

	COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE		
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SUBJECT Strategies and Practices to Eliminate the Use of Unnecessary Restraints		BY Estelle B. Richman, Secretary, Department of Public Welfare Richard J. Gold, Deputy Secretary for Children, Youth and Families Joan D. Erney, Deputy Secretary for Mental Health and Substance Abuse Services Kevin Casey, Deputy Secretary for Developmental Programs Michael Nardone, Deputy Secretary for Medical Assistance	

SCOPE:

- Child Residential and Day Treatment Facilities**
- State Youth Development Centers/Youth Forestry Camps**
- County Chief Juvenile Probation Officers**
- County Children and Youth Social Service Agencies**
- County Mental Health/Mental Retardation Offices**
- ODP Administrative Entities**
- Juvenile Court Judges**
- Providers of Mental Retardation Services**

PURPOSE:

The purpose of this bulletin is to provide guidance to child residential and day treatment programs that are licensed by the Department of Public Welfare (DPW) to assist in the implementation of strategies and practices that lead to the elimination of restraint through promoting environments free of violence and coercion and the safe and best practice management of children.

BACKGROUND:

Restraints bring the risk of serious injury or death of the child or staff; emotional harm and trauma to the child or staff; and the disruption of the relationships between the child, family members, peers and staff. Prone restraints are particularly dangerous because they can impede or even prevent breathing by placing pressure or weight on the child's respiratory system. According to the Coalition Against Institutionalized Child Abuse, at least 73 children in the United States have died as a result of being restrained in the last 18 years; most resulted from the child being restrained in the prone position. All child serving systems within the Department of Public Welfare will work together to eliminate the use of prone restraints in facilities that serve children and reduce the use of restraint all together.

DISCUSSION:

The use of a restraint as an intervention continues to be a concern within Pennsylvania, nationally and internationally. This concern is based upon the risk of serious injury and/or death of the child, youth or staff; emotional harm and trauma to the child, youth, or staff; and the disruption of the relationships between the youth, family members, peers and provider staff, as a result of restrictive procedure use. As such, DPW seeks to support child residential and day treatment providers in promoting environments that enhance a child or youth's quality of life and ensures the safety of the youth and staff.

Restraint should be utilized only as an emergency measure of last resort in order to ensure the safety of all children and staff. Restraints should be used only to prevent a child from injuring himself or others, including preventing a child from absconding from a court-ordered placement. Except in emergency situations where a child is endangering themselves or others, restrictive procedures should only be used after less intrusive behavioral interventions have been employed. Less intrusive interventions include the use of verbal and non-verbal de-escalation techniques by trained staff, such as reducing environmental stimuli, providing a quiet/comfort room¹ and allowing time for the individual to verbalize concerns. Staff should be trained to

¹ A quiet/comfort room is a room that provides sanctuary from stress and/or can be a place for persons to experience feelings within acceptable boundaries. The quiet/comfort room is not an alternative to seclusion and restraint; it is a

engage youth and exhaust alternative options before using a physical intervention to prevent a court-ordered youth from leaving a program. In emergency situations to prevent a youth from harming themselves or others by leaving a program staff are allowed to place hands on youth for the limited purpose of returning them to the safety of the program. Due to the unpredictability of physical, crisis intervention, emergency situations may arise where a youth ends up face down. In these instances, staff should use a transitional movement to another restraint position as safely as possible.

At times it may be appropriate to modify certain facility rules when a child is dealing with a difficult emotional situation. This is not to imply that rules should not be followed, but instead that providers should strike a balance toward changing the environmental rules, if and when certain situations may jeopardize the health and safety of other children and staff. Observation of our youth and knowledge of their history and triggers should lead staff to engage in early intervention of escalating behaviors which remains our best tool for prevention of restraint. Restrictive procedures that respect the dignity of the child or youth should be properly applied by trained staff. Staff should be attentive to the individual's history, prior placement history, triggers, underlying needs and ability to regain control.

Severe, chronic trauma in childhood and adolescence often leads to emotional, cognitive, behavioral and additional problems which may adversely affect a child's development. Therefore, children who display inappropriate behaviors may only be displaying adaptive responses to the life-threatening experiences or trauma that they have faced. Developing supports and skills for children which promote their mentally healthy functioning, in partnership with their families, and the youth themselves, becomes in fact the means to positive long-term outcomes. Children need to be involved in systems which can provide trauma informed care and utilize positive and proactive approaches. Providers that employ trauma informed care make it a priority to listen to children and their families more carefully, so that they can better understand their lives and the challenges they are facing. When children's lives are understood, children can be more successful in overcoming inappropriate behaviors and behavioral health issues.

To achieve trauma-informed care, providers and their staff need to:

- Be respectful of the child and family's perspective and not see themselves as only rule enforcers;
- Meaningfully partner with families, recognizing their complex needs;
- Recognize that a child's placement into an out-of-home setting can also be a source of trauma to children and their families;
- Be educated and committed to providing care sensitive to the child's history of past trauma and current needs;

preventive tool that may help to reduce the need for seclusion and restraint. (LeBel and Stromberg 2004 – National Executive Training Institute)

- Understand that trauma can be measured through the use of various assessment tools;
- Recognize that programmatic changes within the organization may be necessary in providing successful trauma informed care; and
- Understand that staff are professionals and children who have been exposed to trauma will often provoke staff to get attention.

Staff should use debriefing as a restraint reduction tool. Providers should use positive practices, prevention and early intervention techniques and trauma informed care to reduce the use of restraints and/or other restrictive procedures. The use of child-focused approaches and implementation of individualized plans by staff has proven to be effective in helping children and youth to develop self-monitoring and self-control skills. These positive approaches bring about more positive reactions thereby creating a culture of mutual respect between the youth and provider staff.

Through strong leadership, supervision and utilization of the strategies and best practices, outlined in this bulletin, providers can continue to improve their intake screening and assessment processes; case documentation and restrictive procedure planning; increase data collection to show utilization trends; increase the quality and quantity of training and supervision of staff; and increase the use of effective debriefing of incidents with the child, the child's family and provider staff. As these best practices are implemented the following objectives can be achieved:

- Eliminate the unnecessary use of restraints;
- Reduce the use of physical restraint;
- Eliminate the use of prone restraint;
- Eliminate the risk of death;
- Reduce injuries and further trauma to youth and staff;
- Build strong relationships with children and youth to allow effective treatment to occur;
- Reduce the costs which are often incurred by the use of restrictive procedures, such as staff absence, staff turn-over, property damage and workman's compensation claims; and
- Increase family participation in decisions related to their child, which respects the family's culture and perspective and promotes the child and family's health and quality of life.

PRACTICE STRATEGIES AND CONSIDERATIONS:

DPW recognizes that many child residential programs are already using best practice tools to reduce the use of restraint and provide trauma informed care. The Department also recognizes that providers are at different stages of implementation and require unique implementation plans based on the needs of the children and families served and type of service provided. The following six best practice strategies will help facilities to focus on improving the provision of care for children and youth resulting in the reduction of restraints and coercive practices. At a provider's annual inspection or during other site visits, DPW program

representatives will discuss with provider staff how this guidance is being used to eliminate the use of unnecessary restraint.

1. Leadership must support organizational change and adhere to best practice standards.

Management and leadership within residential programs that serve children are responsible for the attitude and culture in their facilities and have the authority to make the changes that are necessary for achieving success in eliminating the use of unnecessary restraint. Consideration should be given to establishing a committee consisting of management and line staff, youth and families to review policy and restrictive procedures use within the facility. Managers must motivate and train staff to implement needed changes and must establish clear policy on the use of restrictive procedures; they should have ongoing meetings to review every restraint to find ways to avoid them in the future. Policies should restrict the use of restraint to emergency situations when the safety of children or staff is jeopardized, and where prior efforts at de-escalation were not effective.

Debriefing after a restraint event is essential to learn about what participated the event but also to proactively attempt to mitigate future events. Facility and staff should be aware of critical events that may upset the child. Often times, calls from home, a court appearance, arguments with staff or other residents can trigger an emotional or physical response from a child under stress. These are the times that staff must take note of what triggers motivate a child to act out.

The agency's policies may need to be revised to reflect that the child or youth not be required to submit to unreasonable expectations in order for the restraint to end. An individual must be released immediately from the restraint when there is no longer a threat or risk to the individual or provider staff, even in the event that the individual does not immediately comply with staff instructions. Effective strategies to end restraints quickly include removing other youth from the area, removing staff that may have angered the child or young adult, or bringing new staff into the situation that have an ongoing, positive relationship with the child.

The facility should ensure effective communication among staff during and across shift changes. Staff are to be informed of changes to a child's restrictive procedure plan in a timely manner. Facilities are strongly encouraged to conduct child specific assessments to determine effective alternatives to the use of restrictive procedures and the types of restrictive procedures to be used that minimize the potential for additional trauma. The outcome of these assessments should be reflected in the child's record. In addition, medications that are used as part of the child's treatment plan may change during the course of treatment. As a result of the medication change, a child's behavior may change

based upon the potential side effects. Direct care staff should be aware of the medication change, in addition to the potential side effects.

Staff must be trained on agency policy and should demonstrate the ability to effectively transfer the application of policy and procedure to their direct care work with children, youth and their families. In addition, family members and youth should have input into the development of facility policy and procedures. Children and families should be oriented to the individualized planning processes and understand that responses to youth may vary according to their individual needs.

2. Use of data to inform practice change.

Many child serving facilities have begun to collect data on the use of restraint. Data collection is an essential component in developing quality improvement protocols. Thorough analysis of data trends including staff training, prevention steps, the associated antecedents, type of restraint, duration, injuries to youth or staff, and debriefing practices is necessary to implement effective systemic change within the facility. DPW is currently working with providers to determine what data elements are being collected so that a common set of elements can be used to measure the reduction of restraint statewide.

3. Workforce development and training for all staff.

Staff must first be aware of the facility's internal guidelines regarding the use of restraint and other restrictive procedures. Each staff person must be trained on the facility's interventions for specific behaviors. In addition, training must offer alternatives to the use of restrictive procedures. Staff members must be trained to recognize a child's specific triggers, warning signs, and how to identify strategies for calming the child, all of which can aid in avoiding the use of restraint. These triggers and strategies shall be identified in partnership with the child and family beginning at the assessment period and continuing thereafter recognizing that triggers may change over time as a child progresses through his/her service/treatment plan.

Facility management is responsible to ensure that direct care staff are transferring the knowledge gained in training into practice. Despite thorough training of staff, emergency situations may arise where restrictive procedures are necessary for safety reasons; therefore annual training in the appropriate use of restrictive procedures must occur.

4. Use of restraint reduction tools.

For the purpose of best practice, it is recommended that all facilities review their admission and intake screening and assessment tools to determine if changes are needed. A thorough screening and appropriate assessments for each child will aid staff in gaining

valuable knowledge about the child's history, attending to the child's daily needs, avoiding future trauma or recurrence of trauma, and the development of a restrictive procedure or crisis management plan. Involvement of the youth and family in the early and ongoing identification of child specific triggers and approaches to mitigate these triggers are essential in our restraint reduction efforts. Engaging youth as partners in the development of their individual treatment and restrictive procedures plans to eliminate restraints leads to more successful outcomes. Lastly, facilities should engage in post-restraint interviews to process the incident and plan to avoid events in the future.

Restraint reduction strategies do not include: Increased involuntary transfers to psychiatric hospitals; increased police intervention; filing assault charges; charging kids as adults or increased discharge of court referred clients from treatment settings as "failure to adjust" (FTA).

5. Include the child and family in organizational change.

Families, children and youth are essential members of the organizational change team. Meaningful family and child input in the design, implementation and monitoring of a quality improvement process provides the facility with valuable information that will lead to improved outcomes for children, families and staff. In addition, the participation of the child and family in the agency's organizational change process will lend increased credibility to these efforts and ensure that the child and family perspectives help inform internal system change.

6. Debriefing techniques

Debriefing requires rigorous analysis of the critical event and should work to reverse or minimize the negative effects of the use of restraint and help management and staff to revise or develop additional strategies to prevent future restrictive procedure use. Generally, there are two types of debriefing: post acute and formal debriefing.

Post acute debriefing should occur immediately after an incident to stabilize the environment and determine why the incident happened and what could have been done differently, by both staff and the child, to improve the outcome. Depending upon the situation, post acute debriefing may need to occur separately for the staff involved and the child. In this case, the staff debriefing should be led by the on-duty supervisor and should allow staff the opportunity to express their feelings regarding the incident.

Formal debriefing is the "formal" review of the incident and includes a broader scope of people. Formal debriefing should occur within 48 hours after the use of a restrictive procedure. Each agency should develop and document, in writing, an internal review process for formal debriefing. The formal debriefing process will aid staff, the child,

family members and other involved partners in determining ways of preventing future episodes and decreasing the frequency of restrictive procedure use. Formal debriefing will aid facilities and programs in providing the best services possible to children and youth and may lead to identification of staff training needs and necessary revisions to provider policy and procedure.

Attendance at the formal debriefing may occur in person or through means of electronic communication and should include representation from the following individuals and/or groups: staff who implemented or witnessed the restrictive procedure; supervisory/management/executive staff (with at least one representative who has the authority to make operational and programmatic changes); clinical staff assigned to the youth (clinical lead, therapist, psychiatrist, etc.), the youth involved in the incident, family members, child advocates and county representatives. Facility staff should provide a supportive environment that is welcoming and non-blaming towards families so that families understand and believe that their input is both valued and results in positive action. A supportive environment would include scheduling meetings at times and locations that support family participation, including evenings and weekends.

During the debriefing the restrictive procedure record should be reviewed. In addition to the restrictive procedure record, it is recommended that the following items also be addressed:

- a thorough discussion about the event which addresses the events precipitating the restrictive procedure;
- changes to the child's plan to determine behavioral management alternatives to avoid crisis for similar situations;
- skills or methods to prevent a future crisis;
- skills to decrease the length of the restrictive procedure which was used;
- recommendations and outcomes (i.e. additional staff training, operational and programmatic changes);
- developing new methods of interacting with individuals; and
- methods to rebuild and enhance the relationship between the child, family and staff as a result of the restraint.

Questions regarding this protocol should be directed to the appropriate DPW regional office. Regional offices can also discuss appropriate restraint holds in the rare occurrences where a child is in danger of hurting themselves or others.

Questions specific to this bulletin may be directed to:

Juvenile Justice Services

Daryl Nelson

717-214-9546

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Child Welfare Services

Ellen Whitesell	717-214-9780	ewhitesell@state.pa.us
Mental Health and Substance Abuse Services		
Scott Talley	717-772-6427	stalley@state.pa.us
Developmental Programs and Mental retardation services		
Pam Kuhno	610-562-6200	pkuhno@state.pa.us

General questions related to the Alternatives to Coercive Techniques Initiative (ACT) and the no prone policy

Office of Policy Development

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