Coordinated Behavior Support Standards Across Children's Service Settings: A Progress Report

Report
to the Governor and Legislature
March 2010

COORDINATED BEHAVIOR SUPPORT STANDARDS ACROSS CHILDREN'S SERVICE SETTINGS: A PROGRESS REPORT

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A Message from the Council on Children and Families

On behalf of the *Committee on Restraint and Crisis Intervention Techniques (RCIT)*, I am pleased to provide a progress report of the work undertaken to implement a set of coordinated behavior support standards across the agencies that authorize the use of restraint. Since the RCIT Committee's release of its initial report in 2007, the Office of Children and Family Services, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the State Education Department have taken measures to make the coordinated standards a part of ongoing practice within their respective systems.

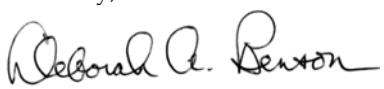
Much work has been done. Regulations are being modified so children across settings have access to behavior supports that will reduce the need for high risk crisis interventions. Additionally, training has been enhanced and is more readily available so a broader range of staff have the skills necessary to provide children with effective behavior supports. Last, state agencies are moving forward to enhance data collection efforts that inform program and policy decisions. We must continue the work begun in these areas so that all state agencies achieve the same high level of implementation.

An outstanding issue that requires continued effort is the use of a single restraint technique for multiply licensed providers with co-located programs. Considerable work was undertaken to move this issue forward; however, the resources required during this difficult fiscal time have delayed our progress.

A new dimension of this report examines issues regarding behavior support practices in children's day treatment programs and, like the original standards, committee members must continue their work so that the recommendations introduced in this report are implemented.

The work begun here is complex. We have made considerable progress and must maintain a long-range view to ensure success. My thanks to RCIT Committee members for their dedication to this issue. I look forward to our continued collaboration.

Sincerely,



Deborah A. Benson
Executive Director
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Executive Summary & Recommendations

The Office of Children and Family Services (OCFS), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Mental Health (OMH) and State Education Department (SED) operate, license or approve child serving programs that authorize the use of crisis intervention techniques. Physical restraint is one of the most restrictive and potentially dangerous forms of crisis intervention. Given the high risks associated with physical restraint, each state agency has longstanding statutes and/or regulations regarding its use. These standards are based on the agency's mission; the unique characteristics and service needs of children served; and federal mandates. The variations in these standards have broad implications for children and staff across service settings. In particular, they have consequences for providers of care that have more than one license from the various state agencies. Clearly, a coordinated set of standards, grounded in research and acknowledged as best practices, results in positive benefits for children served in programs authorized to use restraint. Additionally, coordinated standards improve the ability of staff to fulfill their job responsibilities and provide children with appropriate behavior supports.

Pursuant to Chapter 624 of the Laws of 2006, the Council on Children and Families (Council) was directed to establish the Committee on Restraint and Crisis Intervention Techniques (RCIT). The RCIT Committee was required to identify the most effective, least restrictive and safest techniques for the modification of children's behavior and to establish coordinated standards giving preference to the least restrictive alternative for the use of such techniques.

In 2007, the RCIT Committee produced a report[1] that identified a core set of standards recommended for use by state agencies that authorize the use of restraint in settings that serve children. Specifically, it was recommended that these standards be implemented at programs outlined in Chapter 624 of the Laws of 2006, with the exception of day treatment programs. Day treatment programs were not included in the original work of the committee due to distinct crisis intervention policies that distinguish day treatment programs from residential and inpatient settings. However, it was also noted in that report that the work of the committee should continue to address crisis intervention practices related to day treatment programs.

Chapter 470 of the Laws of 2008 (Appendix A) expanded the responsibilities of the RCIT Committee to report on progress made by each state agency to implement coordinated standards outlined in the original report; report on aggregate agency-specific data and improvements in agency-specific monitoring systems; include children's day treatment programs and any other setting serving children that authorizes the use of restraints in each of the standards presented in the 2007 report; and provide additional recommendations, as necessary. The report presented here details the work conducted, to date, to address the obligations outlined in Chapter 470 of the Laws of 2008.

[1] The 2007 report, Behavior Support & Management: Coordinated Standards for Children's Systems of Care, is available online at: www.ccf.state.ny.us/Initiatives/RestraintRelate/RestraintResources/RestraintReport.pdf

Progress made to implement coordinated behavior support standards in residential and inpatient settings that serve children

In the 2007 report, the RCIT Committee identified a set of coordinated standards to be implemented across residential and inpatient settings that serve children. It was also recommended that the standards be applied to special act school districts. The standards entail:

- Staff trained in recognized, competency-based programs
- Individual behavior support plans available for children at risk of being restrained
- Uniform conditions for the use of restraint
- Use of an accepted physical restraint technique
- Use of monitoring practices during restraints
- Methods that inform quality and practice from the perspective of children and staff
- Monitoring and data reporting to provide a comprehensive view of restraint use and restraint-related injuries

The standards are being implemented primarily through three means. First, most agencies are revising regulations and proposing statute amendments. This strategy, while time consuming, is essential since it increases visibility of standards. Increased access to high-quality training is a second method used to address standards. Last, agencies are in the process of developing or enhancing monitoring systems that provide program and state policy makers with information regarding restraint use and related injuries.

Although work is underway, two particular standards have not been implemented to date. The first is related to the standard calling for uniform conditions for the use of restraint. OCFS, OMH and OMRDD have work underway with respect to this standard and once this work is complete, the three agencies will have statute and regulations that share common conditions across their systems for when a restraint can be used. SED does not have specific regulations pertaining solely to the use of physical restraint. However, in 2007, SED enacted regulations relating to the use of emergency interventions, which would include the use of physical restraint, as well as other program standards for behavioral interventions. SED is reviewing ways to provide greater clarity to schools regarding interpretation of SED regulations that pertain to reasonable physical force and emergency interventions.

The second outstanding issue is related to the standard regarding implementation of a common restraint technique for multiple licensed providers with co-located programs. The 2007 report recommended that OCFS adopt the same restraint technique endorsed by OMH and OMRDD in instances where multiple licensed providers served children in co-located sites. OCFS and the multiple licensed providers with co-located programs have taken substantial steps to identify ways to achieve this standard. However, resource issues are preventing more progress at this time. Although the reason for non-implementation is genuine, the reality of how this influences staff and their interactions with children in these settings cannot be overlooked. The committee will continue efforts to promote consistent implementation of this and all other standards across the four agencies.

Agency-specific Data Systems

Monitoring systems provide critical data for successful risk management, namely information about the rate at which restraints and restraint-related injuries occur. These systems allow state policy makers to examine the frequency of restraint, where and when it occurs, and whether injuries resulted. Moreover, this information, when shared with key audiences, (e.g., board members, staff, program executives) fosters organizational change that supports alternatives to restraint. Due to the important role restraint-related data play in risk management and enhanced safety practices, agencies have outlined a number of ways data monitoring systems, in place and under development, will be enhanced.

The OMH monitoring system used to track restraint information was established in 2001 and is used to provide feedback to programs regarding use of restraint. The length of time this system has been in place allows OMH to view trends for extended periods. The OCFS Automated Restraint Tracking System (ARTS), which was implemented in late 2007, is relatively new and OCFS staff are working with providers to increase the availability and reliability of trend data. OMRDD has an automated system that tracks injuries, not restraints, and is exploring the types of data that could be reported to the Bureau of Quality Management and/or Bureau of Behavior and Clinical Solutions as well as whether the current injury tracking system could be modified to incorporate restraint data. In 2009, SED conducted a statewide survey of residential programs to obtain information from each of its approved programs regarding the school's use of physical restraints, frequency of injuries and the types of training curricula used to instruct staff in crisis intervention.

Standards Applied to Day Treatment Programs

Children's day treatment programs are integrated mental health and special education programs. The programs are certified by OMH as day treatment programs and the education programs that are operated by a private school or Special Act School District are approved by SED. Through these programs, a comprehensive array of mental health and education services are provided to children and adolescents diagnosed with serious emotional disturbances. Children's day treatment programs were not included in the original work of the RCIT Committee due to distinct crisis intervention policies that distinguish day treatment programs from residential and inpatient settings. The committee recognized further work was needed to address behavior support issues related to day treatment programs and Chapter 470 of the Laws of 2008 required the committee to include day treatment in each of the standards presented in the 2007 report. Accordingly, a subcommittee of RCIT Committee members and representatives from children's day treatment programs was convened.

Children's day treatment programs pose a particularly difficult challenge for coordinated standards since the two agencies that oversee these programs have dichotomous policies regarding the use of restraint. SED allows for the use of reasonable physical force in all education settings while OMH prohibits the use of restraint in community-based programs, such as day treatment programs.[2] The goal of the subcommittee was to move these agencies toward more

[2] The exception to this is when OMH operates the education program. Pursuant to Education Law section 112, the rules of the agency operating the school prevail.

common ground by emphasizing standards that (1) promote behavior supports associated with restraint prevention and reduction and (2) increase the guidance provided by agencies to licensed programs regarding how best to address these program differences. When possible, the subcommittee built on standards outlined in the 2007 report. It is the expectation of the RCIT Committee that the incremental steps proposed will begin to lead to more coordinated, consistent practices between the mental health and education staff at the program level, which, in turn, may serve to drive policies that promote positive behavioral supports.

The following standards are based on current research on trauma informed care, input from day treatment staff and administrators and national trends to prevent and reduce the use of restraint.

Staff trained in a recognized, competency-based program

This standard, which was also noted in the 2007 report, is central to effective behavior support. It is recognized that there is considerable variation in the level of functioning among children in day treatment programs. Consequently, staff training should include guidance on directive techniques that can be used by staff, organized on a continuum of responses ranging from prevention through de-escalation of crisis situations.

Use of individual behavior support plans

Use of an individualized behavior support or calming plan, also identified in the 2007 report, is a valuable tool for children and the individuals who interact with them. These plans should be developed by staff and individuals who know the child best, including parents or guardians and the children themselves. It is particularly helpful if parents are well-versed in the plan content and able to use the behavior support techniques described in the plan so they are equipped to support their child at home. Furthermore, as noted in the 2007 report, these plans should build on functional behavioral assessments (FBAs), which provide a thorough understanding of each child's behavior.

Clear behavior support policies jointly developed by OMH and SED

It was noted that providers would benefit from practice guidelines that detail behavior support practices that may be used by the provider; the circumstances under which they may be used; and how the practices will be clinically reviewed. Guidance on directive techniques that can be used by staff, organized on a continuum of responses ranging from prevention through de-escalation of crisis situations would be particularly helpful as well as the level and degree of touch. Furthermore, information should include what practices will be documented and how they will be reported to the respective licensing agencies. Developed jointly by OMH and SED, this document could underscore a common philosophical approach to behavior support and serve to promote a more integrated, consistent approach to behavior support.

Use of a wide range of behavior supports to assist children and staff

This standard underscores the benefit realized when staff have genuine behavior support options available to them, especially options that promote prevention. Staff described how program location, the physical layout and staffing can influence their ability to develop environments that provide children with effective supports. Additionally, education staff indicated access to behavioral consultants substantially improved their ability to address student needs.

Recommendations

Continue work begun to implement standards in settings that authorize restraint

The actions needed to implement the standards outlined in the 2007 report are underway, with each agency assuming responsibility for modifications required within a particular agency. These actions include changes to regulations and statute amendments; modifications and expansion of training programs; and development or expansion of data collection strategies that provide data up to the state level regarding the use of restraints and restraint related injuries. The RCIT Committee acknowledges the work begun and recommends agencies continue efforts until all standards are fully implemented. Of particular importance is the following future work:

Continue efforts to establish a common set of conditions across agencies for the use of restraint
This standard is at the heart of the RCIT Committee and addresses disparities in practices across agencies. The RCIT Committee will continue to monitor the work agencies have in place to modify regulations and statute as well as monitor actions that may be taken by SED to provide greater clarity to providers with respect to SED regulations.

Continue efforts to address use of a common restraint technique at multiple licensed, co-located sites
Staff concerns regarding the appropriate technique to use at multiple licensed sites was a driving force for the original legislation and quickly following the release of the 2007 report, OCFS partnered with OMH, OMRDD and providers to begin implementing the standard that would alleviate this problem. Although additional resources needed to fully implement this standard are not available at this time, the RCIT Committee continues to be committed to this standard and recognizes the importance of RCIT Committee members who represent providers, parents and state agencies to work together to identify resources to accomplish the work begun here.

Continue to advance data systems and use information in policy development and program planning
Data logs at the local level are beneficial to the extent that leadership is able to compile and review the logs. This helps inform practice and can have an impact on the local program. While this activity is fundamental for changes at the local level, it is not sufficient. The RCIT Committee recognizes state policy makers should also be aware of the practices implemented locally since state policy makers are charged with oversight responsibilities. Therefore, the RCIT Committee recommends continuing the work begun so each state agency with oversight responsibility has timely access to data about the use of restraint and restraint-related injuries. This information should be reported to the state level on a regular basis.

Implement behavior support standards in children's day treatment programs

When possible, the standards that have been outlined for day treatment programs build on behavior support standards established in the 2007 report. It is expected the standards proposed for children's day treatment programs will provide greater clarity to providers regarding behavior support practices in this setting and will begin to bridge differences between OMH and SED. The RCIT Committee recognizes the disparities between OMH and SED policies are not fully resolved with these standards and views this as the first in many steps to increase consistency between the two agencies.

Implement behavior support standards in other child serving programs

Chapter 470 of the Laws of 2008 requires the RCIT Committee to review coordinated standards outlined in the 2007 report for all other child serving programs that authorize the use of restraint. Each agency was asked to identify the remaining programs that would be addressed through this expanded legislation. OCFS and SED were the only two agencies that had additional programs not included in the previous legislation. Standards are being implemented within the applicable programs.

Summary

The implementation of coordinated standards is a necessary step for change; however, it is not sufficient. Once the standards are fully in place, they must be exercised on a regular basis. Quality training that is accessible to staff must be complemented with staff supports that help staff apply the skills learned in training to their daily work; behavior support plans that are developed must be reviewed and adjusted promptly; information disclosed in debriefing sessions needs to be used to inform individual care but also used to view how we interact with colleagues and the children we serve. Lastly, the monitoring systems put in place require ongoing review so that the data entered are examined, assessed and used to address outstanding issues that repeatedly appear.

The RCIT Committee will not have fully achieved its goals if it assumes adoption of consistent standards is the endpoint. Instead, ongoing reviews of how the behavior support standards are a part of daily practice and consistent with ever evolving knowledge about behavior supports will need to be made so children and staff have the supports they need to be successful.

Introduction

The Office of Children and Family Services (OCFS), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Mental Health (OMH) and State Education Department (SED) operate, license or approve child serving programs that authorize the use of crisis intervention techniques. Physical restraint is one of the most restrictive and potentially dangerous forms of crisis intervention. Given the high risks associated with physical restraint, each state agency has longstanding statutes and/or regulations regarding its use. These standards are based on the agency's mission; the unique characteristics and service needs of children served; and federal mandates. The variations in these standards have broad implications for children and staff across service settings. In particular, they have consequences for providers of care that have more than one license from the various state agencies. Clearly, a coordinated set of standards, grounded in research and acknowledged as best practices, results in positive benefits for children served in programs authorized to use restraint. Additionally, coordinated standards improve the ability of staff to fulfill their job responsibilities and provide children with appropriate behavior supports.

Pursuant to Chapter 624 of the Laws of 2006, the Council on Children and Families was directed to establish the Committee on Restraint and Crisis Intervention Techniques (RCIT). The RCIT Committee was required to identify the most effective, least restrictive and safest techniques for the modification of children's behavior and to establish coordinated standards giving preference to the least restrictive alternative for the use of such techniques.

In 2007, the RCIT Committee produced a report that identified a core set of standards recommended for use by state agencies that authorize the use of restraint in settings that serve children. Specifically, it was recommended that these standards be implemented at programs outlined in Chapter 624 of the Laws of 2006, with the exception of children's day treatment programs. Children's day treatment programs were not included in the original work of the committee due to distinct crisis intervention policies that distinguish day treatment programs from residential and inpatient settings. However, it was also noted in that report that the work of the committee should continue to address crisis intervention practices related to day treatment programs.

Chapter 470 of the Laws of 2008 (Appendix A) expanded the responsibilities of the RCIT Committee to:

1.	Report on progress made by each state agency to implement coordinated standards outlined in the 2007 report;
2.	Report on aggregate agency-specific data and improvements in agency-specific monitoring systems;
3.	Include children's day treatment programs and any other settings serving children that authorize the use of restraints in each of the standards presented in the 2007 report; and
4.	Provide additional recommendations, as necessary.

The report that follows details the work conducted, to date, to address the four obligations outlined in Chapter 470 of the Laws of 2008.

It is important to note the work of the RCIT Committee is being conducted within the backdrop of increased federal concerns regarding the use of restraint within education settings, as highlighted by the General Accounting Office report *Seclusions and Restraints: Selected Case Studies of Deaths and Abuse at Public and Private Schools and Treatment Centers* that underscored the need for alternative practices that reduce the use of restraints in education settings as well as the recently proposed *Preventing Harmful Restraint and Seclusion Act*. This act recognizes federal protection provided to children against the inappropriate use of restraint in hospitals, health facilities and non-medical community-based facilities and calls for similar protections that take into account factors that may be unique to the school environment.

1. Progress Made to Implement Coordinated Behavior Support Standards

When the RCIT Committee began its work to identify coordinated standards, initial discussions considered whether certain parameters should be established regarding the scope or scale of recommendations that could be proposed. For example, the committee could have limited recommendations to only those standards that did not require additional resources. However, that would have resulted in a skewed set of standards that did not reflect the best and most current knowledge about behavior support practices. Additionally, the committee opted to not limit its work to the two areas identified in its title, namely restraints and crisis intervention. Instead, the committee broadened its work to incorporate a more comprehensive view of behavior supports and placed greater emphasis on principles and practices that promote positive alternatives to restraint and reduce crisis situations.

The resulting seven standards are grounded in research and reflect well-recognized, best practices within the fields of child welfare, developmental disabilities, education and mental health. In fact, given the wide acceptance of these practices, each agency had, to varying degrees, aspects of the standards already in place. However, due to the comprehensive nature of the standards identified by the committee, it was well understood that full implementation across all agencies would require differing amounts of resources and that standards would be realized within varying time frames.

Coordinated Standards Recommended by the RCIT Committee

1. Staff trained in recognized, competency-based programs
2. Individual behavior support plans available for children at risk of being restrained
3. Uniform conditions for the use of restraint
4. Use of an accepted physical restraint technique
5. Use of monitoring practices during restraints
6. Methods that inform quality and practice from the perspective of children and staff
7. Monitoring and data reporting to provide a comprehensive view of restraint use and restraint-related injuries

Approaches Taken to Implement Standards

As noted previously, for some agencies, the implementation of standards meant a continuation and enhancement of ongoing work, while for other agencies it required substantial changes in certain areas. Due to agency differences, a committee approach to work would not suffice.

Rather, the accomplishment of this task required agency-specific steps to be taken; therefore, state agency representatives from the RCIT Committee undertook activities to move standards forward within their respective agencies.

Implementation of standards was not limited to state level considerations since some agencies also had federal regulations to consider when making adjustments to the behavior support standards they had in place. Council staff worked with agency representatives to facilitate coordination so that the work conducted by each agency was advancing coordination rather than fracturing such efforts.

Three major strategies were employed to promote implementation of the behavior support standards. These included proposed revisions to regulations and proposed amendments to statute, modifications to training, and development or improvements to restraint-related monitoring systems. Each of these strategies requires considerable time, especially changes to regulations, which involves a multiple phase process. Of particular relevance, regulation changes must include an opportunity for public review as well as a fiscal impact analysis of the costs associated with the proposed regulations.

Agencies revising regulations are at different stages in this process and that will be described, as relevant, for each standard. A description of the work conducted, to date, to implement each of the standards outlined in the 2007 report follows.

Standard 1: Staff are trained in recognized, competency-based programs

Issues specific to this standard

The RCIT Committee presented training as the first standard since it is considered the foundation for effective behavior supports. Done well, training can substantially change the culture of an environment and alter daily practices. Research findings are clear regarding the important role well-trained staff play in restraint reduction. Competently trained staff have an increased self-awareness of how their own behavior and responses to a child in crisis interact with the child's behavior, are more likely to rely on de-escalation techniques, and are less likely to apply restrictive forms of crisis intervention. Core elements of effective training include staff self-assessment; skill development in effective communication, crisis recognition, crisis prevention, and de-escalation; proficiency in the application of physical restraint techniques; and effective debriefing skills. These components are currently addressed in training curricula endorsed by state agencies.

Although all four of the agencies required staff to be trained in effective crisis intervention practices prior to the 2007 report, members of the RCIT Committee raised concern regarding access to training. Specifically, programs with multiple licenses (i.e., licensed by OCFS and

OMH) had previously taken advantage of the training offered by OCFS since it was comprehensive, widely recognized, and offered without cost to the licensed program. In that training, participants were instructed in the use of a prone restraint technique (as well as a standing, small child and seated restraint technique). However, when OMH made policy changes and prohibited the use of a prone technique, the multiple licensed programs could no longer take advantage of the no cost training so training options were substantially limited.

Progress made toward implementation of standard 1

OCFS

Prior to the 2007 report, OCFS made Therapeutic Crisis Intervention (TCI) training available at no cost. TCI training, which is a well-recognized, competency-based program, was offered to staff in OCFS licensed programs through a contract OCFS maintained with Cornell University. This training continues to be available at no cost to OCFS licensed programs.

The TCI training uses a train-the-trainer approach where individuals from licensed programs attend training. Upon certification of successful completion of the course, course participants then are responsible for instructing their colleagues. The TCI training curriculum instructs individuals in the use of a prone restraint technique as well as the standing, small child and seated restraint techniques. Annual updates in TCI are required and are provided at no cost to certified trainers.

Since the 2007 report, OCFS has worked with staff from Cornell University to expand the types of restraint techniques included in the training and specifically to incorporate a supine technique. The addition of the supine technique was made in fulfillment of a committee recommendation related to another RCIT Committee standard that called for a common restraint technique for multiple licensed providers with co-located programs. The supine technique was formally incorporated into edition 6 of the TCI training and became available during 2009. More information about the common technique is provided in the section that addresses Standard 4 (see page 28).

OMH

OMH policies require staff in state operated programs to be trained in crisis prevention and management. Additionally, federal regulations require staff in Medicaid-funded inpatient settings that serve children to be trained.

Prior to the 2007 report, Prevention and Management of Crisis Situations (PMCS) training was made available to staff in state-operated programs while staff in state licensed residential programs tended to take advantage of the TCI training offered through OCFS. As noted, due to differences in the restraint techniques presented in the TCI and PMCS training, staff in programs licensed by OMH were no longer able to solely rely upon the TCI curriculum. To address this training gap, OMH provided staff in state licensed programs an abridged PMCS training that included instruction in prevention strategies and use of a supine technique, free of charge, to staff in residential treatment facilities (RTF).

Additionally, since the spring of 2009, OMH has provided the full 5-day PMCS train-the-trainer program to 183 trainers from 53 licensed mental health providers. This training is now being offered on an ongoing basis with additional courses added in various regions of the state, as needed. The training is offered free of charge to participants. Furthermore, an instructor update class is available to ensure instructors who were originally trained in PMCS remain abreast and familiar with the latest edition of the PMCS program and instructor material. The instructor updates are intended to ensure the quality of training across all the sites. Updates are offered free of charge.

OMRDD

OMRDD has policy and regulations that require staff with direct service responsibilities working in OMRDD certified settings to be trained in crisis prevention and intervention techniques. The required training curriculum, Strategies for Crisis Intervention and Prevention-Revised (SCIP-R), is available free of charge to staff working in state-operated programs as well as voluntary-operated programs. However, OMRDD, in partnership with a statewide workgroup, is in the process of reviewing and revising its crisis intervention and prevention curriculum so it is more aligned with current research and practice across the country with respect to restraint use. In particular, the new curriculum focuses on debriefing and recovery after use of restraint; provides clear methods to improve monitoring and data collection that allow for meaningful focus on restraint reduction efforts; and incorporates an instructional methodology that maximizes consistency in training content and implementation across the state. The new draft training curriculum, Positive Relationships Offer More Opportunities to Everyone (PROMOTE) comprehensively incorporates multiple aspects of best practices drawn from a variety of disciplines and includes the core components outlined in the 2007 report.

OMRDD will use a new approach to implement PROMOTE training where the training will be organized into several levels of training intensity. All staff with direct service responsibilities will be required to participate in the first level of training that emphasizes positive approaches, de-escalation and alternative behavior support strategies and basic defensive/protective physical interventions. Additional levels of training will be made available only to staff who will be authorized to use different levels of physical restraint because the individuals to whom they provide support require such interventions, and will cover the restraint techniques approved by OMRDD. The second level will teach intermediate physical interventions intended to interrupt and/or control dangerous or unsafe behavior but that maintain a person in a standing or seated position and do not entail take-downs to the floor. The third and highest level of physical interventions will include take downs and floor holds taught only to those staff working with individuals whose behavior may present an immediate risk of harm to self or others and for whom other less intrusive/restrictive techniques are not effective or appropriate. In addition, increased training will be focused on debriefing and recovery activities following any use of restraint. This multi-level approach will be used to maximize staff awareness of the critical aspects of training that can avert the need for more restrictive forms of crisis intervention and to assure appropriate follow up (debriefing, recovery, health checks, documentation) should restraint occur.

SED

SED regulations require any staff who may be called upon to implement emergency interventions be provided with appropriate training in safe and effective restraint procedures in accordance with the school's code of conduct and discipline. For residential schools, staff are required to receive training on a regular, and at least annual, basis. This training must include instruction on techniques of group and child management, including crisis intervention and appropriate restraint training.

SED regulations do not prescribe specific training programs. However, SED recently conducted a survey of all residential schools and findings indicate that 75 percent of residential school staff are trained in the TCI curriculum. Another 15 percent of school staff are trained in the SCIP-R curriculum and the remaining 10 percent receive training through other curricula. Additionally, most Board of Cooperative Educational Services (BOCES) offer crisis prevention and intervention training programs for their component school districts.

In addition to requiring competency-based training, SED increased technical assistance resources statewide to provide training that supports positive behavioral interventions. SED funds behavior specialists and other technical assistance providers in every region of the state. These technical assistance specialists provide training and support to school districts and approved private schools, including residential schools, to develop programs of positive behavioral supports, including school-wide, classroom, small group and individual supports. Also, SED has developed and posted Quality Indicator Review and Resource Guides on Behavioral Supports and Interventions on the SED website at: www.vesid.nysed.gov/specialed/techassist/QIcover.htm.

Work to be done

Two issues are particularly relevant to the successful implementation of the training standard. The first pertains to accessibility. The demand for training is considerable and this is due, in part, to the fact that direct care workers who receive this training tend to have high turnover rates. This means providers are continuously hiring new employees who need to fulfill training requirements. While the demand for training may outpace availability, the expanded number of OMH training sessions directed toward licensed mental health providers will help ease the demand and OCFS and OMRDD will continue to offer their respective training courses.

The next issue related to the training standard focuses on the quality of training. Each of the training programs offered uses a train-the-trainer approach. This is an efficient means to meet the demand for training. As an added benefit, it means there will be staff on site with training expertise. However, training fidelity is a potential concern with a train-the-trainer approach and agencies should be mindful of this quality issue and conduct ongoing reviews to promote an even level of quality in training across locations.

In addition to the staff training that is required by each agency, the RCIT Committee recognized effective training should go beyond the traditional method of staff development and skill development. Specifically, the 2007 report highlighted a form of training that provides staff with well-trained supervisors who are available within the work setting and could provide a form of

ongoing technical assistance where the supervisors offer guidance in effective ways to address daily behavior support challenges. This level of training is a part of the Positive Alternatives to Restraint and Seclusion (PARS) project, an initiative undertaken by OMH through a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). As a result of this project, it is increasingly apparent that technical assistance provided to direct care staff while they are working with children augments the classroom training, helps staff have a more immediate and meaningful application of skills, and, possibly most importantly, serves as a constant reminder to all staff about the importance of alternative methods for behavior support. Recent resource constraints prohibit the implementation of this form of training system-wide at this time; however, it is presented here to be recommended in a less restrictive fiscal environment.

Standard 2: An individual behavior support plan is available for children at risk of being restrained

Issues related to this standard

A variety of terms are used to refer to behavior support plans, including safety plans, calming plans, behavior intervention plans, and crisis prevention plans. Regardless of the term used, these invaluable tools share the common purpose of providing children with critical individualized supports that can be used by staff to recognize crisis triggers, promote early intervention, increase the effectiveness of de-escalation strategies, prevent crises, and ultimately avert the need for physical restraints.

Behavior support plans promote problem-solving collaborations among staff, children and their parents so that serious behavior challenges can be resolved. This two-way feature, where children and their families work with staff to create a tailor-made plan, increases the effectiveness of the plan. Additionally, it increases children's awareness of the types of situations that tend to trigger negative responses, making children more cognizant of coping strategies they can employ to avert such responses. This element of youth involvement has the long-term effect of increasing youths' skills that enable them to control their behavior, which benefits them well beyond their stay in any child serving setting.

The information outlined in an individual behavior support plan is keenly related to the first standard in that this standard complements skills developed in training. Individual behavior support plans support youth and give them a voice about the types of crisis intervention strategies they may need. Furthermore, these plans allow staff to more effectively respond to the crisis and decrease the probability that their actions inadvertently trigger or escalate a crisis.

Progress toward implementation of standard 2

OCFS

At this time, OCFS's proposed regulations encourage but do not mandate the use of behavior plans. OCFS continues to make TCI training available so staff are able to receive guidance in this practice. Implementation of this standard as a funded mandate continues to be a long-term goal of OCFS.

OMH

OMH applies this standard in state operated programs through policy directives that call for the use of crisis prevention plans. These plans are developed from information gathered in interviews with children and, when reasonably possible, other persons the child identifies, such as family members. The interview, which is part of a standard assessment process, addresses the child's individual history and preferences related to behavioral management interventions. Based on this information, the crisis prevention plan identifies such factors as: early warning signs, triggers and precipitants of distress, stress or aggression, which cause the child to escalate, along with techniques, methods or tools that help the child gain control of his or her own behavior. This standard is also supported in federal regulations and the related interpretive guidelines where the importance of child-specific interventions highlight the need for all treatment plans to incorporate this information. Furthermore, the standard is supported through PMCS training, which provides guidance on the development of effective crisis prevention plans.

OMRDD

OMRDD is bound by federal requirements to identify behavioral management needs of individuals served in intermediate care facilities (ICFs). OMRDD applies this requirement more broadly to all licensed programs through its policies and regulations. The OMRDD approach to behavior support is aligned with the Positive Behavior Support model and encompasses many distinctive elements, including emphasis on lifestyle change, functional analysis, multi-component interventions, manipulation of ecological and setting events, antecedent manipulations, teaching adaptive behaviors, building environments with effective consequences, minimizing the use of punishers, distinguishing emergency procedures from proactive programming and social validation. This approach also emphasizes the importance of preserving the dignity of the individuals who are impacted by the interventions used. Functional behavioral assessments (FBAs) and individualized behavior plans are longstanding practices within OMRDD settings. Initially, they were embedded within the federal regulatory framework and now extend to policy and practice in all certified settings.

SED

The use of individualized behavior plans is a longstanding practice within the field of education and this standard was in place prior to the 2007 report. A FBA is a critical assessment used within education settings to determine why youth engage in behaviors that impede learning and to fully understand how a youth's behavior relates to the environment. Information garnered in the FBA is incorporated into a behavioral intervention plan (BIP) that specifies the types of positive behavioral supports and services needed to address the behaviors detailed in the FBA.

SED regulations require that an FBA and BIP be considered for a student with a disability whenever the student exhibits persistent behaviors that impede his or her learning or that of others, despite consistently implemented general school-wide or classroom-wide interventions, whenever the student's behavior places the student or others at risk of harm or injury, and whenever the school district is considering more restrictive programs or placements as a result of the student's behavior. Progress monitoring is an integral part of a youth's BIP and revisions are made as necessary.

Work to be done

This standard is being implemented incrementally, as resources allow. The 2007 report encouraged sites that had cross-agency expertise (teachers, clinicians and behaviorists trained in the use of FBAs and BIPs) to support other staff so all children could have individual behavior support plans and this may be one way to strategically use limited resources. Additionally, RCIT Committee members should work together to secure the resources needed to advance the availability and implementation of a behavior support plan for each child.

Standard 3: Uniform conditions for the use of restraint

Issues related to this standard

Prior to the 2007 report, each agency already had statute or regulations in place that detailed standards regarding the use of physical restraint or reasonable physical force. A number of common features existed across agencies. For example, restraint was not to be used as a form of punishment or as a substitute for less restrictive interventions. Restraint could only be used if all other forms of programmatic de-escalation and crisis intervention had been attempted and were found to be ineffective. Furthermore, restraint could not be used to inflict pain or harm. While there was considerable agreement across agencies, differences existed regarding the conditions that might result in the actual use of restraint.

The RCIT Committee recognized the need for a consistent standard that outlined when a restraint could be employed, regardless of the child service setting. This standard was necessary since it would reduce the chance a child would be restrained unnecessarily, provide greater clarity to staff, and inform children and their families about the types of behavior that may result in the most restrictive form of crisis intervention. More fundamentally, it would mean that the probability a child is restrained would not vary depending on the residential setting in which the child is placed. The standard would be the same for a child in a child welfare, developmental disabilities, education or mental health setting.

In many ways, this standard is at the heart of coordinated practices and speaks to the need for equitable procedures across systems. This standard builds on the first two standards described in that it offers staff greater clarity and guidance about the limited circumstances when a restraint

may be employed. Furthermore, this issue is increasingly in the forefront of federal policy as indicated by the recently proposed legislation, Preventing Harmful Restraint and Seclusion Act, which is intended to prevent and reduce the use of physical restraint and seclusion in schools. This proposed legislation is consistent with existing federal regulations that are in place to protect youth served in various residential settings (e.g., hospitals and intermediate care facilities).

Progress toward implementation of standard 3

Due to the cross-system inconsistencies that existed, agencies began the process of reviewing and revising their regulations and proposing statute amendments. Implementation of this standard was not limited to the state level; federal mandates related to this standard and linked to funding also needed to be considered. Revisions are being made in accordance with federal obligations to increase consistency in agency-specific statutes and regulations and to coordinate practices across state agencies. While the revisions do not need to be identical, the objective of the statute or regulation for each agency needs to be consistent.

In an effort to implement this standard, staff within each agency drafted changes to either statute or regulations and Council staff examined revisions, informing individual agencies on whether the revisions they were proposing moved the RCIT Committee closer or further away from the committee goal of cross-system consistency. Council staff had numerous discussions with state agency staff and commissioners regarding the most effective ways to ensure that uniform conditions for the use of restraint were implemented in a coordinated fashion.

OCFS

OCFS is not bound by any federal regulations that establish conditions for when a restraint may be applied in community-based programs. However, the conditions for the use of restraint are delineated in current state regulations and proposed revisions to incorporate RCIT Committee recommendations have been made. The draft regulations specify that physical restraint should not be used unless all other means of crisis interventions have been attempted and should only be used in *circumstances where the safety of a child or others is in jeopardy*. Previous reference to 'damage to property' as a condition for restraint has been removed from the proposed regulations. This modification, once adopted, will make OCFS conditions for when restraint can be used consistent with the principles outlined in the 2007 report and with OMH and OMRDD. Furthermore, the regulations proposed by OCFS will align with well-recognized best practice standards within the field of child welfare. The proposed regulatory changes are pending a final internal review within OCFS and then will be submitted to GORR.

> *In circumstances where the safety of a child or others is in jeopardy* (OCFS)

OMH

The conditions for restraint are detailed in Mental Hygiene Law (MHL Section 33.04), where the use of restraint is only permitted *when necessary to prevent an individual from seriously injuring him/herself or others* and when less restrictive techniques have been determined to be ineffective. OMH has proposed legislation that comprehensively identifies what actions constitute restraint and identifies those programs that authorize its use. The proposed legislation will bring OMH in alignment with its federal regulations. Additionally, these modifications are consistent with recommendation of the 2007 report as well as regulations proposed by OCFS and OMRDD. The proposed legislation was presented during the 2009 legislative session and OMH is awaiting action by the legislature.

> *Only when necessary to prevent an individual from seriously injuring him/herself or others* (OMH)

OMRDD

OMRDD has federal restraint-related regulations that pertain to intermediate care facilities (ICFs) and these are mirrored through OMRDD regulations, policies and mandated training to apply to all other OMRDD licensed settings. OMRDD has proposed extensive revisions to policies and regulations so that they coincide with the major changes being made to the previously described training curriculum associated with behavior support and crisis intervention strategies. Based on these changes, the use of restraint is permitted only to *interrupt or terminate a truly dangerous situation where serious injury could result*. These changes will promote consistency across agencies, limiting restraint use to circumstances where one's behavior may result in serious injury to the individual or others.

> *To interrupt or terminate a truly dangerous situation where serious injury could result* (OMRDD)

OMRDD proposed regulations have been reviewed by the agency's senior staff and the next step will be to share the draft regulations with staff at OMRDD's Developmental Disabilities Services Offices (DDSO). Once this review has occurred, the draft regulations will be shared with voluntary provider agencies, advocates, individuals and other stakeholders to solicit feedback. At the conclusion of this review process, appropriate revisions will be made to the draft regulations and OMRDD will then review and assess the financial impact of the proposed regulations prior to submitting the draft regulations to GORR for review.

SED

SED does not have regulations pertaining specifically to the use of physical restraint. However, in 2007, SED enacted regulations that outline program standards for behavioral interventions.[3] These regulations, which apply to "children with handicapping conditions," provide guidance regarding emergency interventions and state that such interventions shall be used only in

[3] 8 NYCRR 200.22, Program Standards for Behavioral Interventions.

situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed. These regulations also state that emergency interventions shall not be used as punishment or as a substitute for systematic behavioral interventions that are designed to change, replace, modify or eliminate a targeted behavior. The term "emergency" is defined as "a situation in which immediate intervention involving the use of reasonable physical force pursuant to Section 19.5 (a) (3) [of Title 8 of the New York state codes, rules and regulations] is necessary."[4]

In SED regulations[5] which apply to *all* children, "reasonable physical force," is allowed for the following purposes:

- To protect oneself from physical injury;
- To protect another pupil or teacher or any person from physical injury;
- To protect the property of the school, school district or others; or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties, if that pupil has refused to comply with a request to refrain from further disruptive acts.

As noted above, SED regulations describe the situations when reasonable physical force or an emergency intervention can be used. The regulations are silent regarding what action constitutes reasonable physical force or an emergency intervention (e.g., immobilization of limbs).

SED officials have noted they will provide policy information to SED residential and day treatment providers to provide guidance regarding SED interpretation of these regulations.

Use of reasonable physical force to protect oneself from physical injury, to protect another pupil or teacher or any person from physical injury, to protect the property of the school, school district or others, or to restrain or remove a pupil whose behavior is interfering with the orderly exercise and performance of school or school district functions, powers and duties (SED)

Work to be done

The Council has had extensive discussions with state agency staff and Commissioners regarding this standard. Once the proposed agency-specific regulations are adopted and MHL section 33.04 is amended as appropriate, OCFS, OMH and OMRDD will be closely aligned regarding conditions that warrant the use of a physical restraint. SED officials will provide policy information to residential and any treatment providers to provide guidance regarding SED interpretation of these regulations. Moving forward, each agency will also need to take steps to

[4] 8 NYCRR 200.22 applies to children with handicapping conditions while 8 NYCRR 19.5 applies to children in all educational settings.
[5] 8 NYCRR 19.5, "Prohibition of corporal punishment and aversive interventions."

maintain internally consistent regulations, policies and training, and to make the applicable laws and polices clear to the licensed providers who must implement and comply with them.

Standard 4: Use of an accepted physical restraint technique

Issues specific to this standard

As noted in the standard related to training (standard 1), various forms of physical restraint are presented in the training programs endorsed or provided by OCFS, OMH and OMRDD with prone and supine restraint techniques being predominant. It is accepted that all forms of physical restraint come with inherent risk due to the hazardous circumstances in which restraints are applied—in instances where one's behavior may jeopardize the physical safety of self or others. This is further complicated by the fact that staff must exercise judgment during these volatile times, with respect to whether the restraint is warranted as well as the type of physical restraint technique applied. In single licensed service settings, a common standard about when to use restraint coupled with a standard for regularly available competency-based training can address these issues. However, providers note this is not sufficient for staff employed by multiple licensed providers at co-located programs.

In those limited instances where providers have multiple licenses, trained staff are at risk of implementing a form of restraint not endorsed by a given agency and are at greater risk of extreme scrutiny if they apply a restraint technique inconsistent with the rules of one of the licensing agencies. Therefore, a common physical restraint technique was needed for staff employed by these specific providers.

The RCIT Committee recommended the use of a supine restraint technique be implemented at *multiple licensed providers at co-located sites*. The rationale was that this maximized cross-system coordination necessary for these unique sites. It brought the approach and philosophy of two systems (OMH and OMRDD) in line with a third (OCFS). Certainly, the RCIT Committee realized changes within one service system, namely OCFS, impacted a higher number of staff at the multiple licensed sites. The decision could have been made to make changes in systems that had the fewest staff or children. However, a system view was taken. This was done, in part, to be consistent at the national level as well as state level.

The recommended change had implications for training and required providers with multiple licensed, co-located sites to have staff trained in a supine technique. Furthermore, the prone technique used in the OCFS training requires two staff to complete and it was *preferable* though not required that the supine technique recognized by other agencies use three staff. Given these circumstances, it was strongly recommended in the 2007 report that the supine form of restraint be used at multiple licensed, co-located programs only *in conjunction with comprehensive restraint reduction practices* (e.g., leadership support to reduce restraint; use of prevention techniques to

lessen need for restraint) and that the implementation be phased in so organizational changes could be made in an effective manner.

Progress toward implementation of standard 4

A tremendous amount of effort was undertaken by OCFS staff and staff from multiple licensed, co-located program sites to move the agreed upon (supine) restraint technique forward. OCFS began this process by working with TCI instructors to identify a supine technique that could be incorporated into the TCI training curriculum.

TCI instructors from Cornell University proposed a three-person supine restraint technique for TCI training. OCFS requested that each multiple licensed provider with co-located programs submit a proposal detailing the resources needed to implement the supine restraint requirement. OCFS requested that the proposals incorporate the use of current resources and describe ways in which providers could maximize alternatives to restraint reduction. The proposals, which reflected careful, creative consideration, were reviewed by OCFS and suggestions were made to the providers of possible areas to reduce costs. Additional resources needed to fully implement this standard are not available at this time.

Work to be done

OCFS staff, in partnership with staff from the multiple licensed, co-located programs made considerable efforts to accommodate this standard. Due to differences in physical plant conditions and existing staffing patterns, one voluntary agency has been able to successfully make this change with a second one in the planning process. However, it is not possible to put this standard in place at all impacted multiple licensed, co-located sites at this time. This means the issue related to staff being at greater risk of extreme scrutiny if they apply a restraint technique inconsistent with one of the licensing agencies still stands.

Standard 5: Use of monitoring practices during restraints

Issues related to this standard

Continual monitoring of individuals in restraint is critical due to the health risks that can occur when one is in a highly agitated state. In fact, research cites numerous case studies where death resulted from the absence or inadequacy of monitoring and the benefit of ongoing monitoring during a restraint is fully recognized in best practices. Such monitoring requires staff to carefully observe the individual being restrained to detect signs of physical distress. Therefore, the RCIT Committee recommended, at a minimum, staff applying the restraint be required to monitor the child's skin color, respiration, level of consciousness, agitation and range of motion in

extremities. These were recommended since they serve as key indicators of physical distress and the presence of these conditions could result in negative consequences for the child in restraint.

Current practices for standard 5

Each agency emphasized the need for monitoring prior to the 2007 report. As such, this standard was well established and in place prior to the 2007 report. The standard regarding use of monitoring practices is incorporated into practice through the training curricula endorsed by OCFS, OMH and OMRDD. A description of agency-specific practices follows.

OCFS

The TCI curriculum is the predominant training curriculum utilized by OCFS licensed programs. Staff trained in the use of physical restraints are instructed to conduct periodic assessments of individuals being restrained to determine whether the individuals are experiencing significant physical distress. Additionally, staff are trained to terminate the physical restraint if there are any indications of an injury, difficulty with breathing or a seizure.

OMH

Staff receiving training through the PMCS curriculum are instructed to terminate the physical restraint if there are any indications of significant physical distress, injury, difficulty breathing or a seizure. This training has been available to staff in state operated programs and more recently has become available for licensed mental health providers.

OMH is the only agency bound by federal regulations to monitor youth during a restraint. These federal regulations apply to youth in Medicaid-funded inpatient programs. Additionally, this requirement is echoed in the proposed OMH legislation change that applies to all inpatient settings.

OMRDD

The current and proposed OMRDD training curricula (SCIP-R and PROMOTE respectively) train staff to monitor youth in restraint for signs of significant distress and to terminate the restraint if there are any indications of significant physical distress, injury, difficulty breathing or a seizure.

SED

Teachers in residential settings tend to be trained in the curricula supported by OCFS and OMRDD. Results from a recent statewide survey of residential schools indicate 90 percent of these programs utilize one of the two curricula supported by OCFS and OMRDD. Both training curricula include instructions regarding periodic assessments and monitoring of youth in physical restraints.

Work to be done

The training curricula now in place sufficiently address this standard related to monitoring practices during restraints. Furthermore, the training curricula are reviewed periodically to update content in order to reflect the current research. As necessary, curricula will be revised to incorporate additional monitoring methods.

Standard 6: Methods are in place to inform quality and practice from the perspective of children and staff

Issues related to this standard

Restraint is a crisis intervention of last resort that can have detrimental ramifications at the individual and program level, even when implemented properly. Therefore, a standard was needed to address the events that led to the restraint, the impact of the restraint on the child, and identify ways the restraint may have been prevented. This standard calls for activities that gather information about the restraint from the perspective of the child and staff. These activities are commonly referred to as debriefing.

Debriefing activities from the perspective of the child entail a meeting between staff and youth (or youth's spokespersons, if necessary) involved in a restraint. The purpose of this meeting is to provide an opportunity for youth to describe the impact of the experience and to discuss whether alternative behavior supports could be employed in the future to avert the need for a restraint. As appropriate, the information derived from debriefing activities is used to modify children's behavior support plans.

A second form of debriefing occurs among staff and is used to identify possible program structures or procedures that may have contributed to the use of restraint. This type of review is an invaluable way to assess the extent content in the behavior support plan was utilized and also provides information regarding the types of program adjustments that may be necessary to reduce the need for restraint.

The RCIT Committee recognized that implementation of this standard may require agency-specific adaptations in order to make it most useful for the children served within the different service systems. For example, OMRDD debriefing activities may require certain accommodations based on individuals' cognitive abilities. Due to differences of individuals within each system, debriefing protocols understandably may differ across agencies.

This standard is a critical component of behavior supports since it provides a restorative dimension to crisis intervention and recognizes that a fundamental aspect of restraint prevention and reduction is development of positive relationships with youth. It also provides ongoing opportunities to advance our knowledge and improve practices.

Progress made toward the implementation of standard 6

Prior to the 2007 report, some agencies had federal regulations in place that mandated debriefing activities for some of its programs that authorize restraint, other agencies had training programs that suggested this activity as a best practice while others were silent in both regulatory mandates and training. A certain degree of variability across agencies was due to the fact that this is an

emerging practice. Practitioners are gaining a greater understanding of how these activities can enhance behavior support as well as learning the best way to effectively conduct debriefing sessions. Given that agencies had debriefing practices in place to varying degrees, each agency conducted work internally to advance the implementation of this standard. The steps taken by each agency are described below.

OCFS

OCFS is not bound by federal regulations that require debriefing activities in community-based residential programs and OCFS regulations did not address this activity prior to the 2007 report. Debriefing activities are now a recommended practice in the agency's proposed regulations. The TCI curriculum, which is the most predominant training curriculum used among OCFS licensed programs, instructs staff regarding debriefing activities, if they choose to use them.

OMH

OMH is bound by federal regulations that require debriefing activities in all Medicaid-funded inpatient settings that serve children. Additionally, OMH has a state policy that addresses state-operated programs and this requirement has been incorporated into the licensing process. The PMCS training offered also provides guidance to staff on how to implement this standard.

OMRDD

Similar to OCFS, OMRDD is not bound by federal requirements to incorporate debriefing practices. However, it is well-recognized that restraints can have a powerful impact on youth, regardless of their developmental abilities and the newly revised training curriculum, PROMOTE, incorporates extensive segments of training related to recovery activities following the use of restraint. In this recovery process, staff work with children and other staff to (1) repair the hurt; (2) repair the environment; and (3) repair the relationship following the use of a restraint. This aspect of training underscores the disruption and trauma that can result from the use of restraint and highlights the work that needs to be done to repair relationships. OMRDD policies address the standard of debriefing in an indirect way by making reference to the training curriculum.

SED

SED regulations require that documentation of each emergency intervention be reviewed by school supervisory personnel and that parents are notified of the intervention. The intent of this regulatory requirement is to have staff and supervisory personnel review and discuss the circumstances that led to use of the intervention. Parents are informed when an emergency intervention has been used on their child and can meet with staff to discuss the circumstances around its use. In the event an emergency intervention is used, SED requires education staff to review progress monitoring data from a student's behavioral intervention plan at the Committee on Special Education meetings to consider any changes needed to the student's individualized education program.

Work to be done

Next steps should entail moving proposed regulations forward, finalizing training curricula, seeking additional funding to heighten debriefing as a priority and encouraging youth and parent involvement in debriefing activities.

Standard 7: Monitoring and data reporting to provide a comprehensive view of restraint use and related injuries

Issues related to this standard

Monitoring systems provide state and local policy makers with one of the most fundamental sources of information for successful risk management—knowledge about the rate at which restraints and restraint-related injuries occur. Restraint and injury data allow organizations to know how well pre-established goals are being met so successful strategies can be identified, reinforced and modeled as best practices. Moreover, when data are shared with key audiences, (e.g., board members, staff) organizational change that supports alternatives to restraint is advanced.

The quality of information gained from any monitoring system is influenced by the extent data are complete. More complete data provide greater accuracy and increase the ability to detect system deviations that may require corrective action. This comprehensive picture is essential for individuals who develop policy and plan programs.

Prior to the 2007 report, at a minimum, all agencies required providers to maintain logs that recorded information about restraint use. However, differences existed across agencies in terms of how easily information could be obtained regarding the number and rate of children placed in restraints and the occurrence of injuries to staff and children as a result of those restraints. OCFS was in the beginning stages of implementing an automated system that required providers and state-operated programs to submit data related to restraint use within the child welfare system. OMH had an established automated system but the system lacked information from certain providers (e.g., restraint use in private hospitals). OMRDD had a system that monitored injuries related to restraints but was unable to view this within the context of the total number of restraints. SED required schools serving children in residential settings to maintain logs but this information was not reported to state policy makers.

Given the known risks associated with restraint, the RCIT Committee recommended that each state agency have monitoring systems that provide a comprehensive view of restraint use within each service system, including information on child and staff injuries related to restraint. This standard dovetails with the second major committee responsibility detailed in Chapter 470 of the 2008 laws of New York; therefore, the implementation of this standard is covered in the next section.

2. Aggregate Agency-Specific Data and Improvements in Monitoring Systems

Chapter 470 of the 2008 laws of New York requires the RCIT Committee to report to the Governor and Legislature on agency-specific aggregated data and the improvements in agency-specific monitoring systems. These expanded reporting requirements are consistent with a recommendation of the committee where it was recommended that monitoring of physical restraint use and related injuries become a standard adopted by all agencies that authorize the use of restraint and that all licensed programs report this information to state agencies on a regular basis. Furthermore, the 2007 report recommended that these data be aggregated on a *statewide* level and reviewed by state policy makers for variations and patterns in restraint use and injuries to improve the safety of children and staff in programs that authorize the use of physical restraints.

The RCIT Committee recognized that the collection of monitoring data served a valuable purpose at the program and state level since this information can be used to guide daily practice, program revisions and policies. It was also noted that data should provide a comprehensive view of service systems. More complete data would provide greater accuracy and an increased ability to detect system deviations that may require program or policy changes.

To advance this standard and fulfill responsibilities outlined in Chapter 470, a workgroup of RCIT Committee members met to review data collection practices currently in place for each agency. The goals of this workgroup were to identify data currently collected by each agency; assess the extent data collected were available for program and policy decisions (i.e., available at state and program level); and identify caveats regarding the potential misuse of agency-specific data. A description of agency-specific data collection practices follows.

Data Workgroup Members

John Hans, OMH
Dan Johnson, SED
Shelley Murphy, OCFS
David Robertson, OMH
Jill Pettinger, OMRDD

OCFS

The Automated Restraint Tracking System (ARTS) is a web-based monitoring system used to inform restraint-related policy and practice as well as identify training needs. In place since the fall of 2007, ARTS is used by staff in OCFS licensed and/or operated residential programs. This includes voluntary authorized child care agencies at institutions, group residences, group homes, agency boarding homes, and OCFS residential juvenile justice facilities.

Child-specific data include child's date of birth, gender and unique identification number. Restraint-related data include the type of restraint used; date, time, and duration of the restraint; and information about any injuries experienced by the child and/or staff. Recently, ARTS was modified to capture information regarding the location within a facility where a restraint occurs (e.g., residence, school). Program information includes bed capacity and name of the voluntary

agency facility. The bed capacity is used to calculate restraint rates for each provider. Additional restraint data are recorded in child records and agency logs.

Standard reports available through ARTS allow state policy makers to review restraint use and restraint-related injuries for an individual facility or agency, subsets of facilities or agencies, or statewide.

It is also important to note OCFS has requested a number of enhancements to ARTS, including the capacity to send electronic reminders to agencies to enter their data, and the planned development of inter-operability that would allow agencies with internal databases to share this information seamlessly.

OMH

The New York State Incident Management and Reporting System (NIMRS), in place since 2001, is a web-based monitoring system used by staff in most OMH programs authorized to use restraints. This system was originally developed as an incident reporting system; a separate module was added to provide for reporting of restraint-related data.

Data collection includes information pertaining to child demographics; clinical characteristics; date, time and location of restraint; staff involved in the restraint; debriefing information; and status of injuries to children and/or staff. Additionally, data are collected regarding the behaviors that prompted the restraint, as well as the less restrictive interventions used in an effort to avoid restraint. Information regarding the number of days in care is drawn from another data base and used to calculate restraint and injury rates.

NIMRS is used as a clinical risk management tool for performance improvement that can be used to review restraint use and restraint-related injuries. Providers have access to numerous standard reports to help them identify patterns and trends and to benchmark their rates with other providers.

OMRDD

The Incident Review Management Application (IRMA), in place since 2007, is a data-based documentation system used by staff at state-operated and state licensed programs to track all injuries, including serious reportable injuries that may have resulted during the use of a restraint. Since the primary purpose of IRMA is to examine trends in incidents and allegations of abuse and neglect, the majority of restraint data is maintained in child records or program logs.

OMRDD is considering modifications to IRMA or development of a similar or complementary automated tracking system that would provide state policy makers the ability to review restraint use on an ongoing basis. As a first step, OMRDD is working with providers to develop a statewide survey that will provide information about:

1. the overall rate of restraint and
2. how restraint use varies by restraint type (physical, mechanical).

Once the survey is completed, OMRDD will review the data for quality then final decisions will be made regarding the types of data that will be gathered on an ongoing basis and reported to

state policy makers. OMRDD will also need to consider resources necessary for modifications to IRMA or for development of a similar but distinct restraint data tracking system.

SED

SED regulations, which require detailed documentation of emergency interventions and review by school supervisory personnel, provide schools with data to view trends at district or school level. Schools are required to maintain logs that include data about the child's data of birth; date, duration and reason for the emergency intervention; and location of the intervention.

In 2009, SED conducted a statewide survey of approved private residential schools, special act school districts, state supported schools with residential components, state operated schools and Article 81 schools to learn about schools' behavior management policies and practices as well as to gather and compile data at the state level regarding restraint use and restraint related injuries. The information was gathered for the period of July 1, 2008 through December 31, 2008 and offered SED a comprehensive view of restraint use and injuries.

Table 1 summarizes the data gathered in each setting authorized to use restraint and the level at which these data are available to be used for program and policy modifications.

Table 1. Restraint use and injury data by child settings authorizing the use of restraint.

		Restraint Data		Child Injury Data		Staff Injury Data	
Agency	Child Service Settings Authorizing Restraint	State	Local	State	Local	State	Local
OCFS	Agency Operated Boarding Homes	x	x	x	x	x	x
	Group Homes	x	x	x	x	x	x
	Institutions Operated by Voluntary Authorized Agencies	x	x	x	x	x	x
	Juvenile Justice Facilities	x	x	x	x	x	x
	Supervised Independent Living Programs[1]						
	Foster Boarding Homes[1]						
OMH	State-operated Inpatient/Children's Hospital & Units	x	x	x	x	x	x
	Residential Treatment Facilities	x	x	x	x	x	x
	Article 28 Inpatient/Children's Units[2]		x		x		x
	Article 31 Inpatient/Children's Units[2]		x		x		x
OMRDD[2]	Community-based Intermediate Care Facility		x	x	x		x
	Developmental Center Intermediate Care Facility		x	x	x		x
	Developmental Center Intermediate Care Facility Local Intensive Treatment Center		x	x	x		x
	Children's Residential Program		x	x	x		x
	Individual Residential Alternative		x	x	x		x
	Community Residence		x	x	x		x
SED	Article 89/853 Schools	x[3]	x	x[3]	x	x[3]	x
	Article 81 Schools	x[3]	x	x[3]	x	x[3]	x
	Special Act School Districts	x[3]	x	x[3]	x	x[3]	x
	4201 Schools	x[3]	x	x[3]	x	x[3]	x
	State Supported Schools	x[3]	x	x[3]	x	x[3]	x
	Public & Private Schools		x		x		x

1 Restraint could be legally used in these settings if the agency submitted a plan for use of restraint in these settings and OCFS approved the plan.

2 Steps are in place to collect these data at the state level.

3 Restraint data are maintained in logs at the local level; however, a recent statewide survey was conducted so data could be aggregated and summarized at the state-level.

Improvements in Data Monitoring Systems

Agencies have outlined a number of ways data monitoring systems in place and under development will be enhanced. These activities, which reflect 'work to be done,' are described below.

1. Raise the level of data collection to state agency level

Some agencies maintain comprehensive restraint data at the local level rather than the state level. Clearly, local level data provide valuable information to program planners and are necessary. However, it is also recognized that the same data can be valuable to state policy makers. To increase access to data, OMRDD is investigating the costs and requirements for developing a

complementary module for its incident reporting system. This will allow more comprehensive restraint data to be reported at the state level.

2. Improve data quality

OCFS staff are working with providers to improve timeliness of reporting and to increase response rates so a more comprehensive description of restraint use is available. Also, OMH plans to work with providers to increase accuracy of injury data reported. Currently, the number of injuries is over-reported in the OMH monitoring system where injuries that occur before the restraint are being reported and confounded with injuries that occur during a restraint.

3. Improve ability to observe trends

Our knowledge of restraint practice is dependent upon the amount of time monitoring systems have been in place, with more established systems better able to reflect valid trends. In fact, it is recommended that multiple baselines be established when attempting to measure complex system changes like restraint reduction since it requires a number of factors to be in place before systemic change can occur (e.g., comprehensive implementation of policies, trained data entry staff). OMH and OCFS have the ability to view trends at the state level. The long-term goals outlined by OMRDD also will allow for an ongoing view of practice. A recent statewide survey conducted by SED is a new undertaking and can serve as a baseline for future surveys.

Potential Misuse of Agency-Specific Data

The fields of child welfare, developmental disabilities, education, and mental health frequently use the phrases r*estraint rates* and *restraint-related injury rates* so it can be very easy for state policy makers, providers and advocacy groups to assume the measures are identical across fields. Yet, differences exist due to the roles provided by the respective systems of care. If this information is intended to be used to make sound decisions, what is actually counted and how those counts are used to calculate rates must be carefully reviewed, accurately interpreted and used appropriately.

Although each agency captures similar information on the number of physical restraint occurrences, it would not be meaningful to make comparisons of these aggregate counts across agencies since the agencies vary on factors that influence the number of restraints. For instance, consistent with its federal requirements, OMRDD defines youth as individuals under age 22 while OCFS and OMH typically define youth as individuals under age 18. This means if we 'count' individuals restrained, some agencies may appear to have greater numbers of restraints simply because they serve a wider age range of individuals. Another factor that may be hidden if there is reliance on counts is the scale of the service system. OCFS has a far greater number of service settings and bed capacity for youth than OMH or OMRDD and this too can influence counts.

Restraint *rates* provide greater standardization than counts of restraints; however, these too should not be compared across systems since each agency varies on how rates are calculated. The calculation used by each agency is purposeful and related to the types of decisions made within the systems.

Table 2. presents the types of questions state policy makers are able to answer, based on available data; provides detail of how rates are calculated and highlights caveats to consider when reviewing rates for a particular system.

Table 2. Restraint data and related issues addressed

	OCFS	OMH	OMRDD[6]	SED
Question Addressed with Available Data	What is the proportion of restraints that occurs relative to the size (i.e., total licensed beds) of a residential setting? This can be addressed as a point in time or over a period of time.	What is the proportion of restraints that occur relative to a given number of days a child is in residential placement? This can be addressed as a point in time or over a period of time.	What is the proportion of restraints that occur relative to a given number of days a child is in residential placement? This can be addressed as a point in time or over a period of time.	What is the proportion of restraints that occur relative to the number of children served?
Relevance of Data for Policy & Program Decisions	This information tells us how frequently restraints occur per licensed bed, allowing us to compare the number of restraints across similarly sized residential settings. That is, there are x restraints occurring per every licensed bed.	This information tells us how restraint rates compare across inpatient settings within a given number of days. That is, there are x restraints occurring within every 1,000 inpatient days.	This information tells us how restraint rates compare across settings within a given number of days. That is, there are x restraints occurring within every 1,000 inpatient days.	This information tells us the average number of restraints per child. That is, there are x restraints for every x children in these school settings.
Standardized restraint rate	Total number of physical restraints conducted in a given period of time divided by the total number of licensed beds	Total number of physical restraints conducted in a given period of time divided by the total number of days child is in care	Total number of physical restraints conducted in a given period of time divided by the total number of days child is in care	Total number of physical restraints conducted in a given period of time divided by number of children
Numerator	All physical restraints conducted	All physical restraints conducted	All physical restraints conducted	All physical restraints conducted
Denominator	All possible licensed beds, both occupied and unoccupied.	All the days youth are enrolled, including those days when a child may be home on leave.	All the days youth are enrolled, including those days when a child may be home on leave.	Total number of children served.
Caveats	This rate may appear higher if compared to other agencies since the denominator is fixed, and not dependent on the amount of time children are served in that setting. This rate may be inflated due to the inclusion of restraints occurring in educational settings.	Restraint information is available for state-operated hospitals and state-licensed RTFs. This information is not yet available for Article 28 and Article 31 hospitals with licensed inpatient beds for children.	Data collection methods under development	This calculation is a reflection of the percent of children restrained. It does not take into account that children are more likely to be restrained early in their placements or when they have lengthy placements. To take this into account, SED would have to change the denominator to be number of days in program.

[6] This reflects OMRDD data collection plans. Information will be available once survey is completed.

Concern for safety is the common theme that cuts across all restraint-related data collection practices. This is apparent by the fact that each agency requires providers to collect data, allowing leadership to monitor the frequency of this high-risk intervention and to assess whether current practices are safe for children and staff. This information can be instructive to policy makers and advocates alike; however, it is clear that consumers of these data must have a full understanding of how data are gathered and what is incorporated into these measures to promote a more informed use of data.

3. Behavior Support Standards for Children's Day Treatment Programs

The RCIT Committee, when it was originally convened, focused primarily on behavior support practices in residential and inpatient settings. The committee recognized further work must be done to address behavior support issues related to day treatment programs and Chapter 470 of the Laws of 2008 required the committee to include day treatment in each of the standards presented in the 2007 report. A subcommittee of RCIT Committee members and representatives from children's day treatment programs was convened to address this aspect of committee work.

Behavior supports refer to strategies that provide children and youth with the skills and supports needed to appropriately manage their own behaviors.

Children's day treatment programs pose a particularly difficult challenge for coordinated standards regarding the use of restraint since SED allows for the use of reasonable physical force in all education settings while OMH prohibits the use of restraint in community-based programs, such as day treatment programs. The goal of the subcommittee was to move these agencies toward more common ground by emphasizing standards that (1) promote behavior supports associated with restraint prevention and reduction and (2) increase the guidance provided by agencies to such programs regarding how best to address these program differences. When possible, the subcommittee built on standards outlined in the 2007 report. It is the expectation of the RCIT Committee that the incremental steps taken here will lead to more coordinated, consistent practices between the mental health and education staff at the program level, which, in turn, may serve to drive policies that promote supportive environments where children can make academic gains while learning to address their behavioral challenges. The committee is also clear that this is the first in many steps to resolve this issue.

The RCIT Committee is fully aware that the legislative requirement to coordinate standards could be met with a recommendation to have OMH permit the use of restraint in community-based programs. However, such a recommendation would move New York state decades backwards. It would move practitioners in a direction that contradicts progress made in the field of mental health and would move daily education practice in New York State in a direction that is opposite to that being taken at the national level.[7] Also, this strategy would place focus on the endpoint of behavior support, which is restraint, rather than the starting point, which emphasizes an environmental change that fosters skill development. Due to these serious consequences, a strategy was proposed that took a more comprehensive view of behavior support.

The decision to take a broader view is based on a long-term vision rather than a more expedient short-term one. However, it is an exceedingly difficult decision since staff and administrators responsible for the safety of children in day treatment programs face remarkable challenges each

[7] A 2009 report by the General Accounting Office, *Seclusions and Restraints: Selected Case Studies of Deaths and Abuse at Public and Private Schools and Treatment Centers* underscored the need for alternative practices. Also, the recently proposed federal *Preventing Harmful Restraint and Seclusion Act* calls for the protection of youth in schools that takes into account factors that may be unique to the school environment.

day. The challenges faced by program administrators and staff are real and significant. However, it is also important to be consistent with current research and national trends.

Approach Used

A subset of members from the RCIT Committee and representatives from children's day treatment programs with first-hand knowledge of the daily challenges faced by staff in day treatment programs volunteered to work with Council staff to identify behavior support standards for day treatment programs. This subcommittee met with Council staff and identified critical issues that needed to be addressed in children's day treatment behavior support standards.

Day Treatment Behavior Support Standards Subcommittee Members

- Clyde Comstock, Hillside Family of Agencies
- Claire Crawley, Parsons Child and Family Center
- Kathy Forte, Jewish Board of Family & Children Services
- Kevin King, Onondaga County Day Treatment Program
- Pam Madeiros, Greenberg & Trauring Law Firm
- Michael Norelli, Parsons Child and Family Center
- Stephanie Orlando, Families Together in New York State
- Dennis Richardson, Hillside Family of Agencies

Analysis of Patient Characteristics Data

There is a paucity of research pertaining specifically to day treatment programs and the prevention and reduction of restraint. However, the subcommittee was able to examine children's day treatment programs in New York state by analyzing the OMH Patient Characteristic Survey (PCS). The PCS is conducted every two years and provides a valuable snapshot of individuals served in OMH licensed programs.

The 2007 PCS data were analyzed to identify clinical characteristics of children served in day treatment programs and inpatient settings. These analyses were conducted due to concern that children in day treatment programs were clinically similar to their peers in inpatient settings, with the same behavioral problems and level of functioning. Also, many applications are used to implement day treatment programs[8] and concern was raised that some day treatment settings may be serving children with more serious problems. Due to these concerns, it was important to examine the extent these differences existed since it had implications for any behavior support standards that would be proposed.

Interviews with Children's Day Treatment Staff

Council staff conducted interviews with mental health and education staff at day treatment programs across the state to gather information regarding factors that promote and impede effective behavior support practices in day treatment programs. It was particularly important to speak with mental health and education staff to learn about their daily experiences and to gauge the extent the dual restraint policies influenced their ability to provide behavior supports and assist children. Additionally, many applications are used to implement day treatment programs

[8] A description of the applications is provided in Appendix B.

so it was important to gauge whether the various applications influenced behavior support practices.

Overview of Children's Day Treatment

Children's day treatment programs are integrated mental health and special education programs licensed by OMH with education programs approved by SED. Through these programs, a comprehensive array of mental health and education services are provided within the community to children and adolescents diagnosed with serious emotional disturbances. Professional and paraprofessional clinical and educational staff work together to meet the needs of the children and provide necessary supports until children are able to return to their home school. While academic achievement is a fundamental goal for children served in these programs, mental health needs must be properly addressed in order to effectively achieve academic success. The overarching goals of day treatment programs are to reduce symptoms and improve functioning (e.g., academic and social) while maintaining children in their natural environments by providing ongoing supports to children and their families.

Children enrolled in day treatment programs receive education and related services by the school district where they reside, while mental health services, including family support and skill building services, are provided through OMH funding. Education and mental health services are provided in public schools and BOCES; community and psychiatric hospitals; and approved private schools. Appendix B provides a full description of the applications used to implement day treatment programs.

Children Served in Day Treatment Programs

Data from the OMH Patient Characteristic Survey (PCS) were analyzed to learn more about children served in day treatment programs with respect to how they enter the programs and clinical characteristics that are often used to assess severity of illness and level of functioning. These analyses were conducted due to concerns that some applications of day treatment programs may serve children with more serious emotional disturbances and significant functional impairments than children served in other applications.

Referral Sources to Day Treatment Programs

Most children are referred to day treatment programs through their schools (78.9%) with a small percentage referred by psychiatric inpatient settings (6.7%). This pattern holds for most day treatment settings, with the exception of hospital-based day treatment programs, which have 26.6 percent of their referrals from psychiatric inpatient settings. See Appendix B for more details.

Mental Health Diagnoses

About one in four children served in day treatment programs has a diagnosis of attention deficit disorder (27.5%), with about another two in ten children (17.2%) having a diagnosis of conduct disorder. Nonpsychotic mental disorder and bipolar disorder are the next most frequent diagnoses (13.5% and 13.2% respectively). These are the predominant diagnoses observed when

diagnosis is examined across day treatment applications, with some variation in school-based and intensive day treatment programs. See Appendix B for more details.

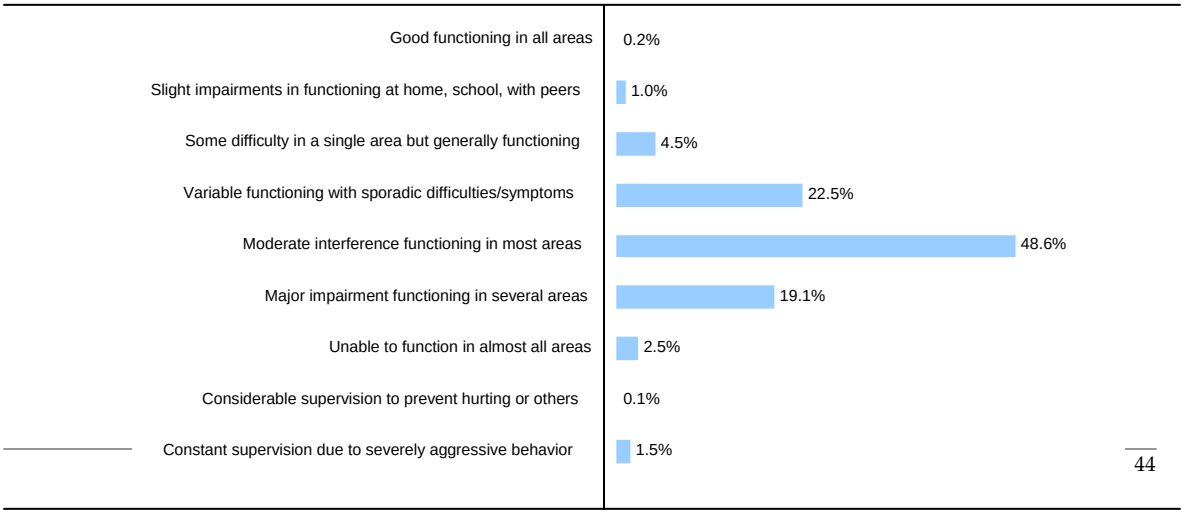
Assessment of Functioning

The Children's Global Assessment Scale (GAS) is a numeric scale (0 through 100) often used by mental health clinicians and physicians to subjectively assess children's level of functioning. The rating takes into account how children deal with daily activities involving home, school and peers. It was important to review level of functioning among children in day treatment programs since day treatment is recognized as one of the highest levels of outpatient care.

Children's Global Assessment Scale
91-100 Superior functioning in all areas (at home, at school, with peers)
81-90 Good functioning in all areas; secure in family, school and peers; transient difficulties
71-80 No more than slight impairment in functioning at home, at school or with peers
61-70 Some difficulty in a single area but generally functioning well
51-60 Variable functioning with sporadic difficulties or symptoms in several but not all areas
41-50 Moderate interference in functioning in most social areas or severe impairment in one area
31-40 Major impairment of functioning in several areas; unable to function in one of these areas
21-30 Unable to function in almost all areas
11-20 Needs considerable supervision to prevent hurting self or others
1-10 Needs constant 24 hour supervision due to severely aggressive or self-destructive behavior

A review of children's GAS scores indicates about one in two children in day treatment programs (48.6%) have a moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area (Figure 1). About two in 100 children (1.6%) have GAS scores that indicate behavior requiring constant or considerable supervision to prevent danger to self or others. These children tend to be diagnosed with a conduct disorder (20.5%), attention deficit disorder (12.8%), or other non psychotic mental disorder (12.8%) and are referred to day treatment programs through their schools (76.9%). Day treatment programs in freestanding or hospital based settings are most likely to serve children with low GAS scores (see Appendix B). *Children in day treatment programs differ substantially from their peers in inpatient settings where 20 in 100 (20.2%) children have GAS scores indicating behavior that may be a danger to self or others.*

Figure 1. Global assessment scale of children in day treatment programs



Factors That Influence Effectiveness of Behavior Supports

Statewide interviews with education and mental health staff were conducted to identify factors that promote and impede effective behavior supports in day treatment programs. Staff interviewed included administrators, educators and clinicians. Some issues have a historical basis and are the result of a shift in service delivery that emphasizes community-based setting over inpatient settings. Other issues pertain to discrepancies in state policies that result in disparate approaches to care while still other issues are practical in nature and are influenced by logistics and resources. Overall, the factors staff identified as necessary for effective behavior support are consistent with previous work and underscore the need for:

- training that helps staff fully integrate education and mental health needs;
- behavior plans that guide interactions with children and provide individualized supports;
- sound leadership at the state and program level;
- clear behavior support policies; and
- access to a full array of behavior supports across all day treatment programs.

Children with complex challenges are able to be served in community settings, increasing the need for consistent policies and training that provide guidance on behavior support techniques.

During interviews with day treatment staff, tenured staff observed that children with complex diagnoses and behavioral challenges are able to receive care in the community through day treatment programs. Staff noted when children with severe GAS scores are referred to day treatment programs, providers are faced with the decision to refuse admission or admit a child with significant behavior challenges. The former decision leaves providers open to criticism of only admitting children with mental health concerns that do not manifest in aggressive or self-injurious behaviors, while the latter decision leaves providers vulnerable to accepting children who may be at risk of restraint to address emergency situations.

Staff interviewed recommended a number of changes that would allow them to address challenges they encounter and their recommendations were consistent with best practices grounded in research. Most recommendations emphasized prevention practices that offset problems before they occur.

Staff Training Addresses an Array of Behavioral Challenges

As PCS data indicate, children's level of functioning varies considerably and staff should have access to training that provides guidance on the full range of techniques that could be used to redirect children during particularly challenging instances. Such training would offer staff assistance in the type of contact that would be permitted in the rare instance a child may not be in the appropriate setting or may have considerable difficulty functioning in the program. The training could be organized in a way that details the continuum of responses to be used.

Many education staff interviewed noted they receive TCI training while mental health staff identified PMCS as the primary training program. Staff recognized coordinated training could

also promote a more coordinated approach to behavior support. Additionally, staff requested to have ongoing opportunities to meet and learn from other day treatment staff across the state.

Behavior Support Plans Are Continuously Updated

Staff described the value of behavior support plans and recognized that staff may not refer to these plans as often as needed. An educator explained how staff who made frequent revisions, as indicated by changes in children's behavior, were more successful in offsetting behavioral problems that could have escalated to more challenging circumstances. This underscores the importance and benefit of developing and organizing education and mental health plans jointly.

It was also noted that family members are essential partners in the development of behavior management/calming plans since behavior supports used consistently between school and home help children develop and replicate coping skills that contribute to their success in the community.

Different state agency policies regarding the use of restraint coupled with various applications of day treatment can influence access to mental health services and behavior support alternatives.

OMH prohibits the use of restraint while SED allows for its use in emergency situations. At times, this has resulted in mental health and education staff having different approaches to behavior support. In an effort to find program solutions to the conflicting policies, some education staff noted they no longer consider restraint to be an option to crisis intervention due to OMH requirements. An unintended yet favorable consequence of the highly restrictive, trauma-informed conditions set by OMH is that education staff also raised standards and have sought alternatives to restraint. On the other hand, education staff described instances when children with aggressive behaviors who needed mental health services were not referred to day treatment programs due to concerns that staff would not be able to restrain the child. The consequence for this may be children do not receive the appropriate services they need.

The different policies of state licensing agencies present considerable challenges for staff and, as noted earlier, incremental steps that can bring these two agencies closer together are critical. Staff who deal with this issue on a daily basis identified three major areas that could bridge the current divide: clear program expectations; greater consistency in the extent mental health and education services are integrated across the various applications of day treatment programs; and access to resources that offer staff genuine options for effective behavior supports.

Sound Leadership to Establish and Continually Reinforce Program Expectations

Staff interviewed described instances when sound leadership benefited children and staff. As an example, BOCES administrators recounted times when general education administrators were critical of the aggressive behavior demonstrated by children in day treatment programs and expected day treatment staff to automatically use restraint, without first attempting primary prevention or de-escalation strategies. Additionally, it was noted that general education teachers expressed concern about their safety and felt uncomfortable having day treatment programs located in the school. BOCES administrators exercised sound leadership by continually

reminding their general education colleagues about the types of behavior supports that are most appropriate for children in day treatment programs.

It was also suggested that brief training sessions be made available to general education staff to help them feel less threatened and help them understand the appropriate steps that should be taken when children begin to display aggressive behavior.

Increase Integration of Education and Mental Health Services

Clearly, children benefit when the approach to behavior support is consistent, underscoring the need for education and mental health staff to utilize similar strategies in their work with children. Staff noted the level of integration tends to vary by how day treatment programs are implemented. Some programs have education and mental health staff working side by side, located within the same classroom or nearby. Other programs use separate rooms that may be located in different parts of a building. Staff noted their proximity to colleagues increases the likelihood they coordinate activities and learn from one another, modeling their own behavior by what is most effective. Staff also identified other activities that increased coordination, including cross-discipline training by peers and interdisciplinary 'grand rounds' meetings.

Resources that Promote Use of Effective Behavior Supports

Education and mental health staff alike noted the importance of using the environment to create a soothing space for children. Options, however, are often limited by staff and spacing. They noted that limited space influences the types of behavior support options they can make available to the children they serve. For example, staff recognized the benefit of having calming areas where children could go when experiencing behavioral challenges. Staff also described instances when they would like to offer children the opportunity to take a walk to 'chill out' but this simple but direct approach to de-escalating behavior is not a viable option due to a lack of staff and space.

Education staff repeatedly cited the knowledge and support they gained by having behavioral consultants available to them. This is especially helpful when mental health and education staff are not located nearby. Staff credited behavior consultants with helping them become more aware of how their own behaviors influence children as well as how to create environments that support their students.

Comfort Rooms: A Preventative Tool Used to Reduce the Use of Restraint and Seclusion in Facilities that Serve Individuals with Mental Illness provides suggestions of ways to promote a therapeutic, trauma-informed culture of healing and recovery in inpatient settings, while significantly reducing the use of restraint and seclusion. A copy of the document is available online at:

http://www.omh.state.ny.us/omhweb/resources/publications/comfort_room/comfort_rooms.pdf

Staff comments were not limited to behavior support within the classroom. In fact, staff highlighted the importance of helping youth practice behavior management skills outside the day treatment setting. This observation is consistent with findings from a recent report developed by *Youth Empowerment* that underscored the dual benefits realized from youth participation in such activities as scouts, student councils, field trips and summer youth employment programs. These experiences allow children to practice behavior management skills in less protected environments while also offering them the ability to have similar experiences as their peers who are not in day treatment programs.

Standards for Behavior Supports

In light of current research on trauma informed care and national trends to prevent and reduce the use of restraints, the following standards are recommended for day treatment programs.

Staff trained in a recognized, competency-based program

The clinical profile of youth in day treatment programs presented earlier in this report brings attention to the fact that day treatment staff work with children who may have considerable variations in their level of functioning. Therefore, training offered should include guidance on directive techniques that can be used by staff, organized on a continuum of responses ranging from prevention through de-escalation of crisis situations. Furthermore, it is recognized that due to the need for an integrated approach across education and mental health staff, the training provided to the respective day treatment staff should promote a common approach to behavior supports that is adopted by OMH and SED.

This standard, which was also noted in the 2007 report, is central to effective behavior support.

Use of individual behavior support plans

Use of an individualized behavior support or calming plan, also identified in the 2007 report, is a valuable tool for children as well as all individuals who interact with the children. The degree to which a plan is child-specific is influenced by the individuals who participate in the development of the plan and should include participants who know the child best, including parents or guardians and the children themselves. It is particularly helpful if parents are well-versed in the plan content and able to use the behavior support techniques described in the plan so they are equipped to support their child at home. Staff interviewed made the observation that children tended to benefit when the plans were revised on an ongoing basis. Furthermore, as noted in the 2007 report, these plans should build on FBAs, which provide a thorough understanding of each child's behavior.

Clear behavior support policies jointly developed by OMH and SED

It was noted that practice guidelines are needed that detail:

- behavior support practices that may be used by the provider;
- the circumstances under which they may be used; and
- how the practices will be clinically reviewed.

Guidance on directive techniques that can be used by staff, organized on a continuum of responses ranging from prevention through de-escalation of crisis situations would be particularly helpful as well as the level and degree of touch. Furthermore, information should include what practices will be documented and how they will be reported to the respective licensing agencies. This would take into account monitoring of incidents. Developed jointly by OMH and SED, this document could underscore a common philosophical approach to behavior support and promote a more integrated, consistent approach to behavior support, especially across the various applications of day treatment programs.

Use of a wide range of behavior supports to assist children and staff

This standard underscores the benefit realized when staff have genuine behavior support options available to them, especially options that promote prevention. Staff described how program location, the physical layout and staffing can influence their ability to develop environments that provide children with effective supports. Additionally, education staff indicated access to behavioral consultants was significantly instrumental in their ability to address student needs.

4. Other child-serving programs that authorize the use of restraint

Chapter 470 of the Laws of 2008 required the RCIT Committee to review the coordinated standards outlined in the 2007 report for all other child serving programs that authorize the use of restraint. Therefore, each agency was asked to identify the remaining programs that would be addressed through this expanded legislation. OCFS and SED were the only two agencies that had additional programs not included in the previous legislation.

OCFS

Previous RCIT Committee legislation addressed most OCFS licensed programs that authorize the use of restraint, with the exception being state-operated juvenile justice facilities. The statutory authority for these facilities is based in Executive Law article 19-G, Sections 500 and 501. Restraint-related regulations outlined in 9 NYCRR 168.3 and OCFS policy (PPM 3247.13) describe specific circumstances under which staff may physically control youth. The policy specifies training requirements, safety precautions and post restraint procedures that must be following after the use of a physical restraint.

OCFS is reviewing the extent to which statute, regulations and policy are consistent with the standards outlined in the 2007 report and have taken steps to promote alignment of policies and practice within the juvenile justice setting as well as increase alignment with other OCFS settings that authorize restraint. To date, much work has emphasized the important role facility leadership plays in restraint reduction. Additionally, data gathered through ARTS are reviewed to observe restraint use at each facility. Steps to fully implement standards outlined in the 2007 report are being taken in conjunction with OCFS corrective actions underway to address concerns outlined in the US Department of Justice report (August, 2009).

SED

SED regulations related to "reasonable physical force" pertain to all programs for which SED has oversight authority (8 NYCRR §19.5). Additionally, SED has emergency intervention regulations that are specific to students with disabilities (8 NYCRR §200.22). SED is reviewing these regulations to determine how best to provide greater clarity regarding their interpretation. Once this is completed, the Council will review materials developed for the education field to determine the extent they are consistent with the standards outlined in the 2007 and current reports.

5. Recommendations

Continue work begun to implement standards in settings that authorize restraint

The actions needed to implement the standards outlined in the 2007 report are underway, with each agency assuming responsibility for modifications required within a particular agency. These actions include changes to regulations and statute amendments; modifications and expansion of training programs; and development or expansion of data collection strategies that provide data up to the state level regarding the use of restraints and restraint related injuries. The RCIT Committee acknowledges the work begun and recommends agencies continue efforts until all standards are fully implemented. Of particular importance is the following future work:

Continue efforts to establish a common set of conditions across agencies for the use of restraint
This standard is at the heart of the RCIT Committee and addresses disparities in practices across agencies. The RCIT Committee will continue to monitor the work agencies have in place to modify regulations and statute as well as monitor actions that may be taken by SED to provide greater clarity to providers with respect to SED regulations.

Continue efforts to address use of a common restraint technique at multiple licensed, co-located sites
Staff concerns regarding the appropriate technique to use at multiple licensed sites was a driving force for the original legislation and quickly following the release of the 2007 report, OCFS partnered with OMH, OMRDD and providers to begin implementing the standard that would alleviate this problem. Although additional resources needed to fully implement this standard are not available at this time, the RCIT Committee continues to be committed to this standard and recognizes the importance of RCIT Committee members who represent providers, parents and state agencies to work together to identify resources to accomplish the work begun here.

Continue to advance data systems and use information in policy development and program planning
Data logs at the local level are beneficial to the extent that leadership is able to compile and review the logs. This helps inform practice and can have an impact on the local program. While this activity is fundamental for changes at the local level, it is not sufficient. The RCIT Committee recognizes state policy makers should also be aware of the practices implemented locally since state policy makers are charged with oversight responsibilities. Therefore, the RCIT Committee recommends continuing the work begun so each state agency with oversight responsibility has timely access to data about the use of restraint and restraint-related injuries. This information should be reported to the state level on a regular basis.

Implement behavior support standards in children's day treatment programs

When possible, the standards that have been outlined for day treatment programs build on behavior support standards established in the 2007 report. It is expected the standards proposed for children's day treatment programs will provide greater clarity to providers regarding behavior support practices in this setting and will begin to bridge differences between OMH and SED. The RCIT Committee recognizes the disparities between OMH and SED policies are not

fully resolved with these standards and views this as the first in many steps to increase consistency between the two agencies.

Implement behavior support standards in other child serving programs

Chapter 470 of the Laws of 2008 requires the RCIT Committee to review coordinated standards outlined in the 2007 report for all other child serving programs that authorize the use of restraint. Each agency was asked to identify the remaining programs that would be addressed through this expanded legislation. OCFS and SED were the only two agencies that had additional programs not included in the previous legislation. Standards are being implemented within the applicable programs.

APPENDICES

Appendix A

Restraint and Crisis Intervention Technique Committee Legislation

Laws of New York, 2008
Chapter 470

An ACT to amend the social services law, in relation to the responsibilities of the restraint and crisis intervention technique committee

Became a law August 5, 2008, with the approval of the Governor.
Passed by a majority vote, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 483-e of the social services law is amended by adding a new subdivision 4 to read as follows:

4. Future responsibilities. In addition to the duties provided in subdivisions one through three of this section, the committee shall have the following responsibilities:

(a) the committee shall report to the governor and legislature, on or before October thirty-first, two thousand nine, on the progress made to implement the recommendations outlined in the September, two thousand seven report; on aggregate agency-specific data and improvements in agency-specific tracking systems in order to provide evidence of system changes; and shall revise the report to specifically include children's day treatment programs and any other setting serving children that authorizes the use of restraint in each of the findings and recommendations presented in such report; and

(b) the committee shall report to the governor and legislature, no later than October thirty-first, two thousand ten, and each year thereafter, on the progress made to implement the recommendations outlined in the September, two thousand seven report, and any new recommendations made in the two thousand nine report, along with any other outstanding issues and recommendations for implementing uniform and coordinated standards that the committee deems appropriate. The committee shall include in its report the implementation of the coordinated standards by each agency, including but not limited to the revision and coordination of regulations, modifications to training curricula and staffing models, and may include a recommendation as to whether the committee should be continued as it exists, expanded, or discontinued.

Appendix B

The Council wishes to acknowledge the assistance provided by Donna Bradbury and Michael Bigley from the Office of Mental Health in development of this information.

Day Treatment Programs

Data from the OMH Patient Characteristic Survey (PCS) were analyzed to identify clinical characteristics of children served in the various applications of day treatment programs and inpatient settings. These analyses were conducted due to concern that children in the various applications of day treatment may differ clinically, with some day treatment programs serving children with more serious emotional disturbances and functional impairments than other day treatment programs. Furthermore, concern was expressed that children in day treatment programs were clinically similar to their peers in inpatient settings, with the only difference between the groups of children being the location where mental health services were provided. It was important to determine the extent these differences existed since it had implications for any behavior support standards that would be proposed.

Applications Used to Implement Day Treatment Programs

A number of applications are used to implement day treatment programs, with programs tending to vary with respect to the location of education services. The degree that mental health staff are incorporated into the educational setting also varies. For example, some education settings have clinicians within the classroom, working closely with education staff. In other instances clinicians are separated from the classroom and assist children outside the classroom setting. The specific applications of day treatment programs are described below[9]

Day Treatment based in freestanding settings: Day treatment services are provided in a campus-like, stand alone setting within the community. Education and mental health staff tend to be located in close proximity to one another.

Day Treatment based in hospital settings: Day treatment services are provided in a hospital setting. Education and mental health staff tend to be located in close proximity to one another.

Day Treatment based in BOCES or District 75 settings: Day treatment services are provided in self-contained settings, where education services are provided in a classroom located within a BOCES or District 75 building and mental health supports are provided in the same location. Education and mental health staff tend to be located in close proximity to one another.

[9] District 75 is a school district in New York City that provides citywide educational, vocational, and behavior support programs for students who are on the autism spectrum, severely emotionally challenged, and/or multiply disabled. District 75 consists of 56 school organizations, home and hospital instruction, and vision and hearing services. The schools and programs are located at more than 350 sites in the Bronx, Brooklyn, Manhattan, Queens, Staten Island and Syosset.

Day Treatment based in general education school settings: Day treatment services are provided in general education school buildings, where education services are provided in a BOCES or special education classroom in a general education building and mental health supports are provided in the same building but not necessarily in close proximity to the BOCES classroom.

Most children are referred to day treatment programs through the education system. However, variations are observed when referral source is viewed by day treatment location. Specifically, day treatment programs that are based in general education schools, BOCES, District 75 or freestanding settings tend to have a higher percentage of youth referred from schools than day treatment programs located in hospitals (Table 3).

Table 3. Referral sources by day treatment setting

	All Day Tx Programs	Gen'l Education based Day Tx	BOCES/Dist75 based Day Tx	Freestanding Day Tx	Hospital based Day Tx	Intensive Day Tx
Education/school settings	78.7%	83.2%	83.4%	85%	48.9%	59.8%
Inpatient settings	6.5%	2.7%	4.6%	3.3%	26.6%	8.4%
Other	14.8%	14.1%	12%	11.7%	24.5%	31.8%

The most frequently noted diagnosis for children in day treatment is attention deficit disorder. Other commonly used diagnoses are conduct disorder, other nonpsychotic mental disorder and bipolar disorder. The types of diagnoses tend to be similar for day treatment programs based in BOCES, freestanding and settings, yet the proportion observed varies. Additionally, school-based and hospital-based programs differ in type of diagnoses (Table 4).

Table 4. Most frequent diagnostic categories by day treatment setting

All Day Tx Programs	Gen'l Education based Day Tx	BOCES/Dist75 based Day Tx	Freestanding Day Tx	Hospital based Day Tx	Intensive Day Tx
Attention deficit disorder (27.5%)	Attention deficit disorder (32.6%)	Attention deficit disorder (24.3%)	Attention deficit disorder (25.3%)	Attention deficit disorder (31.9%)	Other nonpsychotic mental disorder (31.8%)
Conduct disorder (17.2%)	Anxiety disorder (12.8%)	Bipolar disorder (17.8%)	Conduct disorder (25.3%)	Other nonpsychotic mental disorder (22.0%)	Attention deficit disorder (20.6%)
Other nonpsychotic mental disorder (13.5%)	Conduct disorder 11.7%)	Other nonpsychotic mental disorder (15.0%)	Bipolar disorder (12.2%)	Bipolar disorder (12.1%)	Bipolar disorder (13.1%)
Bipolar disorder (13.2%)	Bipolar disorder (11.5%)	Conduct disorder (14.4%)	Other nonpsychotic mental disorder (10.6%)	Conduct disorder (10.2%)	Major depressive disorder (12.1%)

Table 5 provides information regarding level of functioning by day treatment setting.

Table 5. Global assessment scale scores by children's day treatment setting

	All Day Tx Programs	Gen'l Ed based Day Tx	BOCES/Dist75 based Day Tx	Freestanding Day Tx	Hospital-based Day Tx	Intensive Day Tx
Constant supervision due to severely aggressive behavior	1.5%	0%	0.4%	2.8%	3%	0%
Considerable supervision to prevent hurting self or others	0.1%	0%	0.2%	0.2%	0%	0%
Unable to function in almost all areas	2.5%	4.3%	2.0%	1.7%	3%	0.9%
Major impairment of functioning in several areas	19.1%	15.5%	17.6%	24.4%	18%	5.6%
Moderate interference functioning in most areas	48.6%	40.7%	61.1%	46.7%	53%	45.8%
Variable functioning with sporadic difficulties/symptoms	22.5%	28.1%	17.4%	19.9%	20%	35.5%
Some difficulty in a single area but generally functioning	4.5%	7.3%	1.2%	3.9%	2%	12.1%
Slight impairments in functioning	1.0%	3.2%	0%	0.4%	0%	0%
Good functioning in all areas	0.2%	0.8%	0%	0%	0%	0%

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