COORDINATED BEHAVIOR SUPPORT STANDARDS ACROSS CHILDREN'S SERVICE SETTINGS: A PROGRESS REPORT

Report to the Governor and Legislature

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Background

The Office of Children and Family Services (OCFS), Office of Persons with Developmental Disabilities (OPWDD), Office of Mental Health (OMH) and State Education Department (SED) operate, license or approve programs for children that authorize the use of crisis intervention techniques. While restraint, in general, is a high risk intervention, physical restraint is one of the most restrictive and potentially dangerous forms of crisis intervention. Given the high risks associated with physical restraint, each state agency has longstanding statutes and/or regulations regarding its use. These standards are based on the agency's mission; the unique characteristics and service needs of children served; and, in some cases, federal mandates. The variations in these standards have broad implications for children and staff across service settings. As such, a coordinated set of standards, grounded in research and acknowledged as sound practices, can result in positive benefits for children served in those programs that are authorized to use restraint. Where best practices are identified, those can serve as models for practice improvement beyond what is legally required where resources are available to pursue such best practices. Additionally, coordinated standards improve the ability of staff to fulfill their job responsibilities and provide children with appropriate behavior supports.

Pursuant to Chapter 624 of the Laws of 2006, the Council on Children and Families (Council) established the Committee on Restraint and Crisis Intervention Techniques (RCIT). The RCIT Committee was charged with identifying *the most effective, least restrictive and safest techniques for the modification of children's behavior* and establishing coordinated standards giving preference to the least restrictive alternative for the use of such techniques. Additionally, pursuant to Chapter 470 of the Laws of 2008, responsibilities of the RCIT Committee were expanded to include development of annual reports describing progress made by each state agency to implement coordinated standards outlined in the 2007 report as well as a progress report on standards developed for children's day treatment programs and any other settings serving children that authorize the use of restraints.

The least restrictive and safest techniques for the modification of children's behavior call for prevention-oriented policies, environments, and practices. As such, seven standards that addressed policies and procedures related to staff development, practices and program milieu were identified as relevant for all agencies that authorize the use of restraint. These standards reflect a balanced approach to behavior support that involves a shift in philosophy and practices.

Given the importance of these standards in maintaining the safety and well-being of children in programs that authorize the use of restraint, state agencies continue to uphold their commitment to them and sustain efforts to fully implement each standard. During the course of the last year, the full committee was not convened; rather, members of the committee responsible for the implementation of standards met to discuss specific topics (e.g. day treatment, effective strategies to address needs of children with aggressive behavior).

Work Underway to Advance Coordinated Behavior Support Standards in Residential Settings

The extent that coordinated standards are in place varies by state agency. Due to the agency-specific work required to move standards forward (e.g., revision and piloting of curricula; fiscal impact analysis of proposed regulations), the majority of efforts were conducted within each agency so the full committee was not convened. Meetings were held with those committee members responsible for the implementation of standards with discussions focusing on the types of activities in place to move standards forward (e.g. day treatment reviews, identification of effective strategies to address needs of children with aggressive behavior). A status report pertaining to the implementation of each standard follows.

Coordinated Standards Recommended

1. Staff trained in recognized, competency-based programs

2. Individual behavior support plans available for children at risk of being restrained

3. Uniform standards for the use of restraint

4. Use of an accepted physical restraint technique

5. Use of standard monitoring practices during restraints

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

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

Standard 1: Staff are trained in recognized, competency-based programs

State agencies continue to meet this standard by providing support to licensed programs through well-established training curricula. Numerous programs authorized by state agencies to use restraints use Therapeutic Crisis Intervention (TCI), a training curriculum available from the Residential Child Care Project of the Family Life Development Center at the College of Human Ecology at Cornell University. TCI training for certain residential care programs is funded by OCFS. Since 2006, OMH has provided Preventing and Managing Crisis Situations (PMCS) training to numerous licensed providers of inpatient programs. The curriculum Strategies for Crisis Intervention and Prevention-Revised (SCIP-R) is also available to non-OPWDD licensed organizations. All training curricula use a train-the-trainer approach and are free of charge to participants. The training curricula

described below are revised periodically, as knowledge about crisis intervention improves. While the curricula are not identical across agencies, the contents are similar.

Standard 1: Staff are trained in recognized, competency-based programs	
OCFS	The Therapeutic Crisis Intervention (TCI) curriculum is used in the majority of child care agencies, institutions, group residences, group homes, agency boarding homes and foster family boarding homes that are authorized to use restraint. The Crisis Management/Physical Restraint (CPM) curriculum is used in most Division of Juvenile Justice and Opportunities for Youth (DJJOY) facilities. Additionally, a new curriculum, Crisis Prevention and Management (CPM), is being piloted at three DJJOY facilities. OCFS expects to continue to roll this curriculum out to additional facilities and eventually to use it in all of the DJJOY facilities. The curriculum places emphasis on prevention and de-escalation of crises; however, in the event a restraint is required, the form used is dependent on the individual youth. The curriculum also uses a supine rather than a prone restraint.
*OMH	The Preventing and Managing Crisis Situations (PMCS) curriculum is used in state-operated facilities and the program is available to OMH-licensed residential treatment facilities and Article 28 and Article 31 hospitals at no cost. OMH also makes available the Safety Training for Mental Health Workers in the Community for OMH-licensed community-based programs. In the Safety Training for Mental Health Workers in the Community, physical restraint techniques are omitted. This training has been made available to non-OMH licensed programs as well.
OPWDD	SCIP-R is currently used in all OPWDD licensed programs. The Positive Relationships Offer More Opportunities to Everyone (PROMOTE) training curriculum is under development now and will replace SCIP-R. PROMOTE is organized in three levels of training and certification. Curriculum review and demonstration training of level 1 has been completed. Feedback has been positive and many good suggestions for further improvement of the content were made and are being incorporated. It is estimated that about 75 percent of all program staff will only require certification in PROMOTE level 1 training.
SED	SED regulations require staff in approved residential schools to be trained to use safe and effective restraint procedures. A 2008 survey of these schools indicated 90 percent of such schools reported that their staff were trained in the curricula available through OCFS, OMH and/or OPWDD.

Complementary training activities

Other training opportunities are provided in addition to the crisis intervention training made available by OCFS, OMH and OPWDD. Examples of such training are presented below.

Sanctuary Model The Sanctuary Model is a trauma-informed method for establishing an organizational culture in which healing from psychological and traumatic experiences can be addressed. This type of training is particularly important since it underscores that restraint can re-traumatize children and undermine work done by staff to create a positive environment.

State agencies recognize the importance of this approach. At this time OMH have provided training in the Sanctuary Model to a limited number of their licensed programs authorized to use restraint and anticipate making additional training available in the future. All DJJOY facilities, evening reporting centers and community multi-service offices have been trained in the Sanctuary Model.

Dialectical Behavior Therapy (DBT) DBT training is another type of training that has been introduced at a portion of programs licensed by OCFS, OMH and OPWDD. Similar to the Sanctuary Model, DBT is intended to structure the environment in a way that provides support to youth and staff. It combines those strategies traditionally found in cognitive and behavioral therapies with mindfulness practices (e.g., attention to the present moment, assuming a non-judgmental stance). The purpose of this three-pronged approach is to help individuals become aware of their behavior, to build skills that help them cope with detrimental behavior and to use mindfulness strategies that allow them to redirect themselves to more positive thoughts.

Originally, DBT was designed for individuals with self-injurious behaviors, including suicidal thoughts and suicide attempts. But, it since has also been used with many individuals, including both youth and adults, who display behaviors consistent with the diagnosis of borderline personality disorder.

Positive Behavioral Interventions and Supports (PBIS) PBIS is an approach most often used in schools to improve school climate and create safe, effective schools. The underlying goals are to foster an environment that sets school-wide behavioral expectations and supports positive behavior among all students. A three-tier approach that reflects primary, secondary and tertiary prevention is used to support children with varying behavioral challenges.

Webinars in Six Core Strategies and Trauma-Informed Care To allow a broader audience to learn the six core strategies and to provide a basic understanding of trauma-informed care, OMH developed a series of eight webinars. The webinars presented the two-day six NASMHPD curriculum in hour-length segments from February through April 2011 using a technology accessible to a wide range of providers. They were organized around the following topics: Effective Leadership Strategies; Workforce Development; Peer Involvement and Consumer Roles; Prevention Tools; Debriefing; Neurobiological and Psychological Effects of Trauma; Trauma Informed Care; and Using Data to Inform Practice. Announcements of the webinars were sent to the 36 providers participating in the learning collaborative described below, as well as to Article 28 and 31 hospitals statewide. Over 150 people registered to participate in this series of events, and feedback indicated that in many cases groups of staff signed on to these sessions together. The webinars were taped, and the PowerPoint presentations are available through the OMH Office of Quality Management.

Positive Alternatives to Restraint and Seclusion (PARS) Learning Collaboratives Through the SAMHSA grant described above, OMH is offering 29 licensed programs an opportunity to participate in learning collaboratives, intended to help programs in their efforts to prevent the use of restraint and seclusion through the implementation of trauma-informed, recovery-based services. The teleconference learning collaboratives focus on prevention of restraint and seclusion through the creation of coercion- and violence-free inpatient and residential treatment facility (RTF) environments. The collaboratives are based on NASMHPD's six core strategies and draw on the principles of recovery based, trauma-informed care. Led by national experts, the collaboratives provide guidance in the development and implementation of action plans for restraint/seclusion prevention, as well as updated information and expertise regarding model policies, curricula and practices. In addition, they provide a context in which the participating providers discuss and test their ideas, successes and difficulties with fellow colleagues. Consumers and consumer family members also participate in these calls to provide their perspectives. The collaboratives are being offered on a monthly basis from September 2010 through June 2011. Leading the teleconferences are national experts in restraint and seclusion prevention: Maggie Bennington-Davis, MD, Caroline McGrath, R.N., Janice LeBel, Ph.D., and Beth Caldwell, M.S.

Youth Empowerment Restraint Reduction A critical element in any restraint reduction effort requires the voice of individuals at risk of experiencing this event. Therefore, OMH efforts are underway to engage youth in helping licensed programs recognize the impact of restraint on youth and staff, and to identify strategies that effectively use alternative methods to this practice.

Standard 2: An individualized behavioral support plan is available for children at risk of being restrained

Behavior support plans promote problem-solving collaborations among staff, children and their parents so that serious behavior challenges can be averted or resolved before behavior and the response escalate. This two-way feature, where children and their families work with staff to create a tailor-made plan, increases the effectiveness of the plan. Additionally, it increases children's awareness of the types of situations that tend to trigger negative responses, making children more cognizant of coping strategies they can employ to avert such responses. This element of youth involvement has the long-term effect of increasing youths' skills that enable them to control their behavior, which benefits them well beyond their stay in any child-serving setting.

When these plans were first introduced, they tended to focus on information that helped staff in de-escalation activities. Essentially, they were plans to lessen an already stressful situation – more consistent with tertiary prevention approaches. However, current practice has moved more toward secondary and primary prevention. This standard is complemented by training curricula that promote a supportive environment, similar to that established through the Sanctuary Model and other training programs that emphasize trauma-informed care. Additionally, approaches that promote the development of coping skills (e.g., DBT) focus on earlier prevention strategies and offer youth long-term solutions for dealing with behavioral challenges.

Standard 2: Individual behavior support plans available for children at risk of being restrained	
OCFS	OCFS's proposed regulations encourage this practice. Additionally, staff who attend TCI training are able to receive guidance in this practice. The proposed regulations will apply to child care agencies, institutions, group residences, group homes, agency boarding homes and foster family boarding home OCFS DJJOY is currently revising policies at OCFS-operated facilities, subject to the State's recent settlement with the United States Department of Justice. OCFS DJJOY has determined that individualized intervention plans for youth in care would be beneficial, and plans are being developed to implement such a requirement.
OMH	Individual behavior support plans are required by OMH policy directives as well as supported by federal regulations and related interpretive guidelines. Individual crisis prevention strategies are expected for all children served in inpatient and residential treatment settings.
OPWDD	Intermediate care facility (ICF) federal requirements mandate the development of individual, specific treatment and intervention plans and OPWDD applies this requirement more broadly to all of its certified programs through its policies and regulations.
SED	SED regulations require functional behavioral assessments and behavioral intervention plans for each student with a disability; whenever the student exhibits persistent behaviors that impede their

	learning or that of others, despite consistently implemented general school-wide or classroom-wide interventions, whenever students' behavior places them or others at risk of harm or injury; whenever the school district is considering more restrictive programs or placements as a result of students' behavior; or whenever the students' behavior that results in a disciplinary action is determined to be a manifestation of the student's disability.

Standard 3: Uniform standard for the use of restraint

This standard is the cornerstone of cross-system coordination in that it underscores the need for clear guidelines for the appropriate use of physical restraint that are equitable across all systems. The definition of restraint and the conditions that must be present prior to its use should be substantially the same for children, regardless of whether they are in a child welfare, developmental disability, education or mental health setting. Within each system, this standard reduces the chance a child is restrained unnecessarily, provides greater clarity to staff and informs children and their families about the types of behavior that may result in the most restrictive form of crisis intervention. From a cross-system perspective, this standard reduces the likelihood that children's chances of being restrained are dependent upon the setting in which they are placed.

The successful implementation of this standard requires comparability across agencies in two key areas: (1) the definition of restraint (e.g., immobilization of an individual) and (2) the criteria that would justify the use of a restraint (i.e., person's behavior has risen to a level where staff are permitted to manage the behavior using restraint as a crisis intervention). Pending the enactment of proposed changes to current regulations and statute, comparability across state agencies will improve; however, disparities will still exist with some agencies. The Council will continue to focus attention on this standard.

Standard 3: Uniform standard for the use of restraint	
OCFS	OCFS regulations proposed for child care agencies, institutions, group residences, group homes, agency boarding homes and foster family boarding homes
	<u>Definition</u>: physical restraint is defined as the application of physical control that reduces or restricts a child's freedom of movement
	<u>Condition for use</u>: Physical restraint may only be imposed on a child in emergency circumstances and only in circumstances where the immediate safety of a child or others is in jeopardy.[1]
	OCFS DJJOY facilities (re: PPM 3247.13)
	<u>Definition</u>: physical restraint refers to physically controlling a youth and/or physically holding or escorting a youth from one place to another.
	<u>Condition for use</u>: to prevent a youth from harming him or herself, staff members or others; to prevent an escape or AWOL by a youth; to escort a youth who is causing or threatening to cause an immediate serious disruption that threatens the safety of others by refusing to leave a place after being asked to leave.
	DJJOY has a new draft proposed policy (PPM 3247.12) that will be implemented in the three facilities that were reviewed by the U.S. Department of Justice. The conditions for the use of restraint in this draft policy are: to protect the safety of a person, to prevent an

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[1] Current OCFS regulations include destruction of property to such an extent that the safety of a child or others is in immediate jeopardy. This is omitted in the proposed regulations.

	escape from a facility, or to prevent an escape from an off grounds trip. Eventually the draft policy 3247.12 will be implemented at all facilities.
OMH	During the 2010 legislative session, OMH proposed a bill that would have made various amendments to section 33.04 of the Mental Hygiene Law to update and conform the statute to applicable federal regulations, including the language below. Due to lack of progress with the bill, OMH plans to update current regulations to achieve greater consistency with federal standards wherever possible. Definition: a manual restraint means a physical method used to restrict a person's freedom of movement or normal access to his or her body. Conditions for use: restraint [and seclusion] are interventions that may be used for behavioral management purposes only in emergency situations if necessary to avoid imminent, serious injury to the patient or others, and less restrictive interventions have been utilized and determined to be ineffective, or in rare instances where the patient's dangerousness is of such immediacy that less restrictive interventions cannot be safely employed.
OPWDD	OPWDD's most recent draft of proposed behavior management regulation Part 14 NY CRR §633.16 defines restrictive physical interventions that coincide with the proposed new curriculum, PROMOTE. Definition: Restrictive physical/personal intervention techniques that include holds that restrict freedom of movement. Condition for use: To interrupt or control behavior that is posing an immediate health and safety risk to the individual or others.
SED	The Regulations of the Commissioner of Education do not define the term "restraint." They do, however, use the term "use of reasonable physical force." State education regulations prohibit the use of corporal punishment. Definition: Reasonable physical force may include a physical intervention or a physical restraint, but does not include use of a mechanical restraint device to restrain a student. Conditions for use: use of reasonable physical force may be used as an emergency intervention for the following purposes: • 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; provided that, such emergency interventions must be used only in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed and that it is not used as a punishment or as a substitute for systematic behavioral interventions that are designed to change, replace, modify or eliminate a targeted behavior.

Standard 4: Use of an accepted physical restraint technique

The following table depicts the physical restraint technique(s) presented in the training curricula made available to licensed programs. Training curricula offered by OCFS, OMH and OPWDD address the proper implementation of the technique(s) described below as well as the need for appropriate monitoring practices during restraint.

Standard 4: Use of accepted physical restraint technique(s).	
OCFS	TCI training includes four forms of restraint: seated, standing, prone and a relatively new supine. TCI training is available to child care agencies, institutions, group residences, group homes, agency boarding homes and foster family boarding home care through OCFS at no cost. Alternative curricula may be considered. CPM training includes three forms of restraint: seated, standing and supine. The form of restraint used is dependent upon the needs of the youth. For example, a seated restraint may be used for a pregnant teen.
OMH	PMCS training includes one form of a floor restraint: supine; one form of standing restraint; and two forms of removal restraint.OMH allows for the use of other trained techniques with the exception of prone restraint.
OPWDD	SCIP-R and the proposed PROMOTE training include 2 forms of restraint, referred to as restrictive physical/personal interventions – take-downs and floor holds (e.g., supine or side-lying holds).
SED	A 2008 survey of programs indicated 90 percent of the SED approved residential schools provide professional development to staff using TCI and/or SCIP-R training.

This standard is fulfilled in instances where an organization holds a single license (e.g., only licensed by OCFS or only licensed by OMH). However, it remains an unresolved issue for organizations that have multiple licenses with co-located programs (i.e., programs on the same campus or at the same location that are licensed by two or more state agencies). Council staff and RCIT Committee members that have multiple licenses discussed possible next steps that could help move this standard forward. Suggestions included seeking private or federal funding to support the implementation of a common technique that uses additional staffing[2] as well as learning more about strategies proven to be effective with youth who display aggressive behavior since they are most likely to be at risk of restraint. To date, Council staff have not been able to identify foundations interested in funding issues related to restraint but continue to investigate opportunities.

RCIT Committee members with multiple licenses explained that children with aggressive behavior posed particular challenges for staff. In light of the current focus on earlier prevention, Council staff agreed to conduct a review of evidence-based strategies found to be effective with children identified with aggressive behavior. A description of the review is presented in Appendix A.

Standard 5: Use of standard monitoring practices during restraints

This standard, which is critical for the safe implementation of a restraint, was well-established and in place prior to the development of coordinated standards. This standard is incorporated into practice through the training curricula utilized by OCFS, OMH and OPWDD.

Standard 5: Use of standard monitoring practices during restraints	
OCFS	This is addressed in the TCI curriculum In the three DJJOY facilities that were reviewed by the U.S. Department of Justice, a restraint monitor and clinical and medical staff respond to each restraint. In the other DJJOY facilities, medical and clinical staff respond to restraints when available.

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[2] The RCIT Committee recommended that a supine technique be used by multiple licensed organizations with co-located programs. It was *preferable* though not required that the supine technique have three staff available.

OMH	This is addressed in the approved curriculum
OPWDD	This is addressed in the SCIP-R curriculum and will also be a component of PROMOTE
SED	Staff who may be called upon to implement emergency interventions must be provided with appropriate training in safe and effective restraint procedures. The curricula used most frequently by education staff (TCI and SCIP-R) address this in the training.

Standard 6: Methods are in place to inform quality and practice from the perspective of children and staff.

This standard acknowledges that restraints are traumatizing events for children and staff alike. Furthermore, this standard serves to recognize that a fundamental aspect of restraint prevention and reduction is development of positive relationships with youth. Effective use of this standard allows staff to add a restorative dimension to crisis intervention, and staff have noted that incorporating information regarding a child's trauma history during debriefing activities has several advantages. It can broaden and soften discussions during debriefing sessions, tends to remove a tone of blame, and helps staff look at the needs of the child based on a better understanding of that child. The careful implementation of this standard provides organizations with ongoing opportunities to advance our knowledge and improve practices.

Currently, all training programs present information related to this standard. However, the extent this standard is required varies by agency. Additionally, in some instances where it is required, further work can be done to promote a stronger voice among children and youth. For example, in some circumstances, a personal exchange (e.g., conference call, face-to-face interview) is required to fulfill the standard. In other instances, a notification is required (e.g., letter, phone call). Typically, these interactions involve staff and parents. However, it is important to involve children and youth to promote a better understanding of the organizational and/or personal modifications that could improve future circumstances.

Standard 6: Methods are in place to inform quality and practice from the perspective of children and staff.	
OCFS	OCFS proposed regulations encourage this practice and guidance is provided through TCI training. The proposed regulations will apply to child care agencies, institutions, group residences, group homes, agency boarding homes and foster family boarding homes Within DJJOY facilities, PPM 3247.13 requires staff involvement in debriefing activities. A life space interview may be conducted but is not required.
OMH	This practice applies to all inpatient and residential treatment programs that serve children. Debriefing activities are required for staff and youth. Also, OMH has a state policy that addresses state-operated programs and this requirement has been implemented into the licensing process.
OPWDD	The current SCIP-R curriculum includes a recommended debriefing activity. PROMOTE training curriculum will require that a debriefing process occur following use of any restrictive physical/personal interventions in all licensed settings pending adoption of the curriculum. While youth involvement is contingent on their cognitive abilities, family involvement is required unless clinically contraindicated, in which instance an advocate would be involved.

SED	Debriefing techniques are not required at this time. SED's Office of Special Education has posted quality indicators of positive supports and strategies to address student behaviors. See http://www.p12.nysed.gov/specialed/techassist/behaviorQI-310.htm

SED's Office of Special Education have publicly posted quality indicators of positive behavioral supports and strategies to address student behaviors.

Standard 7: Monitoring and data reporting to provide a comprehensive view of restraint use and related injuries

Given the known risk associated with restraint, state agencies have longstanding requirements detailing the type of information providers must record when a restraint is used. However, variations still exist across agencies regarding the extent to which information is automated, easily aggregated and reported to state leadership. These features are necessary for any monitoring system since they promote regular use of information contained in that system, allowing leadership within state agencies and programs to address outstanding issues and continuously improve their systems of care.

Standard 7: Monitoring and data reporting to provide a comprehensive view of restraint use and related injuries	
OCFS	Data are reported to state leadership on an ongoing basis through the Automated Restraint Tracking System (ARTS). ARTS is implemented in child care agencies, institutions, group residences, group homes, agency boarding homes, foster family boarding homes authorized to use restraint and DJJOY facilities.
OMH	Automated data are reported to the state on an ongoing basis through the New York State Incident Management and Reporting System (NIMRS). NIMRS is implemented at state-operated psychiatric hospitals and OMH-licensed residential treatment facilities; and use of the incident module is required in all OMH licensed Article 28 and Article 31 hospitals as of December 31, 2010. Quarterly trend reports are disseminated to leadership.
OPWDD	Data are logged and reviewed at the local agency level for each restraint and are not reported to state leadership unless the restraint results in an injury or constitutes inappropriate or unauthorized use of restraint. The injury data are tracked in the automated Incident Review Management Application (IRMA) and available to state leadership on an ongoing basis.
SED	State regulations require that each school maintain documentation on the use of emergency interventions for each student and that such documentation be reviewed by school supervisory personnel. SED conducted a survey of its residential schools in 2008 to collect incident rates for the use of physical restraints.

Behavior Support Standards for Children's Day Treatment Programs

Background

Children's day treatment programs are integrated mental health and special education programs. The programs are certified by OMH as day treatment programs and the education programs that are operated by a private school or Special Act School District are approved by SED. Through these programs, a comprehensive array of mental health and education services are provided to children and adolescents diagnosed with serious emotional disturbances.

Children's day treatment programs pose a particularly difficult challenge for coordinated standards regarding the use of restraint, since SED allows for the use of reasonable physical force in all education settings while OMH prohibits the use of restraint in community-based programs, which include day treatment programs. Given agency differences, a set of coordinated standards was outlined in the 2009 RCIT report with the understanding that this was the first in a series of incremental steps that would lead to more coordinated, consistent practices between the mental health and education staff at the program level. It was expected that this, in turn, would drive policies that promote supportive environments where children are able to make academic gains while learning to address their behavioral challenges. In light of current research on trauma-informed care and national trends to prevent and reduce the use of restraints, the set of standards below was recommended for day treatment programs.

Coordinated Standards Recommended

- Staff trained in recognized, competency-based program

- Use of individual behavior support plans

- Use of a wide range of behavior supports to assist children and staff

- Clear behavior support policies jointly developed by OMH and SED

Efforts to Advance Standards

A fundamental standard that is the cornerstone for effective practices is related to clear behavior support policies. Following meetings among OMH, SED and Council staff, OMH leadership is taking considerable steps to assist clinical staff within day treatment programs in fully understanding OMH policies and recommended practices. The strong leadership taken by OMH to develop this training will begin to advance the standard of clear behavior support policies used in OMH licensed day treatment programs.

Convene internal workgroup

OMH will convene an internal workgroup consisting of representatives from OMH divisions of Licensing, Counsel, Quality Improvement, and the Children's Division as well as the OMH Bureau of Workforce Development. A youth representative will also be included as a member of the internal workgroup. Initial efforts of the workgroup will focus on the identification of resources available within OMH to assist with behavior supports among day treatment programs. Additionally, members of this workgroup will review past citations to day treatment programs that involved the use of restraint. Once these activities are completed, a meeting with a subgroup of day treatment providers will be conducted.

Meeting with day treatment providers

The primary purpose of this meeting is to gain a more detailed understanding of the perceptions held in the field by day treatment professionals regarding behavior support policies. Based on interviews conducted in 2009 with day treatment staff, it appears there may be a need to provide further clarification regarding OMH behavior support and restraint policies (e.g., clarification on the subject of staff having physical contact with children).

Development of training for day treatment staff

The information gathered through the meeting with day treatment providers, combined with the review of citations, will be used by the OMH workgroup to develop a training curriculum for day treatment *clinical* staff. The training will provide greater clarification regarding OMH policies and will incorporate evidence-based knowledge and promising practices regarding alternatives to restraint and seclusion.

Pilot training curriculum

The training curriculum will be piloted with a small group of day treatment programs, and then revised as necessary.

Disseminate training to day treatment clinical staff

A dissemination plan will be developed and implemented to make this training available to all clinical day treatment staff.

It is recognized that the most effective approach for behavior supports in day treatment programs should involve key education staff; therefore, SED will be invited to fully participate and contribute to the curriculum so the final product reflects a common philosophy shared by both OMH and SED.

Summary

The implementation of standards that are common to all agencies that authorize restraint is fundamental to the quality of state-licensed or state-operated programs, but more so, it is critical to the safety and well-being of children and staff in those programs since the standards reflect how we view children in our care and how we respond to them when meeting their needs. Each agency remains committed to implementing the standards identified by the RCIT and the Council will continue to monitor progress toward full implementation.

Appendices

APPENDIX A

MEMBERS OF THE COMMITTEE ON RESTRAINT AND CRISIS INTERVENTION TECHNIQUES

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INTRODUCTION

Disruptive behavior disorders, which include conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder (ADHD), are among the most prevalent child psychiatric disorders (1). Conduct and oppositional defiant disorders are characterized by antisocial behavior while ADHD is characterized by symptoms of inattention, motor hyperactivity and impulsivity. The symptoms associated with these disorders impact children's ability to function within their families, at school and with peers. As such, these behaviors frequently are the reason why children and youth are referred for psychotherapy (2). In fact, the vast majority of youth across outpatient and inpatient settings in public mental health service systems are referred for behavioral problems (3). Additionally, behavioral problems are the most frequent reason for teacher referrals and aggressive behavior is the most common presenting problem identified by psychotherapists (4).

Addressing disruptive behavior is vital, given the considerable negative impact it has on children's lives when left untreated (1). Children who experience disruptive behaviors are at risk for psychological and social problems, including poor self-regulation, academic performance, as well as poor social interactions with peers and adults (5). Furthermore, it has been shown that chronic aggressive behavior in boys during childhood is a significant risk factor for antisocial behavior in later life (6).

It has been noted that children's outcomes vary when medications are used for the treatment of oppositional defiant disorder or conduct disorder (7). Therefore, emphasis has been placed on psychosocial treatments or a combination of psychosocial treatments with medications. In fact, the American Academy of Child and Adolescent Psychiatry (AACAP) practice parameters indicate medication without any other form of treatment is not sufficient for managing and treating conduct disorder (8) while the Stanford/Howard/AACAP Workgroup on Juvenile Impulsivity and Aggression recommended that medication was not the preferred treatment for children with oppositional defiant disorder or conduct disorder unless psychosocial treatment had failed (9).

Fortunately, more evidence-based practices exist for disruptive behavior disorders than any other childhood disorders (10, 11) with several interventions classified as "evidence-based." Many of these interventions utilize a developmental approach that takes into account the key influences and supports in children's lives (12). Typically, the programs use therapeutic strategies directed *toward children* and

strategies directed *toward caregivers* in parent training models (3). Often a cognitive-behavioral approach is used with children while behaviorally oriented programs are directed toward parents.

Clinicians consider parent training the first line approach for young children while child-training approaches are considered most appropriate for older youth who may have a greater ability to benefit from cognitive-behavioral approaches (7). Still, some research has shown that adjunctive treatments result in superior outcomes with young children as they do for older youth (13).

CHILD FOCUSED STRATEGIES

Cognitive-behavioral therapy (CBT) is a common type of intervention used with children diagnosed with a disruptive behavior disorder. This form of therapy is grounded in the notion that feelings and behavior are directed by internal processes (i.e., thoughts) rather than external factors (e.g., situations, people). This form of psychotherapy emphasizes the link between what we think and what we do. Youth are directed to focus on social cues so they can more accurately interpret social circumstances as well as use non-violent problem-solving skills (14).

In an effort to better understand the dimension of this intervention, Sukhodolsky (2) examined four types of CBT that included:
1. *Affective education:* treatments that focus on covert anger experience and include techniques of emotion identification, self-monitoring of anger arousal and relaxation;
2. *Problem-solving* treatments that target cognitive deficits and distortions and use techniques like self-instruction and consequential thinking;
3. *Skills development* for overt anger expression that uses modeling and behavioral rehearsal to develop appropriate social behaviors; and,
4. *Eclectic or multimodal treatments* in which two or more components of anger are addressed.

The above treatments were classified on a continuum of "less behavioral" (i.e., affective education and problem-solving) to "more behavioral" (i.e., skills development and eclectic) and it was found that skills development and eclectic treatments were significantly more effective than affective education, while problem-solving had a moderate effect. Treatments that taught actual behaviors were more effective than treatments that attempted to modify internal constructs believed to be related to targeted behaviors.

Another aspect examined was related to therapeutic techniques. Sukhodolsky (2) examined outcomes from programs that utilized discussion, modeling, role-play, feedback, emotion identification, relaxation, self-instruction, exposure, homework, and reinforcement. Many of these techniques are common elements shared in a number of evidence-based interventions (3). Effectiveness of treatment tended to increase as the amount of modeling and feedback increased. Furthermore, use of homework was significantly and positively related to therapy outcomes.

When the effect of problem severity on outcomes was examined, Sukhodolsky (2) found that children in the moderate range showed better gains than children in the mild or severe categories. It was suggested that children with moderate anger-related problems who did not have a history of violent behavior benefited most from CBT.

Duration of therapy was not significantly related to overall treatment effects in the Sukhodolsky meta-analysis. This differed from past research where a linear relationship between the amount of sessions attended and a reduction in aggressive, disruptive behavior was observed (15). The differences may be attributed to the type of analysis that was conducted. In a more careful examination that utilized a dose-response approach, it was found that the rate of improvement was strongest in the early stages of treatment, diminishing as the number of sessions increased (16).

In terms of treatment delivery, findings indicated no differences in outcomes were observed when treatments were presented in groups or individually (2, 17-19). Furthermore, a review of school-based CBT programs directed toward youth with hyperactivity-impulsivity and aggression problems found that there was a larger reduction in aggressive/disruptive behavior when programs were delivered within a classroom setting than when treatment was provided using pull-out programs (20). However, regardless of the interventions used, it is strongly suggested that the child training component and any component that requires the child to be present should take place in settings where children are most comfortable. Priority should be given to individual preferences.

While CBT has been shown to be effective with school-aged and adolescent children, a meta-analysis by Bennett indicated CBT was more effective for adolescents compared to elementary school-aged children (21). It was suggested that behavioral parent training interventions may be more effective than CBT for youth ages 6 through 12 years due to the fact that youth at this age are more dependent on parents and benefit from guidance and support (22). Conversely, it was presumed that CBT may be less effective with this age group since they are just beginning to develop the abstract cognitive skills emphasized in this form of intervention (e.g., self-reflection, consequential thinking). McCart did find that as youth advance to higher levels of cognitive development, the impact of CBT is greater.
A particularly valuable aspect of CBT is that its impact has been sustained over time (23).

PARENT FOCUSED STRATEGIES

Parent management training (PMT) is one of the most frequent types of interventions used in clinical practice for children identified with disruptive behaviors (5). The importance of PMT is due to a number of factors. First, parents have the greatest and most frequent influence on the child to manage problematic behaviors and they play a key role to long-term positive outcomes for youth (24). Second, PMT addresses an aspect of therapy not impacted at child-directed therapy. Specifically, PMT address the parent's ability to deal with the disruptive behaviors displayed by the child, decreasing parental stress. Given that children diagnosed with disruptive behavior disorders tend to place considerable stress on parents and siblings this is a critical aspect for children, their parents and siblings. Also, when medication is the therapy of choice, it may not address all behavior problems, including aggression or poor peer relationships. However, PMT can have an impact in these areas. Parent training that promotes consistency and use of positive reinforcement is a component in many evidence-based parent training programs (3). In general, parent mediated interventions tend to include behaviorally oriented parent training.

PMT, which refers to programs that train parents to manage their child's behavioral problems in the home and at school, has emanated from two lines of work. First, maladaptive parent-child interactions, particularly in relation to discipline practices, have been shown to foster and to sustain conduct problems

among children. As such, PMT emphasizes strategies that build more positive child-parent relationships. Second, techniques that rely heavily on principles of conditioning have been extremely useful in altering parent and child behavior. These techniques are incorporated into many PMT programs so that parent-child interactions are modified in ways to promote pro-social child behavior and decrease aggressive behavior.

The overall goal of PMT is to promote the use of positive and consistent child management strategies used by parents in an effort to support development of positive, prosocial behavior in children. In general, PMT encompasses positive parenting and interpersonal skills (such as effective communication and problem solving skills, anger management and ways to give and get support), effective discipline and stress management for parenting.

Typically, therapists provide an overview of underlying concepts related to behavior, model techniques for the parents, and coach parents in how to use the procedures so parents can use them at home. Instructions focus on how to define, observe, and record behavior at the beginning of treatment because once behaviors (e.g., fighting, engaging in tantrums) are defined concretely, reinforcement and punishment techniques can be applied. Reinforcement for pro-social and non-deviant behavior is central to treatment so parents are taught how to use reinforcement and punishment techniques contingent on the child's behavior, to provide consequences consistently, to attend to appropriate behaviors and to ignore inappropriate behaviors, to apply skills in prompting, shaping, and fading, and to use these techniques to manage future problems. The behavior modification techniques employed in PMT teach parents alternative ways to identify and conceptualize child problem behavior, often using role-laying and feedback as instructional techniques (25).

In many PMT programs, the therapist maintains close telephone contact with the parents between sessions. These contacts allow the therapist to provide on-going support and problem-solve when programs are not modifying child behavior effectively.

PMT is one of the most extensively studied therapies for children. The effectiveness of PMT was demonstrated in several studies that compared PMT to other treatments (e.g., relationship, play therapy, family therapies) and control conditions (e.g., waiting-list, placebo). When various treatment methods were examined (e.g., videotape, group discussion, one-on-one, self-administered videotape), group discussion in combination with a videotape approach was shown to be most effective (26).

A considerable benefit of PMT is that its impact tends to be maintained over time (27-30). Follow-up data have shown that gains are maintained from one to three years after treatment has ended. One research team found that noncompliant children treated by parent training were functioning as well as non-clinic individuals' – approximately 14 years later (31). Furthermore, the benefits of PMT often generalize to areas that are not the primary purpose of therapy. For example, improvements in parental adjustment and functioning, marital satisfaction, and sibling behavior have been found to improve following therapy. Also, PMT, either alone or in combination with other techniques, has been applied with promising effects to other populations including autistic children, developmentally disabled children and adolescents, adjudicated delinquents, and parents who physically abuse their children (32).

It is important to note that family characteristics can moderate PMT outcomes and parents' response to PMT may be influenced by variables not directly involving the child. Two characteristics examined were family socioeconomic status and maternal mental health. Both tended to diminish positive treatment effects (25, 33). A review of several behavioral programs for parents found that low parental education,

high maternal psychopathology and low family socioeconomic status had moderate to large effects on outcomes (34, 35). Additionally, marital adjustment, maternal depression and parental substance abuse were shown to moderate outcomes (36). High levels of parental stress, low treatment expectations and limited social support also influenced treatment implementation and outcomes (37). In one review of PMT financial disadvantage was identified as the most significant factor in predicting outcomes. However, it was also reported that individual behavioral parent training for low income parents was superior to training provided in a group setting.

EXAMPLES OF EVIDENCE-BASED PROGRAMS FOR CHILDREN WITH DISRUPTIVE BEHAVIORS

Eyberg and colleagues (7) identified evidence-based psychosocial treatments that met criteria as being either probably efficacious or well-established. In an effort to better understand the key components of evidence-based treatment (EBT), Garland reviewed EBTs that included behaviorally oriented parent training programs and cognitive-behaviorally oriented youth training (3). The common therapeutic content shared across the EBTs reviewed involved use of positive reinforcement, limit-setting, parent-child relationship building strategies, problem-solving, anger management and affect education (3). The types of treatment techniques employed included role-playing/behavioral rehearsal, modeling, setting and reviewing goals, psychoeducation and use of homework (3). For example, many programs promote development of problem-solving skills, self-control facilitated by self statements, anger management and pro-social behaviors (3). Descriptions of effective forms of treatment for children with aggressive, disruptive behavior problems follow.[3]

Anger Coping (38-40)
This is a school-based, cognitive-behavioral intervention for children in fourth through sixth grade. Group discussion and role-playing are used to help children develop problem-solving skills and anger management strategies that can be used in social situations that may provoke anger. Children with lower levels of perceived hostility demonstrate the most improvement after participation.

Collaborative Problem Solving (41)
Collaborative Problem Solving (CPS) emphasizes the need to identify lagging cognitive skills in order to address challenging behaviors of children. Collaborative problem solving between child and parent or child and teacher is the means used to reduce the problematic behavior. This strategy is considered more effective than reward and punishment procedures. CPS has been applied predominantly to youth with externalizing behavior problems, and has been implemented in a wide range of settings, including families, general and special education schools, inpatient psychiatry units, and residential and juvenile correction facilities.

Coping Power (40, 42-44)
An extension of Anger Coping, the Coping Power program is a cognitive-behavioral preventive intervention that typically spans fifth and sixth grade. Coping Power was developed as a school-based

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[3] EBT programs that emphasize universal prevention have not been included here. The programs presented tend to be secondary and tertiary prevention programs designed for children identified as having severe aggressive behavior and/or a DSM-IV diagnosis associated with aggressive behavior.

program and was adapted for mental health settings. This program, which includes a child and parent component, has shown a decrease in substance use and delinquent behavior, as well as a decrease in teacher-rated aggressive and problem behaviors.

Dialectical Behavior Therapy (DBT) (45-47)

DBT is intended to structure the environment in a way that provides support to youth and staff. It combines those strategies traditionally found in cognitive and behavioral therapies for emotion regulation with mindfulness practices (e.g., attention to the present moment, assuming a non-judgmental stance). The purpose of this three-prong approach is to help individuals become aware of their behavior, to build skills that help them cope with detrimental behavior and to use mindfulness strategies that allow them to redirect themselves to more positive thoughts. DBT has shown to be effective with adolescents who demonstrate self-injurious behavior and youth diagnosed with a bipolar disorder.

Helping the Noncompliant Child (HNC) (31)

 HNC is designed for children ages three through eight with non-compliant behavior and their parents. Parents receive training in strategies to improve parent-child interactions (e.g., positive feedback, clear directions). HNC was found more effective than systemic family therapy in reducing child noncompliance.

Incredible Years (IY) (7, 29, 48)

The purpose of this treatment is to reduce aggressive behavior and increase social competence of children. Incredible Years is a set of comprehensive, multifaceted, and developmentally based curricula targeting 2- to 12-year-old children and their parents and teachers. The parent, child, and teacher training interventions that compose Incredible Years are guided by developmental theory on the role of multiple interacting risk and protective factors in the development of conduct problems. Although originally designed to address child conduct problems, the model has been adapted for special populations, including parents involved in the child welfare system. The three forms of training (i.e., child, parent, teacher) have been examined alone as well as in combination with one another. Findings indicate the programs are effective when compared to waitlist or no-treatment groups.

Multidimensional Treatment Foster Care (MTFC) (49-51)

Originally developed as an alternative to residential care, this program is designed for children with severe and chronic delinquent behavior who have been placed in foster care. Treatment focuses on youth skills development, including problem-solving, anger expression and social skills. Three versions are available, depending on the age of the youth (3-5 years; 6-11 years; 12-17 years). The foster parents receive training in behavior modification (e.g., daily token reinforcement). MTFC was shown more effective than group home care for adolescents with chronic delinquent problems.

Multisystemic Therapy (MST) (24)

MST is intended for use with families and adolescents who demonstrate serious antisocial and delinquent behavior. Treatments include cognitive-behavioral approaches, parent training, family therapy and pharmacological interventions. MST is highly individualized and based on youth and family strengths. Much of the research is based on youth in the juvenile justice system.

Parent-Child Interaction Therapy (PCIT) (52, 53)

PCIT is an intensive parent-child treatment designed for parents of children ages 2 through 7 who have been diagnosed with disruptive behavior disorders. Emphasis is on increasing positive parenting skills, providing clear direction, and enhanced parent-child interactions. Treatment involves parents and children. Adaptation is available for physically abusive parents with children ages 4 through 12.
In multiple random control studies with various populations, PCIT was shown to reduce disruptive behavior, increase positive parenting behaviors and decrease negative parent behaviors. It has been found to be effective in the long term for young children with oppositional defiant disorder and AD/HD.

Parent Management Training Oregon Model (PMTO) (54, 55)

PMTO is a behavioral parent training and education model designed and tested with groups of parents of children ages 4 through 12 with moderate to severe disruptive behaviors. PMTO supports parents to increase positive parenting behavior such as establishing systematic consequences, monitoring behavior, and initiating and maintaining positive interactions with their child. Random control studies have shown significant reductions in disruptive behavior and improvements in positive parenting skills.

Positive Parenting Program (Triple P) (56-57)

Referred to as Triple P, this program uses three levels of treatment for parents and children, depending on problem severity. The program is intended for young children. Triple P has some of the most robust empirical evidence in the field. Families receiving Triple P significantly reduce disruptive behavior and dysfunctional parenting.

Problem-Solving Skills Training (PSST) (58-59)

Designed for children, ages 7 through 13 with disruptive behavior, this program focuses primarily on the children with limited parent contact. Children are taught problem-solving strategies. Variations of this training include PSST+, which allows children participate in activities outside the sessions as well as parent management training (PMT), which involves training for parents.

SUMMARY

A review of research indicated several programs are effective in reducing aggressive behavior of children diagnosed with disruptive behavior. The impact of these evidence-based programs is contingent upon how thoroughly the programs are implemented and much has been written regarding the importance of program fidelity. However, even when fidelity is maintained, it has been shown that a number of factors may mediate program effectiveness (e.g., child's age, family economic status, parent mental health).

The evidence-based programs described here demonstrated program effectiveness when groups with similar problems were provided treatment. It is unlikely many service settings will have children with aggressive, disruptive behavior who are identical in their diagnosis, limiting the benefit of group sessions. This means clinicians will need to have a wide range of skills and techniques consistent with a variety of the programs described here in order to meet the diverse needs of children and families served in community settings. Given that many programs for disruptive behavior disorders share common core elements, it has been suggested that increasing clinician's knowledge of these core elements may be a strategy to improve overall practice and basic competencies (3). Furthermore, it has been suggested that adapting effective interventions to address individual children's distortions and deficits may be more

important than rigid adherence to a manual for all children (40). These suggestions, offered by researchers and developers of interventions, are contrary to literature that underscores the importance of program fidelity. However, they recognize that a single treatment or intervention most likely will not accommodate the different needs of children and families and may require clinicians and program administrators to consider the best way to balance knowledge about interventions with the practical implementation of clinical competencies and practices.

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