NASP 2017

EXAMINING SAFETY PROCEDURES IN CRISIS INTERVENTION TRAINING PROGRAMS

Elisabeth Kane, M.A. *University of Nebraska-Lincoln*
Brenda Scheuermann, Ph.D. *Texas State University*

Goals of this presentation-

- Review ethical considerations regarding restraint and seclusion in schools
- Provide overview of safety components of crisis intervention training programs

Policy Update

- Strong advocacy continues
- Federal legislation to regulate restraint and seclusion has been proposed since 2009; no proposed legislation has been enacted.
- State level activity
- ESSA: Each State plan shall describe-

  "(1)...(C) how the State educational agency will support local educational agencies receiving assistance under this part to improve school conditions for student learning, including through reducing '(iii) the use of **aversive behavioral interventions** that compromise student health and safety;" p. 41-42 of pdf

Study of Training Programs

- Identify safety concerns addressed in Crisis Intervention Training
- Highlight major similarities & differences across training programs
- Identify themes and consistencies across training
- Aid consumers on purchasing decisions

Download the results here:

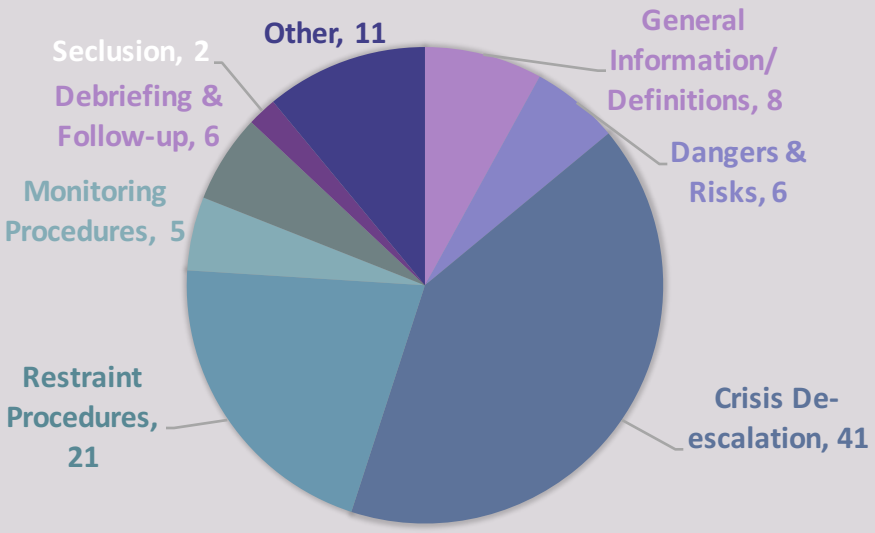
http://k12engagement.unl.edu/study-crisis-intervention-training-programs

17 Crisis Intervention Training Programs
Calm Every Storm, Crisis Intervention Training
Management of Aggressive Behavior (MOAB®)
Nonviolent Crisis Intervention® Program
Oregon Intervention System (OIS)
PMT
Pro-ACT®
Professional Crisis Management (PCM)
Response
RIGHT RESPONSE
Safe and Positive Approaches®
Safe Crisis Management® (SCM)
Safe Prevention Principle and Techniques
Safety-Care™
Satori Alternatives to Managing Aggression (SAMA)
The Mandt System®
Therapeutic Aggression Control Techniques (TACT2)
Therapeutic Crisis Intervention (TCI)

Key Training Components

- General information and definitions
- Dangers and Risks
- Crisis De-escalation procedures
- Restraint procedures
- Procedures for monitoring
- Debriefing and follow up
- Seclusion
- Other topic areas

Average Allocation Across Training Programs



KEY TOPICS

- Safety & Ethical Concerns
- Case Examples
- Safety Topics

Safety & Ethical Concerns

1. Potential for death or injury
2. Repeated use and the failure of programming
3. Disproportionate use with certain groups
4. Problems with implementation fidelity, training, monitoring, and supervision

(Scheuermann, Peterson, Ryan, & Billingsley, 2015; Scheuermann, Ryan, Peterson, & Billingsley, 2014)

THE TRIBUNE, AMES, IOWA SATURDAY, JUNE 12, 2004, PAGE B6

Boy's parents seek ban on restraining children

Mason City child died when treatment center workers allegedly held boy face down on the floor

By MEGANN S. WHITE
Associated Press

DES MOINES — The parents of an 11-year-old boy who died while in residential care in northern Iowa want laws to ban workers from using prone restraints on children.

The technique involves putting a child on his or her stomach and applying physical pressure to immobilize the individual. Critics say it can impede the child's ability to breathe and exacerbate existing problems that could put the child at risk.

Tanner Wilson, who had autism, died Feb. 9, 2001, at Gerard Treatment Center of Iowa, where he was sent when "his anxiety and aggression got the best of him," said his mother, Karen Wilson. Workers allegedly were holding Tanner face down on the floor in what they described as a "routine physical holding" when he stopped breathing.

Karen Wilson

Workers allegedly were holding Tanner face down on the floor in what they described as a "routine physical holding" when he stopped breathing.

"What I would like to see is Tanner's Law' be passed to ban the use of lethal prone restraints ... on children," Karen Wilson said.

Under current law, children can be subjected to mechanical restraints, such as a straitjacket, or physical force, said Laurel Stine, director of federal relations with the Bazelon Center for Mental Health Law, a Washington, D.C.-based advocacy group for people with mental disabilities.

"For years, kids with psychiatric disorders have been most at risk, more so than adults ... and there have been numerous deaths and serious injuries related to its use," Stine said.

Curt Decker, executive director of the National Association of Protection and Advocacy Systems, said it's difficult to track how often restraints are used on children.

"It's hard to tell because it's not something that people will tell you about," he said. "Often, you find out about it after someone has been injured."

Tanner had Asperger's Syndrome, a high-functioning autism characterized by social isolation and repetitive behavior. He moved to Gerard of Iowa when he was 10 and made progress, Karen Wilson said.

She and her husband, Robert, hoped their only child would be ready to come home in May 2001.

Then something went wrong.

"Tanner didn't have to die that day," Karen Wilson said.

Since Tanner's death, the Wilsons have been telling their son's story, advocating for a ban on the use of prone restraint.

"What I'm trying to do now is make a positive impact out of this whole tragedy that this never has to happen to another family again," she said. "There should be another way to try take care of these children without risking their lives."

Gerard of Iowa continues to restrain children, said Jim D'Angelo, president and CEO of Nexus, the parent company.

"We continue to comply with all licensing and federal requirements regarding physical restraints," he said in a statement. He declined further comment.

In 2001, new restraint standards took effect at federally funded psychiatric residential facilities for children:

- Restraint and seclusion may be used only to ensure the safety of the resident or others during an emergency situation.
- Restraint or seclusion may be ordered only by a physician or other licensed practitioner. There also is a time limit — up to 4 hours for youths 18 to 21, 2 hours for those 9 to 17 and 1 hour for those under 9.
- A doctor or licensed practitioner must see the patient no more than 1 hour after the restraint or seclusion is initiated.

"There's been some regulation ... but we find people are ignoring them or disregarding them," Decker said.

"Tanner Wilson was an example, unfortunately, of what's happening around the country. In the name of treating him and restraining him, they killed him."

Curt Decker,
executive director of the National Association of Protection and Advocacy Systems

IOWA Des Moines Register Sunday, July 11, 2004 Page 5B

Parents ask why runaway who died wasn't stopped

ASSOCIATED PRESS

Cedar Rapids, Ia. — A 15-year-old boy who died after falling into the Cedar River in May should have been restrained because he posed a danger to himself, his parents said.

Russell Jankowski had run away from Tanager Place — the private home for children with social or psychological problems that housed him — several times in the weeks before his death.

He ran away for the last time on May 29. His body was found a week later in the Cedar River. Police believe he jumped from a Cedar Rapids bridge.

Russell's parents, Richard and Carol Menadue of Dubuque, question why Tanager Place staff didn't stop him.

Police records show Russell was a threat to himself and others before he left, and should have been restrained, Richard Menadue said.

Tanager Place staff use physical restraints only in emergencies "that endanger the physical safety of the resident or others," said George Estle, chief executive officer of Tanager.

A report indicated that Russell became upset after a confrontation with another person and left his cottage. Staff members followed him out but he tried to hit, kick and throw things at them when they tried to return him to the home.

Menadue said the staff members should have restrained the boy because his violence indicated he was a danger.

Estle declined to comment on the Jankowski case specifically. He said every case is different, and it comes down to a judgment call.

"It depends on the situation," Estle said. "Some kids you might be better off to avoid an escalation."

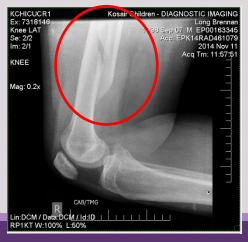
He explained that if staff intervenes with some children, somebody could get hurt.

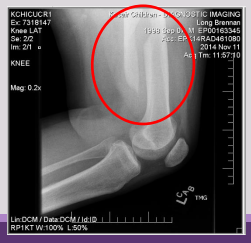
A lawsuit has been filed against the home by Iowa Protection and Advocacy Services Inc., an agency that looks out for the rights of mentally disabled people.

According to the lawsuit, Tanager Place officials have refused to let Iowa Protection and Advocacy investigators interview Russell's roommates and other residents.

Case Example: Brennan

- 16 years old, with autism, attended special school
- Restrained by aide
- Both femurs broken
- 8 days in ICU, surgery, complications





Case Example: Angellika

"Clinic, staff convicted of abuse…in restraint death" (WI)

- 7 years old, with RAD, mood disorder, and ADHD at day treatment center
- Gargling her milk…seclusion…fell asleep…noncompliance…restraint
- Held facedown on floor for several minutes
- Death due to "complications from chest compression asphyxiation"

Case Example: Cedric

"Autopsy: restraint killed student at Killeen school"

- Autopsy: 14-year old perished from excessive pressure to chest
  - Student: 4' 11", 129 pounds
  - History of abuse, neglect and starvation
  - Restrained for trying to leave classroom to go to lunch – became agitated
  - Restrained by teacher and male aide
- Despite his pleas, "I can't breathe," the restraint continued
- Death ruled a homicide

Associated Press, 2002; : http://www.texnews.com/1998/2002/texas/kill0325.html

Safety topics addressed in review:

- Defining clear and imminent danger
- Monitoring for danger
- Emphasis on crisis de-escalation
- Use of seclusion
- Safety of physical restraint procedures
- Training Delivery

Defining Clear and Imminent Danger

Clear & Imminent Danger

- Common consensus: physical restraint procedures are only warranted in cases of clear and imminent danger
- Risk of not intervening outweighs risk of using a restraint
- Accurately interpreting escalating student behavior requires extensive experience and background knowledge (Scheuermann, Peterson, Ryan, & Billingsley, 2015).
- Issues arise when these procedures are used for other circumstances (e.g., compliance)

What is "clear and imminent danger"?

Kentucky:

"The student's behavior poses an imminent danger of physical harm to self or others . . . [and] less restrictive behavioral interventions have been ineffective in stopping the imminent danger of physical harm to self or others, except in the case of a clearly unavoidable emergency situation posing imminent danger of physical harm to self or others".

What is "clear and imminent danger"?

Crisis Intervention Training Program Definitions

"a person: has the ability to injure seriously, shows an intent to injure seriously and immediately, and the threat or attempt would create a need for immediate, professional, medical attention" **(PRO-ACT)**

"It is when people are no longer able to maintain self-control due to a perception that they are unable to cope with the demands presented." **(RIGHT RESPONSE)**

"'Immediately Dangerous' situations are those which 'put self or others at risk of imminent and serious harm, and verbal instructions have failed" **(TACT 2)**

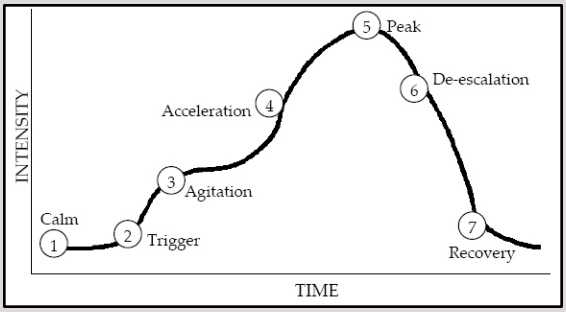
"Acute physical behavior that is likely to result in injury" **(TCI)**

"An immediate threat of harm exists when [it is] 'not separated in time, acting or happening at once, next in order.' (Harper, 2010) The words that characterize such situations are "severe" and "out of control. " **(MANDT)**

Emphasis on Crisis De-escalation

When to Intervene?

- Prevention is key
- Time to intervene is when things are going well
- Recognize early signs of agitation
- Identify and manage antecedents/contributing factors
- Anticipate triggers
- Verbally de-escalate students



"No policy violated when boy was pepper sprayed, cops say"

- 8-year-old, 82-pound boy pepper sprayed by police
- Boy had gotten into trouble on bus
- When he got into the classroom, he began yelling and threatening to kill teacher and another staff member
- Staff members were so afraid that they barricaded themselves into an office as boy escalated
- Teachers had "special training to prevent or de-escalate bad behavior"

Mitchell, 2011: The Denver Post

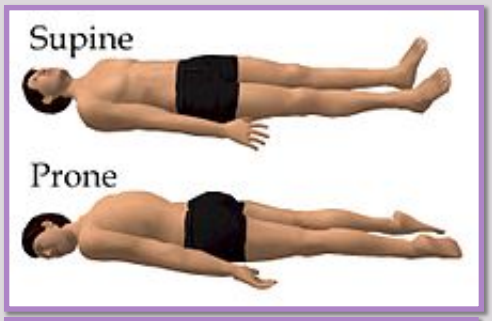
Crisis De-escalation in Training

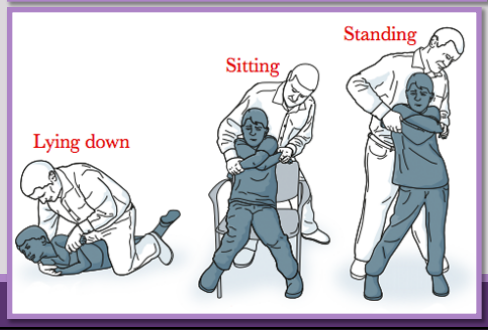
- Emphasis of most Crisis Intervention Training
  - Moving away from "Restraint Training"
- 2/3 of the programs spend the most time on crisis de-escalation, average 41% (range = 20 – 58%)
- All programs train:
  - identifying and managing antecedents to crisis situations;
  - recognizing triggers or signs of agitation;
  - strategies for prevention and early identification of pending crises;
  - verbal or other non-physical de-escalation techniques

Safety of Physical Restraint Procedures

Types of Restraint Procedures

- Supine restraints
- Prone restraints
- Basket hold restraints
- Physical escorts





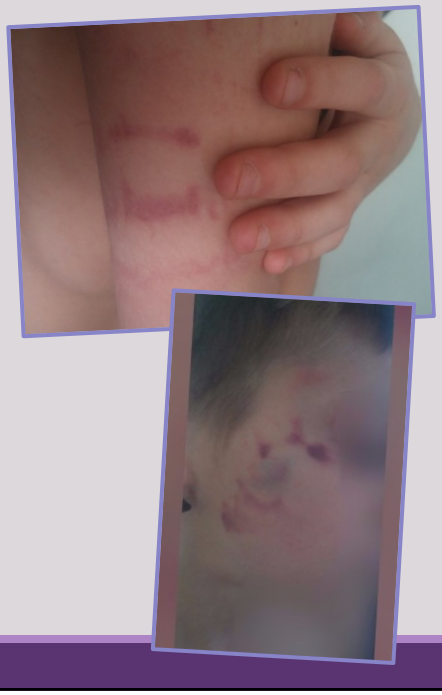
Dangers & Risks:

- Physical Danger & Harm
- Psychological Harm

Risk for both students and staff involved

Physical Harm

- "Hundreds of cases of alleged abuse and death", but difficulty to verify exact number (GAO, 2009, p. 2)
- Estimated that between 8 and 10 children in the United States die each year due to restraint (The Child Welfare League of America, 2002)
- Majority of fatalities due to positional asphyxia, aspiration, or blunt trauma to the chest (Mohr et al., 2003)



Risks Associated with Restraint

Positional Asphyxia
Predisposed when in prone (face down) position

Aspiration
Predisposed when in supine (face up) position

Blunt Trauma to the Chest
Cardiac arrhythmia leading to sudden death

Catecholamine Rush
Result of escalating agitation producing heart rhythm disturbances

Rhabdomylosis
Break down in muscle cells due to strenuous exertion.

Psychotropic Medications
Neuroleptics increase risk of sudden death (2.39 times)

Antidepressants increase QT interval associated with Sudden Death

Many medications inhibit body's cooling mechanisms

Thrombosis
Fatal pulmonary embolism due to being immobile for long periods of time

Physical Injury

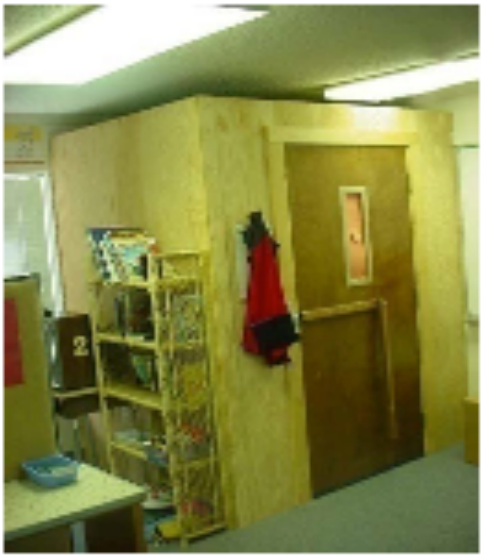
(Mohr, Petti & Mohr, 2003)

Psychological Harm & Trauma

- Physical restraints can results in severe emotional distress and trauma
- Can be particularly harmful for students who have experienced sexual or physical abuse
- **Re-traumatization** can occur when a student who has a history of trauma is restrained, or vicariously traumatized by watching a restraint- can be as damaging if not more damaging than the initial trauma (Dallam 2010, SAMHSA 2014).

Georgia:

•13-year-old Georgia boy hanged himself while secluded in a concrete-walled, locked room. He had previously pleaded not to be locked in the room. He had also previously threatened suicide in school.

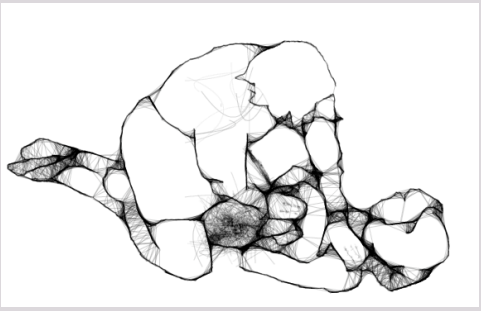


Classroom seclusion room, Kansas

Physical Restraint Procedures

Increased Risk

- Prone (face-down) and supine (face-up) restraints are widely considered to be the riskiest due to potential for suffocation
- Basket holds have increased risk of compressing the airway of young children (U.S. Government Accountability Office, 2009; Peterson et al., 2003)



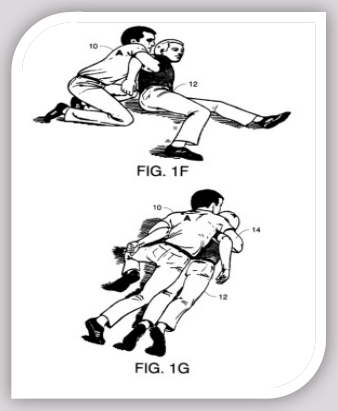
***Due to heightened risk, it takes time & continuous practice to teach physical holds adequately.**

Types of Restraint Procedures

- Specific Types of holds:
  - 4 of the 17 programs trained **basket holds** (23.5%)
  - 8 of the 17 programs trained **prone restraints** (47%)
  - 9 of the 17 programs trained **supine holds** (53%)
  - 15 of the 17 programs trained **transportation or escorts**, and consider it restraint (88%)

*These images are for illustration. They may or may not represent good practice. Most programs which continue to use types of prone or supine restraints have adjusted them to increase their safety.

Training Restraint Procedures



- The % of overall time allocated to training on holds ranged from 8% to 50%
- Average time spent on restraint was 21%
- The number of different types of holds trained ranged from 2 to 27
- All indicate that they should only be used as a last resort intervention

Monitoring for Danger

Monitoring Equipment & Indicators

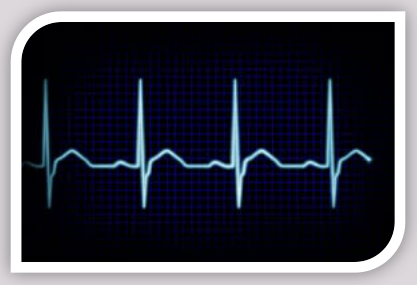
No programs require special equipment for monitoring

- Recommend the use of:
  - Pulse oximeters (n = 1)
  - Automatic defibrillators (n = 2)
  - Counting of respirations (n = 6)
  - Monitor Pulse (n = 5)

Visual and auditory monitoring of breathing/respirations, circulation, eye contact, verbal responses, movement, complexion, blue around fingernails, difficulty breathing, pupils dilated, limp muscles or cold clammy skin, rapid shallow breathing, panting, or grunting

Failure to Monitor

- Cedric (Killeen, Texas)
  - "I can't breathe"
- Girl, 8 years old, refused to finish assignment
  - Sent to time-out room
  - Spent 3 hours in time-out (Crumb, October 2008)



Monitoring Time Limits

- Time limits are crucial to minimize safety
- Only use as long as danger is "clear and imminent"
- 12 programs teach time limits for restraint procedures
- 3 programs have a *required* time limit

Use of Seclusion

Lack of Training Regarding Seclusion

- Only 4 programs train safety guidelines and room specifications regarding seclusion
- Not an emphasis in training
- Lack of training could lead to instances of harm

Please refer to **CCBD Position Paper** for more recommendations regarding seclusion **

Documentation

Documentation

- Proper & timely documentation should occur after every physical hold
- Critical for oversight and accountability
- Should be used to analyze patterns of use and improve preventative practices
- Should be utilized for more than a procedural check mark

Training Delivery

Training & Certification

- Length of training varies based on level of certification
- Trainer-of-Trainer implementation fidelity
- Ensure staff have up to date certification & proficient skills
- Physical skills should be practiced and supervised frequently
- Ask for more training!

Conclusions

- These procedures do not lead to behavior change, and carry safety risks
- Prevention is key! Crisis de-escalation and positive behavior supports should be an emphasis of training
- Develop clear understanding of how to intervene throughout crisis cycle
- Restraint & Seclusion should only be in cases of clear and imminent danger
- Movement away from more extreme holds or ones that have caused most danger (e.g. floor holds)
- Adequate physical training crucial to minimize risk of harm
- Appropriate and constant use of monitoring to identify distress
- Use incident documentation to improve current practices
- Re-certification and practice should occur as frequently as possible

Questions?

Research Collaborators

- Elisabeth Kane
  University of Nebraska-Lincoln
  elisabethjkane@gmail.com
- Brenda Scheuermann, Ph.D.
  Texas State University
  Brenda@txstate.edu
- Reece L. Peterson, Ph.D.
  University of Nebraska-Lincoln
- Michael Couvillon, Ph.D.
  Drake University
- Joseph M. Ryan, Ph.D.
  Clemson University

- http://k12engagement.unl.edu/study-crisis-intervention-training-programs

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Individual Vendor Training Program Allocation of Time for Components (Pie Charts)

Note: Pie charts of all of the vendor training programs are provided in the handout to illustrate variations in time allocations across all eight topics.

All and additional materials are available at:

http://k12engagement.unl.edu/study-crisis-intervention-training-programs

Resources

Child Welfare League of America. (2002). *Behavioral management and children in residential care.* Downloaded from http://66.227.70.18/advocacy/secresfactsheet.htm

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