



MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

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SUBJECT:

Elimination of Restraints through Positive Practices

BY:


Kevin T. Casey
Deputy Secretary for Mental Retardation

INTRODUCTION:

The Office of Mental Retardation (OMR) developed this bulletin in conjunction with its participation in the Department of Public Welfare (DPW) Alternatives to Coercive Techniques (ACT) Initiative. ACT is a department-wide initiative with an initial goal of eliminating unnecessary restraints, and an ultimate goal of having all serving systems be restraint free. ACT partners within DPW include the Office of Mental Retardation, the Office of Mental Health and Substance Abuse Services (OMHSAS), the Office of Children, Youth and Families (OCYF) and the Office of Medical Assistance Programs (OMAP). OMR is committed to supporting effective cross system collaborations for any child or adult served within DPW with a diagnosis of Mental Retardation (MR).

This bulletin outlines the core strategies that are essential in implementing a successful restraint elimination initiative, and provides guidance to consumers, families, providers, advocates and county agencies. Our goal is to reduce and eventually eliminate restraint except in situations of immediate jeopardy and imminent danger, because every person is entitled to be cared for in a violence and coercion free environment.

SCOPE:

Providers who receive funds from the mental retardation system, either directly or indirectly, to provide or secure supports or services for individuals authorized to receive services from a county mental retardation program and providers licensed by the OMR should consider themselves within the scope of this bulletin. This includes but is not limited to the following entities:

- County Mental Health/Mental Retardation Administrators
- Administrative Entities
- Base Service Unit Directors
- Community Residential MR Directors
- Family Living Directors
- Adult Training Facility Directors
- Vocational Directors
- State ICF/MR Directors
- Non State ICF/MR Directors

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
THE APPROPRIATE REGIONAL PROGRAM MANAGER.

PURPOSE:

The purpose of this bulletin is to recommend practices that will assist in the elimination of the need for restraint. Creating a culture of supports that reduces the need for restraints is essential for building an environment that enhances each individual's quality of life. Individuals who are registered with a county mental retardation program or who receive supports and services from facilities licensed by the Department of Public Welfare's Office of Mental Retardation (OMR) are afforded the protections detailed in this bulletin.

This bulletin provides information on the risks associated with restraint as well as information on developing best practice policies and procedures for the reduction and eventual elimination of the need for restraint. It is OMR's desire to work collaboratively with those listed in the scope of this bulletin toward a system in which restraints are seldom used, and then only as a last resort safety measure rather than a behavioral intervention.

As we move toward the reduction and eventual elimination of restraints, the MR system will continue to face challenges. OMR will use the existing Incident Management data as well as ongoing feedback with a multitude of stakeholders to increase our knowledge of the struggles and successes occurring with restraint reduction and elimination throughout our system. OMR will use this knowledge as an evaluation tool to further guide best practices. (The Positive Approaches Paradigm¹) is a cornerstone in achieving the desired culture where the use of restraint is no longer necessary. Also key in this progression is recognizing the impact of trauma and utilizing the tenets of trauma informed care². The recommendations in this bulletin are considered by OMR to be practices that will assist in the elimination for the need for restraint and do not replace or supersede existing regulations.

This Bulletin does not eliminate the use of restraints as an emergency safety intervention.

BACKGROUND:

The elimination of restraints is a key factor in ensuring that individuals experience a quality of life that is consistent with the *Everyday Lives* philosophy. The values inherent in *Everyday Lives* and *Positive Approaches*³ suggest that restraints and restrictive procedures can be drastically reduced and many times eliminated by focusing on what the individual is trying to communicate, how we help to guide the individual's efforts in moving towards positive outcomes, and by ensuring that each individual is properly diagnosed and receiving quality supports. The use of restraints as a behavioral intervention continues to be a concern both in Pennsylvania and nationally due to the risk of serious injury and death, emotional harm and trauma, and the disruption of relationships with family members, peers, and staff. Except in case of emergency, OMR is dedicated to the need for ongoing reduction and the eventual elimination of all restraints and restrictive procedures.

Over the past 10 years, the MR service system in Pennsylvania has made significant progress in supporting individuals who may demonstrate challenging behaviors. Policies and intensive training programs that are strongly based on positive approaches have been effective in the development of services that are focused on support and treatment strategies, i.e. positive practices. Positive practices are defined as person-centered approaches toward applying the Positive Approaches Paradigm. Positive Practices emphasizes learning and teaching alternative behavior within a positive framework rather than using negative consequences or punishment to stop behaviors that are undesirable or dangerous.

OMR supports national and statewide efforts to eliminate the use of restraints and restrictive procedures. To promote this endeavor, OMR issues this bulletin to establish recommended practices that promote moving toward a restraint-free service system. OMR recommends that all providers, on an individual and organizational level, thoroughly examine the reasons for the use of restraints and their overall approaches to positively supporting individuals with challenging behaviors. Viable alternatives that will eliminate the use of restraints are needed to support and improve each individual's quality of life. The integration of behavioral supports is unique to each individual and will be a chief component of each Individual Support Plan (ISP). OMR will provide technical assistance through regional support teams, Health Care Quality Units (HCQU's), statewide instructional meetings, and other means as available.

A DPW objective is to utilize all available resources to safely reduce and eventually eliminate all restraints and restrictive procedures.

Philosophy of Care and Support

OMR encourages all providers to focus on positive approaches and the Positive Approaches Paradigm. Essential to this approach is developing a culture in which behavior is recognized as communication. Facilitating the understanding of this communication and the use of alternate modes and methods of communication is an integral part of self-determination and achieving an Everyday Life. The following value statements emphasize the importance of such a culture and the need to permeate all levels of the MR system:

- The individual is the central focus of the planning team. Family members on the team can be instrumental in suggesting prevention strategies and positive practices specific to the individual.
- Creating a safe and supportive person-centered environment where individuals have choices in matters affecting their everyday lives.
- Staff understanding and incorporating these philosophies is critical at every level, from direct support professionals to managers, in order to create a culture that supports positive approaches. All staff members should be knowledgeable in the positive practices and in the safe use of any restrictive procedure.
- The use of positive practices that are known to be effective in helping the individual. There are a variety of positive practice techniques that may negate the use of restraints. This type of knowledge should be integral in an organization's overall operations and training as well as being explicitly evident in each ISP.
- Prevention and early intervention are critical parts of any plan to support the individual when reducing and eliminating restraints and other restrictive procedures.
- All staff members should be knowledgeable about the use of positive practices specific to the individual they support and be able to demonstrate them where needed. This includes the integration of behavioral and environmental supports that have proven effective for each individual.
- Teaching skills of self-monitoring and self-control to individuals and staff persons.

- Creating a culture of respect and ensuring ongoing training for staff that focuses on all forms of positive practices.

Continuous Risk Management and Quality Efforts

OMR recommends that the following Quality Management efforts be implemented in an effort to reduce and eventually eliminate restraints. Each provider should emphasize ongoing quality improvement efforts through the utilization of their existing risk management processes for the purpose of ongoing review, assessment, and analysis specific to the use of restraints. One way to organize continuous risk management and quality efforts around restraint reduction is by using the framework of practice strategies and considerations outlined in the Department of Public Welfare's (DPW) Special Transmittal⁴ entitled: "*Strategies and Practices to Eliminate the Need for the Use of Restraint*". The six core strategies compliment the recommendations listed below and address broad issues such as leadership, the use of data, and debriefing.

1. Training

Training should be ongoing for all staff and should focus on overall supports for improving an individual's quality of life while maintaining his or her health and welfare. Acknowledging that there are providers that continue to serve and support individuals in a restraint-free environment and provide extensive training for their staff, these guidelines are to be viewed as minimal expectations to help support the person and create a structure that prevents restraint. All providers should have procedures in place that address how people are supported in emergency situations where an individual's health and welfare may be at risk.

All staff should have initial training within 30 calendar days after their first day of employment and prior to working directly with an individual, or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restraints is needed only for those providers who utilize restraint as part of their operating procedures. OMR does not endorse any one curriculum; however, the following is a list of recommended curricula content:

- Environmental design and social, physiological, and cultural motivators for behavior, including information on individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers.
- Positive practices and behavioral support methods that include techniques to de-escalate behavior; listening and communication skills; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a functional analysis.
- Information on "best practice" methods for interacting with individuals who have a dual diagnosis of mental retardation and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.
- Person-centered alternatives to the use of restraint, including an understanding of which positive practices are most effective with particular individuals and teaching strategies that emphasize prevention of future negative incidents. This includes the integration of effective behavioral supports.

- Basic training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger individual safety.
- Awareness of an individual's health history in order to assess increased risk that may occur during the application of a restraint.
- The use of physical restraints, including the proper application of restraints appropriate to the age, weight, and diagnosis of the individual. Also, possible negative psychological effects of restraint and monitoring an individual's physical condition for signs of distress or trauma.
- Definitions of restraint; policies on the use of restraints; the risks associated with the use of restraints; and staff experience the use of physical restraint applies to themselves. This includes debriefing techniques with the individuals they support as well as staff members.

2. Risk Management

OMR recommends that each provider's comprehensive Risk Management Process include:

- Emphasis on ongoing quality improvement efforts directed at reducing and eliminating the use of restraints by using their existing risk management process to review, assess, and analyze their use of restraints on an ongoing basis. A provider- specific plan to proactively address the prevention, detection, evaluation, and correction of any environmental factors and triggers that may lead to the use of restraints should also exist.
- Use of debriefing procedures that address the needs directly following a restraint as well as a more formal debriefing session where events and strategies are discussed in greater depth and detail. The debriefing sessions should work to address trauma and minimize the negative effects of the use of restraint while addressing the following components:
 - Thorough analysis of the events that occurred before, during and after each incident.
 - Strategies to prevent or decrease the time of future restraints
 - Skills or methods to prevent a future crisis.
 - Appropriate additions, deletions, or modifications to an individual's plan, recommendations and outcomes.
- An internal review committee responsible for the review of post-emergency restraint follow-up and the outcomes of that follow-up.
- A provider's Risk Management policy that includes consistent data collection and review of restraint use in accordance with the requirements of MR Bulletin 6000-04-01 entitled "*Incident Management.*"

3. Administrative Review

OMR recommends the following additional review methods:

- The County MH/MR Program or Administrative Entity should review each provider's policies on behavioral supports, restrictive procedures, and restraint use in order to ensure that they comply with current OMR policy. OMR's Bureau of MR Program Operations will review each state center's policies on behavioral supports, restrictive procedures, and restraint use in order to ensure that they comply with current OMR policy.
- OMR Licensing Representatives and the Department of Health Program Representatives, as part of their annual surveys and program monitoring, will review each respective provider in regards to policies on behavioral supports, restrictive procedures, and restraint use.

Reducing Restraints and Restrictive Procedures

Restraint is not treatment or a substitute for treatment. The use of restraints for punitive purposes, discipline, staff convenience, retaliation, or coercion is considered abuse. Each provider is asked to pursue alternative strategies to the use of restraint. For example, physical restraints are used only as a last resort safety measure when there is a threat to the health and safety of the individual or others, and only when less intrusive measures such as redirection, reflective listening, and other positive practices are ineffective in each situation. In the event that a restraint is used, this should be recognized as a trauma to the individual. The restraint has the potential to affect an individual's long and short term mental health, manifest behaviors, affect the relationships they have with staff, and alter their overall care and needs. Recognition that past incidents of restraint should also be viewed as incidents of trauma is essential in eliminating the need for restraint. In order to support this goal OMR recommends that the following measures be implemented as part of all behavior support plans.

- *Seclusion is not used.* Seclusion is defined as placing an individual in a locked room. A locked room includes a room with any type of engaged locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.
- *Chemical restraint is not used.* Chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.
 - When a physician orders a medication that is part of the ongoing individualized plan and has documented as such for treating the symptoms of mental illness, the medication is not considered a chemical restraint.
 - The use of Pro Re Nata (PRN) medication will be done in accordance with procedures outlined in MR Bulletin 00-02-09 entitled "*Pro Re Nata Medication Usage For Psychiatric Treatment – Clarification of Interpretation*". "When utilized, it shall include a post review protocol by the provider's quality improvement/risk management committee to ensure that use of the medication was consistent with the Bulletin's expectations.
- *Mechanical restraint is not used.* Mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of

an individual's body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices.

- When a physician orders a mechanical device to protect the individual from possible harm following surgery or an injury, it is not a mechanical restraint. Examples of mechanical devices that are not restraints include a device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not considered mechanical restraints.
- Manual restraints, also commonly referred to as physical restraints, are used only as a last resort safety measure when the individual is in imminent danger of harming oneself and/or others and other measures are ineffective. Manual restraint is currently defined per 55 PA Code § 6500.172, 6400.202, 2380.161 as a hands-on technique that lasts more than 30 seconds. When a hands-on technique occurring for less than 30 seconds is used to guide or redirect the individual away from potential harm/injury, it is not a physical restraint.
- Certain manual restraints or specific techniques are considered especially problematic and known to increase the risk of injury and death. Given the potential danger and liability related to these actions OMR recommends that the following be implemented:
 - Prone (face down) manual (physical) restraint is not used.
 - No manual restraint that inhibits the respiratory and/or digestive system is used.
 - No manual restraint that involves compliance through the infliction of pain, hyperextension of joints, and pressure on the chest or joints is used.
 - No use of 'takedown' techniques in which the individual is not supported and/or that allows for free fall as the individual goes to the floor.
 - An individual's physical condition is evaluated throughout the restraint in order to minimize the potential of individual harm or injury.
 - Manual (physical) restraint does not exceed 30 minutes within a two-hour time period, per 55 PA Code § 6500.172, 6400.202, 2380.161 part (d).
 - An individual is immediately released from physical restraint when they no longer present a danger to self or others.
 - Support staff monitor the individual for signs of distress throughout the restraint process and for a period of time (up to two hours) following the application of a restraint.

As a way to reduce, and work toward the goal of eliminating restraint it is recommended that providers and Supports Coordinators, consider that the following standards are met before they authorize the use of any restraint:

- Providers train staff in appropriate safety, de-escalation, and crisis management techniques.
- Staff use only the manual (physical) restraints for which they were trained.
- All restraints should be reported in the Home and Community Services Information System (HCSIS) in accordance with the requirements of MR Bulletin 6000-04-01 entitled “*Incident Management.*”
- Staff members responsible for writing support plans should have a minimum of six hours per year of training for professional growth pertinent to state-of-the-art assessment and treatment strategies for individuals with challenging behavioral issues.
- A statement requiring clearance by a physician for the type of procedure to be used with an individual whose restraint reduction plan incorporates the possible use of emergency restraint to protect the individual’s health and safety.
- Restraint, as a behavior modification technique or any use other than to protect health and safety, should not be incorporated as part of any ISP or as the method for modifying and/or eliminating behavior in a behavior plan.
- Restraint is *always* a last resort emergency response to protect the individual’s safety. Consequently, it is never used as a punishment, therapeutic technique or for staff convenience. The individual is immediately to be released from the restraint as soon as it is determined that the individual is no longer a risk to him/herself or others.
- Administrators, supervisors, clinical and direct care staff are accountable for the safe initiation, continued usage and termination of restraint procedures in accordance with established requirements.
- Individual and team involvement in a post-restraint debriefing is critical to determine how future situations can be prevented. It is important, as part of the ongoing planning process to review each occurrence of restraint. Information from the debriefing sessions should, at minimum, be included in the Supports Coordinator monitoring update. These discussions can be separate and distinct with the intended purpose of determining what could have been done differently to avoid the restraint. Any changes to the individual’s plan shall be documented in the ISP.
- Consideration should be given to the potential for trauma related issues. A trauma assessment and training in trauma informed care would be a great benefit in addressing future incidents.

It is recommended that all Providers develop agency wide policies and procedures for the reduction and eventual elimination of restraint. These policies and procedures should outline the specific steps to be taken for the elimination of restraint components in any individual plan as well as general policies and procedures promoting the goal of restraint elimination.

For providers working toward eliminating the need for restraint it is recommended that within one year from the effective date of this bulletin, person centered restraint elimination strategies containing the following positive components be incorporated into all individuals ISP’s. Applicable behavior plans

for individuals that have experienced restraint in the past year should also contain these positive components:

- The ISP should reflect an overall strategy to support and provide services for the person without the need for restraint. If it is felt the individual exhibits behavior that may put the individual at risk of injury to themselves or others, the ISP should reflect strategies that will reduce the likelihood of restraint and protect the person.
- Information about the occurrence of the problem behavior and what specific positive practices can be used to prevent future occurrences. This includes several suggested teaching strategies and intervention techniques that de-escalate or redirect the individual's behavior, as well as information regarding what positive components are currently effective.
- Justification that the proposed plan contains the most effective methods of helping the individual deal with the problem behavior while promoting the safety of the individual and others.
- Information regarding what procedures were unsuccessful in the past and what other positive alternatives might be incorporated in the future if the current alternatives are proven to be ineffective.
- A review of "Sentinel Events" (defined as situations that had the potential for the need for a restraint but the restraint was avoided) to learn and communicate what worked well in avoiding the restraint.
- The types of procedures to be used with an individual whose restraint reduction plan incorporates the possible use of emergency restraint in order to protect the individual's health and safety.

Please contact the Dual Diagnosis point person at the appropriate OMR regional office for information on joining a local Mental Health Support Process (MHSP) group or for further information on additional support in your area. If you are unsure of what OMR regional office to contact please call the OMR customer service number at 1-888-565-9435

Central Region Office of Mental Retardation, Willow Oak Building, Room 430, Harrisburg, PA 17105
(717) 772-6507

Northeast Region Office of Mental Retardation, 100 Lackawanna Avenue, Scranton, PA 18503
(570) 963-4749

Southeast Region Office of Mental Retardation, 1400 Spring Garden Street, Room 306, Philadelphia, PA 19130 (215) 560-2245

Western Region Office of Mental Retardation, 300 Liberty Avenue, Pittsburgh, PA 15222
(412) 565-5144

Additional Resources

- **MR Bulletin 00-04-05** *Positive Approaches*
- **MR Bulletin 00-03-05** *Principles for the Mental Retardation System*
- **Bulletin 00-02-16** *Coordination of Treatment and Support for people with a diagnosis of serious mental illness who also have a diagnosis of mental retardation*
- **OMHSAS Bulletin 02-01** *The use of Seclusion and Restraint in Mental Health Facilities and Programs*
- **Systems Taking Action and Responsibility-Together**, *Successfully Treating and Supporting People with Co-Occurring Mental Illness and Mental Retardation*
- **DPW Special Transmittal** (2006) *Strategies and Practices to Eliminate the Need for the Use of Restraint*
- Hodas, Gordon R. (2005) *Understanding and Responding to Childhood Trauma: Creating Trauma Informed Care PA Office of Mental Health and Substance Abuse Services*
- LeBel, J., and Goldstein, R. (2005): The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56,(9), 1109-1114.*
- National Executive Training Institute (NETI). (2005) *Training curriculum for reduction of seclusion and restraint. Curriculum manual.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC).
- Lovett, H. (1985). *Cognitive counseling and persons with special needs: Adapting behavioral approaches to the social context.* New York: Praeger.
- Lovett, H. (1996). *Learning to listen: positive approaches and people with difficult behavior.* Baltimore: Paul H. Brookes Publishing Co.
- O'Brein, J & Lovett, H., 1992 *Finding a Way Toward Everyday Lives. The Contribution of Person Centered Planning.* Pennsylvania Department of Public Welfare, Office of Mental Retardation. Harrisburg, PA.

Relevant Websites

<http://pacassp.psych.psu.edu/DPWACT/home.htm> - The Annotated Bibliography on Alternatives to Coercive Techniques (ACT) provides a wealth of resources on eliminating the need for restraint

<http://www.nasddds.org/SymposiumOnCoOccurringConditions.shtml> - National Association of State Directors of Developmental Disabilities Services

<http://www.qualitymall.org/directory/dept1.asp?deptid=42> -Features products that assist persons with developmental disabilities in managing their feelings appropriately and dealing with common mental health issues such as depression, anxiety disorders, and drug and alcohol problems

<http://www.thenadd.org/> - The National Association for the Dually Diagnosed (NADD). The mission of NADD is to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.

1. The Positive Approaches Paradigm is comprised of four major components: Environment, Communication, Assessment, and Hanging in There. More detailed information on the topic can be found in *The Pennsylvania Journal of Positive Approaches*, Vol. 1, No. 1, 1996.

² Hodas, Gordon R. (2005) *Understanding and Responding to Childhood Trauma: Creating Trauma Informed Care PA Office of Mental Health and Substance Abuse Services*

³ MR Bulletin 00-04-05 *Positive Approaches*. *Positive Approaches* is also a quarterly publication dedicated to helping people with developmental disabilities and challenging behaviors live fulfilling Every Day Lives.

⁴ DPW Special Transmittal (2006) *Strategies and Practices to Eliminate the Need for the Use of Restraint*