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<tr><td rowspan="2"> </td><td colspan="3">COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE</td></tr>
<tr><td>DATE OF ISSUE
12/19/09</td><td>EFFECTIVE DATE
June 21, 2010</td><td>NUMBER
3800-09-01</td></tr>
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SUBJECT	BY
Strategies and Practices to Eliminate the Use of Unnecessary Restraints	Estelle B. Richman, Secretary, Department of Public Welfare Richard J. Gold, Deputy Secretary for Children, Youth and Families Joan L. 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
Office of Developmental Programs 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, supervised or funded by the Department of Public Welfare (Department) to assist in the implementation of strategies and practices that lead to the elimination of unnecessary restraint through promoting environments free of violence and coercion and the safe and best practice management of children[1].

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 will work together to eliminate the use of prone restraints in facilities that serve children and reduce the use of restraint altogether.

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 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, as a result of restrictive procedure use. As such, the Department seeks to support child residential and day treatment programs in promoting environments that enhance a child's quality of life and ensures the safety of the child 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, or from absconding from a placement program. The child's individualized treatment plan and restrictive procedures plan[2] should address the use of restraint as an emergency measure.

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[1] Throughout this document the term "child" or "children" refers to anyone up to the age of 21, including older youth.

[2] For the purposes of this bulletin, a "restrictive procedure" refers to a restraint, exclusion or

Except in emergency situations where a child is endangering himself or others, restraints 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 room and allowing time for the individual to verbalize concerns. Staff should be trained to engage the child and exhaust alternative options before using a physical intervention to prevent a court-ordered child from leaving a program. Staff is expected to intervene in emergency situations to prevent a child from harming themselves or others by leaving a program. If less intrusive behavioral interventions have been employed and the child is still in danger of leaving the program, staff is allowed to place hands on the child for the limited purpose of preventing the child from absconding or returning the child to the safety of the program. Due to the unpredictability of physical, crisis intervention, emergency situations may arise where a child ends up face down. In these instances, staff should use a transitional movement to another restraint position as soon as safely possible.

Observation of our children and knowledge of their history and triggers should lead staff to engage in early intervention of escalating behaviors that remains our best tool for prevention of restraint. Restraint procedures that respect the dignity of the child should be properly applied by trained staff. Staff should be attentive to a child's history, prior placement history, triggers, underlying needs and ability to regain control. Programs should provide a full range of positive, developmentally appropriate interests and activities, which in turn should reduce the possibility of aggressive episodes.

The occurrence of 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 mental health functioning, in partnership with their families, and themselves, becomes 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. Programs 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.

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other means of modifying behavior. A "restrictive procedures plan" is a plan that addresses the behavior, observable signals or triggers that might precipitate that behavior, suggestions to modify or eliminate the problematic behavior, types of restrictive procedures that can be used and under what circumstances and other requirements specificied in 55 Pa. Code § 3800.203 (relating to restrictive procedure plan).

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

- Be respectful of the child and family's perspective.
- 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.
- Understand that trauma can be measured through the use of various assessment tools, i.e. Functional Behavioral Assessments.
- Recognize that programmatic changes within the organization may be necessary to provide successful trauma-informed care.
- 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. Programs should use positive practices, prevention, and early intervention techniques and trauma-informed care to reduce the use of restraints 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 develop self-monitoring and self-control skills. These positive approaches bring about more positive reactions thereby creating a culture of mutual respect between the child and program staff.

Through strong leadership, supervision and utilization of the strategies and best practices outlined in this bulletin, programs 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, family and 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 children and staff;
- Build strong relationships with children 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 worker's compensation claims; and
- Increase family participation in decisions related to the child that respects the family's culture and perspective and promotes the child and family's health and quality of life. Engaging the family in discharge planning increases the probability for sustained success

in the home and community.

PRACTICE STRATEGIES AND CONSIDERATIONS:

The Department recognizes that many programs are already using best practice tools to reduce the use of restraint and provide trauma-informed care. The Department also recognizes that programs 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 programs focus on improving the provision of care for children resulting in the reduction of restraints and coercive practices. At a program's annual inspection or during other site visits, Department program representatives will discuss with staff how this guidance is being used to eliminate the use of unnecessary restraints.

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

Management and leadership within programs that serve children are responsible for the emotional climate 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, children and families to review policy and procedures. Managers must motivate and train staff to implement needed changes and must establish clear policy on the use of restraints. The committee 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 is essential to learn about what caused the event, but also to proactively attempt to mitigate future events. Management 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 children 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. There are a variety of strategies that can be employed in treatment planning to help anticipate triggers and the types of events that might lead to escalating negative behavior.

Appropriate interventions should be developed for children who are clinically recognized as at risk for restraint. Children with one or more developmental disabilities including autism spectrum disorders, learning disabilities, intellectual disabilities (mental retardation) and attention disorders are at high risk of restraints because of difficulty understanding language or social contexts, slow processing of information, impulsivity, poor motor planning, challenging behaviors, problems with transitions, or difficulty being in group settings. As these children are more vulnerable for escalating, aggressive behaviors, they require specialized approaches that are

individualized for their specific needs including strategies such as more structured activities, lower client to staff ratios, more time to transition, and more visual and verbal cues.

The program's policies may need to be revised to reflect that the child should not be required to submit to unreasonable expectations for a restraint to end. A child must be released immediately from the restraint when there is no longer a threat or risk to the child or staff. Effective strategies to end restraints quickly include removing other children from the area, removing staff that may have angered the child, or bringing new staff into the situation that have an ongoing, positive relationship with the child.

Best practice standards include medical monitoring in conjunction with the use of restraint, including monitoring vital signs during a restraint, and a nursing assessment following the use of a restraint. Management should ensure that staff is trained on underlying medical conditions that may be exacerbated during any type of restraint.

The program should ensure effective communication among staff during and across shift changes. Staff need to be informed of changes to a child's restrictive procedure plan in a timely manner. Programs are strongly encouraged to conduct child specific assessments to determine effective alternatives to the use of restraints 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 program policy and should demonstrate the ability to effectively transfer the application of policy and procedure to their direct care work with children and their families. All staff should be trained on each child's restrictive procedures plan and immediately alerted to any changes to this plan. In addition, family members and the child should have input into the development of program policy and procedures. Children and families should be oriented to the individualized planning processes and understand that responses to the child may vary according to their individual needs.

2. Use of data to inform practice change.

Child-serving programs have begun to collect data on the use of restraint. Data collection is an essential component in developing quality improvement protocols. Programs are encouraged to maintain their own data collection system on restraint usage to ensure access to timely data. Admission criteria, presenting problems, diagnosis history and discharge patterns should be considered as part of analyzing data. Thorough analysis of data trends including staff training, prevention steps, the associated antecedents, type of restraint, duration, injuries to the child or staff, and debriefing practices is necessary to implement effective systemic change

within the program.

3. Workforce development and training for all staff.

Staff must first be aware of the program's internal guidelines regarding the use of restraint and other restrictive procedures. Staff must be trained on the program's interventions for specific behaviors. In addition, training must offer alternatives to the use of restraints. Staff 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 should 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 the child's treatment plan.

Program management is responsible to ensure that direct care staff is transferring the knowledge gained in training into practice. Despite thorough training of staff, emergency situations may arise where restraints are necessary for safety reasons; therefore annual training in the appropriate use of restraints must occur. Staff should follow the crisis intervention curriculum used by the program. Refresher trainings should occur on a regular basis. If time and staff schedules present challenges to conducting formal refresher trainings, management should consider utilizing existing meetings and presenting brief, specific areas of training to review with staff.

4. Use of restraint reduction tools.

For the purpose of best practice, it is recommended that all programs 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 procedures plan. Involvement of the child 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 the child as a partner in the development of their individual treatment and restrictive procedures plans to eliminate restraints leads to more successful outcomes. Lastly, programs should engage in post-restraint interviews to process the incident and plan to avoid events in the future.

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

5. Include the child, family and community in organizational change.

Families and children must be included in moving towards organizational change. Meaningful family and child input in the design, implementation and monitoring of a quality improvement process provides the program 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, invest the child, family and community in the process and develop a shared interest in the outcome and inform internal system change.

6. Debriefing techniques.

Debriefing requires rigorous analysis of the restraint 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 restraint 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 restraint and includes a broader scope of people. Best practice standards suggest that formal debriefing should occur within 48 hours after a restraint. Each program should develop and document, in writing, an internal review process for formal debriefing. The formal debriefing process will aid staff, children, family members and other involved persons in determining ways of preventing future restraints and decreasing the frequency of restrictive procedure use. Formal debriefing will aid programs in providing the best services possible to children and may lead to identification of staff training needs and necessary revisions to program 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 or groups: staff who implemented or witnessed the restraint which includes supervisory, management or executive staff (with at least one representative who has the authority to make operational and programmatic changes); clinical staff assigned to the child (clinical lead, therapist, or psychiatrist), the child involved in the incident, family members, child advocates and county representatives. Program 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 procedures plan should be reviewed. In addition to the restrictive procedures plan, it is recommended that the following items also be addressed:

- A thorough discussion about the event which addresses the events precipitating the restrictive procedure, including methods to prevent a future crisis and a discussion on what could have been done differently to prevent the restraint event.
- Changes to the child's restrictive procedures plan to determine behavioral management alternatives to avoid crisis for similar situations.
- Skills to decrease the length of the restrictive procedure which was used.
- Recommendations and outcomes (i.e. additional staff training, operational and programmatic changes).
- Development of new methods of interacting with individuals.
- 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 Department regional office. Regional offices can also discuss appropriate restraint holds and restraint reduction strategies.

Questions specific to this bulletin may be directed to:

Juvenile Justice Services
Daryl Nelson 717-214-9546 darnelson@state.pa.us
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
Angie Logan 717-772-4141 anglogan@state.pa.us