Spotlight on Prevention

Partnering to Protect People with Special Needs

Reducing the Use of Restraints for People in Care:

The NYS Justice Center for the Protection of People with Special Needs (Justice Center) is committed to supporting and protecting the health, safety, and dignity of people with special needs. Justice Center efforts to fulfil this commitment include abuse prevention initiatives that target specific areas of abuse and neglect, such as this Spotlight on reducing the use of restraints and preventing the deliberate inappropriate use of restraints for people in care.

Placing a person in a restraint puts the person and staff member at risk of trauma, injury, and even death. According to one study, between 50 to 150 people die each year in the United States as a result of seclusion and restraint practices. Furthermore, injury rates to staff in mental health settings where seclusion and restraint are used have been found to be higher than injuries that are sustained by workers in high-risk industries including lumber, construction and mining.[iii] Medical providers now recognize that placing a person in care in a restraint can be highly traumatic and often works against the model of trauma informed care.[iii] While crisis management programs support the use of restraints when absolutely necessary, restraints are commonly used to address loud, disruptive, resistant behavior and can originate from a power struggle between a person in care and staff.[iv] The Medical Director's Council of the National Association of State Mental Health Program Directors (NASMHPD) have deemed the use of restraint as a "treatment failure," and recommend a focus on preventing the use of restraint and seclusion. Given the risks associated with restraints for everyone involved, it is important to aim to find safe alternatives for de-escalating and preventing a crisis.

Commonly used crisis management programs currently in place at provider agencies in New York State include:

- Positive Relationships Offer More Opportunities to Everyone (PROMOTE)
- Strategies for Crisis Intervention and Prevention Revised (SCIP-R)
- Therapeutic Crisis Intervention (TCI),
- Crisis Prevention and Management (CPM) and

- Preventing and Managing Crisis Situations (PMCS).

These programs encourage the use of a wide range of non-physical skills, prevention and de-escalation techniques to assist staff in reducing the need for a restraint. Crisis management programs provide staff members with the skills and knowledge needed to recognize patterns or cues, including environmental factors and the effect of staff's interactions which precede a person in care going into crisis. In addition, these programs encourage debriefing for the person in care and all staff members involved to identify necessary supports and steps that need to be taken to return to normal conditions.

Despite the availability of these crisis management programs, the Justice Center has received numerous reports of incidents involving a person in care being subjected to a deliberate, inappropriate use of a restraint. A deliberate, inappropriate use of a restraint is defined in NYS Social Services law. It means the technique or amount of force used, or situation in which the restraint was used was inconsistent with a person's treatment plan, generally accepted treatment practices and/or applicable state laws, regulations or policies except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm.[v] Restraint is defined by statute as any manual, pharmacological or mechanical measure or device used to immobilize or limit the ability of a person to freely move their arms, legs or body.

The Justice Center analyzed two and half years of data on substantiated cases of deliberate inappropriate use of restraints to identify the factors contributing to this form of abuse, and to identify strategies to prevent it. Twenty-three percent of these cases involved a category two substantiation for deliberate inappropriate use of restraints indicating that the staff who conducted the restraint seriously endangered the health, safety or welfare of a person in care. The information and documentation collected during the investigation that was included in the case record was analyzed to develop this Spotlight on Prevention.[vi] The findings support current research on restraints that reinforce the importance of rigorous use of prevention and de-escalation strategies to prevent hands on interventions and to keep everyone safe.[vii]

The areas analyzed included:

- precipitating factors leading to the restraint,
- time and location of the restraint,
- demographic information on the person in care and staff member(s) including length of employment of the staff, and
- injury and/or impact of the restraint on the person in care.

The leading precipitating factors to the deliberate and inappropriate use of a restraint were verbal or physical aggression by either the person in care or the staff member(s) and/or evidence that the person in care was agitated. This data suggests that power struggles between staff members and people in care can unnecessarily escalate a situation. This finding reinforces the importance of more rigorous efforts to use consistent and well thought out prevention and de-escalation techniques to avoid unnecessary physical contact. De-escalation techniques did not appear to be applied effectively in the substantiated cases reviewed.

Over ninety percent of the cases reviewed involved the use of a manual restraint and the majority occurred during the day in a common area within the program. This finding indicates there is a high likelihood that there are often witnesses to the restraint who may also be impacted by the event. Given the high rates of trauma in the people served, it is important to ensure that everyone, including those who witnessed a restraint, are debriefed and offered support.

The age range for the victims involved in the deliberate inappropriate use of a restraint was between nine and eighty-five years of age, with a median age of seventeen years old. The victims were primarily male. The length of employment for the staff person involved in the substantiated allegation of a deliberate, inappropriate use of restraint was also examined. Some staff involved in these substantiated cases had been employed less than a year and others had been working in the field more than five years. These findings reinforce the importance of a thorough debriefing of both the staff member(s) and the person in care as an opportunity to learn from the incident including identifying the precipitating factors to the restraint, assessing effectiveness of the intervention, and identifying de-escalation and crisis prevention skills in need of improvement.

The deliberate inappropriate use of a restraint resulted in a physical injury sixty percent of time in the substantiated cases reviewed. The most common injuries included head injuries, scratches, scrapes and bruising. In several cases the person in care demonstrated psychiatric distress following the restraint.

Programs that have reduced or eliminated restraints have reported a number of positive outcomes including: reduced injuries to people in care and staff, reduced staff turnover, high staff satisfaction, reduced lengths of stay for people in care, sustained success in the community after discharge and a significant cost savings.[viii] An environment that emphasizes a commitment to safe, therapeutic, and trauma informed care can be promoted by setting a goal to reduce or eliminate restraints, monitoring the use of restraints, and supporting staff members to ensure that they are receiving the training and self-care they need.

Whether you are a person receiving services, care provider, agency administrator, friend or family member, or advocate for people receiving services, you have an important role in preventing a needless tragedy from happening. The information provided in this toolkit is aimed at raising awareness of the serious dangers of restraints, and encouraging the reduction or elimination of restraints by promoting positive alternatives. The toolkit includes:

- case reviews and lessons learned;
- fact sheets for providers, staff members, advocates and people in care;
- a sample debriefing policy; and
- a sample staff self-care document.

Case Reviews and Lessons Learned

The Risk of Restraints

- Increased risk of injury for the staff member and person in care
- Psychological/Emotional Effects: depression, withdrawal, isolation, anger, frustration, demoralization, increased agitation, hostility
- Trauma or re-traumatization for staff member(s) and person in care
- Interferes with relationship between staff member(s) and person in care
- Death due to positional asphyxia, aspiration, agitated or excited delirium

These case reviews involve fictitious victims and represent a collection of facts identified from multiple case investigations. They are used for illustrative purposes only.

Case #1

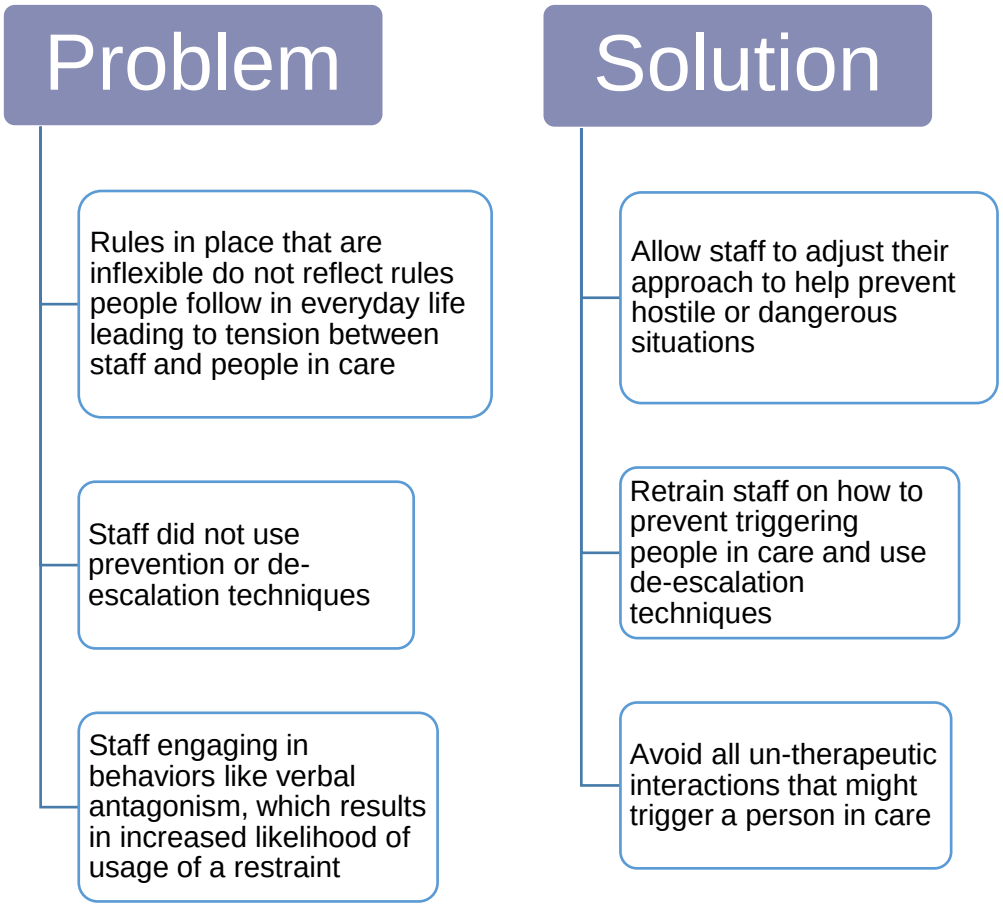
Issues:

- **Power and control**
- **Staff member escalation**

Case Description

Jacob, a nine-year-old in care, had more than the three books that were allowed in his room. Kyle, a staff member, told Jacob he could not have that many books. Jacob became upset and said that he needed the extra books for school. A supervisor intervened and Jacob eventually put some books in the storage room. Kyle began to antagonize Jacob, making comments about Jacob's mom and further escalating the situation by verbally threatening Jacob. Jacob pushed Kyle away and carried his books back to his room. Kyle followed Jacob and initiated a restraint.

After the incident, Jacob reported that he was frustrated and confused and said he could not believe staff treated him this way because he wanted more books. Jacob stated he felt fearful during the verbal exchange with Kyle.



Case #2

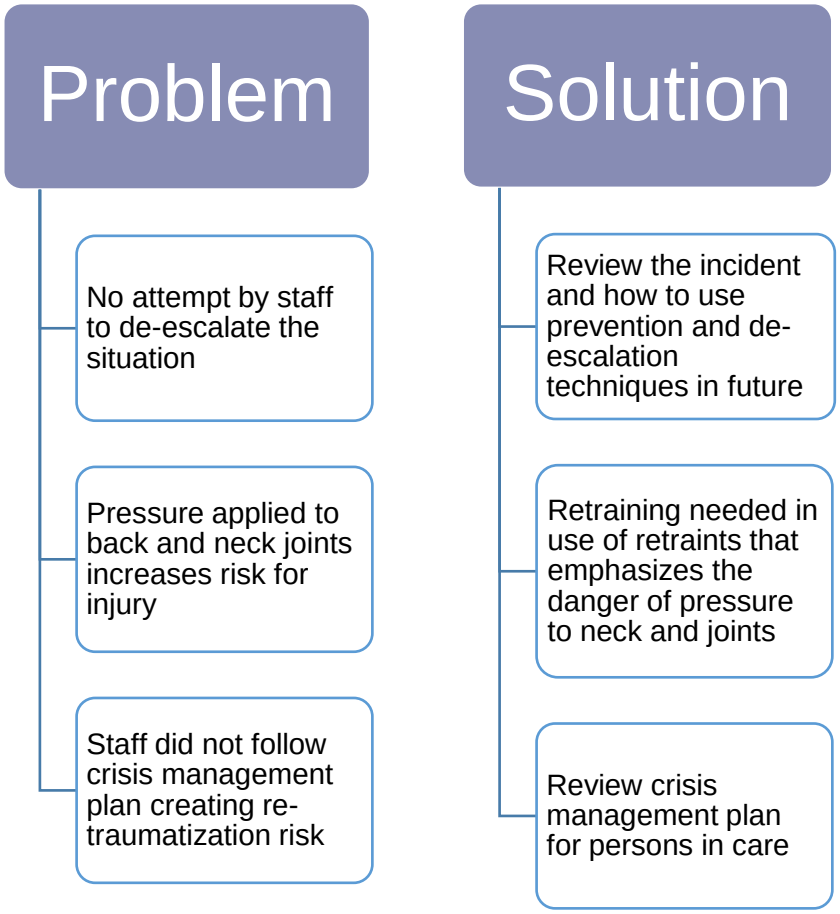
Issues:

- **Disregard for crisis management plan**
- **Dangerous practice**

Case Description

Tom, a 14-year-old, was a student in a classroom with a higher staff to student ratio to meet his needs. Tom was struggling in class and Mike, a direct care professional, asked Tom to go to the quiet room. When Tom attempted to enter a different room, Mike went to block him and Tom tried to punch Mike in the face. Staff attempted to put Tom in a standing restraint but he continued to struggle. Mike grabbed Tom by the neck, took him to the ground and placed his weight on Tom's back and neck area. Tom struggled the entire duration of the restraint, and was grinding his chin into staff and kicking his feet. Another staff member assisting in the restraint removed Tom's shoe and turned his foot sideways to stop Tom from kicking by applying pressure to the joint.

Tom's crisis management plan prohibited staff from grabbing him from behind and to beware of re-traumatization due to Tom's history of abuse. Tom sustained bruising to his face and head. The staff members involved had received training that prohibited the practices used during this restraint.



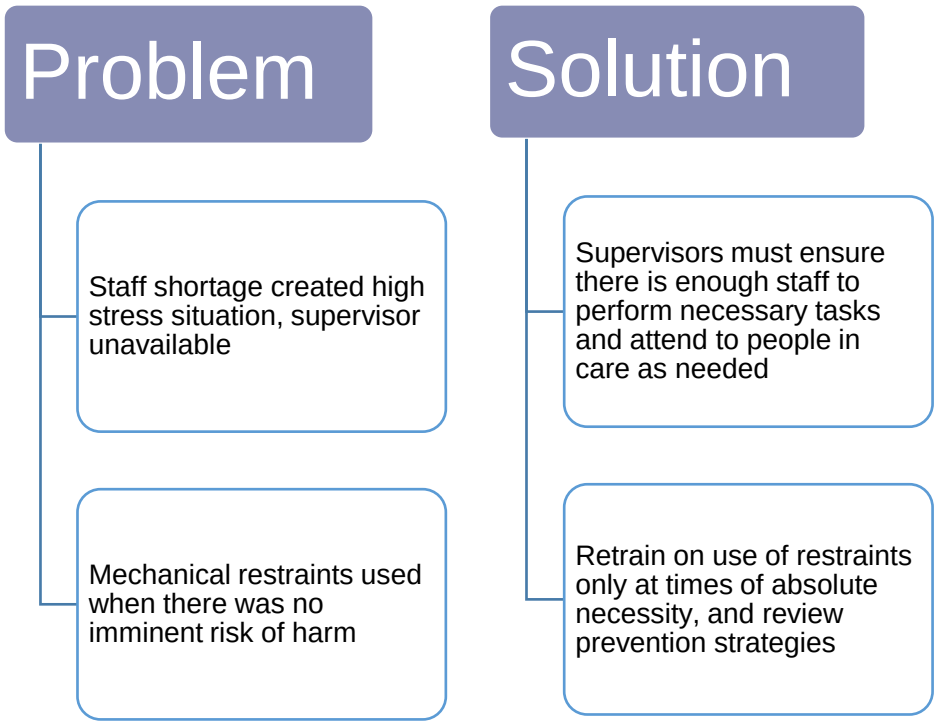
Case #3

Issues:

- **Insufficient staffing**
- **Staff member exhaustion**

Case description

Wanda worked in a group home as a direct care professional. Upon arriving to work, she discovered the home was short a staff member for the day, leaving her to complete dinner and the evening administration of medication on her own while the other staff member took someone to an appointment. Wanda attempted to contact her supervisor for additional coverage, but was unable to reach her. Jim, a resident of the home, used a wheelchair and liked to sit at the dining room table playing cards for enjoyment. Amy, another resident of the home, was non-verbal and used a wheelchair. Wanda was concerned about getting dinner prepared for everyone in a timely manner and completing the evening medication pass. Wanda placed Amy and Jim along with the other residents in the living room, put the television on, and locked the wheels of the wheelchairs so they could not leave. Jim said he wanted to go back to the dining room table and started moving his wheelchair towards the kitchen. Wanda pushed him back into the living room and locked the wheels on the wheelchair a second time.



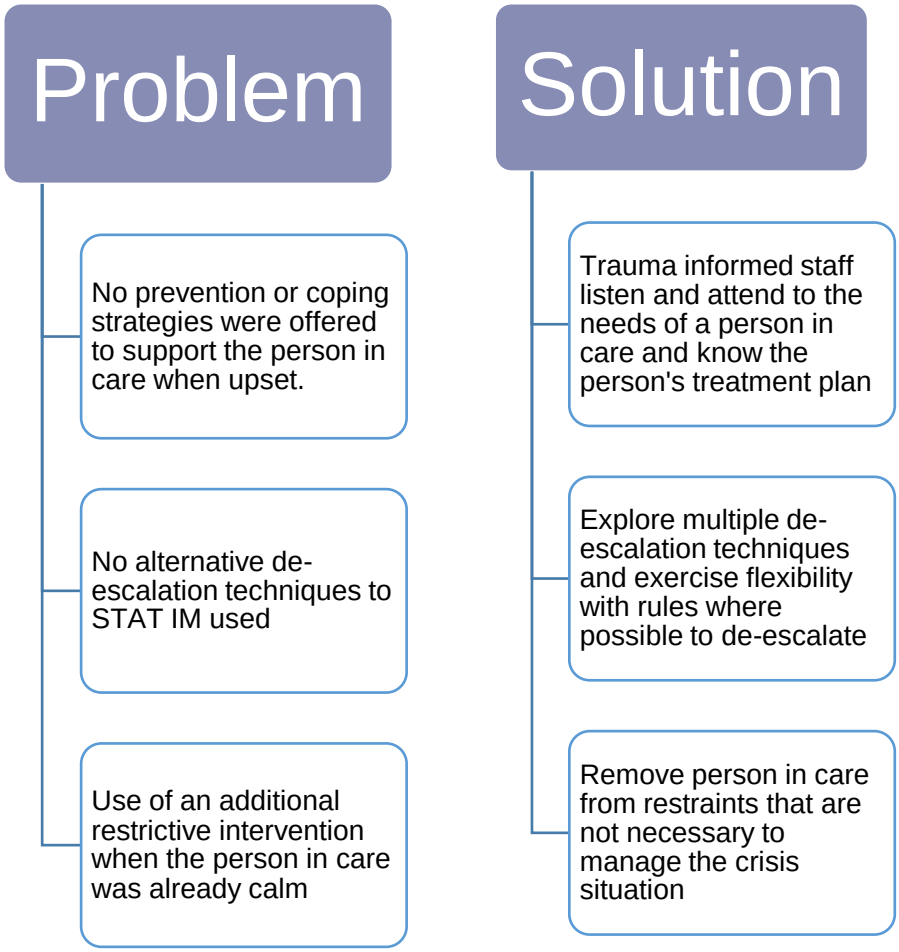
Case #4

Issues:

- **Failure to appropriately assess the situation**

Case description

Sheila, an inpatient in a hospital, was agitated because she was hungry. Sheila began pacing in front of the nurse's station yelling and asking for assistance, and became so agitated that she assaulted a staff member. Dr. Jones ordered a STAT intravenous medication (IM) to be administered so Sheila would not hurt herself or others. After the medication was administered, Sheila calmed down. As a further precaution, Dr. Jones then ordered that Sheila be moved to mechanical restraints for further monitoring.



Partners in Prevention: What Can You Do?

Agencies	Staff	People in Care, Advocates, Families & Friends
Establish a mission statement emphasizing a safe and therapeutic environment that promotes positive behavioral supports and alternatives to restraint. Provide comprehensive employee orientation with clear and concise written guidance for easy reference once on the job. Provide annual refresher trainings on the health and safety risk associated with conducting restraints. Establish individualized crisis prevention plans for people in care Ensure all substitute, respite and part-time staff are educated on all service plans. Foster a trauma informed care environment that includes staff exercising flexibility with applying rules to prevent a person from going into crisis.[ix] Foster an environment which supports open communication between staff and people in care	Know the agency's restraint reduction goals. Remain up to date on all behavior plans for people in care. Keep a clean and organized environment. Seek out and use resources for self-care to improve personal coping skills and personal well-being. Be a role model in behavior management skills to help people in care learn healthy coping skills. Maintain a self-awareness of personal triggers that are counterproductive to treatment and may contribute to an inappropriate restraint. Attend all required trainings on crisis prevention and restraints. Pay attention to early warning signs and make rigorous use of prevention and de-escalation strategies to avoid escalation and use of a restraint.	Become educated on the specific restraint techniques the agency is approved to use. Ask about the agency's process for developing support plans: How often are support plans reviewed and updated? Do people in care, family members or advocates have input in the development of the support plan, treatment goals, or other treatment guidance? Ask about the agency's practices regarding their process for reducing the use of restraints. Let people know ways they can assist you when you're struggling with behavior management. Inform staff of health risks which may increase your risks in a restraint. This may include breathing issues such as asthma, weight, and pre-existing injuries. **Report:** Report Abuse or Neglect to the Justice Center **24/7 Statewide Toll Free Hotline**

while maintaining healthy boundaries. Implement restraint review processes to include trend analysis of factors such as time of day, location or other significant factors. Include de-briefing in the restraint review process for all staff involved, all people in care involved, and witnesses. Ensure appropriate staffing ratios at all times and establish a protocol to ensure staff know how to seek help in a timely manner when needed Evaluate environmental conditions and consider modifications that create comfortable surroundings that support trauma informed care and personal development. **Report:** Report Abuse or Neglect to the Justice Center **24/7 Statewide Toll Free Hotline** **Call 1-855-373-2122** **TTY 1-855-373-2123**	Avoid engaging in or encouraging horseplay with persons receiving services. Call for assistance when needed (ex: when the person in care continues to escalate, if staff present are contributing to the situation escalating). Never apply pressure to the neck, back, chest or joints when using a restraint. **Report**: Report Abuse or Neglect to the Justice Center **24/7 Statewide Toll Free Hotline** **Call 1-855-373-2122** **TTY 1-855-373-2123**	**Call 1-855-373-2122** **TTY 1-855-373-2123**

Remember: Everyone can play a role in reducing and eliminating the use of restraints.

The Justice Center's Partners in Prevention Toolkits

- Article
- Case Reviews and Lessons Learned
- Fact Sheets for People in Care, Provider Agencies and Staff
- Post-restraint Debriefing with Staff
- Staff Check-in

New York State Agencies

- New York State Office for People with Developmental Disabilities: www.opwdd.ny.gov
- New York State Office of Child and Family Services: www.ocfs.ny.gov
- New York State Office of Mental Health: www.omh.ny.gov
- New York State Education Department: www.nysed.gov

Crisis Management Programs

- **Therapeutic Crisis Intervention System:** http://rccp.cornell.edu/tci/tci-1_system.html
- **Prevention and Managing Crisis Situations:** https://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/pmcs.pdf
- **Positive Relationships Offer More Opportunities To Everyone:** https://opwdd.ny.gov/opwdd_careers_training/promote_positive
- **Strategies for Crisis Intervention and Prevention Revised:** https://opwdd.ny.gov/opwdd_regulations_guidance/guidance_documents/strategies_for_crisis_intervention_and_prevention_revised_scip_r**:**

Additional Resources

- https://www.justicecenter.ny.gov/trauma-informed-care-resources
- https://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/
- https://www.samhsa.gov/trauma-violence/seclusion

- https://www.nasmhpd.org/content/seclusion-and-restraint-alternatives
- https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf
- https://www.cwla.org/reducing-restraint-and-seclusion/
- https://www.mentalhealth.org.nz/assets/ResourceFinder/FINAL-SECLUSION-REDUCTION-BEST-PRACTICE-Research-Report.pdf
- http://www.nctsn.org/resources/topics/child-welfare-system
- https://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/assessingchecklist.html

[i] Sailas, E.E.S. & Fenton, M. (2000). Seclusion and restraint for people with serious mental illness. The CoChrane Database of Systemic Reviews, Issue 1. Art. No.: CD001163. DOI: 10.1002/14651858.CD001163 Retrieved November 27,2017 from http://onlinelibrary.wiley.com/wol1/doi/10.1002/14651858.CD001163/full; Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Promoting Alternatives to the Use of Seclusion and Restraint-Issue brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*. Rockville, MD: U.S. Department of Health and Human Services.

[ii] Hundreds Of The Nation's Most Vulnerable Have Been Killed By The System Intended To Care For Them. (1998, October 11). Retrieved November 27, 2017, from http://articles.courant.com/1998-10-11/news/9810090779_1_mental-health-deaths-restraint-policy

[iii] G. Bonner et al., *Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK*, 9 Journal of Psychiatric and Mental Health Nursing 465 (2002).

[iv]Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Promoting Alternatives to the Use of Seclusion and Restraint-Issue brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*. Rockville, MD: U.S. Department of Health and Human Services.

[v] SSL § 488 [1] [d]

[vi] Data based on information in the VPCR as of December 1, 2016.

[vii] G. (2015, September 16). Alternatives to Seclusion and Restraint. Retrieved November 27, 2017, from https://www.samhsa.gov/trauma-violence/seclusion

[viii]Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Promoting Alternatives to the Use of Seclusion and Restraint-Issue brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*. Rockville, MD: U.S. Department of Health and Human Services.; LeBel, J., & Goldstein, R. (2005). The economic cost of using restraint and the value added by restraint reduction or elimination. Psychiatric Services, 56 (9), 1109-14.

[ix] Consider referring to the Justice Center website at http://www.justicecenter.ny.gov/trauma-informed-care-resources