Joint Meeting of the Subcommittee on Safety and Services Subcommittee

May 19, 2011

Bethesda North Marriott Hotel and Conference Center
5701 Marinelli Road
Bethesda, MD 20852

Conference Call Access:

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Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Morning Agenda

10:00 Roll Call, Welcome, and Approval of the Minutes
Susan Daniels, Ph.D.
Acting Director
Office of Autism Research Coordination, NIMH, NIH
Executive Secretary, IACC Safety and Services Subcommittees

10:15 Seclusion and Restraint: Background
Sharon Lewis
Administration on Developmental Disabilities
Administration for Children and Families
Co-Chair, IACC Safety Subcommittee

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Seclusion and Restraint: Background

Sharon Lewis
Commissioner, Administration on Developmental Disabilities
Administration for Children and Families
Co-Chair, IACC Safety Subcommittee

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Morning Agenda – continued

10:45 Seclusion and Restraint: An OSERS Update
Alexa Posny, Ph.D.
U.S. Department of Education

11:15 Seclusion and Restraint in Medicaid Programs
Ellen Blackwell, M.S.W.
Centers for Medicare & Medicaid Services
Co-Chair, IACC Services Subcommittee

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Seclusion and Restraint: An OSERS Update

Alexa Posny, Ph.D.
Assistant Secretary for Special Education and Rehabilitation Services
U.S. Department of Education

Seclusion and Restraint: An OSERS Update

Alexa Posny

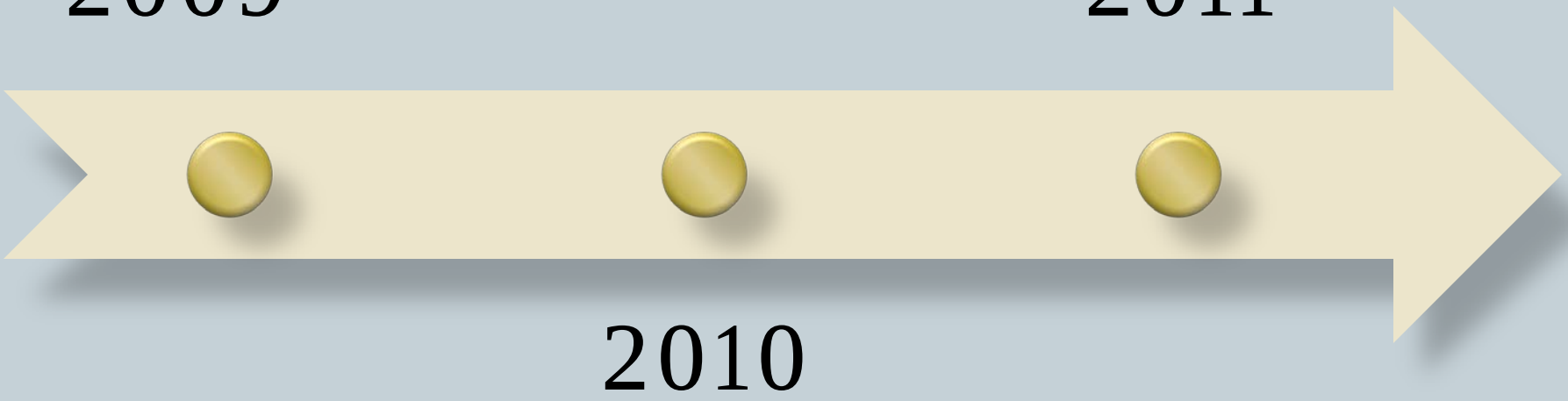
Assistant Secretary

Office of Special Education and Rehabilitative Services

U.S. Department of Education

May 19, 2011

Timeline of Events



Government Accountability Office Report

2009 GAO report findings include—

- No Federal regulations exist
- A wide variety of divergent State regulations govern the use of restraint and seclusion
- There are presently no reliable national data
- Problems with untrained or poorly trained staff were often related to many instances of alleged abuse

Letter to Chief State School Officers

"As education leaders, our first responsibility should be to make sure that schools foster learning in a safe environment for all of our children and teachers."

—Arne Duncan

Secretary, U.S. Education Department

Congressional Letter

"I applaud your interest in addressing this very serious issue…"

—Secretary Arne Duncan
Letter to Congressional committee chairs
December 8, 2009

ED State Summary

Variance among states in—

- Oversight of restraint and seclusion in schools
- Scope and impact of laws
- Restrictions of the use of restraint and seclusion
- Training for school staff

www2.ed.gov/policy/seclusion/seclusion-state-summary.html

ED State Summary Trends

- States vary considerably in their oversight of restraint and seclusion in schools
  - 31 States had legally regulated
  - 19 States had no laws or regulations related to the use of these practices

ED State Summary Trends

- Scope and impact of the 31 states with laws also varied
  - 5 States place some restrictions on the use of restraints but do not regulate seclusion.
  - 1 State regulates the use of seclusion without regulating restraint.
  - Only 8 States specifically prohibit the use of prone (i.e., face down) restraints, which can impede a child's ability to breathe and can become lethal if used with excessive force.

ED State Summary Trends

- States have varied policies regulating the training of school staff on the use of restraint and seclusion,
  - 13 States require that selected school staff receive training before being permitted to restrain children
  - 8 States offer training and technical assistance to local education agencies in providing training to school staff in making decisions about and carrying out proper restraint and seclusion practices

State Updates

Office for Civil Rights

Civil Rights Data Collection—

- Number of students subjected to physical restraint
- Number of students subjected to mechanical restraint
- Number of students subjected to seclusion;
- Total number of incidents of physical restraint, mechanical restraint, and seclusion

www.ocrdata.ed.gov

Legislative Update

111th Congress

- House bill (H.R. 4247) *Keeping All Students Safe Act*
- Senate bill (S. 2860) *Preventing Harmful Restraint and Seclusion in Schools Act*

112th Congress

- House bill (H.R. 1381) *Keeping All Students Safe Act*

What We Need

Positive Behavioral Interventions & Supports (PBIS)…

is a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior.

Working Principles

- Any behavioral intervention must be consistent with the child's right to be treated with dignity and to be free from abuse, regardless of the child's educational needs or behavioral challenges.
- Physical restraint and seclusion should never be used as punishment or discipline, nor in a manner that restricts a child's breathing.
- Every instance of physical restraint and seclusion should be appropriately monitored to ensure the safety of the child, other children, teachers, and other personnel.

Working Principles (Cont.)

- Teachers and other personnel should be trained regularly on the appropriate use of restraint and seclusion and the use of effective alternatives, such as positive behavioral intervention and supports.
- Parents should be informed of the policies on restraint and seclusion at their child's school or other educational setting, as well as applicable State or local laws.
- Parents should be notified promptly following the use of restraint or seclusion on their child, and any such use should be documented in writing.

Working Principles (cont.)

- Policies regarding the use of restraint and seclusion should be reviewed regularly and updated as appropriate.
- Legislation should apply to all children, not just children with disabilities.
- Legislation should promote the collection of data that would enable teachers, staff, and other educational personnel to understand and implement the preceding principles.

Other Items

- Technical assistance document
- Elementary and Secondary Education Act reauthorization
- Individual with Disabilities Education Act reauthorization
- Workforce Investment Act

All Students…

- ***All students*** will acquire the same essential knowledge and skills
- ***All students***' learning will be carefully monitored, and will be given multiple opportunities to demonstrate their learning
- ***All students*** will promptly receive extra time and support if they experience difficulty in learning
- ***All students***' teachers will clarify the standards they will use in assessing the quality of student work
- ***All students*** will be the beneficiaries of educators who have promised to work together collaboratively to use the practices that have a positive impact on their achievement

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Seclusion and Restraint in Medicaid Programs

Ellen Blackwell, M.S.W.
Center for Medicaid & State Operations
Disabled & Elderly Health Programs Group (DEHPG)
Centers for Medicare & Medicaid Services (CMS)
Co-Chair, IACC Services Subcommittee

Seclusion and Restraint in Medicaid Programs

Ellen W. Blackwell, MSW
Center for Medicaid, CHIP, and Survey & Certification
Interagency Autism Coordinating Committee
Joint Services/Safety Subcommittee Meeting

May 19, 2011

THE CHILDREN'S HEALTH ACT OF 2000
Public Law 106-310

- Signed by President Clinton in October, 2000
- Addressed numerous issues including arthritis, diabetes, asthma, birth defects, hearing loss, epilepsy, adoption awareness, childhood obesity, muscular dystrophy, mental health, substance abuse
- Parts H & I directly related to Seclusion and Restraint (S/R)
- Title I- Autism created the Interagency Autism Coordinating Committee (IACC)

The Children's Health Act of 2000 Section 3207

- Requires any health care facility receiving Federal funds to protect resident rights:

  - freedom from physical or mental abuse or corporal punishment

  - specifies circumstances when seclusion or restraint (S/R) may be used

  - requires notification to agencies when S/R related death occurs

  - requires staff training on S/R and alternatives

The Children's Health Act of 2000 Section 3208

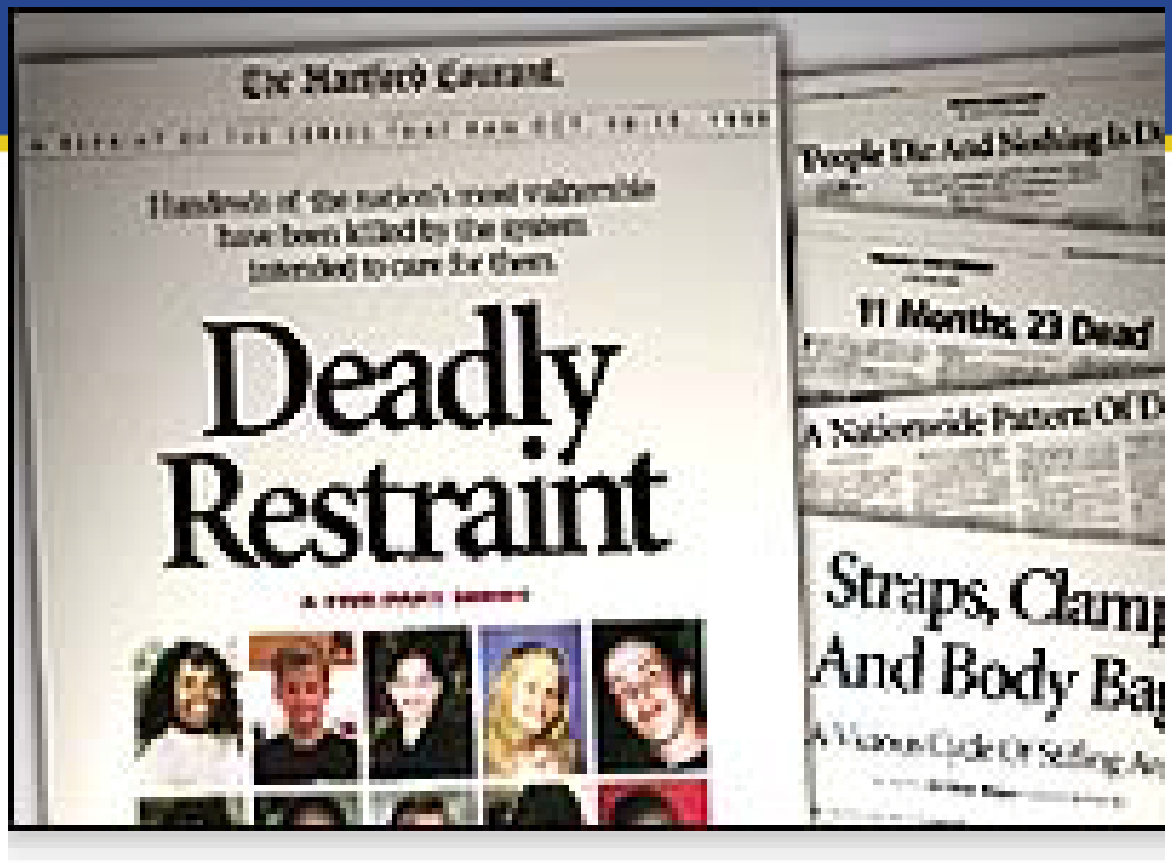
- Requires a public or private non-medical, community-based facility for children and youth:

  - protect and promote the rights of each resident including the right to be free from physical or mental abuse or corporal punishment

  - specifies circumstances when S/R may be used

  - requires notification to State agencies when S/R related death occurs

  - use of S/R in accordance with Federal regulations



In late 1998 and early 1999*The Hartford Courant* published a series of articles documenting deaths and serious injuries resulting from the inappropriate use of S/R in residential treatment facilities serving children.

Hartford Courant Article

- Included a survey conducted by the Harvard Center for Risk Analysis
- Estimated 50-150 S/R deaths occur each year across the U.S. in facilities that served people with behavioral health or ID/DD
- S/R was mostly used for discipline, punishment, and staff convenience
- Causes of S/R death included asphyxia, cardiac complications, drug overdoses/interactions, blunt force trauma, strangulation, choking, fire/smoke inhalation, and aspiration

Congressional Response to "Deadly Restraint" Series

- Members of the Congress requested additional information from the then General Accounting Office (GAO) to help formulate legislative response
- GAO was asked to:

  - examine dangers of S/R and extent used
  - review numbers of S/R injuries/deaths nationwide
  - examine State policies governing S/R
  - describe State experiences
  - review S/R in facilities that receive Medicare/Medicaid funds

1999 GAO Report – "Improper Restraint or Seclusion Use Places People At Risk"

- Report focused on people with mental disorders and/or intellectual disabilities
- Report did not address schools, outpatient treatment, sheltered workshops, drug/alcohol rehabilitation programs, or correctional facilities
- Recommended HCFA issue policies on the use of S/R to individuals in any setting funded by Medicare/Medicaid
- Also suggested HCFA improve requirements for staff training and reporting
- http://www.gpo.gov/fdsys/pkg/GAOREPORTS-HEHS-99-176/pdf/GAOREPORTS-HEHS-99-176.pdf

Health Care Financing Administration (now CMS) Actions 1999-2001

- 64 FR 36070: "Medicare and Medicaid Programs; Hospital Conditions of Participation; Patients' Rights"
- HCFA-2065-IFC: "Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under Age 21
- HCFA-2065-IFC2 – Amendment and Clarification with Request for Comment

Hospital Patients' Rights Condition of Participation

- Located at 42 CFR 482.13(f)(7)
- Issued July 2, 1999
- HCFA conducted research on S/R in adults that it believed translated to children under age 2
- Advocates comments noted S/R of children involves special concerns, including higher rates of restraint
- HCFA indicated it would be more prescriptive regarding S/R use in PRTFs

Interim Final Rule for S/R in Psychiatric Residential Facilities (PRTFs) for Individuals Under the Age of 21

- Issued January 22, 2001
- Children receiving services in PRTFs have the right to be free from restraint or seclusion as a means of coercion, discipline, convenience, or retaliation

  - S/R may only be used to ensure safety of the person or others during an emergency situation

  - S/R must terminate when the situation concludes and safety can be ensured, irrespective of time remaining on any medical order(s)

  - The least restrictive emergency safety intervention must be used

  - Written or "as needed" S/R orders are prohibited

  - Simultaneous use of restraint and seclusion is prohibited

PRTFs

- A non-hospital facility with a provider agreement with the State Medicaid Agency (SMA) to provide the inpatient services benefit to beneficiaries under the age of 21
- Must be accredited by an accrediting organization (e.g. JCAHO)
- Complies with Medicaid Condition of Participation regarding S/R
- Requires reporting of all serious occurrences to the SMA and the State Protection and Advocacy agency

Additional Provisions of the Interim Final Rule

- Defines S/R
- Describes who may order S/R
- Addresses time limits
- Requires one-hour face-to-face assessment and ongoing monitoring
- Requires parental/guardian notification of S/R
- Requires two immediate debriefing sessions
- Describes reporting requirements
- Sets forth staff education and training competencies

Amendment and Clarification with Request for Comment

- Issued May 22, 2001
- Was written primarily in response to concerns raised by commenters regarding RN and psychiatrist shortages
- Clarifies which facilities are subject to the rule
- Modifies reporting requirements to facilitate resident monitoring and death reporting
- Amends "personal restraint" to include safe escorts
- IFC effective May 22, 2001

State Medicaid Director Letter #01-023

- Issued July 22, 2001
- Describes Section 483.474, which describes facility attestation process for compliance with government S/R standards
- Outlines death reporting
- Available at: http://www.napas.org/images/Documents/Issues/Restraint_and_Seclusions/NDRN_CMS_smd071101.pdf
- CMS also issued guidance to State Survey Agency Directors on July 11, 2001 for the oversight and survey process for PRTFs

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Condition of Participation (CoP) for Use of S/R in PRTFs

- Located at 42 CFR § 483.350-76, Subpart G
- Requires that PRTFs "must meet the requirements in § 441.151 through § 441.182"
- Also imposes CHA reporting/training requirements for the use of S/R
- Defines certain terms (drug used as restraint, emergency safety intervention, emergency safety situation, mechanical restraint, minor, personal restraint, restraint, seclusion, serious injury, staff, time out)

What Happened After the IFC?

- PRTFs must report all deaths (not just S/R-related deaths)
- Since 2001, there have been four deaths reported in PRTFs
- One death occurred after "struggling with staff in a protective hold"

CMS Providers with S/R Related Regulations

- Hospitals, including Psychiatric Hospitals
- Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR)
- Nursing Facilities
- Psychiatric Residential Facilities for Individuals Under the Age of 21
- Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

PRTFs in Medicaid

- PRTF services are covered under Medicaid's Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit [Section 1905(a)(16) of the Social Security Act]
- States are not required to use PRTFs to provide particular Medicaid services to children

ICFs/MR in Medicaid

- Congress added the optional ICF benefit in 1967, following reports about dismal conditions in large institutions
- More than 6,000 ICFs/MR in the United States
- Most are privately owned
- Most ICFs/MR are small - <9 beds
- Most clients are served in large ICFs/MR (9+beds)
- Average cost of an ICF/MR is about $118,000/year per person
- Some States no longer operate any ICFs/MR

Condition of Participation (CoP) for ICFs/MR

- Located at 42 CFR § 483.450(a)(1)(i)
- "Client Behavior & Facility Practices"
- Specifies behavior management not be used for discipline, staff convenience, or substitute for active treatment
- Time-out room only with supervision & as part of approved program
- Physical restraints used only when in the person's plan, or as emergency measure, no standing orders, requires record of us, checks, and quick release
- Special requirements for use of drugs for behavior

S/R in Medicare/Medicaid Hospitals

- 2006 Office of the Inspector General (OIG) report "Hospital Reporting of Deaths Related to Restraint and Seclusion": http://oig.hhs.gov/oei/reports/oei-09-04-00350.pdf
- CMS immediately issued a letter to State Survey Agency Directors reminding them of their responsibilities associated with the CoP
- CMS has increased its capacity to monitor and triage, is gathering statistics on S/R and analyzing findings, and developing tools for S/R follow-up

Service Settings Funded by Medicaid that CMS Does Not Directly Monitor

- Home and Community-Based Settings (private home, group homes, residential care facilities, adult care homes, etc.)
- Residential Treatment Facilities or Centers for Children
- Assisted Living Facilities
- Other Facilities (e.g. day habilitation programs, adult day programs)
- Schools

Medicaid in Schools

- 1965 – the Early and Periodic Diagnostic, Screening, and Treatment Service (EPSDT)
- 1975 – The Education for All Handicapped Children Act (now the Individuals with Disabilities Education Improvement Act of 2004 (IDEA)
- 1988 – Section 1903(c) of the Act

Section 1903(c) of the Social Security Act

- Medicaid is the first payor for Medicaid-covered services if they are included in a child's Individualized Education Program (IEP) or Individual Family Service Plan (IFSP), and might alternatively be paid for by Education funds
- Services must be included among those listed in Section 1905(a) of the Social Security Act
- Services must be described according to Medicaid statutory, regulatory, and policy requirements

Home and Community Based Services (HCBS) in Medicaid

- Section 1915(c) HCBS waivers

- Section 1915(i) State Plan coverage
- Section 1905(a) State plan services
- Section 1115 Research and Demonstration Projects
- Section 1915(a) contracts (State-provider)

Quality Requirements in HCBS Waivers

- States must describe a Quality Improvement Strategy (QIS), tied to six assurances:
  - level of care
  - service plan
  - qualified providers
  - health and welfare*
  - administrative authority
  - financial accountability

HCBS Waiver Application

- States must provide CMS with assurances that safeguards are in place to protect the health and welfare of waiver participants
- Requires States describe:
  - Response to critical events or incidents
  - Safeguards concerning restraints and restrictive interventions
  - Medication management and administration

Waiver Application – Appendix G-2

- States must specify:

  - the State entity or entities responsible for oversight/operation of the State based incident management system

  - oversight procedures other than those of the SMA or its operating agency (e.g. developmental disabilities agency)

  - methods for operation of the State incident management system including data collection, trends and patterns, and how data is used to prevent recurrences

  - frequency of oversight activities

State Requirements for Use of S/R in HCBS Waivers

- States must describe the types of restrictive interventions permitted and circumstances under which they are allowed
- For each restrictive method, the State must specify protocols, methods to detect unauthorized use, required documentation, education/training of authorizing personnel

Section 1915 (i) State Plan Coverage Quality Management Strategy

- Service plans address individual needs
- Providers are qualified
- The SMA retains program oversight
- The SMA has financial authority
- Remediation and systems improvement are described
- “State identifies, addresses and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints”

Section 2402 of the Affordable Care Act of 2010

- Directs the HHS Secretary to promulgate regulations that allocate HCBS resources; provide support for individualized, self-directed life; and improve provider coordination
- Section 2402(a)(3) mentions oversight and monitoring of service system functions
- CMS is part of a cross-HHS workgroup to help achieve consistency across government programs

Medicaid Waivers and Demonstrations List

- http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

CMS Regional Offices

- *Region I* (Boston)- CT, ME, MA, NH, RI, VT
- *Region II* (New York) - NJ, NY, Puerto Rico, Virgin Islands
- *Region III* (Philadelphia)– DE, DC, MD, PA, VA, WV
- *Region IV* (Atlanta)- AL, FL, GA, KY, MS, NC, SC, TN
- *Region V* (Chicago) – IL, IN, MI, MN, OH, WI
- *Region VI* (Dallas)- AR, LA, NM, OK, TX
- *Region VII* (Kansas City)– IA, KS, MO, NE
- *Region VIII* (Denver) – CO, MT, ND, SD, UT, WY
- *Region IX* – (San Francisco) AZ, CA, HI, NV, American Samoa, N. Mariana Islands, Guam
- *Region X* (Seattle) – AK, ID, OR, WA

Link to RO/Consortium contact information:
https://www.cms.gov/RegionalOffices/

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Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Morning Agenda – continued

Alternatives to Seclusion and Restraint
Larke Nahme Huang, Ph.D.
Substance Abuse and Mental Health Services Administration
IACC Services Subcommittee Member

12:00 Lunch

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Alternatives to Seclusion and Restraint

Larke Nahme Huang, Ph.D.
Senior Advisor on Children and Families
Administrator's Office of Policy Planning and Innovation
Substance Abuse and Mental Health Services Administration
IACC Services Subcommittee Member

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Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Alternatives to Seclusion and Restraint in Behavioral Health Care

Larke Huang, PhD
Senior Advisor
Administrator's Office of Policy Planning and Innovation (OPPI)
Substance Abuse and Mental Health Service Administration (SAMHSA)

Interagency Autism Coordinating Committee (IACC) Services and Safety Subcommittee
May 19, 2011

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Urgency to Address S&R in Behavioral Health Treatment Settings

- Approximately 50-150 Americans die annually from S&R – thousands others are injured and traumatized (Harvard Center for Risk Analysis)
- S&R should be viewed as a treatment failure that creates barriers to recovery
- May be detrimental to recovery or persons with mental illness; retraumatizing (for consumers and staff)
- Facilities have successfully reduced and eliminated SR (Bennington-Davis; Huckshorn; LeBel)
- Focus on the prevention of the use of SR
- Less recognized: multi-level economic burden

Ongoing Stories in the News

- *Virginia mental hospital violated state law holding a mentally ill patient in solitary confinement for 20 years (Assoc Press, June 2008)*
- *Georgia mental hospital investigation uncovers repeated misuse of seclusion and restraint practices, leading to patient injury and death (Atlanta Journal Constitution, June 4, 2008)*
- *Caregivers abuse patients, and usually get away with it (Raleigh News and Observer, March 1 2008)*
- *Patients die from poor care; families don't hear whole story (Raleigh News and Observer, March 2, 2008)*

Definitions of SR

(From CMS Hospital Conditions of Participation, 2006)

- **Seclusion**: The **involuntary confinement of a patient alone** in a room or area from which the patient is physically prevented from leaving.
- **Restraint: Any manual method or physical or mechanical device, material or equipment, that immobilizes or reduces the ability of a patient to move** his or her arms, legs, body or head freely, attached or adjacent to the patient's body, that he or she cannot easily remove that restricts freedom of movement or normal access to one's body; or a **drug or medication** when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

History and Context

- 1998 Hartford Courant Series
- 2000 Children's Health Act – language re SR for inpatient and community-based facilities
- 2003: SAMHSA - along with NASMHPD - convened a national summit with 200 stakeholders and issued a Call to Eliminate S&R in Behavioral Healthcare.
- 2003: A *National Action Plan* to reach this goal identified the need for a multifaceted approach including: training and technical assistance, data collection, evidence-based practices and guidelines, leadership and partnership development, and rights protection

SAMHSA's Approach to Seclusion and Restraint Use

- SR in mental health treatment is viewed as a safety intervention of last resort, not a treatment modality
- To provide training, technical assistance, and other support to States, providers, facilities, consumers, and families in order to reduce, and ultimately, eliminate seclusion and restraint in mental health and substance abuse treatment;
- To implement changes re SR at the clinical, programmatic and organizational level

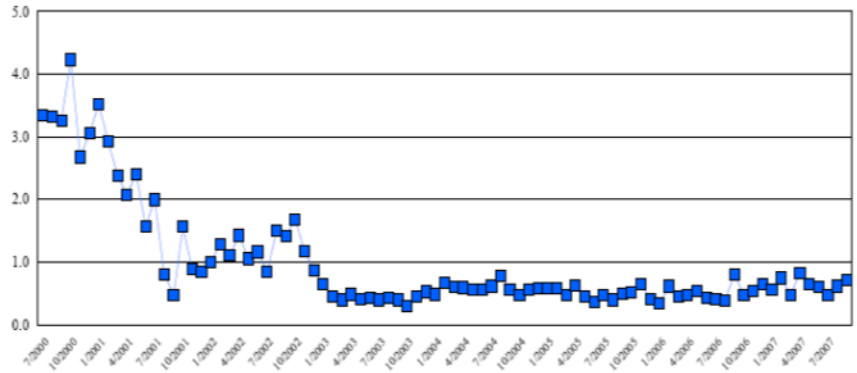
National Public S/R Rates:

(NASMHPD/NRI Performance Measurement System, Feb 2008 and May 2010)

Hours of Restraint /1000 Inpatient Hours (2008, By Age)

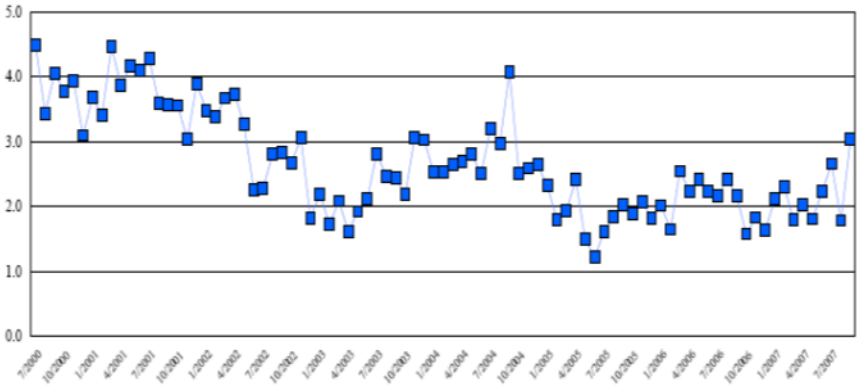
Hours of Restraint Per 1000 Inpatient Hours

Clients age 12 years and under



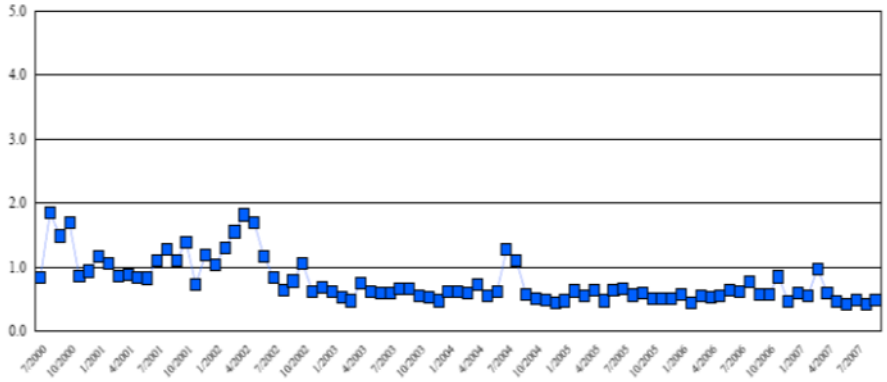
Hours of Restraint Per 1000 Inpatient Hours

Clients age 18-24 years



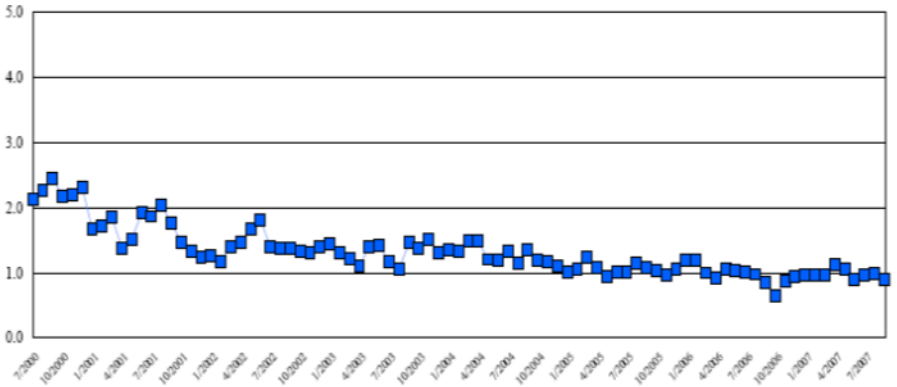
Hours of Restraint Per 1000 Inpatient Hours

Clients age 13-17 years

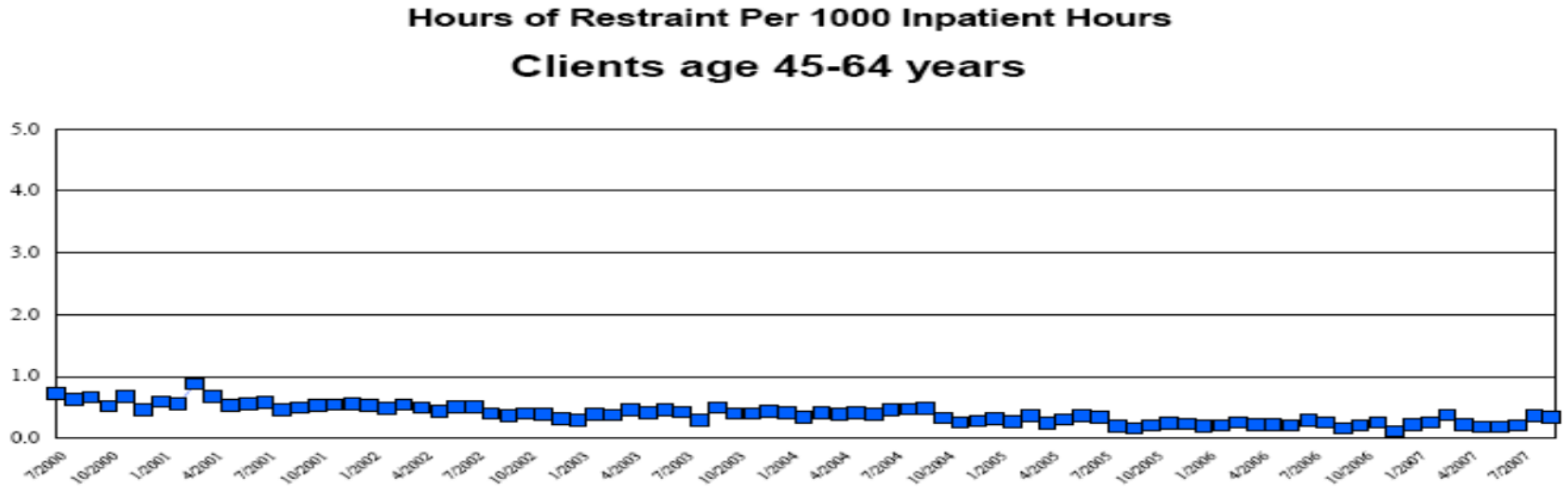


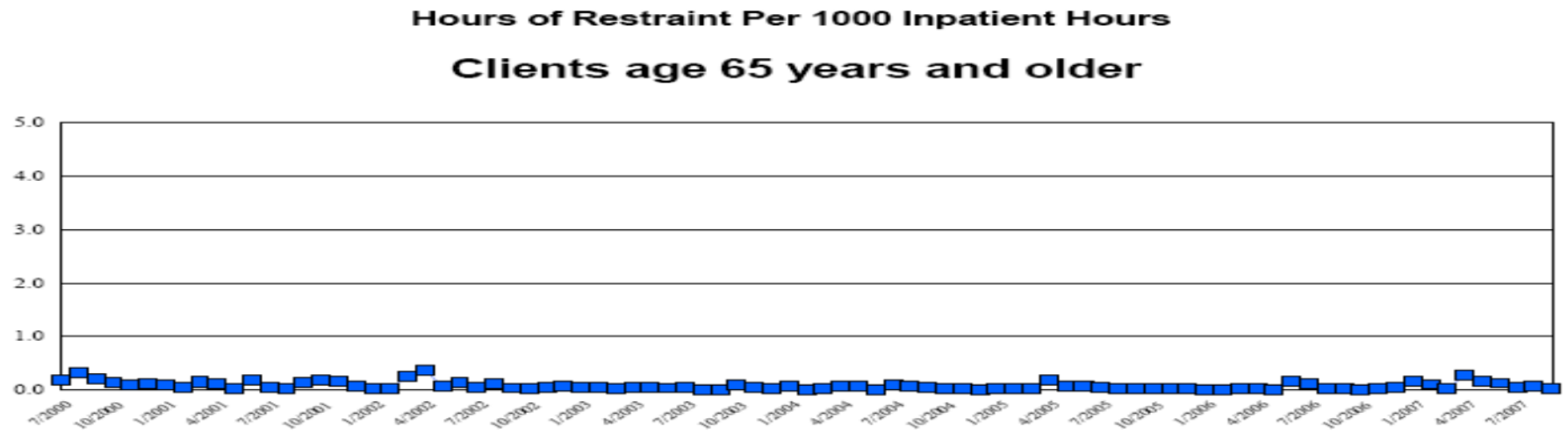
Hours of Restraint Per 1000 Inpatient Hours

Clients age 25-44 years



Hours of Restraint /1000 Inpatient Hours (2008, By Age) continued

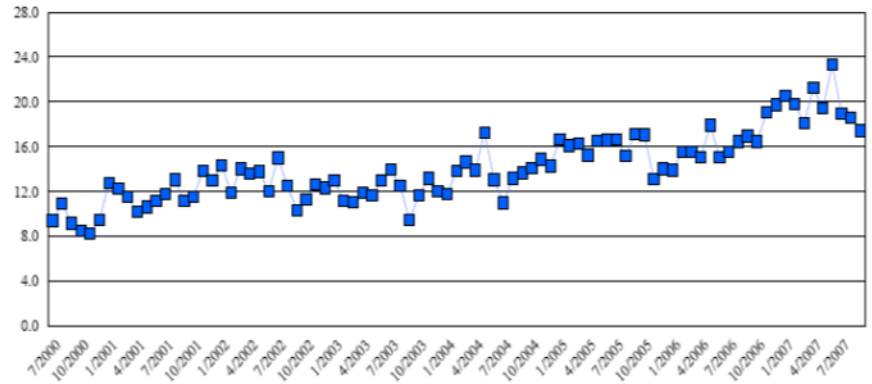




Percent of Clients Restrained (2008, By Age)

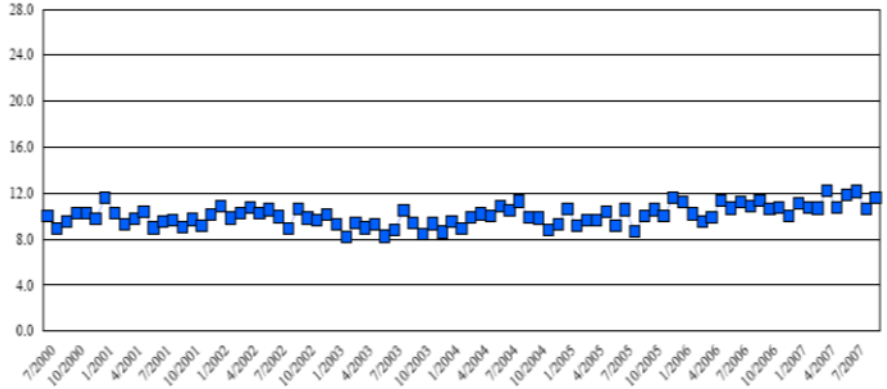
Percent of Clients Restrained

Clients age 12 years and under



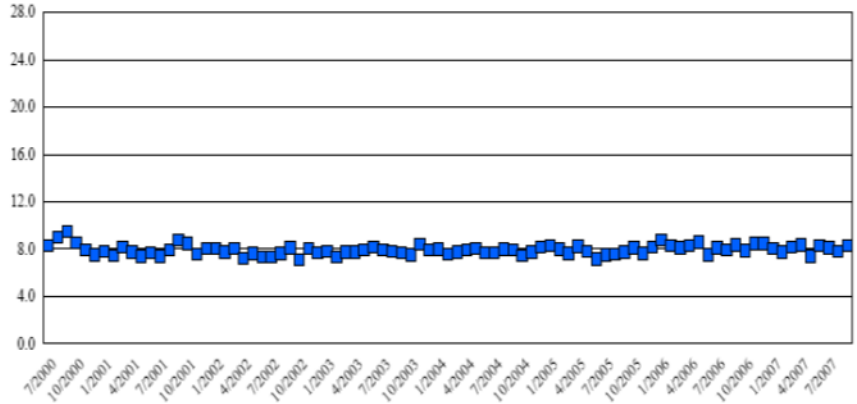
Percent of Clients Restrained

Clients age 13-17 years



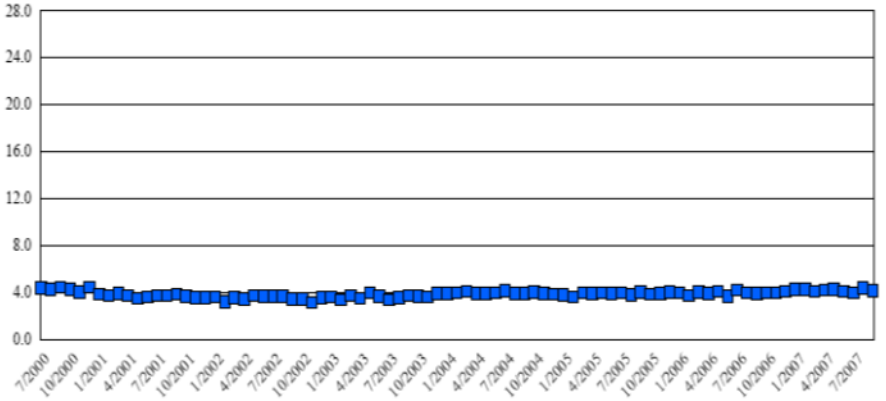
Percent of Clients Restrained

Clients age 18-24 years

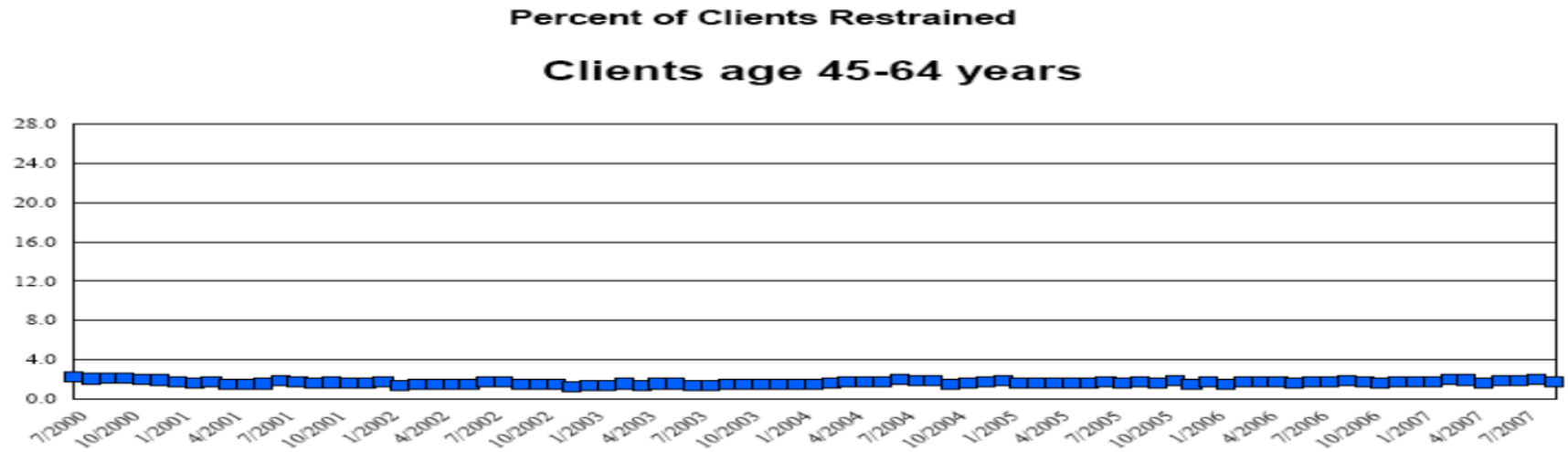


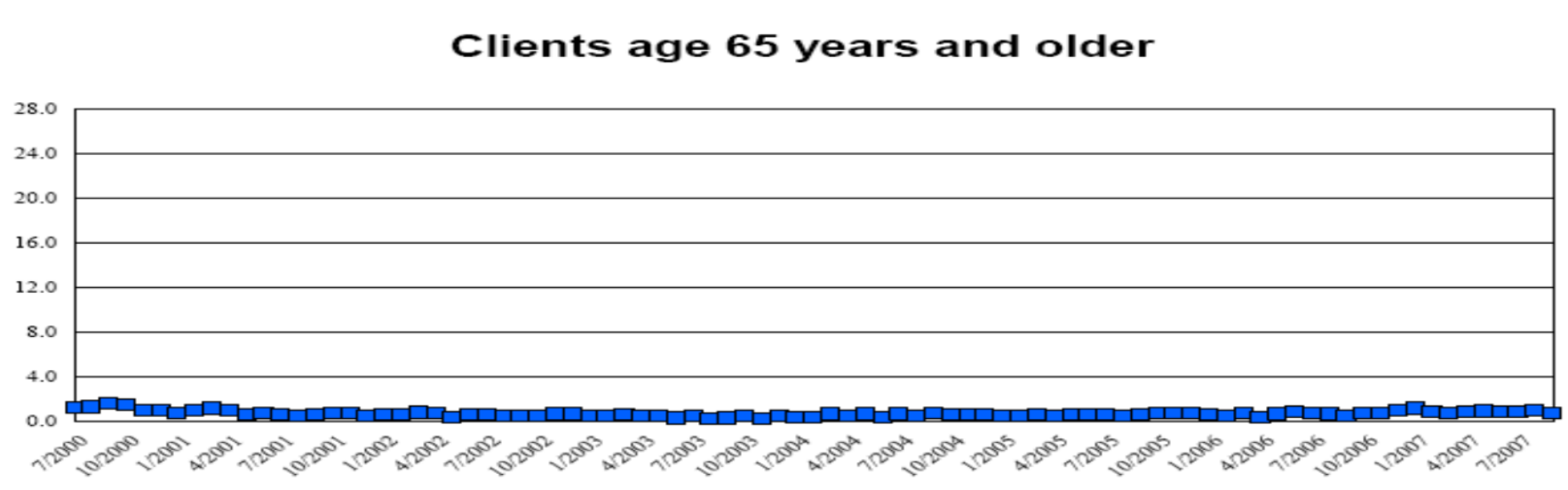
Percent of Clients Restrained

Clients age 25-44 years

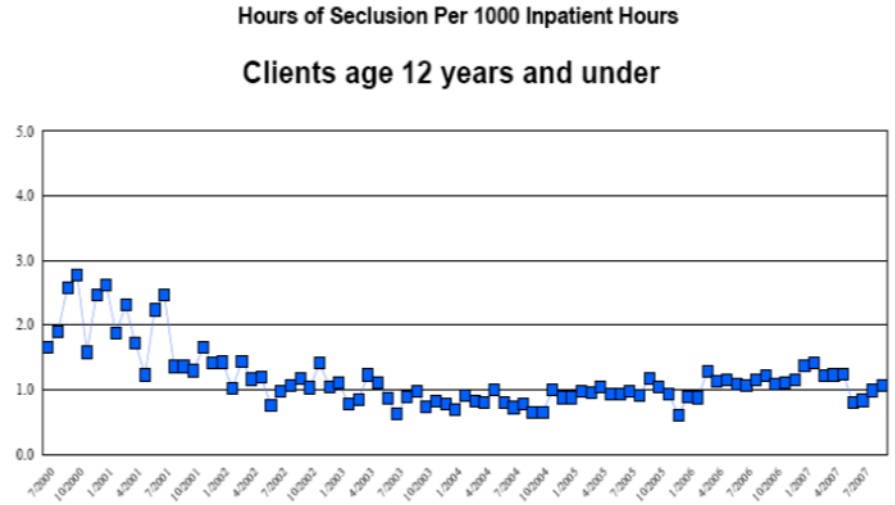


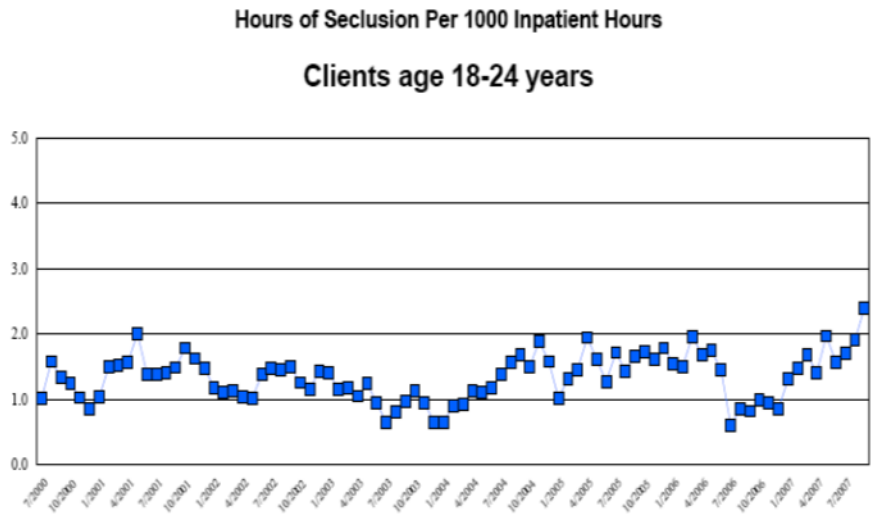
Percent of Clients Restrained (2008, By Age) continued

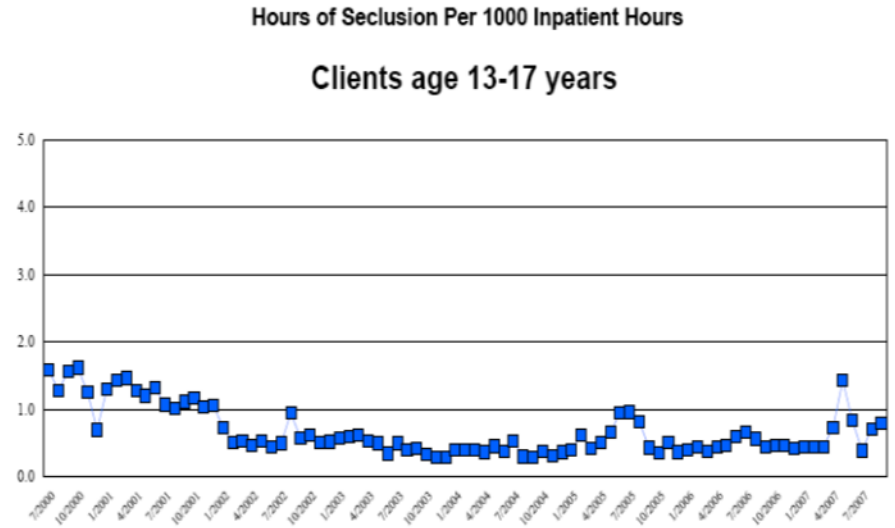


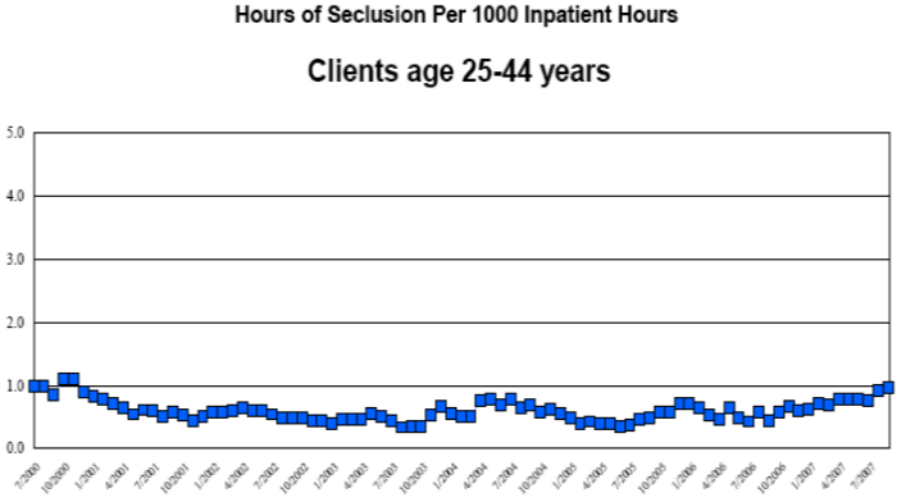


Seclusion Hours (2008, By Age)

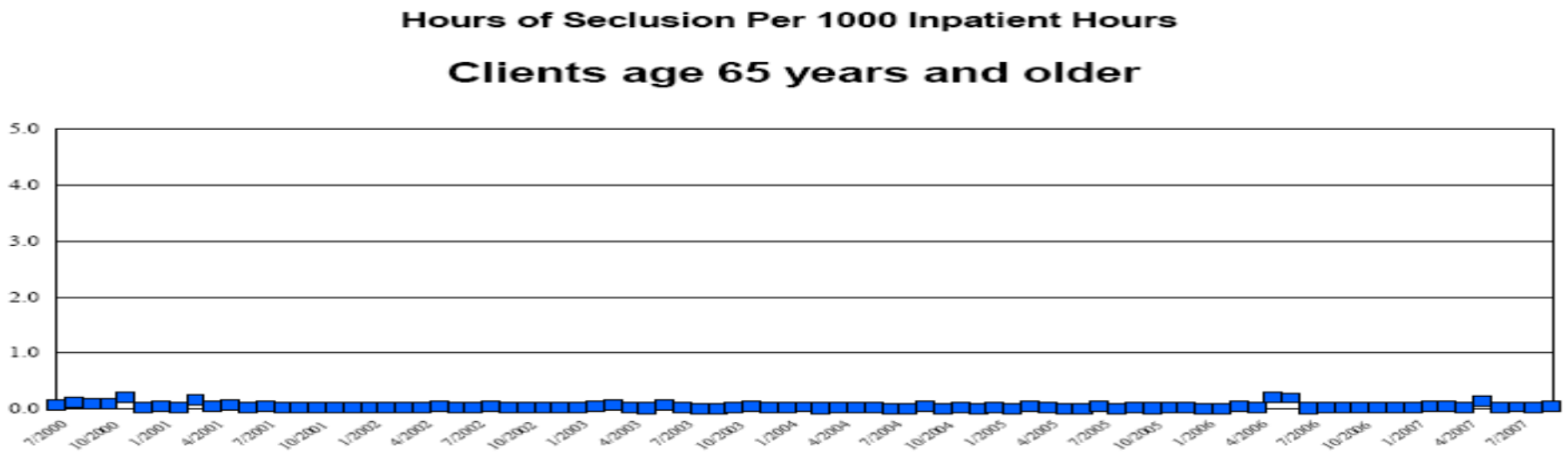


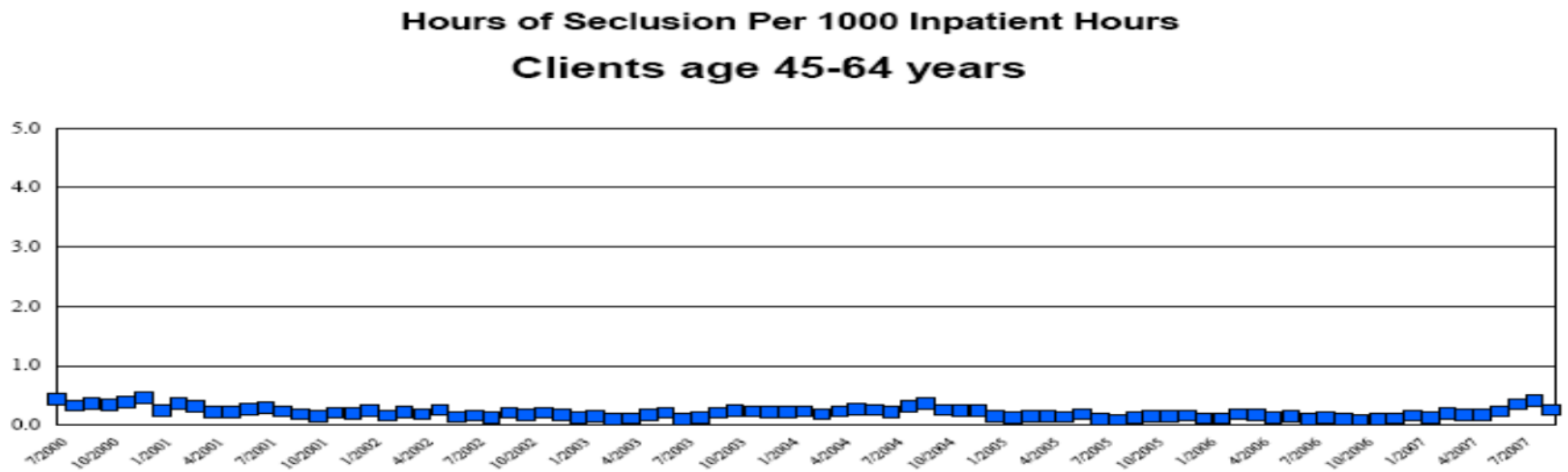




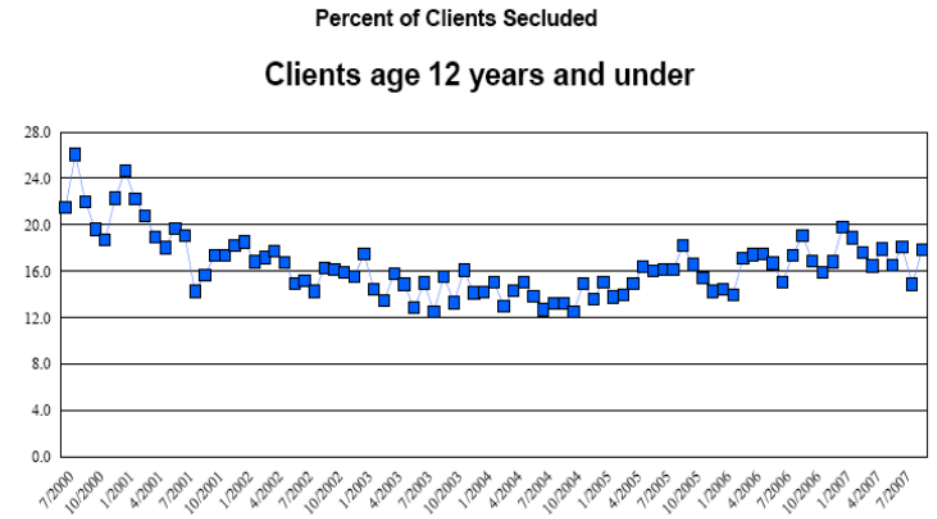


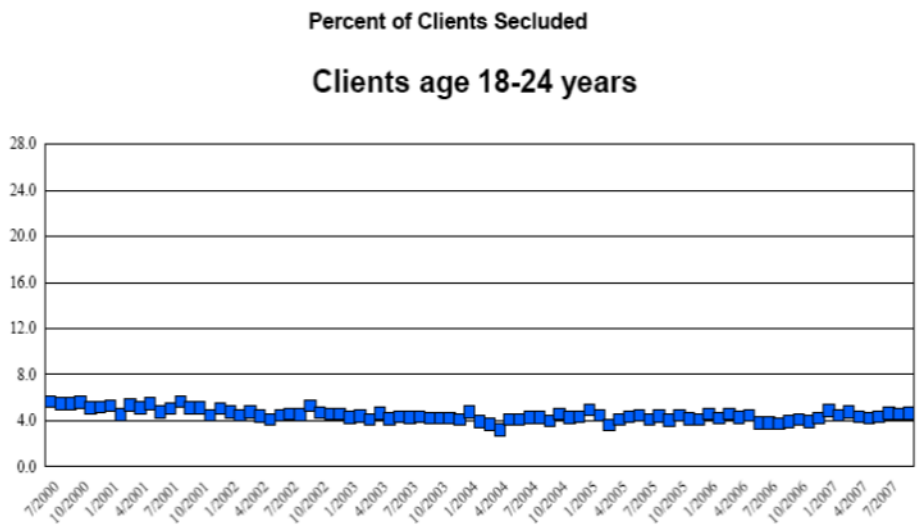
Seclusion Hours (2008, By Age) continued

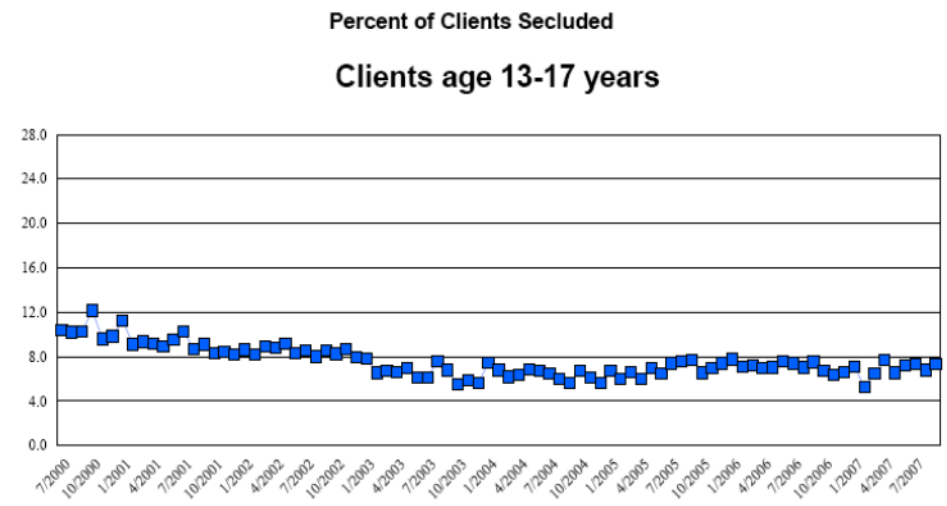


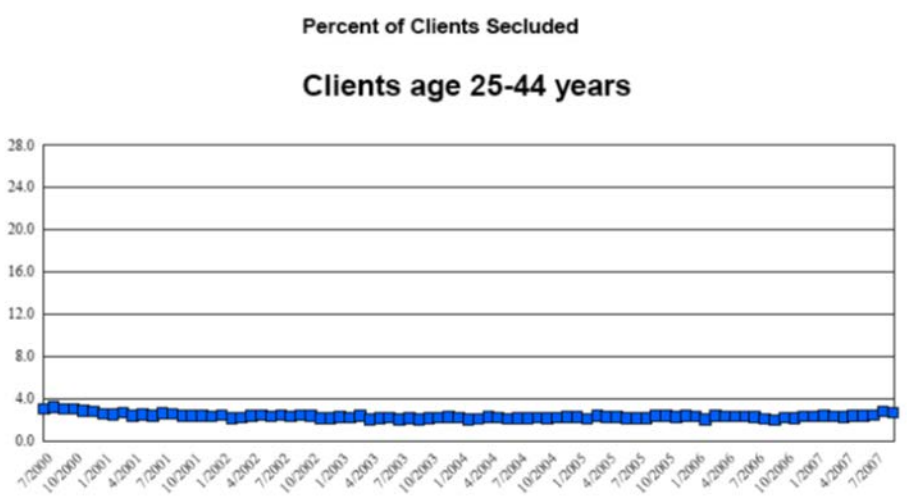


Percent of Clients Secluded (2008, By Age)

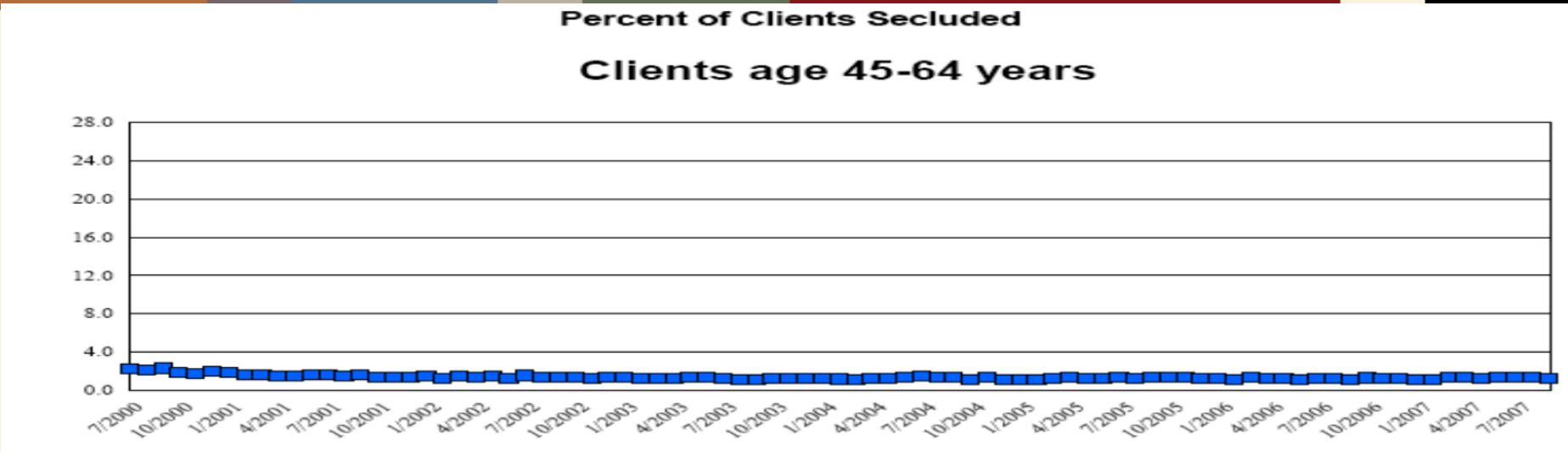


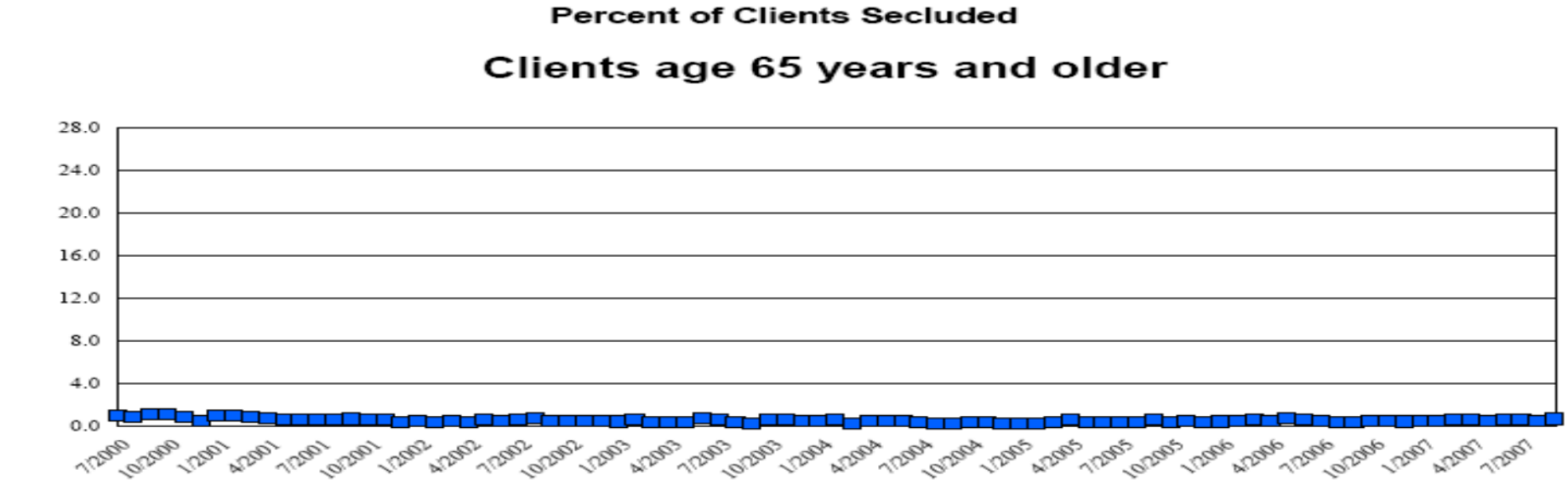






Percent of Clients Secluded (2008, By Age) continued

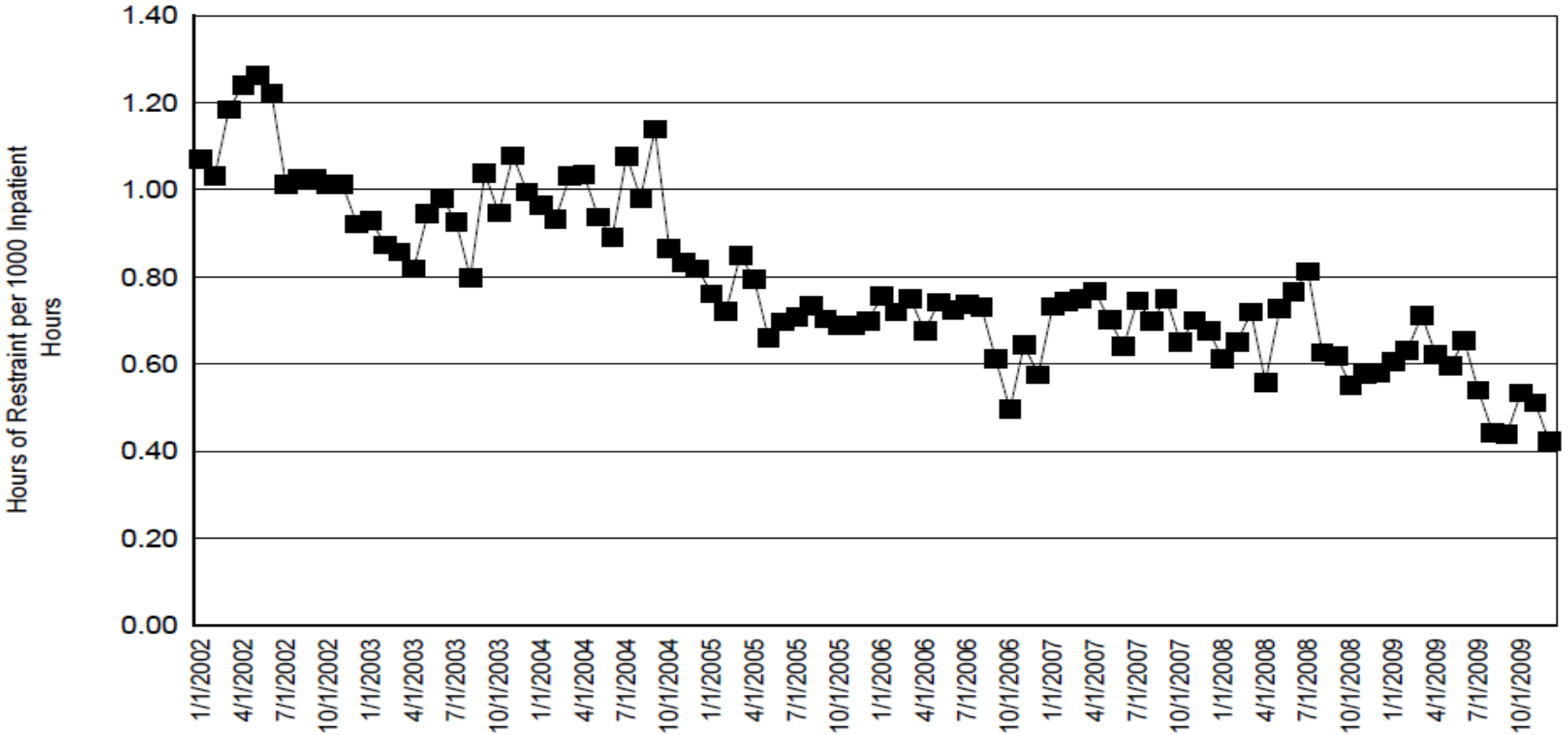




Summary of Data Reports

- Hours of restraint/1000 inpatient hours varies significantly by age group
- 12 yrs and under: from 2000 to 2007, hours of restraint decreased, but percentage of clients restrained increased
- 18-24 yrs: highest times in restraints, yet percent of clients restrained remained level
- Hours of seclusion/1000 inpatient hours decreased for all age groups between 2000 and 2007, except 18-24 yr olds
- Percent of clients secluded remained level in all groups except 12 years and under; highest rates in this age group

Restraint Hours (2010)



Labels on the chart are provided at three month intervals, each square represents the rate for a month.

NRI Performance Measurement System National Public Rates: Restraint Hours. Alexandria, Virginia: National Association of State Mental Health Program Directors Research Institute, May 2010.

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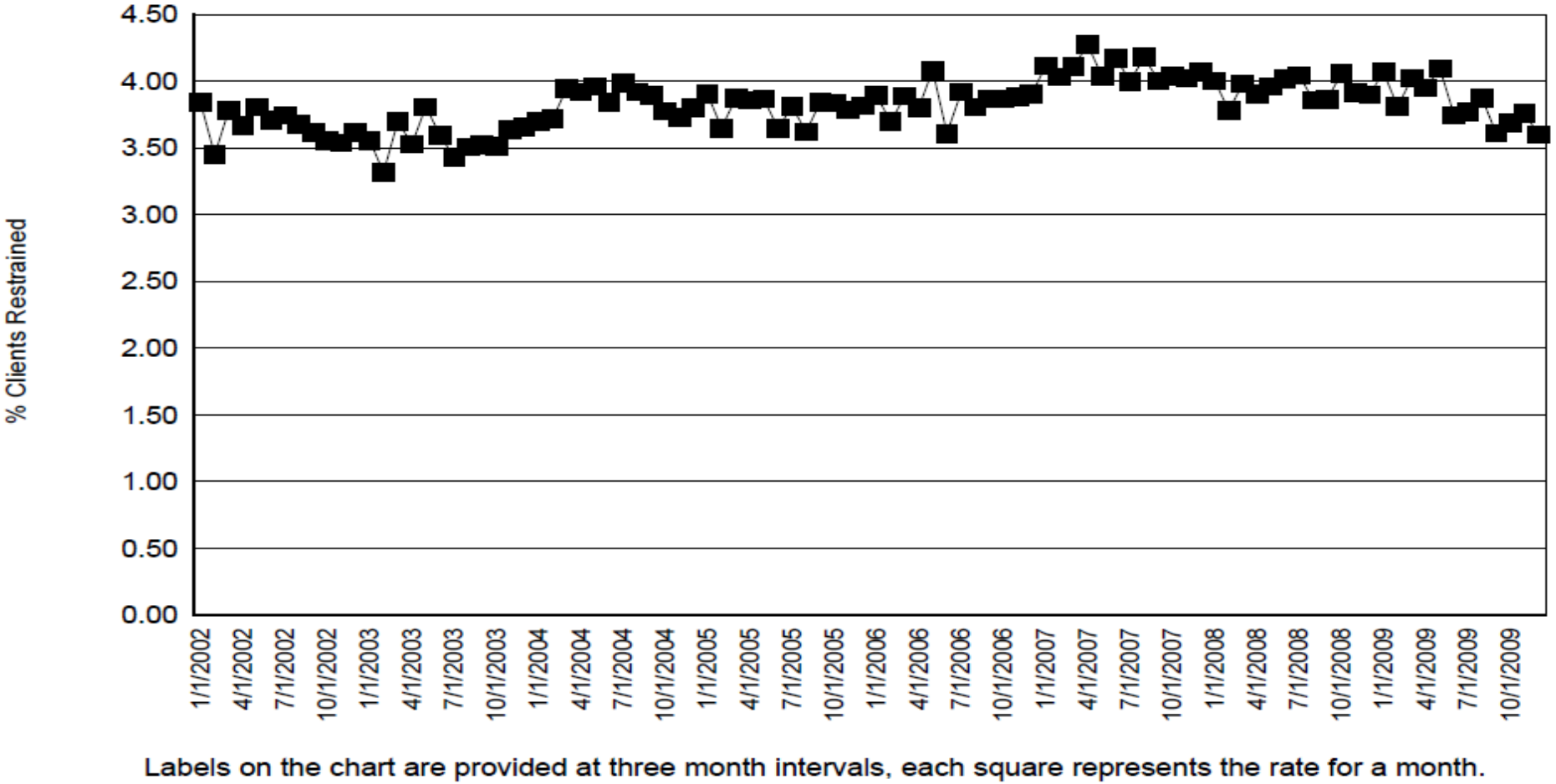
Percent of Clients Restrained (2010)



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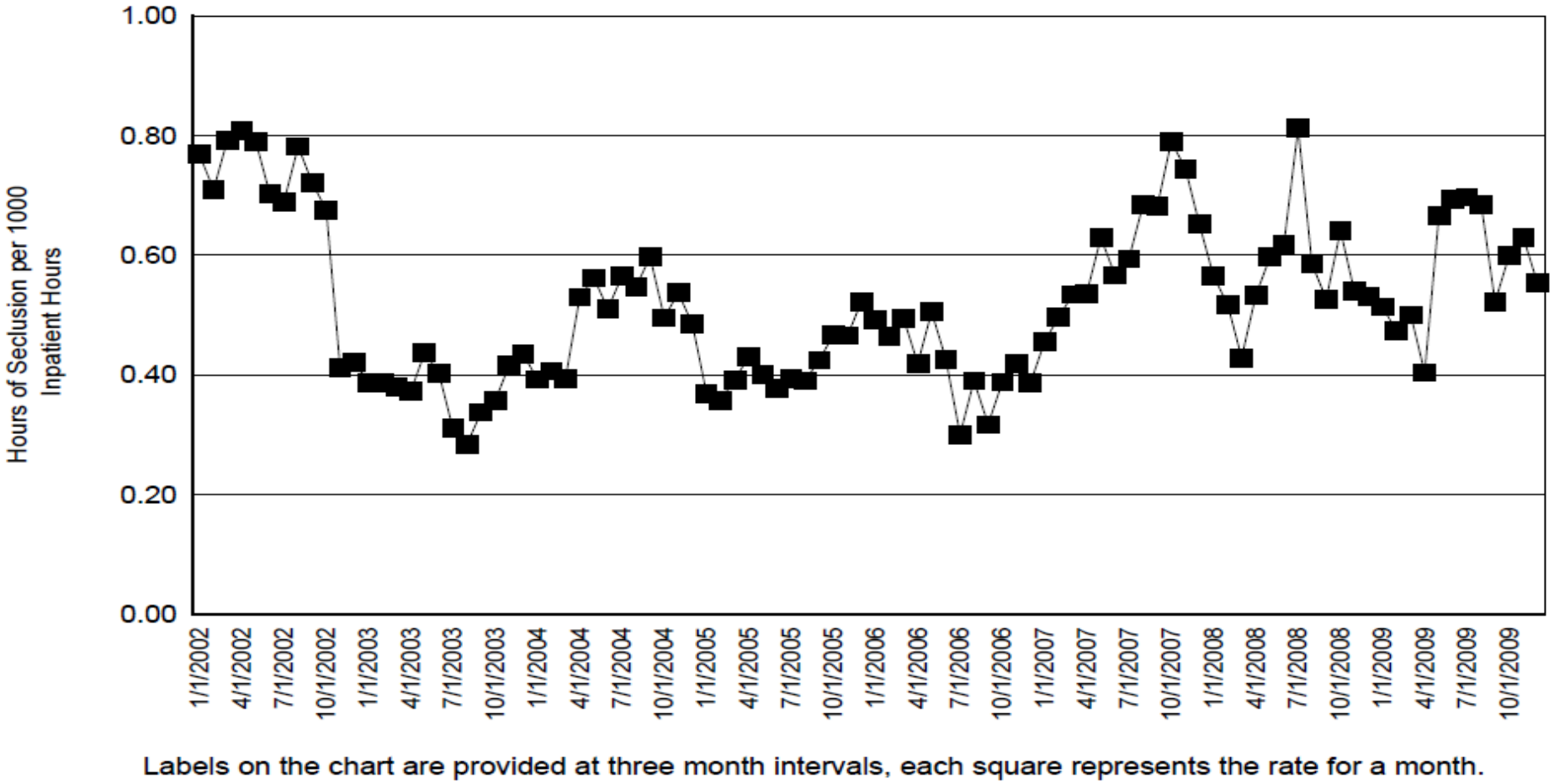
Seclusion Hours (2010)



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NRI Performance Measurement System National Public Rates: Seclusion Hours. Alexandria, Virginia:
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Substance Abuse and Mental Health Services Administration
SAMHSA
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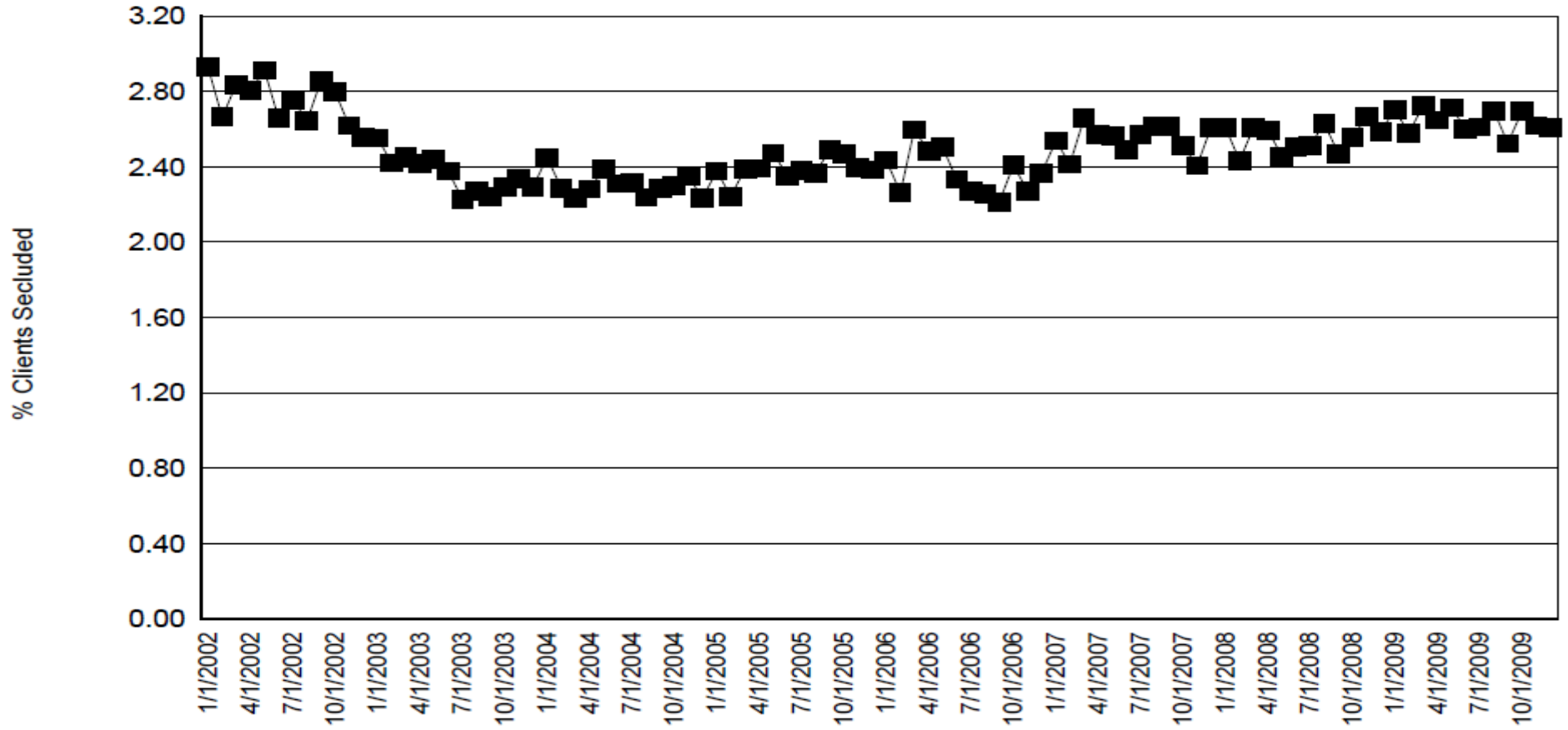
Percent of Clients Secluded (2010)



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NRI Performance Measurement System National Public Rates: Percent of Clients Secluded. Alexandria, Virginia: National Association of State Mental Health Program Directors Research Institute, May 2010

SAMHSA Key Activities

1. State Grant Program and PAIMI Grants
2. Training and TA - National TA Center; uptake of effective strategies to prevent use of SR; communities of practice
3. Addictions Roundtable
4. Facilitate Development of Federal Regulations
5. Data Elements in Facilities Surveys

S/R-Related Budget

Budget for SR Activities at SAMHSA	2006	2008	2010
CMHS: Alternatives to Restraint and Seclusion SIG	$1.7 million	$2.33 million	———
CMHS: PAIMI	$34 million ($33.3 to State P&A Systems; $680,000 TA/Training)	$34 million	$36 million
CMHS: NTAC Coordinating Center for SIG	$392,000	$324,000	$2.4 million
CMHS: Contractor to Process SIG Data	$175,000	$150,000	———

(1) Training and TA Grant Program

- Alternatives to SR SIG Grant Program (two cohorts, total of 16 states)
- National SR Coordinating Center, NTAC/Natl Association of State Mental Health Program Directors (NASMHPD)
- National Evaluation
- PAIMI Program (Protection and Advocacy for Individuals with Mental Illness)

(1) State Grant Program: Alternatives to Seclusion and Restraint

2004

- Hawaii
- Illinois
- Kentucky
- Louisiana
- Maryland
- Massachusetts
- Missouri
- Washington

2007

- Connecticut
- Indiana
- New Jersey
- New York
- Oklahoma
- Texas
- Vermont
- Virginia

Red: State also has a MH Transformation Grant

Green: State proposal to connect MHT and SR efforts

(2) Training/TA

- NTAC/Coordinating Center “Six Core Strategies”: Regional Trainings, limited State and facility TA; prevention strategies; de-escalation, crisis plans, identifying triggers, organizational cultures; reduce coercive care, etc.
- SAMHSA Roadmap Training Curriculum (Consumer-developed)
- Training Video on S&R Alternatives

- National Disability Rights Network’s Training and Advocacy Support Center Provides TA to Protection and Advocacy Agencies re S&R investigations

- National Center for Trauma-Informed Care

Sample Intervention: "Six Core Strategies"

Core Strategies

- Leadership for Organizational Change
- Rigorous Debriefing
- Use of Data to Inform Practice
- Workforce Development
- Use of SR Prevention Tools (e.g, crisis plans, identify triggers, comfort/sensory rooms, etc.)
- Full Inclusion of Consumers and Families

Results:

- Facilities can successfully implement strategies
- Results in significant reduction in use of SR
- Some facilities have eliminated SR
- Reduced conflict in Tx settings

(3) Addictions Roundtable

- 2006 Report and Key Recommendations:
  - Need for data and extent of SR in substance abuse treatment
  - SA field unaware of new and pending regulations; need to prepare treatment facilities and Single State Agencies

(4) Regulations

- CMS Hospital Conditions of Participation
  - -final standard issued 12/06
  - -one hour rule change
  - -new training requirements
  - -reporting of deaths
  - -interpretive guidelines
- Children's Health Act Regulations
  - CHA Part I for Non-Medical, Children's Residential Settings
    - NPRM submitted (Dec 2006)
    - Covered facilities
    - State, facility, and PAIMI responsibilities (specificity of orders, monitoring, training, etc.)
    - SAMHSA implementation costs

(5)Data Elements

- **Data Elements – N-MHSS; N-SSATS:**

  In the 12-month period beginning January 1, 2007 and ending December 31, 2007:

  (a)Has your staff used seclusion or restraint practices with clients?

  Yes___ No___

  (b) Has your facility adopted any initiatives toward the reduction of seclusion and restraint practices?

  Yes___ No___

Making the Business Case

- Organizational Costs
  - Staff time managing SR procedures
  - Time/motion/task analysis: 1hour restraint involved 25 different activities, claimed ~12 hours of staff time to manage and process event
  - Restraint claims >23% staff time; 50% nursing resources to manage SR
  - Opportunity costs – treatment not being provided
  - Client injuries → liability and legal costs
  - Staff injuries→turnover, absenteeism; workforce instability and dissatisfaction

Making the Business Case

- Client/Consumer Costs
  - Physical injury, sometimes death
  - Traumatized/retraumatized
  - Disruption of therapeutic relationships and mistrust of caregivers
  - Loss time for quality care and treatment

Benefits to Clients Associated with Reduction/Prevention of SR Use

- Fewer injuries
- Shorter lengths of stay
- Decreased re-hospitalization
- Less medication use
- Higher levels of functioning at time of discharge
  - (LeBel & Goldstein, 2005; Murphy and Benningto-Davis, 2005; Thomann, 2009; Paxton, 2009)

Concerns and Issues:

- Data Challenges
- Dissemination and uptake of effective approaches to reducing and eliminating SR
- For children: proliferation of unlicensed/unregulated residential treatment centers that move across state boundaries and use coercive techniques
- Expansion into schools and older adult settings; work with Federal partners, Federation of Families
- Coordination with CMS around regulatory actions
- Strengthen linkage with trauma-informed care approaches

Recent Issue Briefs on "Promoting Alternatives to the Use of Seclusion and Restraint"

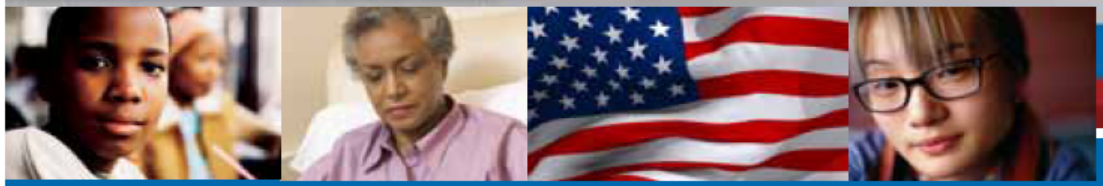
- *A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services (2010)*
- *Major Findings from SAMHSA's Alternatives to Restraint and Seclusion State Incentive Grants Program (2010)*
- *Making the Business Case for Preventing and Reducing the Restraint and Seclusion Use (2010)*

Web link to SAMHSA Seclusion and Restraint Publications and Resources:
http://www.samhsa.gov/matrix2/seclusion_matrix.aspx

Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #1

A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services



MARCH 2010

About the Series:

Promoting Alternatives to the Use of Seclusion and Restraint

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed, in collaboration with partners at the Federal, State, and local levels, consumers, and national advocacy organizations, a series of issue briefs on the use of seclusion and restraint. The purpose of this series is to provide information on the use

Introduction

In the United States each year, it is estimated that 50 to 150 individuals die as a result of seclusion and restraint practices in mental health inpatient residential facilities and many others are injured or traumatized by these events (Weiss et al., 1998). In fact, seclusion and restraint are dangerous and traumatic not only to the individuals subjected to these practices, but also for the staff implementing them. The Government Accountability Office (GAO; 1999a) noted that seclusion and restraint continue to be used in these facilities despite the psychological and physical harm they cause to consumers. The Cochrane Collaboration, which provides reviews of the evidence of health care practices, noted of seclusion and restraint: "few other forms of treatment which are applied to patients with various psychiatric diagnoses are so lacking in basic information about their proper use and efficacy" (Sailas and Fenton, 2000, p.4). In addition, surprisingly, there is no uniform method for tracking these injuries or deaths within States or across the country. The GAO (1999a) highlighted insufficient monitoring and reporting of the use of seclusion and restraint and inconsistent standards for using these practices and reporting their use.

The Substance Abuse Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services and the National Association

Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #2

Major Findings from SAMHSA's Alternatives to Restraint and Seclusion State Incentive Grants (SIG) Program

MARCH 2010

Photo collage of diverse people.

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Promoting Alternatives to the Use of Seclusion and Restraint

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Introduction

Over the past decade, there has been a significant shift in attitude and practice on the use of seclusion and restraint in mental health treatment settings. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) identified the reduction and eventual elimination of seclusion and restraint in mental health and substance abuse treatment as a key priority. Accordingly, SAMHSA developed the Alternatives to Restraint and Seclusion (ARS) State Incentive Grants (SIG) program, with the purpose "to support States in their efforts to reduce and ultimately eliminate the use of restraint and seclusion in institutional and community-based settings that provide mental health services (including services for people with co-occurring substance abuse and mental health disorders)" (Center for Mental Health Services, 2004).

This issue brief, the second in a series on the use of seclusion and restraint, provides a summary of evaluation data from this first cohort of State grantees funded through SAMHSA's ARS SIG program.

SAMHSA's SIG Program

Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #4 Making the Business Case

MARCH 2010

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Introduction

Seclusion[1] and restraint[2] are coercive, high-risk containment procedures that contribute to the problem of violence against consumers and staff members in behavioral health care settings. In fact, an estimated 50 to 150 individuals die each year as a result of seclusion and restraint practices in facilities, and countless others are injured or traumatized (Weiss et al., 1998). These practices are detrimental to the recovery of persons with mental illnesses and adversely affect the quality of care and the safety of all involved (di Martino, 2003; Huckshorn & LeBel, 2009). Equally important, yet often less recognized, is the multilevel economic burden that is inherent in their use (Flood, Bowers, & Parkin, 2008; LeBel & Goldstein, 2005).

Based on clinical best practice, inpatient and residential mental health facilities in the United States and other countries have implemented initiatives to reduce seclusion and restraint use (National Association of State Mental Health Program Directors [NASMHPD], 2009; Nunno, Day, & Bullard, 2008). Several programs that have reduced their use have reported fiscal benefits (LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Sanders, 2009). These

The Business Case for Preventing and Reducing Restraint and Seclusion Use

MAY 2010

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Lunch Break

These slides do not reflect decisions of the IACC and are for discussion purposes only.

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Agenda – continued

1:00 **Seclusion and Restraint: A Brief Look at State Policies and Practices**
Charles Moseley, Ed.D.
National Association of State Directors of Developmental Disabilities Services

1:30 **Seclusion and Restraint: An Epidemic in Our Schools**
Curtis L. Decker, J.D.
National Disability Rights Network

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Seclusion and Restraint: A Brief Look at State Policies and Practices

Charles Moseley, Ed.D.
Associate Executive Director
National Association of State Directors of Developmental Disabilities Services

Seclusion and Restraint: A Brief Look at State Practices and Strategies

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

IACC

May 19, 2011

Charles Moseley Ed.D.

National Association of State Directors of Developmental Disabilities Services

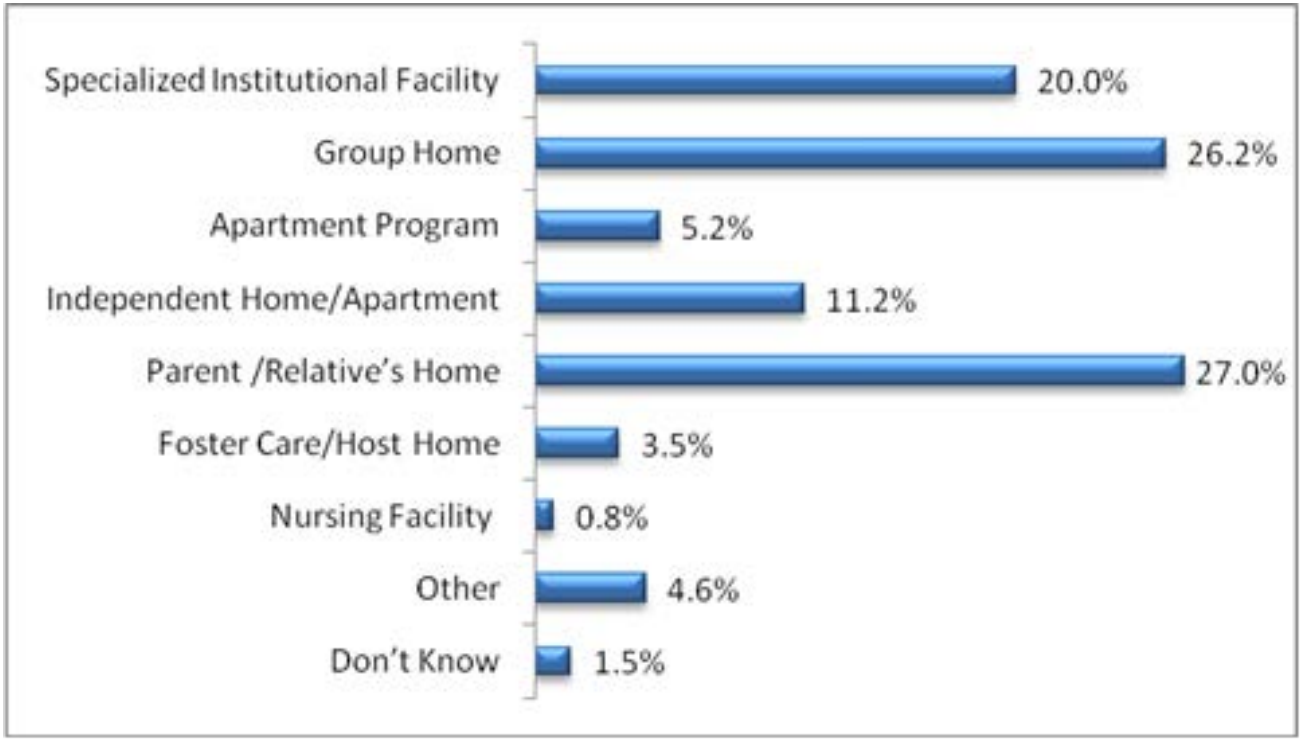
Background

State DD agencies serve people with ID/DD who have complex and challenging conditions

- Approximately 1 million people receiving support
- 36% Co-occurring DD/MI
- 11% Autism (4% in WY to 19% in NJ)
- 15% Cerebral Palsy
- 31% Seizures/neurological conditions
- 5% TBI
- Behavioral disorders
- Communication disorders

2009-10 NCI Consumer Survey

People live in a wide variety of both specialized and typical home and community based settings

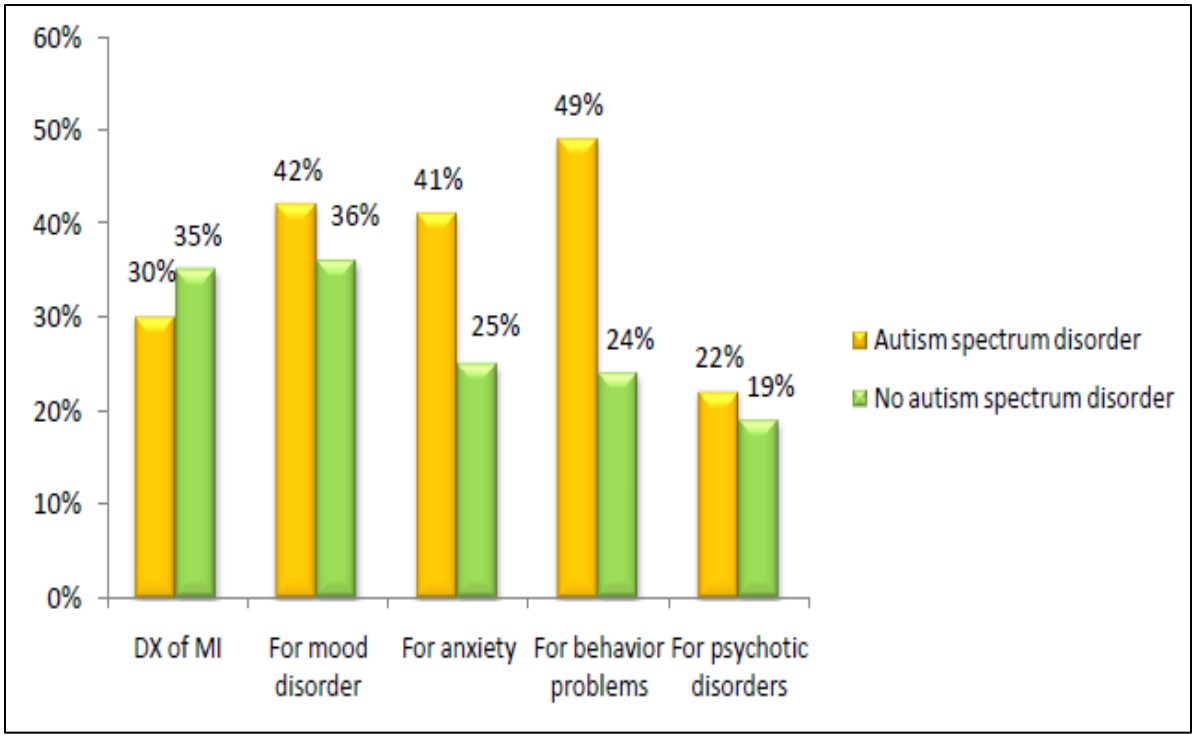


2009-10 NCI Consumer Survey

Characteristics

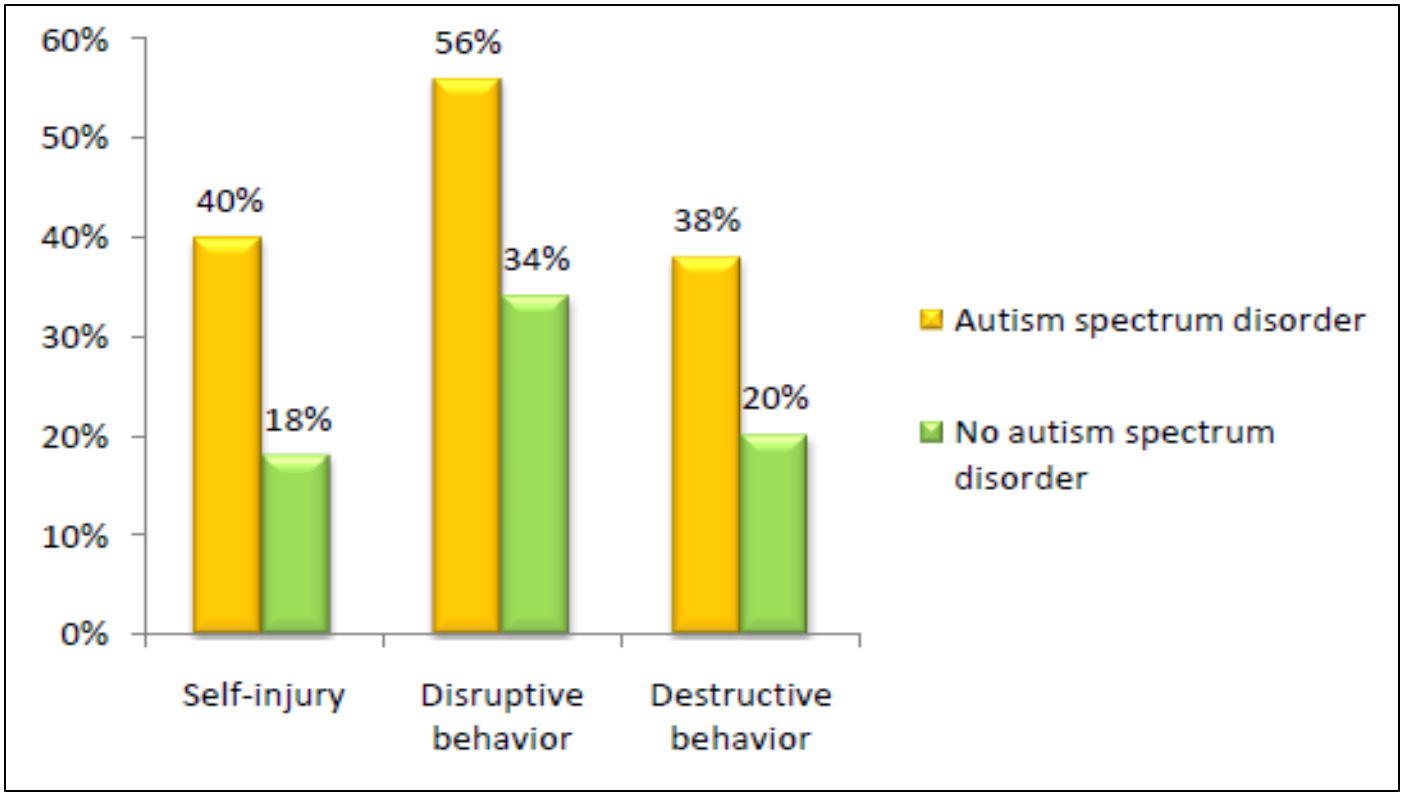
- 29% use nonverbal communication
- 51% take medications for mood disorders, anxiety, behavior problems, *or* psychotic disorders

- *Although fewer people with ASD have MI diagnoses, more likely to receive medication*



2009-10 NCI Consumer Survey

And,…



As a result, are more vulnerable to the use of seclusion and restraint.

2009-10 NCI Consumer Survey

Improving supports for people with challenging conditions is a focus of NASDDDS activities

- Newsletters
- Conferences, symposia
- Teleconferences
- Research
  - Restrictive Procedures
  - Dual diagnosis
  - Challenging behaviors

The use, reduction and elimination of restraint and seclusion in services

- Significant concern to NASDDDS members
- Involves a recognition of trauma in the lives of people with DD
  - More than 90% of people with DD will experience sexual abuse in their lifetime. (ARC, 1995)
  - People with DD are 4-10 times more likely to be victims of crime than those without DD (Wilson and Brewer, 1992)
    - Assault – 3 times higher
    - Sexual assault – 11 times higher
    - Robbery – 13 times higher
  - Over 5 million crimes committed against people with DD each year

Restraint and Seclusion

- In the past was seen as therapeutic
  - Keeps people receiving support and staff safe
  - Helping people regain control
  - Based on clinical evidence and knowledge
  - Used only when necessary, for safety
- But we know now that this is not true
  - Restraint can be a source of trauma experience
  - Restraint may trigger re-experience of trauma
  - Restraint may have been a part of the original trauma

Restraint and Seclusion

- Used for the wrong reasons
  - Failure of other treatment methods
  - Staff convenience
  - Power struggles
- **Unwanted outcomes:**
  - Injuries: Coma, broken bones, bruises, cuts requiring stitches
  - Deaths due to: asphyxiation, strangulation, cardiac arrest, blunt trauma
- **Significantly undermines the ability to develop the positive relationships that people need**

Trauma Informed Care

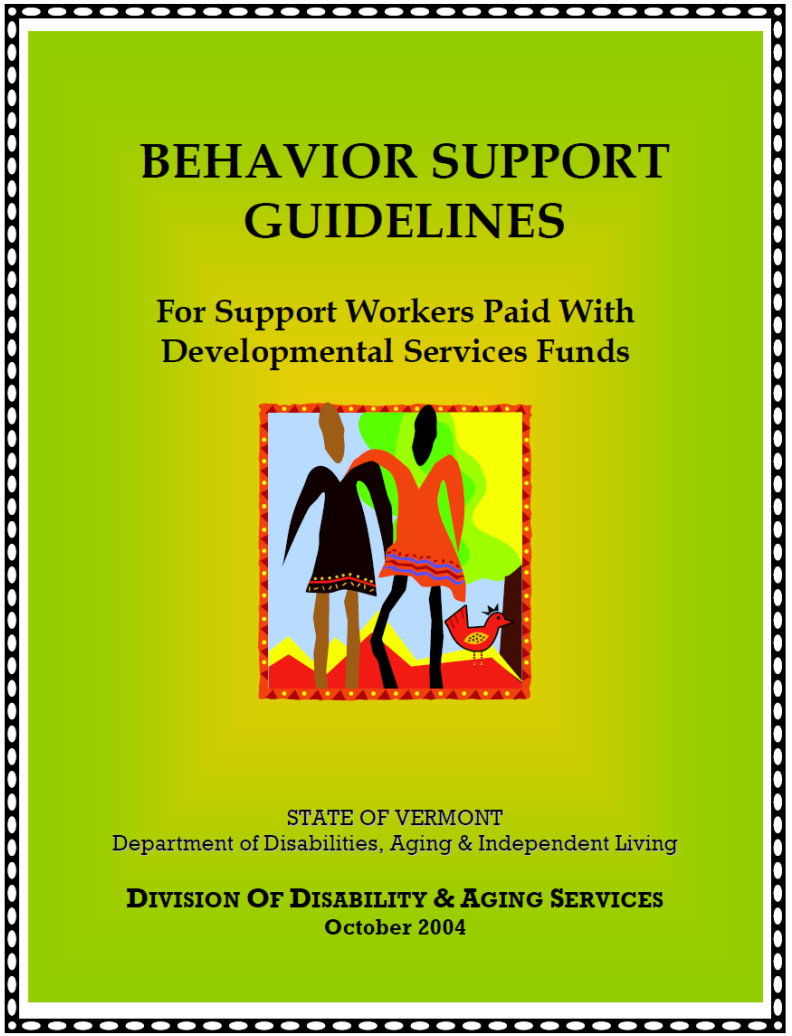
- Recognizes the significant amount of trauma experienced by people with ID/DD
  - In institutions; in schools; in services
- The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism, and disasters (NASMHPD 2004).
- Includes verbal, psychological and emotional abuse
- For persons with DD, the difficulties people have in expressing and resolving the trauma they have experienced

Understanding leads to Change

- Development of positive behavioral support strategies in states across the country
- In-depth program review and reassessment
- Broad based system change in several states
- Vermont
- Maryland
- Ohio

Vermont

- Closed state institution and moved services to community
- Reviewed and rewrote the statutory and regulatory framework
- Clear regulations & system expectations
  - Restraint
  - Restriction of rights
  - Prohibited seclusion



Maryland DDA *Restraint Elimination Initiative*

- Led by DDA Executive Director in Spring 2008
- Goal was the elimination of restraint
- Established a joint Task Force with 18 members from government, provider and advocacy groups
- Final report disseminated in July 2010
- Provided specific recommendations to the DDA management team

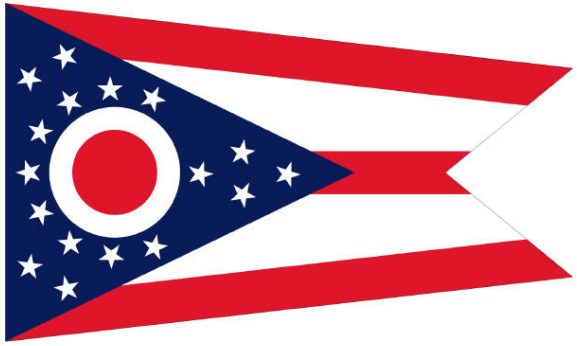
Maryland's System Change Strategy

- Leadership toward organizational change
  - Articulating a vision, values and philosophy that expects S/R reduction
  - Developing and implementing a performance based improvement action plan
  - Holding people accountable to that plan.
- Use of data to inform practice
  - Tracking performance and outcomes
- Workforce development
  - Treatment environment that is less likely to be coercive or trigger conflicts.
  - Intensive staff training and education

Maryland *continued..*

- Use of restraint prevention tools
  - Individualized approaches
  - Person-centered supports and treatment
  - Trauma and risk assessment strategies
- Full inclusion of self-advocates in oversight, monitoring, peer support
- Debriefing activities to analyze every event that takes place

Ohio



A statewide initiative launched by the Director John Martin in 2008

- Intended to bring about lasting change within the DD system
- Shift thinking away from behavior change through aversive measures and toward relationships that support good lives
- Shift away from behavior management to new conversations about what people want and need

Shift in Approach

Away From

- ✓ Focusing exclusively on challenging behavior
- ✓ "Here's how to do it"
- ✓ Importing outside experts
- ✓ Directed by DODD

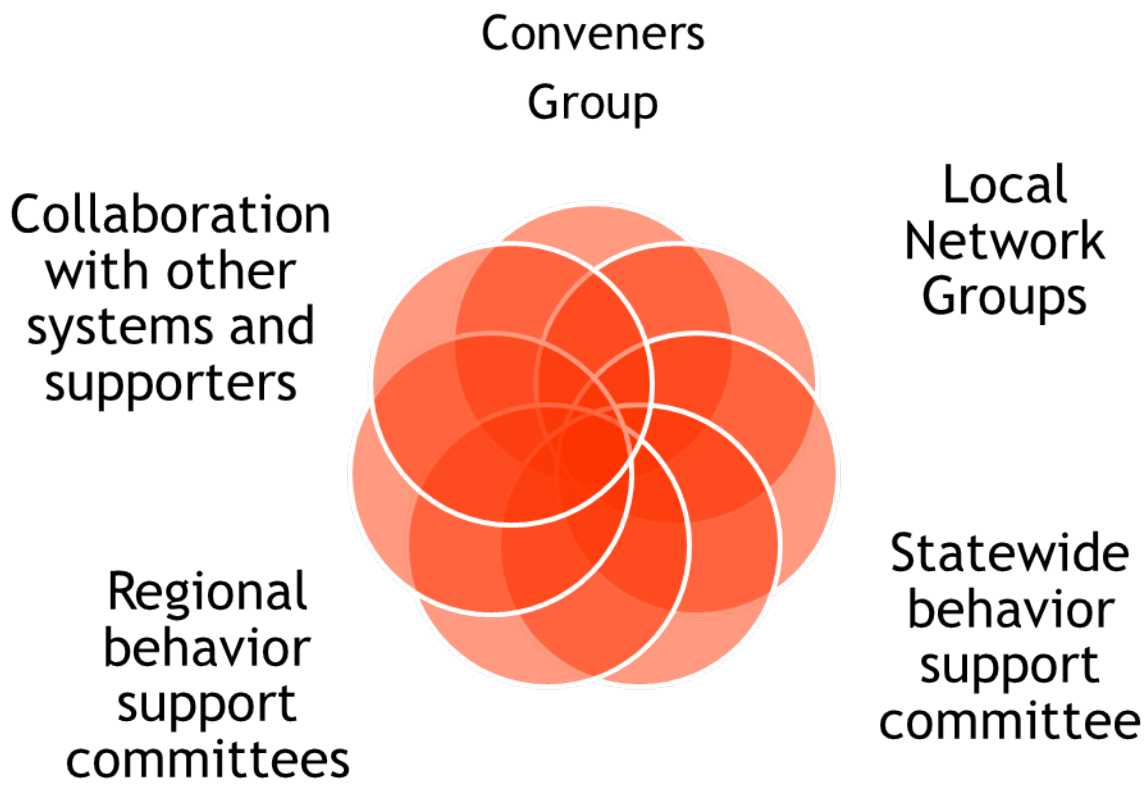
Toward

- ✓ Focus on building culture and practices that support good lives
- ✓ We can learn to do this together
- ✓ Identify and build our capacity
- ✓ Owned by a diverse group of people across Ohio

Initial Focus

- Shifting people's belief through training, tools and resources
- Overview of the Positive Culture Initiative
- Gentle Teaching
- Dangers of Restraint and Seclusion
- Trauma-Informed Care

Components of the Initiative



Behavior Support Advisory Committee

- 2008 Recommended a ban on prone restraints
- 2009 Created Crisis Intervention and Prevention Assessment Tool
- Developed training curriculum
- 2009-2010 Collected data on the use of restraint and seclusion to assess progress toward positive practices
- 2011 Developing guidebook to outline Ohio's approach toward a positive culture

Final thoughts

- State DD agency directors are committed to reducing the use of restraints and seclusion
- Several other states are implementing similar programs
- Work in progress

"I think that any approach that enhances a person's sense of values and dignity is worth a lifetime of trying.

Behavior change should be seen as growth rather than a series of defeats and surrenders."

- Herb Lovett

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Seclusion and Restraint: An Epidemic in Our Schools

Curtis L. Decker, J.D.
Executive Director
National Disability Rights Network

Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Afternoon Agenda - continued

2:00 Effective Implementation of School-Wide Positive Behavior Support: Reducing the Need for Seclusion and Restraint
Robert F. Putnam, Ph.D., BCBA-D
School Consultation
May Institute

2:30 Break

2:45 Discussion

4:00 Closing Comments/Adjournment

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Joint Meeting of the Subcommittee on Safety and Services Subcommittee

Effective Implementation of School-Wide Positive Behavior Support: Reducing the Need for Seclusion and Restraint

Robert F. Putnam, Ph.D., BCBA-D
Senior Vice President, School Consultation
May Institute
Technical Assistance Center for Positive Behavior Interventions and Supports

Effective Implementation of School-wide Positive Behavior Supports: Reducing the Need for Seclusion and Restraint

Bob Putnam Ph.D., BCBA-D

May Institute

OSEP Center on Positive Behavioral Interventions and Supports

National Autism Center

Interagency Autism Coordinating Committee
May 19, 2011

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Executive Director

National Autism Center

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School-wide Positive Behavior Supports

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School-wide Positive Behavior Supports

- **School-wide Positive Behavior Supports (SWPBS) is a systems approach to establishing the whole-school social culture and intensive individual behavior supports needed for schools to achieve social and academic gains while minimizing problem behavior for all students.**

School-wide Positive Behavior Supports

- **SWPBS is NOT a specific curriculum, intervention, or practice, but a decision making framework that guides selection, integration, and implementation of scientifically-based behavioral and academic practices for improving behavior and academic outcomes for all students.**

School-wide Positive Behavior Supports

- **Emphasis on four integrated elements:**
  - **socially valued and measurable outcomes**
  - **empirically validated and practical practices**
  - **systems that efficiently and effective support implementation of these practices**
  - **continuous collection and use of data for decision-making.**

School-wide Positive Behavior Supports

- **SWPBS approaches these issues from a multi-tiered prevention logic to prevent these behaviors from occurring in the first place, and to develop positive, more intensive intervention strategies if the behaviors of a student proves to be unresponsive.**

SWPBS – Guiding Principles

SWPBS – Guiding Principles

- **Invest first in prevention to establish a foundation intervention that is empirically validated to be effective, efficient and sustainable.**
- **Teach and acknowledge appropriate behavior before relying on negative consequences.**

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SWPBS – Guiding Principles

- **Identify students who need more intense support and provide that support as early as possible, and with the intensity needed to meet the student's need.**

SWPBS – Guiding Principles

- **Establish a continuum of behavioral and academic interventions for use when students are identified as needing more intense support.**
- **Use progress monitoring to assess**
  - **the fidelity with which support is provided**
  - **the impact of support on student academic and social outcomes. Use data for continuous improvement of support.**

Concerns About Seclusion and Restraint

Concerns About Seclusion and Restraint

- **Seclusion and restraint refer to safety procedures in which a student is isolated from others (seclusion) or physically held (restraint) in response to serious problem behavior that places the student or others at risk of injury or harm.**

Concerns About Seclusion and Restraint

- **Concern exists that these procedures are prone to misapplication and abuse placing students at equal or more risk than their problem behavior (Hill & Spreat, 1987; Williams, 2009).**

Concerns About Seclusion and Restraint

- **Seclusion and restraint procedures are inappropriately selected and implemented as "treatment" or "behavioral intervention," rather than as a safety procedure.**
- **Seclusion and restraint are inappropriately used for behaviors that do not place the student or others at risk of harm or injury (e.g., noncompliance, threats, disruption).**

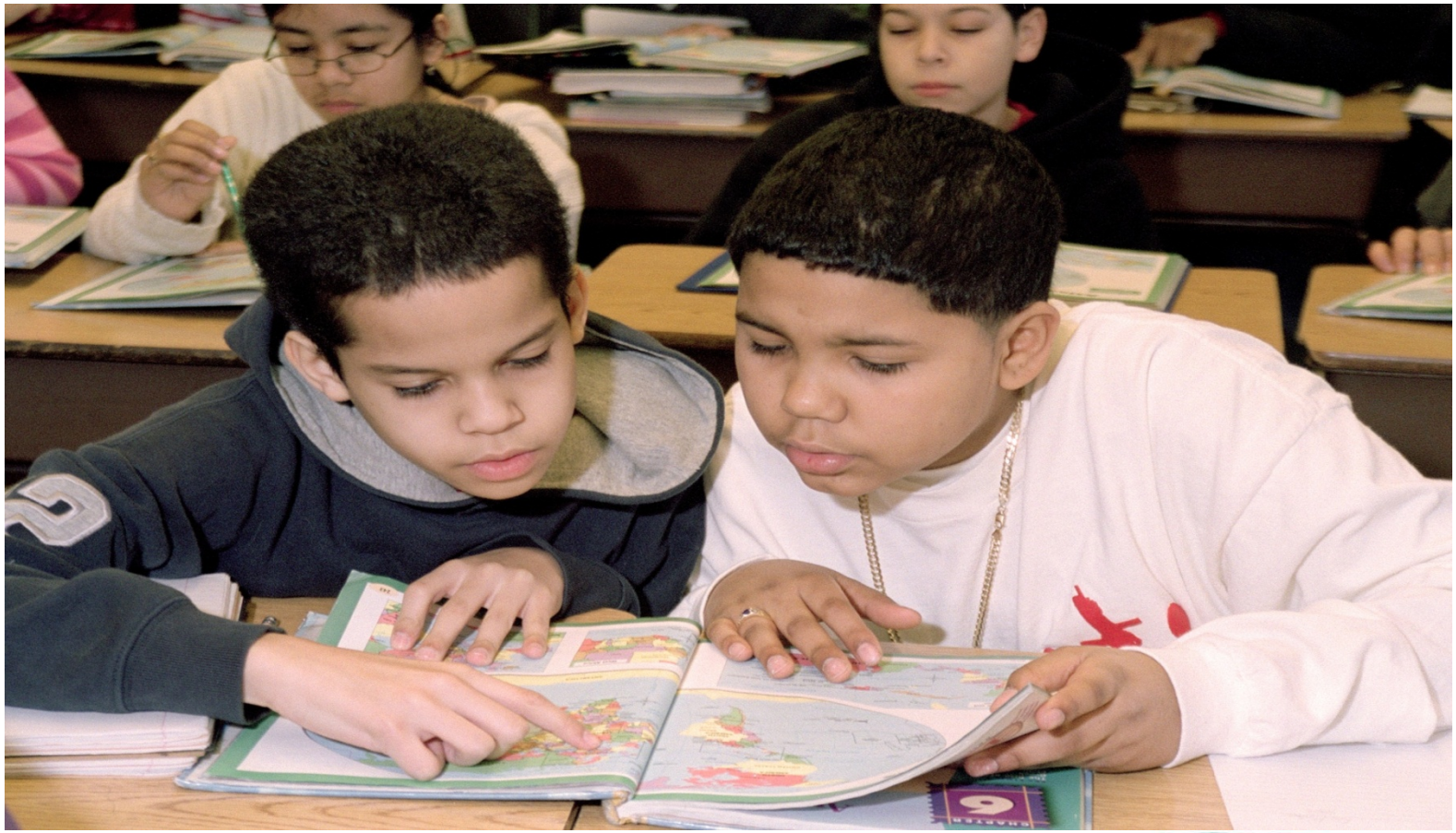
Concerns About Seclusion and Restraint

- **Students, peers, and/or staff may be physically hurt or injured during attempts to conduct seclusion and restraint procedures (Hill & Spreat, 1987; Williams, 2009).**
- **Risk of injury and harm is increased because seclusion and restraint are implemented by staff who are not adequately trained (Cunningham, McDonnell, Easton, & Sturmey, 2003; McDonnell & Sturmey, 2000).**

Concerns About Seclusion and Restraint

- **Use of seclusion and restraint may inadvertently result in reinforcement or strengthening of the problem behavior (Favell, McGimsey, & Jones, 1978).**
- **Seclusion and restraint are implemented independent of comprehensive, function-based behavioral intervention plans.**

Research Supporting Implementation of School-wide Positive Behavior Supports



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Research Supporting Implementation of School-wide Positive Behavior Supports

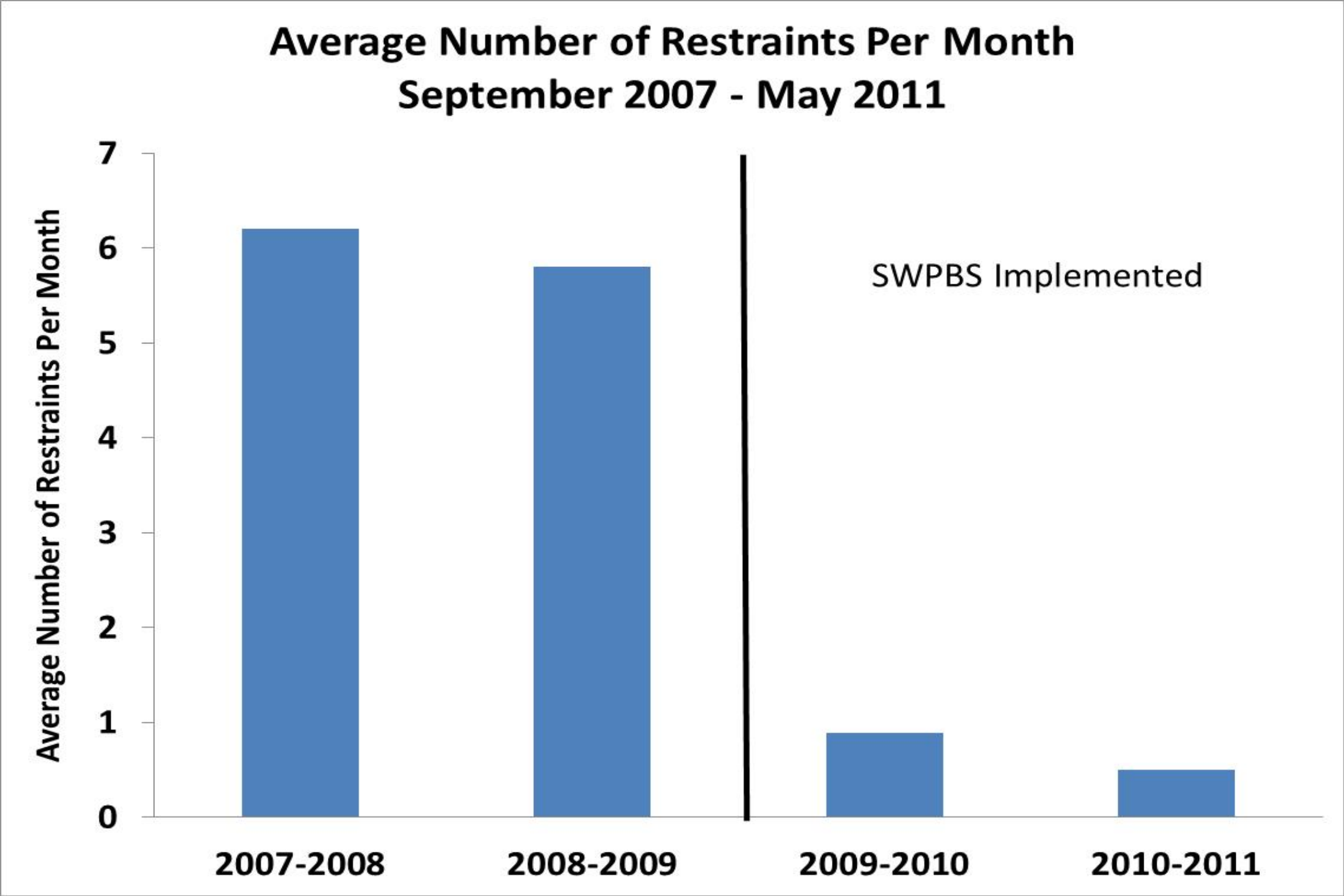
- **Schools are able to implement SWPBS as evidenced by more than 14,000 schools using SWPBS across the nation.**
- **Schools that implement SWPBS demonstrate reductions in problem behavior and improved academic outcomes (Bradshaw, Mitchell, & Leaf, 2010; Horner, Sugai, & Anderson, 2010).**

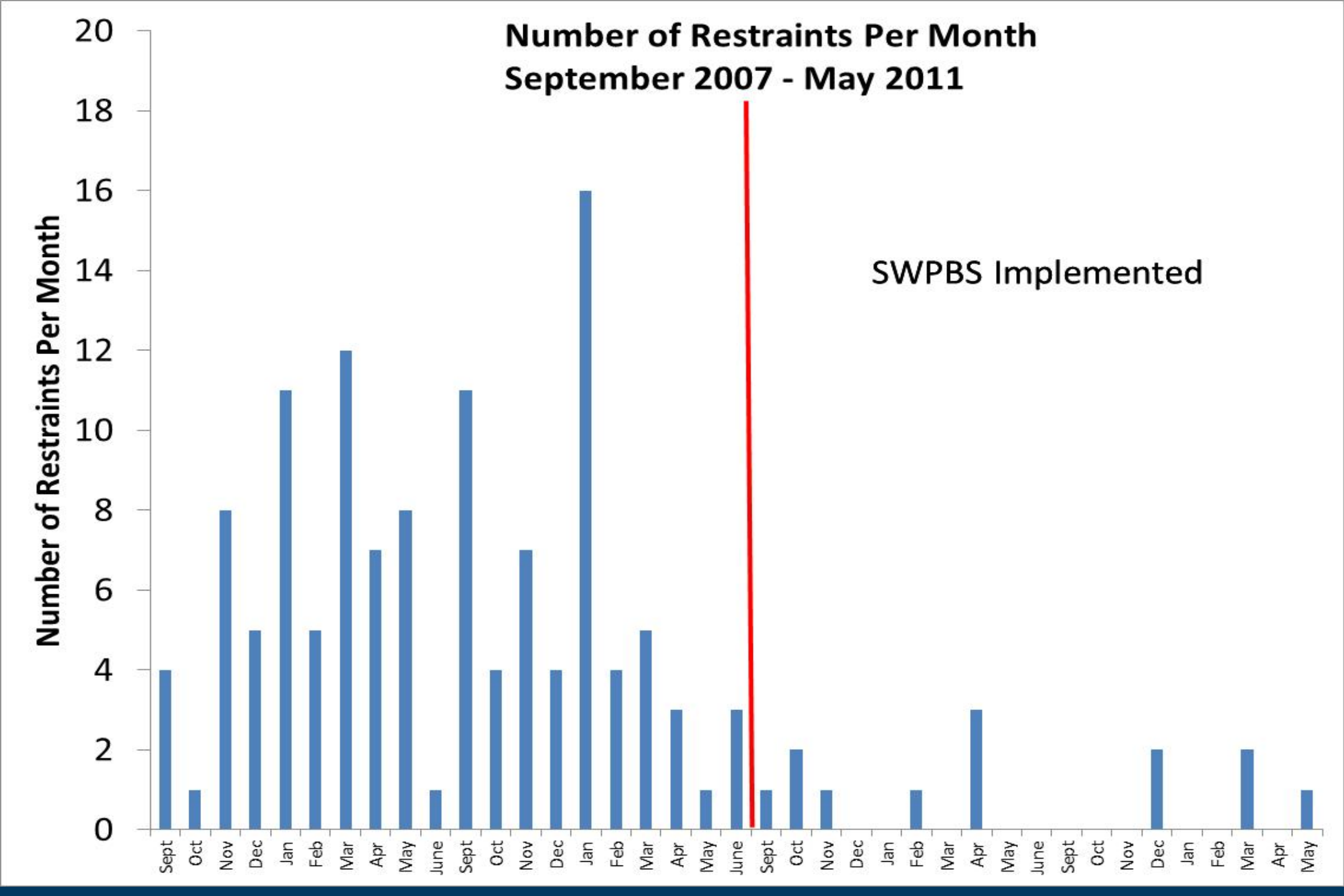
Research Supporting Implementation of School-wide Positive Behavior Supports

- **Preliminary evaluation data indicate that more intensive individual student behavior support is perceived as more effective (and less likely to be needed) when SWPBS is implemented (Medley, Little, & Akin-Little, 2007).**

Research Supporting Implementation of School-wide Positive Behavior Supports

- **Evaluation (but not experimental) data indicate that implementation of SWPBS is**
  - **associated with reduction in the number of instances in which intensive interventions or practices (including seclusion and/or restraint) are perceived as needed,**
  - **increases the effectiveness of comprehensive interventions, and**
  - **improves the maintenance of behavior support gains (Feinberg, Simonsen & Putnam, 2010).**


Average Number of Restraints Per Month
September 2007 - May 2011
Average Number of Restraints Per Month
7
6
5
4
3
2
1
0
SWPBS Implemented
2007-2008
2008-2009
2009-2010
2010-2011


Number of Restraints Per Month
September 2007 - May 2011
SWPBS Implemented
Number of Restraints Per Month
0
2
4
6
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14
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Sept
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School-wide Positive Behavior Supports

- **George (2000) with the implementation of SWPBS in an alternative school in a year over year basis found that:**
  - **the number of physical restraints decreased by 69%**
  - **the number of minutes of seclusion decreased by 77%.**
  - **Only one instance of physical restraint was used in the last 40 days of school.**

Positive Behavior Supports

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Positive Behavior Supports

- **Preventive (Functional Behavior) assessments should be conducted to understand these situations concerning the problem behavior:**
  - **where**
  - **under what conditions**
  - **when**
  - **with whom**
  - **why**

Positive Behavior Supports

- **Functional behavior assessments should include:**
  - **review of archival records**
  - **interviews with parents, family members, and students**
  - **direct observation**
  - **collection of and analysis of observational data**
  - **examination of previous and existing behavioral intervention plans.**

Positive Behavior Supports

- **Any behavioral intervention must be consistent with the student's right to be treated with dignity and to be free from abuse, regardless of the student's educational needs or behavioral challenges.**
- **Behavioral interventions should be preventive, constructive, and positive in their features, implementation, and intent.**

Positive Behavior Supports

- **Behavioral interventions should be empirically documented for its effectiveness and efficacy**
- **Behavioral interventions should be adapted to the contextual or cultural characteristics of the student, staff, and setting**
- **Staff members should be trained to the highest level of implementation fidelity (accuracy and fluency)**

Effectiveness of Positive Behavior Supports

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Effectiveness of Positive Behavior Supports

- **Carr et al., (1999) completed a comprehensive meta-analysis of the efficacy of positive behavior support interventions for people with developmental disabilities who engage in severe problem behavior.**
  - **PBS was found to be effective for examined problem behaviors and across a wide variety of participants, and settings.**
  - **Effect sizes were large and associated with reductions in problem behavior that usually exceeded 80%.**
  - **PBS was most effective when a functional assessment was completed and used to design interventions.**

Effectiveness of Positive Behavior Supports

- **The National Autism Center's National Standard Project found that the vast majority of treatments that have been shown to be effective through well-controlled research come from behavioral fields such as positive behavior supports, applied behavior analysis and behavioral psychology (2009).**

Toward Effective Policy

Toward Effective Policy

- **The majority of problem behaviors that are used to justify seclusion and restraint could be prevented with early identification and intensive early intervention. The need for seclusion and restraint procedures is in part a result of insufficient investment in prevention efforts.**

Toward Effective Policy

- **Seclusion and restraint can be included as a safety response, but should not be included in a behavior support plan without a formal functional behavioral assessment (a process used to identify the context in which the behavior occurs and why the problem behavior continues to occur).**

Toward Effective Policy

- **Seclusion and restraint should only be implemented**
  - **as safety measures**
  - **within a comprehensive behavior support plan**
  - **by highly trained personnel, and**
  - **with public, accurate, and continuous data related to:**
    - **fidelity of implementation and**
    - **impact on behavioral outcomes (both increasing desired and decreasing problem behaviors).**

Questions

- **For more information**
  - **bputnam@mayinstitute.org**
  - **pbis.org**
  - **nationalautismcenter.org**

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Break

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Discussion

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Closing Comments/Adjournment

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