct meetings with the purpose of reviewing restraints that occurred during a given period of time to determine the extent procedures used were consistent with policies as well as to identify organizational factors that could improve restraint reduction. This practice is commonly referred to as debriefing and can follow each restraint.

Use standard protocols to increase the consistency and quality of information gathered during restraint reviews.

The information gathered during restraint reviews serves to improve practice and policy at the individual and population level as well as organizational and system level. Therefore, it is recommended standard protocols be used to gather consistent types of information and that this information be incorporated into quality assurance systems so it may be aggregated and used to inform policy and practice or be done for a given period of time, depending on staffing limitations.

Establish timely, comprehensive monitoring systems to monitor restraint and related injuries to staff and children as a result of those restraints.

The extent restraint and injury data are easily accessible and able to be aggregated varies considerably by state agency and local provider. Therefore, it is recommended automated, web-based monitoring systems be made available to providers, including schools, to record instances of restraint as well as injuries that result from those restraints, both for children and staff. Injury data should be expanded to include injuries requiring first aid as well as severe injuries. The monitoring systems should be designed, at a minimum, to provide the following information:

- Rate of restraint use
- Child injury rates related to restraint
- Staff injury rates related to restraint

At a minimum, state agencies that authorize the use of restraints annually aggregate restraint and injury rates of their respective systems.

The information gathered from the monitoring systems should be reviewed periodically at the aggregate level to identify patterns in the use of restraints and variations in those patterns.

Incorporate into current surveying and licensing processes data pertaining to:

- Rate of restraints
- Child injury rates related to restraint and
- Staff injury rates related to restraint.

Use of restraints places children and staff at risk of injury. This practice also increases risk to the organization as a whole. Therefore, this practice should be monitored carefully and be a criterion used to assess the quality of state-operated and state-licensed programs. As appropriate, populations served will be taken into account when reviewing rates of restraint.

State agencies identify and receive, as necessary, the resources required to implement coordinated standards related to quality assurance.

The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote quality assurance practices within its specific system. However, each agency will need varying degrees of resources to successfully implement the proposed uniform standards related to quality assurance. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary.

I. INTRODUCTION

Due to a variety of circumstances, children and youth experience life events that result in considerable trauma. Additionally, children may have experienced a significant mental health or substance abuse problem. The way children respond to these experiences and problems is often influenced by personal temperament, previous experiences and individual psychological and biological factors. Unfortunately, there are times when the enormity of life stressors or personal problems are perceived to be so great that some children are unable to cope and function, requiring behavior management assistance from adults.

Crisis situations are unexpected or idiosyncratic conditions that challenge a person's ability to cope, often resulting in the individual feeling anxious, depressed and out of control (1). The basic principles of crisis intervention are to quickly intervene, stabilize the individual in crisis, facilitate understanding of the situation, focus on problem-solving, and encourage self-reliance. While the goal of crisis intervention is to help children return to an independent level of functioning, there are times when more restrictive interventions are required. In these instances, trained staff may need to implement restraints to prevent children from causing serious physical injury to themselves or others.

The use of restraints is recognized as 'an intervention of last resort' due to the high-risk outcomes associated with it, including trauma, injury and even death (2, 3). Despite these risks, children⁵ experience restraint at higher rates than adults and are at greater risk of injury during those restraints. Yet empirical evidence that suggests there are *therapeutic* benefits associated with restraint is lacking (4, 5, 6).

The concerns surrounding restraint use are counterbalanced by the need to keep children safe during episodes of extremely aggressive behavior (7, 8, 9). The use of restraints is highly emotional for all involved, including the staff and person involved in the restraint as well as for those who observe it (10, 11). In fact, the event of a restraint is considered so volatile it has been compared to a cardiac arrest in a cardiac care unit. Professionals view restraint

Crisis intervention as used in this report, refers to assistance provided to individuals who experience an event that produces emotional, mental, physical, and/or behavioral distress. Crisis intervention includes a full continuum of supports including prevention, early intervention and restraint.

Physical restraint, as used in this report, refers to the application of physical force by one or more individuals that immobilizes or reduces the ability of another individual to move his or her arms, legs, body, or head freely, for the purpose of preventing harm to self or others. Physical restraint is used in emergency situations and does not include the use of touch for the purpose of calming or comforting the individual, or assistance or support of an individual for the purpose of permitting him or her to participate in activities of daily living (ADL), such as eating, dressing and educational activities or for the purpose of conditioning behavior. This is considered one of the most restrictive forms of crisis intervention⁴.

⁴ This definition is a variation of the definition developed by the Child Welfare League of America (www.cwla.org). The definition of physical restraint notes this form of restraint is used only in emergency circumstances. This is done to distinguish these types of restraints from those used in OMRDD settings where a child may have a conditioning form of restraint noted in an individualized behavior management plan.

⁵ The term 'children,' as used in this report, includes children and adolescents.

use as an emergency measure but also acknowledge the potential for it to be used inappropriately by staff. Furthermore, even when applied appropriately, injury to children or staff could result due to the high risks associated with restraints. In light of these challenges, strategies to promote positive behavior supports and positive alternatives to restraint have gained prominence among professional organizations, advocacy groups and federal authorities.

Cross System Issues

Currently in New York, three systems of care authorize the use of restraint in particular programs that serve children—the Office of Children and Family Services (OCFS), Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD). Each state agency has a set of restraint-related policies and regulations applicable to programs under its jurisdiction. Additionally, the State Education Department (SED) authorizes emergency use of reasonable physical force in schools, including schools that provide educational services to children in programs licensed by OCFS, OMH and OMRDD.

The standards established by each agency authorized to use restraint have been influenced by a number of factors, including agency-specific missions; unique characteristics and service needs of children within the systems of care; and federal mandates that differ for each state agency. While purposeful variations distinguish one agency from another, state agencies do share similarities with respect to standards around use of restraint. In fact, each agency recognizes restraint is to be used only when other interventions have been unsuccessful; staff who implement restraint must be trained and show competency in crisis intervention techniques; and serious injuries resulting from restraints must be documented properly and reported to oversight entities. Two areas where agency standards vary are with respect to the conditions that warrant the use of restraint and the types of physical restraints sanctioned for use. These variations have broad implications for children and staff across service systems as well as consequences for particular providers of care. A fuller description of these issues is outlined below.

Standards for use of restraint

Currently, standards for use of restraint vary across agencies (see Appendix D) with SED providing more circumstances when restraint is allowed. Within SED regulations, emergency interventions may be used in circumstances where it is necessary to protect oneself from physical injury, to protect another pupil or teacher or any person from physical injury, to protect the property of the school, school district or others, or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties.

OCFS has fewer circumstances when restraint is permitted. However, similar to SED, restraint may be used in situations involving property damage. We have learned from a review of state policies that other states further clarify when property damage warrants restraint by noting restraints can be used if property damage results in risk of harm to self or others (e.g., breaking a window).

Mental Hygiene Law is used to determine conditions for restraint in OMH programs and focuses on the criterion of serious injury to self or others. OMRDD uses the criterion of dangerous behavior where serious injury could occur in determining whether a restraint is warranted.

The mixed standards regarding when restraint can be used suggests that risk is relative and dependent upon which system of care provides services rather than the actual event. Even more disquieting, it

means children in certain settings have a higher probability of experiencing this high-risk and traumatic experience.

Restrictive crisis intervention techniques

OCFS, OMH, OMRDD and SED regulations require staff to successfully complete crisis intervention training before they are able to use the most restrictive crisis intervention techniques. The various crisis intervention training curricula required or supported by OCFS, OMH and OMRDD are very consistent regarding crisis prevention, early intervention and de-escalation skills presented to training participants. The area where curricula differences exist is with respect to the type(s) of restrictive crisis intervention techniques (i.e., physical restraint) supported.

These variations in restraint techniques would not necessarily present concern for staff working in licensed programs, given differing state agency jurisdictions, different geographic locations and agency-specific training curricula that incorporate restraint-related policies. However, some service providers have licenses from more than one state agency and programs housed in one location. The providers with more than one operating license from OCFS, OMH and OMRDD are referred to as *multiple licensed providers with co-located programs*. These particular providers have areas where the children in programs licensed by different agencies (OCFS, OMH, OMRDD) may be in common locations, such as the school. Due to differing restraint techniques, staff must be aware of which program and licensing agency has responsibility for each particular child in order to implement the appropriate restraint technique⁶. It should be noted that this scenario will most likely include school staff who are allowed more conditions for restraint use.

Risk-sharing

It is recognized that restraint is the final intervention in a lengthy de-escalation process. Due to this risk, some state agencies have a practice whereby the application of an unapproved restraint technique (i.e., a technique not approved in plan submitted to state agency or technique not permitted by state agency) results in programs being cited with corrective action required. Specifically, the use of an unapproved restraint technique may be considered a form of abuse, which could lead to an abuse investigation that could result in a provider deciding to dismiss that staff member. This process clearly reflects the gravity of restraint risks. At the same time, this practice coupled with differences in authorized restraint techniques poses particular challenges for staff employed by multiple licensed service providers with co-located programs. Staff at these sites have a greater chance of improperly using a restraint technique since children at these sites use common areas (e.g., cafeteria, school, religious settings, medical clinics). Also, risk of improper use of restraint techniques can occur when staff are needed to provide coverage in different programs at the co-located sites (i.e., work in an OMH program and then required to cover an OCFS program).

Summary of cross system issues

Presently, the variations observed across state agency regulations and directives translate to:

- Children with a disproportionate risk of being restrained due to varying standards;
- Licensed programs at disproportionate risk of citations due to varying restraint techniques;
- Staff at disproportionate risk of inadequately or improperly applying restraints due to lack of training; and
- Staff at disproportionate risk of abuse allegations due to risk shifts by providers.

⁶ The variations in restraint practices were not in place at the time these providers sought multiple licenses.

These issues of inequity require the attention and action of state agencies for a number of reasons. First, the variations are associated with state agency regulations and practices and, as such, resolutions must occur at that level. While dedicated providers may identify short-term solutions, they are not responsible for policy or regulations. Furthermore, state agencies have an especially keen responsibility to work with multiple licensed programs with co-located programs to address these variations in standards given the fact that these programs were licensed *prior to* state agency changes in restraint practices and did not have the opportunity to make accommodations for these variations in their capital plans or staffing needs. Last, the resolution requires a sound policy approach with a system-wide focus rather than a transfer of responsibility that results in local solutions, which are inconsistent with the mission and philosophy of the licensing agencies (e.g., staff call police).

Role of the Committee on Restraint and Crisis Intervention Techniques

In Chapter 624 of the Laws of 2006, the New York State Legislature directed the Council on Children and Families to establish the *Committee on Restraint and Crisis Intervention Techniques* (RCIT Committee) to:

1. identify the most effective, least restrictive and safest techniques for the modification of a child's behavior in response to an actual or perceived threat by the child of harm or bodily injury to the child or others;
2. review models of crisis prevention and intervention, including the use of physical restraints; and
3. establish uniform and coordinated standards giving preference to the least restrictive alternative for the use of such techniques. (Appendix A).

The legislation indicates techniques shall include, but not be limited to the use of physical restraint, therapeutic crisis intervention, crisis management or such other de-escalation techniques designed to help staff assist children to manage crisis situations. However, the phrase 'harm or bodily injury to such child or to another person' presupposes conditions at the most restrictive end of the crisis intervention continuum and, as such, specifically refers to forms of restraint. That said, the RCIT Committee recognizes the critical role of positive behavior management practices in any examination of the 'safest' crisis intervention approach and has incorporated these practices into its work. The coordinated standards developed by the Committee may be applicable to adults as well as children.

RCIT Committee Members

As required by legislation, the RCIT Committee includes designees of the commissioners of children and family services, mental health, mental retardation and developmental disabilities, education and health. Also included as Committee members are representatives of statewide provider organizations; representatives of regional provider organizations that represent providers of educational and residential services to children; mental health professionals that provide direct care on a regular basis to children; and parent- and youth-representatives of

Figure 1. Committee on Restraint and Crisis Intervention Techniques

- Council of Family and Child Caring Agencies
- Families Together in New York State
- Greenberg & Trauring Law Firm
- Hillside Family of Agencies
- New York State Coalition for Children's Mental Health Services, Inc.
- New York State Commission on Quality of Care & Advocacy for Persons with Disabilities
- New York State Department of Education
- New York State Department of Health
- New York State Office of Alcoholism and Substance Abuse Services
- New York State Office of Children and Family Services
- New York State Office of Mental Health
- New York State Office of Mental Retardation and Developmental Disabilities
- Parsons Child and Family Center
- The Children's Village, Inc.
- Upstate Cerebral Palsy
- Vanderheyden Hall, Inc.

children requiring special services. Figure 1 presents the state agencies, licensed programs and organizations represented on the Committee.

Guiding Principles

RCIT Committee members unanimously recognize that the use of positive behavior management approaches are fundamental to any effective crisis intervention approach and are at the very core of child and staff safety. For that reason, a set of guiding principles that reflects the Committee's view of crisis intervention was developed and outlines:

- when restraint is warranted;
- the roles of state agencies and providers;
- resources necessary for effective crisis intervention; and
- the responsibilities of leadership, at both the state agency and provider level, to promote crisis prevention practices and the use of restraint in the safest and most individualized manner as possible.

The set of guiding principles is presented in Appendix B.

Approaches Used

Multiple approaches were undertaken by Council staff and RCIT Committee members to examine issues pertinent to crisis intervention and to fulfill the charge of the legislation.

Review of research literature

- The legislation points to the need to have recommendations grounded in sound empirical evidence. To that end, research related to restraint reduction and the use of particular types of restraint was reviewed. Research pertaining to type of restraint technique was particularly relevant given the legislative charge for uniform standards and the current variations in restraint techniques across state agencies. When possible, particular attention was focused on research conducted with children.
- A summary of the literature review is presented in Section II of this report.

Review of best practice standards

- Best practice standards are based on our best knowledge from the research literature as well as expert judgement. A number of national organizations have developed best practice standards that outline recommended practices relative to behavior management and the use of restraint. The focus of these standards tends to be balanced across interests in prevention, intervention and stabilization procedures. Common themes observed are the importance of restraint reduction and the critical roles quality assurance and behavior management planning play in achieving that reduction.
- The review included behavior management standards adopted by the:
 - American Academy of Child and Adolescent Psychiatry (AACAP);
 - Child Welfare League of America (CWLA);
 - The Joint Commission; and the
 - National Association of State Mental Health Program Directors (NASMHPD).
- Position statements by advocacy organizations were also reviewed, including statements from the:

- American Association of Children's Residential Centers;
- Autism National Committee; and
- Federation of Families for Children's Mental Health.
- A summary of the best practice standards is presented in Appendix C.

Review of current regulations

- Given that regulations are the vehicles used by state agencies to implement statute and practices, the specific state and federal regulations each agency has around the issue of restraint were examined. These regulations were reviewed with respect to features outlined in best practice standards to determine the extent current regulations were consistent with best practice characteristics as well as determine the extent regulations were similar across agencies. There appears to be more similarities than differences across state agencies and considerable agreement with best practice standards recommended by national organizations. However, a number of areas exist where policy can be expanded to reflect the most current standards available to us.
- An overview is provided in Appendix D.

Survey of states

- Council staff contacted representatives from other states to determine if the states allowed the use of the supine restraint technique in their child welfare or juvenile justice systems. An overview of findings is presented in Appendix E.

Review of training curricula

- In keeping with requirements of the legislation, various forms of crisis intervention models were reviewed. The models included those training curricula used by state agencies as well as those frequently noted in the field.
- A clear message that emerges from the reviews of research, best practice standards, regulations and communications with providers is the need for sound staff training. Furthermore, it is clear that this training must be competence-based and offered on an ongoing basis.
- The training curricula used by state agencies were reviewed, again, with the purpose of identifying the extent training curricula addressed the best practice standards recommended by national organizations. Considerable similarities were noted across curricula, the exception being types of restrictive interventions (i.e., physical restraint).
- More detailed information on training is provided in Section III.
- A comparison of crisis intervention training models is presented in Appendix F.

Development of subcommittees to operationalize guiding principles

- The guiding principles developed by the RCIT Committee underscored the need to move beyond behavior management techniques to be used in emergency situations. As such, subcommittees were developed to determine the necessary steps required to translate the guiding principles into practice, including the resources that would be required.

Interagency Sessions with Commissioners and Policy Staff

- The Council convened a meeting with the Chair of the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) and Commissioners of OCFS, OMH and OMRDD to identify the best ways to address and mitigate the special challenges faced by multiple licensed providers with co-located programs who must comply with conflicting state agency

regulations concerning use of restraints. Additional discussions were conducted with agency policy staff.

- The focus was on policy and practices within and across systems that would reduce restraint use and equalize the disparity observed at the multiple licensed sites with co-located programs.

Overview of Report

All information described above was used to arrive at a coordinated set of behavior management standards that could be employed by OCFS, OMH, OMRDD and SED to promote the most effective, least restrictive and safest techniques for the modification of behavior for children served in programs delineated in the legislation. The remainder of this report is organized as follows:

Section II. Overview of Research

- A literature review of restraint reduction and safest restraint techniques was undertaken to determine factors that contributed to positive behavior management and restraint reduction, the primary means of promoting safety for children and staff as well as to better understand the risks associated with various forms of physical restraint.

Section III. Guiding Principles in Actual Practice

- A set of guiding principles was developed by the RCIT Committee to set the foundation for coordinated behavior management standards. This section of the report details the activities and resources needed to operationalize the guiding principles and make them transparent and fully integrated into daily program practice.

Section IV. Recommendations for Coordinated Standards and Next Steps

- As required by the legislation, a set of coordinated standards for the most effective, least restrictive and safest techniques for the modification of behavior is detailed along with regulatory changes that may be required to realize the standards. These standards are based on the literature review, a review of nationally endorsed best practice standards, an examination of current regulations as well as the guiding principles. Recommendations for standards and regulatory changes are highlighted.
- Next steps needed to enable agencies and programs to adopt standards are presented.

II. OVERVIEW OF RESEARCH

A literature review was undertaken to help the RCIT Committee identify the 'most effective, least restrictive and safest techniques for the modification of children's behavior in response to an actual or perceived threat by child to harm themselves or others.' The first part of this literature review focuses on child, staff and organizational factors that promote positive behavior management and restraint reduction. However, it is also recognized that restraint may be required in given instances so the review also addresses research that focused on risks associated with physical restraint and particular restraint techniques.

Factors Influencing Restraint Use and Reduction

The widely accepted standard used to discern whether a restraint is necessary focuses on the behavior of the child. 'Risk of harm to the child or others' is the criterion most often used by providers in child welfare, developmental disabilities, education and mental health (12, 13,14). This implies the child's behavior is the sole determinant for use of restraint. Despite this common view, research findings indicate characteristics of staff and the organization also influence use of this high risk intervention and need to be considered in any effort undertaken to promote positive behavior management and reduced use of restraint.

Child characteristics

A number of correlational studies have been conducted to identify characteristics that increase the likelihood a child may experience restraints. Children more frequently placed in restraint or seclusion tend to have common demographic features including being younger in age, a member of a minority group and male (4, 15, 16). Clinical characteristics also distinguish high and low restraint groups. Specifically, children with: a diagnosis of attention deficit disorder, conduct disorder or poor impulse control, attachment disorder, autism, psychosis, schizophrenia, schizo-affective disorders, suicidal ideations, visual hallucinations, hyperactivity and children more likely to receive a disposition to an inpatient setting have a higher occurrence of experiencing restraint. (15, 17-19).

Other factors examined that influenced use of restraint are: longer lengths of stay, children with poor coping skills, and being in foster care or in the custody of children and family services departments (4, 15, 18, 19).

Staff characteristics

A variety of staff variables are also associated with increased use of restraint, including: level of experience, training, and attitudes toward restrictive methods. Teams with inexperienced members tend to use restraints more often than those with experienced members (7, 20). Furthermore, staff decisions to use restraint are influenced by their personal attitudes and perceptions of circumstances. This means the same situation could result in staff making different decisions of whether to implement a restraint. Individuals having a greater need to control the level of violence on the unit used restraints more frequently. Also, restraint was implemented in cases where staff perceived safety threats that included instances where children used aggression toward other children or staff, or in instances where children were noncompliant with staff requests (4, 9, 20-22).

Within educational settings, teachers report restraint has been used in classroom situations to prevent immediate harm to a child or other student, as well as to prevent a child from leaving a classroom, which might eventually result in harm to the child (23, 24). Training programs that emphasize prevention and early intervention techniques were shown to influence staff behavior and increase the strategies they use in a crisis situation (25-28).

Organizational characteristics

Research examining organizational characteristics also indicates there are variations in the use of restraint that can not be explained by the type of children served. Different rates existed regardless of the severity of illness of children served in each psychiatric hospital studied (29). Findings from a study undertaken by the New York State Commission on Quality of Care (30) indicate the organizational culture can influence how restraints are employed. Specifically, treatment preferences and practices of administrators and clinical staff served as key predictors of low rates of seclusion and restraint in state-operated mental health facilities.

On an intuitive level, one might expect higher rates of restraint to be reserved for more restrictive settings. When we consider the continuum of care, it is widely accepted that less restrictive settings, such as community-based programs, serve individuals with less severe symptoms and would rely less on the most restrictive form of crisis intervention. However, type of treatment setting does not necessarily predict use of restraint. This was made apparent by the fact that different rates of restraint were observed in hospitals, group homes, and day treatment programs with the highest rates in the more restricted hospital setting and less restricted community-based day treatment setting (12).

The culture of an organization can distinguish the extent staff rely on restraints. Programs with clear mission statements, policy mandates and cultural expectations related to positive alternatives to restraint showed a decrease in use of restraints. (4, 31). Other organizational features associated with decreased use included: availability of explicit protocols; use of individualized approaches with patients, such as behavior management plans; and a management approach that provided data to staff informing them of monthly restraint rates (25-28).

Staffing ratios

Findings from a two-year study that examined the relationship between gradual increases in the staff-patient ratio at a psychiatric hospital indicated reliance on restraint and seclusion (as measured by hours) decreased as staff-patient ratios increased (62). The improvements observed occurred in conjunction with major restraint reduction efforts so it is difficult to discern the extent staffing ratios and other restraint reduction efforts contributed to a decrease in the number of hours patients were in restraint and seclusion. These findings ring true on an intuitive level and are consistent with qualitative perceptions of professionals; however, we lack information regarding the most cost-effective ratio that maximizes restraint reduction.

The paucity of research regarding staffing ratios does not minimize its importance when one considers 'safe' restraint procedures. Training curricula, although not necessarily grounded in research, suggest optimal staffing ratios for particular forms of restraint, with ratios ranging from one to three staff per child restrained.

Restraint Risks Identified in Case Studies

There is little consensus in the scientific literature concerning the causes of death due to the use of restraints (32). Some researchers examining case studies contend restraint-related deaths are the result of the type of restraint position used while others assert the psychological stress of being restrained triggered or exacerbated physiological reactions (e.g., increased body temperature, cardiac arrhythmia) that were life threatening. An overview of findings follows.

Positional asphyxia

Positional asphyxia results when an individual is placed in a position that interferes with respiration. Most of the case studies of restraint-related positional asphyxia are from the forensic literature and focus on adults in police custody. Prone restraints are the primary form of restraint cited in these case studies. As noted by Paterson (33), the term 'prone restraint' found in these studies does not represent a homogeneous procedure. Instead, it includes a wide range of situations where individuals are held on the floor, generally 'face down.' Most of the prone cases described in the literature involved a technique referred to as a hog-tie or hobble prone restraint (34-37) where an individual is placed face down on the floor with his arms in handcuffs while his legs are cuffed then attached to the handcuffs⁷. This form of a prone restraint is particularly dangerous since it places considerable pressure on the diaphragm, particularly if an individual raises his head in an attempt to breathe (38-39). Many cases examined were complicated by the presence of illegal drugs such as cocaine or high levels of alcohol (40, 41) and it has been suggested that the cause of death in positional asphyxia cited in the forensic literature may involve restraint but is more likely associated with leaving an exhausted, drug affected and unconscious person in a position that results in asphyxia (41, 42).

Not all case reviews reflect positional asphyxia of individuals in police custody. Following a review of restraint-related deaths that occurred in healthcare settings, the Joint Commission reviewers concluded restraining individuals in a prone position [unspecified] may predispose them to suffocation (43). Other cases cited in the literature describe deaths of individuals that were complicated by the use of mechanical or chemical restraints (44); cases where pressure was applied to the back of an individual or used with individuals who had preexisting medical conditions that put them at greater risk (e.g., increased body mass, enlarged heart) (44, 45).

In a review of child restraint fatalities, asphyxia was the most common cause of death (25 cases). This was followed by cardiac arrest (10 cases). Prone restraints were used in 27 of the 38 physical restraints. It was noted that staff utilized restraint procedures not consistent with any recognized crisis intervention training models and did not attend to signs of distress, also fundamental components of established training curricula (2). While this increases an appreciation for the stressful circumstances that accompany restraints, it also raises concern regarding the degree staff are able to easily implement a particular form of restraint and control their own level of exertion during the process, particularly when applying a restraint to a child. This should be a concern for all forms of restraint.

Aspiration

The Joint Commission found restraining individuals in a supine position may predispose them to aspiration (43). This can result from a decrease in consciousness, which is precipitated by individuals' illnesses or types of medication they are using. The supine position *in conjunction with*

⁷ This form of prone restraint is not endorsed for use by OCFS, OMH, OMRDD or SED.

decreased levels of consciousness can interfere with individuals' ability to protect their airways, which can result in death from asphyxia, acute pulmonary edema, or pneumonitis (46).

Agitated or excited delirium

Agitated or excited delirium is another factor associated with restraint-related deaths. Researchers examined fatality cases where excited delirium or aggressive behavior was evident and concluded asphyxial deaths can occur in subjects who are held in a prone position with arms and legs restrained and weight applied to the back (37). O'Halloran and Lewis suggest death of an individual in an excited state can be attributed to cardiac arrhythmia, induced by excited delirium; physical activity from struggling while in restraint; and use of restraint techniques (most commonly hog-tied) that impair movement of the diaphragm (47). Sudden cardiac death can be triggered when the behavioral arousal and psychological stress associated with the restraint experience influences advanced cardiac arrhythmias and emotional extremes (48, 49). The increased agitation results in a release of hormones that produce rhythm disturbances (50). In other reviews of sudden death cases of individuals requiring restraint for excited delirium, the research reviewers found instances of stimulant drug use; chronic disease; and obesity, indicating multiple predictors can contribute to sudden death (51, 52, 36).

Medications

Researchers note the stress of being placed in restraint, *in conjunction with the effects of medication* can place children at risk (32). Psychotropic medication is linked with a syndrome that can cause lethal arrhythmias (53). Certain medications, such as anticholinergic drugs, can decrease normal body cooling mechanisms and children with extreme agitation who are struggling with staff have a decreased ability to discharge or release the heat generated, resulting in an increase in body temperature and increased possibility of life-threatening hyperpyrexia. It has been noted children are more susceptible than adults to the adverse effects of these medications (32).

Physiological Responses to Restraint in Controlled Studies

A number of experimental and quasi-experimental studies were conducted to more rigorously examine the physiological responses to restraint observed in the case studies.

- The effect of prone positioning on perfusion distribution in normal adults was examined by Peces-Barbara and Rodriguez-Nieto. Results indicated carbon monoxide diffusing capacity (ability of body to move oxygen) was consistently lower in prone compared to supine position; alveolar volume was greater in prone compared to supine position and no significant differences were observed in cardiac output or pulmonary tissue volume. (54).
- Reay examined the recovery rate (oxygen saturation & pulse rate) of healthy adults following exercise. Recovery rates for adults in a hog-tie prone restraint position were longer than recovery time of adults in a seated position. (30).
- A study by Schmidt and Snowden examining the effect of positional restraint on heart rate and oxygen saturation indicated there was no significant difference in recovery heart rates of adults in seated position following moderate exercise and adults in a prone position following moderate exercise. When exercise was conducted to simulate a 'police chase' and prone restraint, participants' recovery rates showed a significant difference of oxygen saturation recovery for the first 2 minutes between resting position and restraint; however no differences were observed after

the initial 2 minutes. There was no significant difference in oxygen saturation recovery between resting and seated positions following exercise (55).

- Following exercise, individuals' pulse rate and oxygen saturation were measured (recovery rate) to determine how they differed when in prone, supine and seated positions. Parkes found that recovery time in both restraint positions did not differ significantly from the seated position. The amount of time healthy adults in a prone restraint needed to assume their normal pulse rate was significantly longer than for adults restrained in a supine position. The authors concluded restraint position may be a factor in death during restraint but only where other factors contribute to the overall situation (56).
- Chan conducted a study with 15 healthy adults using a two-phase study. A progressive restrictive pattern of pulmonary functioning was noted as individuals were moved from the seated, supine, prone and hogtie prone positions; while the decline was statistically significant, the declines were all within a normal range of functioning (57).
- To understand the role of weight force, Chan compared the respiratory function of individuals in a seated position, prone position, prone position with a 25 pound weight on the back and the prone position with a 50 pound weight placed on the back. All prone positions were significantly different from the seated position but not from one another. Pulmonary functioning was restricted with and without weight while in prone position but there was no evidence of hypoxia or hypoventilation. The prone form of restraint resulted in a restrictive pulmonary function pattern but did not result in *clinically* relevant changes in oxygenation or ventilation among healthy adults. (58).
- Gustafsson compared the vital capacity, functional residual capacity and gas trapping in children with and without asthma. Assuming a supine position increased gas trapping in children with asthma, not others (59).
- Jonsson and Mossbert studied the influence of being in a supine or seated position among adults with asthma. Three measures of lung function were measured. Results indicated that being in a supine position for a four hour period and not receiving any asthma medication during that time showed a compromise in one of the three lung function measures compared to being in a seated position. No significant differences were observed in two of the three lung function measures. Individuals in a supine position for a 2-hour period showed similar results. Individuals in a supine position for 30 minutes showed no significant difference in lung function measures when in a supine or seated position (60).

Medical review

The dangers of restraint are not limited to those being restrained, as noted in the medical review conducted by CWLA, which delineates staff and child injuries associated with each form of restraint (61). The types of injuries differ for staff and children and vary by restraint position (Figure 2).

Figure 2. Medical Risks Associated with Restraint Positions

| Restraint Position | Risk to Child Being Restrained | Risk to Staff Implementing Restraint |
|---|--|---|
| <p>Prone Restraint</p> <p>Child is placed in a face-down position on the floor</p> | <ul style="list-style-type: none"> • Abrasions, bruises, strained muscles, and other musculoskeletal injuries • Neck and back injuries • Difficulty breathing, including cardiac and respiratory arrest • Decreased circulation to lower extremities • Head banging • Should not be used with very obese children, females who are pregnant, children diagnosed with Down or Prader-Willi syndrome, children who have respiratory disorders that increase the likelihood of restricted airways | <ul style="list-style-type: none"> • Scratches and bites • Stress to knees and back |
| <p>Supine Restraint</p> <p>Child is placed in a face-up position on the floor</p> | <ul style="list-style-type: none"> • Abrasions, bruises, strained muscles, and other musculoskeletal injuries • Difficulty breathing, including respiratory arrest • Head banging • Possible aspiration if child vomits • Self-biting • Trauma and retraumatization stemming from feelings of vulnerability or exposure (e.g., victim of child sexual abuse) | <ul style="list-style-type: none"> • Scratches and bites • Stress to knees and back • Spitting |
| <p>Seated Restraint</p> <p>Child is placed in a seated position on the floor or in a chair</p> | <ul style="list-style-type: none"> • Restricted breathing • Cardiac or respiratory arrest • Neck and back injuries • Abrasions, bruises, strained muscles, and other musculoskeletal injuries | <ul style="list-style-type: none"> • Head butts • Scratches and bites • Spitting |

CWLA also noted a number of factors are associated with decreases in restraint-associated injuries. These factors include:

- Providing adequate caregiver ratios
- Providing adequate staff training
- Optimizing asthma/respiratory status as soon as possible after admission
- Minimizing sedation as soon as possible after admission
- Plans for child-specific medical or surgical conditions
- Development of individualized restraint plans
- Avoidance of power struggles
- Restraining only for safety
- Decreasing the intensity of restraint
- Decreasing the duration of restraint
- Decreasing the frequency of restraint
- Monitoring respiration and skin color
- Maintaining hydration
- Preventing overheating
- Keeping face uncovered

- Monitoring the child's face during the restraint
- Heeding any complaints of "I can't breathe" during the restraint and break the restraint

Summary

Case study reviews serve to remind us of the turmoil that accompanies restraints, regardless of the staffing ratios, quality of training or restraint techniques. Restraints, by the very fact they are conducted when a person's behavior has escalated to the point there is danger to self or others, are highly charged occurrences. Case studies depict instances when trained staff employed procedures not endorsed by any training program reviewed, such as applying neck holds, force to the back, covering the mouth with towels to avoid spitting, and maintaining a person in a hold for extended periods of time, without monitoring them. The experimental and quasi-experimental studies highlight the physiological conditions that occur following vigorous activity but even more compelling is the realization that those conditions are very modestly duplicated in controlled circumstances as evidenced by the studies.

Given the fact that risk is inherent in any restraint, a 'safe' restraint is, at a minimum, one that does not result in physical injury to the child or staff. An epidemiological study—one that studies the causes, distribution and control of disease in populations—would be necessary to determine whether restraint-related injuries and deaths occurred more often using one form of restraint than another. This type of study would provide standardized measures (i.e., rates) that permit us to compare the likelihood of injuries when using prone and supine restraints. Additionally, this restraint-related data would be needed for each population represented by the Committee, namely child welfare, developmental disabilities and mental health before we could determine the degree of safety for each restraint technique and the appropriateness of a uniform standard for these three groups of children⁸.

In the absence of the information described above, the body of research reviewed does point to the risks associated with restraints regardless of the technique used; supports the need for staffing ratios and training that increase the likelihood these high risk interventions can be averted or applied properly; suggests the need for organizational strategies, such as quality assurance practices and strong leadership, to promote restraint reduction and sustain positive alternatives to restraint use; and makes us cognizant that no single method of restraint is safe for all children, obligating us to incorporate individualized crisis prevention and early intervention strategies.

⁸ A retrospective study would be feasible within the developmental disabilities and mental health fields due to the policy changes made by OMH and OMRDD; however, automated data are not available during the periods that would be covered under investigation so data collection would require considerable time and resources. A retrospective investigation is not possible for the child welfare population and would require a prospective study. This study would necessitate OCFS permitting the use of a supine technique on an experimental basis for a given period of time and, again, would take considerable time and resources.

III. GUIDING PRINCIPLES INCORPORATED INTO PRACTICE

In an effort to provide a comprehensive, balanced perspective of the practices needed to fully realize the intent of the guiding principles, subcommittees were developed to review how best to operationalize the principles. Four areas addressed by the subcommittees were:

- Leadership and Workforce Development
- Risk Assessment and Behavior Management
- Training
- Quality Assurance

The following is a description of the work and resources necessary to make the guiding principles a part of daily practice. Considerable emphasis is placed on methods that help children maintain self-control and positive behavior supports utilized by staff to avert the need for restraints.

GUIDING PRINCIPLE: LEADERSHIP COMMITMENT

Leadership commitment is an essential component of effective restraint reduction initiatives and accordingly, leadership and management responsible for providing day and residential, mental hygiene, health care, and educational services to children should continuously seek opportunities to advance restraint reduction efforts and articulate in their practice guidance, training, protocols, policies, and regulations that restraints reflect a last resort intervention.

Leadership Commitment Toward Change

Strong leadership commitment plays a pivotal role in successful behavior management efforts due to the fact that leadership⁹ is instrumental in establishing and reinforcing the values, attitudes and expectations of an organization. These organizational features, often referred to as organizational culture, influence norms held by the group and help establish a code of conduct that shapes the way members in the organization¹⁰ behave (63). In fundamental terms, organizational culture is defined as the way things get done (64). The culture, whether

Organizational culture is defined as the way things get done around here.

⁹ Leadership includes individuals at the level of commissioners, executive directors, facilities directors and other executive staff.

¹⁰ The term organization refers to state agencies and programs that provide services.

stated or implied, is evident in how decisions are made, expectations are set, language is used, and how work is conducted and recognized on a daily basis. This means if positive behavior management is to be successful, it must be a value held by the leadership and efforts to reduce restraint must become a significant part of the organizational culture.

The use of positive alternatives to restraint, as with any organizational change, comes with a certain degree of reservation given the long accepted use of restraint, its traditional association with child and staff safety, and a natural reluctance of organizations to move in an unfamiliar direction. However, this can be offset by the extent leadership identifies the need for positive alternatives to behavior management and promotes them as an organizational value. In fact, a review of effective organizations indicates leadership support of a particular value (e.g., restraint reduction) is the most important contributing factor associated with successful organizational change (65). This is also supported by the New York Commission on Quality of Care and Advocacy for Persons with Disabilities that found rather than facility demographic or patient characteristics, it is the treatment preferences and practices of administrators and clinical staff that are the predictors of low rates of seclusion and restraint (30).

Leadership Practices That Influence Organizational Change

A primary reason for the link between leadership and organizational culture is leadership's unique position to use various strategies, including ongoing communication and the use of management processes, organizational structures and reward systems to institutionalize values that support change (65). A number of practices, as noted in research, are employed by effective leaders to influence an organization's culture and contribute to organizational change. It is important to note these serve as examples and do not include an exhaustive listing of effective leadership strategies. Furthermore, it is well documented that leadership styles and situational context can influence the degree strategies are effective so these factors will also need to be taken into account. It would be inaccurate to make the assumption these are mandated strategies for all leadership in all settings. This information is shared in an effort to more clearly convey strategies that have been effectively employed by individuals in a leadership position.

Clearly articulate restraint reduction as an organizational value

Strategic plans, mission statements, policies, procedures and regulations are many of the ways in which leadership commitment to positive behavior management is made apparent. These documents are the formal mechanisms used within organizations to reflect priorities and communicate expectations for behavior. For this reason, the first stage of many programs designed to alter the culture of an organization begins by having leadership and key staff review these documents to determine if they are compatible with the goal of restraint reduction (e.g., National Association of State Mental Health Program Directors [NASMHPD] leadership training, Crisis, Aggression, Limitation and Management [CALM] training). Those policies and practices that promote and sustain restraint reduction are maintained while those that do not meet the 'values threshold' are modified. This review process promotes positive behavior management as a key priority within the broader context of organizational goals and underscores how it supports the organization's overall mission.

Continually communicate desired values

Organizational change occurs when employees know what is expected of them; consequently, positive behavior management needs to be routinely incorporated into the written and verbal communication leadership has with staff and board members (66, 67). Traditional communication strategies include regular columns in newsletters that focus on the priority topic or having the topic as a standing item on agendas; however, leadership should not underestimate the value of repeated messages with unit heads given the fact that employees tend to learn more from their direct supervisors than they do during formal classroom training.

Another way for leaders to reinforce priorities is to repeat success stories in as many places (e.g., annual meetings) and with as many audiences as possible, underscoring what type of behavior or results are valued. A somewhat less common mechanism for communicating priorities is the use of a questionnaire administered periodically to staff to measure their perceptions regarding how well the organization lives up to its values and beliefs. This serves the dual purpose of assessing staff perceptions while reinforcing priorities. Posters with colloquial statements that reinforce organizational goals are another means used to communicate expectations (63).

Make organizational structure and procedures compatible with the value of restraint reduction

Just as the leadership and staff of an organization must be mindful of structures and procedures that may create undue rigidity for clients, organizational leadership needs to examine the extent rules, procedures, policies or practices are unnecessarily applied to staff. This examination should be done periodically to assess current and future policies.

- Increased visibility of and access to leadership is an effective means to foster an open organizational culture that emphasizes personal interactions, for clients and staff (e.g., increased presence of leadership in program areas, community meetings with staff and leadership). Successful leaders involve staff in the move toward positive behavior management by maintaining a balance between safety of clients with safety of staff. While the commitment for change must begin at the top, these leaders recognize staff are essential partners and that staff often are the first to identify unintended consequences of good-intentioned policies as well as help identify solutions first evident to those who work closest with the clients.
- Another practice associated with improved staff performance is the use of coaching supervision, which offers support to staff in resolving performance issues while holding them accountable. This practice is also associated with job retention (68, 69).
- Use of flexible scheduling and including paraprofessional staff in care planning teams are other strategies suggested to promote a respectful, reciprocal atmosphere that supports staff and contributes to staff retention.
- Development of strategies to improve interdisciplinary communication, such as dissemination of behavior management plans and a team approach to problem solving help minimize blaming and scapegoat practices (70).

Reinforce behaviors that promote positive behavior management

Effective leadership uses success to influence change and promote positive behavior management. Behaviors that are acknowledged or rewarded tend to be repeated and eventually those behaviors become embedded in the way staff conduct themselves. Therefore, key leadership within an organization is encouraged to become aware of successes and continuously acknowledge those efforts. Public statements acknowledging success, awards, and parties to launch projects or recognize accomplishments are examples of symbolic gestures that effectively enhance or modify behavior

within organizations. These practices are particularly important given the amount of time required to change the culture within an organization.

Incorporate accountability

Accountability practices reiterate organizational standards as well as provide leadership and staff with a means to assess how well they are following through on their commitment to use positive alternatives to restraints. Typically, quality assurance systems that monitor and report data are the primary means of accountability. Accountability systems that provide more details regarding the context of restraint use are particularly valuable since they allow leadership to problem solve. For instance, a report that details the rate of restraint is a first step in prevention but a report that details when restraints are used or where they are used will allow for corrective action.

Used correctly, personnel evaluations that indicate how well staff support positive behavior management efforts can reinforce daily practice. For example, personnel items related to this might include a rating of staff's:

- knowledge of the risks associated with restraint;
- ability to engage clients and use active listening skills on a regular basis; and/or
- ability to use de-escalation techniques.

Although negative connotations are often associated with accountability practices, these strategies promote organizational and individual successes in a constructive way by informing leadership with respect to the need for possible changes in procedures and/or supports.

Provide supports necessary to reduce the use of restraints and implement positive alternatives

Many staff have been trained to use restraint as a means to protect child and staff safety and some staff may view reduction of its use as contrary to their training or a negligence of their duties. Therefore, it is important for leadership to provide staff with supports that give staff alternative prevention tools to use as they reduce their reliance on restraints.

Use of calming/sensory rooms: One means of leadership support is the development of areas referred to as calming or sensory rooms. These areas have been used in mental health, juvenile justice and special education settings as alternatives to restraint and seclusion and allow children the space they need to relax, decrease aggressive behavior and self-regulate. The rooms are unlocked, appealing physical spaces painted with soft colors and filled with furnishings and objects that promote relaxation. As with other areas, protocols need to be developed to allow for the safe and proper use of space (71).

Use of crisis intervention experts: Another recognized mechanism of support is the use of staff who specialize in crisis intervention. These staff are crisis intervention experts available on each shift to help floor staff with de-escalation strategies as a crisis begins. The primary role of these individuals is to support the staff so restraints can be averted—they are *not* intended to serve as a witness to the restraint, as is the case in other restraint reduction efforts.

Programs that incorporate crisis experts note several immediate benefits. First, the introduction of an additional staff person on the scene provides a different perspective or approach to the situation, such as different de-escalation techniques. It was also found that a new adult on the scene tended to refocus the youth and avert a restraint. Last, the crisis expert is able to provide behavior management alternatives to the youth (e.g., go for walk) that the main staff are unable to offer, due to staffing

implications (i.e. cannot leave other children). While crisis experts' primary role is to assist in restraint prevention, their secondary roles are to model prevention techniques and mentor staff on an ongoing basis. In particular, it is recommended these individuals focus particular attention to enhancing supervisory skills. This means supervisors may need training that goes beyond training provided to direct care staff.

Adequate staffing: The supports presented above do not diminish the need for adequate staffing, which must be a priority of any leadership committed to restraint reduction. Staff are the first line in child safety and view inadequate staffing as a compromise to the safety of children and staff. A lack of attention to staffing weakens all other efforts to promote alternatives to restraint and puts into question leadership's commitment to reduce the use of restraints, which eventually undermines organizational change. Additionally, the incongruent message and behavior of leadership can influence staff morale and low staff morale has been linked to greater use of coercive interactions with children. CWLA recommends staffing resources include: caregiver-to child ratios necessary to adequately supervise and meet the needs of children; supportive and ongoing clinical and front-line supervision; and opportunities for staff development. An example of how one organization addressed staffing issues was to convert a full-time position to an hourly position allowing for more flexibility and coverage during key hours of the day (61).

Promote hiring and workforce development practices that reflect priority of restraint reduction

Hiring practices and staff orientation

The socialization process used with new employees is an effective approach for sharing values with new staff and can begin as early as the first contact a job candidate has with human resource staff. It has been shown effective leadership recognizes recruitment, hiring practices and staff orientation are opportunities to transfer organizational norms (72) and use these mechanisms to provide employees with clear messages related to organizational goals, positive behavior management and the use of restraint as an emergency intervention.

Clarity about one's responsibilities or the expectations of staff is closely linked to high performance. It is important for job candidates to have an understanding of the children that will be in their care. For that reason, job shadowing is one strategy used both during the interview process and orientation to help individuals understand job requirements and experience organizational norms. Shadowing allows the prospective candidate to assess the extent job responsibilities are aligned with personal expectations. An example given was to have candidates shadow a staff person for a two-hour period during the interview process. This provides candidates an opportunity to realistically observe positive and negative aspects of the job, while viewing organizational values as seen through interactions with other staff and clients. Shadowing is also incorporated into the orientation process and has been linked to staff retention.

Workforce development practices

Provide ongoing competency-based training The primary means leadership has for workforce development is through competency-based training and ongoing supervisory support—two factors critical for effective organizational change (15, 25, 26). In fact, value-related skills development ranks second to leadership commitment in its ability to influence and change the culture of an organization (65). The benefit of competency-based training is supported in a number of research findings that consistently indicate more experienced and better trained staff are less likely to use restraint. For example, staff proficient in the use of verbal de-escalation skills and non-authoritarian limit setting are better able to minimize coercive situations and reduce the need for restraints (74).

Strengthen supervisory skills and expertise It has been shown that employees learn a great deal about how to conduct business, both on a formal and informal level, from their direct managers, which highlights the value of strengthening supervisory skills so supervisors are better equipped to support staff development (65, 72). Enhancing supervisors' ability to mentor staff allows training to extend beyond classroom settings and become a part of daily practice. In particular, supervisors can be a valuable resource to direct care staff in the use of de-escalation and debriefing skills.

Readiness Tools for Restraint Reduction

Two inventory-style assessment tools developed to assess an organization's readiness for positive behavior management are the *CWLA Best Practices in Behavior Support and Intervention* (75) and the *Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint*, (76) developed by David Colton. The self-assessment instrument developed by CWLA is designed to help organizations improve policies, procedures and practices through careful self-assessment. The five major sections covered in the assessment instrument include: ethical and legal framework; administration and leadership; continuum of interventions; medical issues; and professional development and support. A set of standards and indicators that operationalize the standards are provided in each section. It is suggested a review team assess the extent an organization meets the standards by rating each standard using a 4-point scale (consistently reflected, partially reflected, poorly reflected, and clearly inadequate).

The checklist developed by Colton allows for a systematic review of factors that influence reduction of restraint and seclusion while also providing an opportunity to measure progress toward this goal. The checklist comprises nine sections with sets of indicators that measure section content. The nine sections are: leadership; orientation and training; staffing; environmental factors; programmatic structure; timely and responsive treatment planning; processing after the event; communication and consumer involvement; and systems evaluation and quality improvement. A five-point scale is used to assess the extent an organization is moving toward change in each of the nine areas.

Development of Restraint Reduction Plans

A planning tool developed by the National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC) is the *Six Core Strategies to Reduce the Use of Seclusion and Restraint* (77). This tool is intended to guide the design of a seclusion and restraint reduction plan that incorporates a variety of prevention approaches. The core strategies include: leadership toward organizational change; use of data to inform practice; workforce development; use of seclusion and restraint reduction tools (e.g., calming rooms, behavior management plans); consumer roles in inpatient settings; and use of debriefing techniques. The tool is a fundamental component of Leadership Training developed by the NASHMPD NTAC, once again underscoring the necessary and central role of leadership in restraint reduction efforts. Components recommended for a comprehensive restraint reduction strategy include:

- Development of a facility-wide policy statement that outlines for all staff the prevention/reduction approach to the use of restraint and seclusion;
- Identification of data-driven goals to reduce use;
- Announcement of a "kick-off" event and routine celebration of successes;

- Identification of restraint and seclusion reduction champions at all horizontal and vertical organizational layers; and
- Assignment of champions to specific prevention roles.

Cultural Assessment Strategies

Culture changes, such as positive alternatives to restraint, are slow and arduous, requiring ongoing monitoring that allows leadership to assess the current culture, determine the extent it is consistent with the mission of the organization and observe change over time. The strategies described below are intended to assist leadership with this process (78). It is recommended that once the desired change has occurred these tools continue to be used to ensure the culture does not revert back to earlier practices and norms.

- **Culture walk:** Leadership can observe the culture of an organization by taking a walk and looking at physical signs of culture to see the extent these signs are consistent with the message of restraint reduction:
 - How is space allocated?
 - What is posted on bulletin boards or displayed on walls?
 - How are common areas used?
 - How often do staff communicate with children? What is said and how is it said?
- **Culture interview:** This can be done as focus groups with staff or children
 - What would you tell a friend about your organization if he or she was about to work/come here?
 - What is the one thing you would most like to change about this organization?
 - Who is a hero around here? Why?
 - What is your favorite characteristic that is present in this organization?
 - What kinds of people succeed/fail in this organization?
- **Culture survey:** These are written surveys that allow staff to provide information about the culture. Often, information gathered through culture walks or interviews are integrated into these surveys.

Environmental Scanning

Environmental scanning refers to gathering information that concerns the organization's environment as well as serves as a reflection of values. Two forms of scanning commonly employed are content and context scanning. Content scanning focuses on trends and conditions that affect an organization's stated goals while context scanning examines conditions or events that influence goals in an indirect way. These indirect factors can reflect unintended values that undermine an organization's goals. As an example, a home-like décor or healthy food options are not direct services but can have a considerable influence on the well-being of children served. Leadership needs to take into account the way environments can influence children in programs.

RECOMMENDATIONS RELATED TO LEADERSHIP AND WORKFORCE DEVELOPMENT

Either through the development of a *Restraint Reduction Plan* or through individual leadership approaches, leadership identifies and implements strategies to advance positive behavior management and restraint reduction efforts.

Leadership's ability to influence organizational change is a key predictor of successful positive behavior management, including restraint reduction. A primary reason for the link between leadership and organizational culture is leadership's unique position to use various strategies, including ongoing communication and the use of management processes, organizational structures, environmental conditions, and reward systems to institutionalize values that support change.

A number of tools are available to leadership that might be used to assist in determining an organization's readiness to incorporate positive behavioral supports. Additionally, *Restraint Reduction Plans*, if developed and implemented properly, can help organizations identify positive behavior management approaches and reduce the use of emergency restraints.

Examples of activities that can be undertaken by individuals in a leadership role to foster organizational change are outlined in this report in Section III.

Either through the development of a *Restraint Reduction Plan* or through individual leadership approaches, leadership incorporates strategies in hiring or workforce development practices to advance positive behavior management and restraint reduction efforts.

Leadership is able to emphasize the importance of positive behavior management and restraint reduction in hiring and workforce development practices. Some strategies available to support organizational change and increase staff retention include but are not limited to providing job candidates with a clear understanding of organizational expectations, including expectations related to crisis intervention techniques and use of accountability practices that promote positive behavior management and restraint reduction practices, such as items within staff's annual performance reviews.

State agencies provide technical assistance to leadership that allows for the development and implementation of positive behavior management and restraint reduction efforts.

There are many methods available to state agencies to provide technical assistance to support leadership's ability to reduce restraints. Possible forms of technical assistance include but are not limited to annual forums, dissemination of written materials, on-site reviews and leadership training seminars. Different forms of technical assistance may be more effective for some programs than others and program specific support may be required. The most effective form of technical assistance for programs will be decided by each state agency.

**GUIDING PRINCIPLE:
COMPREHENSIVE
STAFF TRAINING**

A comprehensive staff training program, including pre-service and in-service training should be made available to all relevant staff in programs that provide day and residential, mental hygiene, health care, and educational services to individuals. Staff must demonstrate competence in any techniques covered in the training before being authorized to perform them.

Role of Training for Effective Crisis Intervention

Staff training that develops value-related skills ranks second to leadership commitment in its ability to influence and change the culture of an organization. The benefit of competency-based training is supported in a number of research findings that consistently indicate more experienced and better trained staff are less likely to use restraint (15, 16, 20, 79).

Crisis intervention is not a new science. Evidence of its study can be traced back as far as 500 BC when Sun Tzu noted the elements of crisis leadership (1). While the language and specific context have evolved, we incorporate many of the same precepts to the study of crisis intervention. When we examine the skill sets that modern crisis intervention models include we see that not only are they interchangeable and universally accepted but they also maintain the centuries old tenets. Our fundamental goal is to ensure that the universally accepted crisis intervention skill sets can be effectively and consistently delivered to children. So, then the question is not which intervention model or technique

to use, but rather how to ensure that the core skill sets will in fact be utilized. A continuum of training and mentoring is a useful means to accomplishing this end. Unless staff are adequately trained they stand little chance of meeting relative performance expectations. Likewise, even the best trained staff will often perform below expectation if they are not receiving effective support, feedback and role modeling from their superiors.

Features of effective training

Competent staff are more than the sum of skills they acquire during formal training sessions. Competence is the result of a culture that fosters professional development, motivates individuals to strive for excellence, and provides personalized, ongoing support and instruction so that each staff member is in a state of perpetual training. In order to produce competent and effective direct care workers, their training should include but not be limited to the following features (1):

- Crisis prevention skills that are prominent and consistent throughout the continuum of training in order to support a culture that discourages the use of physical restraint.
- Content that is universally comprehensive and accommodates a variety of learning styles and aptitudes in order to consistently produce competent staff.
- Content that is consistent and uniform each time it is presented in order to establish a standard of continuity.
- Competence that is demonstrated in each skill before a participant may successfully complete any formal training.

Elements of Crisis Intervention Identified By Sun Tzu

- Act in a rational, calculated manner; don't respond impulsively
- Provide information, set expectations
- Once a course of action becomes clear, act with resolve and without hesitancy
- Act with consistency
- Expect and be prepared to respond to criticism
- Remain objective, don't respond with personal defensiveness

- Training continues outside of the formal training settings. Supervisors can support staff by continually evaluating and instructing staff in the full range of skills.
- Training content is made universally available for reference and ongoing self-edification.

Core components of crisis intervention training

Staff training should provide a holistic approach to the treatment of children and include a thorough understanding of the trauma, triggers, and re-enactments possible not only in the children but also in the adults who care for the children. In order to produce direct care workers who are competent in crisis intervention, training could include but not be limited to the following skills:

Self-Assessment: One's ability to assess one's individual predisposition respective of crisis situations, prejudices, and work environment correlates directly to one's ability to perform predictably, consistently and in a judicious manner. Staff members must be prepared to deal with emotionally charged situations appropriately, productively, and in accordance with the policies and mission of their employing organization (20, 21, 22).

Interpersonal Skills: One's ability to establish and maintain an appropriate and productive relationship with clients and colleagues is critical to being an effective staff member. One must build trust, communicate genuine caring, demonstrate competence as a mentor and facilitate positive change in order to prevent or reduce the use of the most restrictive forms of crisis intervention. For example, an organizational tone of respect begins with simple social exchanges between staff and clients as well as staff and supervisors (1). In OMH settings, staff members are expected to incorporate day-to-day interactions that promote positive and thoughtful interactions as a way to foster trusting relationships. This approach reinforces the value of respect, develops interpersonal skills and models prosocial behavior for children. As an example, staff members are encouraged to:

- Be good listeners.
- Be involved in community activities.
- Build a sense of community and engage children on a personal level—inquire how children are doing, what they did during the previous shift.
- Offer choices as often as possible. This demonstrates the ability to cooperate, and encourages children to 'own' their own decisions.
- Remember humor is not funny to everyone and sometimes what one finds humorous is hurtful or offensive to others.

Communication Skills: Communication is a two-way process involving both verbal and non-verbal interaction. One's ability to communicate effectively is critical in an environment that depends on one's ability to understand and respond appropriately to an abundance of information (4, 20, 26, 82). In order to communicate effectively one should:

- *Exercise active listening skills:* Communicate to the speaker that they have an interested and attentive audience. This can be accomplished through both verbal encouragements as well as body language and facial expressions (e.g., Make appropriate eye contact and state "Tell me more about that.")
- *Use reflective listening:* This skill involves the periodic summarization of what a person is saying in order to clarify meaning and communicate empathy (e.g., "Ok, it sounds like you're really upset about...")
- *Ask clarifying questions:* Ambiguous information can contain the heart of an issue. Be sure to fully explore any information that is unclear. This is of particular importance when working with

youth who have a marked propensity toward inventive dialect (e.g., “I want to be sure I understand what you’re saying, do you mean that...”)

- *Provide relevant and accurate information:* People like to be informed (e.g., “Normally, in a situation like this you can expect...”)
- *Understand the use and meaning of body language:* Close attention to subtle changes in gestures and facial expressions can alert you to changes of emotional state and content comprehension. Likewise, adjusting your own body language and facial expressions so that they match your intended message is critical to message continuity.

Crisis Recognition Skills: Crisis recognition refers to one’s ability to identify antecedents, environmental elements, and behavior changes that commonly precede and/or accompany a crisis. The ability to identify crisis in its early stages increases a staff member’s ability to intervene in a non-physical manner with a variety of techniques (1).

Crisis Prevention Skills: One must recognize and accommodate for environmental elements with the potential to instigate or otherwise cause a crisis situation relative to individual clients as well as the community at-large. Continuous environmental assessments should be integrated into each staff member’s professional development in order that they remain attentive and proactive relative to maintaining a healthy and therapeutic environment (80).

De-escalation Skills: De-escalation is the result of competent implementation of the aforementioned skill sets once a client is experiencing a crisis. A crisis will commonly begin with a trigger and continue to grow or “escalate” until it either peaks or is acted upon by an outside force. Non-physical crisis intervention is most effective when implemented early in the escalation process. As clients become increasingly agitated their ability to behave rationally decreases and consequently makes de-escalation techniques less effective. In order to effectively de-escalate a crisis, one must competently apply the full range of skills already addressed and intervene as soon as there is any indication of an impending crisis. Even under ideal conditions, periods of crisis may occur as part of the natural growth and treatment process. The key to avoiding a negative outcome is early and effective de-escalation (1, 80, 82).

Physical Restraint Skills: A great deal of attention has been paid to the specific techniques used in physical interventions. In contrast, very little attention has been paid to what distinguishes a safe technique from a dangerous one other than the current prone versus supine debate. Often, when reading about restraint related injuries and deaths, we read that the physical restraint was executed incorrectly (2, 50, 51). Any responsible training that addresses physical restraint will emphasize the following:

- *Appropriate use:* Only as the last means to prevent serious injury or death; never as punishment; never out of convenience; never used as a threat; and never out of frustration.
- *Self Assessment:* Staff must monitor and evaluate their own emotional level and only intervene if they are under control. It is natural to experience elevated emotional levels during times of crisis. Therefore, staff’s ability to recognize and regulate their personal behavior is an indispensable skill. Once an individual’s capacity to control their emotional response has been compromised they are no longer qualified to administer a physical restraint.
- *Safety First:* Illustrate the importance of correct implementation of physical skills. The most dangerous restraint is one improperly administered. Explain that there is zero tolerance for deviating from the specific movements outlined in the training.

- **Monitoring:** Staff should be trained to monitor the medical characteristics of a person who is being restrained and recognize early warning signs of related injuries.
- **First Aid:** Staff can benefit from training in basic first aid so that they are able to address medical issues should they arise during the course of the restraint; this is particularly important if staff do not have access to other staff with medical training.

Debriefing Skills (staff and client): Once a restraint has taken place, it is helpful to determine what triggered it, how it may be avoided in the future, and to limit any possible long term effects which may result. In order to facilitate this process it is constructive for those involved in the incident to be debriefed, as [clinically] appropriate. For example, there may be cases where individuals are unable to participate in this type of activity given limited verbal skills (e.g., autistic child). Emergency use of restraint can have a traumatic effect on both staff and clients. In order to return the milieu to a therapeutic state, persons involved should have their needs attended to (80).

Organization of instructional material that maintains restraint reduction focus

Most crisis intervention training offered by state agencies is organized using the same cycle as a crisis where the early part of training addresses the communication skills, de-escalation techniques or development of behavior management plans used to avert restraints then the latter portion of training 'escalates' to the most restrictive form of crisis intervention, developing competencies related to physical restraints. In a survey of staff trainers at provider sites with multiple licenses, staff members have noted that this approach helps them learn the actual cycle of crisis intervention yet makes restraint use the final message presented in training. Therefore, staff recommend that training curricula be restructured so that the last module emphasizes the value of trauma-informed care and reinforces the organizational values related to general client care, possibly sharing a view of restraint from the client perspective.

Training that Places Use of Restraint into Context

An important element of training that moves beyond skill development is providing staff with an understanding of how restraint could negatively impact children's overall treatment and care. As an example, a staff member was highly competent in the implementation of physical restraints, taking particular care to be sure children were never injured and staff were safe. However, once this well-trained staff member was presented with information regarding how the restraint fit into the 'bigger picture' for children and their well-being, the staff member took greater effort to enhance his de-escalation skills and eventually relied less on restraints as an initial response. This is just one example of how comprehensive training can help put use of restraints into context for staff and children.

RECOMMENDATIONS RELATED TO TRAINING

Provide competency-based training that incorporates a common skill set and maintains a focus on crisis prevention and early intervention while also developing the necessary skills for the safest possible restraint and effective, restorative supports following restraint.

Staff training should provide a holistic approach to the treatment of children, embed the continuous prevention of crisis situations and include a thorough understanding of the trauma, triggers, and re-enactments possible not only in the children but also in the adults who care for the children. Such a training curriculum could address:

- Self-assessment
- Interpersonal skills
- Communication skills
- Crisis recognition skills
- Crisis prevention skills
- De-escalation skills
- Physical restraint skills
- Debriefing skills

While it is critical to re-enforce the full range of skills on a continuous basis, any program hoping to reduce the use of physical interventions should regularly focus on the development of non-physical skills and foster an understanding of how these skills can easily be underutilized in an emergency situation. When confronted with crisis situations, staff are more likely to use the most familiar, effective method for intervention. By increasing staff familiarity and comfort level with non-physical skills, the likelihood that these skills will be utilized will be decreased.

Implement a culture of continuous growth and support for children and staff.

Training should not be looked upon as an isolated event or scheduled recurring event. Rather, in order to effectively develop and maintain the skills necessary to work in a crisis-vulnerable environment one must be continually striving for higher levels of competence. This is achievable only when a culture exists that fosters continuous growth and support for both its clients and its staff. In order to create this culture, the natural and official leaders must be in alignment and work together toward the common goal by role modeling, teaching, and enforcing the positive organizational values and practices in their everyday interactions. One way this can be accomplished is with a multi-tier system of trainers who are working collaboratively to improve the quality of staff performance on a daily basis. At the heart of this system is the idea that anyone who is a leader in the organization is also a trainer.

Make equivalent training opportunities available to staff employed by state-operated and state-licensed programs.

Currently, training opportunities to staff at state-operated programs differ from the training opportunities available to staff at licensed programs. The same training opportunities should be made available to all staff, regardless of how programs are operated, so children within each system of care have staff with consistent skills.

State agencies identify and receive, as necessary, the resources required to implement coordinated standards related to training.

The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote effective staff training within its specific system. However, each agency will need varying levels of resources to successfully implement the proposed uniform standards related to training. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary.

**GUIDING PRINCIPLE:
INDIVIDUALIZED BEHAVIOR
MANAGEMENT PLANS &
RISK ASSESSMENTS**

Planning approaches to behavior management should be individualized and comprehensive, incorporate active risk and safety assessments, and include a full range of interventions with the intent of preventing crisis behavior.

Where not clinically contraindicated, children and their family, guardian or advocate should be active partners with service providers in the development of positive and proactive approaches to behavior management.

Need for Individualized Approach to Behavior Management

It was noted in the previous section that training provided to staff places considerable emphasis on methods for assisting children to maintain self-control and help staff use proactive methods of positive behavior support. In keeping with these approaches, behavior management plans, which are fundamental to the safety of children and staff, should be an integral part of each child's individualized plan of care.

Behavior management plans, often referred to as safety plans or crisis prevention plans, are positive proactive approaches to behavior management that reduce the need for and use of the most restrictive forms of crisis intervention, including restraints. In fact, a number of national organizations recognize the benefit of behavior management plans and endorse their use in best practice standards (12, 13, 14).

Children benefit considerably from behavior management plans since these plans detail individualized supports and proactive interventions children need during the earliest stages of distress to

decrease the chance they will require more restrictive crisis interventions. Additionally, through these plans, children learn positive skills that help them regain control. Equally important, these plans support staff by providing them with information about the continuum of behavior a child may exhibit prior to a crisis and allow staff to intervene and prevent a situation from escalating by using the strategies known to alleviate distress or modify maladaptive behavior for a particular child. The prevention-oriented approach taken with behavior management plans makes them particularly relevant for those settings that have 'no reject, no eject' policies (i.e., service providers are required to take all referrals and keep all children).

In many systems of care, behavior management plans are developed for children who have difficulty with self-control and are either a subsection within children's service plans or distinct plans developed in addition to the service plans. Given the merit of these plans, the RCIT Committee recommends, at a minimum, each child with behavior management problems has an individualized behavior management plan in place.

Assessments to Identify Children in Need of Behavior Management Plans

Research indicates restraints are more likely to be used during the early stages of a child's placement in a residential setting or with children having longer lengths of stay (4). Based on this evidence, best

practice standards reviewed by the RCIT Committee support the use of assessments at intake and on an ongoing basis in order to determine which children are most in need of behavior management plans. This assessment provides an opportunity to make available the necessary type and level of services that could reduce the need for restrictive interventions and increase the likelihood that restraints, if applied, will be done in a safe manner.

Upon intake, it is recommended that interviews be conducted with staff from the referring agency, staff from the child's previous placement, family members and the child in conjunction with a record review. Previous experiences are factors that increase risk of harm to self or others so particular emphasis should be placed on any history of suicide attempts; history of sexual or physical abuse that would place the child at greater psychological risk during restraint; previous assaults; previous exposure to violence (i.e., observed domestic violence or assaults); or incidents when a child was absent without official leave (AWOL). Risk assessment should not be limited solely on a child's previous involvement in restraints.

If it is determined a child needs a behavior management plan, a preliminary plan should be developed and implemented shortly after admission then a comprehensive assessment should be conducted using a standardized, structured protocol and a comprehensive behavior management plan should be put in place. Adopting the standard used by OMRDD, it is recommended this be done within 30 days of the child's admission to the program.

Minimum Assessments Recommended for Individualized Behavior Management Plans

- History of risk factors
- Structured, standardized assessment protocol conduct by qualified staff
- Medical assessment by qualified staff

The structured assessment is an invaluable way to incorporate a variety of techniques that allow staff to diagnose the cause of maladaptive behavior and to identify likely interventions intended to address the behavior. We suggest this thorough analysis be coupled with a degree of flexibility so team members are able to problem solve in a creative manner. Additionally, trauma assessments should be included in assessments given the vulnerability of children served in residential settings. Last, in light of the medical risk associated with restraint, a medical assessment that entails a review of medical records must be conducted by medical staff to determine if preexisting medical conditions, medications or physical disabilities contraindicate the use of certain crisis interventions (e.g., prone or supine restraints).

As noted earlier, behavior management plans can be developed for children newly admitted to a program or following incidents of restraint. However, the RCIT Committee does not recommend a single incident of restraint be used as the sole determination of whether a child needs a behavior management plan. In fact, debriefing strategies following a single event of restraint allows staff, along with children and their families, to identify the types of changes that will help prevent a second crisis from occurring. OMRDD uses the guideline of two restraints within a 30 day period or four restraints within a six month period to determine whether staff should be gathered to discuss a child's need for a behavior management plan. The staff meeting does not automatically warrant the development of a behavior management plan but serves as an opportunity to identify if a child would benefit from a plan. The final decision is based on professional expertise of the staff.

Key Elements of Behavior Management Plans

The behavior management plan serves the dual function of informing staff about effective strategies that can keep children safe and reducing the need for restraints. Therefore, the RCIT Committee recommends these core components be a part of all behavior management plans (82):

- **Identification of antecedents:** These are biological, social, affective and/or environmental factors that increase the likelihood a child will become distressed or begin to use maladaptive behaviors. These factors are commonly referred to as 'triggers' and include examples such as: loud noises; staff refusal to a child's request; peer ridicule of a child; or a family member cancelling a visit.
- **Identification of early warning behaviors:** These are behaviors that indicate a child may be losing behavioral control and typically precede crisis behavior. Examples of early warning behaviors are pacing; clenching teeth or fists; shortness of breath; or slamming a door.
- **Identification of positive behavior supports and replacement behaviors:** These are prosocial behaviors children initiate to replace their maladaptive behaviors. Initially, staff may provide guidance through de-escalation techniques (e.g., suggest child use deep breathing) but the eventual goal is to have children use these skills independently. For instance, strategies might include children seeking out an adult who makes them feel safe whenever they experience distress; taking a walk while being shadowed by staff; moving to a calming room; or using deep breathing exercises to decrease their level of agitation or discomfort. Within the educational setting, this might mean the use of curricular integration where changes are made to the curriculum or instructional strategies in an effort to help the child learn replacement skills. Replacement skills are critical for two reasons. First, plans that incorporate replacement skills are more likely to transfer successfully to other settings and this means children have a greater chance of becoming more independent. Second, the development of replacement skills (i.e., coping skills) is associated with increased resiliency, which is a particularly valuable trait for children who have experienced trauma—a major portion of children receiving services in residential settings.
- **Identification of medical conditions that contraindicate the use of a particular form of restrictive crisis intervention:** Due to the inherent medical risks associated with restraints, each child must have a medical review to determine whether there are existing medical conditions that place the child at increased risk in the event that restraint or a particular form of restraint (e.g., prone or supine) is used. The medical review increases the likelihood that restraints, if applied, will be modified as needed and conducted in a safe, individualized manner. Another factor that could increase medical risks of restraint is the medication currently used; therefore, a review of medications would also be part of this analysis.
- **Plan review date:** A review date allows service providers and families to review the effectiveness of the current plan and to make necessary changes based on that review.
- **Parent awareness:** The strategies outlined in a behavior management plan are intended to support the child when in distress and help the child integrate effective replacement skills.

Therefore, it is particularly helpful if parents are well-versed in the plan content and able to use the techniques described in the plan so they are equipped to support their child once the child is back home.

Participants Involved in Plan Development

The development of behavior management plans should be considered problem-solving collaborations intended to resolve serious behavior challenges. Due to the individualized nature of these plans, it is recommended that individuals who know the child best should be involved in the development of such a plan. Therefore, the RCIT Committee recommends, where clinically not contraindicated, that children and their parents, guardians or advocates be active partners with service providers in the development of these positive approaches to behavior management. This provides parents and children the opportunity to express preferences for particular forms of behavior management interventions, also referred to as advanced directives, and to identify alternatives to restraint. Service providers and education staff that interact regularly with the child also are key members of the team and have primary responsibility for plan implementation. Additionally, given the inherent medical risk of restrictive crisis interventions, such as restraints, a nurse, physician's assistant or medical doctor should be a part of the team.

Staff access to a behavior modification specialist and development of a professionally developed behavioral treatment plan has been shown to reduce restraint and seclusion by 60 percent (62). As such, consideration needs to be given to the level of behavioral knowledge and competence of the professional staff developing these plans. Some licensed programs currently have staff qualified to develop plans while others lack this expertise. It is important to note that the expertise should be shared wherever possible. This will also maximize communication between systems. An example of this is participation of staff from the educational setting who have training and qualifications to develop behavior management plans and conduct functional behavioral assessments. However, state agencies will still need to conduct staffing assessments in those programs that have qualified staff and make the necessary staffing adjustments. In programs where the necessary staff qualifications are lacking, state agencies should make technical assistance available to higher level staff (e.g., supervisors) and the necessary adjustments accordingly.

My Voice

The book, **My Voice** (83), was developed by youth mental health advocates and is a useful mechanism to help children and adolescents reflect on and document their service needs and concerns. Similar to a journal or diary, the book includes 'stems' that are completed by the individual receiving services. For example, open-ended stems include:

- I would like to know more about...
- I find the following things helpful when I am upset...
- In the past, I have had my trust broken in this way...

The purpose of the book is to help youth reflect on what is helpful to them and to use this information to provide a voice in their individualized service plan. Much of the information included would be applicable to a behavior management plan and serves as an excellent tool for self-reflection and staff awareness of the individual child.

An additional book, **My Private Voice** (84), uses the same format as *My Voice* and is intended to provide children and youth an opportunity to explore inner thoughts and feelings at their own pace, without concern of disclosure to others.

Need for Staff Training

To ensure consistent quality of the plans, it is recommend training be made available as necessary for staff responsible for the development of plans. Such training would include staff training in areas of:

- Use of tools that enhance staff understanding of children's maladaptive behavior (e.g., functional behavioral assessments, A-B-C tracking, scatter plots);
- Strategies for teaching replacement skills;
- Communication skills and de-escalation techniques used to prevent crises;
- Strategies to minimize power and control and to increase collaboration and supportive skill-based services (e.g., use of trauma informed care);
- Knowledge of the continuum of behaviors to help staff distinguish variations in behavior (e.g., use of Lalemond Behavior Scale to discern between agitated, disruptive, destructive, dangerous and lethal); and
- Post-restraint strategies to review incidents (e.g., use of debriefing).

Quality Assurance of Behavior Management Plans

Monitoring and evaluation of behavior management plans

Once plans are implemented, they should be monitored regularly and changed as needed. It is recommended that behavior management plans be reviewed at the same interval as service/treatment plans or every six months, whichever is sooner, and revised as necessary. This ongoing monitoring allows staff to determine the fidelity and efficacy of plans. Furthermore, the RCIT Committee recognizes there may be instances that warrant revisions sooner (e.g., high incidents of restraint).

Conduct audits of behavioral management plans

It is recommended that the program directors require regular audits of a sample of plans to assess the degree plans were conducted correctly, consistently and as designed. The findings of these audits should be published at the provider level and shared with the organization's staff and leadership (e.g., Board of Directors).

RECOMMENDATIONS RELATED TO BEHAVIOR MANAGEMENT PLANS & RISK ASSESSMENT

Conduct structured standard assessments at intake and on an ongoing basis to identify children who may have behavior management problems and be at risk of more restrictive forms of crisis intervention.

Research indicates emergency use of restraint is related to the time in which a child receives services. Specifically, children are more likely to experience this type of restraint early in their placement when they are not familiar with the new setting and staff are not familiar with them as well as when children have longer lengths of stay. Therefore, it is necessary for children to have a preliminary assessment conducted upon their arrival to a program to determine the likelihood they may be at increased risk of an emergency restraint. The assessment should be conducted to determine strategies that could reduce the need for the most restrictive form of crisis intervention. Factors to consider in preliminary assessments are described in this report.

The assessment should be conducted periodically, during children's stay in the program to assess whether conditions have changed (e.g., child's risk of restraint may decrease over time).

Each child who is identified as having behavior management problems should have an individualized behavior management plan that is examined on a regular basis for efficacy.

To help staff support children with behavior management issues, it is recommended that an individualized behavior management plan be made available within a reasonable amount of time of the child's arrival to the program. Additionally, the efficacy of the plan should be examined following each restraint.

Where not clinically contraindicated, children and their parents, guardians or advocate actively participate in the development of the child's behavior management plan and approve the plan as written prior to implementation.

Given the individualized approach of a behavior management plan and the serious nature of crisis intervention, it is recommended that children and their parents, guardians or advocates actively participate in the development of the behavior management plan and approve the plan prior to implementation.

Use standard protocols to develop individualized behavior management plans.

Each child should have information in his/her behavior management plan that will allow staff to support him/her in managing behavior. The information should be garnered following a structured, standardized assessment conducted by staff that are qualified and trained as necessary. Additionally, consideration must be given to whether there are medical contraindications.

Where needed, enhance staffing to incorporate qualifications necessary for the development of behavior management plans.

At present, staff with the recommended qualifications may not be available to develop such plans. Therefore, state agencies will need to conduct staffing reviews to determine areas where additional staff may be needed and/or the need for staff with particular qualifications.

State agencies identify and receive, as necessary, the resources required to implement coordinated standards related to behavior management plans and risk assessment.

The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote individualized behavior management approaches within its specific system. However, each agency will need varying degrees of resources to successfully implement the proposed uniform standards related to individualized behavior management plans.

Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary.

**GUIDING PRINCIPLE:
QUALITY ASSURANCE**

Leadership and management at the state and provider level responsible for providing day and residential, mental hygiene, health care, and educational services to individuals should establish quality assurance mechanisms designed to:

- Identify strategies to reduce restraint use at the population and individual level;
- Implement restraint practices in a safe manner;
- Monitor the use of restraints through ongoing data collection and analyses, including the rate of use, occurrence of injuries resulting from the use of restraints, and measures of the effectiveness of such interventions for quality improvement reviews;
- Assess each episode of restraint for necessity, safety, and consistency with regulations, policies and protocols;
- Identify and implement corrective measures where indicated; and
- Keep informed of changes in best practices related to behavior management, the use of restraint, and restraint reduction initiative.

Importance of Ongoing Review and Improvements

Quality assurance mechanisms described in the guiding principle highlight the need for state and provider leadership to balance continuous quality improvement with risk management practices given the potential risks imposed on children, staff and the organization whenever a restraint occurs. Two key priorities should be (a) the use of the least restrictive crisis intervention and (b) an emphasis on practices that allow providers to examine instances of restraint to determine how to minimize use in the future. Continuous quality improvement practices enable leadership to use objective data as a form of serial experimentation to improve services and enhance their ability to manage risk.

Identify Strategies to Reduce Restraint Use at the Population and Individual Level

The 'safe manner' noted in the guiding principles needs to take into account the criterion used to determine if a restraint should be implemented; the level of staff competence; and availability of adequate staff to assist in the restraint.

Use of Restraint Reduction Plans

From a population perspective, a facility-wide¹¹ restraint reduction plan is an effective tool to help leadership identify and implement strategies that promote positive behavior management and reduce restraint use. The National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center (NTAC) has identified six core strategies drawn from the research literature on restraint reduction to incorporate into such a plan, with two strategies placing particular emphasis on quality assurance (77):

1. *use of debriefing techniques;*
2. *use of data to inform practices related to crisis intervention;*
3. identification of activities undertaken by leadership to promote organizational change;
4. workforce development;
5. use of restraint reduction tools to support staff use of positive alternatives to restraint; and
6. involvement of consumers.

CWLA recommends leadership within an organization review current restraint reduction efforts using a self-assessment instrument (75). In the absence of such efforts, the NASMHPD NTAC recommends developing a facility-wide policy statement that describes the prevention and reduction approach that will be employed and establishes goals for reduced rates of restraint. Typically, a highly visible event is used to introduce the effort with key staff identified as 'champions' responsible for implementation of the plan. It is strongly suggested that senior executive staff assume responsibility for oversight and routine review of plan progress. Similar to other options provided under the Leadership Guiding Principle, the use of a restraint reduction plan is a possible, not mandated, means to promote quality assurance.

Use of behavior management plans

As noted previously in this section, behavior management plans are intended to reduce the need for restraints at an individual level (82). Each child's plan includes information regarding factors that may initiate a stressful situation for the child and details effective approaches to lessen the difficulty experienced by the child. Currently, OMH providers develop such plans for children in programs authorized to use restraint; this is suggested but not used by voluntary providers licensed by OCFS. OMRDD and SED require behavior management plans for children with behavior management issues, including those children at risk of restraint.

Implement Restraint Practices in a Safe Manner

Standard for use of restraint

To promote safety and reduce restraint use, all staff need to be fully aware under which circumstances restraint is appropriate. A set of clear protocols regarding the use of restraint is linked to effective restraint reduction programs and several national organizations support the practice standard that restraint be used only as a last resort in *emergency* situations when alternative, less restrictive procedures and methods of intervention have been unsuccessful or cannot be effectively employed, and when it appears from the circumstances that the risk of immediate physical harm to the individual or others from not using a restraint outweighs the risks associated with the restraint.

¹¹ Facility refers to service providers with licensed programs authorized to use restraints, including state-operated facilities and voluntary agencies.

Figure 3. details the conditions under which staff are allowed to use restraint. Currently, standards for use of restraint vary across agencies with SED providing the most circumstances when restraint is allowed. Specifically, reasonable physical force can be used in instances where it is necessary to protect the child or others from physical injury; to protect property of the school, school district or others; or to remove a child whose behavior interferes with the orderly exercise and performance of school or school district functions. OCFS has fewer circumstances when restraint is permitted; however, similar to SED, restraint may be used in situations involving property damage. OMH uses the criterion of serious injury to self or others; OMRDD focuses on dangerous behavior that could result in serious injury.

Figure 3. Conditions for Use of Restraint as Allowed in State Agency Laws/ Regulations/Policies

| | |
|---|--|
| <p style="text-align: center;">OCFS 18 NYCRR 441.17</p> | <p>Restraints may be used to contain acute physical behavior (i.e., behavior that indicates the intent to inflict physical injury upon oneself or others or to destroy property).</p> |
| <p style="text-align: center;">OMH Mental Hygiene Law Section 33.04</p> | <p>Restraint may be employed only when necessary to prevent a patient from seriously injuring himself or others. It may be applied only if less restrictive techniques have been clinically determined to be inappropriate or insufficient to avoid such injury.</p> |
| <p style="text-align: center;">OMRDD Policy Agency Action 633.16 (9/17/94) Policy document SCIP-R (1998)</p> | <p>Physical restraint (restrictive personal interventions) may only be used when a person is displaying dangerous behavior. The purpose of the restraint must be to interrupt or terminate a truly dangerous situation where serious injury could result.</p> |
| <p style="text-align: center;">SED 8 NYCRR 19.5</p> | <p>Immediate interventions involving the use of reasonable force shall be used only in situations in which alternate procedures and methods not involving the use of physical force cannot reasonably be employed. Emergency means a situation in which an immediate intervention involving the use of reasonable physical force is necessary to protect oneself from physical injury, to protect another pupil or teacher or any person from physical injury, to protect the property of the school, school district or others, or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts.</p> |

The mixed standards regarding when restraint can be used means children in certain settings have a higher probability of experiencing restraint. If our intention is to minimize restraints so we minimize risk to children and staff, it follows that we use a common standard that specifies under which conditions restraint is allowed. It is recommended that a common standard be adopted and incorporated into all agency regulations. This should be done in conjunction with the development of resources to support positive alternatives to restraint (e.g., use of behavior management plans, implementation of calming rooms).

Competency-based training

As noted previously in this section, training that provides staff with skills to address the full continuum of crisis intervention is another factor related to safety and positive alternatives to restraint. In particular, competency-based training, which requires training participants to

demonstrate their ability to correctly apply crisis intervention techniques, is recommended as a necessary practice standard by several national organizations.

Currently OCFS, OMH and OMRDD have agency-specific, competency-based training curricula designed to address the full continuum of crisis intervention, including the types of physical restraint sanctioned for use with children in their respective licensed programs. Considerable agreement exists across agency-sponsored curricula. SED requires staff to be provided with appropriate training in a safe and effective restraint procedure; schools are to use a training plan approved by SED.

The amount of training available can differ between state-operated and state-licensed programs, which place staff and children at uneven risk of harm. These uneven conditions can be remedied with a more equitable approach to training.

Adequate staffing

The safe implementation of a restraint requires a balance between physics and biology. For instance, the force needed to restrain a small child may be quite different from one needed to restrain an adolescent, given differences in their size. Staff exertion may also influence the restrained youth's ability to breathe. Therefore, each form of physical restraint requires varying numbers of staff to properly and safely implement the given technique. The forms of physical restraint included in training and permitted for use by state agencies requires a ratio of from one to three staff per child restrained, depending on the specific restraint technique used. For example, prone and supine restraint techniques can require two or three staff while seated and side restraint techniques can require one staff to implement.

Obviously, the type of restraint used will influence staffing demands and in some instances may require an increase of staff. However, making additional staff available for an event we hope to reduce is not the most efficient use of resources. An approach that was used in a CWLA demonstration project to promote restraint reduction and ensure necessary staffing was to incorporate crisis intervention experts. These individuals were available on each shift to help floor staff with de-escalation strategies as a crisis began. These individuals supported staff so restraints could be averted—they were *not* intended to serve as a witness to the restraint. This staffing approach helped divert restraints since it added another adult's approach to crisis prevention and de-escalation while offering the youth in crisis options not possible if additional staff were not available (e.g., go for walk). An expert in crisis intervention has a higher skill level than other staff authorized to use restraint; however, it is expected this individual will have the additional function of serving as a mentor for staff and assist in staff development of de-escalation and debriefing skills.

Reviews of Restraint Use and Implementation of Corrective Measures

Information garnered from restraint episodes has the potential to promote quality of care and minimize the likelihood of future risk by providing leadership with a description of whether less restrictive crisis interventions were employed as a first line of action and the extent implementation was consistent with training protocols and organizational policies. Two types of activities that might be incorporated into such assessments are discussions with children and staff, as appropriate (i.e., some children are non-verbal) and discussions with staff and their supervisor. The first activity focuses on the child and the possible need for revisions in behavior management plans while the

second activity focuses on organizations and the possible need to make adjustments to current practices and procedures. A child-focus allows us to learn what occurred and to identify if any revisions should be made to the child's behavior management plan. For example, this may require a revision of circumstances that serve as stressful triggers, changes in the de-escalation techniques used, or development of prosocial or coping skills. Activities that focus on staff allow the staff and supervisor to review the extent procedures were followed as required and to evaluate whether organizational changes are necessary. For instance, concerns may be raised with respect to safety of the physical environment or current procedures. Staff have noted they prefer conducting post restraint reviews with supervisors rather than fellow staff members since it allows for more immediate corrective action to organizational procedures that require change.

Child and staff assessment refers to a discussion with the child involved in a restraint by staff members that engages the child, allows him/her to express thoughts and/or feelings about the intervention, and examines steps that could be taken to avoid the future use of restraint.

Staff and supervisor assessment refers to a discussion with staff members involved in restraint by senior staff members that covers the rationale for initiating the intervention and identification of strategies that could be used to avoid the future use of restraint.

Both types of activities are valuable risk management tools given the emphasis placed on understanding why a restraint occurred and what can be done to improve the situation rather than a punitive focus of who implemented the restraint. It has been suggested these reviews of restraint be conducted as close to the event as possible to maximize the quality of information gathered. However, in service settings with limited staff it may be more feasible to conduct such sessions over a given period of time.

Structured Protocols

Use of a standard protocol is recommended to guide staff and promote consistency of data collection during reviews of restraints. The NASMHPD NTAC has developed a comprehensive policy and procedure manual while CWLA outlines the type of information that should be documented during these types of sessions (Figure 4) (61). These protocols are shared as examples, not tools mandated for use in each service setting. The key point here is the benefit of a structured protocol.

Figure 4. CWLA Guidelines for Debriefing Documentation

- Description of the event
- Data and time of day of occurrence
- Intervention used and reason for its use
- Duration of intervention
- Children involved
- Caregivers or others involved and their relationship to the child
- Names of others who witnessed the restraint
- Name of person making the report
- Description of any injury to the child including a body chart or photo of any injuries
- Action taken by the provider
- Prevention actions to be take in the future
- Description of any follow-up required
- Documentation of supervisory or administrative review.

Many best practice guidelines endorsed by national organizations recommend parent or legal guardians be notified following the restraint of a child. Given the traumatic effects that can result from restraint, the American Academy of Child and Adolescent Psychiatry also recommends program

staff inform parents of the side effects, such as disassociation or medical reactions that can result from various forms of restraint. While restraint review protocols are recognized as useful tools for guiding staff in gathering consistent data across restraint events, it is also recommend that the skills necessary to complete the protocol be a part of training. Additionally, supervisors' skills should be strengthened through advance training so supervisors can assume responsibility for mentoring and supporting staff in the proper application of this technique. SED requires similar documentation and parent notification.

Monitoring Use of Restraints for Quality Improvement Reviews

Monitoring systems allow leadership to monitor practices and provide them with one of the most fundamental sources of information for successful risk management—knowledge about the rate at which restraints and restraint-related injuries occur. Just as debriefing data inform staff how to modify care for children, monitoring data allow leadership to examine the frequency of restraint, where and when it occurs, and what injuries resulted. Restraint and injury data are important components of *Restraint Reduction Plans*, providing leadership with information regarding where within the system corrective measures are needed in addition to how well the organization is meeting the goals established in the plan. This form of evaluation also helps leadership identify successful strategies that should be reinforced and modeled as best practices. Moreover, this information, when shared with key audiences, (e.g., board members, staff) fosters organizational change that supports restraint reduction.

Need for comprehensive view within systems of care

The quality of information gained from any monitoring system is influenced by the extent data are complete. More complete data provide greater accuracy and an increased ability to detect system deviations that may require corrective action. This comprehensive picture is particularly relevant for policy and program planning. However, currently, we lack easily accessible information for each system regarding the number and rate of children placed in restraints and the occurrence of injuries to staff and children as a result of those restraints. OMH has an automated system in place but the system lacks information from certain providers (e.g., restraint use in private hospitals). OCFS is putting in place an automated system that requires all providers and state-operated programs to provide data related to the use view of restraint within the child welfare system. OMRDD currently uses manual means for data collection. SED does not require schools serving children in residential settings to report school restraints to those service providers. Given the known risks associated with restraint, it is sensible for each state agency to gather data in a manner that affords a comprehensive view of restraint use within each service system, including information on child and staff injuries related to restraint. This information will be further enhanced if restraints occurring in schools could be submitted to programs licensed to serve children in residential settings (e.g., OCFS, OMH, OMRDD).

Accountability

It was noted earlier that development of *Restraint Reduction Plans* promotes positive alternatives to use of restraints and an important part of such plans is the use of monitoring data to assess progress toward that goal. Clearly, leadership of programs authorized to use restraint can benefit from easily accessible reports that allow them to review progress toward positive behavior management. This accountability is equally important at the state level. Therefore, it is recommended that the review of restraint and injury related data be incorporated into state agency licensing and survey processes.

This will maintain the current focus on child and staff safety and encourage use of positive alternatives to restraint.

Keep Informed of Changes in Best Practices

A number of national organizations have done extensive work to identify best practices within their respective fields. It is suggested that periodic updates be provided to the leadership of state licensed and operated programs to promote the most current knowledge on behavior management. A variety of means can be used, including but not limited to leadership seminars, conferences, and dissemination of written materials.

| RECOMMENDATIONS RELATED TO DEVELOPMENT OF QUALITY ASSURANCE MECHANISMS | |
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| Develop and incorporate into regulations a common standard that specifies under which circumstances staff may use restraint. | Currently different standards are outlined in state agency regulations regarding when staff may be required to use restraints. Some standards are broader, encompassing more situations when restraint may be used. This means children in those settings have a greater probability of experiencing restraint. This uneven standard is particularly challenging for children receiving services from multiple-licensed providers where the child may receive services from child welfare or mental health services as well as educational services. For example, a child's behavior in the educational setting may warrant a restraint but that same behavior may not meet the standard for restraint in the residential setting. A common standard used by all state agencies would address this. |
| On a regular basis, conduct a review of restraints to determine the extent staff followed established procedures and to identify modifications that could improve organizational procedures. | On a regular basis, supervisors and staff should conduct meetings with the purpose of reviewing restraints that occurred during a given period of time to determine the extent procedures used were consistent with policies as well as to identify organizational factors that could improve restraint reduction. This practice is commonly referred to as debriefing and can follow each restraint. |
| Use standard protocols to increase the consistency and quality of information gathered during restraint reviews. | The information gathered during restraint reviews serves to improve practice and policy at the individual and population level as well as organizational and system level. Therefore, it is recommended standard protocols be used to gather consistent types of information and that this information be incorporated into quality assurance systems so it may be aggregated and used to inform policy and practice or be done for a given period of time, depending on staffing limitations. |
| Establish timely, comprehensive monitoring systems to monitor restraint and related injuries to staff and children as a result of those restraints. | The extent restraint and injury data are easily accessible and able to be aggregated varies considerably by state agency and local provider. Therefore, it is recommended automated, web-based monitoring systems be made available to providers, including schools, to record instances of restraint as well as injuries that result from those restraints, both for children and staff. Injury data should be expanded to include injuries requiring first aid as well as severe injuries. The monitoring systems should be designed, at a minimum, to provide the following information: <ul style="list-style-type: none"> ▪ Rate of restraint use ▪ Child injury rates related to restraint |

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| | <ul style="list-style-type: none">▪ Staff injury rates related to restraint |
| At a minimum, state agencies that authorize the use of restraints annually aggregate restraint and injury rates of their respective systems. | The information gathered from the monitoring systems should be reviewed periodically at the aggregate level to identify patterns in the use of restraints and variations in those patterns. |
| Incorporate into current surveying and licensing processes data pertaining to: <ul style="list-style-type: none">▪ Rate of restraints▪ Child injury rates related to restraint and▪ Staff injury rates related to restraint. | Use of restraints places children and staff at risk of injury. This practice also increases risk to the organization as a whole. Therefore, this practice should be monitored carefully and be a criterion used to assess the quality of state-operated and state-licensed programs. As appropriate, populations served will be taken into account when reviewing rates of restraint. |
| State agencies identify and receive, as necessary, the resources required to implement coordinated standards related to quality assurance. | The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote quality assurance practices within its specific system. However, each agency will need varying degrees of resources to successfully implement the proposed uniform standards related to quality assurance. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary. |

IV. COORDINATED STANDARDS FOR BEHAVIOR SUPPORT & MANAGEMENT: RECOMMENDATIONS AND NEXT STEPS

Coordinated Standards for Behavior Support and Management

As part of Chapter 624 of the Laws of 2006, the RCIT Committee is required to establish coordinated standards for the most effective, least restrictive and safest techniques for the modification of behavior. Given the serious implications of crisis intervention and the complexity related to the coordination of four service systems, a comprehensive approach was used to identify these standards.

A number of common elements emerge from the literature and best practice standards when one attempts to identify what constitutes safe techniques for behavior management. Not surprisingly, the behavior management and support standards most frequently cited are consistent whether children require services related to developmental disabilities, a mental illness or need child welfare or educational services. Based on the review of the literature, best practice standards, and in keeping with the intent of the guiding principles, it is recommended the following coordinated standards be integrated into the current practice and regulations of OCFS, OMH, OMRDD and SED. At this time, the coordinated standards apply to programs outlined in the legislation, with the exception of day treatment programs and community residences. The Council will continue to work with agencies and Committee members on this topic to address the unique and complex issues related to these particular service settings. Though not specified in the legislation, it is recommended the coordinated standards apply to special act school districts (see Appendix G) in the same manner as they apply to private residential and private non-residential schools. Furthermore, these standards are developed for children; yet it is believed the standards could be applicable to settings that serve adults as well.

Staff trained in a recognized, competency-based program

Staff training is essential for effective crisis intervention. The literature and best practice standards are clear on the need for staff to be trained in the full continuum of crisis prevention and intervention techniques, ranging from sound communication skills, effective de-escalation techniques tailored to the individual child, and use of more restrictive crisis intervention techniques, including physical restraints. In fact, trained staff are more likely to rely on de-escalation techniques and less likely to apply restrictive forms of crisis intervention.

OCFS, OMH and OMRDD laws, regulations and policies reflect this standard. By regulations, staff in programs licensed or operated by these three agencies who may need to use restraint are required to participate in crisis intervention training and are not allowed to implement physical restraints unless they have completed that training. However, not all regulations specify the need for competency-based training and this factor, which is presumed, should be made more explicit.

SED regulations are similar to other agencies in that they specify the need for training in techniques for group and child management, including crisis intervention and appropriate restraint training. Training plans must be approved by SED. In practice, school staff in agencies with a residential component tend to participate in training courses offered to non-school staff. In instances when the provider has a single license, school and non-school staff are trained in the crisis intervention program endorsed by the licensing agency. This becomes more involved when staff are employed by providers with multiple licenses in co-located sites since more than one training program (i.e., training of OCFS, OMH, OMRDD) may be available to school staff. Therefore, it is recommended that competency-based training be made available to staff employed by providers with multiple licenses so all staff, including education staff, will have a consistent set of crisis intervention skills that can be employed with all children in all settings.

Individual behavior management plan available for children at risk of being restrained

The literature notes children are more likely to be restrained when they first enter a program or when they have extended lengths of stay. As such, all children should have the benefit of a preliminary assessment upon admission to a program and on an ongoing basis to determine if they are at risk of restraint and, if so, to identify the most effective forms of crisis prevention and early intervention specific to that child. At a minimum, the assessment should include a history of risk factors; identification of antecedents, early warning behavior and coping mechanisms; and a medical assessment by qualified staff. The likelihood a child will be restrained early in a program is not dependent on the types of services received or the number of licenses a provider may have. This means all children, regardless of the service system or program location should have access to an early risk assessment, followed by an individual behavior management plan as determined by the assessment. A behavior management plan is a valuable tool for all individuals who interact with the child; therefore, it is recommended, particularly in instances where a child may receive education services in addition to services through OCFS, OMH or OMRDD, that the plan be developed with the involvement of all relevant staff (e.g., residential, clinical, educational) and the final document be made available to them. All team members are responsible for implementation of the plan, as written.

The degree to which a plan is individualized will depend upon the involvement of those people who know the child best, including parents or guardians and the children themselves. Therefore, as appropriate, children and their parents or guardians should be actively involved in the development of these plans. Furthermore, the strategies outlined in a behavior management plan are intended to support the child when in distress and help the child integrate effective replacement skills. Therefore, it is particularly helpful if parents are well-versed in the plan content and able to use the techniques described in the plan so they are equipped to support their child in their home.

A uniform standard for use of restraint

Safe techniques for restraint begin with a universal standard of when a restraint *is* and *is not* warranted. Most practice standards recognize restraint should not be used as a means of discipline or punishment, as a substitute for adequate staffing, as a replacement for treatment, or in any circumstance where less restrictive behavior management techniques would be effective. Furthermore, restraint should not be used in circumstances where an individual may be medically compromised. The widely accepted gold standard used to determine when restraint is necessary is in emergency circumstances that jeopardize the physical safety of children or others.

Currently, state agency regulations differ regarding the criterion staff must employ when determining if restraint should be used (See Section III). This variability results in children having a greater or lesser chance of experiencing the trauma of restraint depending on the types of services they receive

and is further complicated when children access services simultaneously. For example, a child may require mental health or child welfare services or services for developmental disabilities and then also access educational services.

OMH regulations stipulate restraint is warranted in cases of serious injury to self or others; OMRDD regulations emphasize a display of dangerous behavior that could result in serious injury. The standard is more broadly defined in OCFS regulations where destruction of property is included and SED regulations extend the set of circumstances in which staff may be allowed to use restraint. Regulations that offer the least flexibility to use restraint will support risk management and reduce the likelihood a child will be restrained unnecessarily.

A single, uniform standard that permits the emergency use of restraint in only the most serious conditions where the safety of the child or others is in jeopardy reduces the chance a child will be restrained unnecessarily; provides greater clarity to staff; and informs children and their families of types of behavior that result in the most restrictive form of crisis intervention. This is particularly true for multiple licensed providers with co-located programs.

Use of an accepted physical restraint technique

Various forms of physical restraint are presented in the training programs endorsed or provided by OCFS, OMH and OMRDD with prone and supine restraint techniques being predominant. It is accepted that all forms of physical restraint come with inherent risk due to the hazardous circumstances in which restraints are applied—in instances where an individual's behavior jeopardizes the physical safety of self or others. This is further complicated by the fact that staff must exercise judgment during these volatile times, not only with respect to whether the restraint is warranted but in the physical application of the restraint. As an example, each form of restraint has steps when staff must make judgments about the degree of pressure to apply to the individual being restrained as well as judgments regarding when to move from one step in the procedure to another and how to coordinate these steps with the co-worker assisting in the restraint. A common standard for when to use restraint coupled with a standard for regularly available competency-based training can address these issues, regardless of the type of restraint used. However, these standards are not sufficient for staff employed by providers with multiple licenses at co-located programs. In these limited instances, trained staff are at risk of implementing a form of restraint not endorsed by a given agency and are at greater risk of being investigated for abuse. Therefore, a single common physical restraint technique is needed for staff employed by these specific providers.

It is recommended a supine technique, which is currently used by two of the three state agencies, be adopted by *multiple licensed providers at co-located sites*. This

change will maximize cross-system coordination necessary for these unique sites. OCFS recognizes

It is recommended a supine technique be adopted among multiple licensed providers at co-located sites to maximize cross system coordination in these unique settings.

The form of supine restraint technique selected will determine which agency is responsible for staff training at the multiple licensed sites.

While the change reflects changes relative to one agency, that is OCFS, the scope of change is considerable given the number of beds licensed by this agency. Time and resources will be needed to properly accommodate for change on this scale.

the need for a cross system approach and has agreed to take proactive steps to reduce risks for children and staff. While this requires changes within one service system, namely OCFS, it is important to note the subsequent number of staff impacted by this change at the multiple licensed sites will be considerable.

The change has implications for training and will require RTC staff currently trained in the use of a prone technique to be trained in a supine technique. Furthermore, the current prone technique requires two staff to complete and three staff members are preferred when implementing the supine technique. Given these circumstances, it is strongly recommended this form of restraint be used only in conjunction with comprehensive restraint reduction practices and that the implementation be phased in so organizational changes can be made in an effective manner.

As noted, there are different forms of supine currently being used and a single form will need to be adopted by all three agencies for use at the multiple licensed sites. The form of supine selected will determine which agency is responsible for training of staff employed by providers with multiple licenses at co-located sites. Prior to this change being implemented, licensing agencies will need time to conduct staffing analyses and it is suggested agencies share their staffing models with sister agencies.

Use of standard monitoring practices during restraints

A clear lesson gleaned from the literature is the importance of monitoring during the time of a restraint. Many case studies highlight instances when individuals already vulnerable from the stress of a restraint were left unattended. Continual monitoring of individuals in restraint is critical given the health risks associated with their agitated state and as such, numerous guidelines note the importance of monitoring with periodic assessments. At a minimum, it is recommended staff applying the restraint monitor the child's skin color, respiration, level of consciousness and agitation and range of motion in extremities every 15 minutes, regardless of the restraint technique used. Currently, this standard is being met through training programs supported by OCFS, OMH and OMRDD. Additionally, these monitoring practices will become a part of restraint procedures implemented by education staff who participate in this training.

Methods that inform quality and practice from the perspective of children and staff

Two methods recommended as standards for effective and safe behavior management are staff/supervisor reviews of restraint and child/staff restraint reviews of restraint. The purpose of these reviews is to learn what can be done at the program- and child-level to reduce the likelihood of future restraints and increase safety for children and staff. OMH uses these practices as a term and condition of Medicaid participation (i.e., CMS regulations); however, no agencies have formal policies or regulations in place at this time related to such practices and revisions will need to be made accordingly.

Monitoring and data reporting to provide a comprehensive view of restraint use and related injuries

Restraint reduction is a critical component of any safe behavior management approach since reduction of the most restrictive and dangerous form of behavior management will increase safety for children and staff. To that end, it is important for organizations to gain an understanding of the rate at which high risk interventions occur. This information, coupled with reviews of restraint incidents, which provides a view of 'why' restraints happen, will increase capacity of programs and state agencies to make improvements to the quality of care available.

It is recommended that monitoring of physical restraint use and related injuries become a practice standard adopted by all agencies that authorize the use of restraint and that this information be reported to state agencies on a regular basis.

Currently, all state agencies require providers to log each occurrence of a restraint and to report any cases that result in serious injury to the designated state agency representative. SED also requires parent notification. Since children in programs with a residential component are not directly under the care of their parents and since the providers serve in the capacity of parents, it is essential that any information regarding use of restraints in educational settings be provided to the program with the residential component. This allows staff in both programs to provide supports to the child during this vulnerable time. Additionally, it is critical for such programs to have the most comprehensive view of restraint use within their systems due to the individual and institutional risks associated with restraint use. This means each agency should identify settings where this information is not currently available and identify ways to incorporate it so a full view of restraint and injury data is available.

Summary and Next Steps

The issues of equity raised initially in this report support the need for coordinated standards that could be adopted by each state agency represented in the legislation to enhance behavioral support strategies currently in place. Although each agency has these standards in place to varying degrees (e.g., staff training, monitoring systems, use of behavior management plans), resources that could assist state agencies to implement these standards at the same level across systems would even out conditions regarding when restraints are applied; the quality of training for those applying crisis intervention strategies; provide an enhanced risk management view, given better monitoring; and improve the overall safety and well-being of children and staff in these settings. Four areas emerge as necessary next steps for the adoption and implementation of the standards described above:

- Revision and coordination of regulations;
- Modification to training curricula sponsored by each agency to incorporate any additional skills;
- Review and modification of staffing models; and
- Development of monitoring systems that gather information related to restraint rate and rates of injuries related to restraints.

It is suggested that representatives from each agency develop an agency-specific work plan that outlines what is necessary for the standards to be implemented within their system and these documents be shared with the Council.

RECOMMENDATIONS RELATED TO DEVELOPMENT OF COORDINATED STANDARDS FOR BEHAVIOR SUPPORT & MANAGEMENT

Revise current state agency regulations, as necessary, to be consistent with the recommended coordinated standards.

Each agency will need to review and make revisions, as necessary, to current regulations so they are consistent with the standards outlined in this report and to its sister agencies. This does not mean identical regulations are necessary but that the objective of the regulations be consistent. Therefore, it is suggested the Council continue to work with state agencies in this process after the report is submitted to the Governor and Legislature.

Implement a coordinated, *cross-system* approach to behavior management and crisis intervention in multiple licensed, co-located service settings.

In an effort to advance cross-system, coordinated practices across the service systems represented at multiple licensed sites, a standard form of physical restraint will be incorporated into staff training and used for children served by each system of care. A supine technique is recommended for use, given the fact that two agencies currently employ this form of restraint. The form of supine restraint technique used will determine which agency is responsible for staff training at the multiple licensed sites.

Revise training curricula sponsored or provided by state agencies, as necessary, to incorporate skills that promote positive behavioral supports and alternatives to restraint.

The training curricula sponsored by each agency may need to be modified to incorporate some of the additional skills recommended. This is applicable for all programs licensed or operated by state agencies. Additionally, training curricula will need to be modified to incorporate the form of supine restraint to be used for training at the multiple licensed sites with co-located programs. This modification will not be necessary for curricula presented at single licensed sites.

Modify state agency staffing models, as necessary, to provide the staffing needed for the successful implementation of coordinated behavior support and management standards.

Staffing modifications may be necessary in some programs. As such, it would be beneficial for state agencies to share staffing models with one another so each agency has a better sense of the best way to proceed for its own agency.

Establish state agency monitoring systems to monitor rates of restraint use and related injuries to children and staff.

The monitoring system should provide a *comprehensive* view of the extent restraint is used within a given system and the rate of injuries that occur to children and staff as a result of those restraints. The monitoring systems should distinguish between those injuries that require first aid attention and those that require medical attention beyond first aid. Additional information of benefit to leadership pertains to where (e.g., school, cafeteria) and when (e.g., time of event) restraints occur. This may require development or expansion of monitoring systems currently in place.

State agencies identify and receive the resources necessary to implement coordinated crisis intervention standards.

The legislation calls for uniform, coordinated standards that promote the safest and least restrictive form of behavior management. To date, each agency has developed certain approaches noted in research and best practice guidelines that promote positive behavior supports within its specific system. These include but are not limited to such best practices standards as the use of individualized behavior management plans, competency-based staff training and monitoring of restraints. However, if the comprehensive, coordinated standards presented here are to be realized, each agency will need varying degrees of resources to successfully implement the proposed

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| | <p>uniform standards. Given the fact that each agency is resourced differently, a step-wise approach to implementation will be necessary. It is suggested that each agency develop a work plan for the implementation of the coordinated standards and share those plans with the Council.</p> |
| <p>Establish a mechanism for the review of changes to regulations that would be applied to multiple licensed providers with co-located programs.</p> | <p>Most of the behavior management standards outlined here are relevant for all providers, regardless of the number and type of licenses held. However, some are especially relevant for the subset of providers with multiple licenses. As such, it is necessary to have a means to review changes in regulations that impact these providers given the consequences these changes have on programs licensed by other service systems. While each agency will retain its independent statutory authority and responsibilities, it is recommended the Council work with state agencies to determine the most appropriate mechanism for the review of such regulations.</p> |

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APPENDICES

Appendix A

RESTRAINT AND CRISIS INTERVENTION TECHNIQUES LEGISLATION

CHAPTER 624

AN ACT to amend the social services law, in relation to establishing a restraint and crisis intervention technique committee and coordinated interagency standards

Became law August 16, 2006, with the approval of the Governor.
Passed by a majority vote, three-fifths being present

The People of the State of New York, represented in the Senate and Assembly, do enact as follows:
Section 1. The social services law is amended by adding a new section 483-e to read as follows:

* § 483-e. Restraint and crisis intervention technique committee.

1. Committee established. There is hereby established within the council a restraint and crisis intervention technique committee comprised of the commissioner of children and family services, the commissioner of mental health, the commissioner of mental retardation and developmental disabilities, the commissioner of education and the commissioner of health. The committee shall include at least two representatives of statewide and regional provider organizations that represent providers of educational and residential services to children, at least two mental health professionals who provide direct care on a regular basis to children served by the program types provided in subdivision two of this section and at least one representative of parents of children requiring special services.

2. Establishment of coordinated standards. The committee shall identify the most effective, least restrictive and safest techniques for the modification of a child's behavior in response to an actual or perceived threat by such child of harm or bodily injury to such child, or to another person, where such child is a resident of, or otherwise served by a residential treatment facility, a children's day treatment program, a family based treatment home, a community residence, an individualized residential alternative, a family care home, day habilitation, day treatment, an intermediary care facility, residential habilitation, an agency operated boarding home, an approved private residential school or an approved private non-residential school. Such techniques shall include, but not be limited to, the use of physical restraint, therapeutic crisis intervention, crisis management or such other de-escalation techniques designed to help staff assist children to manage crisis situations. The committee shall review models of crisis prevention and intervention, including the use of physical restraints. The committee shall establish uniform and coordinated standards giving preference to the least restrictive alternative for the use of such techniques in such children service settings.

3. Recommendations and report. The committee shall develop additional recommendations regarding crisis intervention as it deems appropriate including, but not limited to, appropriate staffing patterns to safely implement such techniques, specific training curriculum and regulatory amendments governing the oversight of staff training efforts implemented by the commissioners. Such recommendations, together with proposed regulations relating thereto, shall be included in a report submitted to the governor and the legislature no later than September first, two thousand seven.

Appendix B

GUIDING PRINCIPLES OF THE RESTRAINT & CRISIS INTERVENTION TECHNIQUES COMMITTEE

The use of restraint as an emergency intervention is used to control the behavior of an individual when the individual's behavior reaches a point where the risk of harm to self or others is immediate. In New York State, the use of authorized restraints as an emergency intervention is a current practice in a variety of private and publicly operated programs including programs under the jurisdiction of the Department of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the State Education Department. However, it is known that inherent physical and psychological risks are associated with this type of intervention.

Given that the safety and well-being of each individual receiving services is paramount, the agencies noted above and the programs under their jurisdiction that provide day and residential, mental hygiene, health care, and educational services must continually strive to reduce the use of restraints and develop alternative effective interventions to address an individual's behavior.

Care and treatment must be rendered in an environment that understands and appreciates the high prevalence of trauma histories among the children we serve and its debilitating impact on their social, neurological, biological, and psychological development. Trauma-informed care addresses these effects by minimizing power and control and increasing collaborative and supportive skill-based services.

The following principles reflect a philosophy on restraint and have been developed to guide the work of the *Restraint and Crisis Intervention Techniques Committee*.

Guiding Principles:

- Whenever possible, work to create a restraint-free environment
- Restraint should be used only as a last resort in emergency situations when alternative, less restrictive procedures and methods of intervention have been unsuccessful or cannot be effectively employed, and only when it appears from the circumstances that the risk of immediate physical harm to the individual or others from not using a restraint outweighs the risks associated with the restraint.
- Restraint should never be used as a form of discipline, punishment, retaliation, or coercion, to substitute for inadequate staffing, or as a substitute for treatment or therapeutic programs. Restraint could be part of the behavior management or safety plan.
- Leadership commitment is an essential component of effective restraint reduction initiatives and accordingly, leadership and management responsible for providing day and residential, mental hygiene, health care, and educational services to individuals should articulate in their regulations, policies, protocols, practice guidance, and training that restraints reflect a last resort intervention and they shall continuously seek opportunities to advance restraint reduction efforts.

- Behavioral support, risk assessment, crisis intervention, and restraint regulations, policies, protocols, training and practice guidance must protect the physical, psychological, and medical well-being of individuals served and the safety of staff.
- Crisis intervention and restraint techniques must be based upon evidence of the effectiveness and safety of the intervention or technique, as well as experiential information and data compiled by the applicable State agency, and implemented by trained staff who have demonstrated competence in the intervention or technique through training programs.
- Planning approaches to behavior management should be individualized and comprehensive, incorporate active risk and safety assessments, and include a full range of interventions, with the intent of preventing crisis behavior.
- Where not clinically contraindicated, the individual service recipient and his/her family/guardian/advocate should be active partners with service providers in the development of positive and proactive approaches to behavior management.
- Leadership and management at the state and provider level responsible for providing day and residential, mental hygiene, health care, and educational services to individuals should establish quality assurance mechanisms designed to:
 - Implement restraint practices in a safe manner;
 - Assess each episode of restraint for necessity, safety, and consistency with regulations, policies and protocols;
 - Identify and implement corrective measures where indicated;
 - Identify strategies to reduce restraint use on individual and population-based levels;
 - Monitor the use of restraints through ongoing data collection and analyses, including the frequency of use, occurrence of injuries resulting from the use of restraints, and measures of the effectiveness of such interventions for quality improvement reviews; and
 - Keep informed of changes in best practices related to behavior management, the use of restraint, and restraint reduction initiative.
- A comprehensive staff training program, including pre-service and in-service training should be made available to all relevant staff in programs that provide day and residential, mental hygiene, health care, and educational services to individuals. Staff must demonstrate competence in any techniques covered in the training before being authorized to perform them.
- The Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Department of Health, and the State Education Department should actively monitor the restraint policies and restraint reduction efforts of programs under their jurisdiction that provide day and residential, mental hygiene, health care and educational services and provide necessary technical assistance to such programs.
- The Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Department of Health, and the State Education Department are responsible for providing technical and other necessary assistance to programs under their jurisdiction that provide day and residential, mental hygiene, health care, and educational services.

Appendix C

SUMMARY OF RECOMMENDED STANDARDS AND PRACTICE GUIDELINES FOR THE USE OF RESTRAINTS

INTRODUCTION

Practice guidelines are essential tools to outline appropriate methods of treatment and care since they are based on the best empirical evidence available and serve as a means to incorporate research into practice by informing practitioners, clinicians and staff of those behaviors and practices that are associated with desired outcomes, such as restraint reduction. When implemented properly, practice guidelines work as quality-improving strategies that promote a consistently high level of care.

A number of professional organizations have developed practice guidelines to identify those practices within their field that increase the safety of restraint use and minimize the need for such a practice. To assist committee members in their work, practice guidelines developed by four organizations were reviewed to identify key features related to the practice of safe restraints and eventual restraint reduction.

The practice guidelines reviewed were developed by the:

- The Joint Commission;
- National Association of State Mental Health Program Directors (NASMHPD);
- American Academy of Child and Adolescent Psychiatry (AACAP); and
- Child Welfare League of America (CWLA).

These organizations differ somewhat in that they address different populations and service settings. Specifically, the Joint Commission and NASMHP focus on guidelines for populations that include children and adults while the AACAP and CWLA guidelines are specific to children and adolescents. With respect to service settings, the Joint Commission and AACAP focus more on hospitals and medical settings while NASMHPD and CWLA include non-medical settings. Despite these variations, the recommended guidelines issued by each of the organizations are markedly similar (Appendix A).

CONDITIONS FOR RESTRAINT USE¹²

Protocols that delineate when restraints are appropriate are critical to restraint reduction since they provide staff with a clear understanding of those specific instances when restraint use is appropriate. The four organizations reviewed show considerable agreement with respect to when restraints must be applied and limited its use to emergency situations. Typically, an emergency situation refers to any circumstance that is a danger to the client or others. The Joint Commission and CWLA also underscore that restraints should be applied only when less restrictive measures (i.e., non-physical interventions) are ineffective. Only AACAP allows for the use of restraint in instances where there may be damage to property.

¹² Each organization was silent with respect to the types of restraints covered by their guidelines; therefore, an assumption was made that the guidelines applied to all forms of restraint.

The organizations are also quite consistent with respect to those conditions when restraint is not appropriate. For example, use of restraint as a means of discipline or punishment is prohibited, as is its use for the convenience of staff or lack of staffing. Furthermore, it is widely accepted that restraint is not a replacement for treatment. Given the serious nature of restraints, NASMHPD and AACAP prohibit the use of restraint unless conducted by trained staff and AACAP further prohibits restraints in instances where patients may be medically compromised. No organization recommends the exclusive use or prohibition of a particular form of restraint.

RECOMMENDED PROCEDURES DURING RESTRAINT USE

Most of the guidelines reviewed place considerable importance on the length of time individuals are to be left in restraint, the level of monitoring required, and the type of assessments to be conducted during that time. These procedures are drawn from the research as factors linked with restraint-related deaths and underscore the risks of this emergency intervention.

Length of Time in Restraint

Overall, guidelines note that restraints should be terminated as soon as possible—once the individual is able to maintain control. The Joint Commission provides detailed guidelines that differ by age of the individual being restrained. For example, children under 9 years of age may be restrained for no longer than an hour and that increases to four hours for individuals 18 years and older.

Monitoring and Assessments

Continual monitoring of individuals in restraint is critical given the health risks associated with their agitated state and as such, the guidelines note the importance of monitoring with periodic assessments. These assessments differ by organization but, overall, it is recommended that vital signs be assessed on a regular basis. The Joint Commission and AACAP require this be done by licensed practitioners.

AACAP requires that one's pulse, blood pressure and range of motion in extremities be checked every 15 minutes for any type of restraint. CWLA does not detail assessments for those placed in physical restraints but has extensive guidelines with respect to assessments required for mechanical or chemical restraints. Specifically, CWLA recommends that an individual's pulse, respiration, blood pressure, level of consciousness, level of agitation, mental status, skin color, as well as temperature, swelling and movement of extremities be checked every 15 minutes while an individual is in a mechanical or chemical restraint. Additionally, it is recommended that the person's temperature be taken every two hours.

Risk Assessment Screenings

A valuable aspect of some guidelines is the need for a comprehensive assessment of children *prior* to admission where the child's needs are considered in relationship to the ability of the program to meet those needs. If the program is appropriate, each child should be provided an individualized behavior management plan that details any conditions where particular forms of restraint may be contraindicated. This preliminary step has two substantial benefits. First, it increases the likelihood that restraints, if applied, will be done in a safe and individualized manner. Additionally, it provides an opportunity to make available the necessary type and level of services, which may reduce the need for restrictive interventions.

NOTIFICATION AND DOCUMENTATION OF RESTRAINTS

Two of the organizations, AACAP and CWLA, recommend providers share their behavior management policies with parents prior to the child's admission to the program. CWLA also

suggests that the techniques be demonstrated so all involved fully understand what restraint techniques are utilized.

Three of the guidelines reviewed, AACAP, CWLA and the Joint Commission, require parent or legal guardians be notified following the restraint of an individual with AACAP requiring that this notification be documented in the child's record. Given the traumatic effects that can result from restraint, this information is critical for family members. In fact, AACAP recommends program staff inform parents of the side effects, such as disassociation or medical reactions that can result from various forms of restraint.

USE OF DEBRIEFING TECHNIQUES AND QUALITY ASSURANCE PRACTICES

Leadership is frequently cited as an essential component of any restraint reduction effort and two important quality assurance factors associated with this effort are (1) the use of debriefing techniques and (2) administrative reviews of restraints. Debriefing sessions provide staff an opportunity to learn from each restraint by reflecting on what was done and strategizing how procedures can be improved in the future. This practice also provides an opportunity to consider modifications in treatment that may improve behavior management plans of individuals. All organizations reviewed recommend debriefing sessions between staff and clients. Debriefing sessions allow staff and clients to review what occurred and make improvements at the individual and program level. Administrative review of restraints provides an organizational perspective to how and where and with what frequency restraints are used, allowing organizations to make improvements on a broader level.

STAFF TRAINING

Staff training is essential for the safe use of restraint. In fact, we have learned that trained staff are more likely to rely on de-escalation techniques and less likely to apply restrictive forms of crisis intervention. The value of properly trained staff is recognized by all organizations and AACAP prohibits restraint if implemented by untrained staff. Both AACAP and CWLA encourage the use of cardiopulmonary resuscitation training in addition to crisis intervention and restraint techniques training.

Each organization also noted the importance of training that was offered on a regular basis. CWLA in particular recognized that the application of restraint techniques occurred infrequently and that training refreshers should be scheduled frequently, with little time between each refresher. This requirement underscores the need for training expertise that is locally based and has the rigor of the less frequently based, extensive training offered by training organizations under contract with providers and/or regulatory agencies.

SUMMARY

The practice guidelines proposed by the organizations are consistent with the research literature regarding restraint reduction. All organizations:

- recognize restraint should be applied as a last resort;
- place a high value on staff training that is ongoing and that emphasizes both physical and non-physical forms of crisis intervention; and
- promote ongoing quality improvement with debriefing and reporting strategies.

Little guidance is given regarding the type of physical interventions most suitable for children and adolescents. AACAP notes safety measures that should be observed if a supine or prone restraint is used while CWLA goes further to suggest there is no one form of restraint that is appropriate for all children. The guidelines presented by CWLA note that all restraints, even properly applied, can be

fatal. The rationale given by CWLA for this position is the fact that the interaction between the restraint hold, the intensity and duration, the medical condition of the child and the attentiveness and procedural technique of the caregiver all influence risk and outcomes. CWLA recognizes that the simple banning of 'forbidden' techniques is not expected to end severe or fatal restraint-associated injuries and includes information related to the types of risks and injuries associated with each form of restraint.

The guidelines reviewed underscore the risk of restraint and the limited instances where it may be warranted. Factors identified in the research that influence restraint reduction—use of explicit protocols; staff training programs; individualized approaches with patients; and management approaches that incorporate feedback to staff regarding restraint activities are all apparent in the standard guidelines. While no explicit guidance is given regarding preferred or safer restraint techniques, the guidelines provide limited information regarding physical risks relative to each technique—information that is currently incorporated into all training programs reviewed.

SUMMARY OF BEST PRACTICE STANDARDS BY ORGANIZATION

| | The Joint Commission | National Association of State Mental Health Policy Directors (NASMHPD) | American Academy of Child and Adolescent Psychiatry (AACAP) | Child Welfare League of America (CWLA) |
|---|--|---|--|---|
| Type(s) of restraint permitted | The type of physical intervention selected considers information learned from the client's initial assessment | Not stated | Not stated Caveats are provided as follows: <i>With supine restraints</i> , a patient's head must be able to rotate freely. <i>With prone restraints</i> , the patient's airway must be unobstructed at all times and the patient's lungs must not be restricted by excessive pressure on the patient's back. | Determined by the provider. No restraint system, hold or use pattern is safe for all children at all times. All restraints, even properly applied, can be fatal. This is due to the interaction between the restraint hold the intensity and duration, the medical condition of the child and the attentiveness and procedural technique of the caregiver. The combination of factors dangerous for one child's restraint, however, could be optimal for another child. Simple banning of 'forbidden' techniques is not expected to end severe or fatal restraint-associated injuries. |
| Purpose of restraint | Restraint is limited to emergencies in which there is an imminent risk of a client physically harming self or staff or others, and nonphysical interventions would not be effective. | Restraint should be used only where there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible. These interventions should be implemented only by competent, trained staff. | The only indications for the use of restraint are to prevent dangerous behavior to self or others and to prevent disorganized or serious disruption of the treatment program including serious damage to property. | To ensure the immediate physical safety of the individual or others when there is an imminent risk of harm to the individual or others, and not less restrictive intervention has been or is likely to be effective in averting danger. |
| Conditions when restraint use is not allowed | The organization does not permit restraint for any other purpose, such as coercion, discipline, convenience, or retaliation by staff. The use of restraint is not based on a client's restraint history or solely on a history of dangerous behavior. | <ul style="list-style-type: none"> ▪ For the purposes of discipline, coercion, or staff convenience ▪ As a replacement for adequate levels of staff or active treatment | <ul style="list-style-type: none"> ▪ As punishment ▪ For the convenience of the program ▪ Where prohibited by state guidelines ▪ By untrained staff ▪ Where a patient would be medically compromised by the institution of restraint ▪ For children and adolescents who have a trauma history, the use of physical and mechanical restraints is discouraged; seclusion may be used preferentially. | <ul style="list-style-type: none"> ▪ As a threat of punishment or form of discipline ▪ In lieu of adequate staffing ▪ As a replacement for active treatment ▪ For caregiver convenience |
| Notification of restraint policy | Client and/or family are told of the organization's policy on restraint and this notification is documented in the client's record | Not stated | Not stated | Not stated |
| Length of time | Verbal and written orders for restraint are | All restraint orders should be limited to | Once the child or adolescent is settled | Any restraint must be limited to the least |

| | The Joint Commission | National Association of State Mental Health Policy Directors (NASMHPD) | American Academy of Child and Adolescent Psychiatry (AACAP) | Child Welfare League of America (CWLA) |
|---|--|--|--|--|
| <i>in restraint</i> | <p>limited to the following:</p> <ul style="list-style-type: none"> ▪ 4hrs: 18yrs and older ▪ 2hrs: 9yrs to 17yrs ▪ 1hr: under 9yrs <p>Once this time has elapsed, if the restraint must continue, a new verbal or written order must be given. Restraint is discontinued when the client meets the behavior criteria for his/her discontinuation.</p> | <p>a specific period of time; however, these interventions usually should be ended as soon as it becomes safe to do so, even if the time-limited order has not expired.</p> | <p>and has regained self control, the restraint should be terminated.</p> | <p>amount of time possible to address the situation and promote safety.</p> |
| <i>Assessments required while in restraint/ Monitoring required while in restraint</i> | <p>A licensed independent practitioner sees and evaluates the client in person. Ages 18yrs and older within 4hrs and ages 17yrs and younger within 2hrs</p> <p>Assessments include, as appropriate to the type of restraint, the following:</p> <ul style="list-style-type: none"> ▪ Signs of any injury associated with applying the restraint ▪ Nutrition and hydration ▪ Circulation and range of motion in the extremities ▪ Vital signs ▪ Hygiene and elimination ▪ Physical and psychological status and comfort ▪ Readiness for discontinuation of restraint | <p>Individuals who have been placed in restraint should be communicated with verbally and monitored at frequent, appropriate intervals consistent with principals of quality care.</p> | <p>All patients in restraint must be monitored continuously. Pulse, blood pressure, and range of motion in their extremities should be checked every 15 min.</p> | <p>Temperature: Every two hours in a mechanical or chemical restraint. Pulse: Every 15min. in a chemical, mechanical, or physical restraint. Respiration: Every 15 min. Blood Pressure: Every two hours in a chemical, mechanical, or physical restraint (if level of agitation allows) Level of Consciousness: Every 15 min. Level of Agitation: Every 15 min. Mental Status: Every 15 min. Skin Color: Every 15 min. in mechanical or physical restraints. Temperature of Extremities: Every 15 min. in mechanical or physical restraints. Swelling of Extremities: Every 15 min. in mechanical or physical restraints. Movement of Extremities: Every 15 min. in mechanical or physical restraints.</p> |
| <i>Notification of parent or legal guardian</i> | <p>The client's family is notified promptly of the initiation of restraint.</p> | <p>Not stated</p> | <p>The parents of the child or adolescent should be informed of the use of any restrictive intervention, including any side effects, such as dissociation or medication reactions.</p> | <p>Residential: family or legal guardian should be notified as soon as possible or according to the wishes of the family. No later than within 24hrs. Day Programs: ASAP, no later than the end of the child's day.</p> |
| <i>Documentation re: parent notification</i> | <p>Not stated</p> | <p>Not stated</p> | <p>A record of the child's or adolescent's parent being contacted regarding any restrictive intervention should be included in the medical documentation.</p> | <p>Not stated</p> |
| <i>Medical treatment of injuries</i> | <p>Not stated</p> | <p>Not stated</p> | <p>Not stated</p> | <p>Medical records, parental permission, and insurance information must be available for use by external resources. Emergency response protocols should include procedures</p> |

| | The Joint Commission | National Association of State Mental Health Policy Directors (NASMHPD) | American Academy of Child and Adolescent Psychiatry (AACAP) | Child Welfare League of America (CWLA) |
|---------------------------------------|---|---|--|---|
| | | | | to grant communication with the individual's parent or guardian and with the licensing authority, as required by statute or regulation. |
| Documentation re: injuries | Injuries and deaths must be reported, as a matter of organizational policy, to the organizational leadership and appropriate external agencies consistent with applicable law and regulation. | States should have a mechanism to report deaths and serious injuries related to restraint, to ensure that these incidents are investigated, and to track patterns of restraint use. | Not stated | Reported in writing to the regulatory agency by the end of the next business day. |
| Debriefing process required | The client and staff participate in a debriefing about the restraint episode. | Individuals who have been restrained and staff who have participated in the intervention usually should participate in debriefings following each episode in order to review the experience and to plan for earlier, alternative interventions. | The use of restraint should be followed by a debriefing discussion that allows the patient to process and understand what has happened. | Debriefings should be conducted <ul style="list-style-type: none"> ▪ Per intervention model selected by the provider ▪ Should take place between staff and resident within 24hrs and should include parents, guardians and other caregivers when deemed appropriate |
| Documentation re: debriefings | Information obtained and documented from debriefings is used in performance improvement activities. | Not stated | Staff participating in a restraint should review the episode in a separate debriefing session and document recommendations and findings for the facility's committee that reviews restraint reports. | Each incident of restraint should be documented after the incident, and an incident report must be filed in the individual's permanent file. Documentation should include: a description of what happened, date, time, intervention used, reason for use, duration, children involved, witnesses, person making report, any injury, action take by the provider, prevention actions to be taken in the future, any follow-up required, documentation of supervisory or administrative review. |
| Staff training & education | Staff is trained and competent to minimize the use of restraint and, when use is indicated, to use restraint safely. Persons authorized to perform restraint should show competence in: <ul style="list-style-type: none"> ▪ Taking vital signs ▪ Recognizing nutritional and hydration needs ▪ Checking circulation and range of motion in the extremities ▪ Addressing hygiene and elimination ▪ Addressing physical and psychological status and comfort ▪ Helping clients meet behavior criteria for discontinuing restraint ▪ Recognizing readiness for discontinuing restraint | Not stated | Repeated training in the management of aggressive behavior is necessary to develop the high degree of competence this work requires. Facilities, staff and physicians should update themselves at least annually on restraint information from academic, regulatory, patient advocacy and professional resources. Programs must train staff in specific strategies that are developmentally appropriate for carrying out physical and chemical restraint. This should include hands on practice with restraint equipment and techniques and biannual cardiopulmonary resuscitation training for staff by a | Orientation and in-service training should be mandated. Communication, conflict resolution, de-escalation strategies, proper use of restraint techniques, CPR & First Aide Training in health issues related to the use of restraint Training must be available on a consistent basis over time. Providers should establish annual training requirements Briefer, more frequent training sessions are more effective in producing improved worker performance on the job. Supplement training, as well s refreshers, should be offered. Training should lead to certification |

| | The Joint Commission | National Association of State Mental Health Policy Directors (NASMHPD) | American Academy of Child and Adolescent Psychiatry (AACAP) | Child Welfare League of America (CWLA) |
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| | <ul style="list-style-type: none"> ▪ Recognizing signs of any incorrect application of restraints ▪ Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the client's physical status ▪ Recognizing how demographic and clinical factors can influence one's reaction to restraint. | | nationally accredited agency, such as the American Red Cross. | |
| Facility Reporting | Not stated | States should have mechanisms to report deaths and serious injuries related to restraints, to ensure that these incidents are investigated, and to track patterns of restraint use. | Not stated | Each restraint should be documented after the incident, and an incident report must be filed in the individual's permanent file. All incidents of restraint should receive administrative review. Each provider should establish systems for tracking the frequency, location, and type of critical incidents that occur.. Leaders should report to the board, at least annually, on the frequency and trends in provider use of restrictive interventions and on injuries and client rights violations that may occur in the use of such procedures. The safety and well-being of children is dependent on personnel having adequate training, supervision, and resources. |
| Quality Assurance | <p>The organization collects restraint data to monitor and improve its performance of processes that involve risks or may result in sentinel events. It uses the data to do the following:</p> <ul style="list-style-type: none"> ▪ Ascertain that restraint is used only as an emergency intervention ▪ Identify opportunities for incrementally reducing the rate and increasing the safety of restraint use ▪ Identify any need to redesign care processes | <ul style="list-style-type: none"> ▪ Quality assurance reviews to identify trends in restraint use within the facility, improve the quality of care and patient outcomes, and help reduce the use of restraint ▪ Clinical reviews of individual cases where there is a high rate of use of these interventions ▪ Extensive root cause analyses in the event of a death or serious injury related to restraint ▪ To encourage frank and complete assessments and to ensure the individuals confidentiality, these internal reviews should be protected from disclosure | <p>An ongoing review of programmatic and patient specific issues regarding restraint in order to assess the need for amendments to the patient's treatment plan and/or the facility's policy and procedures and physicality.. Facilities must have a committee that provides oversight of the practice of restraint. This may include a review of restrictive interventions; restraint equipment; staff training; staff retention; patient and parental concerns about restraint.</p> | Providers should develop mechanisms for quality improvement that are appropriate to their size. |

| | The Joint Commission | National Association of State Mental Health Policy Directors (NASMHPD) | American Academy of Child and Adolescent Psychiatry (AACAP) | Child Welfare League of America (CWLA) |
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| Other considerations | <p>The initial assessment of each client at admission or intake assists in obtaining information about the client that could help minimize the use of restraint.</p> <p>Staff identify:</p> <ul style="list-style-type: none"> ▪ techniques that would help the client control behavior, ▪ where appropriate, the client's need for methods or tools to manage aggressive behavior, ▪ pre-existing medical conditions or any physical disabilities and limitations that would place the client at greater risk during restraint ▪ any history of sexual or physical abuse that would place the client at greater psychological risk during restraint <p>In the client's record, information includes:</p> <p>Any pre-existing medical conditions or any physical disabilities that would place the client at greater risk during restraint</p> <p>Any history of sexual or physical abuse that would place the client at greater psychological risk during restraint or seclusion</p> | <p>As part of intake and ongoing assessment process, staff should assess whether individuals may be at risk of receiving restraint. Staff should discuss with each individual strategies to reduce agitation which might lead to the use of restraint.</p> | <p>The evaluation of an individual should include a review of aggressive behavior, including triggers, warning signs, repetitive behaviors, response to treatment and prior restraint events that are associated with aggressive acts. A medical evaluation of the patient should identify factors that may require modification of restraint procedures.</p> <p>Treatment planning should include strategies to prevent aggressive behavior, deescalate behavior before it becomes necessary to use restrictive interventions and initiate physiological and psycho-pharmacological treatments for treating the underlying psychopathology.</p> | <p>Providers should establish clear criteria for admission and should evaluate each child for service against those criteria—the exception being detention settings.</p> <p>Upon admission, a written description of the provider's rules and behavior management practices; a demonstration of the restraint procedures used by the provider; and the provider's written complaint and appeal procedure should be provided.</p> <p>Children and youth with behavioral difficulties that may necessitate the use of restraint should have in their individualized service plans specific goals and objectives that address the targeted behavior(s) requiring the use of restraint.</p> <p>Develop individualized restraint plans that identify any interventions that are prohibited for that child.</p> |

Appendix D

LAWS, POLICIES AND REGULATIONS RELATED TO RESTRAINT

| OCFS | |
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| <i>Federal Codes, State Law and/or State Regulations</i> | 18 NYCRR 441.17 |
| <i>Applicable to:</i> | <i>Child Care Agencies, Institutions, Group Residences, Group Homes, Agency Boarding Homes & Foster Family Boarding Home Care</i> |
| Type(s) of restraint permitted | Physical, mechanical or pharmacological restraint is permitted. |
| Purpose of restraint | Restraints are used to contain acute physical behavior (i.e., behavior that indicates the intent to inflict physical injury upon oneself or others or to destroy property). Restraints shall be used without purposely inflicting pain or harm and only when other forms of intervention are either inappropriate or have been tried and proved unsuccessful. Mechanical restraints may be used only to transport a child by vehicle in instances where the child constitutes a clear danger to public safety or self. |
| Conditions when restraint use is not allowed | Restraint may not be used until [voluntary] agency's restraint policy has been submitted to and approved by OCFS. Restraint shall never be used for punishment of residents or the convenience of staff. Standing orders for pharmacological restraint are not allowed. Hand and foot cuffs may not be attached to each other (hogtie) nor attached to any object in a vehicle. |
| Notification of restraint policy | Not stated |
| Length of time in restraint | Pharmacological restraint used only for such period as may be necessary to contain acute physical behavior and to prevent physical injury to child or other children. |
| Assessments required while in restraint | Not stated |
| Monitoring required while in restraint | Not stated |
| Notification of parent or legal guardian | Not stated |
| Documentation re: parent notification | Not stated |
| Medical treatment of injuries | If it appears a child may have sustained an injury immediately prior to or during the use of restraint, the child shall be examined by a physician or nurse immediately following the period of restraint. |
| Documentation re: injuries | Report of examination by physician shall be kept in the child's medical record. |
| Debriefing process required | Not stated |
| Documentation re: debriefings | Not stated |
| Staff training & education | Staff must complete six hours of training prior to using restraint. Training updates must be received every six months following initial training. |
| Training Materials | Content of training must include (a) preventive methods; (b) appropriate alternatives to restraint; (c) circumstances when restraint might be necessary; (d) method of applying restraint & rules which must be observed in doing so. |

| OCFS | |
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| Documentation re: staff training | Not stated |
| Facility reporting | <p>Following each instance of restraint, staff must document: (a) a summary of the incident and efforts made to identify and resolve the problem that led to the use of restraint; (b) the reason the restraint was determined necessary; and (c) the child's reaction to the use of restraint must be recorded and kept in the child's uniform case record.</p> <p>Any injury that requires physician services, which in the opinion of the physician may cause death, serious disability or disfigurement, must be reported to OCFS.</p> <p>Any death due to restraint must be reported to OCFS.</p> <p>Each authorized agency shall maintain daily records of the number of children on whom restraints have been used, including name and age of child and type of restraint used.</p> |

| OMH | |
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| Federal Codes, State Law & State Regulations | 42 CFR 483.350 to 483.376 MHL Section 33.04 14 NYCRR 584 & 27.7 |
| Applicable to: | MHL Article 31 Licensed Psychiatric Residential Treatment Facilities |
| Type(s) of restraint permitted | Personal, mechanical, or drugs used as restraint are permitted. |
| Purpose of restraint | Restraints are used only when necessary to prevent a child from seriously injuring self or others and applied only if less restrictive techniques have been clinically determined inappropriate or insufficient to avoid injury. |
| Conditions when restraint use is not allowed | Restraints may not be used (a) when used as a means of coercion, discipline, convenience of staff or retaliation; (b) in conjunction with seclusion or (c) as a standing order. |
| Notification of restraint policy | Upon admission to a facility, the facility must (a) inform the child and parent/guardian in language understood by parent/guardian; (b) obtain signature of parent/guardian as acknowledgement of being informed; (c) provide a copy of policy to parent/ guardian and (d) provide contact information for the appropriate state protection and advocacy organization. |
| Length of time in restraint | <p>A child should be in restraint no longer than duration of emergency intervention. Maximum amounts of time in restraint are:</p> <ul style="list-style-type: none"> • 4 hours for persons 18 to 21 years • 2 hours for persons 9 to 17 years • 1 hour for persons less than 9 years |
| Assessments required while in restraint | <p>Per NYS law, assessment must be made at least once every 30 minutes or more frequently as directed by ordering physician. Within 1 hour of restraint, a face-to-face assessment of the child must be conducted by a physician. The assessment must be of child's physical and psychological well-being.</p> <p>An assessment must be conducted after the restraint is removed.</p> |
| Documentation re: assessment | Not stated |
| Monitoring required while in restraint | Trained clinical staff must be physically present at all times during restraint. |
| Notification of parent or legal guardian | Notification must be made as soon as possible following initiation of the emergency intervention. |
| Medical treatment of injuries | Facility must provide child with treatment and, if necessary, transfer to medical facility for additional medical care. |
| Documentation re: injuries | Any injuries sustained by child and/or staff are to be documented in child's record. |
| Debriefing process required | <p>Debriefing procedures required:</p> <ol style="list-style-type: none"> (1) face-to-face discussion of staff and resident within 24 hours of ESI. This may also include parents and other staff as participants. If parent/guardian present, the debriefing must be conducted in language understood by parent/guardian. (2) Staff briefing to critique incident and effectiveness of procedures/practices used. (3) If an injury occurred, debriefing must be conducted with staff & supervisor regarding circumstances that caused the injury |
| Documentation re: debriefings | Document in child's record that debriefings occurred, persons present, persons excused, any treatment plan changes that resulted from the debriefings. |
| Staff training & education | Staff training must receive training to identify (a) techniques to identify factors that could serve |

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| | <p>as triggers; (b) use of nonphysical intervention skills; (c) safe use of restraint; and (d) certification in CPR.</p> <p>Training must be competency based and requires staff to demonstrate in practice the techniques learned. Staff must have working knowledge of hospital policy; be trained and able to demonstrate competency in the application of restraints, monitoring, assessments, and providing care for patients in restraint before performing any of these actions, as part of orientation, and subsequently on a periodic basis consistent with hospital policy. Also, staff must have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require restraint; use of non-physical intervention skills; choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition; the safe application and use of all types of restraint used in the hospital, including training in how to recognize and respond to signs of physical and psychologic distress; clinical identification of specific behavioral changes that indicate the restraint is no longer necessary; monitoring the physical and psychological well-being of the patient who is restraint, including but not limited to respiratory and circulatory status, skin integrity, vital signs and any special requirements specified by hospital policy associated with the 1 hour evaluation; and the use of first aid techniques and certification in CPR, including required periodic recertification.</p> |
| Training Materials | Must be available for review by CMS, State survey agency, & State Medicaid agency |
| Documentation re: staff training | Training received and competency of staff documented in staff record |
| Facility Reporting | <p>Serious injuries must be reported to the state Medicaid agency and the State-designated Protection and Advocacy system. Deaths must be reported to CMS regional office. Facility must keep records of all restraint incidents.</p> <p>The hospital must report to CMS each death that: occurs while a patient is in restraint; occurs within 24 hours after the patient has been removed from restraint; and each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume the use of restraint contributed directly or indirectly to the patient's death. Each death must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death. Staff must document in the patient's medical record the date and time the death was reported to CMS.</p> |

| | OMRDD |
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| Federal Codes, State Law & State Regulations | MHL 33.04; 41.41 42 CFR 483.400-483.450 14 NYCRR Part 624, 14 NYCRR Part 633 and 14 NYCRR Sec. 681.13 Policy document - Proposed Agency Action 633.16 - Dated August 17, 1994 Policy document - Guidelines for SCIP-R - Dated February 10, 1998 |
| Applicable to: | Residential facilities certified or operated by OMRDD (Intermediate Care Facilities, Family Care Homes, Community Residences, Individualized Residential Alternatives (IRAs), day programs (including Day Habilitation, Day Treatment, Supported Employment, Prevocational Services, sheltered workshops), Home and Community Based Waiver Services, Medicaid Service Coordination, Family Support Services. All requirements are not applicable in all settings. |
| Type(s) of restraint permitted | Personal interventions - those techniques which result in a person being manually protected, constrained or held by another party or parties. Restrictive personal interventions - those personal interventions which are used to bring a person from a standing position down to the floor for the temporary immobilization of a person. Mechanical restraint- any apparatus or equipment, which restricts the free movement or normal functioning of, or normal access to a portion or portions of a person's body or which totally immobilizes a person, and from which a person cannot remove or free him/herself easily. Seclusion is specifically prohibited in all settings. Use of time out rooms is permitted subject to requirements established by OMRDD. |
| Purpose of restraint | Restraints are used only when necessary to prevent an individual from seriously injuring self or others or engaging in dangerous behavior and applied only if less restrictive techniques have been clinically determined inappropriate or insufficient to avoid injury. |
| Conditions when restraint use is not allowed | Restraints must be used in the order of least restrictive to most restrictive. Restraints may not be used as punishment, for disciplinary purposes or for the convenience of staff. Staff must be trained in any type of restraint which they may need to apply. The unauthorized or inappropriate use of restraint is classified as a form of abuse. In some instances, written informed consent must be obtained prior to the use of a restraint if the restraint is part of a behavior management plan. Prior approval from a specially constituted committee must be obtained for restraints used as part of a behavior management plan (except for personal interventions which are not considered "restrictive.") |
| Notification of restraint policy | Individuals and/or parents, guardians or correspondents must be notified of the individual's rights and responsibilities, including rules governing conduct. |
| Order/Initiation of restraint | The use of a mechanical restraining device as part of a behavior management plan requires a written physician's order. The order must be renewed as specified in the plan, but in all cases no less frequently than six months. The use of a mechanical restraining device in an emergency situation may only be imposed on the written order of a physician. If a physician is not immediately available a senior member of staff may apply the mechanical restraining device and is required to summon physician. A new order shall be written for each four hour period and may not be completed in advance. |
| Documentation re: restraint order | A mechanical restraint order must be written by a physician. |
| Length of time in restraint | If an individual is held in a restrictive personal intervention for 10 minutes, a supervisor must be notified. The duration of the application of a single episode should not exceed 20 minutes. An individual's behavior management plan must specify the maximum time period for which a mechanical restraining device may be continuously employed. The mechanical restraining device must be removed at least every 2 hours for at least 10 minutes, except when asleep. |
| Assessments required while in restraint | When personal interventions are being utilized the individual's health and safety must be monitored constantly. The possibility of moving to a less intrusive intervention must always be assessed as well as the individual's circulation, respiration and state of consciousness. When a mechanical restraining device is employed an individual's physical needs, comfort, and safety must be assessed at least once every 30 minutes or more frequently as directed by the ordering physician. |

| | OMRDD |
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| Monitoring required while in restraint | See above. |
| Notification of parent or legal guardian | Parents or guardians must be notified when restraint is a "serious reportable incident." This occurs when a mechanical restraining device prevents the free movement of both arms or both legs, or totally immobilizes a person, or is ordered to control behavior in an emergency, or if medication is ordered which renders a person unable to satisfactorily participate in programming, leisure or other activities. Parents or guardians must be notified when restraint is considered "abuse" because it is unauthorized or inappropriate. |
| Documentation re: parent notification | See above. |
| Medical treatment of injuries | Subsequent to the use of any restrictive personal intervention, a staff member is to examine the person for evidence of injury and so document. |
| Documentation re: injuries | See above. |
| Debriefing process required | Not stated |
| Documentation re: debriefings | Not stated |
| Staff training & education | Staff, graduate level interns and family care providers must receive training in any personal intervention technique, restrictive personal intervention techniques or mechanical restraining device which they may have to employ. A general requirement (not specific to restraints) states that staff must be trained to deliver services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity. (14 NYCRR Sec. 633.4(a)(4)(ix)) |
| Training Materials | Training material for personal interventions and restrictive personal interventions must be the OMRDD training curriculum or another training curriculum which has been approved by OMRDD prior to use. |
| Documentation re: staff training | Training must be documented. |
| Facility Reporting | Each time a restraint is used documentation must be made in the individual's clinical record. The documentation must include a description of the antecedent behavior, time of initiation, time of termination, and the name(s) of staff implementing the restraint. The unauthorized or inappropriate use of restraint may constitute abuse and must be reported and investigated in accordance with 14 NYCRR Part 624. The planned or emergency use of restrictive personal intervention techniques must be monitored on an agency-wide basis including frequency of use and staff and consumer injury. |

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| Federal Codes, State Law and/or State Regulations | <i>Education Law 207, 210, 305; 4401, 4402, 4403, and 4410 8 NYCRR 19.5</i> |
| Applicable to: | <i>Any child in residential care; a foster care child; a homeless child; a preschool child with a disability. For an education program operated pursuant to Title 1, Article 3, Part 1, Section 112 of the Education Law and Part 116 of this Title, if a provision of this section relating to emergency interventions conflicts with the rules of the respective state agency operating such program, the rules of such state agency shall prevail and the conflicting provision of this section shall not apply.</i> |
| Type(s) of emergency interventions [restraint] permitted | Reasonable physical force and time out rooms for unanticipated situations that pose an immediate concern for the physical safety of a student or others. |
| Purpose of emergency interventions [restraint] | Emergency means a situation in which immediate intervention involving the use of reasonable physical force necessary to protect oneself from physical injury, to protect another pupil or teacher or any person from physical injury, to protect the property of the school, school district or others, or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts. Emergency interventions shall be used only in situations in which alternate procedures and methods not involving the use of physical force cannot reasonably be employed. |
| Conditions when emergency | Emergency interventions shall not be used as a punishment or as a substitute for systematic |

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| intervention [restraint use] is not allowed | behavioral interventions that are designed to change, replace, modify or eliminate a targeted behavior. Emergency interventions may not be used in situations in which alternative procedures and methods not involving the use of physical force can be employed. |
| Notification of emergency intervention [restraint] policy | Not stated. |
| Order/Initiation of emergency intervention [restraint] | Not stated. |
| Documentation re: emergency intervention [restraint] order | The school must maintain documentation on the use of emergency interventions for each student, which shall include the name and date of birth of the student; the setting and location of the incident; the name of the staff person or other persons involved; a description of the incident and the emergency intervention used, including duration; a statement as to whether the student has a current behavioral intervention plan; and details of any injuries sustained by the student or others, including staff, as a result of the incident. |
| Length of time in emergency intervention [restraint] | Not stated. |
| Assessments required while in emergency intervention [restraint] | Not stated |
| Monitoring required while in emergency intervention [restraint] | Not stated. |
| Notification of parent or legal guardian | Parent of the pupil shall be notified and documentation of emergency interventions shall be reviewed by school supervisory personnel. |
| Documentation re: parent notification | Not stated. |
| Medical treatment of injuries | School supervisory personnel shall review the report of emergency intervention incidents. The report will also be reviewed by the school nurse or other medical personnel, as necessary |
| Documentation re: injuries | The emergency intervention report should include details of any injuries sustained by the student or others, including staff, as a result of the incident. |
| Debriefing process required | School supervisory personnel shall review report of emergency intervention incident. The report will also be reviewed by the school nurse or other medical personnel, as necessary |
| Documentation re: debriefings | Not stated. |
| Staff training & education | Staff who may be called to implement emergency interventions shall be provided with appropriate training in safe and effective restraint procedures. A written description of the training plan must be submitted to SED for review and approval. Training must include crisis intervention and appropriate restraint training. The department may exempt administrators from such training requirements upon demonstration of substantially equivalent knowledge or experience. |
| Training Materials | Training shall include but is not limited to: (1) child abuse prevention and identification; (2) safety and security procedures; (3) principles of child development; (4) characteristics of child care; (5) techniques for group and child management, including crisis intervention and appropriate restraint training; (6) laws, regulations and procedures; and (7) any relevant information provided by the department. |
| Documentation re: staff training | None stated. |
| Facility reporting | The school must maintain documentation on the use of emergency interventions for each student, which shall include: (1) pupil's name and date of birth; (2) setting and location of the incident; (3) name of staff or persons involved; (4) description of the incident and the emergency intervention used, including duration; (5) statement as to whether the pupil has a current behavioral intervention plan; and (6) details of any injuries sustained by the student or others, including staff, as a result of the incident. |
| Development of a behavioral assessment | Development of a behavior intervention plan may be considered in the following circumstances: (a) when student exhibits persistent behaviors that impede his or her learning or that of others, |

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| | <p>despite consistently implemented general school-wide or classroom-wide intervention; (b) when student's behavior places the student or others at risk of harm or injury; (c) when the CSE or CPSE is considering more restrictive programs or placements as a result of the student's behavior; and/or (d) when required for specific discipline procedures. A functional behavioral assessment shall be based on multiple sources of data including, but not limited to, information obtained from direct observation of the student, information from the student, the student's teacher(s) and/or related service provider(s), a review of available data and information from the student's record and other sources including any relevant information provided by the student's parent. The functional behavior assessment (FBA) shall not be based solely on the student's history of presenting problem behaviors. The FBA shall provide a baseline of the student's problem behaviors with regard to frequency, duration, intensity and/or latency across activities, settings, people and times of the day and include the information in sufficient detail to form the basis for a behavioral intervention plan for the student that addresses antecedent behaviors, reinforcing consequences of the behavior, recommendations for teaching alternative skills or behaviors and an assessment of student preferences for reinforcement.</p> |
| <p>Development of a behavioral intervention plan</p> | <p>A behavioral intervention plan must be developed as a result of the functional behavioral assessment. This plan includes, at a minimum, a description of the problem behavior, global and specific hypotheses as to why the problem behavior occurs and intervention strategies that include positive behavioral supports and services to address the behavior.</p> |
| <p>Documentation of functional behavioral plan</p> | <p>The CSE shall consider the development of a behavioral intervention plan for a student with a disability when the student exhibits persistent behaviors that impede his or her learning or that of others, despite consistently implemented general school-wide or classroom-wide interventions; the student's behavior places the student or others at risk of harm or injury; the CSE is considering more restrictive programs or placements as a result of the student's behavior. A student's need for a behavioral intervention plan shall be documented in the IEP and such a plan shall be reviewed at least annually by the CSE.</p> |

Appendix E

REVIEW OF OTHER STATES' USE OF SUPINE RESTRAINT: SURVEY OF STATE HUMAN SERVICES

| State | Supine | Prone | Other | No Restraint | Comments |
|---------------|--------|-------|-------|--------------|--|
| Connecticut | X | X | X | | While CT encourages the use of supine, it has no regulations to that effect. |
| Idaho | X | X | X | | Must be a technique from a nationally recognized training program. |
| Illinois | | X | X | | IL has five "approved crisis intervention and prevention procedures and models" for "manual restraint." Each provider must select one as part of their "Agency Behavior Treatment Plan" and submit the plan for approval. "Extended restriction means periods of touching or holding by direct person-to-person contact for a period of less than five minutes. Extended restriction shall not constitute manual restraint if it is accomplished with minimum force and is used to prevent a child from completing an act that is likely to result in harm to self or others or to escort a child to a quieter environment." |
| Louisiana | | X | X | | LA allows the use of TCI (prone) and PAMB (side) restraint techniques. |
| Massachusetts | X | X | X | | MA allows licensees to develop and implement their own behavior management techniques (restraint). Licensees are required to "maintain a written statement defining the rules, policies and procedures used in the facility, including, where applicable, the form of restraint used." "The hold commonly described as 'prone basket' in which the resident is lying face down with his arms or hands underneath any part of the chest, may restrict breathing and is therefore prohibited. A straddle position may not be used for any resident with a history of sexual abuse." |
| New Hampshire | X | X | X | | Must be a technique from a nationally recognized training program. |
| New York | X | X | X | | 18 NYCRR 441.17 Restraint of children in care "(c) An authorized agency shall not use any method of restraint unless it has submitted its restraint policy to the department and such policy has been approved in writing by the department and such policy has been approved in writing by the department in accordance with subdivision (d) of this section. (d)(1) To qualify for approval of its restraint policy by the department, an authorized agency must be in compliance with the provisions of this section and section 442.2 (room isolation) of this Subchapter, if applicable, and maintain a section of the agency's policy manual which clearly states the plan and procedures for the use of restraint." [No specific technique or position is prohibited.] |
| North Dakota | | X | X | | ND uses the CPI (standing restraint) technique. Should the CPI restraint go to the floor, only prone holds are allowable and the child must be returned to a standing position as soon as possible. |
| Texas | X | X | X | | "A person qualified in behavioral intervention:" "(A) May use a prone or supine hold on a child in care only:" |

| State | Supine | Prone | Other | No Restraint | Comments |
|---------|--------|-------|-------|--------------|---|
| | | | | | <p>(i) As a transitional hold that lasts no longer than one minute;</p> <p>(ii) As a last resort when other less restrictive interventions have proven to be ineffective; and</p> <p>(iii) When an observer who is not continuously involved in the restraint ensures the child's breathing is not impaired. The observer must be trained in the risks associated with the use of prone and supine restraints, including positional compression or restraint asphyxia. Child-care facilities with a capacity of 50 or fewer children, including foster and foster group homes, are exempt from meeting this observation requirement."</p> <p>"(B) May use other types of personal restraint techniques permitted by facility policy."</p> |
| Vermont | X | X | X | | VT is currently revising its physical restraint regulations. Physical restraint techniques are not addressed in the current or revised regulations. |
| Wyoming | X | X | X | | Must be a technique from a nationally recognized training program. New rules will require that staff are certified by their training program. |

Appendix F

OVERVIEW OF CRISIS INTERVENTION TRAINING¹³

BACKGROUND

Training is an integral part of any effective behavior management system. Staff members who are competent and informed are able to act quickly and decisively when faced with crisis situations. Without this ability, we can not expect consistency of care or adherence to “uniform and coordinated standards” (S. 7617—A). The crisis intervention training models reviewed have been assessed with this idea in mind. The purpose of this review is to provide Committee members with a comprehensive overview of the crisis intervention training models currently in use by state agencies as well as some of those utilized by other entities.

This review includes the following training models:

- Preventing and Managing Crisis Situations (PMCS), used by the Office of Mental Health (OMH);
- Strategies for Crisis Intervention and Prevention – Revised (SCIP-R), used by the Office of Mental Retardation and Developmental Disabilities (OMRDD);
- Therapeutic Crisis Intervention (TCI), used by the Office of Children and Family Services (OCFS) – Division of Development and Prevention Services (DDPS);
- Crisis Management/Physical Restraint (CMPR), used by the Office of Children and Family Services (OCFS) – Division of Rehabilitation Services (DRS); and
- Nonviolent Crisis Intervention, by the Crisis Prevention Institute (CPI);
- Non-Abusive Psychological & Physical Intervention (NAPPI), by NAPPI International.

The review is based on the training materials provided by each of the participating organizations. Key elements of crisis intervention programs were identified including certification process, instructional approach, duration of training, frequency of refreshers, self-assessment, crisis recognition, non-physical intervention, biomechanics of physical interventions, and the monitoring of clients during a restraint.

COMPETENCY BASED CERTIFICATION PROCESS

Competency-based training is an important component of any crisis intervention training program since staff members who are able to demonstrate competence are better prepared to apply the full range of crisis intervention skills presented during training. In fact, providers have noted that programs with a competence based certification feature enable them to better negotiate liability costs with insurance providers.

The SCIP – R and TCI training models are the only two programs reviewed that offer competency based certification upon completion of the training for non-instructor participants. The criteria for attaining certification are as follows:

¹³ ©Preventing and Managing Crisis Situations, OMH, 2006;
© Strategies for Crisis Intervention and Prevention-Revised, OMRDD, 2006;
© Therapeutic Crisis Intervention, Family Life Development Center, 2001;
© CMPR, 2006;
© Crisis Prevention Institute Incorporated, 2006; © Non-Abusive Psychological and Physical Intervention, 2007

- To receive certification in SCIP – R: A participant must demonstrate competency in each of the units covered in the training and score 80 or better on a written exam. This exam includes key lecture topics in its 38 multiple choice and fill in the blank questions. Additionally, each participant must demonstrate competence by executing each of the physical skills for an instructor who notes proficiency.
- To receive certification in TCI: The participant must complete the training and demonstrate competency in each of the verbal and physical skills for an instructor who notes proficiency. Instructors may recommend further training if skills are not properly demonstrated.

PMCS requires course participants to demonstrate competence but does not offer written certification. CPI offers a course completion card to be awarded once a participant has completed the training. The meaning of the card is to be determined by the organization which employs the participant with respect to its policies.

INSTRUCTIONAL APPROACH AND MATERIALS

Instructional Approach

Most training models reviewed utilize a train-the-trainer approach in which the individuals who will be responsible for training the employees at his/her home facility are taught how to present the material by master trainers. This approach is commonly used due to its cost savings. Furthermore, this approach has the benefit of building training capacity within an organization and fostering development of 'local' expertise. However, it is critical that individuals who will serve as trainers at their facilities are provided with clearly defined content in order to ensure that staff members receive consistent and uniform training regardless of the individual instructor presenting the material.

The instructional approach used by CMPR differs from all other training models. OCFS-DRS requires all new direct care employees to attend a five week "Basic Academy Training" during which, professional instructors present CMPR as part of a comprehensive orientation. In some cases, the state instructors are also involved with the ongoing development and improvement of the training model.

Instructional Materials

Each training model utilizes similar presentation formats; however, the specific content of the crisis intervention training models reviewed differs somewhat. Each of the training models includes lectures, group discussions, experiential learning and physical skills practice. The instructional materials for all the programs reviewed provide a clear outline of the subjects and activities that will be incorporated into each section or module (Appendix A).

Most training models reviewed include a student workbook containing activities and training highlights. However, in some instances there is a lack of content detail. This raises an initial concern regarding the quality and consistency of information that will be transferred to staff members as it appears that some of the content is interpreted by individual instructors. This lack of instructional detail is a concern recently echoed by NAPPI instructors. In response, NAPPI has updated their 2007 training manual to contain more content and provide instructors with an easy to follow step-by-step guide complete with sample dialogue.

TCI instructional materials are notable in that they provide content in a textbook format affording participants the opportunity to pre-read each lesson prior to participating in the training. Not only does this allow for a wider range of learning styles, it also serves to equip students with the ability to

ask informed questions and also provides an accessible reference resource long after the training has been completed. Most importantly, it decreases the likelihood of content deviation that may occur with the train-the-trainer approach.

DURATION OF TRAINING

The time needed to conduct staff training can greatly impact the staffing requirements of a facility since this requires facilities to make staffing adjustments to cover those in training. The length of time necessary to train participants differs greatly respective of training model, with some models offering flexible presentation schedules in order to accommodate staffing schedules.

The time requirements for the six training programs reviewed range from 12 hours to five days and are as follows:

- **PMCS:** This training requires 16 hours of training. While this training is traditionally broken down into two days, the training modules can be organized into smaller groups and delivered in multiple sessions in order to accommodate organizational schedules.
- **SCIP-R:** This training can be presented in three to four days respective of the selected curriculum. Not all staff members are trained in all components of SCIP-R with variations made respective of job requirements.
- **TCI:** This training is the longest and arguably most extensive training including five days (27 to 30 hours) of structured activity in addition to reading and homework assignments. While citing that the five day agenda is preferable, TCI also offers an alternative four day agenda (24 hours) that covers the same material. Additionally, TCI offers training without the physical component over a three day period. (18 hours).
- **CMPR:** This training can be presented in three and a half days; however, it is traditionally incorporated into a five week Basic Academy Training for new employees.
- **CPI:** This training can be delivered by an experienced instructor in 12 hours. It is recommended that this time be broken up into two six-hour sessions. Alternatively, options for three four-hour sessions or four three-hour sessions are also acceptable.
- **NAPPI:** Courses range from three hours to five days relative to desired content.

FREQUENCY OF REFRESHERS

Refreshers are abridged versions of an original training intended to reinforce skills and inform participants of any changes to the policies or techniques that were introduced in the original training. Instructors must take care not to dilute the refresher content with subjects that do not directly reinforce a staff member's ability to competently execute the specific skills required of him/her. The general consensus on refreshers is that they should take place every 6 to 12 months and should include physical practice as well as a review of nonphysical intervention skills. Refreshers are particularly important in environments where crisis occurs on a less frequent basis and consequently staff members are not regularly exercising their skills.

The refresher requirements for each model are as follows:

- **PMCS:** Refreshers are to be attended on an annual basis. An outline for the refresher is in the "One Day Review" section of the training manual.
- **SCIP-R:** Refreshers are to be attended on an annual basis.
- **TCI:** Refreshers are to be attended at least every six months and preferably every 3 months.
- **CMPR:** Refreshers are to be attended on a six month basis, no less than twice a year, 4 months apart or 4 hours in length. No outline was provided.
- **CPI:** It is suggested that individuals take either a refresher or an entire training course every 6 to 12 months. No outline was provided.
- **NAPPI:** The training materials do not make reference to refreshers.

NON-PHYSICAL INTERVENTION

Non-physical interventions are behavior management techniques used by staff to help individuals address crisis in its early stages. These techniques include skill sets used by staff to prevent or deescalate potentially volatile situations and decrease the probability that a physical intervention, such as a restraint, would need to be used. Non-physical interventions are essential features of effective behavior management programs and fundamental elements of any training model striving to be the “the most effective, least restrictive and safest” (S. 7617—A).

The training programs reviewed share common foundational ideologies with respect to non-physical intervention skills. Two areas addressed are crisis recognition and self-assessment. A detailed description of non-physical interventions presented during training are presented in Appendix B.

Crisis Recognition

Crisis recognition refers to a staff member's ability to identify antecedents, environmental elements, and behavioral changes that commonly precede and/or accompany a crisis. The ability to identify crisis in its early stages increases a staff member's ability to intervene in a non-physical manner with a variety of techniques. All of the training models reviewed cover crisis recognition and are consistent in content.

Self-Assessment

One's ability to assess their individual predisposition respective of crisis situations and work environment correlates directly to their ability to perform predictably, consistently and in a judicious manner. A staff member must be prepared to deal with difficult situations appropriately, productively, and in accordance with the policies of their employing organization. Each of the training models reviewed, with the exception of NAPPI which did not cover self assessment, tailors its self assessment piece relative to the specific population it is intended to serve. For instance, SCIP-R discusses how personal “beliefs, values and attitudes” about people with developmental disabilities can effect how a person relates to this population. PMCS addresses self assessment as it pertains to individual experiences, both psychological and physiological, in a work environment including behaviorally aggressive clients.

PHYSICAL INTERVENTIONS/RESTRAINTS - BIOMECHANICS

Each of the training models recognizes physical restraint as a high risk intervention only to be used as a last resort. Physical interventions or restraints are executed differently respective of which training model is considered. Likewise, the number of staff members required to correctly execute a restraint varies according to specific technique. This can have implications regarding staffing resources. The training models reviewed require one to three staff members to execute correctly. Three out of the four implemented training models recommend the use of three staff members to execute their preferred method of restraint.

Also noteworthy is the similarity between the PMCS, SCIP-R, and TCI versions of a two person take down. They are almost identical until after the client is already on the floor and staff members begin the process of securing the client's appendages. While some models offer additional methods specific to small children, SCIP-R offers a few different restraint options accounting for a variety of circumstances.

The following is a description of the physical position of each person involved in the restraints offered by each intervention model.

- **PMCS:** The training manual outlines four restrictive techniques—a standing wrap; one person removal; two person removal; and two-person take down. The two person take down is initiated simultaneously by two staff members. Each staff member controls one arm by facing

- the client and holding the client's wrist with his/her opposite hand (i.e. right hand holds left wrist) while reaching under the client's armpit with their opposite hand and grasping the client's shoulder. From this position the client is lowered backwards onto to the floor and secured in the supine position. The client is secured with the help of a third staff member who controls the legs by wrapping their arms around the client's thighs. Once the legs are secure the two original staff members bring the client's hands up next to his/her head via bending the elbow. Each staff member then secures an arm with one knee in the client's armpit, the other knee by the client's wrist locking the arm between their legs and by holding the client's shoulder and forearm down.
- **SCIP-R:** The training manual outlines four restrictive techniques.
 1. *The Two Person Take Down.* This technique is initiated simultaneously by two staff members. Each staff member controls one arm by facing the client and holding the client's forearms with his/her opposite hand (i.e. right hand holds left forearm) while reaching under the client's armpit with their opposite hand and grasping the client's shoulder. From this position the client is lowered backwards onto to the floor and secured in the supine position. If a third staff member is available they would now secure the legs while the original two secure the arms in a slight bicep flex position. Without a third staff member, one staff member secures the arms directly over the client's head by holding the wrists and the other secures the legs by wrapping their arms around the client's thighs.
 2. *The Seated Wrap.* This technique requires two staff members to execute. The client's arms are crossed in front of him/her and held by a staff member who is positioned behind the chair in which the client is seated. The second staff member can hold the client's head if necessary.
 3. *The Seated Escort.* (1 and 2 person variations) The staff member sits next to the client and holds his/her forearm with the same corresponding hand. (i.e. Staff left hand holds client left forearm.) In order to reach the client's far forearm the staff member reached behind the client and under his/her arm. In the two person variation, the second person mirrors the movements of the first.
 4. *The One Person Take Down.* The staff member applies a standing wrap by hugging the client from the side or behind over the client's arms. The staff member then secures the client's arms from behind by crossing the client's arms in front of the client and holding the client's forearms. Now the staff member moves to the floor by kneeling down behind, keeping the client close and then easing him/her to his/her side on the floor with the staff member on his/her side behind him/her still grasping the forearms.
 - **TCI:** This approach utilizes three techniques for restraining.
 1. *Two Person Take-Down Resulting in a Prone Restraint—Initiated by One Person.* The team leader approaches the person from behind and wraps his/her arms around the person, immobilizing the person's arms, keeping his head tucked to avoid being head butted. The team leader's arms should be above the person's elbows and below the shoulders, right in the biceps area. The team leader grabs his wrist to secure the holds. The assisting staff approaches the person from the side and grasps the person's secured arm above the wrist. The team leader then lets go of this own wrist. The assistant slides his free arm under the person's armpit, being careful not to grasp the person's upper arm. Simultaneously, the team leader moves to the opposite side of the person, pivots and slides his arm under the person's armpit, while grasping the person's arm above the wrist with his opposite hand. The team leader must be careful not to grasp the person's upper arm. Both workers gently bring the person's arms across the plane of their bodies, securing the person's arms against their chests. Adults must use caution to avoid hyper extending the person's elbow or pulling on the person's shoulders. The person is now

facing the opposite direction of the adults. The adults stand hip to hip to the person, putting their inside legs close to the person's legs with their feet a bit behind the person's feet. It is important for workers to stay as close to the person as possible. The closer workers are, the more control they have and the safer the person remains. Both staff simultaneously take one step forward with their outside legs and kneel on the floor on their inside knees. This action brings the young person down backwards. The workers break the person's fall by letting their knees make contact with the floor first and bringing the person down between them. The adults bring the person the rest of the way to the floor, rotating their hands so that the palms of their hands make contact with the floor and help brake the person's fall. It is important that both staff remain very close to the person to ensure maximum control. The team leader passes the person's arm to the assistant. The assistant begins to slide down the length of the person's body, holding the arm that was passed to him (above the wrist) while bringing the other arm close to the person's side on the floor. The team leader then turns toward the person and while remaining very close, puts one hand under the person's back (between the shoulder blades) and the other hand at the small of the back. The team leader then rolls the person over, using both arms to turn the person toward the assistant. The assistant lets go of the arm on the floor and recaptures it after the roll. The assistant maintains control of the person's legs while hold the arm that was passed to him. Care is given to make sure no undue pressure is placed on the person's shoulders during the roll over and the worker securing the legs does not use the arm passed to him to pull the person toward him.

2. *Two Person Take-Down Resulting in a Prone Restraint—Initiated by Two Persons.* With a signal from the team leader, the team leader and the assisting worker simultaneously approach the person from opposite sides and grasp the person's arm above the wrist with their outside hands. Both workers slide their inside arms under the person's armpits, being careful not to grasp the person's upper arms. Both adults gently bring the person's arms across the plane of their bodies, securing the person's arms against their chests, the persons' hands at the adult's waist. Workers must not hyper extend the person's elbow or pull on the person's shoulder. The workers stand hip to hip to the person, putting their inside legs close to the person's legs with their feet a bit behind the person's feet. It is important for workers to stay as close to the person as possible. The closer workers are, the more control they have and the safer person remains. Both workers simultaneously take one step forward with their outside legs and kneel on the floor on their inside knees. This action brings the person down backwards. The workers break the person's fall by letting their knees make contact with the floor first and bringing the person down between them. The workers bring the person the rest of the way to the floor rotating their hands so that the palms of their hands make contact with the floor and help break the person's fall. It is important that both staff remain very close to the person to ensure maximum control. The team leader passes the person's arm to the assistant. The assistant begins to slide down the length of the person's body, holding the arm that was passed to him (above the person's wrist) while bringing the other arm close to the person's side on the floor. Be careful not to put weight on the person's stomach or chest. The team leader then turns toward the person, and while remaining very close puts one hand under the person's back (between the shoulder blades) and the other hand at the small of the back. The team leader then rolls the person, using both arms to turn the person, toward the assistant. The assistant lets go of the arm on the floor and recaptures it after the roll. The assistant maintains control of the legs while holding the arm that was passed to him. Care is given to make sure no undue pressure is placed on the person's shoulder during the roll over and that the worker securing the person's legs does not use the arm passed to him to pull the person towards him. The team leader moves to the side bringing her leg close to the person to secure the person's arm close to his side. The team

leader leans across the person resting her weight on her arm on the opposite side of the person. Care is taken to make sure that weight is not placed on the back of the person in order not to restrict the person's ability to breathe. If the team leader's arm is not long enough for this maneuver, the team leader places her hand by the person's arm, supporting her own weight above the person. (If the team leader cannot maintain control of the person because the person is too wide and the team leader's arms are too short, a third person may be necessary. The team leader must never place her weight on the back or chest of the person). The assisting staff member holds both of the person's arms above the wrists while securing the legs. Care is used to make sure weight is not placed on the persons' knees or ankles.

3. *Small Child Restraint*: A single staff member, positioned behind the client, crosses the client's arms in front of him/her, grasps the client's forearms securing the client's arms. From this position, the staff member drops one knee and lowers the client to the floor guided along the inside of the staff members opposite leg. Once the client reaches the floor, the staff member kneels behind the client still holding the client's forearms. A second staff member may help secure the client's legs by wrapping his/her arms around the client's thighs while facing away from the client's body. There is also a variation on this technique in which the staff member, having already crossed and secured the client's arms in front of him/her, backs up to a wall and braces against it while sliding down to a seated position with legs astride the client and the client's legs out front.
- **CMPR**: This technique requires one, but preferably two staff member to execute. The restraint is initiated by reaching over the client's shoulders from behind and hooking the client's arms. (This is the same position for an escort.) Next, the staff member helps the client to a seated position by taking a step backwards and kneeling behind him/her. Finally, the staff member turns to either side and rolls the client over to the prone position. During this process the staff member has not changed his/her hold. This technique provides for another staff member to assist when necessary. There are 3 basic moves from initiation to final position. There is also a seated variation for small children.
 - **CPI**: This approach utilizes two different techniques for restraining.
 1. *The Team Control Position*: This technique requires two staff members to execute. The staff members stand next to the client facing the same direction on opposite sides. With their outside hands, staff members grasp the forearm of the client and position the client's forearm by the staff members outside hip. While doing so, staff members are keeping their inside legs in front of the client and using their inside hands to guide the client forward and down so that the client's shoulders are resting on the thighs of the staff members and his/her arms are back by each staff member's outside hip. The staff members are now standing inside foot forward and turned slightly away from each other while the client is bent over at the waist with his/her torso 2 – 2½ feet from the floor.
 2. *The Children's Control Position*: A single staff member, positioned behind the client, crosses the client's arms in front of him/her, grasps the client's forearms securing the client's arms across the client's chest. Both client and staff member remain standing.
 - **NAPPI**: The description was ambiguous. Photographs have been requested and should be in route.

MONITORING DURING PHYSICAL INTERVENTIONS/RESTRAINTS

Monitoring children during restraint is commonly sighted as critical to preventing injury or death. PMCS, TCI, SCIP-R, CMPR, and NAPPI each outline protocols for monitoring the client as part of their training.

The monitoring protocols for each model are as follows:¹⁴

- **PMCS:** Pages 7 and 17 of Module 5 in the training manual state:
 1. Whenever a recipient demonstrates the need for serious medical attention in the course of an episode of seclusion or restraint, medical priorities shall supersede psychiatric priorities including the placement of a person in seclusion or restraint.
 2. Constant one-on-one observation is required.
 3. A written assessment is required at the initial application and every 15 minutes thereafter.
 4. Recipients cannot be fed while in restraint, unless clinically indicated.
 5. Vital signs must be taken when recipient is in: Seclusion – immediately, every two hours thereafter, and upon release. Restraint – immediately, hourly, and upon release.
 6. Release can occur when recipient is no longer a danger to self or others.
 7. Physician who has ordered seclusion or restraint must be accessible.
 8. Each facility must develop and implement its own written procedures.

- **SCIP-R:** In addition, to the following monitoring concerns, the SCIP-R training manual provides a list of medical conditions which may complicate physical interventions. As noted on page 148 through 150 of the training manual:

“Some signs and symptoms to be observed for and immediate remedial action taken during an intervention:

 1. Cyanosis (blue color of a body part), i.e., face, lips fingernail beds, hands, legs. Indication = Restricted circulation of that body part or inadequate breathing. Person must be released. If there is blueness of a body part, you must release or loosen grip until color returns. Notify nurse if any of above occur.
 2. Mottling (paleness, yellow color) of any body part.
 3. Hyperventilation (rapid breathing) This could lead to a serious complication called Respiratory Alkalosis, if not corrected immediately. Person could pass out.
 4. Hypoventilation (slow, shallow breathing) This could lead to complication called Respiratory Acidosis, if not corrected. Person could pass out Let person breathe freely. No weight on chest wall.
 5. Vomiting – Could lead to aspiration and cause a respiratory emergency. A person who has recently eaten a meal may be more susceptible to vomiting. Light meals are present in the stomach for up to 1 ½ hrs. Medium meals are present for 3-4 hours. Heavy meals are present for 4-6. Allow vomitus to escape the mouth by turning person’s head to the side, or placing on his/her side with face to side. In some instances of aspiration, vomiting may not be noticeable. Be sure to monitor status continually. Let person up. Notify nurse.
 6. Broken bones – You may hear bones crack. Release individual’s affected part and assess situation. Notify nurse.
 7. Unresponsive – Release individual. Assess vitals. Call Nurse. CPR if indicated.
 8. Seizure during intervention – Release individual and protect from injury. Notify nurse.
 9. Excited Delirium – A state of extreme mental confusion brought on by an intense struggle.
 10. Helmets – Can be a risk to an individual during a restrictive personal intervention. Helmets should always be removed if a person is in a restrictive personal intervention in order to monitor vital signs.

Generally, the use of personal intervention must be terminated immediately if the person shows signs of physical distress such as: sudden change of color, hyperventilation, difficulty breathing, or vomiting.”

¹⁴ All materials presented are copyrighted and for Committee review purposes.

- TCI: As noted on page 33.2c of the student workbook:
"Always monitor the young person during a physical restraint for sign of distress:
 1. Make sure the position of the young person's body is appropriate to positions taught in training.
 2. Assure that the young person is not showing breathing problems which may be related to the restraint or some other health problem and/or physical overextension; these signs include:
 - rapid shallow breathing
 - panting, grunting
 - the face turns a dusky purple color
 - absence of breathing
 3. Assure that young person is not vomiting or bringing up fluid that could obstruct breathing
 4. Assure that young person's head and neck are in a safe position to prevent injury
 5. Watch for other signs of distress, which include:
 - extremities cold to the touch
 - face becomes flush or ashy
 - bleeding or bruising
 - seizures
 - unconsciousness
 - complaints of "I can't breath" or "I have chest pain"
 - limpness of the arms and legsTerminate the physical restraint if there are any indications of significant physical distress or injury, difficulty breathing or seizure. Immediately seek medical attention."
- CMPR: The OCFS policy states:
"A resident in mechanical restraints must be continuously supervised/monitored and evaluated to ensure that the resident is securely restrained but not in a manner which is likely to cause pain, injury or illness i.e., handcuffs/foot cuffs must not be applied so tightly that they cause pain or injury."
- CPI: The training materials do not make reference to monitoring.
- NAPPI: As noted on page 94 of the training manual:
"Chart Monitor ABCs. From the instant that we begin restraining someone, we should be monitoring their body, looking for pain, injury, and self-maintenance capacity, especially the ABCs. It is NAPPI's high recommendation that all employees who restrain be CPR certified, and we strongly recommend that an uninvolved observer monitor the physical well-being of the person being restrained. If there is injury or distress, the organization must have a plan to immediately release and treat the person being restrained without endangering others."

PMCS Content Outline

MODULE 1

- Program Objectives
- Module 1: Learning Objectives
- Purpose of the PMCS Program
- Benefits of the PMCS Program
- PMCS Integration with other Initiatives
- Approaches to PMCS

MODULE 2

- Module 2: Learning Objectives
- What is Behavior (2)
- Factors Influencing Behavior
- Biological Factors
- Psychological Factors (2)
- Environmental Factors
- Antecedents: Behavioral Warning Signs
- Stumbling Blocks
- Common Responses which may Negatively Affect the Outcome of a Situation

MODULE 3

- Module 3: Learning Objectives
- PMCS 4 Step Process
- Preventing and Managing Crisis Situations: Step 1 – assessment
- Individual Crisis Plan (4)
- Preventing and Managing Crisis Situations: Step 2
- Continuum of Interventions
- Day to Day Interaction (2)
- Early Stage Intervention (3)
- Middle Stage Intervention (3)
- Late Stage Intervention (2)
- Stages of Behavior – Interaction/Intervention
- PMCS Process: Steps 4 and 5
- Physiological Considerations Impacting Staff
- Psychological Considerations (3)
- Psychological Response to Stress (2)
- Staff Physical Attire
- Environmental Considerations (3)
- Nonverbal Calming Techniques
- Verbal Calming Techniques

MODULE 4

- Module 4: Learning Objectives
- Proactive Management
- Progression and Justification of Physical Interventions
- Safe and Supportive Stance
- Blocking Punches
- Slip Punch Deflection
- Kick Deflection
- Front Choke Deflection
- Front Hair Pull Release
- Front Hair pull Release (Long Hair)
- Back Hair Pull Release (Short Hair)
- Front Choke Release with Arms Extended
- Front Choke Release with Arms Bent
- Back Choke Release
- One Hand Grasp Release
- Two Hand Grasp Release
- Bite Release
- One-person removal
- Two-person removal
- Two-person take down
- Standing wrap
- Positional asphyxia

MODULE 5

- Module 5: Learning Objectives
- Seclusion and Restraint are Safety Interventions
- Principals of Seclusion and Restraint (2)
- Specific Restraints
- Seclusion
- Advance Preferences
- Procedures for Seclusion and Restraint
- Monitoring Procedures
- Release and Follow-up Procedures
- Trauma-informed care: impact of restraint and seclusion

MODULE 6

- Module 6: Learning Objectives
- Post-Acute Event Analysis
- Formal Debriefing
- Team Review of Performance
- Documentation

SCIP-R Content Outline

UNIT 1

Upon the completion of this module, the participants will be able to:

- Discuss the concept of behavior support.
- Discuss the mission of the agency as it reflects positive practices and Person Centered Planning.
- Demonstrate that their own attitudes and feelings toward individuals with disabilities affect their actions.
- Discuss the need for a program in crisis management.
- Demonstrate an awareness of the physical and emotional responses staff experience during a crisis situation.
- Discuss the administrative and regulatory support for the SCIP – R program.

UNIT 2

Upon the completion of this module, the participants will be able to:

- Understand that behavior serves a purpose for an individual.
- Describe how internal and external antecedents may interact to affect behavior.
- Identify characteristics of persons with developmental disabilities which contribute to challenging behaviors.
- Discuss the importance of developing and sustaining supportive relationships with persons with developmental disabilities.

UNIT 3

Upon the completion of this module, the participants will be able to:

- Discuss how proactive, active and reactive interventions are used to address challenging behavior and relate to the concept of the SCIP gradient.
- Discuss the importance of a supportive and functional environment as a basis for program planning and environmental assessment.
- Compare “traditional” behavior management with positive behavior supports.
- Identify the five major elements for supporting positive behavior.

UNIT 4

Upon the completion of this module, the participants will be able to:

- Identify the phases of behavior escalation and appropriate staff responses.
- Identify psychological and physical considerations and early warning sign.
- Use calming techniques and avoid escalators when responding to early warning sign of a crisis.

UNIT 5

Upon the completion of this module, the participants will be able to:

- Identify guidelines for the use of Personal Intervention Techniques.
- Demonstrate Personal Interventions.

PERSONAL INTERVENTION (Physical Intervention)

UNIT 6

Upon the completion of this module, the participants will be able to:

- Perform the necessary steps immediately following a personal intervention.
- Report and document the facts following a crisis situation.
- Contribute to the Behavior Support Planning Tool to define a course of action for a person's challenging behavior.

TCI Content Outline

DAY ONE

Activity 1: Warm up.

Activity 2: Stress Model of Crisis (A Typical Crisis)

Activity 3: Assessing the Situation

Activity 4: The Importance of Self-Awareness: What Am I Feeling Now?

Activity 5: The Importance of Knowing the Young Person

Activity 6: Awareness of the Environment: How is the Environment Affecting the Young Person?

Activity 7: Intervention approaches

Review the day and assign the homework.

DAY TWO

Briefly review day one.

Activity 8: Verbal Crisis Communication

Activity 9: Identifying Feelings and Making Reflective Responses

Activity 10: Practicing Active listening

Activity 11: Behavior Management techniques

Activity 12: Practicing Behavior management techniques

Activity 13: Anger and the Crisis Cycle

Activity 14: Nonverbal Crisis Communication

Activity 15: Protective Interventions

Review the day and assign the homework.

DAY THREE

Briefly review days one and two.

Activity 16: I ASSIST

Activity 17: The Life Space Interview

Activity 18: Practice the Life Space Interview

Activity 19: Choosing a Safety Intervention

Activity 20: Breaking up Fights and Standing Holds

Activity 21: Team Restraints

Activity 22: Small Child Restraint

Activity 23: Letting Go Process

Activity 24: The LSI after Restraint

Review the day and assign the homework.

DAY FOUR

Briefly review days one, two, and three.

Activity 25: Responding to Feelings vs. Behavior

Activity 26: Practice Protective Interventions

Activity 27: Practice Breaking up Fights and Standing Holds

Activity 28: Practice Small Child Restraint

Activity 29: Practice Team Restraint

Activity 30: Three Person Restraint and Transferring Control

Activity 31: Letting Go Role Plays

Activity 32: Crisis Intervention Role Plays

Review the day and assign the homework.

DAY FIVE

Briefly review days one, two, three, and four.

Activity 33: Safety Issues and Documentation

Activity 34: Implementation of the TCI System

Activity 35: Testing

CPI Content Outline

UNIT I

- Learn how to identify four behavior levels that may be exhibited by an individual during a crisis situation.
- Learn what staff approaches are effective at each level in response to behaviors being exhibited and prevent the crisis from continuing.

UNIT II

- Explore nonverbal elements of communication that can significantly impact a crisis situation.
- Understand the importance of and demonstrate that appropriate body language can reduce the anxiety of a person in crisis and improve the safety of staff members.
- Develop an awareness of nonverbal behaviors and cues that can assist in effective intervention.

UNIT III

- Foster an awareness of how the delivery of a verbal statement is more important than the actual words used.
- Understand the components of speech that affect how a verbal statement is interpreted.
- Practice delivering verbal statements in ways that are productive and nonproductive in defusing a crisis.

UNIT IV

- Learn to identify different stages of escalation in verbal behavior.
- Learn staff responses to each stage of verbal escalation that can prevent crisis from developing further.
- Learn how to set limits with individuals who are acting out verbally.
- Learn effective listening techniques that can assist in defusing a crisis situation.

UNIT V

- Develop an awareness of the external circumstances and influences that impact an individual's behavior.
- Learn how to avoid taking an individual's behavior personally.
- Understand the reciprocal relationship between the behavior of staff and those in their care, particularly during a crisis.
- Develop coping mechanisms that can help staff maintain a calm, professional manner during confrontations.

UNIT VI

- Increase their awareness of the different sources of fear.
- Identify productive and unproductive behaviors caused by fear.
- Learn how fear and anxiety can stimulate positive and productive responses during crisis situations.

UNIT VII

- Learn the different forms of physical attack.
- Learn how to maintain safety when a person becomes physically aggressive.
- Practice CPI Personal Safety Techniques to avoid injury to both staff and acting-out individuals in behavior becomes physical.
- Build confidence in their abilities to keep themselves and others safe in crisis situations.

UNIT VIII

- Develop an awareness of the key principles of safe physical intervention, the risks involved with physical intervention and how to avoid those risks.
- Decide when it's appropriate to physically intervene.
- Develop team intervention strategies and techniques.
- Effectively control and transport an individual who has acted out physically.
- Assess the physical and the psychological well-being of those involved in a crisis.

UNIT IX

- Apply the material covered in the training to a “real life” situation.
- Develop an understanding of the point of view of the individual in crisis.

UNIT X

- Learn how to reunite communication with the person who acted out and protect the therapeutic relationship between the care giver and care receiver.
- Learn the key steps for debriefing after a crisis.
- Learn how to use a crisis experience to assist the care receivers to prevent future crises and also to improve future staff interventions.

NAPPI Content Outline

SECTION 1 - H.E.R.O. – Humane & Effective Response Options

- Introduction to NAPPI (S.M.A.R.T.-Principles)
- The Lalemond Behavior Scale
- Behavior Scale Documentation
- Stand and Shout
- Behavior Scale Response options

SECTION 2 – Defusing the Violent Incident

- Making a Clear Request
- Keeping a Conversation on Track
- Offering Choices
- Defusing Techniques

SECTION 3 – Generating Cooperation

- Skills for Generating Cooperation
- Green Behavior Scale

SECTION 4 – Developing a Culture of Partnership

- Becoming a Person of Influence
- Developing Relationships
- Praise Scale

SECTION 5 – Community Safety

- Personal Safety Survey

SECTION 6 – Self-Promotion Skills

- Physical S.M.A.R.T. Principles & Skills
- Warm Ups
- Wrist Release
- Front Choke Escape
- X-Shield

SECTION 7 – Physical Restraining Skills (Non-mechanical)

- NAPPI Restraint Avoidance
- Stay Inside the Box
- Holding Event Time Line
- One-Arm Body Wrap
- Capture/Wrap
- Physical Skills Practice
- Levels of Resistance
- Minimum Impact Restraint
- Post-Incident Review

SECTION 8 – Advanced Verbal Skills

- Really Listening
- Problem/Emotion/Solution
- Staff Response Scale

SECTION 9 – Advanced Culture Changing Skills

- S.W.I.A.
- The Visit
- Threat Assessment
- Office Safety Set Up

SECTION 11 – Advanced Restraining Skills

- Following a Pierson to the Floor
- Wrestling Separation
- Mechanical Restraints (Physical Modifications)

PMCS Non-Physical Intervention Office of Mental Health

This training model teaches a four step process for crisis intervention.

The process is as follows:

1. *Assessment:* Upon admission, an initial assessment interview is conducted with the individual to develop their Individual Crisis Prevention Plan (ICPP). The ICPP outlines effective strategies and/or calming techniques based on the past experiences of the recipient.
 - Identify Triggers – Ask: what upsets him/her, what makes him/her feel scared, and what makes him/her feel angry. .
 - What upsets you?
 - Early Warning Signs - Ask about:
 - Behaviors
 - Cues
 - Coping strategies
 - Coping Strategies – Ask:
 - What helps?
 - How can staff help?
 - Who should we contact?
 - What is preference for: medication; mouth or injected; seclusion or restraint
2. *Interaction/Intervention:*
 - Before crisis: Build a rapport with the client with ongoing positive interactions.
 - During escalation of crisis there are three stages of intervention; Early Stage, Middle Stage, and Late Stage.

In the “Early Stage Intervention” of crisis, evidenced by subtle changes in the client’s normal behavior, staff members should:

- Recognize behavior exhibited by recipient.
- Alert other staff to the situation,
- Provide an environment that fosters communication,
- Be supportive and empathetic
- Supportive Stance
- State to the recipient “I noticed that you are... (state your observation)... Would it help you if we talked about what is upsetting you?”
- Provide opportunity for separation from others.
- Offer clear, simple choices from Crisis Prevention Plan.
- Continue to intervene with the recipient and consider the preventive, adjunct and calming strategies of the continuum of intervention.

In the “Middle Stage Intervention” of crisis, evidenced by more aggressive behaviors such as threatening tone and behaviors, disruptive and destructive behaviors and an increase in body or extremity movements are observed, staff member should:

- Initiate immediate intervention.
- Notify/involve clinical staff.
- Coordinate actions with other staff.
- Be prepared for further escalation.
- Supportive Stance.
- Set limits for recipient to feel safe.
- Provide choices, but be directive and non-judgmental.
- Offer options from Crisis Prevention Plan.
- Offer change in environment.
- Offer medications.

- Keep other recipients safe.
- If escalation continues, activate emergency response.
- Continue to intervene with the recipient and consider the preventive, adjunct and calming strategies of the continuum of interventions.

In the "Late Stage" of a crisis, evidenced by threatening bodily harm of self or others, use of a weapon or other violent actions, staff members should:

- Team response.
 - Supportive stance; offer space.
 - Proactive management of physical interventions.
 - Continue to use calming techniques.
 - Consider physical intervention.
 - Coordinate team response.
 - Restraint or seclusion if justified.
- After crisis: (see steps three and four)
3. *Documentation*: "Communication between shifts is vital. Staff need to be alerted to changes in schedules or routines and if someone is having a 'bad day.' Documentation needs to be very specific as to what problems are identified and which techniques have been successful."
4. *Follow-up*:
- Patient evaluation by RN/PA
 - Post acute event analysis: An analysis by key individuals involved in the procedure to:
 - Post acute event analysis: An analysis by key individuals involved in the procedure to:
 - Assess immediate needs.
 - ID steps needed to return to pre-crisis milieu
 - Assure communication.
 - Evaluate need for emotional support.
 - Formal Debriefing:
 - Delineate what happened.
 - How participants feel about the events
 - Identify training and operational needs.

SCIP-R Non-Physical Intervention

Office of Mental Retardation and Developmental Disabilities

This training model places strong emphasis on understanding difficult behaviors. It details the purpose behavior serves for the client and thereby providing participants with keys to defusing difficult behaviors. Participants are also educated specifically about behaviors with regard to OMRDD populations. In addition to providing several verbal and nonverbal calming techniques, this training model utilizes a six step intervention model. The following is an abridged version. Each step is explained in greater detail in the training manual:

1. *Identify*
 - Evaluate the situation and the person's emotional reaction to it.
2. *Reflect*
 - If you are reasonably confident that you have accurately assessed the situation, reflect this to the individual.
3. *Reassure*
 - Let the person know that you are ready to help to deal with the situation.
4. *Redirect*
 - Get the person moving, acting (physically involved) in a different direction so he/she can't sulk, dwell on the problem or get further worked up.
5. *Praise*
 - Be sure to reinforce the person when he or she recommences constructive activity.
6. *Follow-up*
 - Once the individual has regained sufficient self control, it may be beneficial to use the "teachable moment" to work on relevant skills.

TCI Non-Physical Intervention Office of Children and Family Services - DDPS

The entire first half of the five day training covers pre-restraint skills including recognition of environmental indicators, communication skills, and TCI's model of nonphysical crisis intervention, "I ASSIST."

The "I ASSIST" approach breaks down as follows:

- *I* – Isolate the situation;
- *A* – Actively listen;
- *S* – Speak calmly, assertively, respectfully;
- *S* – Make statements of understanding before instructions or requests;
- *I* – Invite the young person to consider positive outcomes and behaviors;
- *S* – Give Space – it facilitates consideration of requests and avoids focusing on adult;
- *T* – Give Time for the young person to process and respond to request.

CMPR Non-Physical Intervention Office of Children and Family Services - DRS

This training refers participants to “Redl’s 12 Interventions” which are as follows:

1. *Planned Ignoring*--A technique where you make a conscious decision to ignore an inappropriate behavior when you know the youngster has the knowledge and maturity to use an appropriate behavior.
2. *Signal Interference*--Some sign, either verbal or nonverbal, that stops an inappropriate behavior.
3. *Proximity*--When a problem is developing, staff moves close to the problem area and by their presence ends the problem
4. *Involvement in Interest Relationships*--Showing an interest in and talking about an area of particular concern to youth, in an attempt to divert their attention from a stressful situation.
5. *Hypodermic Affection*--A staff member gives a youngster experiencing difficulty a dose of caring and concern, beyond the normal amount.
6. *Humor or Self-Criticism*--The use of humor or self-criticism by a staff member, never at the youth’s expense, which eases the tension level in a given situation.
7. *Hurdle Help*--Giving the youngster a boost such as reminding them of past accomplishments, to get them over the frustration of not being able to do something.
8. *Interpretation as Interference*--To explain the meaning of something that has happened so as to reduce a stressful situation.
9. *Regrouping*--Changing the arrangement or positioning of youth to stop some negative behavior.
10. *Restructuring*--Changing the pattern or order of activities to better meet the needs of a situation.
11. *Direct Appeal*--Telling the youngsters truthfully what is going on and asking for their help to control the situation.
12. *Limitation of Space and Tools*--Confining the area or the access to items that might be dangerous when the situation warrants it.

Appendix G

LIST OF SPECIAL ACT SCHOOL DISTRICTS

| <i>Name of School</i> | <i>Location</i> |
|---|--------------------|
| Abbott Union Free School District | Irvington |
| Berkshire Union Free School District Berkshire Junior - Senior High School | Canaan |
| Edwin Gould Academy: Ramapo Union Free School District | Chestnut Ridge |
| George Junior Republic Union Free School District | Freeville |
| Greenburgh-Eleven Union Free School District at Children's Village | Dobbs Ferry |
| Greenburgh-Graham Union Free School District | Hastings-on-Hudson |
| Greenburgh-North Castle Union Free School District | Dobbs Ferry |
| Hawthorne-Cedar Knolls Union Free School District: Hawthorne Cedar Knolls | Hawthorne |
| Hawthorne-Cedar Knolls Union Free School District: Linden Hill | Hawthorne |
| Hopevale Union Free School District | Hamburg |
| Little Flower Union Free School District | Wading River |
| Mt. Pleasant-Blythedale Union Free School District | Valhalla |
| Mt. Pleasant Cottage School Union Free School District: Mt. Pleasant Cottage School | Pleasantville |
| Mt. Pleasant Cottage School Union Free School District : Edenwald Center | Pleasantville |
| Randolph Academy Union Free School District | Randolph |
| West Park Union Free School District | West Park |



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